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ASSESSING THE NATIONAL GOVERNORS ASSOCIATION'S PROPOSALS TO ALLOW INCREASES IN COST-SHARING CHARGES TO MEDICAID BENEFICIARIES

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On June 15, the National Governors Association released preliminary policy recommendations on Medicaid reform. Among other things, the NGA recommended a substantial restructuring of current federal cost-sharing rules for Medicaid. NGA's proposed cost-sharing policy would let states "establish any form of premium, deductible or co-pay" in Medicaid for all populations and all services.

This would give states substantial new discretion to increase cost sharing. The only upper bound on the cost-sharing charges that could be imposed would be a rule that beneficiaries' total cost-sharing expenses could not exceed 5 percent of family income for people with incomes below 150 percent of the poverty line, and could not exceed 7.5 percent of income (almost one-twelfth of a family's annual income, or nearly one month's worth of income) for people with incomes above that level.

The NGA recommendation would permit cost-sharing for the first time for Medicaid beneficiaries such as poor pregnant women and children and also for services such as emergency care.¹ Medicaid currently exempts pregnant women and children from cost-sharing charges to ensure that cost-sharing does not deter the use of primary and preventive care during these key developmental periods of life. Most of Medicaid's low-income beneficiaries, except the "medically needy" and those in Medicaid waiver programs, also are shielded from monthly premiums; premiums have been found to deter enrollment in health insurance by people of limited means. NGA's proposal appears to erase all of these longstanding protections.

Medicaid already permits small copayments to be charged to poor senior citizens, people with permanent disabilities and other adults. The NGA proposal would allow the amounts of these copayments to rise rather dramatically. Current Medicaid policy establishes caps of between 50 cents and \$3 per service on copayments for most services, in recognition of the fact that most Medicaid beneficiaries live in poverty. The NGA recommendation would let states increase copayments to, for example, \$10, \$20, or more for each service — and also allow states to charge sizeable monthly premiums to all Medicaid beneficiaries — as long as the aggregate amount that a family was required

¹ States may, however, apply for Medicaid waivers to charge copayments for non-emergency care provided in emergency rooms.

to pay did not exceed 5 percent or 7.5 percent of its income. An extensive body of research demonstrates that imposing significant cost sharing on low-income households has been found to have pronounced adverse effects.

In defending NGA's recommendations in this area, some governors have correctly noted that the Medicaid copayment limits of 50 cents to \$3 per service have not changed for many years, while prices have risen. The NGA proposal, however, would permit increases in cost-sharing that vastly exceed the erosion of the current co-payment limits by inflation. In addition, as a recent Center analysis demonstrates, the average out-of-pocket costs that Medicaid beneficiaries bear already are significantly higher as a percentage of income — and have been growing faster in recent years — than the out-of-pocket costs that middle-income people with private health insurance pay.²

The NGA has said its Medicaid cost-sharing recommendations are modeled on current SCHIP policy. The policies that apply in SCHIP, however, are not necessarily appropriate for Medicaid since Medicaid serves a significantly poorer population than SCHIP does, and in any case, the increases in cost-sharing that the NGA is proposing go well beyond what SCHIP policy permits. Medicaid primarily serves people with incomes below the poverty line. SCHIP, by contrast, serves children in families with incomes above 100 percent or 133 percent of the poverty line. In addition, a large proportion of those on Medicaid are pregnant women, senior citizens, or people with disabilities or chronic diseases, who often require substantially more medical care than children typically do — and for whom the burdens posed by having to make sizeable co-payments each time a health service is used would accordingly be much greater. In short, the NGA's proposed increases in cost-sharing could impose substantial hardships on Medicaid beneficiaries, who tend to be both poorer and sicker than SCHIP enrollees.

It also should be noted that the NGA recommendations do not include key beneficiary protections that SCHIP provides. Under SCHIP, children in families with incomes below 150 percent of poverty may not be charged copayments that exceed \$5 per service or premiums that exceed \$19 per month. The NGA proposal appears to contain no such limitations on the charges that could be imposed on Medicaid beneficiaries with incomes below 150 percent of poverty. In addition, SCHIP prohibits charging copayments or deductibles for preventive health care, while the NGA proposal would permit such charges. Similarly, under SCHIP, cost-sharing may never exceed 5 percent of a family's income even for those above 150 percent of the poverty line, while the NGA would raise this ceiling to 7.5 percent of income for Medicaid beneficiaries in this income range, thereby setting the ceiling 50 percent higher than the maximum charges that SCHIP allows.

In making these recommendations, the NGA added a caveat that these policies should be monitored and evaluated, and if the evidence shows that access to appropriate health care is being compromised, the policies should be revised. However, this matter already has been extensively studied.³ There already is compelling evidence that imposing higher copayments on people with low incomes reduces their access to essential health care, with adverse consequences for their health status, and that imposing premiums on low-income people lowers enrollment in public health insurance programs and increases the ranks of the uninsured.

² Leighton Ku and Matt Broaddus, *Out of Pocket Expenses for Medicaid Beneficiaries are Substantial and Growing*, May 31, 2005.

³ Leighton Ku, *The Effect of Increased Cost Sharing in Medicaid: A Summary of Research Findings*, May 2005.