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THE HOUSE RECONCILIATION BILL'S PROVISIONS ON MEDICAID CO-PAYMENTS AND PREMIUMS: ARE THEY MILD OR HARSH?

By Leighton Ku, Vikki Wachino and Robert Greenstein

The Medicaid provisions of the budget reconciliation bill the House of Representatives passed on November 18 would make major changes in the standards governing the co-payments and premiums that low-income Medicaid beneficiaries can be required to pay. Some defenders of the bill have sought to portray these changes as modest and mild.

For beneficiaries below the poverty line, the bill (as modified shortly before it was brought to the House floor) retains the current limit on co-payments of $3 per health care service or medication, although the $3 level would be raised each year by the amount of the *medical care component* of the Consumer Price Index, which rises twice as fast as the general inflation rate — and at least twice as fast as poor families' incomes, on average.

For millions of low-income beneficiaries *just above* the poverty line, however, the increases allowed in co-payments and premiums would be very large and likely would have harsh effects. For the first time in the program's history, six million near-poor children and many other near-poor beneficiaries could face co-payments that could be set as high as $20, $30, or more for each doctor visit. These beneficiaries could be required to pay hefty premiums as well. Total charges could be as high as $900 a year for a family of three trying to make ends meet on $18,000 a year.

KEY FINDINGS

- **For the first time in Medicaid's history, millions of near-poor children and other beneficiaries could face co-payments of $20, $30, or more per doctor visit and could be charged sizable premiums as well. A family of three struggling to make ends meet on $18,000 a year could face total Medicaid charges of as much as $900 a year.**
- **For people *below* the poverty line, co-payment charges would be lower, but would rise faster than their incomes and consume a larger share of their incomes with each passing year.**
- **The co-payments for prescription drugs that could be charged to poor Medicaid beneficiaries would exceed those that poor *Medicare* beneficiaries will pay under the new Medicare drug law, while the co-payments and premiums that could be charged to Medicaid beneficiaries just above the poverty line would be substantially higher than those allowed under the SCHIP program.**
- **A large body of medical research demonstrates that charges like these lead substantial numbers of low-income families to forgo needed services and prescription medications. CBO has concluded this would occur under the House bill.**
- **Last-minute changes made in the House's bill co-payment provisions would have only a modest effect; according to the Congressional Budget Office, these changes would lessen the magnitude of the Medicaid reductions made by raising co-payments and premiums by only four percent over ten years.**

An extensive body of medical research compiled over a number of years shows that among low-income people, even modest increases in co-payments can cause significant numbers of beneficiaries to go without various health care services and prescription medications, including services and medications essential to their health. The research also demonstrates that imposing premium charges on low-income households usually causes substantial numbers of low-income individuals not to enroll in health care coverage and to become uninsured.[1]

What the House Bill Would Do

The House bill's provisions regarding co-payments and premiums have a number of facets. The House provisions would make the following changes in Medicaid.[2]

- The bill would allow large increases in co-payment charges, and the imposition of substantial premiums for the first time in Medicaid's history, for six million low-income children and many other beneficiaries. The people who would be most heavily affected include:

  -- children aged six and over, and working parents, with incomes above the poverty line even if the family's income exceeds the poverty line by only a few dollars;

  -- children under six whose family incomes are above 133 percent of the poverty line; and

  -- people with serious disabilities and other adults whose incomes are modestly above the poverty line and who are not also enrolled in Medicare.[3]

- *Under current law*, low-income beneficiaries in these categories can be charged $3 for each doctor or hospital visit or other health service and $3 for each prescription, unless they are children.[4] Children may not be charged co-payments today. In addition, under current law, Medicaid beneficiaries generally may not be charged premiums.[5] These rules reflect the extensive body of

[1] Bill Wright, Matthew Carlson, Tina Edlund, Jennifer DeVoe, Charles Gallia and Jeanene Smith, "The Impact of Increased Cost-sharing on Medicaid Enrollees," *Health Affairs*, 24(4):1107-15, July/August 2005. Leighton Ku, "The Effect Of Increased Cost-Sharing In Medicaid: A Summary Of Research Findings," Center on Budget and Policy Priorities, Rev. July 7, 2005.

