Fact SHEET

Cost-Sharing in Medicaid:

It's Not about "Skin in the Game"—It's about Lives on the Line

Faced with budget shortfalls and rising Medicaid costs, states are asking the federal government for broad discretion to increase cost-sharing—the amount that people pay out of their own pockets in premiums, copayments, and deductibles to receive services through Medicaid. The proposals would remove the current reasonable limits on how much states can charge people who must rely on Medicaid—including low-income children, pregnant women, people with disabilities, and the elderly on low incomes—before they can see a doctor, get a diagnostic test, pick up prescription drugs, or receive other timely treatment.

Current Medicaid program rules prohibit states from charging premiums (with some minor exceptions). While states may charge copayments, co-insurance, or deductibles for health care services, the amount they can charge is limited, and they may only charge one of these per service. Children and pregnant women are specifically exempted from paying *any* out-of-pocket costs, which ensures that pregnant women can get prenatal care and that children can obtain immunizations and other preventive and primary care services. Proposals on the table at both the state and federal level would remove these reasonable and important limitations.

Proponents of higher out-of-pocket costs have suggested that the low-income people served by Medicaid should have "skin in the game."[1] This, it is argued, would make them less likely to make unneeded visits to the doctor or to seek out unnecessary treatment. There is absolutely no evidence to support the assertion that low-income people are over-utilizing the health care system. However, there is ample evidence that increased cost-sharing discourages people from seeking *necessary* care: Increasing the copayments charged to those with low incomes has been shown to reduce their access to critical, needed services, leading them to seek more costly care later.[2] Further, a significant body of research has shown that charging premiums to low-income people deters them from enrolling in coverage and thereby increases the ranks of the uninsured.

■ Limited budgets leave little for out-of-pocket health care costs

Individuals and families living at the poverty level (and many people who rely on Medicaid are far below this level) struggle to make ends meet to pay for housing, food, transportation, and child care, let alone health care.[3]

The math is not complicated. There simply isn't much money left to pay a premium or copayments after paying for absolute essentials. And our simplified family budget does not include expenses such as toiletries, school supplies, shoes, clothing, cleaning supplies, holiday or birthday gifts, savings for a child's education, life insurance, furnishings, and any emergency expenses (fixing a broken water heater, for example).

Budget for Family of Four at the Federal Poverty Level[4]

	Monthly	Yearly
Income:	$1,568	$ 18,810
Expense:		
Housing	$ 440	$ 5,274
Utilities	$ 196	$ 2,350
Transportation	$ 404	$ 4,852
Food	$ 401	$ 4,815
Child care	$ 109	$ 1,304
Money left after paying bills	**$ 18**	**$ 215**

■ People in poor health often face multiple copayments

People must rely on Medicaid because they have very low incomes and/or because they are very sick and need a lot of care. Elderly people and people with disabilities, for example, comprise a quarter of Medicaid beneficiaries and often have multiple chronic conditions and disabilities. Due to their increased need for extensive health care services and prescription drugs, even small copayments or co-insurance charges can add up and quickly become unaffordable.[5]

■ Cost-sharing can mean waiting for health care—or skipping it entirely

When cost-sharing is increased, low-income children, pregnant women, people with disabilities, and the elderly are all less likely to enroll in Medicaid and more likely to delay or forego necessary health care services.

- **With higher cost-sharing, people who rely on Medicaid do not enroll in public programs, drop out if they are enrolled, or churn in and out of the system**

  Extensive research illustrates a *strong* inverse relationship between participation in public programs and premium levels: When premiums are charged, fewer people enroll. Analyses of data from Washington state, Hawaii, and Minnesota found that only 57 percent of the uninsured would participate in public health insurance programs when premiums were set at 1 percent of income. If premiums rose as high as 5 percent of income, only 18 percent would participate.[6] An analysis of seven states that increased cost-sharing between 2001 and 2005 shows significant enrollment losses among people subject to increased premiums, with the steepest losses coming from those with the lowest incomes.[7] For example, when Vermont increased Medicaid and SCHIP premiums in January 2004, 4,500 people dropped out of the program in the first month alone.[8] Furthermore, as cost-sharing causes public programs to become unaffordable for these families, most of them become unin-

sured.[9] This translates into higher health care costs for everyone because people with private insurance end up paying more for every uninsured individual in their state. [10]

- **Higher cost-sharing forces people who rely on Medicaid to cut back on necessary, urgent medical services**

  The most cited and rigorous research on cost-sharing, the RAND Health Insurance Experiment, found that among adults with incomes that were less than twice the poverty level, those subject to limited cost-sharing were only 59 percent as likely to seek timely and effective health care and 65 percent as likely to seek care for their children as those who were not subject to cost-sharing. Even when cost-sharing was limited to a maximum of 5 percent of income, the RAND findings uniformly demonstrated a significant negative impact on the use of necessary acute and preventive care.[11] Subsequent studies have confirmed that even very limited cost-sharing reduces health care utilization. One survey of enrollees in TennCare, Tennessee's Medicaid program, documented that 39 percent of enrollees said they could not afford even $3 -$5 copayments.[12] The Office of Technology Assessment recommended to Congress in 1993 that "if health effects are a concern, Congress should be cautious about the extent to which cost-sharing is relied on to control costs, especially for *sick*, low-income individuals."[13]

