pb

policy brief

FAMILIES AT RISK:

THE IMPACT OF PREMIUMS ON CHILDREN AND PARENTS IN HUSKY A

SUMMARY OF FINDINGS

The state of Connecticut is planning to impose premiums on families with monthly incomes ranging from $636 to $2,353 who are receiving health coverage through HUSKY A, the state's Medicaid program. These are families of three with incomes between 50 percent and 185 percent of the federal poverty level (FPL). While premiums may be appropriate at some income levels, it is clear from the experiences of other states that imposing this burden on families with very low incomes causes many of them to lose health coverage or avoid signing up for coverage altogether.

More than 86,000 people in Connecticut can be expected to lose coverage as a result of the planned imposition of premiums.

In short, the higher the premium relative to a family's income, the greater the likelihood the family will lose coverage. No state in the country has charged premiums to children at these low-income levels.

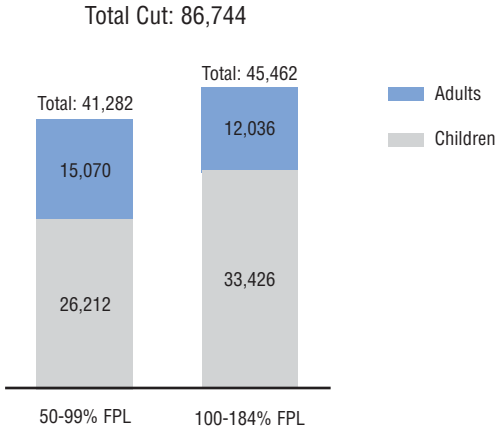
Connecticut Health Foundation

THE ANTHEM FOUNDATION OF CONNECTICUT, INC.

Applying a model developed by researchers at the Urban Institute to Connecticut data shows that more than 86,000 people in Connecticut can be expected to lose coverage as a result of the planned imposition of premiums. Over two-thirds – 69 percent – would be children.

Figure 1

Over 86,000 Children and Parents Could Lose Coverage if Premiums are Adopted



Source: Georgetown University Health Policy Institute Analysis.

The expected impact of premiums on HUSKY A enrollment is as follows:

- Enrollment can be expected to decline by a total of 86,744 adults and children. Of those who could lose coverage, 59,638 – approximately 69 percent – would be children. The remaining 27,106 are parents or pregnant women.[1]
- Of these adults who can be expected to lose coverage, 1,006 are pregnant women.
- Just under half of those who can be expected to lose coverage would be children and parents whose incomes fall below the poverty level – 26,212 children and 15,070 adults – a total of 41,282 people with monthly family incomes ranging from $604 to $1,196.
- The remaining 33,426 children and 12,036 adults who can be expected to lose coverage come from families whose incomes range from 100 percent to 184 percent of the poverty line.

INTRODUCTION

In August 2003, the Connecticut General Assembly passed the state's budget for fiscal years 2004 and 2005.[2] The "budget implementer" directs the Department of Social Services (DSS) to make dramatic and unprecedented changes to HUSKY A.

Under the premium proposal:

- All families with incomes at or above 50 percent of the FPL – $636 a month for a family of three – would be assessed premiums.
- Families with incomes between 50 percent and 100 percent of the FPL (between $636 and $1,272 a month) would pay $10 per family member per month, with a $25 family maximum.
- Families with incomes from 100 percent to 185 percent of the FPL (between $1,272 and $2,353 a month) would pay $20 per person, with a $50 family maximum.
- Families who do not pay their premiums for two months would lose coverage.

HOW WILL THESE CHANGES BE IMPLEMENTED?

The Department of Social Services cannot impose premiums without obtaining a federal waiver of Medicaid minimum standards. The Department will request a waiver under section 1115 of the Social Security Act from the Centers for Medicare and Medicaid Services (CMS), the federal agency that oversees the Medicaid program. Before submitting the waiver to CMS, DSS must allow for a 15-day public comment period and submit the proposed waiver and any public comments it receives to the Appropriations and Human Services Committees of the Connecticut General Assembly.[3] While the Committees may advise the Commissioner of Social Services of their approval, denial or modifications of the waiver proposal, the Committees' actions are not binding on the Commissioner.

PREMIUMS AND FAMILY BUDGETS

Most families participating in HUSKY A are earning a living through low-wage jobs.

In August 2003, only 17 percent of adults and children enrolled in HUSKY A were receiving cash assistance.

