

Cutting Children's Care: How Capped Enrollment and Premiums Have Put Children's Health Care Out of Reach

The monthly premium that I pay for my daughter's coverage just went up from \$10.50 to \$45.32. This increase will greatly affect my family. As it is now I live paycheck to paycheck. I am currently struggling just to buy food, pay rent and utilities. Every dollar I have to pay for other expenses takes away food from our table.

~ A mother from Salem with a child enrolled in the Children's Medical Security Plan (CMSP)

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Children's Health Access Coalition

Health Care For All

30 Winter Street, Boston MA 02108

(617) 350-7279 ~ <http://www.hcfama.org>

Also available at <http://www.hcfama.org/acrobat/cuttingchildrenscare.pdf>

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I. EXECUTIVE SUMMARY

In the past year the Massachusetts government has made severe cuts to health care programs for children. Because of this, thousands of children are on a waitlist for coverage, and thousands more are being charged new premiums their families cannot afford. Taken together, the cuts will increase the number of uninsured children in Massachusetts by over 20%, and will have serious consequences for the economic well-being of both families and the state as a whole.

The most serious cuts for children have been in two programs:

- The Children's Medical Security Plan, known as CMSP, a limited health plan intended to be available to all children with no other health insurance.¹
- MassHealth, the state's Medicaid program, which covers one in four Massachusetts children.

CMSP Waitlist

CMSP enrollment was capped at 26,114 children in November 2002 due to inadequate funding. CMSP now has a waitlist of over 6,500 children,² waiting an average of over four months before being enrolled.

CMSP will soon have to lower its enrollment cap to 21,450 children in order to stay within its current appropriation. By June 2004, over 10,600 children will need CMSP coverage but not receive it.³

New Premiums for CMSP and MassHealth

CMSP raised premiums significantly in November 2003 because of Fiscal Year 2004 budget cuts. As a result, nearly 10,000 children are now paying four times as much in CMSP premiums as they did last year. For example, a family of four earning \$37,000 per year saw monthly premiums rise from \$10.50 to over \$45 per child per month.⁴ CMSP also imposed premiums for the first time on over 2,000 children from families with incomes as low as \$28,000 per year for a family of four; these families now pay \$10.50 per child per month.⁵

¹ CMSP is a limited "wrap-around" program—many children in CMSP receive their hospitalization services through the Massachusetts Uncompensated Care Pool, also known as "free care."

² Massachusetts Department of Public Health, December 2003.

³ Children's Health Access Coalition calculation based on CMSP expenditure figure of \$4,434,650 for July- November 2003, and FY03 CMSP costs of \$45.99 per child per month. (Source for cost data: Department of Public Health, December 2003.) This assumes that enrollment is reduced by attrition at a rate of 1,400 children per month until the new 21,450 caseload is reached in February 2004. Caseload would then stay at about this level through June 2004. (In practice, caseload would be further adjusted depending on actual enrollment and costs. If attrition is slower than expected, for example, caseload would have to be reduced still further.) Calculations assume that CMSP costs per child grow by 5% in FY04 and FY05, and that demand increases by 6.5% in the remaining half of FY04 and in FY05. (6.5% is half of the average growth in CMSP demand over the previous four years; this reduced rate assumes an improved but still weak economy.)

⁴ At family income levels of 201-400% of the federal poverty level (FPL). See Appendix 4 for other 2003 federal poverty level guidelines.

⁵ At family income levels of 150-200% of FPL.

Also in November, Massachusetts began charging MassHealth premiums to almost 9,000 children from very low-income families. For example, a family of four earning as little as \$25,000 per year now pays \$12 per child per month, with a maximum of \$15 per family.⁶ Some legal immigrants earning as little as \$19,000 per year for a family of four are now also charged these premiums.⁷

These premiums price CMSP and MassHealth out of reach for many low-income families who already struggle to pay for food and other basic needs. Many will be unable to pay the premium and will lose their coverage. Others will not enroll due to cost.

Based on the experiences of other states, the premium increases can be expected to cause nearly 1,000 children to drop off MassHealth—over 10% of children affected by these increases.⁸

Impact

The cuts to CMSP and MassHealth will increase the number of uninsured Massachusetts children. Even without the new cuts, the state estimates that over 54,000 children were uninsured in Massachusetts in 2002.⁹ **The enrollment cap and the premium increases in CMSP and MassHealth combined will increase the number of uninsured children by over 20%.¹⁰**

Uninsured children receive inadequate care, often delayed until an illness has become an emergency. The costs of children's untreated illnesses fall on families, hospitals, health centers, insurers, businesses, and taxpayers. Furthermore, a rise in uninsured children comes with loss of wages and productivity for parents who must care for their sick children. This hurts both the economic stability of families and the economic health of employers and the Commonwealth.

The children of Massachusetts deserve to have health care—and Massachusetts *can* afford it. The Children's Health Access Coalition calls on the Governor and the Legislature to make affordable health care available to the children of Massachusetts by adequately funding CMSP and by rolling back the new CMSP and MassHealth premiums for children.

⁶ At family income levels of 134-149% of FPL.

⁷ At family income levels of 101-149% of FPL.

⁸ Calculation by: Leighton Ku, Center on Budget and Policy Priorities, December 2003, using figures for number of children affected by new premiums from: Division of Medical Assistance, December 2003.

⁹ Calculated from: Massachusetts Division of Health Care Finance and Policy. Health Insurance Status of Massachusetts Residents, Third Edition. January 2003. Other estimates for the number of uninsured children in Massachusetts range as high as 94,000. (Source: Kaiser Family Foundation. "Massachusetts: Rate of Nonelderly Uninsured by Age, State Data 2000-2001, U.S. 2001." State Health Facts Online, <http://www.statehealthfacts.kff.org>, December 2003.)

¹⁰ Children's Health Access Coalition calculation, December 2003.

II. THOUSANDS OF CHILDREN LOSING HEALTH COVERAGE

A. Overview of Children's Health Coverage

From 1996 until November 2002, all children in Massachusetts under age 19 were eligible for some type of health coverage, regardless of family income. Due to health program cuts, children's access to health coverage has become uncertain. Low-income families may not be able to afford premiums for programs specifically designed to serve their children, and because an enrollment cap has been imposed on CMSP, thousands of children wait months on a waitlist for coverage.

The main source of children's health coverage is private, employer-based insurance. In 2001, 66% of children in Massachusetts had this type of coverage; that number is decreasing.¹¹

The "safety net" for children who do not have private health insurance consists of four main elements, all with significant limitations:

- MassHealth¹² covers approximately 408,000 children,¹³ but has recently increased premiums for thousands of low-income children.
- The Children's Medical Security Plan (CMSP) covers about 24,000 children for preventive and primary care only. CMSP has increased premiums and has a waitlist of

over 6,500 children.¹⁴ The enrollment cap will soon have to be lowered, leaving over 10,000 children uninsured, as explained below.¹⁵

- Schools offer limited free health services and have experienced major budget cuts in the past two years.
- "Free care," partially reimbursed through the Massachusetts Uncompensated Care Pool, is available in varying degrees at hospitals and community health centers. This type of coverage typically covers only emergency services and hospitalization, and does not include several important services, such as prescriptions and specialist care.

The state estimates that over 54,000 children were uninsured in Massachusetts in 2002.¹⁶ The Children's Health Access Coalition calculates that by summer 2004, the enrollment cap and the premium increases in CMSP and MassHealth combined will result in an increase in the number of uninsured children of over 20%.¹⁷

B. Children's Medical Security Plan: Waitlist, Lower Enrollment Cap, and New Premiums

The Children's Medical Security Plan (CMSP) currently provides health coverage to about 24,000 children under age 19 who have no health insurance and do not qualify for MassHealth,¹⁸ either because their families' incomes are too high or because their

¹¹ Kaiser Family Foundation. "Distribution of Children 18 and Under by Insurance Status, State Data 2000-2001, U.S. 2001." State Health Facts Online, <http://www.statehealthfacts.kff.org>, December 2003.

¹² Massachusetts and many other states have changed the names of their Medicaid programs to remove perceived stigmas. MassHealth is the name used in Massachusetts for Medicaid and SCHIP, the State Children's Health Insurance Program.

¹³ Massachusetts Division of Medical Assistance, October 2003.

¹⁴ Massachusetts Department of Public Health, December 2003.

¹⁵ Children's Health Access Coalition calculation, December 2003. See also footnote 3.

¹⁶ Calculated from: Massachusetts Division of Health Care Finance and Policy. Health Insurance Status of Massachusetts Residents, Third Edition, January 2003. See also footnote 9.

¹⁷ Children's Health Access Coalition calculation, December 2003.

¹⁸ A child may be on MassHealth Limited (which provides only emergency services) and CMSP simultaneously.

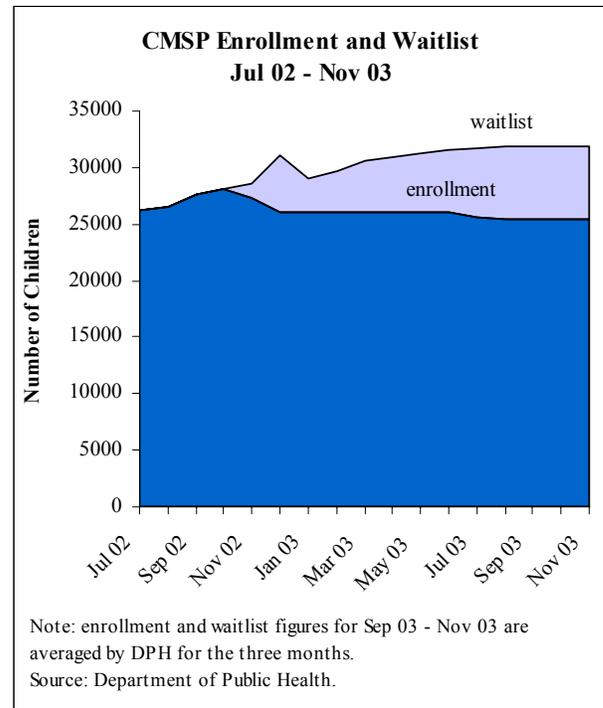
immigration status precludes eligibility. CMSP helps children by covering both preventive care, such as immunizations and checkups which can detect serious illnesses early on, and primary care, including the treatment of such problems as asthma and infections, which can develop into much more serious conditions if left untreated.¹⁹ It does not, however, cover emergency services or hospitalization.

