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The Impact of Premiums on Families in BadgerCare Plus

by Joan Alker, Martha Heberlein and Wesley Prater

Key Findings

- Wisconsin's Governor is considering increasing charges that low-income families pay for health care. We modeled two possible scenarios which estimate the impact of charging premiums from three to four percent of families' incomes on participation rates in BadgerCare Plus. **Our findings suggest that such changes would result in between 49,422 and 87,298 fewer children and their parents participating in BadgerCare Plus.**

- Experience from other states suggests that **those losing coverage are more likely to use the emergency room as a usual source of care.**

- Raising premiums is likely to result in "adverse selection" which means that **those families that remain in BadgerCare Plus are likely to have greater health needs and thus higher costs.**

Background

Governor Scott Walker of Wisconsin introduced his biennium budget for 2011-13 on March 1, 2011. The budget includes $466 million in unspecified cuts to Wisconsin's BadgerCare Plus, the state's Medicaid program. Many of these cuts have not been detailed yet, however, in the Governor's "budget repair bill" (Act 10), the Wisconsin Department of Health Services (DHS) would have executive authority to make changes and cuts to the Medicaid program that have traditionally been done by the state legislature. These changes could include raising premiums and/or other cost sharing charges for families in BadgerCare Plus.

Cost sharing and premiums are typically very limited in the Medicaid program because they can create barriers to needed care for very low-income populations.[1] Federal cost sharing rules most recently amended by the Deficit Reduction Act of 2005 (DRA) prohibit states from imposing premiums on Medicaid beneficiaries below 150 percent of the federal poverty level (FPL) and total cost sharing may not exceed five percent of family income.[2]

The Secretary of Wisconsin's Department of Health Services, Dennis Smith, recently stated in a Joint Committee on Finance meeting that, "Federal law allows us to require families to provide five percent of family income to the cost of their care, and we think it's appropriate for families above 100 percent of poverty to be contributing something to their health care costs."[3] More recently, the Legislative Fiscal Bureau's Paper #341 released to the Joint Finance Committee, describes the proposed BadgerCare Plus changes by the Administration this way - "This plan will … revise cost sharing requirements to be more comparable with private health insurance coverage while still ensuring affordability by capping copayments, coinsurance and premiums at five percent of family income."[4]

Families above 150 percent of the FPL in Wisconsin are already paying premiums in BadgerCare Plus ranging from 0.4 percent to 5.0 percent of their income if an adult is covered.[5] Child-only coverage does not currently require a premium contribution until 200 percent of FPL. Smith's remarks suggest that the state may be considering expanding the group of families in BadgerCare Plus who are paying premiums by lowering the floor to 100 percent of the FPL ($18,530 for a family of three) and requiring premiums for child-only coverage between 100 and 200 percent of the FPL.

Figure 1:
Current Premiums for a Family of Three
(1 Parent, 2 Children)

	Federal Poverty Level	Annual Premium	Share of Income
Family coverage*	<150%	$0	0%
	150-160%	$120	0.43%
	160-170%	$324	1.09%
	170-180%	$816	2.59%
	180-190%	$1,464	4.39%
	190-200%	$1,764	5.00%
Child only coverage	200-230%	$240	0.62%
	230-240%	$360	0.84%
	240-250%	$552	1.24%
	250-260%	$816	1.76%
	260-270%	$1,056	2.19%
	270-280%	$1,320	2.64%
	280-290%	$1,632	3.15%
	290-300%	$1,968	3.66%
	300%+	$2,341	4.21%

*For child only coverage, a premium is not required.

Because low-income families have so little disposable income, the higher the premium as a proportion of a family's income, the lower the participation rate can be expected to be.

