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The Impact of Program Changes on Enrollment, Access, and Utilization in the Oregon Health Plan Standard Population

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THE IMPACT OF PROGRAM CHANGES ON ENROLLMENT, ACCESS, AND UTILIZATION IN THE OREGON HEALTH PLAN STANDARD POPULATION

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EXECUTIVE SUMMARY

In February 2003, in an effort to expand Medicaid coverage within tight fiscal constraints, the Oregon Health Plan (OHP) underwent a significant redesign of benefits, cost-sharing and premium structure. The OHP2 redesign resulted in two tiers of coverage, OHP Plus and OHP Standard, and a premium subsidy program. The OHP Plus benefit package and cost sharing structure is similar to the original OHP and serves the federally-mandated Medicaid populations: children and pregnant women, low-income elderly and individuals meeting the SSI definition of disability. OHP Standard, designed for Oregon's expansion population,[1] includes a reduced benefit package, expanded co-pays and increased premiums. Premium rules were also tightened for the OHP Standard group: individuals are now disqualified from benefits for non-payment of premiums and locked-out from OHP for six months following a disqualification. In addition, monthly premiums are no longer waived for certain groups.(e.g., homeless, zero income).

In order to assess the impact of recent program changes, a mail-return survey was conducted between November 2003 and February 2004 with a random sample of OHP beneficiaries who were enrolled as of February 2003, immediately before the program changes were implemented. The survey assessed issues related to enrollment, health care access, health care use, and financial and health status and covered a six-month period following the OHP changes. A total of 2,783 individuals completed surveys, 1,405 individuals in OHP Plus and 1,378 in OHP Standard.

This report presents descriptive survey results for the 1,378 OHP Standard enrollees and addresses the impact of recent program changes on 3 key outcomes: enrollment, health care access, and utilization.

Key Findings

Enrollment

- Nearly half (44%) of OHP Standard enrollees lost coverage for all or part of the six months following the changes.

- More than two-thirds (67%) of those who lost coverage remained uninsured.

- OHP Standard Enrollees with the lowest incomes--0%-10% of Federal Poverty Level (less than $931 annual income for a single person) --were significantly more likely to report difficulty paying premiums and copays.

[1] OHP expansion includes adults, age 19 to 64, earning below 100% of federal poverty level ($9,310 annual income).

- Nearly half (44%) of those who lost coverage indicated that increased program costs, in the form of premiums and co-pays, were among the main reasons for losing coverage.

- For those in the lowest income group (0%-10% FPL), more than half (57%) reported that increased program costs were among the main reasons for losing coverage.

Health Care Access

- Those who lost coverage were significantly more likely to report unmet needs for medical care, urgent care, mental health care and prescription medications than those who were continuously enrolled.

- Persons with a chronic illness who lost coverage were more likely to report unmet health care needs.
    - 64% of those with a chronic illness who lost coverage reported unmet health care needs.
    - 69% reported they could not afford their medication.

- Nearly three-fourths (72%) of those with unmet health care needs indicated that cost was the main barrier.

- OHP Standard enrollees who lost coverage were more than twice as likely as those who retained coverage to report having no usual source of care, and were four times more likely to identify a hospital emergency department as their usual source of care.

Health Care Utilization OHP Standard Population

- Loss of coverage significantly increased the risk of an emergency department visit among those in the lowest income group (0-10% of FPL) and those with a chronic illness.
    - 43% of those in the lowest income group who lost coverage reported an emergency department (ED) visit in the past six months compared to 35% of those who retained coverage.
    - Among people with a chronic illness, 49% of those in the lowest income group who lost coverage reported an ED visit compared to 34% of those in the lowest income group who maintained coverage.

I. INTRODUCTION

In early 2003, Oregon redesigned the Oregon Health Plan in an effort to expand Medicaid coverage within tight fiscal constraints. Using the new flexibility allowed states in the Health Insurance Flexibility and Accountability (HIFA) Demonstration Initiative and an 1115 waiver, Oregon, once again, embarked on new territory. The original policy goal of the redesign was to incrementally expand coverage for children, pregnant women, parents and childless adults from 170% of the federal poverty level (FPL) to 185% FPL. The planned expansion would maintain budget neutrality by offering tiered benefit packages and increased cost sharing.

The redesign, referred to as "***OHP2,"*** was comprised of three Medicaid benefit packages (1) OHP Plus, (2) OHP Standard and (3) the Family Health Insurance Assistance Program (FHIAP), a premium subsidy program. The ***OHP Plus*** **benefit package** and cost sharing structure is similar to the original OHP, and serves the population who are categorically eligible for Medicaid services under federal law (e.g, Temporary Aid to Needy Families, Old Age Assistance (OAA), disabled populations (SSI) and eligible Medicaid and SCHIP children. The ***OHP Standard*** **benefit package**, designed for Oregon's adult expansion population (adults in families and adults without children), is leaner and for the first time implements significant copayments. Additionally, while premiums have been charged to the expansion population since 1995, changes were made to the premium structure as part of OHP2 as shown in Table 1. Administrative changes were made to the premium policy as well: eliminating discounts for couples and establishing new rules, discontinuing coverage immediately for non-payment and instituting a six-month lockout for non-payment of premiums.

Table 1. Changes in OHP Premium Structure

Previous OHP Premium Structure (Single/Couple):		
	Single	Couple
0-50% FPL	$6.00	$6.50
50-65% FPL	$15.00	$18.00
66-80% FPL	$18.00	$21.00
80-100% FPL	$20.00	$23.00
OHP2 Premium Structure (Single/Couple)		
	Single	Couple = Two Singles
0-10% FPL	$6.00	$12.00
11-50% FPL	$9.00	$18.00
50-65% FPL	$15.00	$30.00
66-85% FPL	$18.00	$36.00
86-100% FPL	$20.00	$40.00

In March of 2003, as Oregon's budget shortfall became more severe, the Oregon legislature eliminated coverage for outpatient behavioral health, dental, durable medical equipment, vision, and for a brief period, prescription drugs for the OHP Standard population. Except for increasing OHP eligibility for children and pregnant women and FHIAP eligibility to 185% FPL, the expansions that had been part of the waivers were not implemented. February enrollment data show 88,874 individuals enrolled in OHP Standard, but by the end of 2003 the OHP Standard population declined by 46%, to 47,957 covered lives. This decline stands in stark relief to the same time period in the previous year when this category changed from 93,722 (Feb., 2002) to 91,174 (Dec. 2002), a decline of 2.7% (Department of Human Services, 2003).

In order to assess the impact of program changes on individuals enrolled in the OHP, a team of researchers from the Office for Oregon Health Policy and Research (OHPR), Portland State University, the Providence Health System's Center for Outcomes Research and Education (CORE) and the Office of Medical Assistance Programs, recruited 2,783 OHP members to participate in a two-year cohort study. The purpose of this study is to follow a cohort of individuals who were enrolled in the OHP in February of 2003, just prior to the implementation of program changes, and assess the effects of those changes on enrollment, access to care, service utilization, and financial and health outcomes of OHP beneficiaries. Using a prospective cohort design, a group of 1,378 OHP beneficiaries who experienced changes in their benefits, premiums and copays, will be compared over a two-year period with a group of 1,405 beneficiaries who were enrolled during the same time period, but experienced no changes.

This report details findings from the baseline survey, conducted between November, 2003, and February, 2004, and addresses the impact of recent OHP changes on the 1,378 OHP Standard beneficiaries who participated in the study.

II. METHODS

Sample

A stratified random sample of eligible study participants was obtained from the OHP Medicaid eligibility files. Eligible study participants included adults who were OHP eligible for at least 30 days prior to February 15, 2003, when the initial wave of program changes were implemented for the Standard population. An initial sample of 10,819 individuals were selected, evenly divided between OHP Standard and OHP Plus. Additionally, over-sampling was employed to ensure adequate representation among African-American, Native American, and Spanish-speaking populations; a total of 500 people from each racial/ethnic group were randomly selected. Of those initially sampled, 8,487 were ultimately found to be eligible for the study – the remainder were either deceased, had moved out of state or had no current address at the time of the study start date.

A letter explaining the study, a consent form, and an initial survey was mailed to each member of the sample. Surveys were conducted in both English and Spanish. For those not responding to the initial survey, between November 2003 and February 2004, two additional survey attempts were made at one-month intervals. Between each survey mailing, reminder postcards were sent, and in February 2004, telephone reminder calls were conducted among those who had not completed surveys.

The final cohort consists of 2,783 adults who agreed to participate in the two-year study, 1,405 from OHP Plus and 1,378 from OHP Standard, for a response rate of 33%. The response rate for the current study is consistent with the national average for Medicaid surveys.[2]

Survey

An unique survey instrument was designed to assess Medicaid enrollment, health care access, utilization, and financial and health outcomes. The instrument draws from widely accepted data collection tools, including the CAHPS survey, the Community Tracking Study and the SF-12 health assessment instrument. To ensure instrument validity, cognitive testing of the survey instrument was conducted with a small sample of OHP members who agreed to take the survey and participate in a validation interview. Spanish language surveys were translated and then independently back translated to ensure fidelity of translation.

Measures

Information about OHP eligibility group (e.g., OHP Plus or Standard), income category, and respondents' primary language were obtained from OMAP eligibility files. All other measures including demographic variables, enrollment, health care access and utilization were obtained from self-reported mail-return surveys. Although self-reported health care utilization can be subject to recall bias (Roberts et al., 1996), in order to minimize bias the assessed time period was limited to six months and multiple complementary items were used for access outcomes: all based on previously validated survey instruments.

III. RESULTS

Sample characteristics

[2] For example, the national Consumer Assessment of Health Plans Survey (CAHPS) benchmarking database reports a 37% response rate for Medicaid surveys, and CAHPS typically includes telephone follow up for non-responders (Westat, 2001).

As shown in Table 2, the sample characteristics were remarkably representative of the sample from which it was drawn. Women, Whites, and English speakers were significantly more likely to respond, however differences were relatively small.