CMSP was created in 1994, and expanded in 1996, to address the problem of the many Massachusetts children who were uninsured and not eligible for Medicaid. Families of any income level can enroll in CMSP, and there is a sliding scale system of premiums and co-payments.²⁰ CMSP has become crucial for working families by offering affordable health coverage. In fact, the majority of children on CMSP have parents who work more than 35 hours per week.²¹

Lower Enrollment Cap Expected

Due to inadequate funding in the state Fiscal Year 2003 budget, in November 2002 CMSP capped enrollment at 26,114 children. The new waitlist grew steadily and now stands at 6,545.²² Children seeking coverage must wait an average of over four months with no health care coverage before being enrolled. In addition to capping enrollment, DPH also reduced benefits and eliminated emergency department coverage in December, 2002. The chart at right

illustrates the growth of the CMSP waitlist in the past year.



CMSP was cut by an additional \$3.4 million in the state Fiscal Year 2004 budget. In order to stay within its FY04 appropriation, CMSP will soon have to lower its enrollment cap to 21,450 children. **By June 2004, over 10,600 children will need CMSP coverage but not receive it.**²³

In FY05, if CMSP receives the same level of funding as it did in FY04, an average of 14,000 children will not receive the coverage they need. Beyond this, it is likely that there will be thousands of children who are eligible for CMSP but whose families will not apply because they are discouraged by the waitlist or the premiums.

¹⁹ CMSP is administered by the Center for Acute Care and Ambulatory Services within the Massachusetts Department of Public Health. Unicare Life and Health Insurance Company manages and coordinates benefits.

²⁰ Co-payments are on a sliding scale from \$2 - \$8 for services such as office visits for illness or injury, lab and diagnostic tests, and outpatient mental health care. The maximum prescription drug benefit is \$200 per year. The maximum durable medical equipment benefit is \$200 per child per year; for asthma, diabetes, and epilepsy it is \$500 per year.

²¹ Massachusetts Department of Public Health. "Update on CMSP Survey and Evaluation: Investigating Churning and Crowd Out." February 2002.

²² Massachusetts Department of Public Health, December 2003.

²³ Children's Health Access Coalition estimate, December 2003. See also footnote 3.

Recent Changes: Premiums

On November 1, 2003, CMSP raised premiums significantly, as explained in the chart below.

Families with incomes below \$36,800 per year for a family of four²⁴ must now pay \$10.50 per child per month—affecting about 2,000 children. Massachusetts residents in this income bracket are already nearly twice as likely to be uninsured as higher-income residents.²⁵

Families earning as little as \$37,000 per year for a family of four now have to pay \$45.32 per child per month—over four times as much as they paid last year for their children's premiums. It is important to note that the budget language establishing the new CMSP premium structure refers to \$45.32 as the *household* premium for this income range, but \$45.32 is the premium being charged for each individual child.

Please see Appendix 1 for list of CMSP enrollment and waitlist numbers by city.

A family in Hampden County has two children, ages 6 and 15. Both children have been enrolled in CMSP for approximately 6 years. One parent is self-employed and the family has an annual income of \$40,000, putting the family at approximately 217% FPL. Last year, the family paid \$10.50 per child per month in premiums—a total of \$21 per month or \$252 per year, to cover both children. The children's premiums quadrupled in November and the family now must pay over \$90 per month or \$1080 per year, to cover both girls. Because of these higher premiums, the family was forced to disenroll the girls from the plan and they are now without health coverage.

Changes to CMSP Premiums as of November 2003					
Income level for family of 4*	Poverty level	Old premium per child	New premium per child	Maximum per family	Number of children affected**
\$27,600 - \$36,800	150-200%	\$0	\$10.50	\$31.50	2,000
\$36,801 - \$73,600	201-400%	\$10.50	\$45.32	None	9,700

* Families with incomes below \$27,600 (<150% FPL) will continue to pay no premium; families with incomes above \$73,600 (>400% FPL) will continue to pay \$52.50 per child per month.

** Approximate figures from: Massachusetts Department of Public Health, December 2003.

²⁴ 200% of the federal poverty level.

²⁵ Massachusetts Division of Health Care Finance and Policy. Health Insurance Status of Massachusetts Residents, Third Edition.

Increased premiums will cause children to lose health coverage

While the CMSP waitlist has created a crisis in children's access to care, the waitlist issue may soon appear to become less severe because CMSP coverage has become so expensive that thousands of children may lose coverage, and many others will be discouraged from enrolling. Lower waitlist figures will not indicate a decrease in need for CMSP, but rather the program's decreased affordability.

There was a year when both my girls were sick and I had to take them to the doctor all the time. I counted on CMSP for coverage for this care. But when premiums increased so dramatically in November we couldn't afford the program anymore. I had to drop CMSP on Nov. 1, and now the girls aren't covered. They get partial free care that only helps pay for part of our costs. Children should never go without health insurance.

~ A mother from Hampden County with two children enrolled in CMSP

In light of the increased CMSP premiums, many families are finding that the limited CMSP benefits are outweighed by their cost. The new CMSP premium of \$45.32 (for families from 201-400% of FPL) is in fact set at about the actual cost of coverage.²⁶ (Families on CMSP with incomes above 400% FPL—\$73,600 per year for a family of four—are paying *more* than the average cost to the state of their children's care.)

Although coverage protects against unexpected costs, parents who are already struggling financially—especially those whose children seem healthy—may understandably consider

²⁶ Total FY03 costs averaged \$45.99 per child per month. Source: Massachusetts Department of Public Health, December 2003.

foregoing CMSP coverage in order to meet other basic family needs such as food or rent.

The premiums will also exacerbate a dangerous trend in children's insurance: CMSP enrollees, who mainly come from low- and middle-income working families, already are increasingly losing their coverage for non-payment of premiums.²⁷

The CMSP appeal process makes no allowance for families who cannot afford the premiums. A family in this situation cannot appeal until the child is terminated for nonpayment of premiums. Premiums are never waived due to hardship; the only possible remedy is reinstatement in CMSP if the parents can somehow arrange to pay the overdue premiums.

C. MassHealth: New Premiums and Additional Barriers

MassHealth, the Massachusetts Medicaid program, provides comprehensive coverage for 408,000 children under age 19, or one in four children in the Commonwealth.²⁸ MassHealth is the primary source of health coverage for children whose families cannot afford private insurance. MassHealth is a federal-state partnership program, with the federal government contributing 50% of the cost for most enrollees and up to 65% of the cost for some children. MassHealth has been administered by the Division of Medical Assistance (DMA).²⁹

²⁷ Nonpayment of premiums caused 29% of disenrollments in 2003, up from 16% in 2002. Source: Massachusetts Department of Public Health, November 2003.

²⁸ For more information on MassHealth, see the following: Greenberg J. The Facts on MassHealth: What It Is. Why It Works, Boston: Health Care For All, November 2002. Also: Quigley K, Shelto A, Turnbull N. MassHealth: Dispelling Myths and Preserving Progress, Boston: Massachusetts Health Policy Forum, 2002.

²⁹ In a recent reorganization of state health and human services agencies, administration of MassHealth was moved to the

Covering children through MassHealth is relatively inexpensive. Although they make up 45% of Massachusetts Medicaid enrollees, children account for only 17% of the state's Medicaid spending.³⁰ It costs an average of \$1,825 per year (in state plus federal dollars) to insure each child on Medicaid, compared to \$7,377 for each adult.³¹

Please see Appendix 2 for a list of MassHealth enrollment by county.

Recent changes

Until November 2003, almost no MassHealth recipient with an income below 150% FPL was charged a premium. The chart below outlines the new premiums, which affect nearly 9,000 children.³²

DMA has imposed additional barriers on families seeking to maintain their children's health coverage. DMA does not accept premiums in cash, and significant numbers of

low-income families do not have checking accounts.³³ Thus they will have to incur additional costs for monthly money orders (typically \$1-\$3 each) to DMA in order to pay premiums. This presents a logistical and financial barrier to regular premium payments. In addition, DMA has shortened the period for renewing coverage from 60 to 30 days, and does not provide stamped, addressed return envelopes.

Increased premiums will cause children to lose health coverage

A number of studies nationwide have shown that Medicaid premiums are barriers to enrollment for low-income families. Research on the impact of increased premiums and co-payments consistently demonstrates that low-income people are likely to drop off health plans as premiums and co-payments rise. Even small increases can cause economic strain for families at such low income levels.

Changes to MassHealth Children's Premiums as of November 2003					
Program name	Income level for family of four	Poverty level	Old premium per child	New premium per child	Maximum per family
MassHealth Standard*	\$24,473 - \$27,600	134-150%	\$0	\$12	\$15
MassHealth Special Status Immigrants**	\$18,401 - \$27,600	101-150%			

* Children under 6 are exempt from the premiums.

** These are a group of legal immigrant children also enrolled in MassHealth Standard; children under 6 are not exempt.

Center for Acute and Ambulatory Care within the Department of Public Health.

