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**The Impact of Health Insurance Policy Changes
on Californians with Severe Chronic Disease**

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Abstract

Two recent changes in health policy will likely negatively impact state budgets and the health of low-income Californians with chronic disease. The new cost-sharing for medical visits, pharmaceuticals, and inpatient stays in California's Medicaid program (Medi-Cal) and the exclusion of the undocumented and individuals who have been legal residents for less than five years from the insurance expansions that The Patient Protection and Affordable Care Act of 2010 provides will reduce medical care utilization and may raise, rather than lower, state costs. Based on historical Medi-Cal utilization patterns, people living with HIV (PLWH) would average \$514 in cost-sharing fees annually. The undocumented may lose coverage entirely and face even higher costs. The charges are high relative to the low incomes of both Medi-Cal recipients and the undocumented and are likely to discourage relatively inexpensive, but productive, medical care. Increasing patient costs harms patient health, harms public health, and increases state spending on medical care.

Keywords: Affordable Care Act, health policy, Medicare, Medicaid, health insurance

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The Impact of Health Insurance Policy Changes on Californians with Severe Chronic Disease

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Introduction

The Patient Protection and Affordable Care Act of 2010 (ACA) will inaugurate the greatest change in health policy in the United States since the passage of Medicare and Medicaid legislation in 1965. It mandates that all individuals be covered by health insurance and significantly expands Medicaid eligibility to persons, irrespective of disability status, who are below 133% of the federal poverty level. By setting a uniform eligibility standard, the ACA eliminates the variation that currently exists in eligibility standards across states.

To support health insurance purchase for those above the income threshold for Medicaid, the ACA institutes substantial reforms to the nongroup health insurance market by promoting the creation of Health Insurance Exchanges, by outlawing medical underwriting, and by providing for guaranteed issue of insurance. The ACA attempts to make health insurance more affordable by subsidizing private insurance for low-income individuals and small firms, by eliminating the “donut hole” in Medicare drug coverage, and by setting up mechanisms to control costs. The ACA also includes initiatives to improve the quality of care in the Medicare program.

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Ironically, shortly after the passage of the ACA held out the promise that medical care would become more accessible and affordable for low-income Americans in the future, many states were taking measures that reduced the affordability of medical care for low-income people in the near term. The recession that began in 2008 has caused the Medicaid rolls to swell and has exacerbated the budget shortfalls that many states are experiencing. California, like many other states, has passed a budget that includes cuts to many state services, including its Medicaid program (called Medi-Cal).

The first goal of this paper is to explore how the cuts to the Medicaid program designed to reduce Medi-Cal spending in the short term will affect a particularly vulnerable group of low-income Californians—people living with HIV. The second goal is to understand longer-run impacts of the ACA on Californians living with HIV. The focus on people living with HIV allows us to examine a group where medical care, particularly antiretroviral therapy (ART), is very productive in improving health and where data are more available than for some other conditions. Although HIV is used as an example, the results should be generally applicable to low-income individuals who have chronic diseases that are responsive to medical treatment, and for whom access to medical care has significant health benefits. The next section presents an empirical analysis of the effect of Medi-Cal cost sharing on Californians with HIV, while the following section examines the impact the ACA will have on people living with HIV (PLWH) in California. A final section draws lessons for California health policy.

How will Medi-Cal policy changes affect Californians living with HIV?

Background

Faced with a massive projected state budget deficit in fiscal year 2011-12, Gov. Jerry Brown proposed a number of changes to California's Medi-Cal program. The governor's proposal, which was passed by the legislature, imposes cost sharing on all Medi-Cal enrollees except those with both Medi-Cal and Medicare coverage (the dual coverage group) and Medi-Cal HMO enrollees. Patients will be charged the following fees for using Medi-Cal services:

1. \$5 co-payment for each visit to a medical care provider, federally qualified health center or rural health center
2. \$3 and \$5 co-payments per prescription with no coverage for over-the-counter drugs
3. \$50 co-payments for each emergency room visit (both emergency and non-emergency)

4. \$100 co-payment per hospital inpatient day, with a maximum of \$200 per stay.

The governor had initially proposed a “hard cap” to limit Medi-Cal payment for physician office and clinic visits to 10 per year and a “hard cap” of six prescriptions per month for adult Medi-Cal enrollees. The legislature rejected these “hard caps” in favor of a “soft cap” that limits the number of provider visits for which Medi-Cal will pay to seven a year, but allows for exemptions if a physician certifies that the visit will prevent the need for inpatient or emergency care.