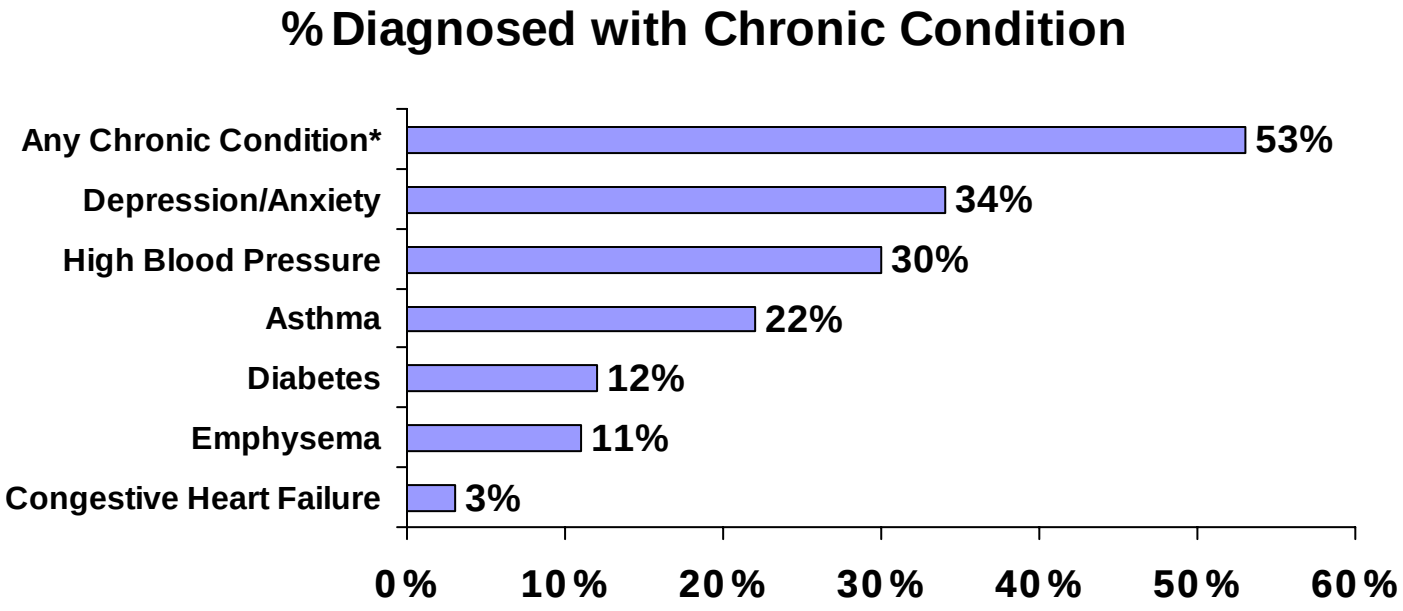
Table 2. Sample Demographic Characteristics

Gender	Eligible Sample (n=8,487)	Respondents (n=2,783)
Male	39.4%	32.8%
Female*	60.6%	67.2%
Race/Ethnicity		
Asian	3.5%	2.1%
African-Am	10.0%	8.1%
Hispanic	14.1%	11.6%
NA/AN	9.5%	9.1%
White*	62.8%	69.1%
Language		
English*	87.9%	92.0%
Spanish	7.6%	6.0%
Russian	1.4%	0.6%
Vietnamese	1.3%	.8%
Other	1.7%	0.6%
Population		
OHP Plus	51.6%	50.7%
OHP Standard	48.4%	49.3%

* $p < .05$

Additionally, in order to assess their health status, survey respondents were asked if they had been diagnosed as having one of 5 common chronic conditions. As shown in Figure 1, a large proportion of the OHP Standard population reported being diagnosed with at least one of five chronic physical conditions including hypertension, asthma, diabetes, congestive heart failure or emphysema. Additionally, more than one-third of the respondents had been diagnosed with depression or anxiety.

Figure 1. Percent of OHP Standard Population Reporting Chronic Conditions.



*excludes Depression/Anxiety

Impact of OHP Changes on Enrollment and Insurance Status

A large proportion of OHP Standard enrollees lost their OHP coverage and remained uninsured.

As shown in Chart 1, 44% of the OHP Standard respondents lost coverage for one or more months during the six-month study period compared to 12% of the OHP Plus population. Of those in OHP Standard who lost coverage, more than half had no coverage for entire six-month period. This is consistent with OMAP administrative data for the same time period indicating the number of OHP Standard beneficiaries declined by 46%.

The majority of OHP Standard respondents who lost coverage remained uninsured at the end of the study period. Chart 2 shows the current insurance status of OHP Standard enrollees at the time the survey was completed. More than two-thirds (67%) reported being uninsured, 13% returned to the OHP and 9% received employer sponsored insurance. The remaining 11% reported "other" coverage.

OHP Standard enrollees diagnosed with a chronic condition were significantly more likely to maintain their coverage. More than half (58%) of those with a

chronic condition reported continuous enrollment compared with 50% of those with no chronic condition (p.<.01).

> ***Compared to those with higher incomes, those whose incomes were below 10% of the federal poverty level reported more difficulty paying premiums and copays and were more likely to report cost as the main reason for losing coverage.***

While premiums have been charged to the Oregon Medicaid adult expansion population since 1995, this survey shows that changes in both the premium structure and administration have had significant impacts on the lowest income clients.

Among those in OHP Standard enrolled for at least one of the six months prior to the survey, a substantial number indicated that the new premiums and copays were usually or always difficult to pay, and those with the lowest incomes were significantly more likely to report difficulty. For example, 26% of those with incomes above 10% of the FPL reported difficulty paying premiums compared to 39% of those with lower incomes (Chart 3). Nearly all respondents, however, indicated that paying OHP premiums was "worth it to prevent higher health care costs," 89% of those with higher incomes indicated premiums were worth paying compared to 85% of those with lower incomes. Among those with higher incomes, 19% reported difficulty paying copays as did 41% of those with lower incomes.

For those who lost coverage, nearly half indicated that one of the main reasons for losing coverage was the increased cost associated with premiums and copays. As shown in Chart 4, when asked the "main" reason for losing coverage, the most common responses included that they could not afford the premiums (31%) or that their incomes increased making them ineligible for benefits (31%). A large percentage of individuals also indicated they could not afford co-pays (27%) or that they owed premiums from a prior eligibility period (27%). Far less common reasons included turning in a late application (10%), obtaining insurance coverage from another source (10%), or losing their mental health or chemical dependency benefits (9%).

Respondents were allowed to check as many reasons for losing enrollment as applied to them, thus, many respondents checked more than one reason for losing coverage. In order to better understand the relative impact of increased costs, responses to this question were divided into two mutually exclusive categories – those related to program costs including premiums, copays, or owing back premiums, and reasons not related to cost including increased income, late paperwork, or loss of benefits.

Chart 5 shows the mutually exclusive categories of responses. Nearly half (44%) of the OHP Standard respondents who lost coverage reported that program

costs, including the cost of copays, premiums, or owing back premiums, were one of the main reasons they lost coverage. Moreover, loss of coverage appeared to be driven by a cumulative effect of both premiums and copays, 28% of the total reported more than one reason related to cost. Very few individuals reported copays alone or premiums alone as the main reason for losing coverage - 4% reported only cost of copays, 5% reported only premium cost, and 7% reported only owing back premiums. More than half of the respondents (56%) did not list one of the cost-related reasons.

Prior analyses of enrollment data (McConnell and Wallace, 2004) showed that a disproportionate number of those disenrolled immediately after the OHP changes were those in the lowest income category. In order to ascertain whether this trend was related to increased program costs, reasons for losing coverage were compared across income categories. As Chart 6 shows, OHP Standard enrollees with the lowest incomes (0%-10% of FPL) were significantly more likely to list cost related reasons for losing coverage, 57% of those in the lowest income category reported a cost reason for losing coverage compared to 38% of those with higher incomes ($p.<.01$).

Clearly, the increased costs associated with the OHP2 presented a hardship for many OHP Standard enrollees. However, as Chart 7 shows, when asked if they would be willing to reapply for OHP if the monthly premiums were reduced by $3, more than half of those in the lowest income category indicated they would reapply (56%) and nearly half (43%) of those in higher income categories indicated that they would do so.

Impact of Losing Coverage on Health Care Access

Loss of OHP coverage resulted in increased unmet need for medical care, prescription medications, and mental health care, especially for those with a chronic illness.

The majority of those who lost coverage for some or all of the six months following OHP changes reported having unmet health care needs. When asked "Was there ever a time when you needed health care, but did not get it?" 28% of those with continuous coverage indicated they had unmet health care needs, compared to 58% of those who lost coverage. For those who remained uninsured, 64% reported unmet needs, compared to 30% of those who had some kind of insurance coverage (Chart 8). Similarly, the majority of those who lost coverage reported they were unable to get urgent care for an illness or injury when they needed it, 61% of those who lost coverage reported they were unable to get care right away for an illness or injury compared to 33% of those who were continuously insured. Among those who remained uninsured, 66% reported not getting urgent care right away, compared to 35% of those who had insurance coverage. (Chart 9).

The most common reason reported for not getting needed care was cost. As shown in Chart 10, 72% of those who lost coverage reported that cost was the main reason for unmet health care needs, as did 35% of those with continuous coverage. Additionally, among those who maintained OHP coverage, 24% indicated they had unmet health care needs because they could not afford the copays.

For those needing prescription medications, cost proved to be a substantial barrier. As shown in Chart 11, 56% of those who lost coverage reported being unable to afford needed medications, as did 46% of those who were continuously enrolled.

Similarly, loss of coverage was associated with greater unmet need for mental health care. Although nearly one-third of the OHP Standard population (29%) reported needing treatment for a mental health condition, more than half of those who lost coverage were unable to receive needed treatment and just over one-third of those with continuous coverage were unable to obtain treatment (Chart 12).

The impact of lost coverage was especially great for those with a chronic illness. Individuals diagnosed with one of five chronic medical conditions who lost coverage were more than twice as likely to report an unmet medical care need than those who remained covered (64% vs. 31%, respectively). Likewise, 69% of those with a chronic illness who lost coverage reported they could not afford needed medications compared to 55% of those who retained coverage. (Chart 13).

Another important indicator of access is having a usual source of care. OHP Standard members who lost coverage were more than twice as likely to report having no usual source of care (26% vs. 11%, respectively), and were four times more likely to report using the emergency department as their usual source (8% vs. 2%, respectively). Those who maintained coverage were considerably more likely to report a private clinic as their usual source, but were only slightly more likely to report a public clinic was their usual source of care compared to those who lost coverage (Chart 14).

Impact of Losing Coverage on Health Care Utilization

Loss of coverage increased emergency department (ED) utilization for those in the lowest income category, especially among those with a chronic illness.

Given that loss of OHP coverage was associated with an increased risk of having no usual source of care, it was not surprising that individuals who lost coverage were less likely to report having an outpatient physician visit in the past six months. As shown in Chart 15, among those who lost coverage, only 55% reporting having an outpatient visit, compared with 82% of those who retained coverage. Surprisingly, there was no overall difference between these two groups in emergency department use, 30% of both groups reported at least 1 ED visit in the past six months.