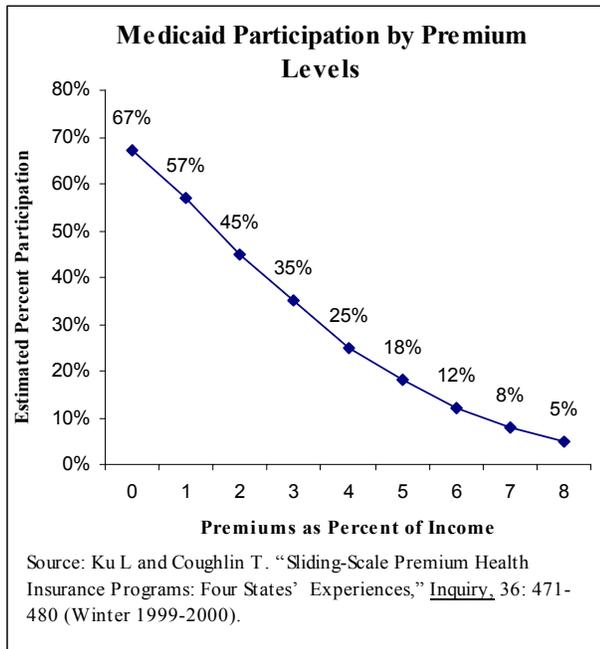
³⁰ American Academy of Pediatrics and National Association of Children's Hospitals and Related Institutions. "Massachusetts Medicaid Facts."

³¹ Ibid.

³² Division of Medical Assistance, December 2003.

³³ Low-income individuals are less likely than those well off to have a bank account. Nationally, approximately 10% of all households do not have bank accounts, and 80% of those have household income less than \$10,000. Source: Federal Reserve Board, "Capital Connections," Vol. 3, No. 2; Spring 2001.

Participation in Medicaid programs declines when premiums are raised even slightly. The chart below is based on studies of Medicaid premiums in Washington, Minnesota, and Hawaii, where increasing premiums by even a small percentage of a family's income resulted in significant declines in enrollment.³⁴



Based on this model, we predict that nearly 1,000 children will drop off MassHealth due to the new premium increases—about 10% of children affected by these increases.³⁵

Higher premiums will also prevent additional numbers of eligible low-income families from enrolling.

Other states have also implemented premiums, with similar results. For example, the state of Maryland recently started charging premiums of \$37 per family, regardless of the number of children per family, to children on Medicaid

³⁴ Ku L and Coughlin T. "Sliding-Scale Premium Health Insurance Programs: Four States' Experiences." *Inquiry*, 36: 471-480 (Winter 1999-2000).

³⁵ Calculation by: Ku L, December 2003.

with incomes from 185-200% FPL. Half of the children in that income range have since dropped from the program because of the premiums. Similarly, Oregon recently began charging monthly premiums of \$6 to \$20 for its Medicaid program. Within three months, enrollment levels dropped by 29%.³⁶

D. Private Health Insurance: Inaccessible to Many Families

Private health plans are moving further beyond the reach of working families living near the poverty level because of high unemployment, fewer employers offering health insurance, and the increasingly prohibitive cost of health plans that are offered by employers or available for individual purchase.

Tens of thousands of Massachusetts residents have lost their jobs in the last two years. In October 2003 over 190,000 residents, or 5.6% of the state's potential workers, were unemployed³⁷ and likely to have lost any health insurance they had from employers.³⁸

An increasing number of families cannot afford health insurance even when their employers offer it, because of the high cost of the employee's share of the premiums. Between 2002 and 2003, premiums for employer-sponsored health insurance rose 13.9%, to \$9,068 per year for a family plan. According to a recent analysis, "[this was] the third

³⁶ Oregon Department of Human Services. News release, "State officials shifting health plan premium grace period by five days." July 14, 2003. As reported in Ku L and Broaddus M. *Funding Health Coverage for Low-Income Children in Washington*. Washington, D.C.: Center on Budget and Policy Priorities, November 2003.

³⁷ Massachusetts Division of Employment and Training. "Labor Force and Unemployment Data," http://lmi2.detma.org/lmi/lmi_lur_a.asp, December 2003.

³⁸ Health insurance coverage through the Medical Security Plan (MSP) is available to unemployed persons and their families below 400% of the federal poverty level, but only while they are eligible for unemployment benefits. The state recently began imposing premiums as high as \$120 per month on families for this plan.

consecutive year of double-digit premium increases and the highest premium increase since 1990. Premiums increased substantially faster than overall inflation (2.2%) and wage gains for non-supervisory workers (3.1%).³⁹

Concurrently, employer contributions to the total premium cost of individual plans dropped 6% on average in Massachusetts, and the employee monthly contribution increased 61% (from \$57 to \$92). During the same period, premiums for family plans rose from \$667 to \$852 per month (28%) and the employee contribution to employer-sponsored family plans also increased 28% on average.⁴⁰

E. Free Care: Limited Services for Uninsured Children

Another critical—but inadequate—source of support for children's health care is "free care" provided by hospitals and community health centers. Children's care may be covered by the Uncompensated Care Pool, depending on both family income and on what free care is available at local institutions.⁴¹ Children with family incomes up to 200% FPL are eligible for free care at hospitals and health centers for medically necessary services; for children with family incomes 201-400% FPL, partial free care is available. The services covered vary from institution to institution, and rarely include prescription drugs, doctors' fees for hospital care, or specialist care. In 2002, 50,000

children received free or partial free care, constituting 14% of Pool users.⁴²

Free care is expensive for the institutions that provide and fund it, including hospitals, insurers and state government. Moreover, families who use hospital care for uninsured children risk finding that free care is not available to them, and incurring high medical debt.

F. School and Community Health Programs: Major Cutbacks

School health services have in the past provided broad care to Massachusetts children. In the 2001-2002 school year, 567,000 students in 110 districts received care funded with state assistance.⁴³ In 2002, some 2,400 school nurses served Massachusetts students, with both state and municipal funding. Besides the traditional services which school nurses provide, such as routine and emergency care and health education, school nurses also now manage the care of many children with special health needs, such as tube feeding or ventilator-assisted breathing. School nurses increasingly report that they are the only source of care for significant numbers of children.⁴⁴ School health funding, however, has plummeted; the "essential school health services" line item was halved in the Fiscal Year 2004 state budget.

Community health centers provide comprehensive primary health care to many children who are Medicaid-eligible, uninsured or underinsured. However, community health centers have also experienced severe budget strains, as they continue to treat an increasing

³⁹ Claxton G, Holve E, Finder B, Gabel J, Pickreign J, Whitmore H, Hawkins S, Dhont K. Employer Health Benefits: 2003 Summary of Findings. Kaiser Family Foundation and Health Research and Educational Trust, 2003.

⁴⁰ Massachusetts Division of Health Care Finance and Policy. http://www.state.ma.us/dhcfp/pages/pdf/emp_pres.pdf, December 2003.

⁴¹ The Uncompensated Care Pool is not a system of care but a partial reimbursement mechanism for free care provided by hospitals and community health centers. The "Pool" is funded by the state, hospitals and health insurers and is currently running a deficit, meaning that health centers and hospitals that care for uninsured people are not being fully reimbursed for this care. The Pool is significantly underfunded, and its future after FY04 is unclear.

⁴² Calculated from: Madden S. "Data on the Uncompensated Care Pool," (presentation to the UCP Working Group). Massachusetts Division of Health Care Finance and Policy, December 2003.

⁴³ Massachusetts Department of Public Health. Enhanced School Health Services Program Data Report. February 2003.

⁴⁴ Massachusetts School Nurse Organization. Personal communication with Marcia Buckminster, February 2003.

number of children and adults who have lost coverage and/or benefits.

III. IMPACT OF HEALTH CARE CUTS ON CHILDREN

A. The Importance of Preventive and Primary Care

A young girl in Hampden County was diagnosed with leukemia in 1996. At the time, the girl had coverage for primary and preventive care through CMSP. Because of this coverage, the family discovered that their daughter had an enlarged spleen. If they hadn't had the tests, their daughter might have died in a matter of days. Because they detected the leukemia she was able to receive treatment.

Children who lose or cannot obtain CMSP, MassHealth, or other coverage face many problems. The consequences for children who lack health insurance are numerous and well-documented. For example, uninsured children use fewer medical and dental services and are less likely to receive routine preventive check-ups and immunizations.⁴⁵ In 2002, 30% of uninsured children did not visit a physician, compared to 8% of insured children.⁴⁶ Readily treatable childhood conditions, such as ear infections, that can affect hearing and language

⁴⁵ For more information on health care utilization by uninsured children, see Appendix 3.

⁴⁶ Some uninsured children may qualify for free or partial free care at hospitals and community health centers. As noted above, however, many important health services typically fall outside the scope of free care, such as prescription drugs (in most communities) and specialty outpatient care. Source: Massachusetts Division of Health Care Finance and Policy. Health Insurance Status of Massachusetts Residents: Third Edition.

development, are more likely to go undetected in uninsured children.⁴⁷

B. Serious Consequences of Delayed Medical Care

Uninsured children are less likely to be treated for childhood illnesses. The Kaiser Commission on Medicaid and the Uninsured reports that uninsured children are over five times more likely to have an unmet need for medical care and over three times more likely not to receive a necessary prescription drug. Furthermore, uninsured children who are injured are 30% less likely than insured children to receive medical treatment.⁴⁸ People without insurance are hospitalized at least 50% more often than the insured for avoidable conditions such as pneumonia and uncontrolled diabetes.⁴⁹

If I did not have CMSP, I wouldn't have been able to get an MRI for my child's knee injury. Emergency coverage is really expensive, and if she didn't have CMSP, she wouldn't have any coverage at all.

*~ Mother from Salem
with a child on CMSP*

Educational impact

Lack of health care can cause lifelong deficits in education and productivity, which hurt not only the child but also society as a whole. Just as lack of insurance cuts down on worker productivity for adults, it results in poorer academic performance for children: uninsured

⁴⁷ Institute of Medicine. A Shared Destiny: Effects of Uninsurance on Individuals, Families, and Communities. March 2003.

⁴⁸ The Kaiser Commission on Medicaid and the Uninsured. "Children's Health – Why Health Insurance Matters." May 2002.

⁴⁹ The Kaiser Commission on Medicaid and the Uninsured. In Their Own Words: The Uninsured Talk About Living Without Health Insurance. September 2000.

children are 25% more likely to miss school than insured children.⁵⁰ Poor hearing, if untreated, can result in hampered language development and poor school performance.⁵¹

Impact on community health

The community at large is affected by children not receiving adequate care. Uninsured children who cannot get treatment often come to school and day care settings sick, and can easily infect others.

