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policy brief

FAMILIES AT RISK:

COST OF PROPOSED MEDICAID AND HUSKY A CHANGES TO THE CONNECTICUT ECONOMY

SUMMARY OF FINDINGS

- Connecticut can expect to lose over $96 million in federal funding if changes to Connecticut's Medicaid program are implemented as planned in the state's budget. Among other economic effects, this reduction in federal funding can be expected to cause a loss of just under 1,800 jobs.
- The number of uninsured children in Connecticut can be expected to rise by 43 percent if premiums are implemented as planned.
- This sharp increase in the number of uninsured children and adults can be expected to result in over $93 million in annualized costs being shifted to providers, to other areas of the federal and state budgets, and to low-income persons themselves.

INTRODUCTION

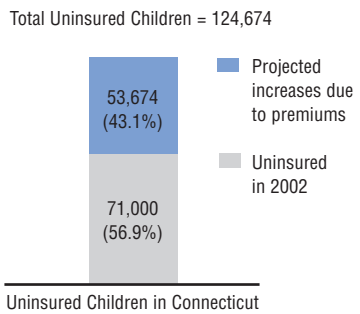
As a result of changes included in Connecticut's state budget for fiscal years 2004 and 2005, families, seniors and persons with disabilities, who receive their health care through the state's Medicaid program, will see significant changes in their health coverage. Most of these changes require federal approval through a waiver submitted to the federal Centers for Medicare and Medicaid Services (CMS) under Section 1115 of the Social Security Act. This waiver application has not yet been submitted.

Earlier briefs in this series described the impact of these changes on the health of children and their families, seniors and persons with disabilities. Most notably, over 94,000 persons — the majority of whom are children — can be expected to lose Medicaid coverage as a result of new premiums the state is planning to impose if federal approval is received.[1] In addition, new charges for prescription drugs and doctor visits as well as a reduction in covered benefits will result in less access to needed care.[2]

This brief examines the impact of the proposed changes on the state's economy and its health care system. Medicaid is the largest health care program in every state and currently serves over 51 million persons nationwide. Medicaid is also the single largest source of federal funds coming into every state. In Connecticut, HUSKY A provides health coverage to almost one in four children — higher than the national average of 20 percent. In fiscal year 2004, Connecticut is expected to receive $1.8 billion in federal Medicaid funding.[3] Nationwide, Medicaid constitutes 17 percent of all personal health care spending.[4] Thus any changes to Connecticut's HUSKY A and Medicaid programs will have immediate and ongoing effects on the rest of Connecticut's health care system and the state's budget.

Figure 1

The Number of Uninsured Children in Connecticut Would Almost Double



Note: 71,000 uninsured children were uninsured for all of 2002 based on CPS estimates.

Source: March 2003 CPS and Georgetown Health Policy Institute analysis. Assumes that 90 percent of children losing coverage due to premiums will become uninsured.

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THE ROLE OF FEDERAL FINANCING

Medicaid is jointly financed by the federal and state governments. It is an open-ended, federal funding source based on a matching system. Connecticut's regular matching rate is 50 percent.[5] This means that for every dollar that Connecticut spends on Medicaid services, the state is able to buy two dollars of health services because of the federal matching funds that come to the state.[6] Conversely, if Connecticut seeks budget savings through cuts in its Medicaid program, federal funds are lost, and services have to be cut twice as deeply as would services in a program with no federal match.

CHANGES WOULD CAUSE STATE TO LOSE MILLIONS OF FEDERAL DOLLARS

If Connecticut receives federal approval for the changes authorized in the state budget, these budget reductions will result in the state's losing federal matching funds. Most of this loss of funding will occur as a result of children and their parents losing coverage because they are unable to pay the required premiums. It is expected that *Connecticut could lose over $96 million in federal funding in FY2005 if the changes are fully implemented.*[7]

Table 1
Cutting Medicaid Funding Doubles Services Loss

Matching Rate	State Funds Saved	Federal Funds Lost	Services Cut
50%	$100 million	$100 million	$200 million

This loss of federal dollars has major consequences for the state's economy — and most notably for the health care sector. Medicaid funding stimulates Connecticut's economy by bringing in federal dollars from out of state, and returning federal tax dollars to Connecticut that would otherwise be spent elsewhere. This money flows to health care providers, managed care companies and others to provide services to Medicaid enrollees.

