NATIONAL HEALTH LAW PROGRAM

What Makes Medicaid, Medicaid?
– Affordability

David Machledt

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Key Takeaways

- Medicaid provides important protections to reduce barriers to enrollment, keep necessary services affordable, and prevent financial ruin due to medical bills.
- Under current law, states may customize their Medicaid programs, including the option impose premiums for some enrollees and cost-sharing for services.
- Research consistently shows that imposing premiums and cost-sharing on low income persons create barriers to care and coverage, and are not associated with substantial cost savings.
- Cost-sharing is a blunt tool to shape health care seeking behavior, especially when the costs of medical services are nearly impossible to find out ahead of time.
- Proposals to cut federal funding for Medicaid would result in budget pressures and push states to raise cost-sharing and create more barriers to care for low income persons on Medicaid.

Discussion

Affordability is foundational to accessible health care. High premiums keep people from getting insured, increase uncompensated care in hospitals and emergency departments, and worsen medical bankruptcies. People facing high cost-sharing often delay and forgo needed care, even when they know this may lead to worse outcomes and expensive treatments down the road.[1]

At low incomes, people face impossible decisions – medicine or food; personal care services or rent. Medicaid, the nation's largest health insurance program, is designed specifically to meet the needs of such low-income individuals. And because affordability is so fundamental to access, Congress included robust affordability protections in the Medicaid program to keep out-of-pocket expenses low and encourage utilization of the most cost-effective services. This brief explores the program's affordability protections.

Key Affordability Terms

Premium: fees paid, typically monthly, for coverage of a defined set of health care benefits for a defined period of time.

Cost-sharing: the total portion of expenses for covered health care services and supplies that the patient must pay out-of-pocket.

- Deductible: cost-sharing a patient must pay out-of-pocket before the insurer covers any expenses during a given benefit period.
- Coinsurance: cost-sharing where an enrollee must pay a percentage of the costs of any covered health they receive that care.
- Copayment: a flat cost-sharing fee paid upon receipt of a covered service or item.

Out-of-pocket maximum: a cap on total patient spending per benefit period. The OOP maximum typically does not include premiums for private insurance, but does in Medicaid.

Medicaid Law Prohibits Premiums for Most Low-Income Enrollees

Requiring low-income individuals to pay premiums or similar enrollment fees for health coverage keeps some people from enrolling. Low-income people face great financial strain and in many cases simply cannot afford even small premiums.[2] For those with no credit cards or checking accounts, simply making a premium payment can be a significant challenge. Evidence shows that when Medicaid enrollees have been subjected to premiums, substantial numbers drop out sooner rather than later.[3] As one might expect, this effect is greater as income decreases or as premiums increase.[4] Recognizing these barriers, Congress enacted

provisions that generally prohibit Medicaid premiums on individuals with incomes below 150% of the federal poverty level (FPL), or $37,290 for a family of three in 2023.[5] Other provisions exempt certain groups, such as Native Americans, from premiums at any income level.
In the late 1990s and early 2000s, the Centers for Medicare & Medicaid Services (CMS) approved a number of demonstrations that charged premiums for limited-service benefit packages intended for non-elderly adults. Oregon, for example, charged sliding scale premiums to enrollees below the FPL and implemented a lock-out for nonpayment in 2003.[6] In the first year, enrollment dropped by nearly half for the affected population. A number of other states, including Washington, Rhode Island, Maryland, Vermont, and Utah also experienced substantial disenrollment after implementing premiums or enrollment fees on lower-income individuals.[7] In response to such experiences, at least four states reconsidered, abandoned or ultimately discontinued policies to implement premiums in Medicaid or CHIP.[8]

Despite that experience, yet another iteration of charging premiums to Medicaid enrollees followed the Supreme Court's decision that permitted states to reject the Affordable Care Act's adult Medicaid expansion without penalty. In a handful of states, CMS permitted premiums up to 2% of household income (about $33.50/month for an individual at 138% FPL) through § 1115 demonstrations.[9] Indiana has the harshest requirements of any state, with an approved waiver requiring premium payment prior to full enrollment and allowing a 6-month lockout penalty for failure to pay premiums. These premiums were suspended when the COVID-19 public health emergency began, but may be reinstated after the PHE ends in May, despite evidence that they create substantial barriers.