Widening racial and ethnic health disparities

Children of color and immigrants in Massachusetts are disproportionately affected by ill health. These children are already over-represented in the low-income populations that enroll in CMSP and MassHealth. The increases in premiums and resulting increase in uninsured children will further aggravate existing disparities related to ethnicity, race, and immigration status. Twenty-two percent of Hispanics and 14% of Blacks/African Americans in Massachusetts are presently uninsured, compared to only 8% of Caucasians.⁵²

Children with special health needs

For children with special health care needs, a lack of insurance can be particularly dangerous and potentially fatal. Yet, among children with special health needs, nearly a third of uninsured children are unable to get needed care. Over

one in five uninsured children with special health needs did not see a doctor in 2001.⁵³

IV. FAMILIES' FINANCIAL STABILITY AT RISK

A. Impact of New Premiums on Low-Income Families' Budgets

A health insurance premium of \$12 or \$15 per month would not constitute a hardship to middle- or upper-income families, but for the low-income families using CMSP and MassHealth, the new premiums can present a serious barrier to care. The charts on the following page illustrate the estimated financial situation of a family with children on CMSP and a family with children on MassHealth, using the middle of the eligible income range for each program. These charts use statistics for the city of Worcester, which is close to the Massachusetts average. Families in the Boston area face even higher expenses. It is clear that finances for these low-income families are very tight even before considering the new premiums, especially for MassHealth families.

⁵⁰ Florida Healthy Kids Corporation. Healthy Kids Annual Report. February 1997. As reported in Rosenbaum S, Lambrew J, Shin P, Regenstien M, Ehrmann T, Roby D. Health Care Coverage in Massachusetts: Far to Go, Farther to Fall. Boston: Blue Cross Blue Shield of Massachusetts Foundation, September 2002.

⁵¹ Salazar v. District of Columbia, 954 F. Supp. 278 (D.D.C. 1996).

⁵² Kaiser Family Foundation. Massachusetts: Rate of Nonelderly Uninsured.

⁵³ The Kaiser Commission on Medicaid and the Uninsured. "Children's Health - Why Health Insurance Matters."

Impact of CMSP Premiums on a Family Budget

Estimated cost of living for a family of four, 2 adults and 2 children, in Worcester, with a monthly income of \$3,450 (225% FPL).

Monthly income	\$3,450
Housing	- \$785
Child care	- \$1,058
Food	- \$554
Transportation	- \$433
Miscellaneous	- \$307
Remaining funds	= \$313
CMSP premiums	- \$90.64
Remaining funds	= \$222.36

Note: Health costs for adults such as insurance, medications, co-payments, and deductibles for medical care are not included in these calculations.

Calculations based on: Pearce D and Brooks J. The Self-Sufficiency Standard for Massachusetts. Boston: Women's Educational and Industrial Union, April 2003.

Impact of MassHealth Premiums on a Family Budget

Estimated cost of living for a family of four, 2 adults and 2 children, in Worcester, with a monthly income of \$2,162 (about 140% FPL).

Monthly income	\$2,162
Housing	- \$785
Child care	- \$1,058
Food	- \$554
Transportation	- \$433
Miscellaneous	- \$307
Remaining (deficit) funds	= (- \$975)
MassHealth premiums	- \$15
Remaining funds	= (- \$990)

← Even before factoring in the new MassHealth premiums, this family would be at a \$975 monthly deficit if their basic needs were met.

Note: Health costs for adults such as insurance, medications, co-payments, and deductibles for medical care are not included in these calculations. Also, a family with this income may be eligible for subsidies such as Food Stamps, childcare, rental assistance, and earned income tax credit, although there are usually long waiting lists for childcare and housing assistance. Such subsidies are also not included in these calculations.

Calculations based on: Pearce D and Brooks J. The Self-Sufficiency Standard for Massachusetts. Boston: Women's Educational and Industrial Union, April 2003.

The cost of living for families in Massachusetts increased dramatically from 1998 to 2002, and Massachusetts continues to have one of the highest costs of living in the nation.⁵⁴ In many communities, an income of 200% of the federal poverty line—\$36,800 for a family of four—is not adequate to even meet the basic needs of food, housing, heat, child care, and transportation.⁵⁵ To increase health care costs creates an often impossible burden on such low-income families.

Studies have shown that low-income families tend to prioritize necessities such as food, rent, childcare and transportation to and from work.⁵⁶ Yet some families will make health care a top priority, particularly families whose children have special health needs. In order to pay premiums to continue health coverage, these families may be forced to cut back on food, childcare, or heat. No family should be forced to choose between such basic needs.

B. High Medical Costs for Uninsured Families

If children are uninsured but are able to obtain care, their families may face exorbitant costs. About half of uninsured people have reported struggling to pay expenses such as food and rent, and the vast majority (70%) were forced to deplete their savings to pay medical bills.⁵⁷ A recent study found that “one in ten Massachusetts residents reported a time in the past year when they did not get the medical care they needed due to the high cost.” As

⁵⁴ Pearce D and Brooks J. The Self-Sufficiency Standard for Massachusetts. Boston: Women's Educational and Industrial Union, April 2003.

⁵⁵ Hudman and O'Malley. Health Insurance Premiums and Cost-Sharing.

⁵⁶ Ibid.

⁵⁷ Duchon L, Schoen C, Doty M, Davis K, Strumpf E, Bruegman S. Security Matters: How Instability in Health Insurance Puts U.S. Workers at Risk. New York: The Commonwealth Fund, December 2001. As reported in Rosenbaum et al. Health Care Coverage in Massachusetts: Far to Go, Farther to Fall. Boston: Blue Cross Blue Shield of Massachusetts Foundation, September 2002.

many as 11% of these residents considered filing for bankruptcy.⁵⁸ Uninsured families also experience increased stress and decreased quality of life because of the financial risks they face.⁵⁹

Even though uninsured families are often poor, they pay, on average, up to 40% of their medical costs by themselves. Uninsured families pay 88% of their prescription drug costs, 47% of their ambulatory care costs, and 7% of hospital costs. Despite these attempts by uninsured families to pay for their own care, health care providers frequently incur a high level of unreimbursed expenses when they take care of uninsured people.⁶⁰

We are a family of four. My husband and I both have diabetes. I alone take seven prescriptions a month. I picked up only two prescriptions last week and the co-pay was \$30 – that's food out of my children's mouths. My 11 year old son who has ADHD (two prescriptions a month) and asthma (3 prescriptions a month) was just diagnosed with depression, which means more monthly medications.

Ask the legislators how I cope with an original net pay of \$320 a week minus \$70 for insurance and \$160 for rent. Now these figures don't include my phone bill, gas heat in a very old and drafty building, my electric bill, gas for the car (so we can have transportation to school and work), insurance to keep our car on the road legally, or food for our nutrition.

~ Mother from Pittsfield with two children enrolled in MassHealth

⁵⁸ Blendon R J, DesRoches C M, Raleigh E, Benson J M. The Uninsured in Massachusetts: An Opportunity for Leadership. Boston: Blue Cross Blue Shield Foundation, October 2003.

⁵⁹ The David and Lucile Packard Foundation. “Health Insurance for Children: Analysis.” The Future of Children, Volume 13 – Number 1, Spring 2003.

V. EFFECTS ON THE MASSACHUSETTS ECONOMY

A. Diminished Wages and Productivity for Parents

Childhood illness is associated with parents having to be absent from work as well as unemployment.⁶¹ Higher uninsurance among children means not only higher rates of illness but also loss of wages and productivity for parents who must care for sick children. The Women's Educational and Industrial Union estimates that a single mother of an uninsured child with asthma would lose about \$900 a year in lost wages due to time taken for care-giving for the child—more than twice the wages lost by a comparable mother in a situation where the child had health insurance.⁶²

A Texas study found that working parents of uninsured children missed 550,000 more days of work than those with insured children, costing Texans more than \$20 million in lost wages.⁶³ When parents must miss work or even lose their jobs due to their children's illness, productivity is reduced and turnover increased in those firms, affecting the state's economy as a whole.

⁶⁰ Institute of Medicine. *A Shared Destiny*.

⁶¹ Smith L, Romero D, Wood P et al. "Employment Barriers Among Welfare Recipients and Applicants with Chronically Ill Children." *American Journal of Public Health*, 2002; 92:1453-1457.

⁶² Dryfoos P, Bigby JA, Kuhlthau K, Robinson L. *The Health Economic Sufficiency Standard: Measuring the Economic Burden of Health Care and Illness on Massachusetts Families*. Boston: The Women's Educational and Industrial Union, June 2003.

⁶³ Heard M and Gifford C. "We Can't Let Our Children's Health Slide." *The Boston Globe*, December 7, 2002.

B. Loss of Federal Funds

Because of the way federal reimbursement rules operate, premiums are a particularly ineffective way of generating savings for the Commonwealth. Massachusetts generally receives federal matching funds that cover 50%-65% of the costs of insuring children through MassHealth. As a result, MassHealth needs to cut over two dollars worth of services in order to save one dollar in state funds. Making matters worse, before reimbursing the state, the federal government deducts premium revenue from the cost of care, so the state loses reimbursement for the portion of the cost of care that families pay in premiums. In effect, this means that a portion of the premiums paid by MassHealth families goes to the federal government, rather than to the state.

The chart on the following page illustrates how this works when premiums are imposed on children where the Commonwealth is eligible for a 65% reimbursement rate. For simplicity, the example assumes the cost of the child's health care is \$100 per month, so the total medical cost for a year is \$1,200. Premiums are \$12 per child per month, or \$144 for a year.

As a result, despite collecting premium revenue of \$144, the state saves only 35% of that amount, or \$50.40. The rest of the premium revenue goes to the federal government. In effect, imposing premiums on MassHealth recipients is equivalent to raising taxes on low-income people and forwarding most of the tax revenue raised to the federal government.