This brief examines the impact of increasing or adding premiums for families in BadgerCare Plus at income levels between 100 and 200 percent of the FPL. Given that the Administration's proposal may include multiple cost sharing mechanisms (i.e., deductibles, copayments, and coinsurance payments may also be required), we examine the impact of increasing or adding premiums for families in BadgerCare Plus at three percent and four percent of family income – leaving room below the five percent cap for the other cost sharing charges to be added. We examine how participation in BadgerCare Plus would be affected by employing a model developed by researchers at the Urban Institute and previously employed by the Wisconsin Legislative Fiscal Bureau to estimate the impact of a premium proposal put forth in 1997.[6]

How Will These Changes Be Implemented?

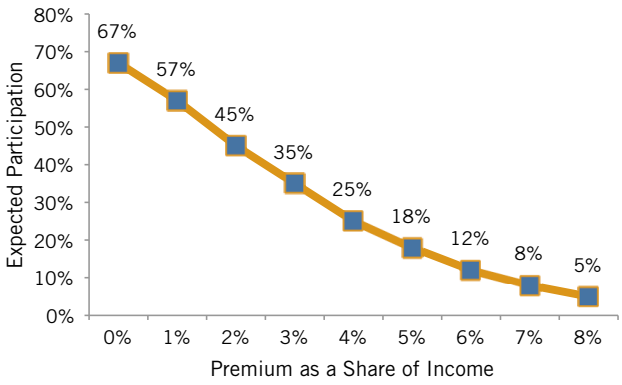
Medicaid was established for families and individuals with low incomes and/or disabilities. Because premiums reduce access to health care for low-income populations, federal Medicaid rules limit the amount of premiums that beneficiaries may be charged, especially for children. The DRA gave states new options to charge some cost sharing and premiums to Medicaid beneficiaries, especially those who are not deeply impoverished. But federal standards in the DRA do not allow states to impose premiums on families with incomes below 150 percent of the FPL in the Medicaid program or in CHIP-funded Medicaid expansions.

Since DRA rules do not allow premiums for families with incomes below 150 percent of the FPL, the Wisconsin Department of Health Services would have to obtain federal research and demonstration authority (more commonly known as a "Section 1115 waiver") to impose premiums on these families. The Centers for Medicare and Medicaid Services (CMS), the federal agency that oversees the Medicaid program, would have to approve this request. In doing so, the federal government would need to determine that charging premiums "is likely to assist in promoting the objectives" of the Medicaid Act. The state's ability to charge premiums is also currently constrained by Section 2001(b) of the Affordable Care Act (ACA) that requires states to maintain current eligibility standards to ensure stability in their programs in advance of the implementation of the major provisions of ACA in 2014. Because premiums lead to declines in enrollment, federal guidance has been clear that imposing new premiums would violate the ACA "maintenance-of-effort" provisions.[7]

Other State Experiences with Premiums

Based on data from Medicaid programs in three states, Urban Institute researchers have shown that even a small premium (one percent of a family's income) decreased and/or deterred enrollment by 16 percent. Because low-income families have so little disposable income, the higher the premium as a proportion of a family's income, the lower the participation rate can be expected to be. Premiums of three percent of a family's income are estimated to reduce participation by as much as half, and declines of 74 percent are estimated for premiums at five percent of family income.[8] New or increased premiums have been shown to reduce enrollment or increase/hasten disenrollment in state Children's Health Insurance Programs (CHIP) in Arizona, Florida, Kansas, Kentucky, Maryland, Missouri, New Hampshire, New Jersey, Rhode Island, and Vermont.[9] In past years, a number of states (Connecticut, Maryland, Virginia, and Washington) have reversed their plans to increase premiums, realizing the potential consequences on children and families.[10]

Figure 2:
The Expected Effect of Increasing Premiums on Participation Rates



Source: L. Ku & T. Coughlin, "Sliding-Scale Premium Health Insurance Programs: Four States' Experiences," Inquiry, 36: 471-480 (Winter 1999/2000).

What Impact would raising premiums for families in BadgerCare Plus have?

