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Cost Sharing In Medicaid: Issues Raised by the National Governors Association's Preliminary Recommendations

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I. Introduction

Over the next few months, policymakers and a new White House-established Commission will consider proposals to restructure Medicaid. For federal policymakers, these efforts are prompted in large part by broader federal deficit reduction targets. States, however, are also seeking Medicaid changes aimed at reducing the rate of growth in state Medicaid spending and increasing state flexibility.

On June 15, 2005, the National Governors Association issued a Preliminary Report on Medicaid Reform and presented its proposals to the Congress. Among other things, NGA recommends major changes to Medicaid's cost sharing rules. Its policy calls for the elimination of all current federal standards for what constitutes affordable coverage in Medicaid. In their place, NGA proposes giving states broad flexibility to set premiums, deductibles, co-payments and other forms of cost-sharing on any and all Medicaid beneficiaries, as well as on any and all services used by Medicaid beneficiaries. The sole federal limit on cost sharing proposed by NGA would be a requirement that a family's cost sharing payments cannot exceed five percent of total income. Since the idea of a five percent cap on out-of-pocket spending is borrowed from the State Children's Health Insurance Program (SCHIP), NGA often describes its proposal as "making Medicaid more like SCHIP." In actuality, SCHIP provides a number of additional cost sharing protections – beyond the five percent cap – that are not included in NGA's proposal for Medicaid.

From a beneficiary perspective, NGA's cost sharing proposal is significant because it would allow states to increase dramatically the amount low-income families with children, impoverished seniors, and people with disabilities must pay to enroll in and use health care services. A substantial body of research indicates that even modest premiums or increases in cost sharing requirements will have an immediate and negative effect on the ability of Medicaid beneficiaries to use health care services. In this context, it is important to review the NGA proposal to assess the magnitude of changes it would allow in cost sharing and to evaluate the potential implications for beneficiaries of using a variation on current SCHIP rules to set federal cost sharing standards for Medicaid.

This Issue Brief describes the NGA cost sharing proposal; reviews current cost sharing rules in SCHIP; and identifies key issues that arise from the NGA proposal.

II. NGA's Cost Sharing Proposal[1]

Adopted June 15, 2005, NGA's Preliminary Report on Medicaid Reform makes the following recommendation with respect to cost sharing:[2]

> *"A new vision for cost-sharing should make Medicaid look more like S-CHIP, where states have broad discretion to establish any form of premium, deductible, or co-pay for all populations, for all services, and could make them enforceable. As in SCHIP, financial protections to ensure that beneficiaries would not be required to pay more than 5% of total family income (no matter how many family members are in Medicaid) are a critical balance to this proposal. For higher-income households (for example, those above 150% FPL), a 7.5 percent cap could be applied as under the current HIFA waivers."*

The policy notes that the current Medicaid rules have not been revised since 1982. It suggests that any new policies would be monitored and revised "if the evidence shows that increased cost-sharing harms appropriate access" to care.

III. Background: SCHIP Cost Sharing Rules

SCHIP offers states enhanced federal matching payments (enhanced, relative to Medicaid matching payment rates) to expand coverage for children whose family incomes are above the Medicaid income levels that were in effect in 1997 when SCHIP was created. States can use SCHIP funds to cover newly eligible children, either by increasing Medicaid eligibility levels for children or by enrolling children in a separate child health program (or by combining the two approaches). If a state uses SCHIP funds to expand Medicaid, Medicaid cost sharing rules apply. If a state operates a separate child health program, the SCHIP rules apply to the children enrolled in these programs.

The SCHIP cost sharing rules are as follows:

- **Specific limits on premiums and other cost sharing for children between 100 and 150 percent of the federal poverty line.** For children in families with incomes between 100 and 150 percent of the federal poverty line ("FPL" – See Table 1), states can charge limited premiums, and they may impose copayments ranging from $1.00 to $5.00, depending on the cost of the service.[3] (As discussed below, young children with incomes below 133 percent of FPL and older children under 100 percent of FPL are not covered in SCHIP.) In addition, SCHIP regulations include a "backup" protection – the total amount of premium

[1] As used in the NGA report, the term "cost sharing" refers to premiums as well as other forms of charges imposed on beneficiaries such as copayments and co-insurance.