Impact of New Premiums on Federal Reimbursement for MassHealth Costs				
	Medical costs	Premium revenue from family	Federal reimbursement (65% of costs minus premiums)	State cost
Without premiums	\$1,200	\$0	\$780	420
With premiums	\$1,200	\$144	\$686.40	\$369.60
Savings or costs due to premiums		Cost of \$144	Savings of \$93.60	Savings of \$50.40

C. Higher Costs for Uncompensated Care

Research shows that imposing premiums on Medicaid enrollees does not necessarily produce cost savings overall.⁶⁴ If higher premiums mean members drop out of MassHealth, the cost of their care will be borne by the Uncompensated Care Pool. Moreover, by losing the comprehensive benefits provided by MassHealth, they will be more likely to use expensive emergency care and/or be hospitalized for conditions that could be prevented by early and regular care.

In Massachusetts, the average cost of a single emergency room visit for a child is over \$550⁶⁵ – while a year’s worth of CMSP coverage for a child costs less than \$550.⁶⁶ Prevention and primary care save money, and children who go without them are more likely to end up in expensive emergency departments. Hospitals and health centers that provide care for these

uninsured children often charge part of the costs to families, with consequences discussed earlier.

When increased premiums mean children cannot keep or obtain CMSP or MassHealth coverage, the higher cost of care will be borne by the Uncompensated Care Pool. The Pool is funded by fixed contributions from hospitals and insurers, as well as state and federal matching funds. The Pool is already in fiscal crisis and cannot reimburse providers for the full cost of care provided. As the uninsured population increases, hospitals and health centers will more quickly exhaust their free care allocation and be left with no resources to pay for care.

These increased costs are then passed on to the public in the form of higher prices for health services and employer-based insurance. The situation can begin to spiral downward, as increased premiums cause more employers and workers to forego coverage, thus adding to the problem of uncompensated care. Hospitals and health centers may also cut costly public benefit services that are subsidized by other activities such as specialty health services and clinics.

⁶⁴ Hudman and O’Malley, Health Insurance Premiums and Cost-Sharing.

⁶⁵ Derived from: Massachusetts Division of Health Care Finance and Policy. “Emergency Department Data by Service Use.” <http://www.state.ma.us/dhcfp/pages/dhcfp234.htm>, No date; taken from website in December 2003. Figures are for FY02.

⁶⁶ The full monthly cost for a child on CMSP in FY03 was \$45.99. Source: Massachusetts Department of Public Health, November 2003.

D. Impact of Premiums on CMSP and MassHealth Program Costs

Another problem with imposing or increasing premiums on low-income families in CMSP and MassHealth is that the families with healthier children may be more likely to drop their coverage. Similarly, the less healthy may be more likely to enroll than the relatively healthy. If this type of "adverse selection" occurs, it will result in enrollees with higher-than-average medical needs, leading to higher medical expenditures per beneficiary. Adverse selection can cause premiums to spiral upward over the long term.⁶⁷

Charging premiums also results in increased administrative costs for notifying and billing enrollees, collecting premiums, and terminating coverage for enrollees who do not pay their premiums.⁶⁸

VI. RECOMMENDATIONS

The Children's Health Access Coalition calls on the Governor and the Legislature to protect basic health care for Massachusetts children. The cuts to children's health care have left over 6,500 children on a waitlist for the Children's Medical Security Plan and will result in lower CMSP enrollment. The cuts also have led to increased premiums for CMSP and MassHealth, to a point where many low-income families will not be able to afford health care for their children. This impinges upon children's health and well-being, threatens the economic security of their families, and is fiscally detrimental to the Commonwealth.

We recommend that the Governor and Legislature:

1. Roll back Children's Medical Security Plan premiums to October 2003 levels by passing "*An Act Ensuring Low-Income Children's Access to Basic Health Care*".
2. Roll back MassHealth premiums for children to October 2003 levels by passing "*An Act Ensuring Low-Income Children's Access to Basic Health Care.*"
3. Fully fund CMSP to make the program once again available to all children without other coverage by eliminating the enrollment cap.

The children of Massachusetts deserve to have health care.

⁶⁷ Ku and Coughlin. The Use of Sliding Scale Premiums. As reported in Hudman and O'Malley. Health Insurance Premiums and Cost-Sharing.

⁶⁸ Ibid.

APPENDICES**A. Children's Medical Security Plan Enrollment and Waitlist Numbers, by City**

Source: Massachusetts Department of Public Health, December 2003.

B. Children Enrolled in MassHealth, by County

Source: Massachusetts Executive Office of Health and Human Services, December 2003.

C. Children's Uninsurance and Health Care Utilization Rates for 2002

Source: Massachusetts Division of Health Care Finance and Policy. Health Insurance Status of Massachusetts Residents, Third Edition. January 2003.

D. Federal Poverty Level Guidelines for 2003

Calculated by Health Care For All and Massachusetts Law Reform Institute using federal poverty level guidelines set by the United States Department of Health and Human Services.

Acknowledgements

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The Children's Health Access Coalition wishes to thank Children's Hospital for its generous support.

The Children's Health Access Coalition

Founded in 1995, the Massachusetts Children's Health Access Coalition (CHAC) is dedicated to ensuring that all Massachusetts children have access to and receive comprehensive health services. CHAC is an alliance of consumers, health care providers, children's health advocates, and other groups. This broad-based coalition has played a role in all child health access legislation since 1996.

CHAC is now leading a campaign to restore children's health programs that were cut in the past year. The coalition is working with families, legislators, and advocates to bring premiums back to affordable levels and to restore CMSP. For more information about the campaign, contact Stacey Auger, Children's Health Campaign Coordinator, Health Care For All, at (617) 275-2935 or auger@hcfama.org. For more information about CHAC, contact Lucy Meadows, Manager, Children's Division, Health Care For All, at (617) 275-2932 or meadows@hcfama.org.

Appendix 1.

**Children's Medical Security Plan Enrollment and Waitlist Numbers by City
August 30, 2003**

CITY	Enrollment	Waitlist	CITY	Enrollment	Waitlist
ABINGTON	45	≤20	BOSTON	3152	939
ACTON	55	≤20	ALLSTON	114	≤20
ACUSHNET	35	≤20	BOSTON	393	128
ADAMS	27	≤20	BRIGHTON	170	45
AGAWAM	43	27	DORCHESTER	725	298
ALFORD	0	≤20	EAST BOSTON	608	156
AMESBURY	48	≤20	HYDE PARK	210	77
AMHERST	91	≤20	JAMAICA PLAIN	156	≤20
ANDOVER	45	≤20	MATTAPAN	170	51
ARLINGTON	79	≤20	READVILLE	≤20	0
ASHBURNHAM	≤20	≤20	ROSLINDALE	233	42
ASHBY	≤20	≤20	ROXBURY	207	61
ASHFIELD	≤20	≤20	SOUTH BOSTON	107	25
ASHLAND	65	≤20	WEST ROXBURY	59	≤20
ASHLEY FALLS	≤20	≤20	BOURNE	≤20	≤20
ASSONET	≤20	≤20	BOXBOROUGH	≤20	≤20
ATHOL	23	≤20	BOXFORD	≤20	≤20
ATTLEBORO	88	29	BOYLSTON	≤20	0
AUBURN	≤20	≤20	BRADFORD	36	≤20
AUBURNDALE	≤20	≤20	BRAINTREE	61	≤20
AVON	≤20	≤20	BRANT ROCK	≤20	0
AYER	25	≤20	BREWSTER	48	≤20
BALDWINVILLE	≤20	≤20	BRIDGEWATER	48	≤20
BARNSTABLE	≤20	≤20	BRIMFIELD	≤20	≤20
BARRE	≤20	≤20	BROCKTON	997	226
BECKET	≤20	0	BROOKFIELD	≤20	≤20
BEDFORD	22	≤20	BROOKLINE	106	≤20
BELCHERTOWN	23	≤20	BROOKLINE VILLAGE	≤20	0
BELLINGHAM	35	≤20	BURLINGTON	33	≤20
BELMONT	39	≤20	BUZZARDS BAY	≤20	≤20
BERKLEY	≤20	≤20	BYFIELD	≤20	≤20
BERKSHIRE	≤20	≤20	CAMBRIDGE	202	55
BERLIN	≤20	≤20	CANTON	32	≤20
BERNARDSTON	≤20	≤20	CARLISLE	≤20	≤20
BEVERLY	125	27	CARVER	30	≤20
BILLERICA	79	30	CATAUMET	≤20	≤20
BLACKSTONE	≤20	≤20	CEDARVILLE	≤20	0
BLANDFORD	≤20	≤20	CENTERVILLE	62	≤20
BOLTON	≤20	≤20	CHARLESTOWN	51	21
BONDSVILLE	≤20	≤20	CHARLTON	≤20	≤20

Notes: This list includes over 100 localities in addition to recognized cities and towns. To find figures for a given area, please check under all commonly-used town names plus designations such as "North Quincy," "South Wellfleet," etc. Because of Health Insurance Portability and Accountability Act (HIPAA) requirements, CMSP enrollment and waitlist figures for cities with 1 - 20 enrollees cannot be specified.

Source: Department of Public Health, December 2003.

