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Premiums and Cost-Sharing for Low-Income Adults

Jordan Banks

Health insurance premium and the specific design of patient cost-sharing affect the willingness and ability for low income adults to seek needed health care services. A growing body of research on these effects suggests:

- An increase in premiums reduces the likelihood an individual will enroll in coverage and the length of enrollment;
- An increase in premiums can lead to breaks in coverage in the short run;
- An increase in patient cost-sharing, especially from zero to any level, will reduce use of some health services which will be greater for more elastic services (emergency room is least elastic and labs are most elastic);
- Lower use rates in response to cost-sharing are due to some low-income adults avoiding some or all services, rather than lower use of all services by many people; and
- Within a range of 0% to 300% of FPL, lower income families are more vulnerable to the effects of premium increases and cost sharing, abandoning coverage or not seeking initial coverage due to cost.

Examples of Cost-Sharing

Cost-sharing refers to the proportion of direct health care costs borne by patients with health insurance; the rest of those costs are paid by the insurance company or program. Most private insurance plans for groups or individuals have deductibles—the amount of health care costs paid by the patient before insurance benefits begin—that can range from a few hundred dollars to $5,000 or $10,000. These plans often also require copayments (set fees) or coinsurance (a percentage of the provider's fee) at the point of service.

Under the 2010 Affordable Care Act, individuals can obtain health insurance through either federal or state insurance exchanges, and these plans include various types of patient cost-sharing. The ACA, however, provides subsides through the insurance exchanges for people with incomes up to 400% of Federal Poverty Level (FPL) that reduce both the premiums and cost-sharing levels.

Under standard federal rules, state Medicaid programs do not charge Medicaid beneficiaries any premiums or cost-sharing fees. Several states received federal approval ("waivers") to charge Medicaid beneficiaries some premiums and cost-sharing, including Kansas, Kentucky, Wisconsin, Florida, and New Hampshire. These state programs create an opportunity to examine the effects of premiums and cost-sharing on low income individuals.

Findings

IN KENTUCKY, INCREASING PREMIUMS FROM $0 TO $20 FOR ENROLLEES INCREASED THE PROBABILITY OF ENDING ENROLLMENT BY MORE THAN EIGHT PERCENTAGE POINTS IN THE FIRST THREE MONTHS.

The Center for the Study of Health in Public Policy (SHIPP) is an interdisciplinary research center that explores how all policy—not just healthcare policy—impacts the health of individuals and communities.

Director: Michelle Garrison, PhD

Evidence

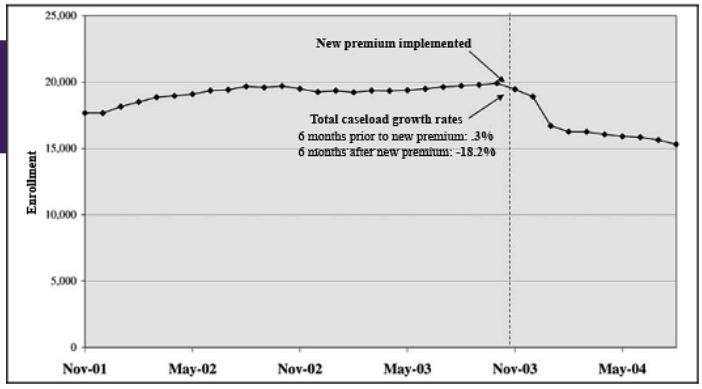
Premiums

A 2014 study of Wisconsin's Medicaid program found that an increase in premiums from $0 to $10 per month for non-elderly and non-disabled adults and families reduced enrollment in Medicaid by 1.4 months and reduced the probability of being enrolled for a continuous year by 12 percentage points. Eligibility for Medicaid in Wisconsin is more generous than other states' programs, covering childless low-income adults and caretakers to pregnant women up to 200% FPL and pregnant women up to 300% of FPL.[1] The short run effect of raising the premium suggests that changes in premiums in the short run could disrupt continuity of care for low income adults.

A 2007 study of the Kentucky State Children's Health Insurance Program (SCHIP) found that increasing premiums from $0 to $20 for enrollees increased the probability of ending enrollment by more than eight percentage points in the first three months and by almost four percentage points in each six-month period after the first three months.[2]

This study corroborated the author's earlier findings from a review of premium increases in Kentucky, Kansas, and New Hampshire that premium increases led to disenrollment.[3] Kentucky introduced a $20 premium for its SCHIP enrollees with incomes 151-200% FPL. Kansas premiums tripled, then decreased by 1/3, also for enrollees with incomes of 151-200% of FPL; the initial premium was $10 for enrollees with income up to 176% FPL and $15 for the remaining enrollees. New Hampshire increased premiums from $20 to $25 for families whose incomes ranged from 185-249% FPL and $40 to $45 for those up to 300% FPL. The monthly out-of-pocket maximum also increased from $100 to $135. This same study found that families with incomes from 185%-249% of FPL were substantially more likely to leave their plan or not enroll in a plan than families with 250%-300% FPL. Finally, the study from Kansas did not find a significant impact on enrollment from the introduction of premiums, but the authors speculate this could be attributable to a lack of an enforcement mechanism.

