

## Increasing Cost-Sharing in Medicaid: A Bad Solution to Budget Issues

Asking people with insurance to pay a portion of their health care costs isn't a new idea. The rationale is that if people have to pay a part of their medical costs, they will be more careful health care consumers. However, many people on Medicaid simply do not have the money to pay a portion of their medical expenses. For them, cost-sharing can mean that they can't get the care they need when they need it, which often leads to more costly care in the future, and ultimately costs the health system more.

In spite of ample evidence that cost-sharing in Medicaid is a bad idea, many states facing tight budgets are seeking to increase cost-sharing in Medicaid.<sup>1</sup> (See "Cost-Sharing in Medicaid: What Is Allowed" below for more information.) If your state is seeking to increase cost-sharing in Medicaid, you should let your policy makers know that this bad idea should be off the table.

### Cost-Sharing in Medicaid: What Is Allowed

Federal rules already allow states to impose cost-sharing on people insured through Medicaid. However, there are also limits on cost-sharing measures to make sure that they don't keep people from getting the services they need. This briefly outlines current Medicaid cost-sharing rules. Some states are asking the Centers for Medicare and Medicaid Services (CMS) for permission to go beyond these rules and impose higher cost-sharing.

- While states may charge copayments, co-insurance, or deductibles for health care services, the amount they can charge is limited, although it can vary by family income. States can only charge one type of cost-sharing per service.
- Certain groups (e.g., children and people who are terminally ill) and certain services (e.g., pregnancy-related services) are exempt from out-of-pocket costs.
- Current Medicaid program rules prohibit states from charging premiums, with some exceptions.
- States can impose higher cost-sharing for non-emergency use of a hospital emergency room, within limitations.

For more detailed information on Medicaid cost-sharing rules, see *Premiums, Copayments and Other Cost Sharing*, available online at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Cost-Sharing/Cost-Sharing.html>.

## Limited budgets leave little money for out-of-pocket costs.

A simplified family budget can illustrate the difficulty that low-income families already have just paying for housing, food, and transportation. After these essentials, there is little left at the end of the month to cover any added costs. That's why cost-sharing for low-income families can mean that non-emergency care may be postponed until it becomes more costly emergency care.

The table shows a sample budget for a single parent with two children living at the federal poverty line. It illustrates how families living at the poverty level cannot even pay for the bare necessities without already going into the red. This leaves absolutely no room to pay for cost-sharing in health care. It is important to note that this budget does not even include essential expenses like clothing, school supplies, household items, toiletries, or putting away money in savings.

Budget for Family of Three at 100 Percent of Poverty

	Monthly	Yearly
Income	\$1,590.83	\$19,090.00
Expenses		
Housing	\$368.50	\$4,422.00
Utilities	\$278.50	\$3,342.00
Transportation	\$535.67	\$6,428.00
Food	\$435.58	\$5,227.00
<b>Money left after paying bills</b>	<b>-\$27.42</b>	<b>-\$329.00</b>

**Source:** Bureau of Labor Statistics, *Consumer Expenditure Survey*, "Table 5: Composition of consumer unit: Average annual expenditures and characteristics" (Washington: Bureau of Labor Statistics, 2010), available at <http://www.bls.gov/cex>, accessed May 8, 2012.

**Note:** The data for this table are drawn from the Consumer Expenditure Survey generated by the Bureau of Labor Statistics of the U.S. Department of Labor. It is the only federal survey that collects information on both the average expenses of consumers and their characteristics—for example, family composition. It is also important to note that our simplified family budget does not include expenses such as child care, toiletries, school supplies, cleaning supplies, holiday or birthday gifts, savings for a child's education, life insurance, furnishings, taxes, and any emergency expenses (fixing a broken water heater, for example).

Our budget is based on national data. When advocating against cost-sharing in your state, you may want to include a more localized budget. Local data will show the legislators in your state what the actual effect of any increases in cost-sharing will be. (Check with your local or state government to see if they have comparable statistics.)