[2] This is not an exhaustive list of all co-payment and premium charges in the bill.

[3] Many disabled Medicaid beneficiaries are not enrolled in Medicare, either because they are in the two-year waiting period required for Medicare after a person becomes eligible for Social Security disability benefits, or because they do not have the necessary work record to qualify for Social Security and Medicare (because, for example, they have been seriously disabled since childhood or early adulthood and hence were not able to work much — and do not qualify based on their parents' work records because their parents have not yet died, retired, or become disabled themselves — or because they are women who have been caring for young children at home and have not yet amassed a sufficient work record).

[4] Other groups exempt from co-payment charges under current law include pregnant women, people in long-term care institutions (who generally spend nearly their entire incomes on medical expenses) and terminally ill individuals receiving hospice services.

[5] Under current law, states can charge Medicaid premiums to the "medically needy" (individuals with catastrophic medical expenses), to certain groups of beneficiaries to whom Medicaid coverage has been extended under certain state "waiver" programs, and to a few other groups. These groups constitute a small percentage of Medicaid beneficiaries.

research showing that co-payments and premiums reduce access to health care among low-income households.

- *Under the House bill*, these rules would change rather radically.

  -- For the groups listed above (such as children and parents with incomes modestly above the poverty line), premiums could be charged, and there would be *no dollar limit* on how high the premiums could be set. In addition, higher co-payments could be charged for each health care service, and there similarly would be *no dollar limit* on how high the co-payment charges could be set.[6] The sole limit would be that total premium and co-payment charges could not exceed 5 percent of a family's annual income. For a family of three trying to make ends meet on $18,000 a year, the charges thus could total $900.

  -- Research suggests that the 5-percent-of-annual-income limit would not offer much protection to these beneficiaries. Various studies have documented that co-payments and premiums set well *below* five percent of income result in large barriers to health care for many low-income individuals. For example, analyses conducted at the Urban Institute, based on experiences in several states, indicate that if premiums reach five percent of a family's income, only about one-sixth of individuals eligible for Medicaid will participate.[7]

  -- Moreover, under a five percent cap that applies to *annual* income, many individuals would face out-of-pocket costs in the initial months of the year that would consume far more than five percent of their income during those months. For example, if a family making $18,000 per year experienced a major health problem — say, the mother contracted a catastrophic illness or the family was injured in a car accident — it might need to spend $450 per month for two months, or nearly a third of its income in each of those months, before it reached the 5 percent cap. If the family could not afford such large cost-sharing amounts in those months, health care providers could deny it services.

  -- These increased co-payments and premiums also would make it harder for beneficiaries to afford other necessities. A recent study of the impact of increases in co-payments and premiums in an Oregon health care program for low-income households found that more than one-third of people who were subject to these increased charges (along with restrictions on their covered health care benefits) reported having to cut back on food to pay for medical costs.[8]

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[6] The bill would exempt preventive services for children, pregnancy-related services, emergency care, and family planning services from co-payments. In addition, the bill would allow states to establish a "tiered co-payment" system for prescription drugs, under which maximum co-payment charges for medications would apply, but children below the poverty line and pregnant women could be required to make co-payments for "non-preferred" drugs rather than being exempt from such co-payments.

[7] Leighton Ku and Teresa Coughlin, "Sliding-Scale Premium Health Insurance Programs: Four States' Experiences," *Inquiry* 36: 471-480 (Winter 1999-2000).

[8] Bill Wright, Matthew Carlson, Jeanene Smith, and Tina Edlund, "Impact of Changes to Premiums, Cost-Sharing and Benefits on Adult Medicaid Beneficiaries: Results from an Ongoing Study of the Oregon Health Plan," The Commonwealth Fund, July 2005.

The Minnesota Study

A recent study in Minnesota found that that when the state (using current-law authority) established tiered drug copayments of $1 for generic drugs and $3 for brand name drugs — much less than the levels the House bill allows — half of the Medicaid patients attending a public hospital went without some medications that their doctors prescribed because of problems meeting their copayments. Of those who went without, about one-third experienced more serious health problems, like strokes, diabetes problems or asthma attacks, and required expensive emergency room care or hospital admission. The researchers found that "even small copayments can have serious consequences for low-income patients and can result in substantial increases in emergency room or hospitalization costs for Medicaid patients."*

*Melody Mendiola, et al. "Consequences of Tiered Medicaid Prescription Drug Copayments Among Patients in Hennepin County, Minnesota," Hennepin County Medical Center, Minneapolis, MN. Posted Oct. 2005 at http://www.hcmc.org/depts/medicine/documents/Hennepincopaymentstudy.pdf.