[2] The NGA proposal was developed by a work group of 11 Governors and is "preliminary" and subject to revision when reviewed by the full membership of the NGA. The NGA Preliminary Report on Medicaid Reform can be found at http://www.nga.org/cda/files/0506medicaid.pdf.

[3] The $5.00 copayment can be charged on services with a total cost in excess of $80.

Table 1.

Federal Poverty Line for a Family of Three, 2005

	Annual Income	Monthly Income
100% FPL	$16,090	$1,341
133% FPL	$21,400	$1,783
200% FPL	$32,180	$2,682

Note: The federal poverty line varies by family size; amounts are adjusted by the federal government each year (typically in February) to adjust for inflation .

and cost sharing obligations a family incurs on behalf of its children cannot exceed five percent of its income.

- **Overall cap on out-of-pocket costs for children above 150 percent of FPL.** For children with family incomes above 150 percent of FPL, SCHIP imposes no limits on the particular amounts that can be charged (premiums, copayments or deductibles), but a family's total out-of-pocket costs for SCHIP benefits cannot exceed five percent of its income.

- **Exemptions for selected services and groups.** No cost sharing can be charged for well-child care or for Native American or Alaska Native children.

IV. Issues Raised by the NGA Interim Policy

The NGA's Preliminary Report recommends that Medicaid cost sharing rules should look like those used in SCHIP. SCHIP and Medicaid, however, play very different roles in the health care system and these differences have significant implications for cost sharing policies. In addition, the policy would modify or omit some of the key beneficiary protections included in SCHIP.[4]

[4] Changes in cost sharing rules also raise important implementation issues affecting beneficiaries, states, and providers; CCF is considering these issues in the context of its broader cost sharing inquiry. These implementation issues are not disused in this Issue Brief.

Key Differences Between Medicaid and SCHIP

Medicaid and SCHIP serve distinctly different populations (Figure 1). By and large Medicaid serves a lower-income group of people (children and adults), many of whom also have far more extensive health care needs than most SCHIP children.

Figure 1.

Medicaid and SCHIP - Key Differences in Populations Served

Medicaid Enrollees	SCHIP Enrollees
Children, all income levels	Children with incomes *above* Medicaid (at least above 100%/133% of FPL)
Children in foster care	
Pregnant women	
Parents	
Children and adults with disabilities	Some children with special health care needs, but children often become eligible for Medicaid when a disability is identified or becomes severe
Seniors	
Other groups, including women with breast and cervical cancer, working disabled adults	

- **SCHIP serves a higher income population.** By definition, SCHIP cost sharing rules only apply to children whose family income is *above* Medicaid eligibility levels. The current SCHIP rules do not impose cost sharing on children with low incomes, including children under age six below 133 percent of poverty and older children below 100 percent of FPL. In many states, Medicaid coverage of children extends above these income levels, effectively expanding the universe of low-income children who currently are not subject to SCHIP cost sharing rules. By contrast, the NGA policy would allow cost sharing in Medicaid for children and adults at all income levels, even those with incomes below the poverty line.

- **SCHIP is not designed to cover people with disabilities and seniors.** Unlike Medicaid, SCHIP has no responsibility for providing care to adults with disabilities or seniors, and it has little experience even with children with serious illnesses or disabilities. SCHIP children are generally healthy, and if they develop significant health care problems, they often become eligible for Medicaid.[5] Cost sharing can be particularly burdensome for those with significant health care needs. Even relatively moderate charges for physician visits, prescription drugs, laboratory tests, and other treatment can lead to unaffordable costs for children and adults with asthma, diabetes, cancer, heart conditions, AIDS or multiple medical problems.

[5] Medicaid has various eligibility categories that allow coverage for children who have family incomes above "regular" Medicaid eligibility levels but who have high medical expenses.

NGA's Preliminary Policy Offers Less Protection than SCHIP

As described below and in Figure 2, the NGA proposal would apply to Medicaid a version of the SCHIP rules that omit or weaken some of their key beneficiary protections.

- **The policy does not include any exemption from cost sharing based on income.** As noted above, implicit in the SCHIP cost sharing rules is an exemption from all cost sharing for the lower-income children who are enrolled in Medicaid. The NGA policy, however, does not carve out any protections based on income. The policy would apply even to children and adults with no or very little income.