These health care providers are also employers, and they pay the salaries of their employees with the Medicaid funding they receive. These employees, in turn, are consumers of goods and services and pay state and local taxes with their earnings. This spending stimulates more economic activity, including job creation and increased production of services in other areas of the economy through what is commonly called the "multiplier effect." Investments in other areas of the state's budget, which, do not draw down a federal matching dollar, do not have a similar effect on the state's economy because funds are merely being reallocated from one area of the state's economy to another.

Thus, states can expect negative economic effects as a result of cutting Medicaid spending. These negative economic effects include job loss (usually concentrated in the health care sector), lost employee wages and business activity (the production of goods and services), and declines in state and local tax revenues.

Numerous states have conducted studies to examine the multiplier effect of federal Medicaid funding.[8] In addition, a national study developed state-specific multipliers that can be applied to estimated cuts in state Medicaid spending.[9] This study found, for example, that for every $1 million Connecticut loses in federal funding, 18.66 jobs are lost.[10] Applying this multiplier to the loss of federal funding that will result from Connecticut's planned changes in HUSKY A and Medicaid, the following economic effects are projected:

Table 2
Economic Impacts of Lost Federal Funds

Projected Loss of Federal Dollars	Jobs Lost	Lost Employee Wages	Lost Business Activity
$96 million	1,791	$75.84 million	$202.56 million

IMPOSING PREMIUMS WILL SWELL THE NUMBER OF UNINSURED

As described in previous briefs in this series, it is expected that 94,074 children, parents, seniors and persons with disabilities will lose Medicaid coverage because they are unable to pay their premiums. The vast majority of these families and many of the disabled persons who lose Medicaid can expect to become uninsured, while many of the seniors will become underinsured.[11] *An additional 80,000 persons in Connecticut are likely to become uninsured if the premiums are implemented as planned.*[12] As Figure 1 shows, this would represent a 43 percent increase in the number of uninsured children in Connecticut. An additional 1,500 persons losing coverage are adults with high medical needs.

IMPOSING PREMIUMS – ONE STATE'S EXPERIENCE

In January of 2003, Oregon began charging premiums to adults with incomes below the federal poverty line. By October of 2003 enrollment in the Oregon Health Plan (the state's Medicaid waiver program) had declined from 87,700 to 44,800 — a 49 percent reduction.[13] Oregon is conducting a number of studies to examine the impact of this decline in enrollment on the health care system. Preliminary findings from one study show a *17 percent increase in the use of the emergency room by uninsured patients since the premiums were imposed.*[14]

WHAT HAPPENS TO THOSE WHO LOSE INSURANCE?

Uninsured persons suffer worsened health outcomes as compared to people with insurance. They receive less preventive care, are diagnosed at more advanced stages of disease, and have higher mortality rates.[15] Uninsured persons continue to use health care services and incur costs to the health care system and also to themselves.[16] Health care debt is a leading cause of personal bankruptcy.[17] But for those persons becoming uninsured because they lose their Medicaid coverage, these costs will no longer be reimbursed by the Medicaid program.

WHAT HAPPENS TO THE HEALTH CARE SYSTEM?

Researchers at the Urban Institute have found that uninsured persons cost the health care system approximately 51 percent of the cost of an insured person.[18] A substantial percentage of these costs are absorbed by health care providers — with hospitals suffering the greatest impact. Other providers likely to absorb costs include community health centers and other clinics and physicians. Costs are also shifted to other areas of government spending. These include: the Veterans Administration, Indian Health Service hospitals, funding for uncompensated care through federal programs such as Medicare and Medicaid Disproportionate Share Hospital, as well as state and local government funding for health related services. Costs are also shifted to low-income families, increasing their debt load and raising the risk of personal bankruptcy.

If premiums are implemented as planned and Connecticut's uninsured population increases by 80,000, *an annualized cost-shift of over $93 million can be expected.*[19] This cost will have to be absorbed by health care providers (especially hospitals) and low-income individuals themselves and will likely result in increased demand in other areas of the state's budget. *Ultimately, providers will shift a percentage of these costs to other patients who are insured — and their employers who purchase the coverage — by raising their rates.*

WHAT HAPPENS WHEN CO-PAYMENTS ARE IMPOSED?

As mentioned previously, the state plans to impose new charges for prescription drugs and doctor visits. The state intends to seek federal approval to charge these copayments for children and pregnant women. Increased copayments are already in place for all other adult beneficiaries.