-- For beneficiaries *below* the poverty line, the $3 co-payment charge would be retained, as noted above. The $3 charge level would, however, be raised each year in accordance with the percentage increase in the medical care component of the Consumer Price Index. Use of the medical care component of the CPI to make this adjustment would be quite problematic. The medical component of the CPI rises at about *twice* the rate of the overall CPI. The incomes of people below the poverty line, by contrast, tend to rise *more slowly* than the CPI, on average. (Wages at the low end of the pay scale have stagnated, and the minimum wage has been frozen without any adjustment for inflation since 1997.) As a result, the co-payments that many impoverished beneficiaries would face would rise considerably faster than their incomes and consume a larger share of their limited incomes with each passing year.

People Who Are Sick or Have Serious Disabilities Would Be Hit Hardest

- These increases in co-payments would have the harshest effects on people with disabilities or other significant medical conditions. People who are sick or disabled need the most health care. They require the most health care services and are prescribed the most medications.

- They consequently are subject to the largest volume of co-payments. When charges for each health service and prescription are increased, these individuals are the people most harshly affected.

Additional Change Makes New Provisions Harsher

Making the effects of the new premium and cost-sharing charges still harsher, the House bill would repeal a longstanding safeguard of Medicaid law that prevents health care providers from denying services to Medicaid patients who cannot afford their co-payments. In another major reversal of policy, the House bill would authorize states to allow providers to deny health care services and prescription drugs to beneficiaries unable to meet their cost-sharing obligations. Because more patients will have difficulty affording the new, higher co-payments, this change in policy would heighten the risk that patients will be unable to obtain medications or health care they need.

CBO Finds These Charges Would Reduce Access to Care

The Congressional Budget Office expects these increases in co-payment and premiums charges would lead to Medicaid patients forgoing various health care services or not enrolling in Medicaid at all. In its estimate of the savings that these House provisions would generate, CBO noted that its savings estimate "reflect[s] CBO's expectation of reduced utilization of services due to higher cost-sharing requirements and decreased participation in Medicaid by individuals who would be required to pay premiums."[9]

Moreover, in a supplementary analysis of the Medicaid provisions of the House bill, CBO stated that about 80 percent of the savings from the increases in co-payments are expected to come from decreases in the use of services such as doctors' visits and prescribed medications and that the number of people who would lose coverage altogether because they would have trouble paying the premiums ultimately would exceed 100,000.[10]

CBO also said that the reduced use of health care services would result in more emergency room visits and higher emergency care costs. Those costs would occur because some people's health would worsen as a result of not securing care on a timely basis.

Shortly before the bill was brought to the House floor to a vote, a provision in the prior version of the bill that would have raised the co-payment charge for people below the poverty line from $3 today to $5 by 2008 was removed from the bill.[11] Changes were not made, however, in the much larger increases in co-payments and premiums the bill contains for beneficiaries just above the poverty line.

As a result, this change in the bill caused the Congressional Budget Office to lower its estimate of the Medicaid reductions that would result from the bill's co-payment and premium increases by only a modest amount — from $12.1 billion over ten years to $11.6 billion, a reduction of just four percent. (Similarly, CBO lowered from $30.1 billion to $29.6 billion over ten years its estimate of the reductions that the bill would generate from the *combination* of its co-payment and premium provisions and its provisions scaling back the health care services that Medicaid covers.)

Will These Provisions Promote Personal Responsibility?

Some proponents of these changes argue that the increased charges will make beneficiaries more responsible. The implication is that low-income Medicaid beneficiaries currently are over-using care

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[9] Congressional Budget Office, "Reconciliation Recommendations of the House Committee on Energy and Commerce," October 31, 2005.