When people are unable to pay their premiums, they may end up using emergency rooms and inpatient hospital care rather than seeking routine preventive care, which are more expensive.

Currently, as shown in Figure 1, parents on BadgerCare Plus are paying premiums if their incomes exceed 150 percent of FPL that range from 0.4 percent to 5.0 percent, depending on their income. We examined two possible scenarios that impose new or increased premiums on families in BadgerCare Plus assuming that children would also be subject to premiums in the future. In particular, we looked at low-income families with incomes between 100 to 200 percent of the FPL.

The first scenario assumes that all families between 100 and 200 percent of the FPL in BadgerCare Plus are expected to pay premiums at three percent of their income. If premiums at this level were imposed, our research indicates that sharp declines in current BadgerCare Plus participation could occur. It would be expected that 49,422 fewer children and parents would be enrolled in BadgerCare Plus under the more conservative three percent scenario.

The second scenario assumes that all families eligible for BadgerCare Plus between 100 and 200 percent of the FPL are expected to pay four percent of their income. If premiums at this level were imposed, it would be expected that 87,298 fewer children and their parents would be enrolled in BadgerCare Plus. It is important to note that these estimates suggest a level of precision that is not possible to achieve with this model, but they do provide a sense of the magnitude of the coverage losses that would ensue from raising premiums.

It is also impossible to say with precision which of these families would find other sources of coverage, but given the declining levels of affordable employer-sponsored coverage for families with low incomes, it is likely that many of these children and their parents would become uninsured. Research using administrative and survey data has estimated that of newly-enrolled individuals in the BadgerCare Plus expansion, approximately 20 percent had access to ESI.[11]

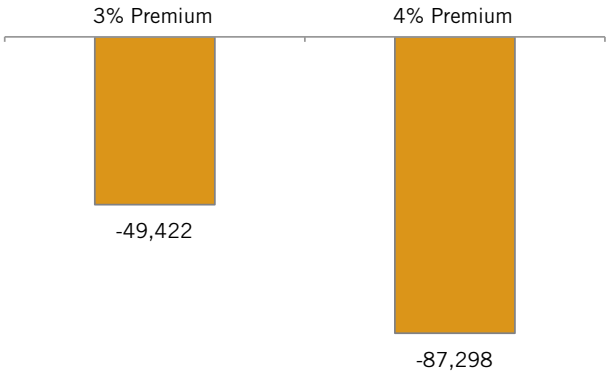
To the extent that the state expects to achieve savings from raising premiums, it is not only because of anticipated new premium collections but also because many families would be expected to lose BadgerCare Plus coverage.

Other Impacts of Increased Premiums

When people are unable to pay their premiums, they may end up using emergency rooms and inpatient hospital care rather than seeking routine preventive care, which are more expensive.[12] Oregon increased premiums for its Medicaid expansion program, which included people with incomes below the poverty line. Once this increase was in effect, almost 50 percent of those enrolled lost coverage, and of this group, almost 75 percent became uninsured. Those who were dropped were almost five times more likely to report the emergency room as their usual source of care than individuals who stayed enrolled.[13]

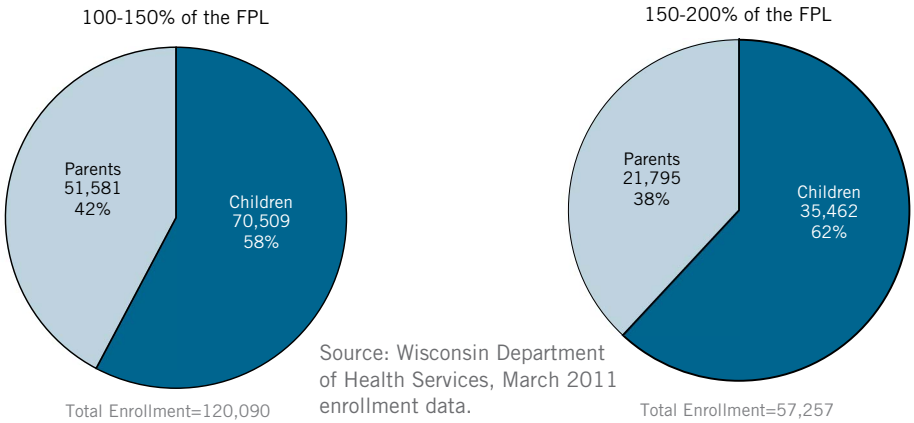
A Florida study also found that imposing premiums in its CHIP program caused healthier children to disenroll at higher rates, a phenomenon known as "adverse selection."[14] Adverse selection can raise the cost of serving children and families left in the program, as fewer healthier people remain to share the risk.[15]