However, the relationship between lost coverage and ED use differed across income groups. Specifically, Individuals with the lowest incomes were more likely to have an ED visit than those with higher incomes, and among the lowest income group, losing coverage was associated with increased use of the emergency department. As shown in Chart 16, 35% of those in the lowest income group who were continuously enrolled reported an ED visit compared with 43% of those who lost coverage. Among the higher income group, 27% of those who lost coverage had an ED visit compared with 24% of those with continuous coverage.

Moreover, among people with chronic conditions, the relationship between income, lost coverage, and ED use was even more dramatic. For individuals with chronic conditions in the lowest income group, loss of coverage was associated with a substantial increase in ED use. In this group, 34% of those with continuous coverage had an ED visit compared with 49% of those who lost coverage. This means that nearly half of those in the lowest income group who had a chronic illness went to the ED to receive care in the past six months. However, among those with higher incomes, there was little difference in ED use between those who maintained and those who lost coverage, 30% of those who maintained coverage had an ED visit, compared to 29% of those who lost coverage.

IV. DISCUSSION

This study reports the baseline results of a prospective cohort study designed to examine the effects of recent program changes on the OHP Standard population. The initial survey results presented in this report suggest that these program changes had immediate consequences on insurance coverage and health care access and utilization for thousands of low income Oregonians. A substantial proportion of OHP Standard beneficiaries reported difficulty paying premiums

and copays, and many reported losing their insurance coverage because they could not afford the out-of-pocket insurance costs. The impact of increased costs on enrollment were felt most acutely among the poorest individuals, those whose incomes were below 10% of the federal poverty level (or $931 annual income for one person).

This study has several limitations that may impact findings. First, because these findings are based on a return rate of 33%, it is possible that generalizability is limited to the subset of respondents who completed a survey. However, because the study sample appears to closely resemble the general OHP population from which it was drawn, it is likely that results are generalizable to the OHP Standard population as a whole. Another important limitation is that the major outcomes reported in this study were derived from self-reported surveys, which present a potential recall bias. As noted at the outset, however, steps were taken to reduce such bias including limiting recall periods to six months and using previously validated survey questions. Finally, because this survey was cross-sectional, associations identified between program changes and outcomes may not be causal.

V. CONCLUSION

Despite inherent limitations, available evidence reported in the current study is consistent with several other studies recently conducted examining the effects of recent OHP changes. For example, an examination of OMAP enrollment data before and after February of 2003 showed a dramatic drop in OHP Standard enrollment, especially among those with incomes below 10% of federal poverty level (McConnell and Wallace, 2004). Results from the current survey suggest that this group was more likely to report difficulty paying increased costs, and was more likely to lose coverage and delay or forgo care as a result. Another study conducted on Oregon's Medically Needy population, a program recently cut in the budget crisis, found rates of unmet prescription medication needs similar to those found in the current study (Zerzan, 2004). Likewise, analysis of prescription medication claims in the period before and after the implementation of increased cost-sharing in early 2003 showed a 33% reduction in the number of prescription claims in the months following February, 2003 (Hartung, 2004). Finally, an analysis of emergency room utilization at Oregon Health & Science University reported a 17% increase in ED utilization among the uninsured in the three months following the OHP changes (Lowe and McConnell, 2004). Taken together, these studies provide strong evidence that increased program costs have resulted in loss of coverage, unmet health care and medication needs, and increased emergency department utilization for the most vulnerable Oregonians.

The current study sheds additional light on the aforementioned trends in enrollment and utilization by demonstrating that many OHP Standard enrollees reported difficulty paying premiums and copays, and that loss of coverage was driven, in part, by increased costs, especially among those with the lowest

incomes. Loss of coverage resulted in cascading effects on health care access and utilization, especially among those with the lowest incomes and the chronically ill. Those who lost coverage could not afford to obtain needed medical care and prescription medications, and were less likely to have a usual source of care.

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Chart 1.

OHP Standard members were more likely to lose OHP coverage. Those who lost OHP were asked how many of the last 6 months had they been without coverage...

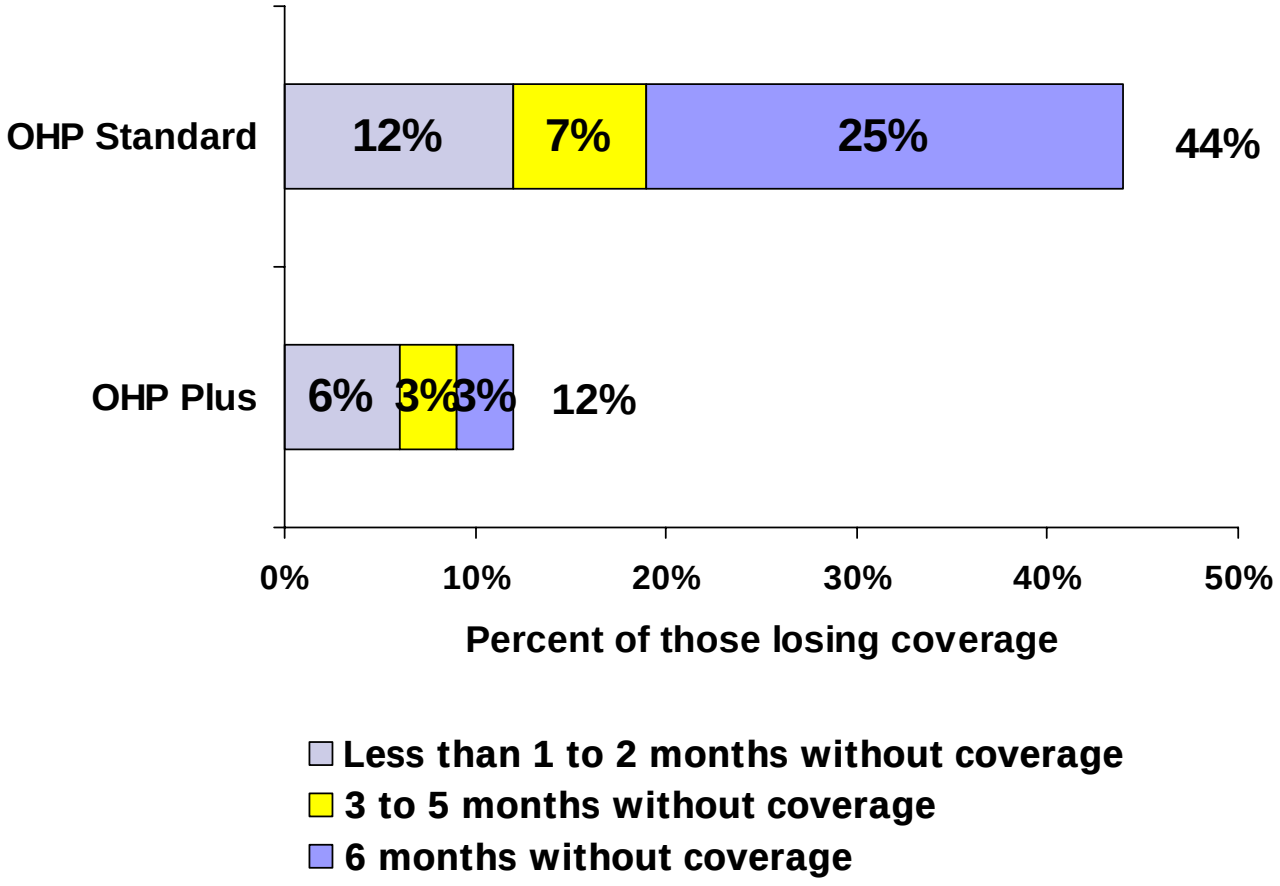


Chart 2.
Most OHP Standard clients who left do not currently have health insurance coverage.