It has been well established that increased copayments reduce access to care.[20] In addition, however, copayments place additional administrative burdens on the providers who must collect them. Because many low-income families are already having difficulty meeting expenses for housing, food, and other basic needs, many providers conclude that it is not worth the effort to collect the co-payments, and simply absorb the costs themselves.

Vermont provides an example of how the imposition of co-payments results in reimbursement reduction for providers. A recent study by that state found that a $3 copayment for hospital outpatient services was collected only 15.7 percent of the time, even after follow-up billing by the hospital. Collection rates for higher inpatient copayments were even lower — 12.5 percent.[21] Vermont expects this low rate of collection to continue.

Changes in the HUSKY A benefit package will shift costs to other areas of the Connecticut budget. For example, when children cannot get the behavioral health care they need in HUSKY A, their families may be forced to seek services from the Department of Children and Families voluntary services program.[22]

CONCLUSION

The proposed changes in Connecticut's Medicaid program — new premiums, reductions in benefits, and increased copayments — will result in reduced access to essential health care services and poorer health outcomes for thousands of Connecticut citizens. In addition, the attendant cutbacks in federal funding can be expected to precipitate job loss and other economic hardships. The number of uninsured and underinsured will increase, meaning more uncompensated care demands on hospitals, community health centers and other providers, as well as expanded use of costly emergency room services.

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1 See Alker, J and Solomon, J. *Families at Risk: The Impact of Premiums on Children and Parents in Husky A,* November 2003; *and Families at Risk: Imposing Premiums on Elderly and Disabled Persons in Husky A,* December 2003. Available from the Connecticut Health Foundation at www.cthealth.org.

2 Solomon J, Lee, MA, Alker, J. *Families at Risk: The Impact of Co-payments and Reduced Benefits on Children Enrolled in HUSKY A.* Available at www.cthealth.org.

3 Centers for Medicare and Medicaid Services (CMS) Forms 37 and 21B.

4 Wachino, V., Schneider, A. and David Rousseau *Financing the Medicaid Program: The Many Roles of Federal and State Matching Funds* (Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured) January 2004.

5 Currently Connecticut, like all states, is receiving a temporary increase of 2.95 percent in the federal matching assistance percentage rate enacted as part of the "Jobs and Growth Tax Relief Reconciliation Act of 2003." This enhanced matching rate will expire by July 1, 2004, unless Congress extends it, so it is assumed for the purpose of this analysis that Connecticut's matching rate will return to its regular rate of 50 percent in state Fiscal Year 2005. If Congress were to extend the matching rate, the economic effects of cutting Medicaid would be even more profound.

6 A few services are reimbursed at higher matching rates – for example family planning services are matched at 90 percent for all states. See *The Medicaid Resource Book* (Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured) July 2002, p. 94.

7 Georgetown Health Policy Institute analysis based on state estimates of savings from benefits changes from the Connecticut State Budget 2003-2005, Office of Fiscal Analysis, Connecticut General Assembly, p. 360 and estimates of lost federal share as a result of enrollment declines resulting from the imposition of premiums. To obtain the estimate of lost federal dollars, it was assumed that participants would have received services for ten months. The average monthly cost for children and parents was assumed to be $177.82 based on SFY04 Statewide average capitation rates from the Connecticut Department of Social Services. For the medically needy, the average monthly cost was assumed to be $904.50. This amount was calculated based on CMS MSIS data for Connecticut's non-institutionalized medically needy from FY2001 trended forwarded to FY2005 using the CMS actuarial estimates from the National Health Expenditure Projections 2002-2012 (published in February 2003). Finally the expected offsetting revenue that the state would retain from premiums paid was subtracted to get a final estimate of federal dollars lost.

8 Two such examples are *Economic Impact of Medicaid on South Carolina.* (Moore School of Business, University of South Carolina), January 2002, and Crispin-Little, J. *Economic Impact of Medicaid and CHIP on the Utah Economy.* (Bureau of Economic and Business Research, University of Utah), January 2003.

9 *Medicaid: Good Medicine for State Economies* (Washington, D.C.: Families USA), January 2003. The multiplier is based on an input-output analysis using the RIMS II model created by the U.S. Department of Commerce, Bureau of Economic Analysis. For more details, see the Methodology section of the Families USA report at www.familiesusa.org.

10 Ibid, p.8.

11 Most seniors on Medicaid are also eligible for Medicare ("dual-eligibles"), but they receive prescription drug coverage and other additional benefits through Medicaid. The recently enacted Medicare prescription drug benefit does not become available until 2006.

