Policy Matters Ohio

Budget
February 2015

Making Medicaid work

Financial requirements can prevent patients from getting care

Wendy Patton

Monthly premiums that the Kasich administration wants to charge some Medicaid recipients could backfire because they will pose a serious barrier to health care for some. People unable to afford the premiums may delay treatment or turn to emergency rooms, which will drive up costs.

More than 490,000 Ohioans whose wages are too low to buy insurance signed up for Medicaid health care coverage in Ohio under the Affordable Care Act's Medicaid expansion. They can now see a doctor to manage chronic conditions such as diabetes or high blood pressure, and prevent serious illness. As more people see a doctor, fewer come into the emergency room with medical crises and without insurance. This is good for the patient, who is healthier, and good for the health system, which is strengthened financially. This also controls health-care costs for the rest of us. Imposing monthly premiums on poor people could put this virtuous cycle in reverse.

Cost-sharing through insurance premiums and co-payments is standard in the health care system, but can keep the poor from seeking and affording care. Their limited incomes are spent to meet other basic needs, such as food and shelter.

Key findings

- Research over 40 years shows financial requirements discourage the poor from getting health care
- Health-care premiums proposed by the Kasich administration could average $20 a month, in addition to co-pays.
- The cost of monthly payments is higher for people without bank accounts who must purchase money orders.
- Administrative costs of collecting premiums are high, sometimes exceeding the amount collected.

The executive budget will require premiums up to 2 percent of adjusted income for low-wage, childless adults.[1] If they don't pay they may lose coverage. Those who lose coverage because they haven't been able to pay the premium may have to pay what they owe for prior months before they can regain care.[2] This may be expensive to enrollees, harder to repay if they fall behind, and expensive for the state to track and administer.

[1] Ohio Office of Health Transformation at http://www.healthtransformation.ohio.gov/LinkClick.aspx?fileticket=yOkp04xrGu8%3d&tabid=252

[2] Premium payments are required under the Ohio Revised Code for one program: the Medicaid Buy-In for Workers with Disabilities. Director John McCarthy pointed out in a meeting on February 9, 2015 that premium repayment requirements would probably parallel current law. Premium payment is defined under 5160:1-5-30(F)(3), referencing 5101:1-38-01.3.

Financial requirements may keep poor families from getting care

The administration has proposed a reauthorization of Medicaid expansion to provide coverage for working-poor adults. This is excellent for the half-million Ohioans who gained needed health coverage under Medicaid expansion in 2014. But the executive budget released February 4 has added a requirement that some adults with income between 100 and 138 percent of poverty – $11,770 to $16,242 in annual earnings for a single person – pay a monthly premium for coverage. These men and women would pay a premium of $20 a month, on average, in addition to co-pays for medical services.[3] Some months, they may not have enough income to make that payment. Coverage may be lost, leading to medical complications and higher costs to the system.

Improving health and controlling costs under national health-care reform depends on expanded preventive care and predictable payment for providers. Requiring a financial contribution discourages low-income people from seeking health care and, in some cases, leads to an increase in expensive emergency room treatment that goes unpaid, a substantial body of research finds.[4]

The RAND Health Insurance Experiment of the 1970s, a definitive study on this issue, found that co-payments led to a much larger reduction in use of medical care by low-income adults and children than by those with higher incomes. Low-income families lost far more because of financial contribution requirements than middle and high-income people. [5]

State-level studies assessing how financial requirements affect the use of health care by low-income people over the past decade corroborate these findings:

- Wisconsin imposed premiums of 3 percent of household income on adult Medicaid patients in July 2012. Three months later, nearly a quarter of this group had been dropped from Medicaid because of non-payment.[6]

- Physicians at Minneapolis' main public hospital surveyed patients attending medical clinics in mid-2004. Of 62 patients covered by Medicaid or medical assistance, more than half (32) reported that they had been unable to get their prescriptions at least once in the

---

[3] *Id.*

[4] "Premiums and Cost-Sharing in Medicaid: A Review of Research Findings," Kaiser Commission on Medicaid and the Uninsured, February 2013 at http://kaiserfamilyfoundation.files.wordpress.com/2013/02/8417.pdf ; Samantha Artiga and Molly O'Malley, "Increasing Premiums and Cost Sharing in Medicaid and SCHIP: Recent State Experiences," Kaiser Commission on Medicaid and the Uninsured at http://kaiserfamilyfoundation.files.wordpress.com/2013/01/increasing-premiums-and-cost-sharing-in-medicaid-and-schip-recent-state-experiences-issue-paper.pdf Leighton Ku and Victoria Wachino, "The Effect of Increased Cost-Sharing in Medicaid." July 2005 at http://www.cbpp.org/cms/?fa=view&id=321

[5] The RAND study found that copayments did not significantly harm the health of middle- and upper-income people but did lead to poorer health for those with low incomes. The study found that among low-income adults and children, health status was considerably worse for those who had to make copayments than for those who did not. (In the RAND study, low income was defined as the lowest third of the income distribution, which is roughly equivalent to being below 200 percent of the poverty line.) For example, copayments increased the risk of dying by about 10 percent for low-income adults at risk of heart disease - Joseph Newhouse, Free For All? Lessons from the Rand Health Insurance Experiment, Cambridge: Harvard University Press, 1996, cited in Leighton Ku and Victoria Wachino, "The Effect of Increased Cost-Sharing in Medicaid." July 2005 at http://www.cbpp.org/cms/?fa=view&id=321