[10] Congressional Budget Office, "Additional Information on CBO's Estimate for the Medicaid provisions in H.R. 4221, the Deficit Reduction Act of 2005," November 9, 2005. The CBO estimate of the number of people who would lose coverage as a result of the imposition of premiums may be too low. The CBO assumption that 110,000 people ultimately would lose coverage (in 2015, after these changes had fully phased in) rests on an assumption that states would apply premiums only to two million beneficiaries. Under the House bill, states would be allowed to charge premiums to a much larger number of beneficiaries than that. If states did so, the number of eligible low-income people losing coverage would be higher. (In addition, CBO's estimate of the proportion of people who would lose coverage due to the premiums appears to be lower than the research literature would suggest.)

[11] A related provision raising this co-payment charge each year in accordance with increases in the medical care component of the CPI was retained.

Are Medicaid Beneficiaries Getting An Easy Ride Under Current Law?

There appears to be a misperception that because the $3-per-service Medicaid co-payment charge has not been raised in some time, Medicaid beneficiaries are paying little if anything in out-of-pocket health care costs, and are paying a *smaller* percentage of their income in such charges with each passing year.

This is not correct. In fact, it is the opposite of the truth. A recent study of out-of-pocket medical spending by Medicaid beneficiaries found between 1997 and 2002 (the last year for which the relevant data were available), the out-of-pocket medical expenses of low-income adult Medicaid beneficiaries grew an average of about 9 percent per year, much faster than their incomes. The study also found that out-of-pocket medical costs have risen at a faster rate among Medicaid beneficiaries than among privately-insured middle-income individuals.* (These figures on increases in the out-of-pocket costs of Medicaid beneficiaries likely reflect actions in recent years in many states to increase Medicaid co-payment charges and to reduce the health care services that Medicaid covers, within the limits that the law currently allows. Those changes have increased beneficiaries' out of pocket costs significantly.)

That study also found that low-income adult Medicaid beneficiaries now pay significantly more in out-of-pocket medical costs, as a percentage of income, than privately-insured middle-income people do.

* Leighton Ku and Matt Broaddus, "Out-of-Pocket Medical Expenses for Medicaid Beneficiaries Are Substantial and Growing," Center on Budget and Policy Priorities, May 2005.

because the amounts they are charged for health care are too low. Such a belief, however, is not supported by the evidence. Recent studies show that adult Medicaid beneficiaries already pay a larger share of their limited incomes for out-of-pocket medical expenses that privately-insured middle-income people do. (In dollars terms, Medicaid beneficiaries' out-of-pocket costs are lower, but as a percentage of income, their costs are higher. This includes out-of-pocket costs for health care services that Medicaid does not cover.) In addition, a recent Urban Institute study found that people on Medicaid use health care services at about the same rate as people with private insurance and are somewhat more likely than privately insured people to have unmet medication needs.[12]

New Co-Payment and Premium Charges Would be More Severe than Under Medicare or SCHIP

Finally, for beneficiaries *below* the poverty line, the new schedule of allowable charges for prescription drugs would be *higher* than those under the Medicare prescription drug law, while for Medicaid beneficiaries *above* the poverty line, the allowable charges would significantly *exceed* those permitted under the State Children's Health Insurance Program (SCHIP).

- Under the Medicare prescription drug law, Medicare drug co-payments for elderly and disabled people who also receive Medicaid and have incomes below the poverty line may not exceed *$1 for generic drugs and $3 for brand-name drugs* in 2006. These levels will be adjusted in future years by the overall Consumer Price Index, *not* by the medical CPI, which rises about twice as fast.

[12] Teresa Coughlin, Sharon Long and Yu-Chu Shen, "Assessing Access to Care Under Medicaid: Evidence for the Nation and Thirteen States," *Health Affairs*, 24(4):1073-1083, July/August 2005.

- Similarly, for Medicaid patients modestly above the poverty line, the allowable charges would be set much higher than the charges that can be imposed on people in the same income ranges under SCHIP. In SCHIP, children whose families have incomes between 100 percent and 150 percent of the poverty line can be charged no more than $5 for each co-payment and no more than $16 a month in premiums for a family of three. (These limits are *in addition to* an SCHIP rule that total co-payments and premiums may not exceed five percent of a family's income.) There would be no such dollar limits under the House bill.