> An independent evaluation of premiums in the Healthy Indiana Plan found that nearly one in four (23%) of otherwise eligible applicants did not make the initial payment required to begin coverage.[10]

These policies affected only the "least vulnerable" segment of Indiana's Medicaid expansion: individuals with incomes from 101-138% FPL who are not medically frail or otherwise exempt. Early evaluations of Indiana's premiums raised serious concerns that premiums in Indiana's new demonstrations create barriers to coverage. **Nearly three out of ten times a low-income Hoosier faced a barrier due to a required HIP premium payment to start coverage or to remain enrolled, he or she could not overcome the barrier.**[11] The front-end enrollment barrier presented the bigger obstacle, with nearly one in four (23%) not making the initial payment to start benefits.[12] Although these people could reapply, only about half ever did so successfully.[13] Overall, 55% of Hoosiers who applied and were found eligible for Indiana's expansion missed a premium payment at some point, resulting either in failure to begin coverage, disenrollment, or shift to a plan with higher copays and/or fewer benefits.[14]

Such barriers are exactly what Congress sought to avoid when it enacted the Medicaid premium prohibition below 150% FPL.

Cost-sharing's Impact on Low-Income Individuals and Families

The back-end cost-sharing associated with actually using covered services can be substantial. In its simplest expression, cost-sharing seeks to reduce the use or overuse of ineffective or less cost-efficient medical care, though there is a wide gap between intent and reality in this arena.[15] Research on cost-sharing consistently supports several key conclusions regarding its impact on Medicaid enrollees:[16]

- **Untailored cost-sharing, in practice, is not "smart."** As currently structured, the most common forms, especially deductibles and coinsurance, are too broad and imprecise to shape more efficient health seeking behavior or effectively reduce systemic health costs without negatively impacting low-income beneficiaries' health and financial well-being. Research **over the last four decades** has consistently concluded that the imposition of cost-sharing on low-income and vulnerable populations reduces use of both essential and less essential care in roughly equal proportions and correlates with increased risk of poor health outcomes.[17]

- **Cost-sharing substantially impedes access to care for individuals with lower incomes.** At lower incomes, even small copays substantially and significantly reduce access to needed care.[18] The financial burden of cost-sharing increases as household income decreases, magnifying this effect.

- **Increased cost-sharing reduces utilization across many types of services.** In particular, cost-sharing reduces adherence to medications, frequency of office visits, access to preventive services and utilization of mental health services.[19]

- **Decreased utilization due to cost-sharing often increases the likelihood of adverse health events.** Evidence is strongest that reduced prescription adherence increases adverse events. This effect seems to increase with age, poorer health status, and lower income.

- **Cost-sharing disproportionately impacts individuals with chronic illness and mental health and substance use disorders.** These individuals have higher health expenses and face higher risk of adverse events. On top of that, cost-sharing for mental health services and substance use disorder treatment historically exceeds cost-sharing for general health care, though mental health parity laws aim to reduce such

discrepancies.[20]

- **Cost-sharing may not reduce overall costs by much, but it does shift health care costs.** In the Medicaid program, cost-sharing shifts costs from state and federal governments to low-income enrollees and, to some extent, their providers.[21]

To help protect low income enrollees, Congress established limits on out-of-pocket expenses, as well as state flexibility. The following section explains these flexibilities, limitations, and several recent proposals by states to increase cost-sharing beyond the federal limits.