## Cost-sharing makes it hard for people to afford necessary care.

States impose cost-sharing to discourage people from seeking unnecessary care, but for low-income people, cost-sharing makes it hard to afford necessary care, too. Cost-sharing in Medicaid, therefore, is particularly troublesome because the beneficiaries have very low incomes or are very sick and need a lot of care.

The most widely cited study on cost-sharing is the RAND Health Insurance Experiment. Among low-income participants in that study, cost-sharing reduced the likelihood that adults and children would receive timely and effective health care. It showed that even

limited cost-sharing can have a significant negative impact on the use of necessary acute and preventive care.<sup>2</sup> (See “The RAND Health Insurance Experiment Revisited” on page 4 for a more detailed discussion of the RAND study.) Subsequent studies have confirmed that even very limited cost-sharing reduces use of high-priority care—particularly in people with lower incomes.<sup>3</sup>

- Studies looking at high-risk populations have found significantly better health outcomes for low-income populations in plans without cost-sharing than for those in plans with cost-sharing.<sup>4</sup>
- With cost-sharing, people will be less able to afford the care they need.<sup>5</sup> Many people on Medicaid have high health needs, so even small copayments or co-insurance charges can add up and quickly become unaffordable.<sup>6</sup>

### Delayed care can be more expensive care.

When low-income people delay necessary care, it can mean that easily treatable conditions become more difficult and more costly to treat, or worse, they lead to the need for emergency care.

- There is a strong correlation between increased cost-sharing and increased emergency room use and higher costs in general.<sup>7</sup>
- A quarter of all people on Medicaid are seniors or people with disabilities who already have high health care needs, so cost-sharing that leads to more expensive care later on makes a bad problem worse.

### Cost-sharing can discourage people from enrolling in coverage, increasing the number of uninsured in the state.

Cost-sharing in Medicaid creates a barrier to getting affordable health care. This is particularly true for people with the lowest incomes. Some states charge enrollment fees or premiums in their health insurance programs. Even amounts that seem small to many will impose a real hardship on very low-income families.

- Studies show that cost-sharing consistently decreases the number of people enrolled in Medicaid. Cost-sharing causes people to leave the program, and it prevents people from enrolling in the first place.<sup>8</sup>
- Most families who have to leave the Medicaid program become uninsured and do not have access to necessary health care.<sup>9</sup>

## Cost-sharing does not produce significant Medicaid savings and can pass costs on to the rest of us.

States imposing cost-sharing often do so saying it will raise revenue for the Medicaid program and decrease health care spending. However, it is very unlikely that higher cost-sharing in Medicaid will lead to any health care savings.

- A state can actually lose money when it imposes cost-sharing because it will have to spend more money collecting the charges from enrollees than it will bring in.<sup>10</sup>
- Higher cost-sharing makes people drop out of the program and increases the number of uninsured. This translates into higher health care costs for everyone because people with private insurance end up paying more to offset the health care costs from uninsured individuals in their state.<sup>11</sup>

### The RAND Health Insurance Experiment Revisited

Those who support increased cost-sharing in Medicaid often cite a classic 1982 study conducted by RAND. The study, called the Health Insurance Experiment, was a large-scale multi-year study that tracked the effect of different levels of cost-sharing on participants' use of health care services.<sup>12</sup> Proponents of cost-sharing say that the study showed that cost-sharing reduced use of health services and made people more prudent and better consumers. However, that interpretation oversimplifies the study findings.

