

**HEALTH INSURANCE PREMIUMS AND COST-SHARING:
THE IMPACT ON LOW-INCOME POPULATIONS**

Medicaid and the State Children's Health Insurance Program (SCHIP) have increased access to health care and improved health outcomes for millions of low-income individuals. Although private plans often employ cost-sharing and premiums as mechanisms to reduce utilization and control costs, these approaches have been limited in Medicaid because it serves a population with high health care needs and limited resources. This brief highlights research findings on the impact of premiums and cost-sharing for the low-income population. These findings show that even low premiums can depress participation in public health programs and cost-sharing can negatively affect health care utilization and outcomes for low-income people.

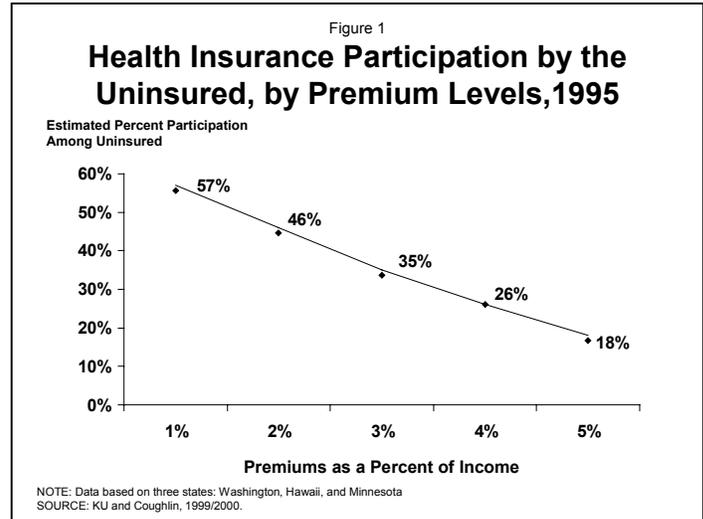
COST-SHARING AND PREMIUMS IN MEDICAID AND SCHIP

Medicaid finances health and long-term care services for 47 million people, including many of the nation's poorest and most vulnerable individuals. Over half of Medicaid beneficiaries have incomes below poverty level (\$14,630 for a family of three in 2001). Under Medicaid, low-income children and pregnant women are protected from cost-sharing. In addition, elderly and disabled beneficiaries who receive SSI cash assistance are also protected from cost-sharing. States have greater latitude for all other groups of Medicaid beneficiaries; however, copays have to be nominal (generally either 5% of the state's payment for the service or up to \$3). Cost-sharing cannot be imposed on any beneficiaries for emergency room visits, family planning services and hospice care. States may impose income-related premiums on certain optional eligibility groups such as the medically needy and working disabled individuals.

Under SCHIP, which targets low-income children, the amount of cost-sharing permitted depends on the type of SCHIP program and the child's family income. In SCHIP programs that are Medicaid expansions, the Medicaid rules apply; that is, children cannot be charged cost-sharing or premiums. By contrast, under separate SCHIP programs, such charges are allowed (except for preventive services and American Indian/Alaska Native children). Cost-sharing, not including premiums, is limited to 5% of annual family income for all children, with some further protections for children in families under 150% of the federal poverty level.

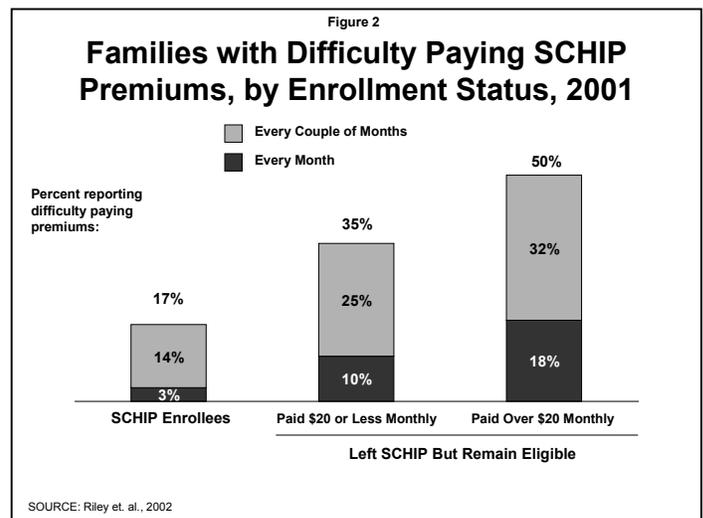
**HEALTH INSURANCE PREMIUMS CAN LIMIT
PARTICIPATION IN PUBLIC PROGRAMS**

In publicly subsidized health coverage targeted at the low-income population, premiums are typically not charged or are determined on a sliding-scale basis because family



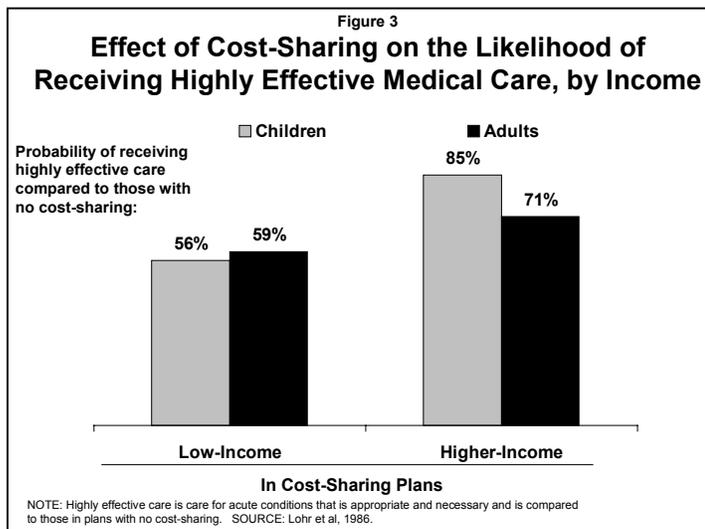
finances are limited. Research using data from Washington, Minnesota, and Hawaii estimated participation rates among the eligible population in health programs with premiums and found that participation declined from 57% to 18% as premiums rose from 1% to 5% of family income (Ku and Coughlin, 1999/2000) (Figure 1).

