

# Proposed Medicaid Premiums Challenge Coverage for Florida's Children and Parents

Florida's Experience with

## MEDICAID REFORM

*Florida's proposed changes to its Medicaid program include a requirement for nearly all Medicaid beneficiaries, including children, who are enrolled in managed-care plans to pay a \$10 monthly premium as a condition for Medicaid eligibility. This could result in 800,000 Florida children and parents – the majority of them children in very-low-income families – leaving Florida Medicaid and losing access to health coverage because they cannot afford the premium.*

In spring 2011, the Florida Legislature passed House Bill (HB) 7107, which set the terms for major changes in the state's Medicaid program. Among its provisions, the law calls for nearly all Medicaid beneficiaries, including children, who are enrolled in managed-care plans to pay a \$10 monthly premium as a condition for Medicaid eligibility. (Those living in nursing homes would be exempt).<sup>(1)</sup>

Although states have limited ability under federal law to impose premiums in Medicaid programs, Florida's proposal exceeds the allowed premiums and thus requires a waiver from the federal government. That waiver request currently is before the Centers for Medicare & Medicaid Services (see the accompanying brief "Looking Ahead to 2012, What Changes Are in Store for Florida's Medicaid Program?").

While some states charge premiums in their Medicaid or Children's Health Insurance (CHIP) programs, it is typically at higher income levels. No state currently charges premiums to Medicaid children with family incomes below the poverty line. Florida's proposed premium requirement is likely the most far-reaching to date because the state seeks to apply a relatively high charge to everyone in the program regardless of income or age.

To understand what the implications of such a premium charge might be, researchers at the Health Policy Institute at Georgetown University analyzed the experiences of other states that have instituted premium requirements, and used an independent mathematical model to project the impact Florida's premiums would have on Medicaid enrollment. The results were startling. The model suggests that the premium requirement, if approved, could result in 800,000 Florida children and parents finding themselves unable to

pay the premium and disenrolling from Florida Medicaid. This represents nearly half (45 percent) of the children and parents currently covered.

### PROPOSED NEW PREMIUMS

The motivation for the new premium was stated by Rep. Matt Hudson (R), the chairman of the Florida House Appropriations Health Subcommittee, who said that the premiums would make "people personally responsible for their own health."

"This is not a budgetary decision – it's a philosophic stand," he said. "Everyone else in society is paying a portion of their own health care, including the military and retirees, so why shouldn't this segment of the population?"<sup>(2)</sup>

Representatives of Florida CHAIN and the Florida Center for Fiscal and Economic Policy paint a different picture, suggesting that the premium would be "particularly onerous for several reasons," including the fact that it applies regardless of a family's income or any hardship or special circumstance.

They further note their concern that this broad premium threatens access to care and reflects "a basic disregard for the well-being of vulnerable patients."<sup>(3)</sup> Medicaid in Florida provides health coverage to about 1.8 million children and parents whose eligibility is based on different categorical and income criteria. These beneficiaries represent about two-thirds of all Florida Medicaid enrollees. Although many others who are eligible for Medicaid based on their disabilities

or old age will also be liable for the new premiums, they are not the focus of this brief. This brief focuses primarily on four groups:

Families who are eligible for Medicaid because they include a working parent with dependent children and have incomes of no more than 59 percent of the federal poverty level (FPL), sometimes called TANF-based coverage;

Families with an unemployed parent who are eligible if family income is less than 22 percent of FPL; and children age 19 and 20 with family income less than 22 percent of FPL;

Children who are eligible based on age and income criteria: up to 133 percent of FPL through age 5, and up to 100 percent of FPL through age 19;<sup>(4)</sup>

Pregnant women who are eligible based on income up to 185 percent of FPL.

Exhibit 1 illustrates typical incomes and premiums that may apply in these different categories.

### EXPERIENCES AROUND THE COUNTRY

Research is clear that cost sharing and premiums charged to families at very low income levels, such as the vast majority of enrollees in Florida's Medicaid program, inhibit access to needed care.

As of January 2011, 34 states charged premiums or enrollment fees to children enrolled in Medicaid or CHIP programs.<sup>(5)</sup> Most of these limit premiums to CHIP programs and apply them only at higher income levels. Only eight states have premiums that reach families with incomes at 101 percent of the federal poverty level.<sup>(6)</sup>

Premiums are charged to Medicaid adults in 23 states, and about half start charging premiums for some adults below the poverty level.

