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Researchers Repeatedly Find Cost Sharing Harms Medicaid Beneficiaries' Access to Care and Health Status

- Cost-sharing is one of the most studied aspects of the Medicaid program. Over three decades of research overwhelmingly establish that heightened copayments make it harder for beneficiaries to afford medical services, while premiums make it harder for eligible individuals 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 Increased Cost Sharing in Medicaid: A Summary of Research Findings* (2005), *available at* http://www.cbpp.org/cms/?fa=view&id=321.

- 100,000 people lost Medicaid coverage in Missouri because of less generous eligibility standards, higher premiums and the expansion of copayments to nearly all Medicaid-covered services and prescription drugs. After Missouri cut Medicaid, the number of uninsured individuals increased, hospitals became burdened with more uncompensated care, and revenue shortfalls 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.

- Medicaid cost sharing adds to families' financial hardship, forcing difficult choices between necessary health care and other basic necessities.

  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.

- Nominal copayments are associated with significant reductions in the use of clinically important drugs. When the Oregon Medicaid program implemented copayments for prescription drugs, set at $2 for generics and $3 for brand name drugs, utilization of prescription drugs declined by 17%. Reduction in prescription drug use was observed in every therapeutic category studied with the greatest reductions occurring for drugs treating depression and respiratory disease.

  Daniel Hartung *et al., Impact of a Medicaid Copayment Policy on Prescription Drug and Health Services Utilization in a Fee-for-Service Medicaid Population*, 46 MED. CARE 565, (2008) available at http://www.ncbi.nlm.nih.gov/pubmed/18520310

- A dramatic reduction in Medicaid enrollment occurred in Oregon after the state imposed new copays, ranging from $5 for an outpatient physician visits and $250 for an inpatient hospital admissions, and new premiums ranging from $6 to $20 a month. Those who left the program because of the heightened cost sharing 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 who left the program for other reasons.

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

- The Oregon Medicaid program's copayment policies did not provide the expected cost savings because individuals skipped preventive care and used 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/.

- Women living in areas with lower median incomes were disproportionately affected by cost sharing and more likely to forgo breast cancer screening than women from more affluent areas. An analysis of Medicare plans also found that breast-cancer screening rates, among women who should be screened according to clinical guidelines, were 77.5% in full coverage plans, compared to only 69.2% in cost sharing plans.

  Amal Trivedi *et al, Effect of Cost Sharing on Screening Mammography in Medicare Health Plans,* 358 NEW ENG. J. MED. 375 (2008), *available at* http://*www.nejm.org/doi/full/10.1056/NEJMsa070929#t=article*

- Patients in low-income areas are significantly more sensitive to increases in drug copayments than patients from high- or middle-income areas. Increased drug copayments make it more likely that low-income patients will be unable to adhere to medication instructions, worsening health disparities. A 10% increase in copayment for certain drugs (statins) decreased medication adherence by more than 12% for patients living in an area with a median household incomes of less than $30,000 compared with a decrease of less than 2% for patients living in areas with a median income of more than $62,000.

  Michael Chernew et *al, Effects of Increased Patient Cost Sharing on Socioeconomic Disparities in Health Care,* 23 J. GEN. INTERN MED. 1131, (2008), available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2517964/?tool=pubmed

- Because low-income families live on slim margins, even nominal copayments lead to unmet medical needs. Families, outreach workers, and providers in Washington State all reported that immigrant families had significant difficulty paying for prescription drugs when new copayments were imposed.

  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 instituting a Medicaid copayment of $2 per prescription led to 13% of enrollees not filling their prescriptions because they couldn't afford the co-pay. When enrollees started getting charged $3 copayments for doctor visits, 11% of enrollees did not to go to the doctor because they couldn't afford it.

  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.

- When a prescription coinsurance and deductible cost-sharing policy was introduced in Quebec, Canada, the use of essential drugs decreased by 14% for welfare beneficiaries. This caused emergency room visits to increase by 78% and serious adverse health events to increase by 88%.

  Robyn Tamblyn, et al., *Adverse Events Associated with Prescription Drug Cost-Sharing among Poor and Elderly Persons*, J. AM. MED. ASS'N (online ed. January 2001), *available at* http://jama.ama-assn.org/content/285/4/421.long

- Elderly and disabled Medicaid beneficiaries who reside in states that charge copayments have lower rates of prescription drug use. The primary effect of copayments is to reduce the likelihood that beneficiaries will fill their doctors' prescriptions. This burden falls disproportionately on beneficiaries in poor health.

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

- Caps placed on prescription drugs in the 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, because 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,* 331 NEW ENG. J. MED. 1072 (1991), *available at* http://www.nejm.org/doi/full/10.1056/NEJM199110103251505

- The imposition of $1.00 copayments for services in California in the 1970's caused affected Medicaid beneficiaries to reduce their use of necessary care, decreasing immunizations by 45%, Pap smears by 21.5%, and obstetrical care by 58%.

  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.