Other research shows that many families who participate in these programs have difficulty paying premiums even when the amounts are relatively low (Figure 2). A study of the impact of charging premiums under SCHIP found that 17% of parents with children enrolled reported periodic trouble paying these premiums. Of families who have left SCHIP, but remain eligible, up to 50% report difficulty paying premiums when premiums exceeded \$20/month (Riley et al, 2002).



COST-SHARING HAS A GREATER IMPACT ON LOW-INCOME POPULATIONS

Cost-sharing has a disproportionate impact on low-income people. A number of the research studies have used data from the RAND Health Insurance Experiment (HIE) -- a randomized, controlled experiment supported by the federal government in the 1970s that remains the most comprehensive, rigorous study of cost-sharing, health care utilization and outcomes that exists. Analysis of RAND data showed that low-income children in cost-sharing plans had only a 56% likelihood (85% for higher-income children) of receiving highly effective care for acute conditions relative to those with no cost-sharing (Lohr et al, 1986). Similarly, low-income adults in cost-sharing plans had a 59% likelihood of receiving highly effective care relative to those with no cost-sharing. Higher income adults in cost-sharing plans fared better – they had a 71% likelihood of receiving highly effective care (Figure 3). Low-income children in the cost-sharing plans were also significantly less likely to receive care for 14 health services compared to low-income children without cost-sharing, while higher income children were not affected except for acute respiratory infection (Newhouse, 1996) (Figure 4).



A number of studies have shown that Medicaid beneficiaries have difficulty affording medications and that copays often decrease access to prescription drugs, especially for the poorest and sickest populations. Findings consistently demonstrate Medicaid beneficiaries use less prescription drugs in states that impose co-payments, even when copays are nominal (Nelson et al, 1984; Roemer et al, 1975; Stuart and Zacker, 1999). Over a quarter (26%) of Medicaid beneficiaries reported that they did not fill a prescription because they could not afford it despite being a Medicaid-covered benefit in all states (Cunningham, 2002). Furthermore, the RAND study showed that low-income adults in plans with cost-sharing were three times less likely to use appropriately prescribed antibiotics as those with no cost-sharing (Newhouse, 1996).

Figure 4
Health Care Services That Children Were Less Likely to Receive Due to Cost-Sharing, by Income

Low-Income Children	Higher-Income Children
Significantly less likely to receive care compared to those with no cost-sharing for:	
<ul style="list-style-type: none"> • General Medical Exam • Vision Exam • Otitis Media (Both Acute and Non-Acute) • Influenza • Acute Upper Respiratory Infection • Streptococcal Sore Throat • Acute Bronchitis • Diarrhea and Gastroenteritis • Skin Rashes and Other Skin Diseases • Acute Sprains and Strains • Lacerations, Contusions, and Abrasions • Other injuries and adverse effects 	<ul style="list-style-type: none"> • Acute Upper Respiratory Infection

SOURCE: Newhouse, JP. *Free For All? Lessons From the RAND Health Insurance Experiment?* Washington, DC:RAND, 1996.

POORER HEALTH OUTCOMES ARE ASSOCIATED WITH HIGHER COST-SHARING FOR LOW-INCOME POPULATIONS

Findings from the RAND experiment showed significantly better health outcomes for low-income individuals in plans without cost-sharing compared to similar populations with cost-sharing for three conditions: improved diastolic blood pressure for those with hypertension; a 10% reduction in the risk of dying for those at high risk (high blood pressure, high cholesterol, smoker); and improved vision (Brook et al, 1983; Keeler et al, 1985; Lurie et al, 1989). Adverse health outcomes are associated with cost-sharing for prescription drugs among poor and elderly persons. A recent study found the use of essential drugs – drugs that either prevent deterioration in health or prolong life – decreased 14% for poor and 9% for other elderly individuals after implementing cost-sharing policies and led to higher rates of serious adverse events and greater emergency room use (Tamblyn et al, 2001).

CONCLUSIONS

Research shows that premiums can discourage enrollment in health insurance programs and cost-sharing disproportionately affects low-income people, reduces the use of beneficial, cost-effective services, preventive care and prescription drugs and can result in worse health outcomes. Limiting access to services through cost-sharing, particularly outpatient care, may result in higher costs overall, if more expensive services, such as hospital care, are used instead. In view of the greater health needs and limited resources of low-income individuals, these findings warrant caution as policymakers consider the use of premiums and cost-sharing in public programs for people with modest or low incomes.

Drawn from *Health Insurance Premiums and Cost-Sharing: Findings From the Research on Low-Income Populations*, Kaiser Commission on Medicaid and the Uninsured, March 2003 (#4071).

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