Figure 1:
Kentucky SCHIP Enrollment Changes after Premiums Were Introduced



Source: Kenney, G., et al. 2006

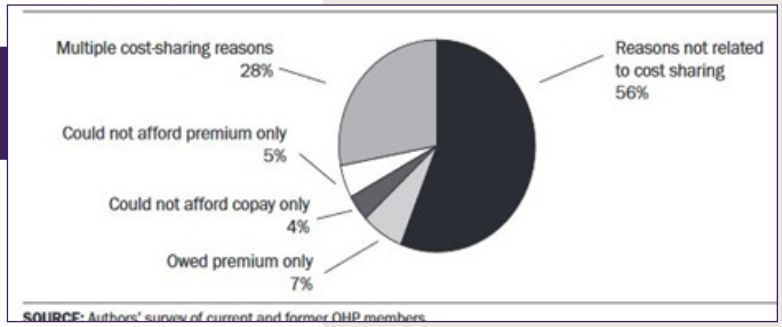
In 2006, changes in Medicaid plans made it possible to examine the effect of premiums on plan selection for low income adults under 300% of FPL. Chan and Gruber (2010) create a model that suggests a premium increase of $10 per month was associated with an 8-16% reduction in choosing a given plan.[4] A study of Florida SCHIP found patients with poorer health status were less affected by premium increases than those with better health status, and higher income patients were less affected by premium increases than low income patients. Additionally, families with FPL 101% to 150% experienced a 61% decrease in enrollment length from a $5 increase in premiums, whereas the 151% to 200% group experienced a 55% decrease in enrollment length from the same policy.[5]

Findings

A 2014 MASSACHUSETTS STUDY SUGGESTS THAT INCREASING COPAYMENTS WILL MAKE IT MORE LIKELY THAT SOME LOW INCOME ADULTS WILL DISCONTINUE ALL CARE THAN THAT SOME LOW INCOME ADULTS WILL REDUCE SOME CARE.

Although this drop in enrollment could mean patients are no longer getting needed care, it is possible that some are seeking care elsewhere. A study four years earlier examined whether low income adults who discontinue enrollment in health plans due to premiums seek care elsewhere, either with different plans or through other coverage options. Of those who did leave Medicaid after premium increases, that 2010 study found that 56% sought other insurance coverage. The study also found that patients who were chronically ill were much less likely to leave Medicaid because of the introduction of premiums. How quality of care is affected after discontinuing enrollment is unclear.[6]

Figure 2:
New York State percent uninsured under the age of 65 before and after reforms.[4]



Source: Wright, B., et al. 2005

Cost-Sharing

The RAND Health Insurance Experiment of the late 1970s provides the best information we have on the effect of coinsurance compared to free care. In 2013, Aron-Dine, Einav, and Finklestein re-examined health insurance attrition rates during the RAND study, showing a pattern of higher attrition and decisions not to engage in the study when coinsurance rates were higher; attrition ranged from 12% to 37% from free care to 95% coinsurance, respectively. Further, all coinsurance rates above free care reduced demand for all types of health services and overall spending.[7]

In 2003, Oregon increased copayments (up to $250 for an inpatient visit) and premiums (ranging from $6 to $20) for Medicaid enrollees earning up to 100% FPL. Of this cohort, 44% dropped insurance, and of those who did, most were concerned with total out-of-pocket cost, but 5% left because they could not afford the premium only, 4% for the copay only, and 7% because they owed on the premium payment. The study further found cost-sharing was the reason for leaving for 68% of families with zero income, 39% of families earning between 26% and 100% of FPL, and 24% for those above 100% of FPL, demonstrating the significant role income plays in the impact of cost sharing.[8]

In 1999, a simulation designed to examine the effect of copayments on low-income adults with incomes up to 300% FPL showed that increasing copayments would make patients less likely to fill any prescription rather than to be partially compliant to a pharmaceutical regimen. A 2014 Massachusetts study of families and adults with income up to 300% of FPL suggested that it is more likely some low income adults will discontinue all care than that some low income adults will reduce some care, corroborating earlier findings in the literature.[9,10]

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