CITY	Enrollment	Waitlist	CITY	Enrollment	Waitlist
CHATHAM	≤20	≤20	FALL RIVER	672	160
CHELMSFORD	30	≤20	FALMOUTH	21	≤20
CHELSEA	701	180	FAYVILLE	≤20	≤20
CHERRY VALLEY	≤20	≤20	FEEDING HILLS	42	≤20
CHESHIRE	≤20	≤20	FISKDALE	≤20	≤20
CHESTER	≤20	0	FITCHBURG	299	75
CHESTERFIELD	≤20	≤20	FLORENCE	≤20	≤20
CHESTNUT HILL	28	0	FORESTDALE	≤20	≤20
CHICOPEE	139	61	FORT MYERS	≤20	0
CHILMARK	≤20	0	FOXBORO	35	≤20
CLARKSBURG	≤20	≤20	FRAMINGHAM	893	120
CLINTON	79	23	FRANKLIN	29	≤20
COHASSET	≤20	0	FREETOWN	≤20	≤20
COLRAIN	≤20	≤20	GARDNER	44	24
CONCORD	≤20	≤20	GEORGETOWN	≤20	≤20
CONWAY	≤20	≤20	GILBERTVILLE	≤20	0
COTUIT	≤20	≤20	GILL	≤20	0
CUMMAQUID	≤20	0	GLOUCESTER	120	26
DALTON	21	≤20	GOSHEN	≤20	0
DANVERS	45	≤20	GRAFTON	≤20	≤20
DARTMOUTH	≤20	≤20	GRANBY	35	≤20
DEDHAM	60	≤20	GREAT BARRINGTON	≤20	≤20
DEERFIELD	≤20	0	GREEN HARBOR	≤20	≤20
DENNIS	≤20	≤20	GREENFIELD	34	≤20
DENNISPORT	26	≤20	GROTON	≤20	≤20
DIGHTON	≤20	≤20	GROVELAND	≤20	≤20
DOUGLAS	≤20	≤20	HADLEY	≤20	≤20
DOVER	≤20	0	HALIFAX	26	≤20
DRACUT	100	≤20	HAMILTON	≤20	0
DUDLEY	≤20	≤20	HAMPDEN	≤20	≤20
DUXBURY	≤20	≤20	HANCOCK	≤20	≤20
EASTBRIDGEWATER	33	≤20	HANOVER	≤20	≤20
EAST BROOKFIELD	≤20	≤20	HANSON	23	≤20
EAST DENNIS	≤20	≤20	HARDWICK	≤20	≤20
EAST DOUGLAS	≤20	≤20	HARVARD	≤20	0
EAST FALMOUTH	79	21	HARWICH	50	≤20
EAST FREETOWN	≤20	≤20	HARWICH PORT	≤20	≤20
EAST LONGMEADOW	≤20	≤20	HATFIELD	≤20	≤20
EAST MILTON	≤20	≤20	HAVERHILL	180	66
EAST ORLEANS	≤20	0	HAYDENVILLE	≤20	≤20
EAST OTIS	≤20	0	HINGHAM	≤20	≤20
EAST SANDWICH	≤20	≤20	HINSDALE	≤20	≤20
EAST TAUNTON	21	≤20	HOLBROOK	37	≤20
EAST TEMPLETON	≤20	0	HOLDEN	≤20	≤20
EAST WALPOLE	≤20	0	HOLLAND	≤20	≤20
EAST WAREHAM	≤20	≤20	HOLLISTON	≤20	≤20
EAST WEYMOUTH	32	≤20	HOLYOKE	103	37
EASTHAM	≤20	≤20	HOPEDALE	≤20	0
EASTHAMPTON	43	≤20	HOPKINTON	≤20	≤20
EASTON	≤20	0	HOUSATONIC	≤20	0
EDGARTOWN	69	≤20	HUBBARDSTON	≤20	0
ELMWOOD	≤20	0	HUDSON	92	21
ESSEX	≤20	0	HULL	≤20	≤20
EVERETT	425	87	HUNTINGTON	≤20	≤20
FAIRHAVEN	70	≤20	HYANNIS	305	46

CITY	Enrollment	Waitlist	CITY	Enrollment	Waitlist
HYANNISPORT	≤20	0	MILLBURY	≤20	≤20
INDIAN ORCHARD	≤20	≤20	MILLERS FALLS	≤20	0
IPSWICH	46	≤20	MILLIS	≤20	≤20
JEFFERSON	≤20	≤20	MILLVILLE	≤20	≤20
KINGSTON	27	≤20	MILTON	33	≤20
LAKEVILLE	25	≤20	MINOT	≤20	0
LANCASTER	28	≤20	MIRAMAR	≤20	0
LANESBORO	≤20	≤20	MONPONSETT	0	≤20
LANESVILLE	≤20	≤20	MONSON	≤20	≤20
LAWRENCE	676	236	MONTAGUE	≤20	≤20
LEE	40	≤20	MONTEREY	≤20	0
LEEDS	≤20	≤20	MONUMENT BEACH	≤20	≤20
LEICESTER	≤20	≤20	NAHANT	≤20	≤20
LENOX	≤20	≤20	NANTUCKET	58	≤20
LENOX DALE	≤20	0	NATICK	51	≤20
LEOMINSTER	337	57	NEEDHAM	22	≤20
LEVERETT	≤20	0	NEEDHAM HEIGHTS	≤20	0
LEXINGTON	44	≤20	NETOWN HIGHLANDS	≤20	0
LEYDEN	≤20	0	NEW ASHFORD	0	≤20
LINCOLN	≤20	≤20	NEW BEDFORD	600	194
LINWOOD	≤20	0	NEW BRAINTREE	≤20	0
LITTLETON	≤20	≤20	NEW MARLBORO	≤20	0
LONGMEADOW	21	≤20	NEW SALEM	≤20	0
LOWELL	982	233	NEWBURY	≤20	≤20
LUDLOW	47	≤20	NEWBURYPORT	27	≤20
LUNENBURG	22	≤20	NEWTON	110	22
LYNN	869	238	NEWTON CENTER	≤20	≤20
LYNNFIELD	27	≤20	NEWTONVILLE	≤20	0
MALDEN	358	89	NORFOLK	≤20	0
MANCHAUG	≤20	0	NORTH ADAMS	32	≤20
MANCHESTER	≤20	≤20	NORTH ANDOVER	46	21
MANCHESTER BY THE SEA	≤20	0	NORTH ATTLEBORO	46	≤20
MANOMET	≤20	≤20	NORTH BILLERICA	≤20	≤20
MANSFIELD	47	≤20	NORTH CARVER	0	≤20
MARBLEHEAD	21	≤20	NORTH CHATHAM	≤20	≤20
MARION	≤20	0	NORTH CHELMSFORD	≤20	≤20
MARLBOROUGH	413	47	NORTH DARTMOUTH	50	≤20
MARSHFIELD	34	≤20	NORTH DIGHTON	0	≤20
MARSHFIELD HILLS	0	≤20	NORTH EASTHAM	≤20	0
MARSTONS MILLS	45	≤20	NORTH EASTON	≤20	0
MASHPEE	49	≤20	NORTH EGREMONT	≤20	≤20
MATTAPOISETT	23	≤20	NORTH FALMOUTH	≤20	≤20
MAYNARD	33	≤20	NORTH GRAFTON	≤20	≤20
MEDFIELD	≤20	≤20	NORTH HATFIELD	≤20	≤20
MEDFORD	137	50	NORTH OXFORD	≤20	0
MEDWAY	≤20	≤20	NORTH PEMBROKE	≤20	0
MELROSE	42	≤20	NORTH QUINCY	26	≤20
MENDON	≤20	≤20	NORTH READING	≤20	≤20
MERRIMAC	≤20	≤20	NORTH UXBRIDGE	≤20	≤20
METHUEN	154	52	NORTH TRURO	≤20	0
MIDDLEBORO	94	34	NORTH WEYMOUTH	≤20	≤20
MIDDLETON	≤20	≤20	NORTHAMPTON	27	≤20
MILFORD	190	26	NORTHBORO	≤20	≤20
MILL RIVER	≤20	≤20	NORTHBOROUGH	≤20	0

CITY	Enrollment	Waitlist	CITY	Enrollment	Waitlist
NORTHBRIDGE	≤20	≤20	SANDWICH	38	≤20
NORTHFIELD	≤20	≤20	SAUGUS	60	21
NORTON	38	≤20	SCITUATE	≤20	0
NORWELL	0	≤20	SEEKONK	≤20	≤20
NORWOOD	117	27	SHARON	36	≤20
OAK BLUFFS	42	≤20	SHEFFIELD	≤20	≤20
OAKHAM	≤20	≤20	SHELBURNE FALLS	≤20	0
ONSET	≤20	0	SHELDONVILLE	≤20	0
ORANGE	≤20	≤20	SHERBORN	≤20	≤20
ORLEANS	21	≤20	SHIRLEY	≤20	≤20
OSTERVILLE	≤20	≤20	SHREWSBURY	67	25
OTIS	≤20	≤20	SHUTESBURY	≤20	≤20
OXFORD	≤20	≤20	SIASCONSET	0	≤20
PALMER	21	≤20	SOMERSET	32	≤20
PASADENA	≤20	0	SOMERVILLE	413	78
PAXTON	≤20	0	SOUTH ATTLEBORO	≤20	≤20
PEABODY	202	53	SOUTH BARRE	≤20	≤20
PELHAM	0	≤20	SOUTH CHATHAM	≤20	0
PEMBROKE	38	≤20	SOUTHDARTMOUTH	30	≤20
PEPPERELL	28	0	SOUTH DEERFIELD	≤20	0
PERU	≤20	0	SOUTH DENNIS	36	≤20
PETERSHAM	≤20	0	SOUTH EASTON	≤20	≤20
PINEHURST	≤20	0	SOUTH GRAFTON	≤20	≤20
PITTSFIELD	122	51	SOUTH HADLEY	32	≤20
PLAINFIELD	≤20	0	SOUTH HAMILTON	≤20	≤20
PLAINVILLE	≤20	≤20	SOUTH HARWICH	0	≤20
PLYMOUTH	165	40	SOUTH LANCASTER	≤20	≤20
PLYMPTON	≤20	≤20	SOUTH LAWRENCE	≤20	≤20
POCASSET	≤20	0	SOUTH LEE	≤20	≤20
PRINCETON	≤20	0	SOUTH ORLEANS	≤20	≤20
PROVINCETOWN	≤20	≤20	SOUTH WALPOLE	≤20	≤20
QUINCY	185	86	SOUTH WELLFLEET	≤20	≤20
RANDOLPH	115	48	SOUTH WEYMOUTH	24	≤20
RAYNHAM	≤20	≤20	SOUTH YARMOUTH	60	≤20
RAYNHAM CENTER	≤20	≤20	SOUTHAMPTON	≤20	0
READING	29	≤20	SOUTHBORO	≤20	≤20
REHOBOTH	≤20	≤20	SOUTHBOROUGH	≤20	0
REVERE	441	110	SOUTHBRIDGE	45	≤20
RICHMOND	≤20	≤20	SOUTHWICK	36	≤20
ROCHDALE	≤20	≤20	SPENCER	23	≤20
ROCHESTER	≤20	≤20	SPRINGFIELD	409	164
ROCKLAND	57	≤20	STERLING	≤20	≤20
ROCKPORT	22	≤20	STOCKBRIDGE	≤20	0
ROSEDALE	≤20	0	STONEHAM	37	≤20
ROWE	≤20	≤20	STOUGHTON	137	29
ROWLEY	≤20	≤20	STOW	≤20	≤20
ROYALSTON	≤20	≤20	STURBRIDGE	≤20	≤20
RUSSELL	≤20	≤20	SUDBURY	≤20	≤20
RUTLAND	≤20	≤20	SUNDERLAND	≤20	≤20
SAGAMORE	≤20	≤20	SUTTON	≤20	≤20
SAGAMORE BEACH	≤20	≤20	SWAMPSCOTT	29	≤20
SALEM	188	51	SWANSEA	43	≤20
SALISBURY	22	≤20	TAUNTON	184	69
SANDISFIELD	≤20	0	TEATICKET	≤20	0