Medicaid Limits Cost-sharing to Maintain Access for Enrollees

Medicaid allows states to impose cost-sharing on services. Deductibles are generally not allowed but states may impose limited copayments and coinsurance depending on the service, eligibility group, and income level of the enrollee. Individuals with incomes below the FPL have the lowest copayments – last listed as no more than $4.00 for a doctor visit or a preferred prescription drug.[22] States can charge these individuals higher amounts for a few services, such as $8.00 for a non-emergency emergency department (ED) visit or a non-preferred prescription drug and up to $75 for an inpatient visit.[23] Additional protections apply to ED and non-preferred drug copays, such as an exceptions process for those who have a clinical benefit from selecting a non-preferred drug.[24] States can also set considerably higher limits on individuals with incomes above the poverty line – up to 10% of Medicaid costs for most services for individuals between 100-150% FPL.

In addition to the general limits, Congress exempted certain vulnerable populations and services from cost-sharing altogether. Most children, women eligible through the Breast and Cervical Cancer Treatment Program option, Native Americans, and certain individuals receiving long-term supports and services may not be charged cost-sharing. Exempt services include recommended preventive services, emergency services, and some reproductive health services described below.

These cost-sharing limits and exemptions are an essential part of Medicaid's design. Without doubt, high cost-sharing leads low-income people to delay or forego needed care.[25]

Cost-sharing Protections for Families

Recognizing the key role preventive screening and prenatal care play in successful pregnancy, childbirth, and early childhood development, Congress established additional protections for children and pregnant people. Medicaid encourages states to increase access to coverage and care for children and pregnant people. Over half of the states provide full Medicaid coverage for pregnant people with incomes up to at least twice the federal poverty level. In all, Medicaid helps cover almost half the births in the United States and provides immediate coverage to infants born to a Medicaid-enrolled parent.[26]

> Eliminating cost-sharing obligations increases contraceptive use, improves enrollees' ability to choose the contraceptive method that best suits their needs, and ultimately allows enrollees to avoid unintended pregnancies.[27]

To enhance access to regular prenatal screening, which can lower the risk of later health complications, Medicaid law also exempts pregnancy-related services. Medicaid also excludes most children under the age of 18 from cost-sharing.[28] This attention to enhancing access at critical life developmental stages may help explain the growing body of research showing that Medicaid coverage improves children's educational and occupational success later in life.[29]

Additional Cost-sharing Protections

Medicaid also includes three additional affordability protections to ensure access to care for the lowest-income populations.

No denial of treatment. First, Medicaid law requires that anyone who is living at or below the FPL cannot be denied treatment due to their inability to pay the copayment.[30] Notably, while such a person cannot, for example, be denied a prescription at the pharmacy, that person is not absolved of their obligation to repay the debt.

Waiver of co-pays. Second, Medicaid law specifically allows providers to waive copays for their patients.[31] Again this statutory right recognizes the fact that cost-sharing can present a serious barrier for low-income enrollees and shows Medicaid's expectation that providers have the flexibility to prioritize access to care over these potential barriers.

Cost-sharing limits. Third, Medicaid law requires that no individual in poverty can be charged aggregate cost-sharing in excess 5% of their household income in a month or quarter.[32] For an adult in a family of three at 138% FPL – the high end of Medicaid expansion

– the quarterly aggregate cap would be $428.84 per household in 2023. This out-of-pocket limit differs in important ways from the limits found in private insurance. The aggregate cap includes both Medicaid premiums and cost-sharing for the whole household, while most private insurance limits exclude premiums and set separate individual and family caps. Most private insurance also calculates limits annually. But costly health events typically cluster together in the same month or quarter, so having a lower quarterly cap lessens the impact of these one-time events on low-income enrollees and their families.[33]

Taken together, these Medicaid protections dramatically improve the affordability of care for low-income individuals, particularly those who have more extensive and ongoing health care needs, meaning they can actually afford to use their insurance and get treatment. It comes as no surprise that a controlled study in Oregon comparing similar populations with and without Medicaid found that Medicaid coverage nearly eliminated catastrophic medical expenses and substantially reduced financial strain for the Medicaid group.[34] After two years, positive screens for depression were thirty percent lower in the Medicaid group, while Medicaid enrollees also displayed better medication adherence for diabetes and reported improved overall health.[35]

Protections for Older Adults – Medicare Savings Programs (MSPs)