If Florida goes forward with the proposed \$10 premiums at all income levels, it would be the only state to apply a premium this broadly to both children and adults.

In at least 11 states, research has shown that enrollment declined as a result of new or increased premiums charged to Medicaid beneficiaries, although specific policies and results varied considerably.<sup>(7)</sup>

In Missouri, for example, researchers found a 30 percent decline in enrollment over two years following the 2005 introduction of new premiums.<sup>(8)</sup> In Maryland, 28 percent of children disenrolled in one year in which some at higher income levels were charged \$37 monthly premiums.<sup>(9)</sup> Premiums for Oregon adults with incomes below the poverty level dropped overall enrollment by more than half, from 100,000 to 30,000.<sup>(10)</sup> Changes were more modest in some other states.

Other studies used surveys to look at the impact of Medicaid and CHIP premiums nationally, finding that higher premiums lead to lower enrollment in these public programs.<sup>(11)</sup>

What happens to these children and families when they leave Medicaid?

Those who lose public coverage may seek to obtain private policies, for example employer-sponsored insurance for those who are working. However, coverage often is not available to those with low incomes, because even those with jobs are less likely to work for employers that offer coverage. In 2005, only 40 percent of workers whose incomes were below the poverty level were eligible for employer-sponsored insurance – and only about 60 percent of those between 100 and 200 percent of the poverty level were eligible.<sup>(12)</sup>

Furthermore, premiums for workers are far higher than typical Medicaid premiums.<sup>(13)</sup> As a result, the vast majority are likely to end up with no insurance, particularly among those at lower income levels.

**EXHIBIT 1. Illustrative Premiums under Florida's Proposal**

Type of Family With Medicaid Coverage	Assumed Family Income	Yearly Premiums	Premium as Percent Of Income
Family with 1 parent and 2 children (TANF-based coverage)	\$11,000	\$360	3%
Family with 1 unemployed parent and 2 children (eligibility based on unemployed status)	\$4,000	\$360	9%
Family with 2 covered children (eligibility based on income)	\$13,000	\$240	2%
Pregnant woman, no children (eligibility based on pregnancy)	\$14,000	\$120	1%

**ESTIMATING THE IMPACT OF NEW PREMIUMS**

In 1999/2000, the Urban Institute, a nonpartisan economic and social policy research organization, drew on the experience of three states to model the impact of new or increased premiums for low-income families in other state Medicaid programs.<sup>(14)</sup> The Urban Institute researchers found that even a small premium decreased or deterred enrollment as families found themselves without the resources needed to pay a monthly premium (Exhibit 2).

Specifically, the Urban Institute's model showed a premium that represents 3 percent of family income is estimated to reduce participation by about half, while a premium that represents 6 percent of family income would lead four of five enrollees to lose coverage.

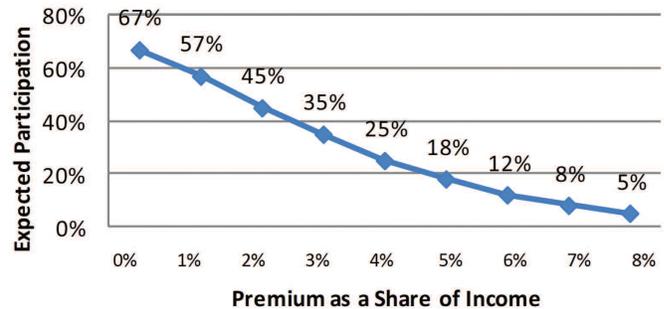
Because the Florida law sets the same premium for everyone regardless of income or family size, the premiums charged to a family with extremely low income can represent a large share of their income – reaching a level at which past experience suggests that families will almost certainly forgo coverage.

But even at somewhat higher income levels, the premiums called for in the proposal would still represent 1 percent of family income. According to the Urban Institute model, this level of income is still associated with about one in six families dropping coverage.

Applying this model to Florida, one would expect about 807,000 fewer children and parents would be enrolled in Florida's Medicaid program because of the proposed \$10 monthly per-person premiums (see Methodological Appendix).<sup>(15)</sup>

Children will bear the brunt of the losses, largely because there are far more children than adults enrolled in Florida's Medicaid program. More than 80 percent of those dropping coverage – about 663,000 – would be children (Exhibit 3).