Figure 3:
The Effect of Premium Increases on Participation



Source: Georgetown CCF Analysis based on CPS-weighted enrollment figures. See methodology for full details.

Figure 4:
BadgerCare Plus Enrollment, March 2011



Source: Wisconsin Department of Health Services, March 2011 enrollment data.

Conclusion

Research and state experience is clear that the higher the premiums are for BadgerCare Plus beneficiaries, the more participation rates will decrease. As many of these families lack access to other affordable coverage, they will become uninsured and risk losing access to health services. Increasing premiums can lead to adverse selection, raising the cost of those still enrolled in BadgerCare Plus. Estimates of state savings from such a proposal should closely examine what share is attributable to a new source of revenues (i.e., premium collections) and what share results from children and parents' loss of BadgerCare Plus coverage. The budget deficit facing Wisconsin is significant, but caution should be used when discussing changes that could be harmful to the health of children and families.

Joan Alker, Martha Heberlein and Wesley Prater of Georgetown Center for Children and Families prepared this issue brief.

The Center for Children and Families (CCF) is an independent, nonpartisan policy and research center whose mission is to expand and improve health coverage for America's children and families. CCF is based at Georgetown University's Health Policy Institute.

We would like to thank Matt Broaddus at the Center on Budget and Policy Priorities for his assistance with the CPS data and Karina Wagnerman for her work on report production and design.

Endnotes

1. S. Goodell & K. Swartz. "Cost-sharing: Effects on Spending and Outcomes," Robert Wood Johnson Foundation (December 2010).; and The Kaiser Commission on Medicaid and the Uninsured, "Health Coverage for Low-Income Populations: A Comparison of Medicaid and SCHIP," (April 2006).
2. States can choose to calculate the 5% cap based on charges imposed each month or each quarter. States have to incorporate all members of a family that are enrolled in Medicaid when calculating the cap.
3. D. Smith, DHS Agency Briefing before the Wisconsin Joint Committee on Finance (April 6, 2011).
4. Legislative Fiscal Bureau, "Paper #341: Unspecified Program Changes to Medical Assistance (DHS –Medical Assistance—Services)" (May 24, 2011) Attachment 2.
5. Families that have child-only coverage do not pay a premium unless their income is above 200% of FPL.
6. Legislative Fiscal Bureau, "Health Care Proposals for Low-Income Children and Uninsured Families" (September 8, 1997).
7. Letter from Cindy Mann, Director of Center for Medicaid, CHIP and Survey & Certification, Centers for Medicare and Medicaid Services, to State Medicaid Directors (SMD# 11-001) (February 25, 2011).
8. L. Ku, "Charging the Poor More for Health Care: Cost-Sharing in Medicaid," Center on Budget and Policy Priorities (May 7, 2003); and L. Ku & T. Coughlin, "Sliding-Scale Premium Health Insurance Programs: Four States' Experiences," Inquiry, 36: 471-480 (Winter 1999-2000).
9. See G. Kenney, et al., "Assessing Potential Enrollment and Budgetary Effects of SCHP Premiums: Findings from Arizona and Kentucky," Health Services Research, 42: 2354-2372 (August 2007);