The more than 33,000 PLWH in California insured by Medi-Cal have extensive needs for health care. Thus, it is important to know how the proposed changes will affect this vulnerable population.

Methods

In order to forecast how Medi-Cal cost-sharing will impact beneficiaries with HIV, we first projected expected use of Medi-Cal services in FY11/12 based on Medi-Cal claims for persons living with HIV in California in 2007, the most recent year for which detailed Medi-Cal claims data are available. Although medical costs rise over time, it is reasonable to assume that quantities of services used are relatively invariant from year to year. Annual estimates were based on data for Medi-Cal beneficiaries 18 years of age or older, who were eligible for Medi-Cal the entire year, were not dually eligible for Medicare, and had no long term care (LTC) stays during the year. We used a conservative definition of “visit,” which excluded encounters for laboratory or x-rays that occurred independent of a physician or clinic visit and we excluded physician claims that did not occur in an outpatient setting and those claims that were exempted from cost sharing (e.g., pregnancy or EPSDT). To calculate expected costs, we multiplied the average utilization in each category by the new cost-sharing fees. We also estimated the average cost-sharing for the highest quartile of users.

Findings

We identified 33,083 persons with HIV who were covered by Medi-Cal in 2007, of whom 22,266 were over 18, enrolled the entire year and did not have LTC stays. Forty-five percent of the full year enrollees also had Medicare coverage. Total Medi-Cal expenses for PLWH who were enrolled for all 12 months totaled \$347 million/year, of which California’s share is 50%. Medi-Cal costs averaged \$23,394 for PLWH who only had Medi-Cal coverage and \$6,692 for PLWH who were covered by both Medi-Cal and Medicare. Co-payments will be required of the 11,463 individuals covered only by Medi-Cal who did not have Medicare as their primary insurer.

Table 1. Use of Medi-Cal Services by Full-Year Eligibles and Predicted Cost- Sharing

Service Type	% Users	Number of Services		Predicted Cost Sharing		
		Users Mean	All Mean	Users Mean	Users Max	All Mean
Physician Visits	94.4%	16.0	15.1	\$ 80	\$ 900	\$ 75
Emergency Room Visits	41.1%	3.3	1.4	\$167	\$1250	\$ 69
Medications (#)	95.5%	61.8	59.0	\$309	\$1350	\$295
Hospital Stays	18.9%	2.2	0.4	\$397	\$2000	\$ 75
Total				\$517	\$4760	\$514

Table 1 shows in the first data column the percent of Medi-Cal enrollees who used each of the four categories of service (physician and clinic visits; emergency room visits; medications; and inpatient stays). The next two columns show the average number of each service used by those who had at least one Medi-Cal claim for the service, and the average over all enrollees. The last three columns show the level of cost-sharing that would be imposed, based on the historical utilization patterns for those who used the service, for the highest user of the service and an overall average calculated over all beneficiaries, not just those using the service.

Over 94% of Medi-Cal beneficiaries with HIV visited a doctor or clinic during the year; on average, those using provider services made 16 visits (see Table 1). Considering the entire population of PLWH, whether or not they visited a provider, the average number of visits is 15.1. In addition to visiting physician offices and clinics, 41% of Medi-Cal beneficiaries also sought care in an emergency department. Users of emergency departments averaged 3.3 such visits annually.

Medications are central to maintaining the health of PLWH and medication use was near universal, with 95.5% filing a Medi-Cal drug claim during the year. The number of medications used was also large, averaging 59 drugs per year for all enrollees. Among the 11% of the Medi-Cal enrollees who were hospitalized, the average number of stays was 2.2.

The last three columns of Table 1 show the impact of applying the proposed cost-sharing amounts. Given the observed patterns of utilization, we calculate that, on average, PLWH covered exclusively by Medi-Cal for the entire year would be required to pay \$514 for medical care. More than half of this charge is medication expense. Those who filed any drug claims averaged 61.8 medications per year, which will result in projected costs of \$309. PLWH with high medication use could be charged as much as \$1,350. Looking at total costs for all services, a person who

used as much medical care as the highest user in 2007 would have been charged \$4,760. The top quartile of users of medical care would average co-payments of \$1,196.

The “soft caps” on annual numbers of physician and clinic visits will potentially affect more than half (54%) of the Medi-Cal beneficiaries with HIV. Although the cap can be relaxed with the recommendation of a physician, the need to get an exemption introduces an additional barrier to accessing medical care. On average, Medi-Cal beneficiaries who exceeded the cap of seven visits had 18 visits over the cap. If Medi-Cal were to deny payment for all visits beyond the first seven, the cost to patients exceeding the cap would be substantial (over \$5,000) because they would need to pay the entire cost of the visit, not just the co-pay.