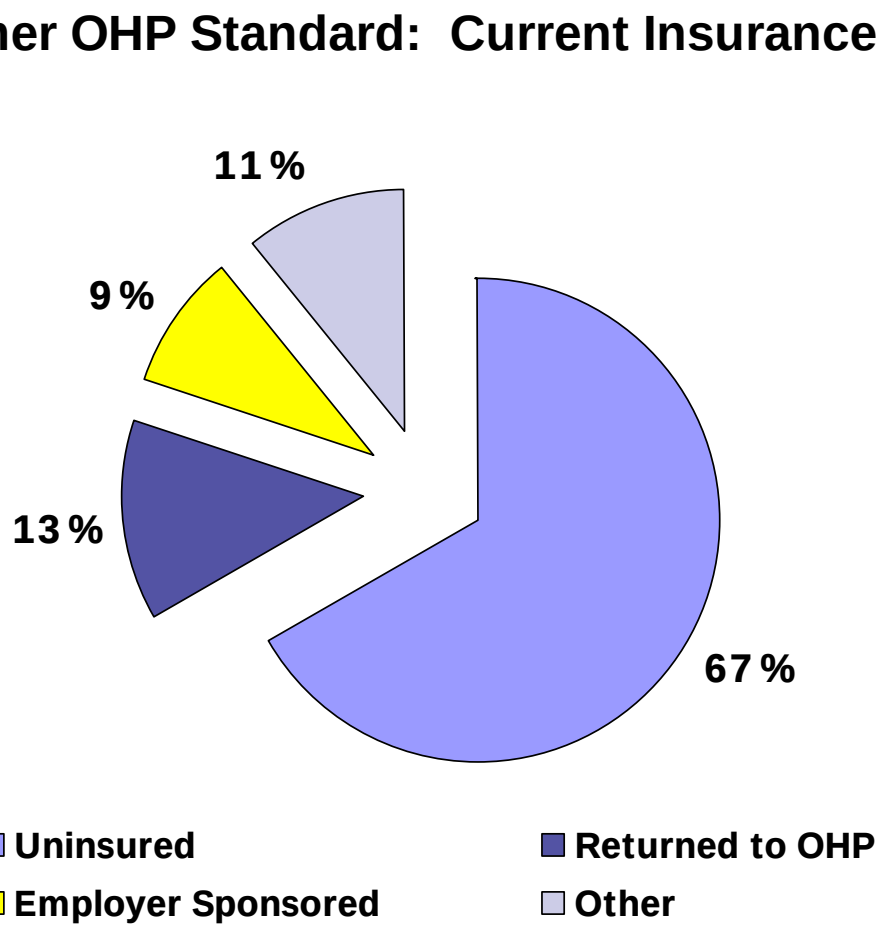
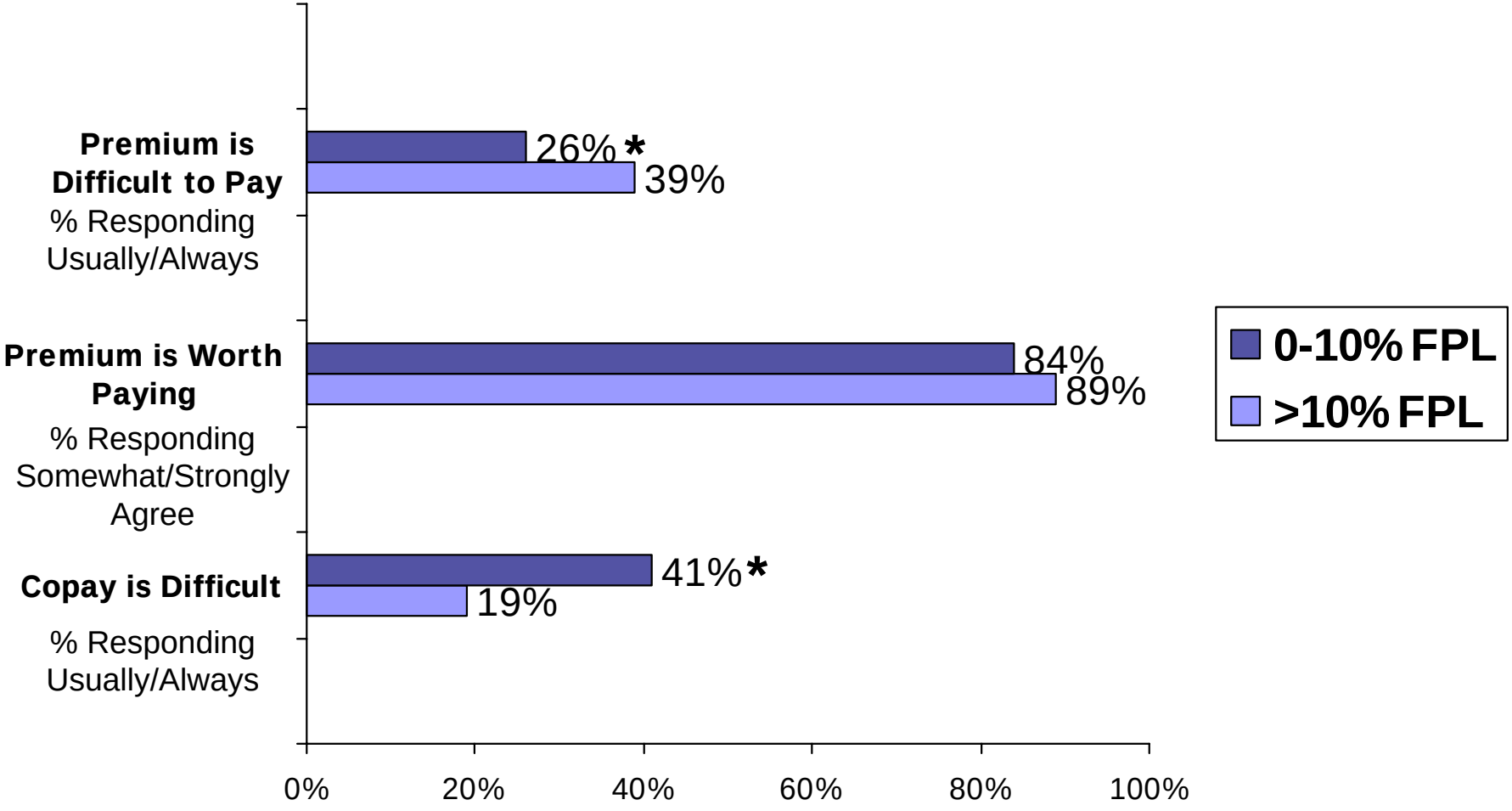
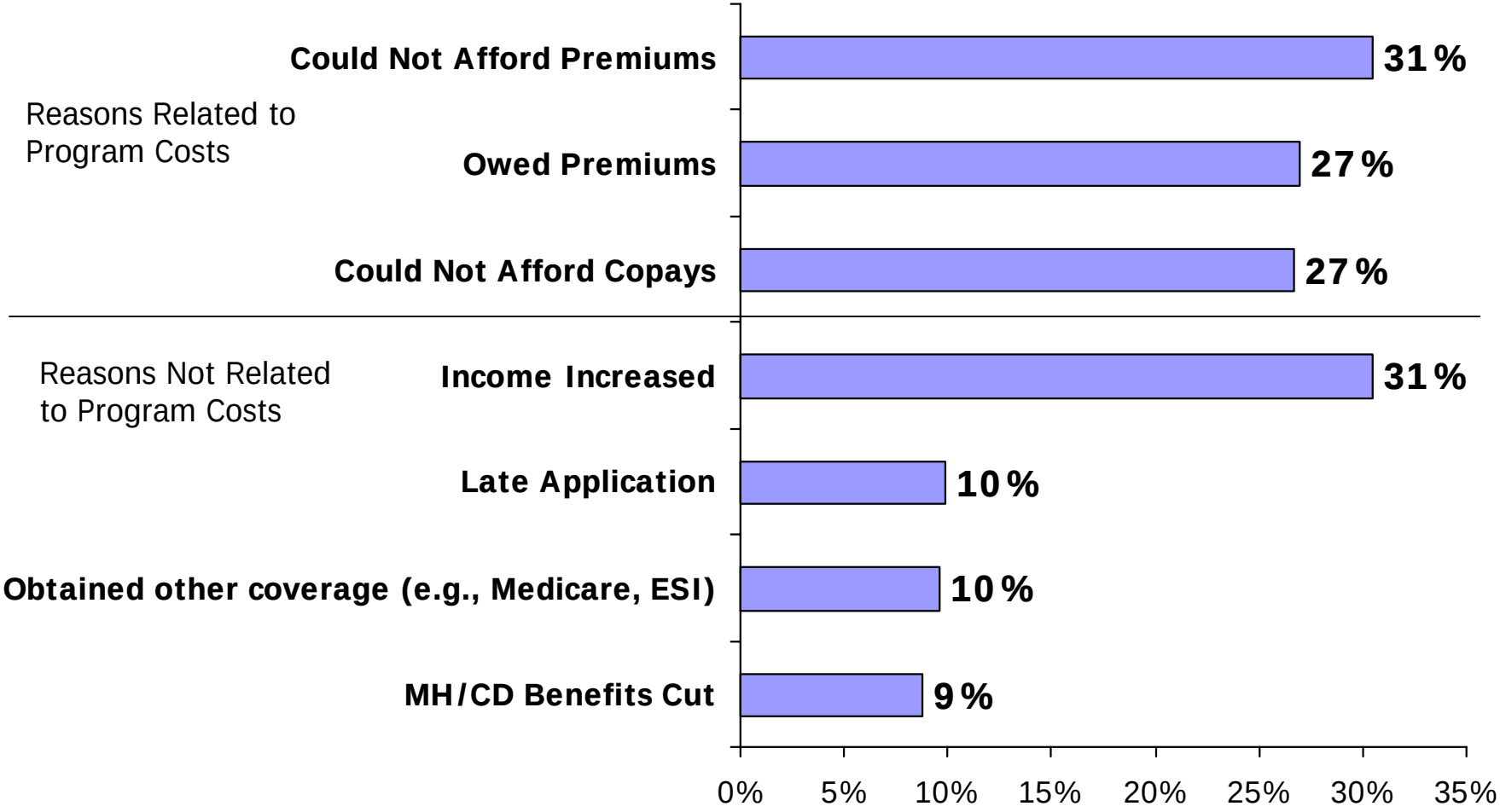


Chart 3.
Those with lower incomes reported more difficulty paying premiums and copays.



* p < .05

Chart 4.
Many of those who lost coverage reported program costs as a main reason...



Note: Categories are not mutually exclusive. Will not sum to 100%.

Chart 5.

Among those reporting program costs as reasons for loss of coverage, most cited both premiums and copays as factors...