Because the study has been used so often, RAND scholars revisited the study in 2006 and 2007 to further explain the meaning of their previous Health Insurance Experiment results and explore what subsequent studies

have said.<sup>13</sup> In their paper, *The Health Insurance Experiment: A Classic RAND Study Speaks to the Current Health Care Reform Debate*, the authors point out that cost-sharing has mixed results. It can reduce the use of health services, but that is true for both necessary as well as unnecessary services. The authors say that cost-sharing “reduced both needed and unneeded health services. Indeed, subsequent RAND work on appropriateness of care found that economic incentives by themselves do not improve appropriateness of care or lead to clinically sensible reductions in services use.”<sup>14</sup> The paper also notes that among lowest-income and sickest study participants, the individuals who had no cost-sharing had better health outcomes on some key variables, including control of hypertension.

## Conclusion

States continue to use cost-sharing as a way to balance their budgets even though it makes care unaffordable for the people who need it the most. When cost-sharing is introduced, people leave the program and are forced to go without necessary care. Also, the link between higher cost-sharing and budgetary savings may be more myth than fact—making the states' justification for increasing cost-sharing in the first place a dead end. It's important to let your state know that the effects of cost-sharing in Medicaid will likely cause more budgetary issues in the long run and to urge legislators to take it off the agenda.



## Endnotes

<sup>1</sup> *Moving Ahead Amid Fiscal Challenges: A Look at Medicaid Spending, Coverage and Policy Trends: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2011 and 2012* (Washington: Kaiser Commission on Medicaid and the Uninsured, October 2011), available online at <http://www.kff.org/medicaid/upload/8248.pdf>. In fact, 34 states continue to impose cost-sharing on children as a way to raise money in either their Medicaid program or in their Children's Health Insurance Program (CHIP). *Premium and Copayment Requirements for Children* (Washington: Kaiser Family Foundation, January 2012), available online at <http://www.statehealthfacts.org/comparereport.jsp?rep=85&cat=4>, accessed May 8, 2012.

<sup>2</sup> 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); *The Health Insurance Experiment: A Classic RAND Study Speaks to the Current Health Care Reform Debate* (California: RAND 2006), available online at [http://www.rand.org/content/dam/rand/pubs/research\\_briefs/2006/RAND\\_RB9174.pdf](http://www.rand.org/content/dam/rand/pubs/research_briefs/2006/RAND_RB9174.pdf).

<sup>3</sup> Judith H. Hibbard, Jessica Greene, and Martin Tusler, "Does Enrollment in a CDHP Stimulate Cost-Effective Utilization?" *Med Care Res Rev* 2008 65: 437 (April 2008); Katherine Swartz, *Cost-sharing: Effects on Spending and Outcomes* (Princeton, NJ: The Robert Wood Foundation Synthesis Project, December 2010), available online at <http://www.rwjf.org/pr/product.jsp?id=71583>.

<sup>4</sup> Julie Hudman and Molly O'Malley summarized important studies looking at how cost-sharing affects blood pressure control, vision, and premature deaths in low-income people, see 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).

<sup>5</sup> Bill J. Wright, Matthew J. Carlson, Heidi Allen, Alyssa L. Holmgren, and D. Leif Rustvold, "Raising Premiums and Other Costs for Oregon Health Plan Enrollees Drove Many to Drop Out" *Health Affairs* 29, no. 12 (December 2010): 2311-2316. In 2003, Oregon introduced various copayments and a monthly premium on a sliding scale to their Medicaid program. Medicaid beneficiaries began to experience greater medical debt and reported not being able to afford necessary care. (For more information about Oregon's experience with cost-sharing in Medicaid see endnotes 8 and 9.); See also 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).

<sup>6</sup> Julie Hudman and Molly O'Malley, *Health Insurance Premiums and Cost-Sharing: Findings from the Research on Low-Income Populations*, op. cit.

<sup>7</sup> Karen Champion, *Surviving the Perfect Storm: Impacts of Benefit Reductions and Increased Cost Sharing in a Medicaid Program* (Washington: Academy Health July 2008), available online at <http://www.hcfo.org/files/hcfo/HCFOfindings0708.pdf>; Julie Hudman and Molly O'Malley, op. cit.

