NHeLP
NATIONAL HEALTH LAW PROGRAM

Protect Medicaid Funding
Affordability
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A personal story from a family in California:

Leah is a feisty three-year old who loves animals and Winnie the Pooh. She's also a fighter. She was born eight weeks early, with pure esophageal atresia, which means that there was a long segment of her esophagus missing, and no connection between her esophagus and her stomach. She has Down Syndrome, and was also born with holes in the walls of her heart, and a hole in her diaphragm that eventually caused digestive organs to migrate into her chest cavity. Leah has chronic lung disease, which puts her at risk of complications and hospitalization any time she gets a respiratory infection. When Leah was born, she spent nearly six months in the NICU and PICU before a surgery could be performed to connect her esophagus and stomach. She spent another month in the hospital after surgery, and finally came home on her seven-month birthday. But that was only the beginning of Leah's journey.

Because of her multiple health conditions, Leah has already been in the operating room 21 times. Leah gets special therapy to learn how to eat without getting food into her lungs or stuck in her esophagus. She also gets physical, occupational and speech therapy to minimize

delays due to Down Syndrome. Leah uses sign language to communicate because she does not speak, and she has a g-tube and nighttime oxygen. She requires constant supervision, even more than a typical child her age, because she has no concept of danger and safety. Having a full-time care provider is critical for Leah's wellbeing.

Luckily, Leah has Medicaid through California's waiver for children with developmental disabilities, which helps her family to afford the cost of her care and keep her at home. Leah's parents have private insurance through an employer, but their private insurance would not cover all of the care she needs, especially the cost of a fulltime home care provider. And without Medicaid they would not be able to keep up with the hours of therapy and doctor visits every week in addition to her usual care regimen alone. Having help from Medicaid keeps Leah's care affordable for her family, and allows her to focus on having tea parties with her favorite stuffed animals.

Affordability

Medicaid provides a long-term investment in health that helps people succeed. It increases the diagnosis and early treatment of chronic conditions, enhances educational achievement and future earnings for covered children, and reduces health care disparities.[1] Medicaid coverage is tailored to the unique needs of low-income individuals and families, but still costs less per enrollee than employer-based insurance.[2] Despite Medicaid's proven success and efficient use of funds, opponents repeatedly seek to cut or cap funding for the program. These proposals seriously jeopardize the health and financial security of the 97 million people who benefit from Medicaid each year.[3] Medicaid's core consumer protections make the program work for enrolled populations, including children, parents, pregnant women, low-income workers, older adults, and people with disabilities. This fact sheet explains how Medicaid cost sharing standards keep enrollees' out-of-pocket costs low and examines how Medicaid funding caps would threaten those affordability protections.

Why Medicaid is important for ensuring access to affordable care:

- **Medicaid provides strong affordability protections for low-income individuals.** Medicaid generally forbids premiums on low-income households (below $30,240 for family of three) because even small premiums keep people from signing up. Medicaid allows states to charge copays and coinsurance, but sets strict limits on that cost sharing because even small required payments reduce access to needed services.[4] Medicaid also prohibits providers from denying care to individuals below the poverty level if they cannot afford to pay.

- **Medicaid cost sharing limits help the most vulnerable access services they rely on.** Medicaid prohibits cost sharing for key services, such as pregnancy-related services and preventive care. Medicaid also completely exempts some vulnerable populations from cost

sharing, including Native Americans and most children and adolescents.

- **Medicaid's affordability protections improve health outcomes.** Medicaid enrollees are less likely to skip medications or delay care due to cost.[5] Lower out-of-pocket costs improve access to primary and preventive care and increase likelihood of treatment for chronic conditions like diabetes and mental health conditions.[6] One recent study shows that depression rates declined after individuals began Medicaid coverage.[7]

- **Medicaid improves people's financial security.** States must limit all Medicaid cost sharing to no more than 5% of household income per *month or quarter*.[8] Medicaid's cap is almost universally lower than the *annual* out-of-pocket caps in private insurance. The shorter increment also shields low-income individuals from incurring debilitating medical debt from a single expensive event or complication.[9] Medicaid sharply reduces medical bankruptcies and interactions with debt collection agencies.[10]

How funding caps would make Medicaid less affordable:

- **Funding caps would likely lead states to increase cost sharing to maximum legal limits.** Funding caps reduce federal Medicaid funding and shift costs onto states. Faced with less money to provide the same Medicaid coverage, states would increase cost sharing to reduce utilization and push costs onto enrollees. However, increasing cost sharing discourages people from using both essential and non-essential services.[11] The resulting barriers to care are tied to worse health outcomes and more expensive care needs down the road, especially for populations with higher health risks, like seniors and people with disabilities.[12]

- **Funding caps would likely erode Medicaid affordability protections.** With less federal funding under funding caps, states would likely also attempt to reverse long-standing federal affordability standards. States may seek to impose premiums and eliminate cost sharing limits. Several states have already aggressively sought exceptions to Medicaid's rules prohibiting premiums. These states have requested permission to charge premiums, terminate people for failure to pay, and lock them out for six months after termination. Budget gaps resulting from funding caps would only increase this trend. States may also attack other core protections, such as out-of-pocket maximum limits and rules requiring providers to treat patients in poverty who cannot afford copayments.