Proposed co-payments for Medi-Cal services present a significant financial burden for the average PLWH because only persons with low levels of income qualify for Medi-Cal coverage. The majority of PLWH who are on Medi-Cal qualify as a result of receiving SSI Disability Income, which was reduced to \$830/month in California as of July 1, 2011. The challenge will be even more severe for PLWH who require large amounts of medical care over the year. For example, for the top quartile of medical care users, average co-payments will amount to 12% of their meager SSI disability payments of \$9,960 per year. And the person with the greatest cost-sharing would owe an amount equal to 48% of his annual income.

Impact of the ACA on Californians living with HIV

One of the ACA’s stated goals is to reduce the number of uninsured Americans by expanding eligibility for public insurance through the Medicaid program and by subsidizing the purchase of private insurance through Health Insurance Exchanges. The Congressional Budget Office projects that as a result of the provisions in the ACA, there will be 32 million fewer uninsured in 2019, Medicaid rolls will increase by 16 million, and 24 million people will participate in the Insurance Exchanges. (CBO, 2011).

The ACA’s provisions will be particularly important for people living with chronic conditions. Historically, eligibility for Medicaid has been categorical, that is, available to certain low-income children and their families and to the low-income disabled. This has resulted in a Catch-22 for persons with severe, treatable chronic diseases that can lead to disability. Medicaid coverage would allow such individuals to purchase the medical care that would allow them to avert disability; but, in the past, they could not qualify for Medicaid coverage unless they were already disabled. This has been a particular problem to low-income people living with HIV, since the disability-preventing antiretroviral medications cost about \$12,000 per year.

The ACA eliminates this Catch-22 by making Medicaid available to all citizens (and some legal residents) with income below 133% of the federal poverty line, irrespective of disability status. (California obtained a Section 1115 Medicaid waiver that allows this provision to start as of 2011.) Health Insurance Exchanges will be established to provide subsidized access to health insurance for near poor individuals. In addition, the ACA outlaws denial or rescission of insurance due to health conditions, institutes guaranteed issue and renewability, and eliminates lifetime limits on claims.

The ACA will expand health insurance options for most, but not all, low-income Californians. Unfortunately, the undocumented and individuals who have been legal residents for less than five years (the two groups are hereafter referred to as “undocumented”) are not eligible for this expanded health insurance coverage. This is a particularly critical issue for California, home to large numbers of undocumented individuals. The issue may become more acute if implementation of the ACA leads politicians to consider that the uninsured problem has been “solved”, and therefore to drastically reduce programs that have historically supported the uninsured, such as the Disproportionate Share Program or the Ryan White Program for people living with HIV. Counties in California have the obligation to be providers of last resort, but this begs the question of where the funding for that care will come from.

Discussion

What will be the impact of these near-term and long-term changes to health policy on the use of medical care, on the health of Californians, and on the state budget? We have shown that, in the near term, low-income Californians with severe chronic disease will bear heavy financial costs to obtain medical treatment that was formerly free to them under Medi-Cal. We quantified the cost-sharing burden using data on Californians living with HIV. We have also argued that, despite the general expansion of health care coverage that the ACA will bring about, one group—the undocumented—may experience worse access to medical care as a result of cut-backs in programs designed for the uninsured.

Medi-Cal recipients with chronic disease are facing substantial levels of cost-sharing, and the undocumented may face the prospect of even higher costs, since they may lose coverage entirely. The effect of co-payments in reducing the demand for medical care is well established (Newhouse et al., 1993; Swarz, 2010; Baicker and Goldman, 2011). Cost-sharing can reduce unnecessary use and moral hazard, for example, decreasing emergency department use for nonemergency care (Hsu et al., 2006; Wharam et al., 2007). However, cost-sharing can also reduce use of medically necessary services and appears to have particularly large effects on pharma-

ceutical use, which can be a cost-effective means of treating many chronic diseases (Joyce et al., 2002; Gaynor et al., 2007; Maciejewski et al., 2010).

The substantial amounts of care needed by persons living with chronic disease requiring frequent visits to medical care providers and multiple prescriptions imply heavy cost-sharing requirements. These charges are sufficiently high relative to their low incomes for both current Medi-Cal recipients and for the undocumented with chronic disease, that the increase in cost-sharing will discourage use of appropriate medical care. For low-income individuals with chronic disease, the reduced use of medical care may result in significant health declines.

