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Cost Sharing Studies and the Impact on Medicaid Beneficiaries

- Cost-sharing has been one of the most studied aspects of the Medicaid program and data overwhelming supports that copayments make it harder for beneficiaries to afford medical services, while premiums make it harder for eligible beneficiaries to enroll and maintain coverage. The adverse consequences of cost sharing include poorer health and increased use of high-cost services like emergency rooms.

  Leighton Ku & Victoria Wachino, *The Effect of Increase Cost Sharing in Medicaid: A Summary of Research Findings* (2005), *available at* http://www.cbpp.org/cms/?fa=view&id=321.

- When 100,000 people lost Medicaid coverage in Missouri because of higher cost-sharing, the number of uninsured individuals increased, hospitals became burdened with more uncompensated care, and revenue short falls forced community health centers to charge patients more and obtain larger state grants.

  Stephen Zuckerman *et al., Missouri's 2005 Medicaid Cuts: How Did They Effect Enrollees And Providers?* HEALTH AFF (online ed. Feb. 2009), *available at* http://content.healthaffairs.org/content/early/2009/02/18/hlthaff.28.2.w335.full.pdf+html.

- Cost sharing in Medicaid forces families to choose between financial hardship and reducing their children's enrollment and usage of medical services.

  Thomas M. Seldon *et al., Cost sharing in Medicaid and CHIP: how does it affect out-of-pocket spending?*28 HEALTH AFF. W607 (online ed. 2009), http://content.healthaffairs.org/content/28/4/w607.full.

- Cost sharing increases in Oregon's Medicaid Program led to a dramatic reduction in enrollment. Those who left the program because of cost-sharing increases had inferior access to needed care, were significantly less likely to visit a primary care physician, and used the emergency room more often than those leaving for other reasons.

  Bill Wright, et al., *The Impact Of Increased Cost Sharing On Medicaid Enrollees*, HEALTH AFFAIRS (online ed., July/August 2005), *available at* http://www.healthaffairs.org/RWJ/Wright.pdf.

- The Oregon Medicaid program applying copayments to beneficiaries did not provide the expected cost savings because individuals refrained from preventative care in favor of more costly hospital emergency care.

  Neal T. Wallace *et al., How Effective Are Copayments in Reducing Expenditures for Low-Income Adult Medicaid Beneficiaries? Experience from the Oregon Health Plan,* 43 HEALTH SERV. RES. 515 (2008), *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2442363/.

- Because low-income families live on slim margins, even cost sharing in nominal and modest amounts will lead to unmet medical needs. Families, outreach workers, and providers in Washington State all noted that when immigrant families became subject to new copayments for prescription drugs, many families had significant difficulty paying for them.

  Mark Gardner & Janet Varon, *Moving Immigrants from a Medicaid Look-Alike Program to Basic Health in Washington State: Early Observations*(May 2004) *available at* www.nohla.org/pdf-downloads/Moving-Immigrants-from-a-Medicaid-Look-Alike-Program-to-Basic-Health-in-Washington-State-Early-Observations.pdf.

- A Utah study found that a co-payment of $2 per prescription lead to a decrease of about 30 prescriptions per week for every 1000 Non-traditional enrollees (parents of eligible children). A $2 co-pay also lead to a decrease of 21 outpatient claims per month per 1,000 traditional enrollees (pregnant women, children, and most blind, disabled and elderly enrollees).

  Office of the Executive Director, Utah Department of Health, *Medicaid Benefits Change Impact Study,* UTAH PUBLIC HEALTH OUTCOME MEASURES REPORT, (December 2003), *available at* http://health.utah.gov/hda/reports/MedicaidBenefitsChangeSummary.pdf.

- Elderly and disabled Medicaid beneficiaries who reside in states that charge copayments in Medicaid have lower rates of prescription drug use. The primary effect of copayments is they reduce the chances a Medicaid recipient will fill a prescription. This burden falls disproportionately on beneficiaries in poor health.

  Stuart B, Zacker C*., Who Bears the Burden of Medicaid Drug Co-payment Policies?* HEALTH AFFAIRS (online ed., March/April 1999) *available at* http://content.healthaffairs.org/content/18/2/201.long.

- Caps placed on prescription drugs in New Hampshire Medicaid program increased the cost of mental health services by a factor of more than 17 compared to the savings in drug expenditures due to the fact that beneficiaries were more likely to be admitted into hospitals or nursing homes.

  Steven B. Soumerai *et al., Effects of Medicaid Drug-Payment Limits on Admission to Hospitals and Nursing Homes,* 325 NEW ENGLAND J. MED. 1072 (1991), *available at* http://www.nejm.org/doi/full/10.1056/NEJM199409083311006#Top=&t=articleTop.

- A study conducted in the 1970's, when California implemented co-payments in its Medicaid program, found that beneficiaries subject to $1 copays per service lead to a decrease in immunizations by 45%, Pap smears 21.5%, and obstetrical care 58% decrease compared to beneficiaries not subject to copayments.

  As described by Julie Hudman and Molly O'Malley, *Health Insurance Premiums and Cost-Sharing: Findings from the Research on Low-Income Populations*, (March 2003), *available at* http://www.kff.org/medicaid/upload/Health-Insurance-Premiums-and-Cost-Sharing-Findings-from-the-Research-on-Low-Income-Populations-Policy-Brief.pdf.