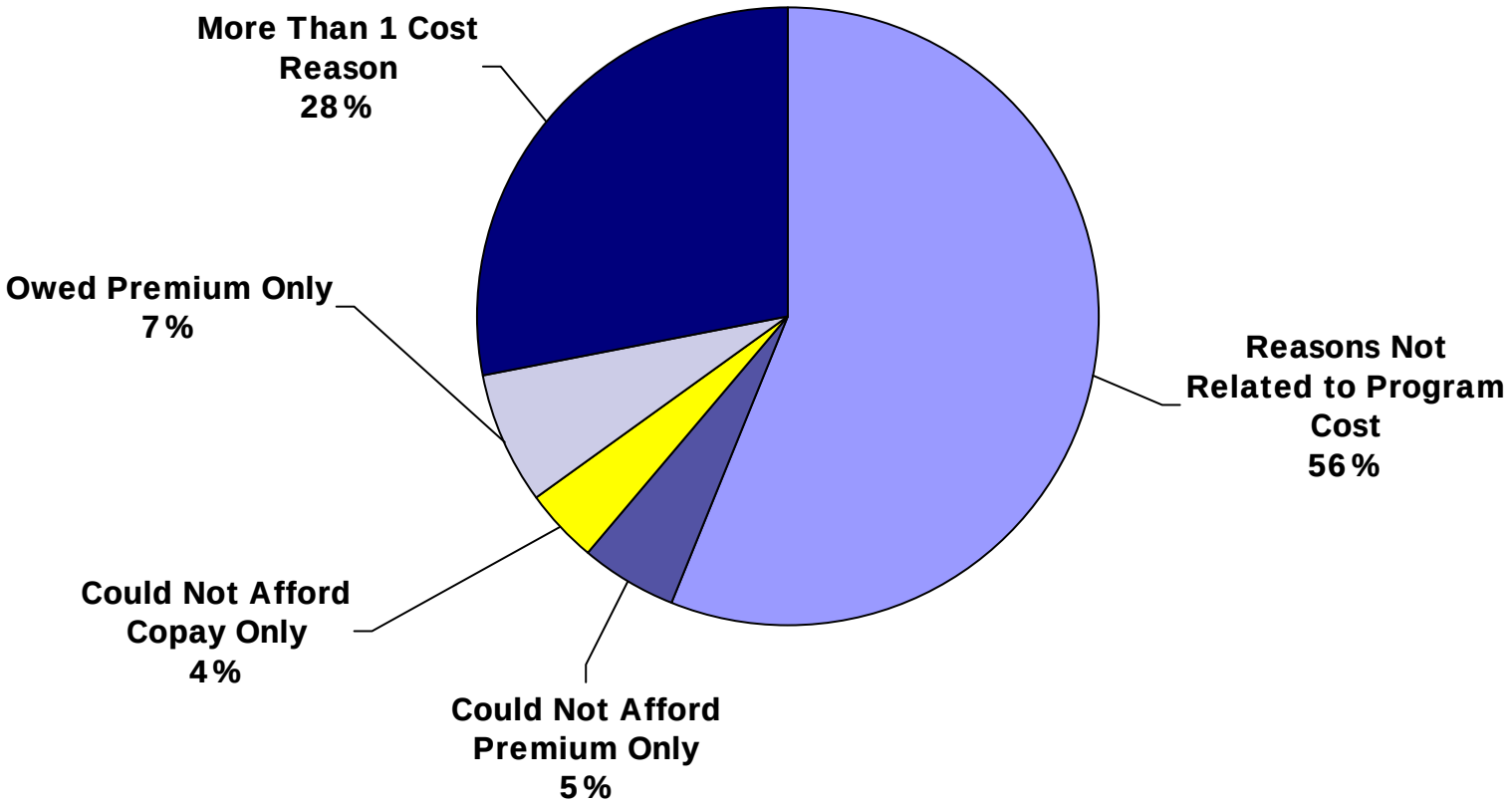
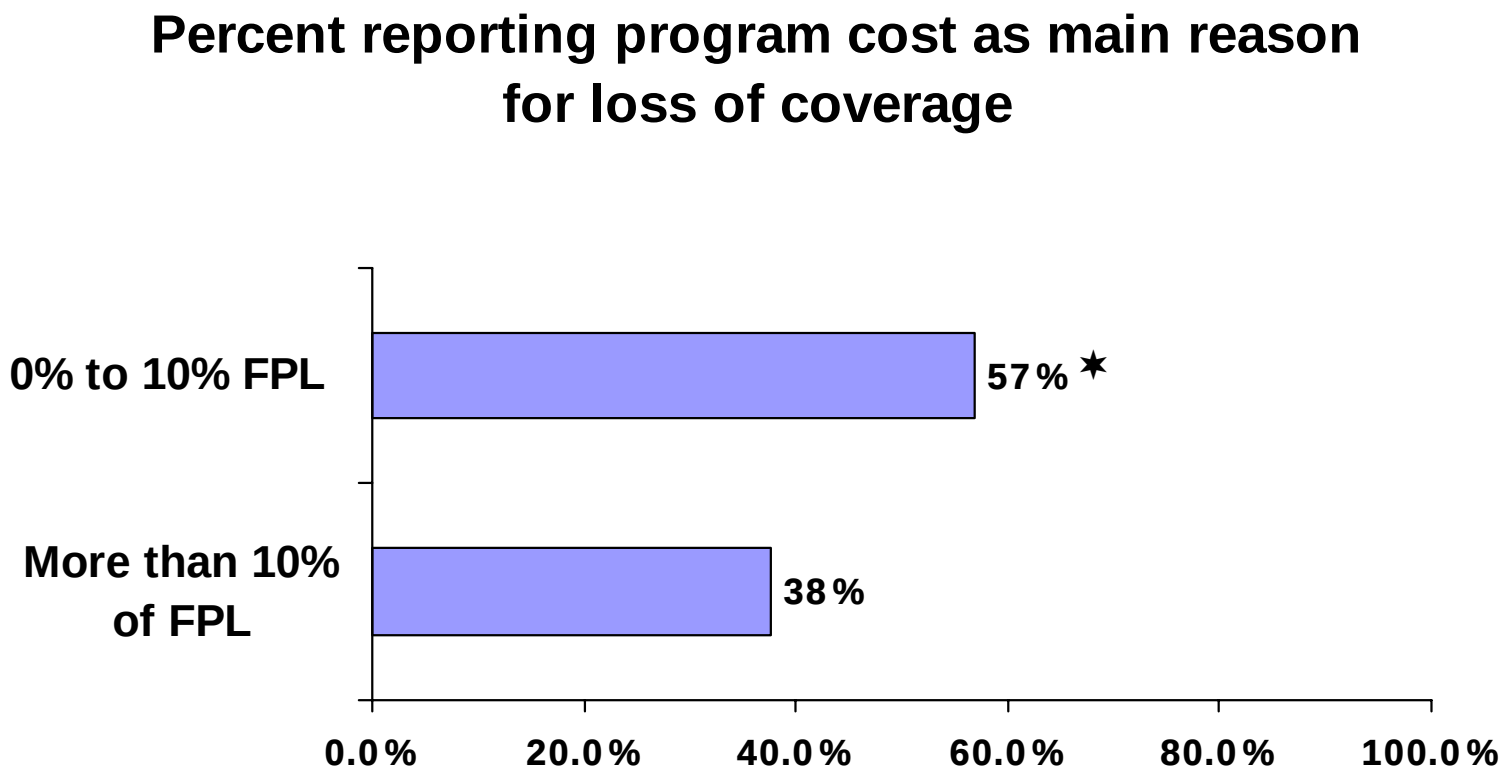


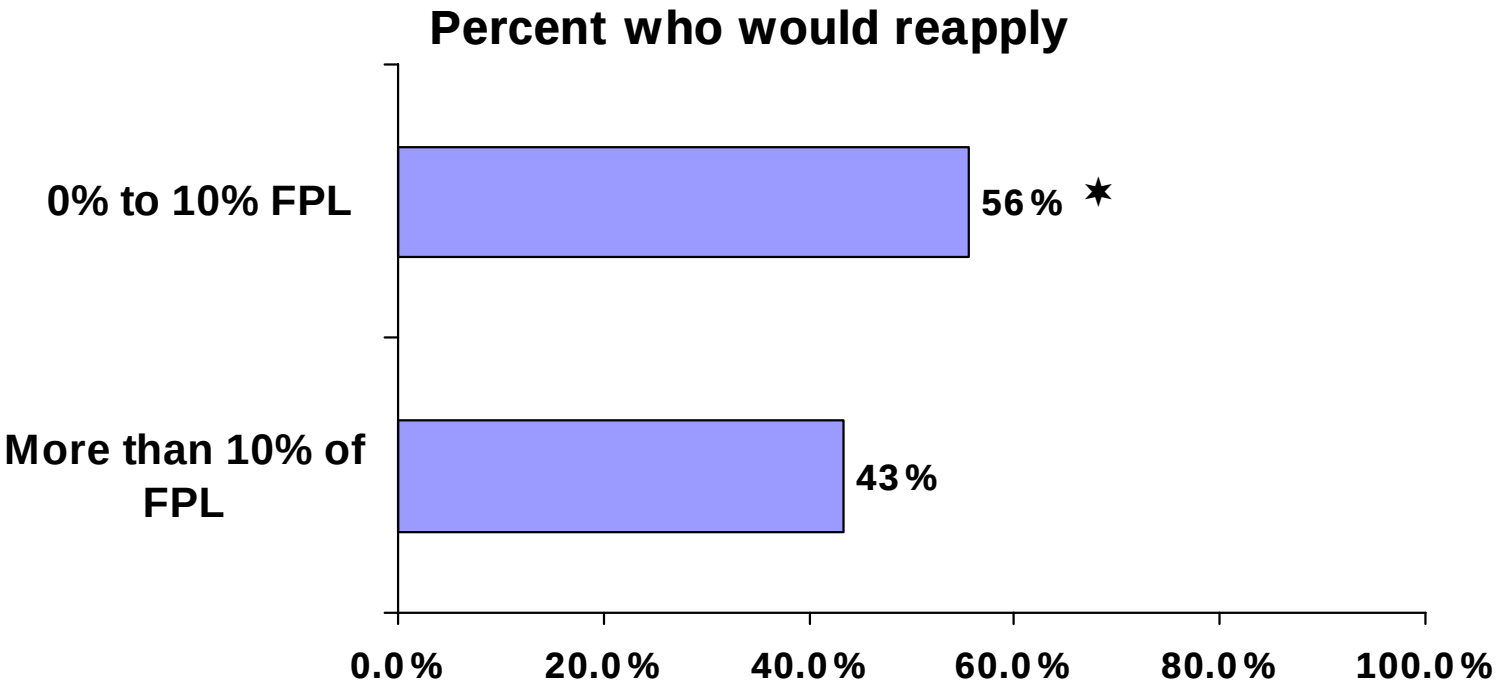
Chart 6.
Cost sharing disproportionately affected lowest income group...



* p<.01

Chart 7.
Respondents state a willingness to pay with small decreases in premiums...

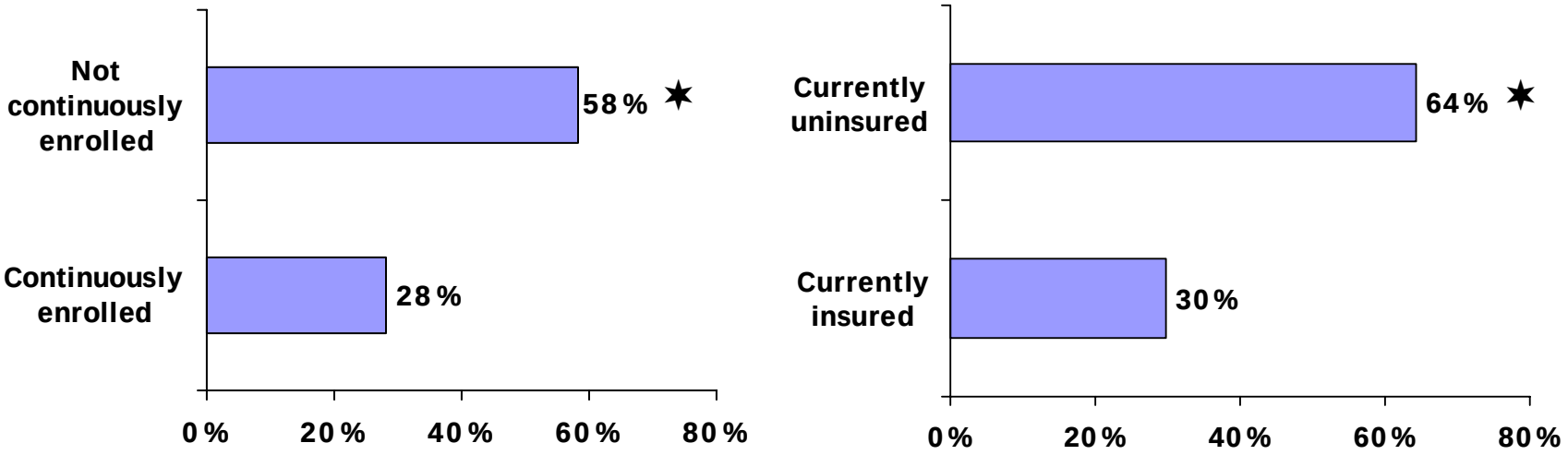
If Premiums were lowered by $3 per month would you continue without coverage or reapply for OHP?



