Georgetown University Health Policy Institute
Center for Children and Families

November 17, 2005

Six Million Children on Medicaid Could be Subject to Dramatically Higher Premiums and Cost-Sharing Charges Under the House Budget Bill

By Jocelyn Guyer and Cindy Mann

The budget bill adopted by the House on November 17, 2005 contains far-reaching changes to the federal standards governing the affordability of care provided to children and others who rely on Medicaid for health care coverage. The key premium and cost-sharing changes in final the House budget bill include:[1]

- Giving states very broad flexibility to impose premiums and cost-sharing on most children and other Medicaid beneficiaries in low-income families with income just above the federal poverty line ("FPL") ($1,341 a month for a family of three in 2005.)

- Increasing the maximum amounts that states can charge seniors, people with disabilities, and parents below the poverty line for using most services.

- Allowing states to impose new cost-sharing charges on all beneficiaries, including children below the poverty line, if they use "non-preferred" drugs or use an emergency room for non-emergency care.

The Congressional Budget Office (CBO) has estimated that the premium and cost-sharing provisions of the House bill will reduce federal Medicaid spending by $11.2 billion over the next ten years.[2] By 2015, it estimates that some 11 million people – about half of whom would be children – will be subject to cost-sharing for the first time and an additional 6 million people to higher cost-sharing. The agency has indicated that the primary source of the savings will come from Medicaid beneficiaries using fewer services and being less likely to enroll in coverage when faced with higher cost-sharing and premiums.[3]

Key issues for children raised by the proposed changes in the House budget bill include:

- **Six million children in low-income families could be subject to dramatically higher cost-sharing and premiums**

  The Proposal: Currently, families cannot be required to pay to enroll their children in Medicaid or to use health services. Under the proposal, states would be allowed to charge premiums and cost-sharing (e.g., co-payments and deductibles) for children ages six and older with income above 100 percent of the FPL. Children under age six would be subject to charges if they are above 133 percent FPL. (Preventive services would be exempt from

charges). The only limit is an annual cap on the total charges a family can be required to pay set at five percent of family income.

Implications for Children: Some six million low-income children in families just above the poverty line would lose all current federal cost-sharing protections if the House budget bill is adopted.[4] For example, states could require such families to pay an annual deductible of $100, $200, or, theoretically, as much as $800 or more (depending on family income). Or, states could charge $10, $20 or more each time such a child needs a medication or service. Although not officially classified as poor, these children typically are in low-income working families with very limited resources. If faced with premiums and cost-sharing at the maximum levels allowed under the House bill, research shows many will lose Medicaid and join the ranks of the uninsured or forego necessary services.[5]

- **The 5 percent cap proposed in the House bill does not assure access to affordable care.**

Proposal: In place of all current federal standards governing cost-sharing and premiums, the House bill would require only that a family's cost-sharing and premium obligations be limited to no more than 5 percent of its annual income.

Implications: The five percent cap is likely to offer little meaningful assistance to many low-income families. Many of them can be expected to find Medicaid unaffordable long before they reach such a cap. An Urban Institute analysis of various state health insurance programs, for example, found that participation drops to fewer than one in five eligible people (18 percent) when premiums reach

Implications of Proposed Cost-Sharing Changes: A Frontline Perspective

The experiences of Kevin Hall, a 12-year old from Columbus, Ohio, illustrate the ways that cost-sharing charges of $10, $20, or more could add up quickly for children in Medicaid struggling with chronic conditions.

Kevin has suffered from severe allergic asthma for most of his life. For a long time, it was out of control and he needed a great deal of medical care. At one point, Kevin was taking 13 drugs a day, and, despite careful monitoring, he was in the doctor's office and in the emergency room several times a month. Even with health insurance through her job, Kevin's mother, Renee Hall, was left with extraordinary – and unaffordable-- copayments and coinsurance charges. Finally, she was able to enroll Kevin in Medicaid, which now pays for treatments that have vastly improved his health. As Renee Hall explains, Medicaid "helped me keep my son alive and allowed me to hold onto my job."

