

## **Increased Cost-Sharing in Medicaid Hurts Women and Their Families**

(June 2005)

Medicaid fills a key role in providing coverage to populations that would otherwise have difficulty obtaining health insurance. Under the program, low-income parents, children, disabled and elderly receive a wide range of essential health care services. The majority of adult beneficiaries are women, and many of these women head their households.

With states facing increasing fiscal pressures in recent years and large federal cuts to Medicaid looming, state Medicaid programs are looking at cost-sharing as a way to contain program costs. *Cost-sharing measures can reduce costs by discouraging the use of health care services,*<sup>1</sup> especially in the short term. In the long run, though, cost-sharing policies increase financial burdens on other parts of the health care system and hurt beneficiaries.

This has real implications for the access to care and health status of low-income populations. *On average, a working mother with two children is eligible for Medicaid if she makes \$231 or less a week. On this sort of budget, a family would be hard-pressed to find the resources to pay a co-payment if in need of medical care.*

### **What is Cost-Sharing?**

*Cost-sharing* refers to the out-of-pocket payments, usually in the form of co-payments, that beneficiaries are required to make in connection with the receipt of a covered service under their health insurance plan. The majority of states use co-payments – fixed amounts that must be paid by the beneficiary at the time the service is received – as their primary cost-sharing device. Some states also impose premiums, which are prepaid payments made to a health plan by beneficiaries.<sup>2</sup>

### **Cost-Sharing Requirements in Medicaid**

Current Medicaid law forbids cost-sharing for certain *populations*, including children under age 18, pregnant women, terminally ill individuals in hospice, and inpatients in nursing facilities<sup>3</sup>, and two *services*, namely emergency services and family planning. For all other populations and services, states can impose “nominal” cost-sharing.<sup>4</sup>

Also, federal law forbids participating physicians, hospitals, and other providers from collecting additional payments from their patients. Thus, under current law, providers must serve the Medicaid patient, even if the person can not pay the required cost-sharing.<sup>5</sup>

### **Cost-Sharing Hurts Low-Income Populations**

Co-payments are intended to limit the overuse of health care. However, particularly with low-income populations, the result of imposing co-payments can go beyond limiting overuse. *Research shows that co-payments cause patients to avoid or delay essential medical care, and premiums lead many to drop out of publicly funded health insurance programs all together.* While co-payments cause modest reductions in consumption of care by middle-income people, low-income people face much more serious consequences. One comprehensive study found that

*low-income adults and children reduced their use of appropriate medical care services by 44% when they were forced to make co-payments.*<sup>6</sup> This study also found that co-payments lead to poorer health among low-income adults as compared to those not subject to this form of cost-sharing. For those of higher incomes, there was no significant effect on health status.

Similarly, premiums affect low-income people's access to care. One multi-state study showed that *premiums set as low as 1% of family income led to a 15% reduction in participation in publicly funded health insurance programs, while a 3% premium led to almost a 50% decrease in enrollment.*<sup>7</sup>

The consequences of all types of cost-sharing can be especially serious for Medicaid beneficiaries because they have severely limited financial means and already bear a large out-of-pocket burden for their health expenses. On average, non-elderly, non-disabled adults on Medicaid with incomes below the federal poverty level spend *three times* as much (by percentage of income) on out-of-pocket payments than the amount spent by middle-class adults with private coverage.<sup>8</sup> Also out-of-pocket medical expenses for non-elderly, non-disabled adult Medicaid beneficiaries grew *twice as fast* as their income.<sup>9</sup>

### **Findings from the States: Cost-Sharing Measures Hurt Medicaid Beneficiaries**

As of 2003, about 43 states had begun to charge co-payments to some adult Medicaid beneficiaries. The effects of these and other cost-sharing measures have been the subject of much analysis. Here are findings from two states:

- In 2003, Oregon received permission through a Section 1115 waiver to make benefit reductions and impose premiums and higher co-payments for poor adults on Medicaid which led to the following effects:<sup>10</sup>
  - Enrollment fell by nearly 50% in the group newly subject to premiums (ranging from \$6-\$20 per month depending on income).
  - Sixty percent of those who left Medicaid reported an unmet health need.
  - One-third of the adults who remained in Medicaid reported an unmet health need as a result of co-payments.
  - The number of emergency room visits by uninsured patients increased by 17% in the three months immediately following the implementation of the Medicaid changes.
- After Utah imposed small co-payments on Medicaid beneficiaries with incomes below the poverty line, there was a significant reduction in their access to care and utilization:<sup>11</sup>
  - Even though the co-payments were small - \$2 or \$3 dollars per service – they created a barrier to care for impoverished individuals.
  - Two-fifths of effected beneficiaries reported that they had to reduce the amount they spent on food or housing to cope with the increased out-of-pocket payment.