12 Georgetown Health Policy Institute analysis assumes that 90 percent of parents and children will become uninsured. The percentage of families with children reporting third-party coverage (a requirement of receiving Medicaid) in Husky A is substantially lower than 10 percent. If families are not already privately insured, it is extremely unlikely that a family disenrolled for nonpayment of premium will be able to afford coverage on the private market. For the Medically Needy our estimate is based on a projection that 10,000-12,000 persons will be subject to medically needy premiums once their eligibility for other categories has been assessed, and 29 percent of persons paying premiums will lose coverage based on our earlier analysis. Using ratios from the FY2001 CT MSIS data, we assumed that all of the seniors would remain covered and one-third of the persons with disabilities would be eligible for Medicare based on national estimates – see *Dual Eligibles: Medicaid's Role for Low-Income Medicare Beneficiaries* (Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured), January 2004.

13 "Changes in Enrollment Among OHP Standard Clients with OHP2 Implementation" presentation by J. McConnell, Oregon Health & Science University, and N. Wallace Portland State University, in collaboration with the state of Oregon Office for Health Policy and Research January 2004.

14 *Changes in Access to Primary Care for Oregon Health Plan Beneficiaries and the Uninsured: A Preliminary Report Based on OHSU Emergency Department Data,* Oregon Health Research and Evaluation Collaborative, September 2003.

15 See Jack Hadley, "Sicker and Poorer: The Consequences of Being Uninsured," *Medical Care Research and Review* Vol. 60, No. 2 (Supplement), June 2003 and *Care Without Coverage: Too Little, Too Late* (Washington, D.C.: Institute of Medicine), May 21, 2002.

16 Jack Hadley and John Holahan, "How Much Medical Care do the Uninsured Use, and Who Pays for It?" *Health Affairs Web Exclusive,* February 12, 2003.

17 Melissa B. Jacoby et al. "Rethinking the Debates over Health Care Financing: Evidence from the Bankruptcy Courts" *New York University Law Review* Volume 76, Number 2, May 2001.

18 Hadley and Holahan, ibid.

19 Georgetown Health Policy Institute analysis from estimates of anticipated Husky A costs if this population had remained enrolled in FY2005 multiplied by 51 percent per the Hadley and Holahan findings.

20 For a review of the literature, 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: Washington, D.C.), March 2003.

21 *Report to the General Assembly on Co-Payments and Premiums* Prepared by the Department of Prevention, Assistance, Transition and Health Access, State of Vermont, January 1, 2003.

22 For background on the voluntary services program and why families may be forced to seek care from the Department of Children and Families, see www.cthealth.org.

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policy brief

FAMILIES AT RISK:

THE IMPACT OF PREMIUMS ON PREGNANT WOMEN IN MEDICAID

SUMMARY OF FINDINGS

- At least 2,000 low-income pregnant women can be expected to lose Medicaid coverage if premiums are imposed.
- These uninsured pregnant women will have difficulty obtaining early prenatal care and essential care and family planning services after giving birth; their babies will not automatically be covered for timely well-baby care and immunizations.

INTRODUCTION

In August 2003, the Connecticut General Assembly passed a law requiring that the Department of Social Services (DSS) ask the federal government for a waiver that would make dramatic and unprecedented changes to HUSKY A coverage for pregnant women:

- Pregnant women in families with incomes as low as $636 per month — which is 50 percent of the federal poverty level for a family of three — would be required to pay monthly premiums for coverage during pregnancy and 60 days after the birth. Benefits would be terminated if premium payments are not made for two months.

If federal approval is granted, these changes represent reversal of Connecticut's long-standing public commitment to improving maternal and infant health. These changes will add to the effect of other recent cutbacks in eligibility for parents of children in HUSKY A.[1]

PREMIUMS WILL REDUCE ACCESS TO PRENATAL AND WELL-BABY CARE

An estimated 2,000 pregnant women, that is about 30 percent of those enrolled at any point in time during the year, can be expected to lose coverage and will likely be uninsured when they give birth.[2] Uninsured pregnant women will have difficulty obtaining early prenatal care and essential care and family planning services after giving birth. Their babies will not automatically be covered for timely well-baby care and immunizations.

MEDICAID IS IMPORTANT FOR CONNECTICUT'S FAMILIES AND COMMUNITIES

In Connecticut, Medicaid covers more than one of every four births.[3] In the largest cities, Medicaid covers most of the births, including 60 percent of births in Hartford, 51 percent in New Haven, 47 percent in Waterbury and 43 percent in Bridgeport.