* p<.05

Chart 8.
Loss of OHP and lack of current insurance lead to higher unmet need

Was there ever a time in the past 6 months when you needed care but did not get it?

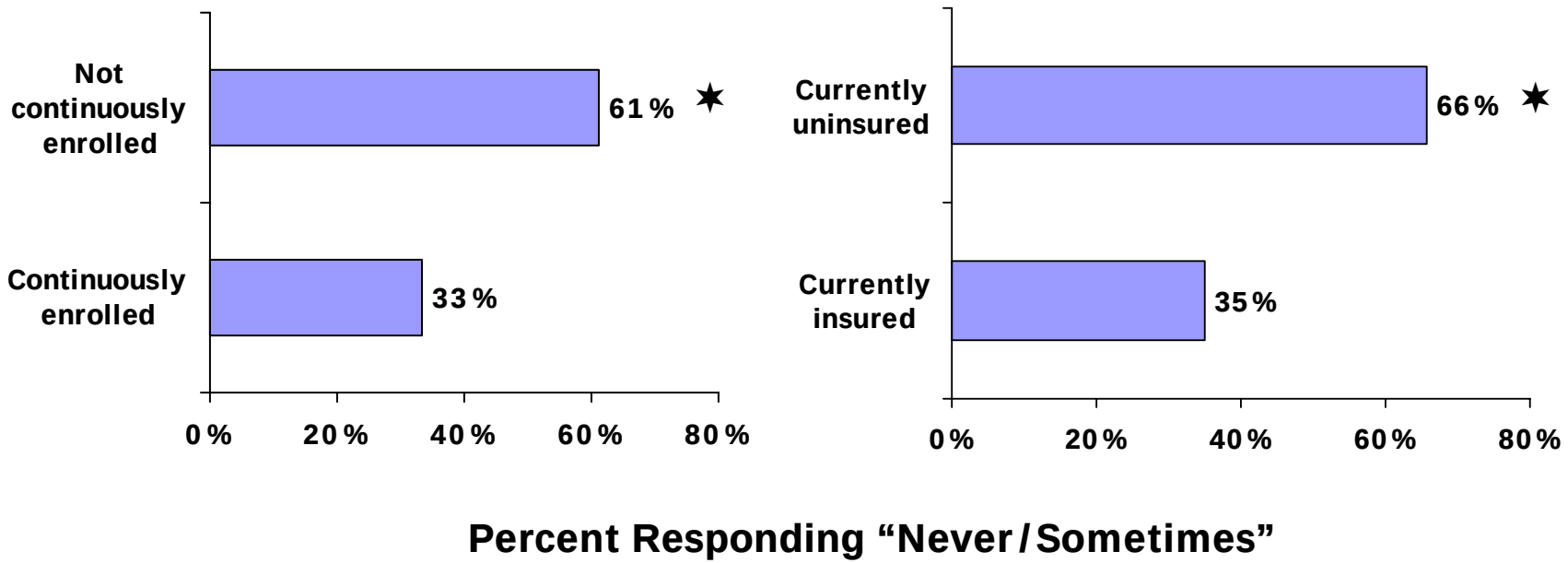


Percent Responding "YES" to Unmet Health Care Need.

✶Significantly different, p<.01.

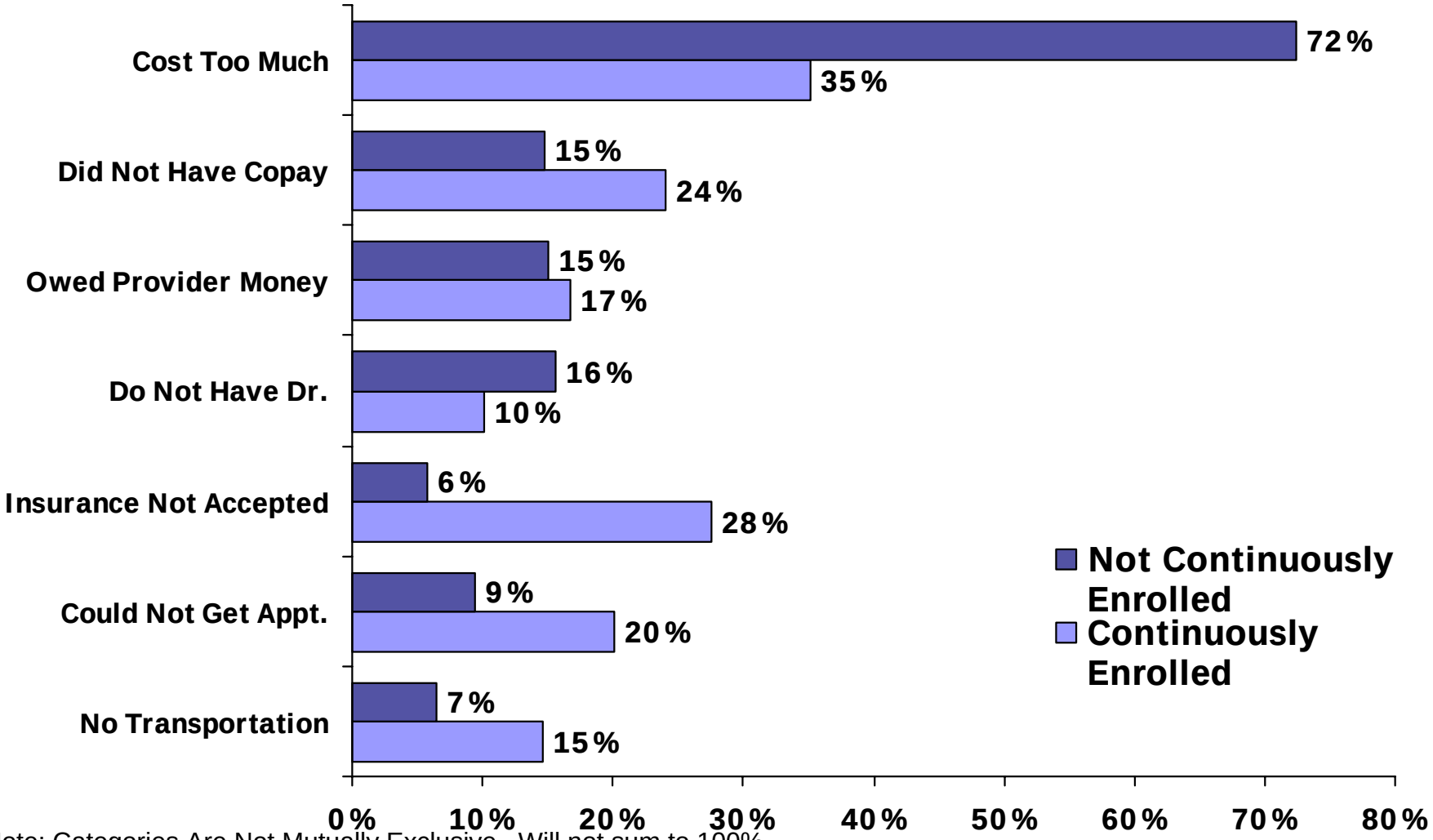
Chart 9.
Loss of OHP and lack of current insurance lead to higher unmet need, even for urgent care...

When you needed care right away for an illness or injury, how often did you get care as soon as you wanted?



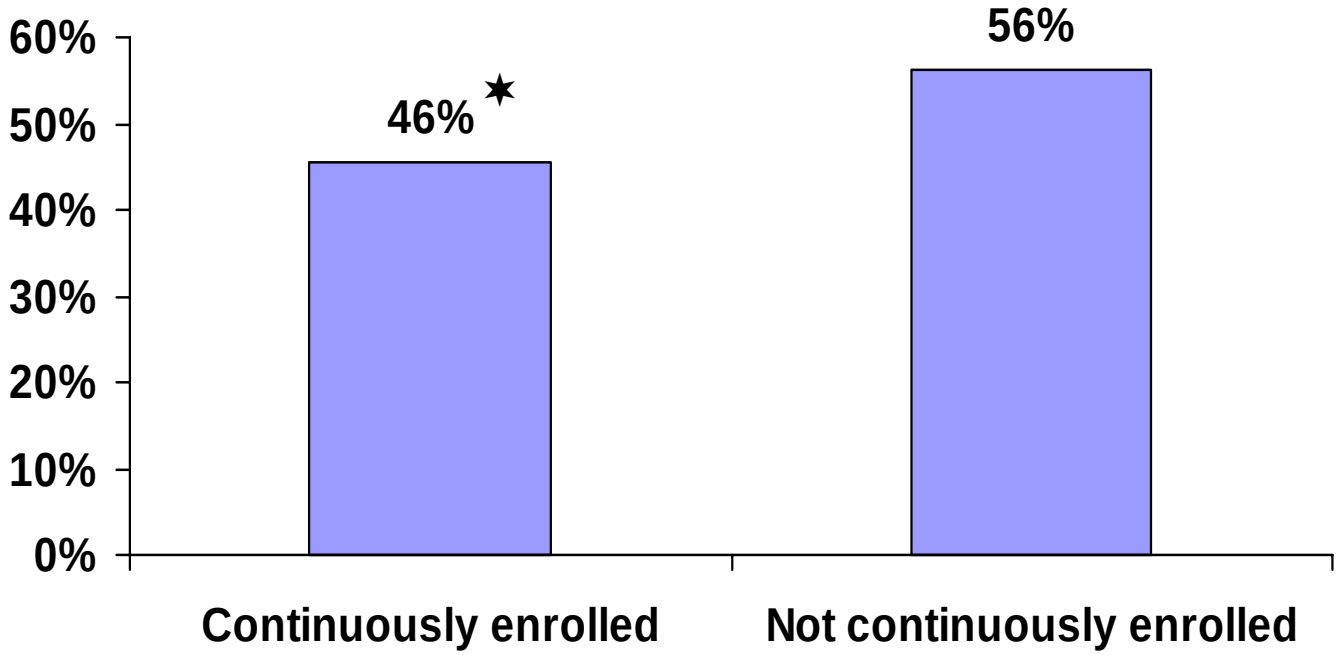
✶Significantly different, p<.01.

Chart 10.
Cost was a major reason for not getting needed care...



Note: Categories Are Not Mutually Exclusive. Will not sum to 100%.

