Issue brief

Cost Sharing in Medicaid

As states consider whether to expand their Medicaid programs, some states have proposed plans that include new cost sharing requirements. Since Medicaid has traditionally imposed little or no cost sharing upon participants, it is important to examine the potential consequences of such proposals.

State proposals would require varying levels of cost sharing depending on income, and some have also included work requirements for beneficiaries. **The March of Dimes supports access to health care for women, children and families and is deeply concerned about the financial burden of cost sharing for low-income individuals eligible for Medicaid.**

Issue highlights

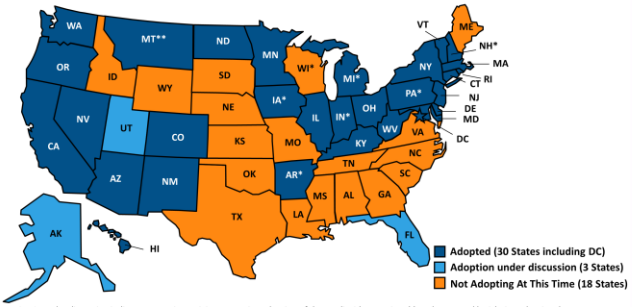
- The Affordable Care Act provided for expansion of Medicaid to individuals with incomes less than 138% of the federal poverty level. This expansion is now optional for states due to a 2012 Supreme Court ruling.
- Research shows that cost sharing (both copayments and premiums) reduces enrollment and utilization in insurance, especially among low-income populations.
- States should consider options for insuring access to care for all Medicaid-eligible individuals, and promote policies that encourage access to necessary health care services.

How does cost sharing affect access to care?

Cost sharing may include copayments (paid at the point of service) or premiums (paid monthly as partial payment for coverage), both of which have been shown to reduce access to care, especially among low-income populations.

- Traditionally, the purpose of cost sharing is to reduce utilization and overall cost. However, studies have shown that cost sharing also reduces use of preventive services and prescription drugs,[1] as well as chronic disease management.[2] Reduced use of preventive and disease management services could ultimately increase overall health care costs if individuals delay care until more expensive treatment is required.
- Premiums have been shown to reduce enrollment in Medicaid and CHIP. [3,4] Increasing Medicaid premiums from 0 to 10 dollars per month has been shown to decrease continuous enrollment by 1.4 months and reduce rates of full year enrollment by 12% for both children and adults.[5]
- Given that only modest cost sharing is permitted in Medicaid, the revenue collected may be exceeded by the administrative cost of collecting premiums and copayments.[3]

Current Status of State Medicaid Expansion Decisions



NOTES: Under discussion indicates executive activity supporting adoption of the Medicaid expansion. **MT has passed legislation adopting the expansion; it requires federal waiver approval. *AR, IA, IN, MI, PA and NH have approved Section 1115 waivers. Coverage under the PA waiver went into effect 1/1/15, but it is transitioning coverage to a state plan amendment. Coverage under the IN waiver went into effect 2/1/15. WI covers adults up to 100% FPL in Medicaid, but did not adopt the ACA expansion.
SOURCE: "Status of State Action on the Medicaid Expansion Decision," KFF State Health Facts, updated May 26, 2015.
http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/

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References

[1]Remler DK, Green J. Cost-sharing: a blunt instrument. *Ann Review Public Health* 2009;20:293-311
[2]Manning WG et al. Insurance and the demand for medical care: evidence from a randomized experiment. *Am Econ Rev* 1987;77:251-77.
[3]Wright BJ et al. Raising premiums and other costs for Oregon health plan enrollees drove many to drop out. *Health Aff* 2010;29:2311-6
[4]Abdus S et al. Children's Health Insurance Program premiums adversely affect enrollment, especially among lower-income children. *Health Aff* 2014;33(8):1353-59.
[5]Dague L. The effect of Medicaid premiums on enrollment: A regression discontinuity approach. *Journal of Health Economics* 2014;37: 1-12.