- **Key SCHIP protections for families between 100 and 150 percent of FPL are not included in the NGA policy.** While the NGA suggests a five percent cap on out-of-pocket spending, SCHIP actually offers far more substantial protections to children between 100 percent and 150 percent FPL. For children in this income range, SCHIP establishes specific limits on premium and cost sharing charges, as well as requires the "backup" protection that out-of-pocket costs cannot exceed

Figure 2.
Key Differences Between SCHIP Cost Sharing Rules and NGA Proposal

Issue	SCHIP rule	NGA proposal
Protections for lower income people	Lower income children effectively exempt from cost sharing	Everyone subject to new cost sharing rules, including people below poverty
Protections for people between 100-150% FPL	Limits the amount states can charge per service, *plus* includes a back up overall 5% cap on total cost costs	No limits on amounts that could be charged per service; *only* an overall 5% cap on total costs
Protections for people above 150% FPL	5% cap	7.5% cap
Protections relating to particular health services	Well-child care exempt from cost sharing	All services would be subject to cost sharing

five percent of income. NGA, however, does not propose SCHIP's stronger and more specific guidelines for children between 100 percent and 150 percent of poverty and, instead, borrows only the notion of a five percent cap.[6]

[6] See Rosenbaum et al, "An Analysis of Implementation Issues Relating to CHIP Cost-Sharing Provisions for Certain Targeted Low-Income Children," George Washington University Medical Center, Center for Health Services Research and Policy, prepared for the Health Care Financing Administration and the Health Resources and Services Administration under contract no. 98-OA-140506. Based on a review of

- **Families above 150 percent of FPL could be subject to Medicaid cost sharing obligations up to 50 percent greater than in SCHIP.** The NGA policy suggests an out-of-pocket cap as high as 7.5 percent of income for families above 150 percent of poverty. SCHIP limits cost sharing to five percent of income for such families. *For a parent with two children, earning $12 an hour, 40 hours a week, at a 7.5 percent cap, the annual cost of Medicaid cost sharing obligations could amount to four weeks of pay.* Few families at this income level could afford to give up a month's pay, even for health coverage.

- **All services could be subject to cost sharing under the NGA policy; by contrast, SCHIP exempts all well-child care.** Concern over the impact that cost sharing could have on children's access to primary and preventive care prompted Congress to exempt well-child care from SCHIP cost sharing, including well-baby and well-child visits, immunizations, and preventive dental care. By contrast, the NGA policy proposes that cost sharing be allowed for all services.

Summary

NGA's cost sharing proposal would effectively eliminate all current federal standards for what constitutes affordable coverage in Medicaid. The alternative that NGA has put forth often is described as simply taking SCHIP rules and using them as a model for Medicaid. In actuality, the NGA proposal would be significantly harsher than current SCHIP rules, both because it would omit key SCHIP protections and because it would apply an SCHIP rule designed for children in more moderate-income families to impoverished children, seniors, and people with disabilities enrolled in Medicaid.

A recent analysis conducted by the Center on Budget and Policy Priorities shows that whatever charges might be imposed by the Medicaid program are *in addition* to substantial out-of-pocket costs that Medicaid beneficiaries already bear, and the research on the consequences of undue cost sharing on low-income populations consistently shows that even relatively modest costs will be beyond the reach of low-income people and result in them losing out on needed coverage and care.[7] In this context, the NGA proposal on cost sharing, if adopted, would significantly undermine the ability of Medicaid to fulfill its fundamental mission to provide affordable care to impoverished children and families, as well as seniors and people with disabilities.

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cost-sharing policies in place in the early years of SCHIP implementation, this analysis showed that it is particular limitations on premiums and cost-sharing obligations, rather than the overall five percent cap, that are the operative source of protection from cost-sharing charges for most children in SCHIP.

[7] Leighton Ku and Matthew Broaddus, Out-*of-Pocket Medical Expenses for Medicaid Beneficiaries Are Substantial and Growing,* Center on Budget and Policy Priorities, June 2006. Samantha Artiga and Molly O'Malley, *Increasing Premiums and Cost-Sharing in Medicaid and SCHIP: Recent State Experiences*, Kaiser Commission on Medicaid and the Uninsured, May 2005.