**EXHIBIT 2: Expected Effect of Increasing Premiums on Participation Rates**

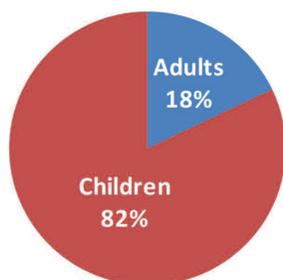


Should this occur, it would likely blunt the success of Medicaid and CHIP in Florida in reducing the number of uninsured children to historically low levels. Florida's children today are much less likely to be uninsured than adults, precisely because they have had Medicaid and CHIP to protect them from the decline in employer-based coverage and the rising costs of insurance.

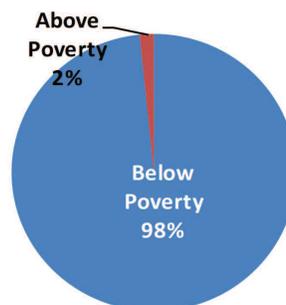
By contrast, 54 percent of Florida's nonelderly adults with incomes under 133 percent of the poverty level are uninsured today, but only 17 percent receive insurance through Florida's relatively limited Medicaid program.<sup>(16)</sup> The proposed new premiums could make the story worse. About half of adults currently covered by Medicaid – about 145,000 people – would be projected to disenroll (see Methodological Appendix).

Under the new rules, if approved, Florida would apply the same premiums to everyone regardless of income. But the impact of the new premiums would affect disproportionately those with the lowest incomes (Exhibit 4). About 98 percent of those projected to drop enrollment have incomes below the poverty level – in part because these families are the vast majority of those enrolled in Florida's Medicaid program.

**EXHIBIT 3: Four-Fifths of Those Expected to Lose Enrollment Are Children**



**EXHIBIT 4: Most Beneficiaries Expected to Disenroll Are Below Poverty**



Families with lower incomes also have more competing needs for their limited resources. A family (one parent and two children) at 75 percent of the federal poverty level has only \$13,700 in income to cover costs for rent, utilities, food, child care, taxes, and the cost of other necessities. If the rent on an apartment is just \$600 per month, it would absorb half of this family's income. In that situation, health insurance premiums at \$30 per month may look like an unaffordable luxury.

It is important to note that these estimates cannot by their nature be precise since many factors influence individual decisions. Nonetheless, they provide a sense of the magnitude of the coverage losses that could result from the new premiums.<sup>(17)</sup>

One important factor is that Florida's current participation rate in Medicaid is low by national standards. Enrollment of eligible children in Florida is 70 percent, well below the national average of 82 percent (in fact, the fifth lowest of all states).<sup>(18)</sup>

It is possible that some families would find other sources of coverage. But the declining availability of affordable employer-sponsored coverage, especially for families with low incomes, makes it likely that many of the children and their parents will become uninsured.

### **FURTHER IMPACT**

The potential loss of Medicaid coverage for 807,000 children and parents is more than a statistic. Those who end up with no insurance because they cannot pay their Medicaid premiums are more likely to end up using emergency rooms and inpatient hospital care as a result of avoiding or delaying primary and preventive care.<sup>(19)</sup> This could lead to increased uncompensated care and accompanying costs throughout the health system as they are shifted to other payers. Florida's physicians and hospitals that treat patients who cannot pay will bear part of this burden in reduced revenue. Other state and local safety-net programs may incur added costs as well.<sup>(20)</sup>

The new premiums could mean a greater degree of people cycling on and off coverage, which in turn can add to state administrative costs. People may decide to forgo paying premiums when they are healthy and need few services. But when illness arises, they would be more likely and willing to pay the premium and enroll. One result is that the average cost for remaining program participants becomes higher.

A 2002 study found evidence of this pattern of adverse selection in Florida's CHIP program, where premiums caused healthier children to disenroll at higher rates.<sup>(21)</sup>

### **CONCLUSION**

The evidence drawn from the experience of other states demonstrates clearly that new proposed premiums for Florida's program could lead to substantial disenrollment from Medicaid. More than 800,000 children and their parents are projected to drop their Medicaid coverage if \$10 monthly per-person premiums are implemented.