### **Cost-Sharing Will Hurt the Health of Women and their Families**

The findings from Oregon and Utah along with the abundance of other studies<sup>12</sup> on the effects of co-payments and premiums on low-income populations point to the fact that increased cost-sharing in Medicaid:

- makes participation in publicly-funded health coverage like Medicaid unaffordable;
- prevents access to primary and preventive care;
- leads to poorer health outcomes for low-income families;

- leads to more complicated health conditions that require more expensive care and greater inappropriate use of the emergency room; and
- increases both the rate of uncompensated care and the pressure on safety-net providers.

Women and their families do not fare well when costs for Medicaid coverage and care exceed their ability to pay, leaving many uninsured and with unmet medical needs.

Although cost-sharing rates have not increased since the 1980s, neither has the amount of income that a family is allowed to have in order to qualify for the Medicaid program in many states. In fact, in most states, Medicaid only covers the very poorest parents. Imposing more cost-sharing on these populations simply would force many to go without care.

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<sup>1</sup> Cindy Mann and Samantha Artiga, “The Impact of Recent Changes in Health Care Coverage for Low-Income People: A First Look at the Research Following Changes in Oregon’s Medicaid Program.” Kaiser Commission on Medicaid and the Uninsured, June 2004.

<sup>2</sup> Premiums are not generally considered cost-sharing because they are not part of the financial liability for a service for which an individual has established coverage. However they do require an out-of-pocket cost to beneficiaries and therefore have many of the same effects of cost-sharing. Andy Schneider et al. “The Medicaid Resource Book.” Kaiser Commission on Medicaid and the Uninsured, July 2002, pg 62.

<sup>3</sup> This restriction applies to those inpatients in hospitals and nursing homes that are required to apply most of their income to the cost of their care. Andy Schneider et al. “The Medicaid Resource Book.” Kaiser Commission on Medicaid and the Uninsured, July 2002, pg 64.

<sup>4</sup> Andy Schneider et al. “The Medicaid Resource Book.” Kaiser Commission on Medicaid and the Uninsured, July 2002 (Nominal cost-sharing is defined as \$2 per month per family for a deductible, between \$.50 to \$3.00 for co-payments, and a five percent coinsurance of the state’s payment rate for the item or service.)

<sup>5</sup> Even though the provider can’t withhold the service, the patient is still liable to the provider for the allowable cost-sharing amount.

<sup>6</sup> Leighton Ku, “Charging the Poor More for Health Care: Cost-Sharing in Medicaid.” Center on Budget and Policy Priorities, May, 7, 2003 (citing the 1992 The Rand Health Insurance Experiment, <http://www.rand.org/health/hiedescription.html>).

<sup>7</sup> Leighton Ku, “The Effect of Increased Cost-Sharing in Medicaid: A Summary of Research Findings.” Center on Budget and Policy Priorities, May 31, 2005.

<sup>8</sup> Leighton Ku and Matthew Broaddus, “Out-of-Pocket Medical Expenses for Medicaid Beneficiaries are Substantial and Growing.” Center on Budget and Policy Priorities, May 31, 2005.

<sup>9</sup> For those below the poverty line, out-of-pocket payments grew by an average of 9.4% per year from 1997 to 2002, while over the same period of time, income grew only 4.6% annually. Leighton Ku and Matthew Broaddus, “Out-of-Pocket Medical Expenses for Medicaid Beneficiaries are Substantial and Growing.” Center on Budget and Policy Priorities, May 31, 2005.

<sup>10</sup> The Office for Oregon Health Policy and Research and the Office of Oregon Medical Assistance Programs formed a research collaborative to help inform state and national policymakers about the effects of changes to the Medicaid program. For a summary of their results, please see Cindy Mann and Samantha Artiga, “The Impact of Recent Changes in Health Care Coverage for Low-Income People: A First Look at the Research Following Changes in Oregon’s Medicaid Program.” Kaiser Commission on Medicaid and the Uninsured, June 2004.

<sup>11</sup> Leighton Ku and Matthew Broaddus, “Out-of-Pocket Medical Expenses for Medicaid Beneficiaries are Substantial and Growing.” Center on Budget and Policy Priorities, May 31, 2005.

<sup>12</sup> There are many studies in addition to the Rand Health Insurance Experiment that document the effects of cost-sharing on beneficiary populations. For a review of the research, see Julie Hudman and Molly O’Malley, “Health Insurance Premiums and Cost-Sharing: Findings from the Research on Low-Income Populations.” Kaiser Commission on Medicaid and the Uninsured, March 2003, available at <http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14310>