B. Shenkman, "Healthy Kids Program Changes in State Fiscal Year 2003-2004: Associations with Enrollee Case-Mix, Health Care Expenditures, and Disenrollment; Tab O, Impact on Cost Sharing," A Report to the Healthy Kids Corporation (November 2004); G. Kenney, et al., "Effects of Premium Increases on Enrollment in SCHIP," Inquiry, 43: 378-392 (Winter 2006/2007); J. Marton, "The Impact of the Introduction of Premiums into a SCHIP Program," Journal of Policy Analysis and Management, 26: 237-255 (March 2007); Maryland Department of Health and Mental Hygiene, "Maryland Children's Health Program: Assessment of the Impact of Premiums, Final Report," (April 2004); J. Ferber, "Measuring the Decline in Children's Participation in the Missouri Medicaid Program: An Update," Legal Services of Eastern Missouri (September 2006); J. Miller, et al., "Demographics of Disenrollment from SCHIP: Evidence from NJ KidCare," Journal of Health Care for the Poor and Underserved, 15: 113-126 (February 2004); RI Medicaid Research and Evaluation, "Results of Rite Care Premium Follow-Up Survey #2," (July 2004); and S. Kappel, "Effects of Medicaid Premiums on Program Enrollment: Preliminary Analysis," Vermont Joint Fiscal Office, (April 8, 2004).

10. L. Ku & Victoria Wachino, "The Effect of Increased Cost-Sharing in Medicaid: A Summary of Research Findings," Center on Budget and Policy Priorities (July 7, 2005).
11. L. Dague, et al., "Estimates of Crowd-Out from a Public Health Insurance Expansion Using Administrative Data," National Bureau of Economic Research (working paper Cambridge, MA, May 2011).
12. Ibid.
13. M. Carlson & B. Wright, "The Impact of Program Changes on Health Care for the Oregon Health Plan Standard Population: Early Results from a Prospective Cohort Study, " Office of Oregon Health Policy and Research (March 2004).
14. E. Shenkman. et al. "Disenrollment and Re-enrollment Patterns in SCHIP," Health Care Financing Review (Spring 2002).
15. J. Alker & J. Solomon, "Families at Risk: The Impact of Premiums on Children and Parents in Husky A," Connecticut Health Foundation (January 2005).

Methodology

These estimates are based on the model depicted in L. Ku & T. Coughlin, "Sliding-Scale Premium Health Insurance Programs: Four States' Experiences," **Inquiry**, 36: 471-480 (Winter 1999/2000). March 2011 enrollment data were obtained from the Wisconsin Department of Health Services; the Wisconsin Council on Children and Families provided the current premium schedule.

Current premiums in Wisconsin are based on family composition (i.e., a three-person family with two parents and one child enrolled face a different premium than a family with one parent and two children) and are imposed on a sliding scale based on income. We calculated the participation rate for each income level and family structure using the model put forth in Ku & Coughlin. The participation rate was determined under three scenarios: the current level of premiums paid, an across-the-board premium of three percent of income, and an across-the-board premium of four percent of income.

To estimate the decline in enrollment from these participation rates, we applied weights based on the 2010 Current Population Survey (CPS) to the actual March 2011 enrollment figures. Note that these enrollment data are broken down by income (although not as finely as the current premium schedule is defined), but not by family composition. The share of Medicaid enrollees in each family structure and income level was calculated from the CPS. This share was then applied to the overall enrollment figures obtained from the state to obtain an approximate enrollment number for that particular group.

The change in enrollment for each of these groups was then calculated based on the corresponding participation rate for that group. It is important to note that there are some families, who based on their current premium burden, would be paying less under either proposed scenario; participation among such families is expected to rise. This potential increased participation is also captured under this methodological approach. The changes across the income level and family composition groups were then aggregated to produce an overall estimate of the change in enrollment as a result of the two modeled premium changes.