- **Funding caps would lead to more uncompensated care and worse outcomes.** With funding caps, states would likely scale back Medicaid affordability protections, and this would have terrible consequences. The individuals who drop out of coverage due to unaffordable premiums would appear in the health care system with more advanced illness and emergency conditions, resulting in uncompensated care costs which harm the entire

system. Individuals with unaffordable cost sharing would simply skip medical treatments, resulting in worse health outcomes and more expensive treatments later.

- **Funding caps will hurt the most vulnerable.** Individuals of color are more likely to be low-income and enrolled in Medicaid. Weakening the affordability protections in Medicaid will reduce their access to care and worsen health disparities. Lower-income communities will see a reduction in their health security and an increase in debt and medical bankruptcies.

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[1] Harvey W. Kaufman et al., *Surge in Newly Identified Diabetes among Medicaid Patients in 2015 within Medicaid Expansion States under the Affordable Care Act*, 38 DIABETES CARE 833 (2015) (Medicaid coverage improves diabetes screening and treatment initiation); DAVID W. BROWN ET AL., NAT'L BUREAU OF ECON. RESEARCH, MEDICAID AS AN INVESTMENT IN CHILDREN: WHAT IS THE LONG-TERM IMPACT ON TAX RECEIPTS? 20 (2015), http://www.nber.org/papers/w20835 (Medicaid improves long-term outcomes for children); Thomas C. Buchmueller et al., *Effect of the Affordable Care Act on Racial and Ethnic Disparities in Health Insurance Coverage* 106 AM. J. PUB. HEALTH 1416, 1420 (2016) (Medicaid expansion reduced health care disparities).

[2] TERESA COUGHLIN ET AL., KAISER COMM'N ON MEDICAID & THE UNINSURED, WHAT DIFFERENCE DOES MEDICAID MAKE? 4, 7 (2013), http://kaiserfamilyfoundation.files.wordpress.com/2013/05/8440-what-difference-does-medicaid-make2.pdf (Employer-based coverage would cost 28% more than covering the same low-income individual with Medicaid).

[3] CONG. BUDGET OFFICE, DETAIL OF SPENDING AND ENROLLMENT FOR MEDICAID FOR CBO'S MARCH 2016 BASELINE (2016), https://www.cbo.gov/sites/default/files/51301-2016-03-Medicaid.pdf. Though 97 million individuals enrolled in Medicaid over the course of 2015, the average monthly enrollment was 76 million. *Id*. This underscores the importance of Medicaid as a source of coverage for individuals who temporarily lose coverage, such as individuals between jobs.

[4] BUREAU OF LABOR STATISTICS, DEFINITIONS OF HEALTH INSURANCE TERMS, http://www.bls.gov/ncs/ebs/sp/healthterms.pdf. Cost sharing is the portion of expenses for healthcare services and supplies not covered by the insurer that the patient must pay out-of-pocket. Types of cost sharing include deductibles, copayments, and coinsurance. A deductible is the amount a patient must pay out-of-pocket before the insurer covers any expenses during a given benefit period. Following payment of the deductible, most patients have copayments or coinsurance for the remainder of the coverage period. A copayment is a flat amount paid upon receipt of care, and coinsurance is a percentage amount paid upon receipt of care. Marisa Elena Domino et al., *Increasing Time Costs and Copayments for Prescription Drugs: An Analysis of Policy Changes in a Complex Environment*, 46 HEALTH SERVS. RES. 900 (2011); LEIGHTON KU ET AL., CTR. ON BUDGET & POLICY PRIORITIES, THE EFFECTS OF COPAYMENTS ON THE USE OF MEDICAL SERVICES AND PRESCRIPTION DRUGS IN UTAH'S MEDICAID PROGRAM (2004), www.cbpp.org/files/11-2-04health.pdf.

[5] Benjamin Sommers et al., *Changes in Utilization and Health among Low-Income Adults after Medicaid Expansion or Expanded Private Insurance*, 176 JAMA INT. MED. 1501 (2016);

[6] *Id. See also,* Katherine Baicker et al., *The Oregon Experiment – Effects of Medicaid on Clinical Outcomes*, 368 NEJM 1713 (2013) (Medicaid reduces depression and increases treatment initiation for diabetes); JUDITH DEY ET AL.,OFFICE OF THE ASSISTANT SEC'Y FOR PLANNING & EVALUATION, BENEFITS OF MEDICAID EXPANSION FOR BEHAVIORAL HEALTH, 2 (Mar. 28, 2016).

[7] Katherine Baicker et al., *supra* note 6.

[8] For a person with income at poverty level, a quarterly aggregate cap would be $150 in 2016.

[9] Thomas M. Selden et al., *Cost Sharing in Medicaid and CHIP: How Does It Affect Out-of-Pocket Spending?*, 28 HEALTH AFFS. w607, w614 (2009).
[10] LUOJIA HU ET AL., NAT'L BUREAU OF ECON. RESEARCH, THE EFFECT OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT MEDICAID EXPANSIONS ON FINANCIAL WELL-BEING, http://www.nber.org/papers/w22170; Katherine Baicker et al. *supra* note 6.
[11] Emmett B. Keeler, *Effects of Cost Sharing on Use of Medical Services and Health*, 8 MED. PRACTICE MANAGEMENT 317 (1992), *available at* http://www.rand.org/pubs/reprints/RP1114.html.
[12] Sujha Subramanian, *Impact of Medicaid Copayments on Patients with Cancer*, 49 MED. CARE 842 (2011); Amitabh Chandra et al., *Patient Cost-Sharing and Hospitalization Offsets in the Elderly*, 100 AM. ECON. REV. 193 (2010).