Connecticut has devoted considerable resources to improving birth outcomes by ensuring that low-income women have access to prenatal care and other services they need when pregnant. Connecticut was among the first of 39 states to expand Medicaid coverage beyond the federally mandated income level to women in families with income up to 185 percent of the federal poverty level. For many years, Connecticut has supported community-based outreach and case management aimed at linking newly pregnant women with early prenatal care and Medicaid coverage for mothers and infants. Eligibility for babies born to mothers covered by Medicaid is automatically processed within days after birth, thus ensuring access to well-baby care in the first weeks of life.

Low birthweight is a major determinant of infant mortality in the United States....For nearly 20 years, prenatal care has been endorsed as one important strategy for preventing low birthweight....

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MEDICAID IS IMPORTANT FOR WOMEN'S AND INFANTS' HEALTH

Disadvantaged women, especially those living in poverty or in poor health, are at increased risk for poor maternal and infant health outcomes.[4] Compared to women with higher incomes, they are more likely to delay beginning prenatal care, experience multiple health-related risk factors and give birth to babies with low birthweight and other problems. These differences in risk make a strong case for improving policies and programs whose aim is to ensure access to prenatal care and other services for Connecticut's low-income pregnant women.

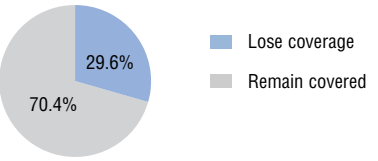
Low birthweight is a major determinant of infant mortality in the United States.[5] Infants weighing less than 2500 grams (5 pounds 8 ounces) at birth are nearly ten times more likely to die in the first year of life; those weighing less than 1500 grams (3 pounds 2 ounces) are more than 30 times more likely to die, especially in the early weeks after birth. Low birthweight babies who survive are far more likely than normal weight babies to experience serious short-term complications as well as long-term health problems. For nearly 20 years, prenatal care has been endorsed as one important strategy for preventing low birthweight, especially among women at greatest risk for low birthweight and preterm births.[6]

Congress extended Medicaid coverage in order to reduce financial barriers to obtaining prenatal care. Medicaid expansions, like those enacted in Connecticut in the early 1990s, have improved access to care by reducing the percentage of births to uninsured women and increasing the percentage of pregnant low income women with early and adequate prenatal care.[7]

CONCLUSION

After over a decade of reducing financial barriers to obtaining early and adequate prenatal care, Connecticut is proposing a policy that will reverse efforts to improve maternal and infant health. As the number of uninsured pregnant women grows, the demand will increase for hospitals and other safety net providers to absorb more uncompensated costs for their care.

30 Percent of Low-Income Pregnant Women in HUSKY A Would Lose Coverage Due to the Proposed Premiums



Note: Pregnant women who live in families with income between 50-185 percent of poverty will be required to pay premiums.

Source: Georgetown University Health Policy Institute analysis.

REFERENCES

1 Effective April 1, 2003, income eligibility level for parents of children in HUSKY A was reduced from 150 percent of the federal poverty level ($22,890 for family of three) to 100 percent of the federal poverty level ($15,260 for family of three). In addition, parents who are legal immigrants but have been in the U.S. for less than five years and apply for coverage after June 30, 2003, are no longer eligible.

2 Methods: Based on analyses of HUSKY A enrollment data and Connecticut birth data linked with enrollment data by the Children's Health Council, an estimated 6,922 pregnant women will subject to premiums at any point in time during the year. The expected participation as a function of premium cost was determined based on a model developed by Ku and Coughlin (2000):

$$(P/1-P)=0.7239-0.4555X$$

where P = the estimated participation rate for an income cohort and X = the premium level as a percentage of income.

This estimate includes 1,000 women in pregnant women coverage groups who are in danger of losing coverage, as reported in the first policy brief, *Families at Risk: The Impact of Premiums on Children and Parents in HUSKY A.* For a more detailed explanation of the methodology, the expanded Methodology section for this brief is available at www.cthealth.org.

3 Children's Health Council. *Births to Mothers in HUSKY A*: 2001. Hartford, CT: CHC, 2003. In 2000, there were 9,630 births to women enrolled in HUSKY A (Medicaid managed care) and 1,874 births to women in fee-for service Medicaid. In 2001, there were 9,506 births to women enrolled in HUSKY A and 2,145 births to women in fee-for service Medicaid.

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