Medicaid helps low-income Medicare enrollees to pay for Medicare out-of-pocket costs. While Medicare is nearly universally available for older adults, premiums and back-end cost-sharing can be steep, including hospital visit deductibles ($1,600/visit), Part B premiums ($164.90/month for most), prescription drug expenses, and outpatient deductibles and coinsurance ($226/year and the standard twenty percent of costs for most services).[36] Those costs can add up quickly for an enrollee population that typically has significant care needs. To reduce the burden, Medicaid covers nearly all Medicare cost-sharing for Medicare beneficiaries under the FPL with low assets. For Medicare enrollees with slightly higher incomes, MSPs cover the Medicare Part B premiums. That alone saves enrollees nearly $2,000 annually.

These programs make healthcare more affordable for millions of older adults and people with disabilities and offer people the chance to access the care they may need to stay healthy and maintain active and integrated lives in their communities. Unfortunately, a large proportion of Medicare enrollees eligible for these programs remain unenrolled. A recent proposed rule would streamline the MSP enrollment process and so increase MSP participation for lower-income older adults and people with disabilities.

Threats to Medicaid Cost-sharing Protections

Any proposal in Congress that pares back federal funding for the program would endanger these key affordability protections. Medicaid cuts shift financial responsibility for Medicaid to the states and to enrollees. Proposals like imposing a cap on federal funding for Medicaid or lowering the federal matching rates for certain Medicaid groups would likely have to also allow states flexibility to curb enrollment or reduce services. **Proposals that would create such "additional flexibilities" for states may undermine Medicaid's critical affordability protections.**

One likely way states will pursue such flexibilities is through § 1115 demonstrations. Even without the added budget pressures federal funding cuts would create, states have successfully petitioned the federal government to conduct premium and cost-sharing "demonstrations" on their adult Medicaid expansion groups.[37] As noted above, Indiana imposes both a waiting period for those who do not prepay premiums and a six-month lockout for enrollees over the FPL who do not pay premiums on time.

States already facing budget constraints would likely use the federal cuts to reduce enrollment and services through increased cost-sharing, lock outs, and other measures.

Conclusion

For more than fifty-five years, Medicaid has provided access to affordable health services that would otherwise be unavailable to many. Medicaid's strong affordability protections provide states flexibility to customize their programs while assuring that those services remain accessible. Threats of federal cuts to Medicaid now surfacing in discussions of the federal budget and debt ceiling threaten to roll back these critical design features that have helped make Medicaid such a success.

Additional Resources

- For information on other aspects of Medicaid, see our entire series on What Makes Medicaid, Medicaid.