Many could become uninsured, resulting in reduced access to needed medical services. As a result, health providers across the state would have to share in the consequences by providing services without compensation. Florida's taxpayers also could face new costs as a result of higher costs for safety net programs and cost-shifting to other private and public payers in the system.

## ENDNOTES

- (1) The law also calls for virtually all Medicaid beneficiaries to be enrolled in managed care if they are not already. For more details, see "Looking Ahead to 2012, What Changes Are in Store for Florida's Medicaid Program?" by Joan Alker, Jack Hoadley, and Laura Summer, Georgetown University Health Policy Institute, December 2011.
- (2) Phil Galewitz, "Florida Pushing New Fees For Most Medicaid Recipients," Kaiser Health News, May 15, 2011.
- (3) Laura Goodhue, Florida CHAIN, and Karen Woodall, Florida Center for Fiscal and Economic Policy, Letter to the Centers for Medicare & Medicaid Services, October 11, 2011.
- (4) Children below age 1 are eligible with incomes up to 185 percent of FPL. Some children at higher income levels may obtain coverage through Florida's CHIP program. Martha Heberlein et al., "Holding Steady, Looking Ahead," Kaiser Family Foundation, January 2011.
- (5) Martha Heberlein et al., "Holding Steady, Looking Ahead," Kaiser Family Foundation, January 2011.
- (6) Minnesota has a premium that applies to some below poverty, but a recently approved waiver (not yet implemented) will eliminate premiums for children at or below 200 percent of poverty. Nevada's CHIP program has a premium that applies to some children under poverty, depending on the source of income or family composition.
- (7) 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, May 2005; Leighton Ku and Victoria Wachino, "The Effect of Increased Cost-Sharing in Medicaid: A Summary of Research Findings," Center on Budget and Policy Priorities, July 7, 2005.
- (8) Stephen Zuckerman, Dawn M. Miller, and Emily Shelton Pape, "Missouri's 2005 Medicaid Cuts: How Did They Affect Enrollees And Providers?" Health Affairs 28 (2): w335-w345, March/April 2009.
- (9) 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, May 2005; Leighton Ku and Victoria Wachino, "The Effect of Increased Cost-Sharing in Medicaid: A Summary of Research Findings," Center on Budget and Policy Priorities, July 7, 2005.
- (10) Leighton Ku and 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) Genevieve Kenney, Jack Hadley and Fredric Blavin, "Effects of Public Premiums on Children's Health Insurance Coverage: Evidence from 1999 to 2003," Inquiry 43(4): 345-361, Winter 2006/2007; Jack Hadley et al., "Insurance Premiums and Insurance Coverage of Near-Poor Children," Inquiry 43(4): 362-377, Winter 2006/2007.
- (12) Lisa Clemans-Cope, Genevieve M. Kenney, Matthew Pantell, and Cynthia D. Perry, "Access to Employer-Sponsored Health Insurance among Low-Income Families: Who Has Access and Who Doesn't?" Urban Institute, 2007. A more recent study showed that about 28 percent of lower-wage firms (those with more than 35 percent of workers earning \$23,000 or less annually) offer coverage, compared to 68 percent of firms with fewer lower-wage workers. Kaiser Family Foundation & Health Research & Educational Trust, "Employee Health Benefit 2011 Annual Survey" (September 2011).
- (13) In 2011, for family coverage, employees pay 28 percent of the premium or \$4,129 annually. Premiums would be about 17 percent of income for a three-person family at 133 percent of the federal poverty level, near the high end of the Medicaid beneficiaries potentially subject to the proposed premium. Kaiser Family Foundation & Health Research & Educational Trust, "Employee Health Benefit 2011 Annual Survey" (September 2011).
- (14) Leighton Ku and Teresa Coughlin, "Sliding-Scale Premium Health Insurance Programs: Four States' Experiences," Inquiry 36(4): 471-480, Winter 1999-2000. A rough validation of this model, based on more recently published studies of new or increased premiums, supports the general accuracy of the model, although many factors affect the specific outcomes in different states. We believe that use of the model for Florida is appropriate, though the estimates should be regarded as illustrating the general direction and magnitude of outcomes, not precise estimates.
- (15) As detailed in the methodological appendix, this analysis excludes several groups who would also be affected.
- (16) See Jack Hoadley and Joan Alker, "Understanding Florida Medicaid Today and the Impact of Federal Health Care Reform," Policy Brief, April 2011.
- (17) In the analysis we tested a variety of different scenarios – some of which would yield even higher estimates. For example, some mothers might try to pay premiums to keep their children insured, but not themselves. This could result in a somewhat smaller loss of coverage for children, but more lost coverage for adults.
- (18) Genevieve M. Kenney et al., "Who and Where Are the Children Yet to Enroll in Medicaid and the Children's Health Insurance Program?," Health Affairs 29(10): 1920-1929, October 2010.
- (19) See, for example, Leighton Ku and Victoria Wachino. "The Effect of Increased Cost-Sharing in Medicaid: A Summary of Research Findings," Center on Budget and Policy Priorities, July 7, 2005; Bill J. Wright et al., "Impact of Changes to Premiums, Cost-Sharing, and Benefits on Adult Medicaid Beneficiaries: Results from an Ongoing Study of the Oregon Health plan," The Commonwealth Fund, July 2005.
- (20) Genevieve M. Kenney et al., "Effects of Premium Increases on Enrollment in SCHIP," Inquiry 43(4): 378-392, Winter 2006/2007.
- (21) Elizabeth Shenkman et al., "Disenrollment and Re-enrollment Patterns in SCHIP: Findings from Three States," Health Care Financing Review, Spring 2002.