CITY	Enrollment	Waitlist	CITY	Enrollment	Waitlist
TEMPLETON	≤20	≤20	WEYMOUTH	99	≤20
TEWKSBURY	33	≤20	WHATELY	≤20	≤20
THORNDIKE	≤20	0	WHITE HORSE BEACH	≤20	≤20
THREE RIVERS	≤20	≤20	WHITINSVILLE	≤20	≤20
TOPSFIELD	≤20	≤20	WHITMAN	38	23
TOWNSEND	≤20	≤20	WILBRAHAM	≤20	≤20
TRURO	≤20	≤20	WILLIAMSBURG	≤20	≤20
TURNERS FALLS	≤20	≤20	WILLIAMSTOWN	≤20	≤20
TYNGSBORO	32	≤20	WILMINGTON	25	≤20
UPTON	≤20	≤20	WINCHENDON	27	≤20
UXBRIDGE	22	≤20	WINCHESTER	≤20	≤20
VINEYARD HAVEN	84	≤20	WINTHROP	50	≤20
WAKEFIELD	28	≤20	WOBURN	90	24
WALES	≤20	0	WOLLASTON	≤20	≤20
WALPOLE	≤20	≤20	WOODS HOLE	≤20	≤20
WALTHAM	249	76	WORCESTER	1,162	247
WARE	≤20	≤20	WORONOCO	≤20	0
WAREHAM	37	≤20	WORTHINGTON	≤20	0
WARREN	≤20	≤20	WRENTHAM	≤20	≤20
WARWICK	≤20	0	YARMOUTHPORT	37	≤20
WATERTOWN	86	21			
WAYLAND	≤20	≤20	TOTAL	25,445	6,395
WEBSTER	50	≤20			
WELLESLEY	≤20	≤20			
WELLFLEET	22	≤20			
WENDELL	≤20	0			
WENHAM	≤20	0			
WEST BARNSTABLE	24	≤20			
WEST BOYLSTON	≤20	≤20			
WEST BRIDGEWATER	≤20	≤20			
WEST BROOKFIELD	≤20	≤20			
WEST CHATHAM	≤20	0			
WEST DENNIS	≤20	≤20			
WEST HARWICH	≤20	0			
WEST HATFIELD	≤20	0			
WEST HYANNISPORT	≤20	0			
WEST MEDFORD	0	≤20			
WEST NEWBURY	≤20	≤20			
WEST NEWTON	34	≤20			
WEST OTIS	≤20	0			
WEST SPRINGFIELD	87	33			
WEST STOCKBRIDGE	≤20	0			
WEST TISBURY	23	≤20			
WEST TOWNSEND	≤20	≤20			
WEST WAREHAM	≤20	≤20			
WEST WARREN	≤20	0			
WEST YARMOUTH	79	27			
WESTBOROUGH	67	22			
WESTFIELD	86	51			
WESTFORD	32	≤20			
WESTMINSTER	≤20	≤20			
WESTON	≤20	≤20			
WESTPORT	39	≤20			
WESTWOOD	≤20	≤20			

Appendix 2.

Children Enrolled in MassHealth, by County

November 30, 2003

COUNTY	Percent of MassHealth Caseload			Distribution Within County		
	Children	Adults	Total	Children	Adults	Total
	0- 18	19 and over	Enrollment	0- 18	19 and over	
BARNSTABLE	3%	3%	3%	42%	58%	100%
BERKSHIRE	2%	2%	2%	43%	57%	100%
BRISTOL	10%	11%	11%	42%	58%	100%
DUKES	0%	0%	0%	44%	56%	100%
ESSEX	13%	12%	12%	45%	55%	100%
FRANKLIN	1%	1%	1%	44%	56%	100%
HAMPDEN	14%	11%	12%	48%	52%	100%
HAMPSHIRE	2%	2%	2%	42%	58%	100%
MIDDLESEX	14%	16%	15%	41%	59%	100%
NANTUCKET	0%	0%	0%	42%	58%	100%
NORFOLK	5%	6%	6%	37%	63%	100%
PLYMOUTH	7%	6%	7%	45%	55%	100%
SUFFOLK	18%	17%	17%	45%	56%	100%
WORCESTER	12%	12%	12%	44%	56%	100%
Grand Total	100%	100%	100%	44%	56%	100%

Source: Massachusetts Division of Medical Assistance, December 2003.

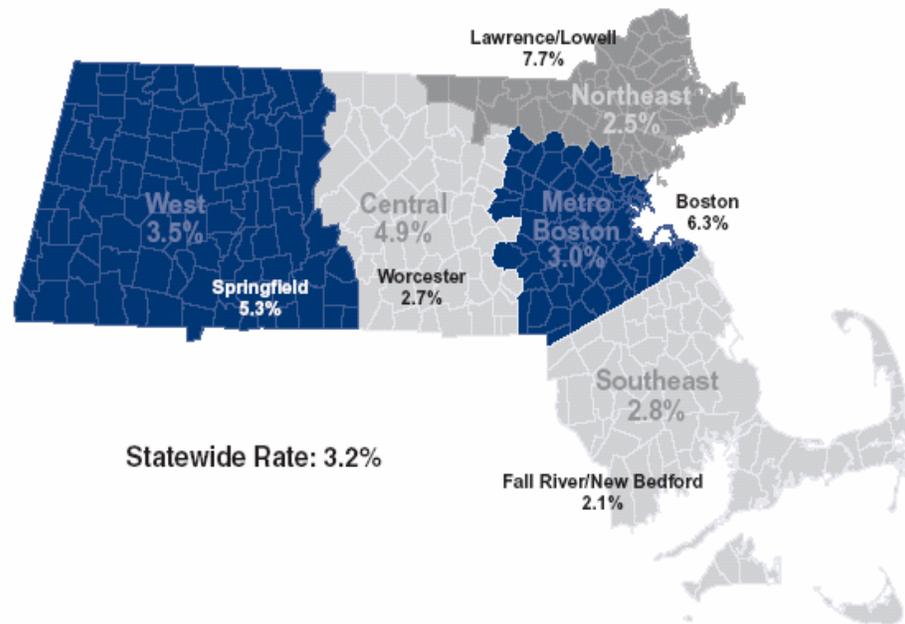
Appendix 3.

Children's Uninsurance and Health Care Utilization Rates for 2002

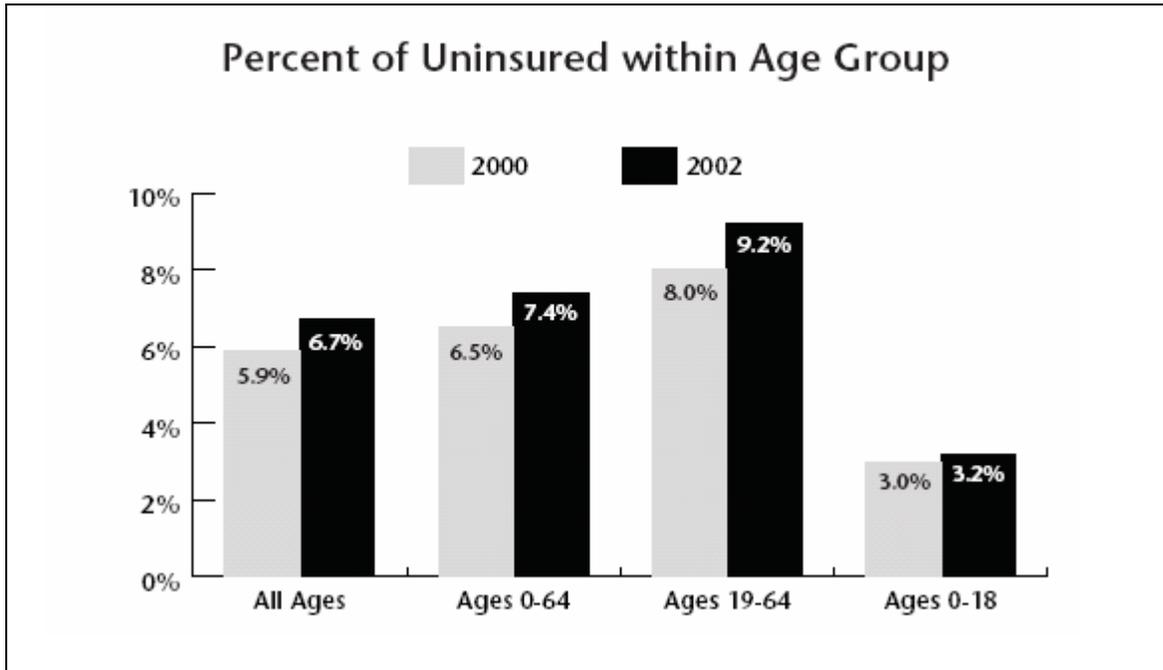
Non-Elderly Uninsured within an Age Group

	Five Urban Areas	Statewide
All Ages	10.4%	6.7%
Ages 0-64	11.3%	7.4%
Ages 19-64	14.0%	9.2%
Ages 0-18	5.2%	3.2%

Uninsured Children by Region and Urban Area, Ages 0-18



Source: Massachusetts Division of Health Care Finance and Policy. Health Insurance Status of Massachusetts Urban Area Residents: Access Update (Vol. 2, No. 1). April 2003.