Studies show significantly better health outcomes for low-income populations in plans without cost-sharing compared to similar populations with cost-sharing for multiple conditions: improved diastolic blood pressure for those with hypertension; a 10 percent reduction in the risk of premature death for those at high risk (high blood pressure, high cholesterol, smoking); and improved vision.[14] One extensive literature review found several studies showing a strong correlation between increased cost-sharing and increased emergency room use and higher costs in general.[15] In one study of almost 4,000 patients who were 65 or older, those at highest risk for out-of-pocket expenditures were most likely to die within five years.[16] Another study of the elderly in 2002 showed that high out-of-pocket costs led to noncompliance with recommended drug use and increased pain and severity of conditions.[17]

■ Increased cost-sharing does not yield significant Medicaid program savings

The collection of cost-sharing and premiums adds to both the cost and complexity of administering the Medicaid program; many states have discontinued charging copayments for this very reason.[18] Furthermore, the money a state collects from premiums and cost-sharing is not eligible for federal Medicaid matching funds. Substituting beneficiary dollars (i.e., cost-sharing) for state dollars in the Medicaid budget will save the state some money—but less than the federal matching funds that will be lost. At the same time, cost-sharing forces people to forgo needed health care, causing them to become sicker and need more expensive care later on, increasing costs in the long run.

Endnotes

[1] Remarks of Governor Phil Bredesen at the National Press Club on June 24, 2005, available online at http://www.tennessee.gov/governor/viewArticleContent.do?id=559&page=0.

[2] Leighton Ku, *The Effect of Increased Cost-Sharing in Medicaid: A Summary of Research Findings* (Washington: Center on Budget and Policy Priorities, May 2005).

[3] Boushey, Heather, Chauna Brocht, Bethney Gundersen, and Jared Bernstein, *Hardships in America: The Real Story of Working Families* (Washington: Economic Policy Institute, 2001).

[4] All data cited in "Budgeting for Poverty" (Washington: Catholic Campaign for Human Development, 2005). Available online at http://www.nccbuscc.org/cchd/povertyusa/tourtext.pdf

[5] Julie Hudman and Molly O'Malley, *Health Insurance Premiums and Cost-Sharing: Findings from the Research on Low-Income Populations* (Washington: The Kaiser Commission on Medicaid and the Uninsured, March 2003).

[6] Leighton Ku and Teresa Coughlin, *The Use of Sliding Scale Premiums in Subsidized Insurance Programs* (Washington: The Urban Institute, March 1997). Available online at http://www.urban.org/entitlement/premium.htm.

[7] Samantha Artiga and Molly O'Malley, *Increasing Premiums and Cost Sharing in Medicaid and SCHIP: Recent State Experiences* (Washington: Kaiser Commission on Medicaid and the Uninsured, May 2005).

[8] Ibid

[9] Ibid

[10] Kathleen Stoll, *Paying a Premium: The Added Cost of Care for the Uninsured* (Washington: Families USA, June 2005).

[11] Key Findings of the RAND Health Insurance Experiment Study are described in Geri Dallek, A *Guide to Cost-Sharing and Low-Income People* (Washington: Families USA, October 1997).

[12] Celia Larson, *TennCare and Enrollee Cost-Sharing: A Survey of the Previously Uninsured and Uninsurable Enrollees in Davidson County*, prepared by the Health Care Services Evaluation Division of the Metropolitan Health Departent of Nashville and Davidson County. September, 1996. As cited in Geri Dallek, A *Guide to Cost-Sharing and Low-Income People*, op. cit.

[13] Office of Technology Assessment, U.S. Congress, *Benefit Design in Health Care Reform: Background Paper—Patient Cost-Sharing*, OTA-BP-H-112 (Washington: U.S. Government Printing Office, September 1993).

[14] Julie Hudman and Molly O'Malley, *Health Insurance Premiums and Cost-Sharing: Findings from the Research on Low-Income Populations*, op. cit.; p. 9 cited findings from the RAND Health Insurance Experiment Study.

[15] Ibid.

[16] Mark P. Doescher, Peter Franks, Jessica S. Banthin, and Carolyn M. Clancy, "Supplemental Insurance and Mortality in Elderly Americans: Findings from a National Cohort," *Archives of Family Medicine,* Vol. 9, March 2000, pp. 251-57.

[17] Jae Kennedy and Christopher Erb, "Prescription Noncompliance due to Cost Among Adults With Disabilities in the United States," *American Journal of Public Health,* 92, July 2002, pp. 1120-24.

[18] State of Maine survey of four states that dropped copayments (Idaho, Georgia, Utah, and Washington), as cited in Families USA, *A Guide to Cost-Sharing and Low-Income People* (Washington: Families USA, October 1997).

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