

Partnership for Medicaid Partnership for Medicaid

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Medicaid Cost-Sharing Changes Warrant Careful Examination*

Systemic changes involving cost-sharing should not dramatically alter the fundamental goals and structure of the program and that in no case should Medicaid coverage be conditioned on payment of cost-sharing (premium amounts).

Medicaid beneficiaries at or below 100 percent of the federal poverty level should not face any increase in co-pays, and strict limits should be set for those above 100 percent.

Further, Medicaid beneficiaries with chronic illnesses should be exempt from co-pays after a reasonable number of visits or services. Therefore, it is vital that the current prohibition against denial of care for individuals who are unable to pay any co-payment be continued.

Policymakers must consider the complexities of designing and implementing new Medicaid cost-sharing provisions and that protections for providers serving a disproportionate share of Medicaid beneficiaries ought to be part of any change to the Medicaid cost-sharing requirement.

As lawmakers consider restructuring the cost-sharing provisions, we urge them to consider the impact of such changes when combined with other modifications that are made to the safety net program.

*The ideas and opinions expressed in this document reflect the contributions of individual members of the Partnership. While every effort has been made to achieve consensus among all members, the ideas expressed in this document are not necessarily those of, nor are they endorsed by, any particular member organization(s) of the Partnership.

BACKGROUND

Except for certain instances, the Medicaid program historically has limited cost-sharing requirements on enrollees. For example, Federal Medicaid law prohibits states from imposing cost sharing on services for children under 18, services related to pregnancy, family planning or emergency services, and services provided to nursing facility residents who are required to spend all of their income for medical care except for a personal needs allowance.

Numerous studies and reports over the years have found that, for low-income individuals and families, higher cost-sharing levels consistently result in reduced access to, and use of, health care services, leading to poorer health status. Research has also shown that increased co-payments can have a negative impact on providers who serve large numbers of low-income individuals, and that the cost of administering co-payments often exceeds the amounts collected.

It has been suggested, however, that increased Medicaid cost-sharing requirements hold potential to encourage appropriate use of health care services, thus potentially lowering the overall cost of care in the program. The Partnership for Medicaid recognizes that current Medicaid cost-sharing rules have not been updated since the 1980s, leading to increased attention by federal and state policymakers to consider revising these rules. As lawmakers move forward with this effort, the impact of such changes on poor and low-income populations warrants extremely careful examination.

POTENTIAL SOLUTIONS

Any systemic changes involving cost-sharing should not dramatically alter the fundamental goals and structure of the program. Changes to current Medicaid cost-sharing policy should neither deter enrollment nor diminish timely access to appropriate care. Instead, any revisions to cost-sharing should be guided by current Federal statute which prohibits cost-sharing that would make Medicaid unaffordable to the low-income beneficiaries it covers.

- CURRENT LAW ON COST-SHARING -

- Cost-sharing exemptions: Children, pregnant women for pregnancy-related services, terminally ill beneficiaries receiving hospice care, inpatients, emergency services and family planning services and supplies
- Allowable "nominal" cost-sharing: \$2 deductible per month per family, \$0.50 to \$3 co-pay, and co-insurance of 5% of state payment rate. Non-emergency services furnished in emergency rooms can be billed for double the deductible or co-pay.
- Assurance of care: Providers must accept Medicaid as payment in full and may not withhold care due to failure to pay.

In no case should Medicaid coverage be conditioned on payment of cost-sharing (premium amounts). Studies have documented that, among low-income individuals and families, failure to pay coverage premiums is frequently due to unexpected financial emergencies. In such cases, loss of coverage has almost universally led to being completely uninsured. To the extent that cost-sharing is imposed, it should only be in the form of co-payments for certain services.

Medicaid beneficiaries at or below 100 percent of the federal poverty level should not face any increase in co-pays, and strict limits should be set for those above 100 percent. This modification also could include restricting increased cost-sharing to certain higher income populations to reflect the expansion of Medicaid to these populations.

Medicaid beneficiaries with chronic illnesses should be exempt from co-pays after a reasonable number of visits or services. For these individuals more frequent medical attention is often needed to maintain their well-being compared to a healthy individual. Increasing the financial burden of care for individuals with chronic illnesses could compel them to forgo needed services. The result is that these individuals will require more costly health care services in the long-term. **Thus, it is vital that the current prohibition against denial of care for individuals who are unable to pay any co-payment be continued.**

Policymakers must consider the complexities of designing and implementing new Medicaid cost-sharing provisions. Coordination between the private sector and the Medicaid program *(to ensure that a streamlined system is established that will monitor beneficiaries' use of service)* is paramount to successful implementation.

Protections for providers serving a disproportionate share of Medicaid beneficiaries ought to be part of any change to the Medicaid cost-sharing requirement. Lawmakers must take into account that increased cost-sharing could lead to increase pressures on providers and the health care safety-net, including in increased demand for charity care, emergency room use and strains on clinical resources. For example, new cost-sharing requirements will discourage low-income persons with mental illnesses from obtaining initial psychiatric evaluations leading directly to increased psychiatric emergency admissions. The Partnership suggests that a study be mandated to calculate the impact of higher co-payments on the safety net and on access and utilization by beneficiaries.

Finally, cost sharing is expected to be one of potentially several areas addressed in Medicaid reform deliberations. As lawmakers consider restructuring the cost-sharing provisions, they must **consider the impact of such changes when combined with other modifications that are made to the safety net program.**

- RECOMMENDATIONS -**
- Populations that are Currently Exempt from Cost-Sharing Should Remain Exempt, including All Children and All Pregnant Women.
 - Beneficiaries with Income Below 100% of Poverty (FPL) Should Pay Cost-Sharing No Higher than Current Law Allows
 - Prohibitions Against Denial of Care for Inability to Pay Should Remain
 - Cost-Sharing Should be Income-Sensitive for Individuals above 100% FPL
 - Cost-Sharing Should be Simple to Apply and Administer
 - Outer Limits Should Be set to Protect those with Multiple or Chronic Conditions