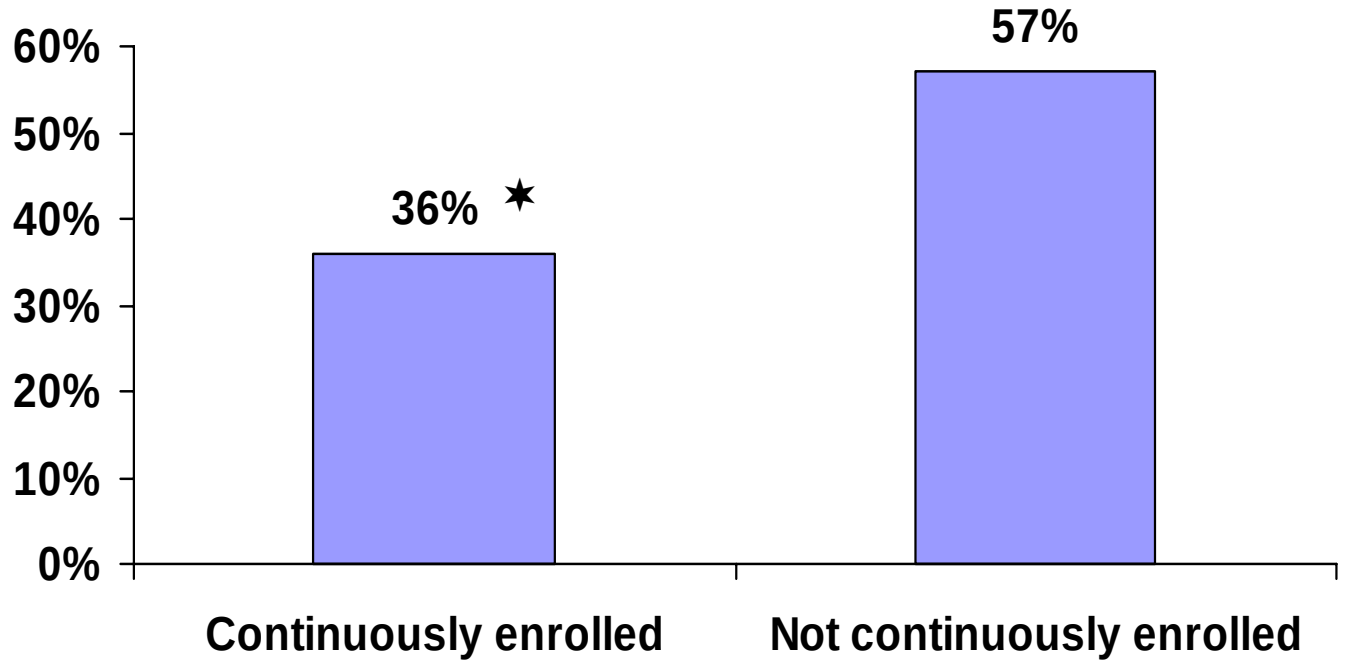
Chart 11.
Those who lost coverage were more likely to report that they have not purchased needed prescription medications due to cost…



Percent reporting could not afford prescription medications.

★ Significantly different, p<.05.

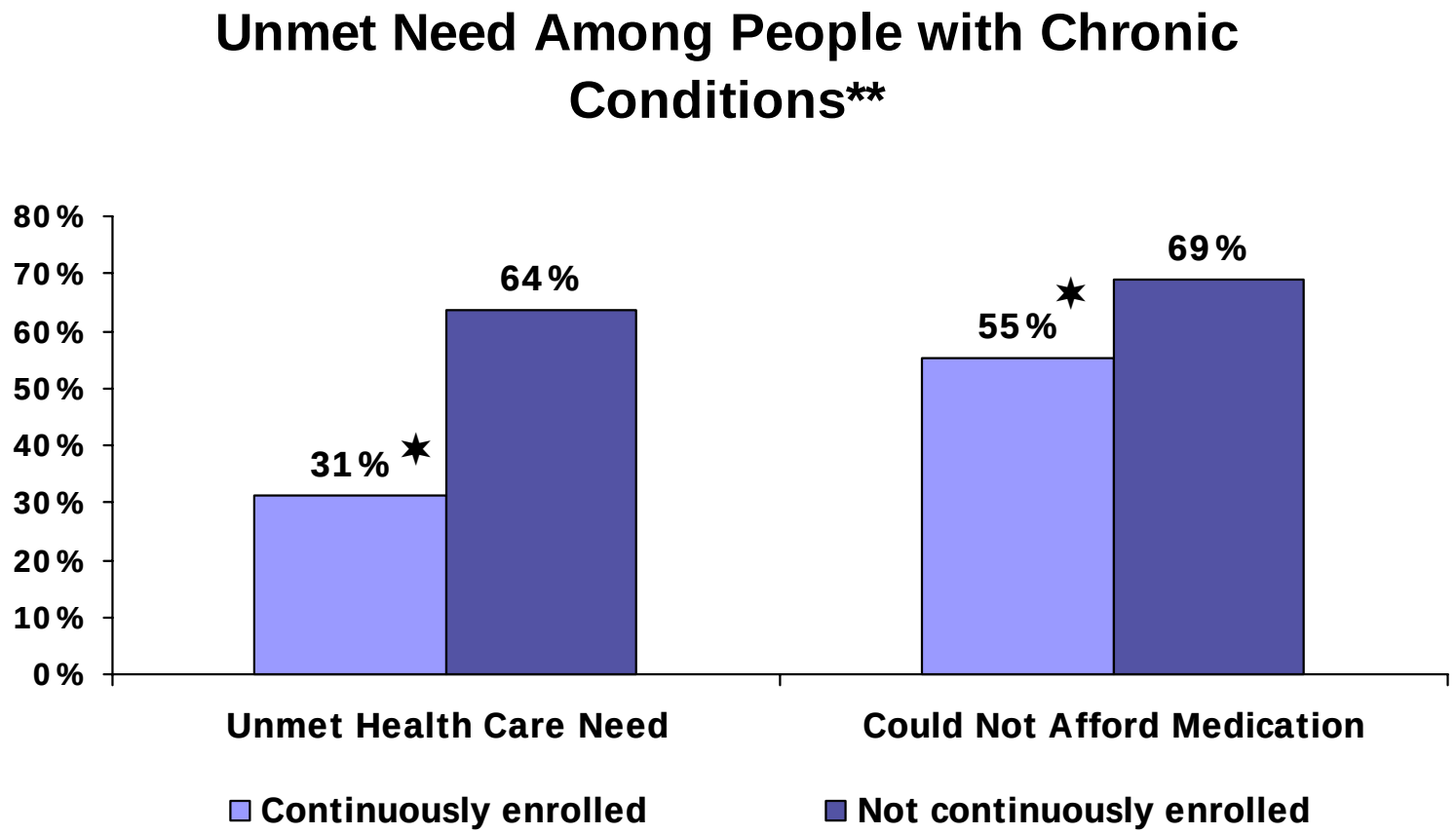
Chart 12.
OHP Standard clients who lost coverage were more likely to report unmet mental health care needs...



Percent who needed but never received mental health care.

★ Significantly different, p<.01.

Chart 13.
Loss of OHP Standard coverage particularly affected those with chronic conditions...

