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July 18, 2005

NEW RESEARCH SHEDS LIGHT ON RISKS FROM INCREASING MEDICAID COST-SHARING AND REDUCING MEDICAID BENEFITS

By Leighton Ku

Congress and the newly appointed HHS Medicaid Commission are considering changes to reduce federal Medicaid expenditures. Recent recommendations from the National Governors Association would eliminate most federal standards with regard to the amounts that low-income Medicaid beneficiaries may be charged for health care coverage and services and significantly scale back federal standards governing the health benefits that Medicaid provides. Two research papers published in the July/August issue of the journal *Health Affairs* shed important new light on the potential effects of such policy changes.

One study, by Bill Wright, Matthew Carlson and other researchers, examines the effect of the higher cost-sharing changes instituted in 2003 in the Oregon Health Plan Standard (OHP), a component of the Oregon Medicaid program.[1] The researchers surveyed a sample of enrollees and examined their status six months after OHP premiums and copayments were increased and other changes were made.

Nearly half (44 percent) of the OHP enrollees in the survey lost Medicaid coverage within six months of the policy changes being instituted. This was consistent with program data, which show that the total number of enrollees declined over this period by 46 percent, or 50,000 people. In contrast, over the same time period one year earlier, before the program changes were instituted, enrollment declined by less than three percent.

The researchers found that almost half of those surveyed who lost coverage (44 percent of those losing coverage) reported they lost coverage because of problems related to the increased cost-sharing charges — that is, because of difficulties paying the increased premiums and/or copayments.[2] Those who left as a result of the cost-sharing increases were considerably poorer than those who reported leaving the program for other reasons; the study found that "Increased cost-sharing disproportionately affected the most economical vulnerable OHP members." More than four-fifths of those who lost coverage due to the increases in cost-sharing had not found alternative forms of insurance and remained uninsured six months after the cost-sharing changes took effect.

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[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.

[2] This may be a conservative estimate. Some people may have been embarrassed to say that they could not afford small premiums and copayments and may have given other reasons for leaving (e.g., they may have said they did not feel they needed the program any more).

- About two-thirds of those who left the program as a result of the increases in cost-sharing reported that they had been unable to get needed health care during the six months after losing Medicaid coverage. Nearly two-thirds reported being unable to afford some prescription drugs.

- Those who left OHP because of the increased cost-sharing were much less likely to have a usual source of care and, consequently, were much less likely to have had a primary care visit (e.g., a doctor's office visit) in the six months after the cost-sharing changes were instituted. They were three times *more* likely to report using emergency rooms as their normal source of care and about twice as likely to have had an actual emergency room visit in the six-month period than those who left for other reasons.

- About two-fifths of those who left OHP for cost-sharing reasons reported having more than $500 in medical debts by the end of the six-month period. Among those who left the program for other reasons, the percentage with medical debts of this magnitude was half as high.

- These medical debts may have affected access to care. The percentage of people refused medical treatment because they had outstanding debt to a health care provider was three times as large among those who left the program because of the increases in cost-sharing as among those who left the program for other reasons.

The study's authors concluded, "Although some proponents of cost sharing argue that even the very poor can pay a few dollars a month in premiums, our findings suggest otherwise." They also noted that the social costs incurred as a result of a shift in care among very poor individuals from primary care to hospital emergency rooms "may well negate any potential savings associated with increasing the cost sharing burden of Medicaid members." (See box on page 3 for further excerpts from the study's conclusions.)

Is Medicaid a "Cadillac" Program?

The second study, by Urban Institute researchers Teresa Coughlin, Sharon Long and Yu-Chu Shen, compared access to and use of health care services by adult Medicaid beneficiaries and low-income privately-insured adults, using the 1999 and 2002 National Survey of America's Families.[3] After statistically controlling for differences in age, income, race/ethnicity, health status and other factors, they found that adults on Medicaid and those with private insurance had comparable access to, and use of, physician services, receipt of breast exams and Pap smears for women, and comparable unmet needs for medical care, surgery or dental care. Medicaid beneficiaries were, however, somewhat less likely to report having a dental visit and slightly more likely to report having an unmet need for medications. The authors noted that dental care and prescription drugs are optional services in Medicaid and that state Medicaid programs often limit or exclude prescription drug and dental coverage, which may explain these gaps. Similar trends were found in the 13 states examined more closely (Alabama, California, Colorado, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Texas, Washington and Wisconsin).

[3] 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.

Excerpts from Study on Increased Cost Sharing in the Oregon Medicaid Program

The following are among the study's key findings and policy conclusions.

"First, increased cost sharing acted as a key driver of plan leaving. Among OHP members for whom cost sharing increased, administrative data show a 46 percent drop in enrollment in the year after the changes were implemented….

"The vast majority of those who left OHP because of cost sharing went on to become uninsured: 82 percent had not found other insurance by the time of our survey, six months after the program changes. Furthermore, it seems likely that the impact of cost sharing on insurance status cascaded into other outcomes as well. First, those who left OHP because of cost sharing had greater unmet need for care and were more likely not to buy prescription drugs because of cost than those who left for other reasons. Second, they were less likely to have a usual source of care and were more likely to use the ED as a usual source of care. Third, they had fewer primary care visits and more hospital ED visits over the six months after the policy changes were implemented. Finally, they had accumulated more medical debt and were more likely to have been refused care because of that debt….

"Oregon's policy change had profound, cascading impacts on access, utilization, and financial outcomes for those who were enrolled when the policy went into effect. Those who left because of the cost sharing were disproportionately very poor….Although some proponents of cost sharing argue that even the very poor can pay a few dollars a month in premiums, our findings suggest otherwise. The very poor — those least likely to find other insurance — tend to experience reduced access, greater medical debt, and shift in usage patters away from primary care and toward the hospital ED compared with those who left OHP for reasons unrelated to cost sharing. The social costs of such a shift in care patterns should be carefully considered, since they may well negate any potential savings associated with increasing the cost-sharing burden of Medicaid members….

"This study illustrates the sizable impacts that changes in Medicaid policy can have on individual lives. Oregon implemented higher cost sharing in an attempt to improve OHP's financial solvency. However, faced with even modest cost-sharing increase, thousands of people were no longer able to afford coverage at all….

"For a person affected by this policy change, losing health insurance could have led to their going without needed health care in an urgent situation, not filling costly prescriptions, losing access to a primary care physician's office, and facing the ED as the only option for care. But impacts travel beyond the individual level. The state's health care system quickly found itself faced with a new population of uninsured poor people, with reduced access to primary care and increased ED use."

The authors concluded that "Medicaid is often criticized for being a costly, low-quality health insurance program that pays providers poorly and suffers from low provider participation. It is also widely believed, however, that Medicaid is a 'Cadillac' health insurance program that offers a rich benefit package at little or no cost to beneficiaries. Given that we found comparable access for people whether they were covered by Medicaid or private insurance, our results help dispel both of these myths." They advise that "policymakers should exercise caution when considering Medicaid cutbacks — which, owing to the current fiscal situation, are actively being debated by state and federal decisionmakers. A likely outcome of benefit reductions is that [Medicaid] beneficiaries' access will fall below that of the low-income privately insured."

These studies indicate that Medicaid has been successful in its mission of improving health care access for low-income people who otherwise would be uninsured but that changes that appear modest (such as "modest" increases in premiums and co-payments) can have cascading effects of low-income beneficiaries and lead to significant reductions in access to insurance and health care. Efforts to reduce federal or state Medicaid expenditures should seek to avoid changes that will reduce or impair access to affordable health care by low-income beneficiaries.