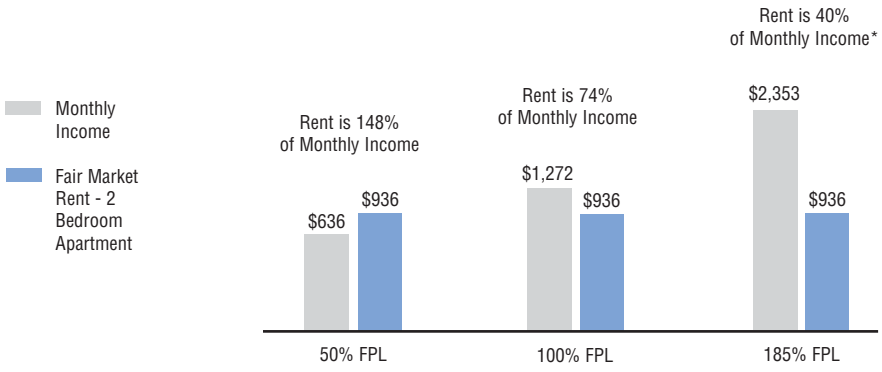
Almost all the families who would be charged premiums have incomes between 50 percent and 185 percent of the FPL – annual incomes ranging from $7,630 to $28,231 for a family of three.[4] With the high cost of living in Connecticut, these families are struggling just to meet their basic needs. For example, the average cost of a two-bedroom apartment in Connecticut is $936 – almost one and a half times the monthly income of the lowest-income families required to pay premiums.[5]

Additional premium costs are especially difficult because, despite strict cost-sharing limits in Medicaid, low-income families are already spending much more of their incomes on health care than higher-income families. Specifically, non-disabled, non-elderly adult Medicaid beneficiaries with incomes below poverty spent an average of 2.3 percent of their incomes on out-of-pocket heath expenses. By comparison, middle-income adults with private insurance spent an average of 0.5 percent.[6]

With the high cost of housing, child care, food and transportation, many HUSKY A families simply will not be able to afford premiums to purchase their health coverage.[7] The result: many are likely to lose coverage and become uninsured.

Figure 2

Average Rents for HUSKY A Families



**Note: Housing is considered affordable if it costs no more than 30 percent of the renter's income.*

Source: Based on Fair Market Rents for 2-Bedroom Apartments from "Out of Reach 2003: America's Housing Wage Climbs" National Low-Income Housing Coalition.

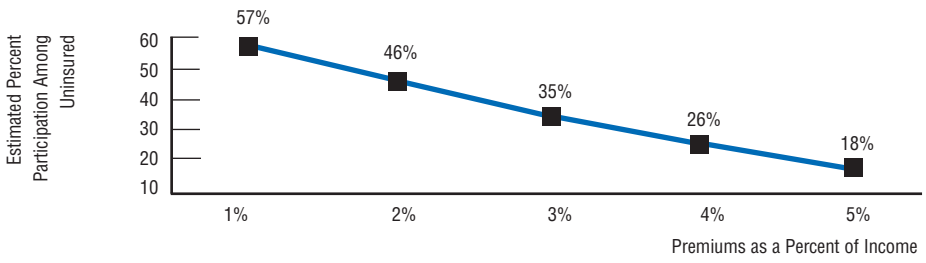
THE IMPACT OF PREMIUMS ON HUSKY A PARTICIPATION

Research findings are clear: charging premiums to low-income families reduces participation in public health insurance programs.[8] A model developed by Urban Institute researchers, based on the experiences of three states that charged premiums to eligible low-income individuals and families, found that the higher the premium the lower the rate of participation. Even a relatively small premium – equivalent to 1 percent of a family's income – reduced enrollment by 16 percent (see figure 3).[9]

Studies of Medicaid and the State Children's Health Insurance Program (SCHIP) programs in Oregon and Florida found that when premiums were imposed, children and families disenrolled at substantially higher rates. In Oregon re-enrollment declined by 38 percent when premiums were imposed.[10] The Florida study also found that imposing premiums in its SCHIP program caused healthier children to disenroll at higher rates – a phenomenon known as "adverse selection." Adverse selection can raise the cost of serving children left in the program.[11]

Figure 3

Health Insurance Participation by the Uninsured, by Premium Levels



Note: Data based on three states – Washington, Hawaii, and Minnesota.

Source: Kaiser Commission on Medicaid and the Uninsured, based on Ku and Coughlin, 1999/2000.

The premiums adopted by the Connecticut legislature require families to pay between 1.7 percent to 3.9 percent of their incomes to enroll in coverage. No other state in the country has charged premiums to children with incomes below the poverty line.[12] Families at the lowest income levels would face the greatest hardship because they would pay the highest amount relative to their income – and they have the least discretionary income. When premiums are adopted, families will be deterred from enrolling their children, or they may drop out of the program because of their inability to pay.