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**PROPOSED MEDICAID PREMIUMS  
CHALLENGE COVERAGE FOR FLORIDA'S  
CHILDREN AND PARENTS**

To estimate the expected levels of coverage loss, Georgetown researchers examined four categories of children and parents, as described in the brief. For each group, assumptions were made about income levels. For some groups, census data was used to estimate the number of people at different income levels with a weighted average income calculated. For other groups, a conservative assumption was made that all individuals have the maximum allowable income. In general, for purposes of relating income to the poverty level, researchers assumed a family size of three (one parent and two children), although in some categories only the children have Medicaid coverage.

Individuals in single-parent low-income families who meet TANF eligibility guidelines. For this group, the assumed income was at the maximum eligibility level of 59 percent of FPL.

Unemployed parents and children in families where family income meets AFDC Standards. For this group, the assumed income was at the maximum eligibility level of 22 percent of FPL.

Children eligible based on age and income criteria. Researchers divided this group into those below and

above 100 percent of FPL, and used weighted average income estimates of 84 percent and 124 percent.

Pregnant women based on income criteria and not eligible based on other criteria. Researchers divided this group into those below and above 100 percent of FPL, and used weighted average income estimates of 75 percent and 152 percent.

Excluded from the analysis are about 575,000 beneficiaries eligible for Medicaid based on their participation in supplemental security income as a result of their age or disability, about 250,000 qualified Medicare beneficiaries, as well as several other smaller groups.

In general, this analysis is conservative. For example, researchers assumed incomes at 59 percent of the poverty level for groups with TANF-based eligibility. Since this income is the maximum for eligibility, some would have lower incomes, thus increasing the likelihood of disenrolling according to the model. Researchers tested some different methods of assigning incomes; in general, estimates from these tests showed similar or larger numbers projected to disenroll. Researchers also tested a model where parents would drop their own coverage to make it easier to keep their children covered. Under this assumption, the number of children dropping coverage is reduced, but even more adults end up without coverage.

GROUP	ASSUMED AVERAGE PERCENT OF FPL	ENROLLMENT CHILDREN 2009-2010	CHILDREN PROJECTED TO DROP ENROLLMENT	% OF CHILDREN PROJECTED TO DROP	ENROLLMENT ADULTS 2009-2010	ADULTS PROJECTED TO DROP ENROLLMENT	% OF ADULTS PROJECTED TO DROP
Families with TANF-based eligibility: maximum of 59% FPL	59%	643,792	340,940	53%	171,135	90,269	53%
Families with Unemployed Parents: maximum of 22% FPL	22%	165,120	156,342	95%	43,893	41,559	95%
Children under 100% FPL	84%	617,669	154,336	26%	NA	NA	NA
Children over 100% FPL	124%	68,215	11,196	16%	NA	NA	NA
Pregnant Women under 100% FPL	75%	NA	NA	NA	64,308	11,010	17%
Pregnant Women over 100% FPL	152%	NA	NA	NA	14,777	1,165	8%
TOTAL		1,494,797	662,813	44%	294,112	144,364	49%