The Health Insurance Experiment found only modest health effects among the general nonelderly population randomly assigned to greater cost-sharing plans with income-related deductibles (Newhouse). However, recent research documents increased hospitalization following implementation of copayments for outpatient visits and pharmaceuticals (Chandra et al., 2010; Goldman et al., 2007; Gaynor, 2007). Analyses of the effect of cost-sharing for pharmaceuticals on patients with congestive heart failure, high cholesterol, diabetes, or schizophrenia have also found negative health consequences (Soumerai et al., 1994).

In the case of HIV, reducing antiretroviral use is likely to result in higher, not lower, total health care expenditures. Antiretroviral medication, while expensive, has been found to lower annual costs because lower inpatient costs more than offset the medication expense (Bozzette et al., 2001; Schackman et al., 2006). Examining another chronic condition amenable to medication, high cholesterol, Goldman et al. (2006) concluded that total health care costs would be three to five percent less over four years if cholesterol-lowering drugs were provided for free. Indeed, many private insurers are instituting Value-Based Insurance Designs (VBID), whereby patient cost-sharing is lower for drugs and interventions that are shown to be effective in preventing complications (Chernew et al., 2010). Thus, imposing financial barriers (cost-sharing or eliminating insurance) on individuals with severe chronic disease is likely to be penny-wise and pound-foolish.

For infectious diseases such as HIV, there is an additional reason to maintain access to medication. Several randomized controlled trials have now documented that antiretroviral treatment reduces transmission of the HIV virus (NIAID, 2011; Burman et al., 2008), providing solid confirmation for observational studies that found consistent effects of treatment in lowering HIV transmission (Attia et al., 2009; Blower et al., 2000; Charlebois et al., 2011; Das et al., 2010). In this case reimbursing for HIV treatment is crucial not only to preserve the health of individuals with HIV (Lundgren et al., 2008), but also to preserve public health by reducing transmission of the virus.

Another cause for concern is the likely effect of both the short-term and long-term cost-control policies in increasing health disparities across ethnic groups. HIV

has disproportionate impacts on African-Americans in California. African-Americans represent only 6.2% of the state's population, but account for 18.6 of all Californians living with HIV or AIDS (State of California, 2011b; U.S. Census, 2011), and 26% of nonelderly Medi-Cal enrollees (Kaiser Family Foundation, 2009). Latinos make up 37.6% of all Californians, 28% of nonelderly Medi-Cal enrollees, and 29.5% of living HIV/AIDS cases; but Latinos accounted for over half of the increase in cases between 2009 and 2010 (authors' calculation from State of California 2011b). Thus, both Medi-Cal cost-sharing and caps, and the potential loss of Ryan White care for the undocumented, risk taking ART away from those low-income groups most affected by HIV. This will have a differential impact on health, but also on transmission rates in minority communities since treatment has been shown to provide very effective prevention.

The caps on the numbers of visits for which Medi-Cal would pay were designed to leave unaffected 90% of the beneficiaries who use a particular service (State of California, 2011a). The perverse result of this decision is that the heaviest costs fall on the 10% of Medi-Cal beneficiaries with chronic disease. These individuals, whose health is most dependent on receiving medical treatment, will bear the brunt of high levels of cost-sharing for medical visits and prescriptions. Thus, the cost-sharing plan departs fundamentally from optimal insurance, which seeks to relieve the financial burden on those who are sickest and to spread the costs of their treatment more broadly over those without illness. The disproportionate effects of Medi-Cal cost sharing fall upon on a minority of individuals who require frequent use of medical care to monitor and treat chronic disease. Such individuals may as a result forego medical care that is relatively inexpensive to provide, but costly if avoided. These circumstances lead us to call for exempting persons with severe chronic illness from the cost-sharing requirements or, at a minimum, setting a cap on their out-of-pocket cost-sharing.

The situation faced by the undocumented if Ryan White programs are curtailed will be even more severe than that faced by Medi-Cal recipients. Both groups are similar in having low income that makes them quite sensitive to required patient payments for medical care. We can confidently predict that use of medical care will fall for both groups, with negative consequences for their own health and, in the case of HIV/AIDS, greater rates of transmission to others. Research findings suggest that state and county costs for treating Californians living with HIV/AIDS are likely to increase, rather than fall.

We have used HIV as a lens through which to examine the impact of Medi-Cal cost-sharing and lack of access to the insurance expansions health reform will deliver. However, we believe that the conclusions are more widely applicable to all Californians with severe chronic disease.

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