Source: Massachusetts Division of Health Care Finance and Policy. Health Insurance Status of Massachusetts Residents, Third Edition. January 2003.

Massachusetts Children, Ages 0-18

	2002 Percent Distribution of Population	2002 Percent Distribution of Uninsured	2002 Percent Distribution of Insured
Age			
0-18	30.4%	13.0%	31.7%
0-5	32.9%	36.9%	32.8%
6-12	36.8%	31.3%	37.0%
13-18	30.3%	31.9%	30.3%
Gender			
Male	51.8%	42.6%	52.1%
Female	48.2%	57.4%	47.9%
Race/Ethnicity			
Sample sizes for the uninsured children are too small to report.			
Income			
< 200 FPL	22.9%	52.1%	22.0%
>= 200 FPL	77.2%	47.9%	78.0%

Uninsured Children 1998 to 2002

	2002 Rate	2000 Rate	1998 Rate
Age			
0-5	3.5%	3.0%	4.6%
6-12	2.7%	2.6%	4.7%
13-18	3.3%	3.3%	5.1%
Regional Rate for All Children?			
Metro Boston	3.0%	2.6%	3.5%
Northeast	2.5%	2.4%	3.6%
Southeast	2.8%	4.1%	5.6%
Worcester	4.9%	4.0%	4.6%
West	3.5%	2.1%	6.3%

Note: All data presented are from the Massachusetts Survey of Health Insurance Status.

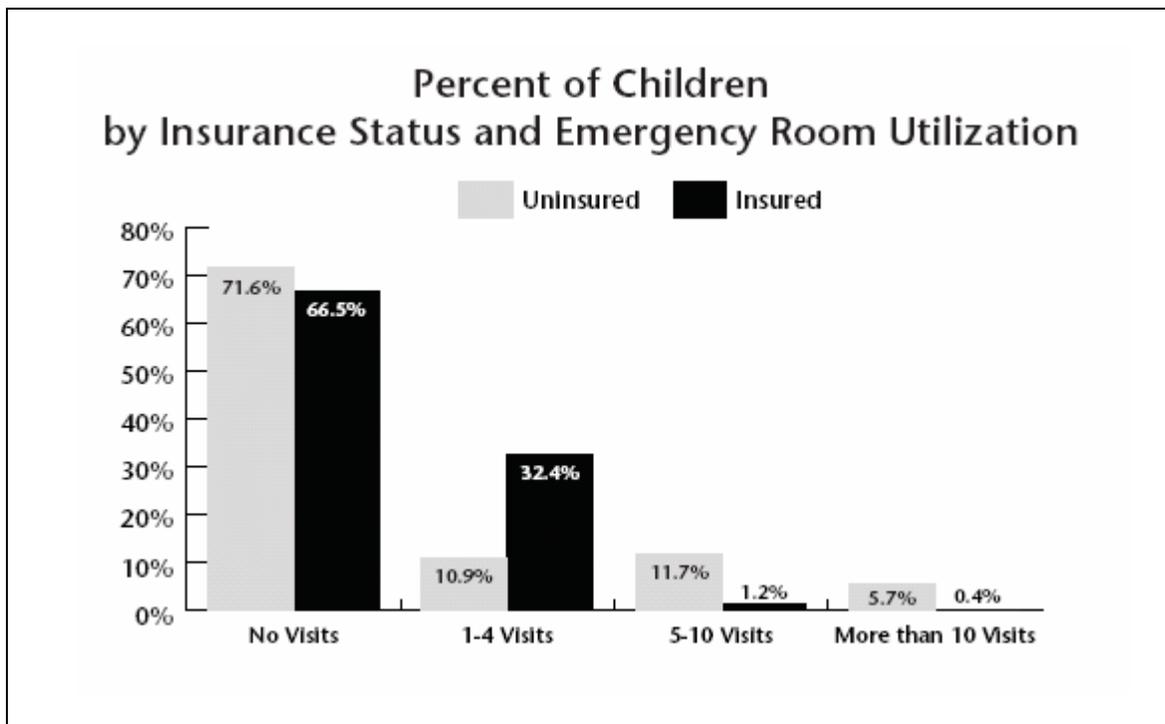
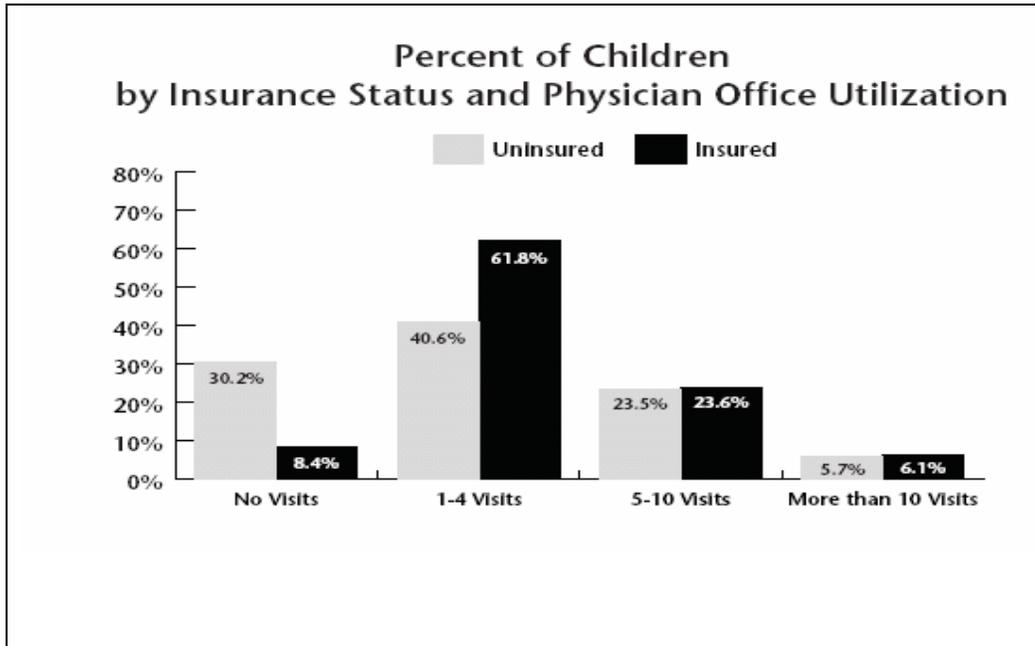
Source: Massachusetts Division of Health Care Finance and Policy. Health Insurance Status of Massachusetts Residents, Third Edition. January 2003.

	Access to Care			Ages 0-18*		
	Uninsured Rates			Insured Rates		
	2002	2000	1998	2002	2000	1998
Received Needed Care						
Yes	47.4%	73.8%	85.9%	76.8%	76.1%	80.6%
Physician Office Visits						
None	30.2%	34.2%	8.1%	8.4%	11.7%	7.9%
1-4	40.6%	38.1%	78.7%	61.8%	62.6%	59.0%
5-10	23.5%	21.4%	11.8%	23.6%	19.2%	23.0%
>10	5.7%	6.3%	1.4%	6.1%	6.5%	10.0%
ER Visits						
None	71.6%	70.8%	72.4%	66.5%	73.0%	67.5%
1-4	10.9%	21.8%	26.1%	32.4%	25.3%	29.1%
5-10	11.7%	7.4%	1.5%	1.2%	1.5%	2.8%
>10	5.7%	0.0%	0.0%	0.4%	0.2%	0.5%
Dental Visits						
None	19.9%	18.8%	n/a	23.8%	11.5%	n/a
One or more	80.1%	81.2%	n/a	76.2%	88.5%	n/a

*Due to the small number of uninsured children, sample sizes are small leading to larger variation around the rates.

Note: All data presented are from the Massachusetts Survey of Health Insurance Status.

Source: Massachusetts Division of Health Care Finance and Policy. Health Insurance Status of Massachusetts Residents, Third Edition. January 2003.



Source: Massachusetts Division of Health Care Finance and Policy. Health Insurance Status of Massachusetts Residents, Third Edition. January 2003.

Appendix 4.

Federal Poverty Level Guidelines for 2003

Family Size	100% FPL		133% FPL		150% FPL		200% FPL		400% FPL	
	Monthly	Yearly								
1	\$749	\$8,980	\$996	\$11,943	\$1,123	\$13,470	\$1,497	\$17,960	\$2,993	\$35,920
2	\$1,010	\$12,120	\$1,344	\$15,888	\$1,515	\$18,180	\$2,020	\$24,240	\$4,040	\$48,480
3	\$1,272	\$15,260	\$1,692	\$20,296	\$1,908	\$22,890	\$2,544	\$30,520	\$5,087	\$61,040
4	\$1,534	\$18,400	\$2,040	\$24,472	\$2,300	\$27,600	\$3,067	\$36,800	\$6,133	\$73,600
5	\$1,795	\$21,540	\$2,388	\$28,648	\$2,693	\$32,310	\$3,590	\$43,080	\$7,180	\$86,160
6	\$2,057	\$24,680	\$2,736	\$32,824	\$3,085	\$37,020	\$4,114	\$49,360	\$8,227	\$98,720
7	\$2,319	\$27,820	\$3,084	\$37,001	\$3,478	\$41,730	\$4,637	\$55,640	\$9,273	\$111,280
8	\$2,580	\$30,960	\$3,432	\$41,177	\$3,870	\$46,440	\$5,160	\$61,920	\$10,320	\$123,840
Each add'l person add	\$262	\$3,140	\$349	\$4,176	\$393	\$4,710	\$524	\$6,280	\$1,047	\$12,560

Calculated by Health Care For All and Massachusetts Law Reform Institute using federal poverty level guidelines set by the United States Department of Health and Human Services.