<sup>8</sup> Bill J. Wright, et al., op. cit. Also as a result of the 2003 cost-sharing measures in Oregon, enrollment in Medicaid decreased by 46 percent, or 40,917 individuals, within the first 6 months. About half of the people who left said it was because they could not afford the new premiums. In addition, once enrollment went down, it stayed down. (For more information about Oregon's experience with cost-sharing in Medicaid see endnotes 5 and 9.) Studies of public health insurance programs in at least 8 other states—Arizona, Kentucky, Maryland, Rhode Island, Utah, Vermont, Washington, and Wisconsin—and Los Angeles, California, have shown a similar relationship to varying degrees, but the principle stays true: Higher cost-sharing creates a barrier to participation in the Medicaid program. See the following: Genevieve Kenney, James Marton, Joshua McFeeters, and Julia Costich "Assessing Potential Enrollment and Budgetary Effects of SCHIP Premiums: Findings from Arizona and Kentucky," *Health Services Research* 42, 6 Pt 2 (December 2007): 2354-2372, available online at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2151316>; Michael R. Cousineau, Kai-Ya Tsai, and Howard A. Kahn, "Two Responses to a Premium Hike in a Program for Uninsured Kids: 4 in 5 Families Stay in as Enrollment Shrinks by a Fifth," *Health Affairs* 31 no. 2 (2012): 360-366; Samantha Artiga and Molly O'Malley, op. cit.

<sup>9</sup> Bill J. Wright, et al., op. cit. Also as a result of the 2003 cost-sharing measures in Oregon, one out of every three people who left Medicaid remained uninsured at the end of the 30-month study. One out of four people reported experiencing a coverage gap of more than 18 months. (For more information about Oregon's experience with cost-sharing in Medicaid see endnotes 5 and 8.); See also Samantha Artiga and Molly O'Malley, op. cit.

<sup>10</sup> In 2006, the Arizona Medicaid program calculated the maximum amount of money they could raise if they collected the full amount of cost-sharing allowed under the Medicaid rules, and they found it would take \$2.77 in administrative costs for every \$1 they could raise in cost-sharing. See Janet Napolitano and Anthony D. Rodgers, *Fiscal Impact of Implementing Cost Sharing and Benchmark Benefit Provisions of the Federal Deficit Reduction Act of 2005* (Phoenix: Arizona Health Care Cost Containment System, December 2006), available online at [http://www.azahcccs.gov/reporting/Downloads/CostSharing/FINAL\\_Cost\\_Sharing\\_Report.pdf](http://www.azahcccs.gov/reporting/Downloads/CostSharing/FINAL_Cost_Sharing_Report.pdf).

<sup>11</sup> Kathleen Stoll and Kim Bailey, *Hidden Health Tax: Americans Pay a Premium* (Washington: Families USA, May 2009), available online at <http://familiesusa2.org/assets/pdfs/hidden-health-tax.pdf>.

<sup>12</sup> 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); Individual papers written by RAND as a part of the Health Insurance Experiment are available online at <http://www.rand.org/health/projects/hie/hiepubs.html>.

<sup>13</sup> *The Health Insurance Experiment: A Classic RAND Study Speaks to the Current Health Care Reform Debate* (Santa Monica, CA: RAND, 2006), available online at [http://www.rand.org/content/dam/rand/pubs/research\\_briefs/2006/RAND\\_RB9174.pdf](http://www.rand.org/content/dam/rand/pubs/research_briefs/2006/RAND_RB9174.pdf); Emmett B. Keeler, Joseph P. Newhouse, and Robert H. Brook, *Selective Memories For 25 Years, the RAND Health Insurance Experiment Has Stoked Competing Claims* (Santa Monica, CA: RAND, 2007), available online at <http://www.rand.org/publications/randreview/issues/summer2007/health.html>.

<sup>14</sup> *The Health Insurance Experiment: A Classic RAND Study Speaks to the Current Health Care Reform Debate*, op. cit.

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