[6] State of Wisconsin Department of Health Services "Wisconsin Medicaid Premium Reforms: Preliminary Price Impact," Table 4: Premium enrollment impacts. Findingshttp://www.dhs.wisconsin.gov/publications/P0/P00447.pdf

last six months because of copayments of $3 for brand name drugs or $1 for generic drugs. Eleven of the patients who failed to get their medications had 27 subsequent emergency room visits and hospital admissions for related disorders. For example, patients with high blood pressure, diabetes or asthma who could not get their medications experienced strokes, asthma attacks and complications due to diabetes. [7]

- More than a decade ago, Oregon raised premiums for adults with incomes below the poverty line. Premiums ranged from $6 per month for people with no income to $20 per month for people with incomes at the poverty line. Nine months later, nearly half had lost their coverage. About three-quarters of them became uninsured."[8]

- A 2003 survey of low-income adults covered by Medicaid in Utah found 27 percent had lost coverage, and more than a quarter of them cited copays as the cause. Of those who did not re-enroll, 20 percent reported copays were too high to use services. About half of all respondents who had left Medicaid had not seen a physician for 12 months. Many who needed care reported difficulty getting services, particularly mental health care, alcohol/drug treatment, and dental services.[9]

- In January 2004, Vermont increased premiums in its Medicaid and State Children's Health Insurance programs. During the first month of increased premiums, enrollment declined by 11 percent, or 4,500 people. Cost was reported as the reason by 70 percent of those who lost Vermont's coverage, which included adults with incomes between 50 percent and 185 percent of poverty. [10]

- In January 2002, Rhode Island began charging premiums ranging from $43-$58 per month, to families with incomes above 150 percent of poverty. Nearly one in five families could not afford to pay and dropped coverage over the next three months. Nearly half of surveyed families who lost coverage reported being unable to afford the premium as the reason.

- In Maryland, families were subject to $37-per-month premiums in the children's insurance program. Coverage was dropped for 28 percent of children. Parents cited a premium-related reason in nearly one of five cases, and state legislators subsequently eliminated the premiums.

Just paying for Medicaid care becomes a second barrier. Low-income families who lack bank accounts in states requiring a financial contribution may find making timely payments expensive and

---

[7] Melody Mendiola, Kevin Larsen, et al. "Medicaid Patients Perceive Copays as a Barrier to Medication Compliance," Hennepin County Medical Center, Minneapolis, MN, presented at the Society of General Internal Medicine national conference, May 2005 and American College of Physicians Minnesota chapter conference, Nov. 2004.

[8] Center for Budget and Policy Priorities and Georgetown University Center for Children and Families, Letter to Secretary Kathleen Sibelius regarding proposals for the Iowa Marketplace Choice Plan and Iowa Wellness Plan, September 26, 2013 at http://ccf.georgetown.edu/wp-content/uploads/2013/09/IA-Longer-Comments-Final.pdf

[9] Utah Primary Care Network Disenrollment Report. Utah Department of Health Center for Health Data, Office of Health Care Statistics, August 2004, cited in "Premiums and Cost-Sharing in Medicaid: A Review of Research Findings," Kaiser Commission on Medicaid and the Uninsured, February 2013 at http://kaiserfamilyfoundation.files.wordpress.com/2013/02/8417.pdf

[10] Kaiser Health http://kaiserfamilyfoundation.files.wordpress.com/2013/01/increasing-premiums-and-cost-sharing-in-medicaid-and-schip-recent-state-experiences-issue-paper.pdf

logistically challenging. The Federal Deposit Insurance Corporation's 2013 survey of unbanked and underbanked households found that 7.2 percent of Ohio households have no bank account[11] (just over 328,000 households). These households can't pay bills online or with credit cards. Purchasing a money order adds to the overall cost of the premium.

Some programs disenroll Medicaid recipients for non-payment of premiums. Material describing the executive budget proposal for 2016-17 on the website of the Office for Health Transformation indicates this may happen under the administration's plan.[12] Director John McCarthy of the Ohio Department of Medicaid pointed out that there is precedence in disenrollment for non-payment under the Medicaid program for disabled workers. Reinstatement in the program requires full repayment of missed premium payments.[13] Just one missed payment could grow into two, then three, and become a permanent barrier to regaining health coverage in the system.

Creating a system that accommodates the financial struggles of low-income families can be difficult. Low-income families live on tight budgets and unexpected expenses, such as a car repair or layoff, cause hardship. Waiving a financial contribution for health care because of financial hardship makes sense, but is administratively burdensome. Some states have found the cost of collection and monitoring exceeds the value of premiums. Virginia imposed a $15-per-child, per-month premium on low-income families but eliminated them when officials found nearly 4,000 children were at risk of losing coverage for nonpayment. In addition, a study showed that the state was spending $1.39 in administrative cost to collect every $1 in premium.[14]

Requiring premiums for access to health care works against public health and a more efficient, effective health-care system. It's a lose-lose strategy. The goal of policymakers should be to reduce barriers to care and encourage participation, allowing individuals to lead healthier, more productive, financially stable lives.

---

[11] Federal Deposit Insurance Corporation, 2013 FDIC National Survey of Unbanked and Underbanked Households (Appendices), Table G-2, page 118, https://www.fdic.gov/householdsurvey/2013appendix.pdf

[12] Ohio Office of Health Transformation, Op.Cit.

[13] See footnote #2, above.

[14] Virginia Department of Medical Assistance Services memo, (May 15, 2002); see also, L. Summer & C. Mann, "Instability of Public Health Insurance Coverage for Children and Their Families: Causes, Consequences, and Remedies," The Commonwealth Fund (June 2006). Cited in Tricia Brooks, Handle with Care: How Premiums Are Administered in Medicaid, CHIP and the Marketplace Matters, Georgetown University Center for Families and Children at http://www.healthreformgps.org/wp-content/uploads/Handle-with-Care-How-Premiums-Are-Administered.pdf