Under the House bill, the Halls could face premium and cost-sharing charges of up to $1,450, an amount that represents what they need each month to pay for the private insurance that Mrs. Hall buys through her employer, the heating bill, electric bill, and food for the family. Having fought so hard to get Kevin -- who used be classified as disabled -- to a place where he can now play on the school basketball team and do other everyday things, Kevin's mother would defer paying other bills, borrow money, or do whatever else it takes to pay for his care if faced with such costs. But, given that the family has no room in its budget, his care would again be a major financial burden for the Halls even with Medicaid.

Source: *Why Medicaid Matters, The Frontline Perspectives of People with Chronic Conditions*, by the Center for Children and Families, Georgetown University, and the National Health Council, September 28, 2005, http://ccf.georgetown.edu/pdfs/ccfnhcfullreport.pdf and interview with Renee Hall, November 2, 2005.

five percent of income. Moreover, the cap is based on five percent of a family's annual income. Families with high medical needs would have to pay well over five percent of their income on a monthly or quarterly basis before they reached this annual cap. The bill also makes no provision for tracking families' cumulative out-of-pocket costs, increasing the risk that even those families who remain enrolled in Medicaid despite high costs will face administrative barriers to gaining any meaningful protection from the five percent cap.

- **SCHIP provides significantly stronger federal guidelines as to what constitutes affordable coverage.** The House bill would offer most children covered by Medicaid with income above poverty significantly less protection than SCHIP. Under SCHIP, children with income up to 150 percent of poverty face premiums of no more than $16 a month and cost-sharing of no more than $5 per service, but neither of these limits would apply to children in Medicaid under the House bill.

- **Even children below poverty would be subject to new cost-sharing.** The changes in the law are most dramatic for children with income just above the poverty line, but the bill also would allow states for the first time to impose cost-sharing charges on children living in poverty. Such children could face costs of up to $3 for medications not considered "preferred" by a state and for non-emergency use of an emergency room.[6] Even poor disabled children and children with chronic conditions could be subject to such cost-sharing. These maximum allowable charges would be increased annually by medical inflation. Since medical inflation can be expected to grow at about twice the rate of the average family income of Medicaid beneficiaries, these maximums would become ever more difficult for families to afford over time.

---

[1] For a table that summarizes the premium and cost-sharing provisions included in the House bill, see "A Summary of Federal Medicaid Cost-Sharing and Premium Standards: Current Law v. the House Budget Bill," located at www.ccfgeorgetown.org.

[2] CBO Cost Estimate, Reconciliation Recommendations of the House Committee on Energy and Commerce, October 31, 2005; updated CBO cost estimate on final House bill; and letter from Douglas Holtz-Eakin to Chairman Barton on November 9, 2005.

[3] CBO estimates that about 80 percent of the savings from higher cost sharing would be due to decreased use of services, while the remaining 20 percent would be due to lower payments to providers (who may have difficulty collecting cost-sharing fees from low-income families with limited resources). With regard to savings due to premiums, about 75 percent would be due to higher premium receipts and the remaining 25 percent to lower enrollment.

[4] CCF's estimate of the number of children under age 6 with income above 133 percent of FPL and ages 6 to 17 with income above 100 percent of poverty. This estimate was derived by applying the share of children classified as optional in 2001, according to an Urban Institute analysis of MSIS data prepared for the Kaiser Commission on Medicaid and the Uninsured, to CBO estimates of the total number of children expected to enroll in Medicaid in 2005.

[5] S. Artiga & M. O'Malley, *Increasing Premiums and Cost-Sharing in Medicaid and SCHIP: Recent State Experiences*, Washington, DC: Kaiser Commission on Medicaid and the Uninsured, March 2005.

[6] In deciding which drugs are to be considered "preferred," states would be required to include any medication classified as such by the TRICARE pharmacy program on the date of enactment.