Figure 4

Connecticut Premiums as a Percentage of Income for a Family of Three

FPL	Annual Income	Monthly Income	Monthly Premiums	Premium as % of income
50%	$7,630	$636	$25	3.9%
75%	$11,445	$954	$25	2.6%
99%	$15,107	$1,259	$25	2.0%
125%	$19,075	$1,590	$40	2.5%
150%	$22,890	$1,908	$40	2.1%
184%	$28,078	$2,340	$40	1.7%

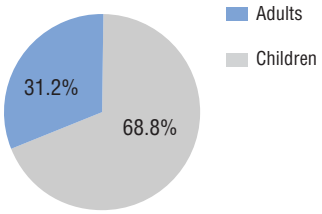
**Based on the Federal Poverty Level for a family of three, Federal Register, Vol. 68, No. 26, February 7, 2003, pp. 6456-6458. Assumes two children and a parent participating for families below poverty and two children for families above poverty since parent eligibility was lowered to 100 percent FPL. Some parents are still eligible above 100 percent FPL so the percentage of family income that premiums represent is underestimated for those families.*

This loss of coverage would be an enormous problem because the vast majority of these children and families are likely to become uninsured. Children in Medicaid clearly enjoy better access to needed health services than children who lack insurance. In 2002, for example, 75 percent of Medicaid-covered children received one or more well-child visits as compared to 46 percent of uninsured children.[13]

Figure 5

More than 2/3 of Those Losing Coverage Could be Children

Total Cut: 86,744



Source: Georgetown University Health Policy Institute Analysis.

FINDINGS

Applying the model developed by Urban Institute researchers to estimates of families in Connecticut who will be required to pay, the effects of premiums on enrollment in HUSKY A can be estimated as follows:

- Enrollment in Husky A can be expected to decline by 86,744 adults and children. Of these persons who can be expected to lose coverage, 59,638 – approximately 69 percent – would be children; the remaining 27,106 would be parents or pregnant women.
- Of the adults that can be expected to lose coverage, 1,006 would be pregnant women.
- Just under half of those who can be expected to lose coverage would be children and parents whose income falls below the poverty level – 26,212 children and 15,070 adults – with monthly incomes ranging from $604 to $1,196 a month.
- The remaining 33,426 children and 12,036 adults who can be expected to lose coverage come from families whose incomes range from 100 percent to 184 percent of the poverty line.

CONCLUSION - THE COST OF IMPOSING PREMIUMS

Imposing premiums on low-income families, particularly at the very low-income levels that Connecticut is contemplating, will cause severe and dramatic reductions in enrollment in HUSKY A. As a result, the vast majority of these children and their parents will become uninsured and lose access to needed health services; hospitals and other providers can expect to provide increasing levels of uncompensated care; and higher costs may ensue due to the potential for "adverse selection" among children and families who remain in HUSKY A.

METHODOLOGY

Georgetown University Health Policy Institute estimates are based on the following model developed by Ku and Coughlin to determine the expected participation as a function of premium cost:

(P/1-P) = .7239 - .4555X
P = the estimated participation rate for an income cohort
X = the premium level as a percentage of income

(See Ku and Coughlin "Sliding-Scale Premium Health Insurance Programs: Four States' Experiences," *Inquiry* 36:471-480 Winter 1999/2000.)

Two categories were constructed based on August 2003 enrollment data: 1) children and adults between 50 percent and 99 percent FPL; 2) children and adults from 100 percent to 184 percent FPL.

The following assumptions were made about August 2003 Husky A enrollment data:

- It was assumed that children in the coverage groups designated for children in the care and custody of the Department of Children and Families would not pay premiums and they were not included in the analysis.
- For families receiving cash assistance, it was assumed that 27 percent of families with earnings would pay premiums because the combination of their earnings and cash grant would put them in the 100-185 percent FPL income group. (Based on data from CT Department of Social Services report DMS8079A, as of 8/31/03.) The remainder of the families receiving cash assistance were not included in the analysis because it was assumed that all of their incomes would fall below 50 percent of poverty based on the value of the cash grant in most areas of the state. This is an underestimate of the families that will be asked to pay premiums because families in Region A (Stamford and lower Fairfield County) receive cash assistance above 50 percent FPL.
- It was assumed that 90 percent of the families in the family coverage group had incomes between 50-99 percent FPL as the eligibility limit for this group is 100 percent FPL and the vast majority of families with incomes below 50 percent FPL would be receiving cash assistance.
- It was assumed that families in the transitional medical assistance coverage group (TMA) had income between 100-185 percent FPL, because by definition they must have become ineligible for family coverage. However, the impact of premiums on these families is underestimated because it was assumed that all families in this income range would only pay premiums for two children since adults over 100 percent FPL are ineligible unless they are on TMA.
- It was assumed that children in the poverty-level coverage group were in families with incomes between 100-185 percent FPL, because this coverage group includes children whose parents are not eligible for coverage.
- It was assumed that an average family size is three (one parent and two children) because this is the average size of families on the TANF caseload.