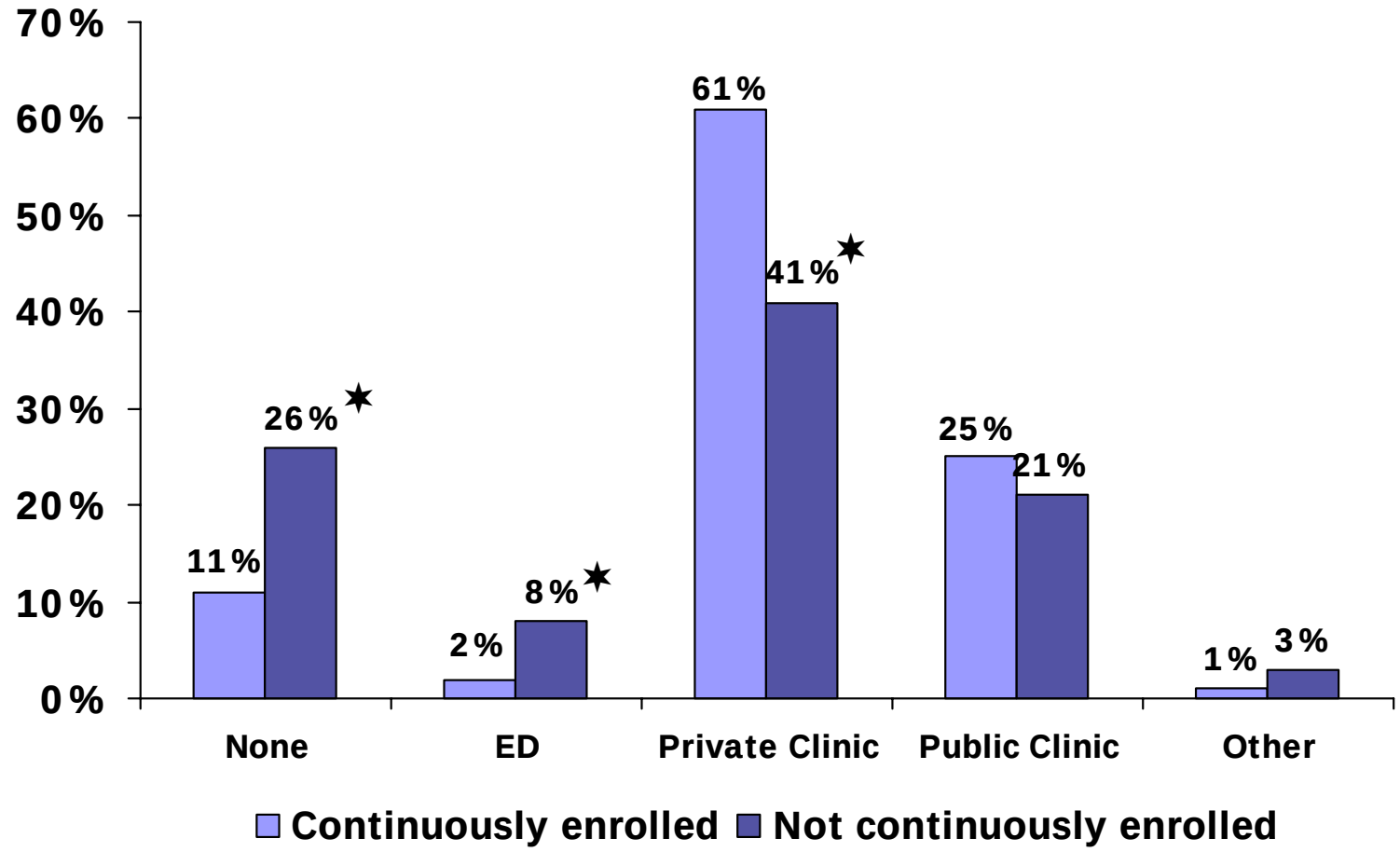


**Diabetes, Asthma, Hypertension, CHF, Emphysema

Significantly different, p<.01

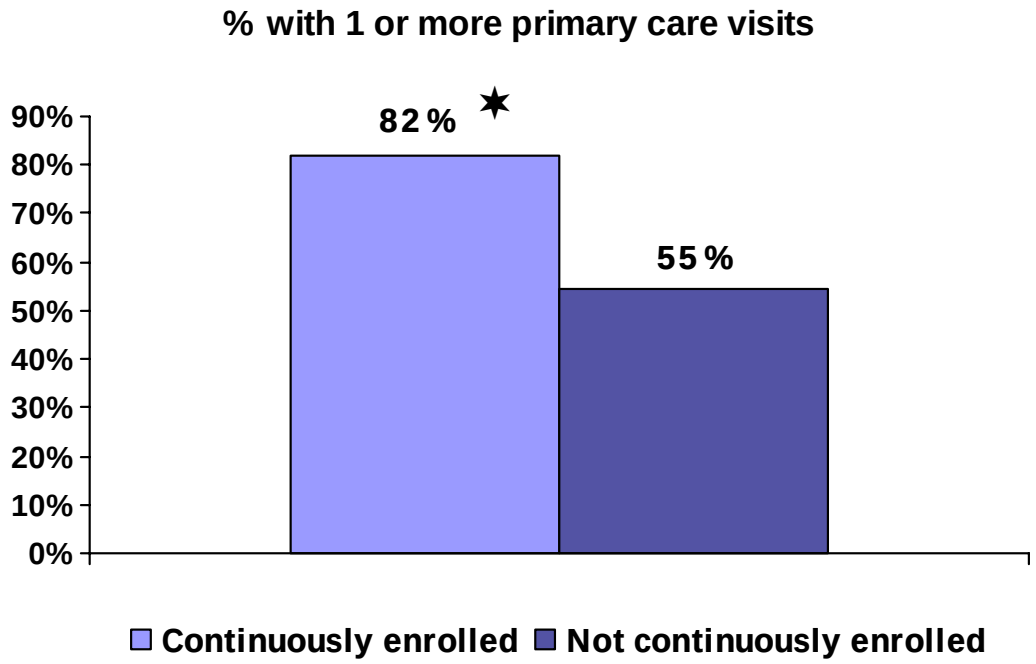
Chart 14.

Those who lost coverage were more likely to report no usual source or that the ED was their usual source of care...



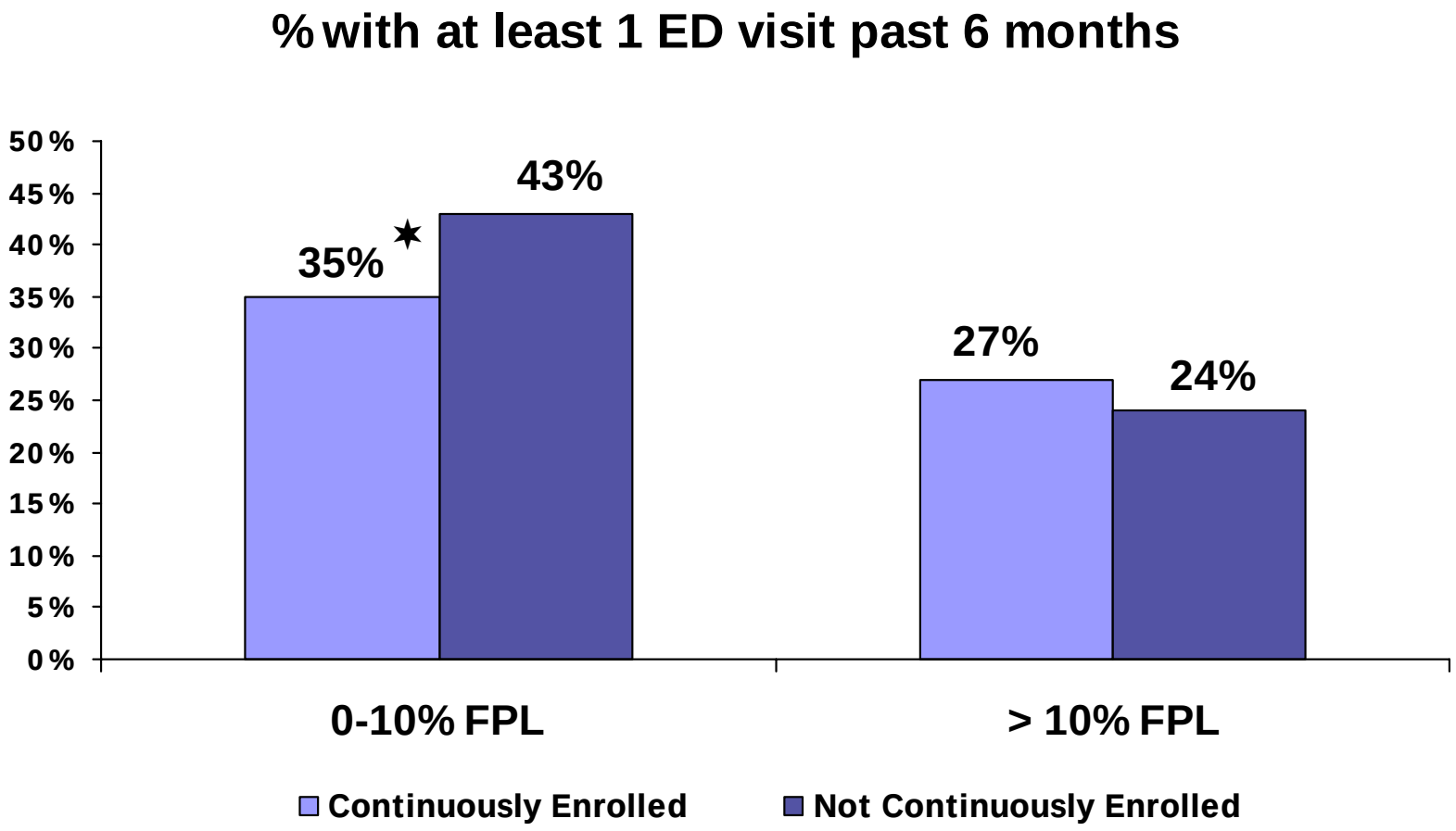
★ Significantly different, p<.01

Chart 15.
Those who lost coverage were less likely to have an outpatient visit...



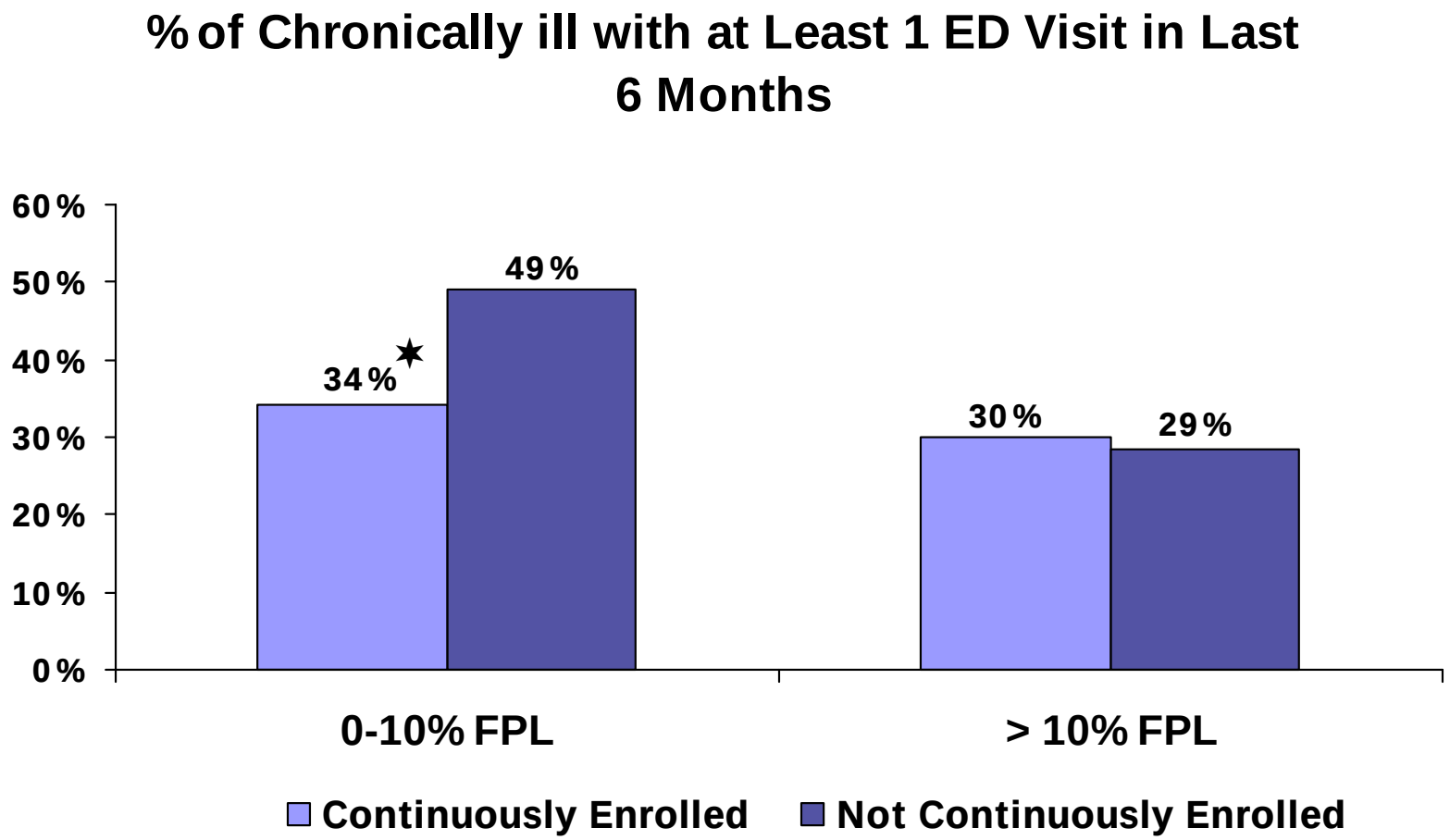
✶Significantly different, p<.01

Chart 16.
Loss of coverage increased Emergency Department use, especially among the lowest income group...



✶Significant difference, p<.05

Chart 17.
Continuous enrollment mitigates ED use for lowest income persons with chronic illness...



★Significant difference, p<.05.