For families between 50 percent and 99 percent FPL, the model was applied to three different scenarios. First it was assumed that 90 percent of the families had incomes of 50 percent FPL and 10 percent had in-comes of 99 percent FPL; second, an even distribution of families at 50 percent FPL, 75 percent FPL, and 99 percent FPL; and finally that 90 percent of the families were at 99 percent FPL and 10 percent at 50 percent FPL. These assumptions produced a range of 32,218 to 53,039 persons losing coverage. The equal distribution scenario fell squarely in the middle – 41,282 – so this distribution was chosen for the final analysis.

For families between 100 percent and 184 percent FPL, it was assumed that premiums would constitute 2 percent of their income which equates to an average income of 160 percent FPL for families in this cohort. Data from numerous studies suggest that these families are clustered at the lower end of this income range. (See, for example, Dan Bloom and Laura Melton, "Connecticut's Jobs First Program: An Analysis of Welfare Leavers," MDRC, December 2000.) Thus, it is very unlikely that the average income of these families is this high, so the impact of premiums on this group is probably underestimated.

REFERENCES

1 See Methodology section for more details.

2 Section 72, Public Act 03-3.

3 Conn. Gen. Stat. §17b-8.

4 The only time a family could have income above 185 percent of the federal poverty level and remain on HUSKY A is during the two-year period after the family loses coverage because its income has gone above the poverty level. During that two-year period, there is no income eligibility test.

5 *Out of Reach 2003: America's Housing Wage Climbs* (Washington, D.C.: National Low Income Housing Coalition).

6 Leighton Ku, *Charging the Poor More for Health Care: Cost-Sharing in Medicaid* (Washington, D.C.: Center on Budget and Policy Priorities, May 7, 2003), p. 3.

7 According to the Connecticut self-sufficiency standard developed under a contract between the Connecticut Office of Policy and Management and the University of Washington School of Social Work, a Hartford family of three (one working parent with one preschool and one school-aged child) would need $162 for transportation, $412 for food, $958 for child care, and $632 for other expenses. The total income necessary for self-sufficiency would be $3,400 a month. Diana Pearce, *The Self-Sufficiency Standard for Connecticut, 1999* (1998 self-sufficiency standard in 2003 dollars adjusted for inflation using the CPI-U).

8 See Leighton Ku and Teresa Coughlin "Sliding-Scale Premium Health Insurance Programs: Four States' Experiences," *Inquiry*, Vol. 36: 471-480, Winter 1999/2000, and Judith Feder and Larry Levitt, *Choices Under the New State Health Insurance Program: What Factors Shape Cost and Coverage?* (Kaiser Commission on the Future of Medicaid, 1998). Also, for an overview of the research see Julie Hudman and Molly O'Malley, *Health Insurance Premiums and Cost-Sharing: Findings from the Research on Low-Income Populations* (Kaiser Commission on Medicaid and the Uninsured, March 2003).

9 Ku and Coughlin.

10 Susan Haber, Janet Mitchell, and Annie McNeill, *Effects of Premiums on Eligibility for the Oregon Health Plan* (Health Economics Research, Inc., May 22, 2000).

11 Elizabeth Shenkman, Bruce Vogel, James Boyett and Rose Naff, "Disenrollment and Re-enrollment Patterns in SCHIP," *Health Care Financing Review*, (Spring 2002).

12 Donna Cohen Ross and Laura Cox, *Preserving Recent Progress on Health Coverage for Children and Families: New Tensions Emerge* (Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, July 2003).

13 Genevieve M. Kenny, Jennifer M. Haley and Alexandra Tebay, *Children's Insurance Coverage and Service Use Improve* (Washington, D.C.: Urban Institute, July 31, 2003).

Monette Goodrich,
Connecticut Health Foundation
Editor

Joan Alker,
Health Policy Institute,
Georgetown University
Co-author

Judith Solomon,
Connecticut Voices for Children
Co-author

If you would like a copy of our policy brief, contact Monette Goodrich at monette@cthealth.org or at 860.409.7773.

Connecticut Health Foundation

270 Farmington Avenue, Suite 357
Farmington, CT 06032
www.cthealth.org