ENDNOTES

[1] David Grande et al., *Life Disruptions for Midlife and Older Adults with High Out-of-Pocket Health Expenditures*, 11 ANN. FAM. MED. 37 (2013); Jeffrey Kullgren et al., *Health Care Use and Decision Making Among Lower-Income Families in High-Deductible Health Plans*, 170 ARCHIVE INTERNAL MED. 1918 (2010).
[2] Madeline Guth, Meghana Ammula & Elizabeth Hinton, Kaiser Family Found., *Understanding the Impact of Medicaid Premiums & Cost-Sharing: Updated Evidence from the Literature and Section 1115 Waivers* (2021), https://www.kff.org/medicaid/issue-brief/understanding-the-impact-of-medicaid-premiums-cost-sharing-updated-evidence-from-the-literature-and-section-1115-waivers/view/footnotes/.
[3] Salam Abdus et al., *Children's Health Insurance Program Premiums Adversely Affect Enrollment, Especially among Lower-Income Children*, 33 HEALTH AFF. 1353 (2014); Leighton Ku & Teresa A. Coughlin, *Sliding-Scale Premium Health Insurance Programs: Four States' Experiences*, 36 INQUIRY 471 (1999); Bill J. Wright et al., *The Impact of Increased Cost-sharing on Medicaid Enrollees*, 24 HEALTH AFF. 1106 (2005); Samantha Artiga & Molly O'Malley, Kaiser Family Found., *Increasing Premiums and Cost-sharing in Medicaid and SCHIP: Recent State Experiences* (2005), https://www.kff.org/medicaid/issue-brief/increasing-premiums-and-cost-sharing-in-medicaid/.
[4] Leighton Ku & Teresa A. Coughlin, *supra* note 3.
[5] 42 U.S.C. § 1396o(c). Although Medicaid law is very clear about this premium policy, HHS has recently given a few states questionable permission to apply premiums below 150% FPL – the states have been allowed to apply mandatory premiums for individuals from 100-150% FPL and voluntary premiums for individuals below 100%. Both of these policies fly in the face of clear evidence that such premiums are harmful and represent a serious departure from the carefully calculated design of Medicaid, which prohibits premiums for individuals that the evidence clearly shows cannot afford to pay those premiums. Medicaid law on premiums, if correctly applied, is uniquely designed to protect the needs of Medicaid beneficiaries.
[6] Samantha Artiga & Molly O'Malley, *supra* note 3, at 2.
[7] *Id.*
[8] Leighton Ku & Victoria Wachino, Ctr. on Budget & Pol'y Priorities, *The Effect of Increased Cost-Sharing in Medicaid: A Summary of Research Findings* (2005), http://www.cbpp.org/cms/?fa=view&id=321. The states were VA, MD, CT, and WA.
[9] CMS has not allowed disenrollment for nonpayment for anyone below the FPL.
[10] The Lewin Group, Inc., *Healthy Indiana Plan 2.0: POWER Account Contribution Assessment*, ii (2017), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-POWER-acct-cont-assesmnt-03312017.pdf.

[11] In all, 57,189 of roughly 195,000 individuals who ever faced a required premium were disenrolled or not enrolled due to nonpayment at least once. *Id.*
[12] *Id.*
[13] *Id.* at 12.
[14] *Id*. at 8.
[15] David Machledt and Jane Perkins, Nat'l Health Law Program, *Medicaid Premiums and Cost-sharing* (Mar. 2014), https://healthlaw.org/resource/medicaid-premiums-and-cost-sharing/.
[16] *Id.*
[17] Ku & Wachino, supra note 8.
[18] *Id.*
[19] See Machledt & Perkins, supra note 15.
[20] Dominic Hodgkin et al., *Cost-sharing for Substance Abuse and Mental Health Services in Managed Care Plans*, 60 MED. CARE RES. REV. 101, 108 (2003). Note: The Mental Health Parity and Addiction Equity Act of 2008, expanded under the ACA, significantly limits the capacity for health plans to charge higher cost-sharing for mental health and substance abuse disorder services. For more details on the scope and limitations of mental health parity law, see Elizabeth Edwards, Nat'l Health Law Program, *The Mental Health Parity and Addiction Equity Act of 2008* (Jan. 2014), https://healthlaw.org/resource/mental-health-parity-and-addiction-equity-act-of-2008/.
[21] See Neal T. Wallace et al., *How Effective Are Copayments in Reducing Expenditures for Low-Income Adult Medicaid Beneficiaries Experience from the Oregon Health Plan*, 42 HEALTH RES. & EDUC. TRUST 515 (2008). Many providers never collect copayments due and put additional financial pressure on safety net providers. See Samantha Artiga, Petry Ubri, and Julia Zur, Kaiser Family Found., *The Effects of Premiums and Cost-Sharing on Low-Income Populations: Updated Review of Research Findings* (June 1, 2017), https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/.
[22] 42 U.S.C. §§ 1396o(a)(3), 1396o(b)(3), 1396o-1(c)(2); 42 C.F.R. §§ 447.52(b)(1), 447.53(b). See also further restrictions at 42 C.F.R. §§ 447.56(a). Note that beginning in October 2015 the cost-sharing maximums for copays were indexed annually to the medical care component of the Consumer Price Index. Updated maximums have not been posted on CMS's website, which still lists the FY 2013 table.
[23] 42 U.S.C. §§ 1396o(a)(3), 1396o(b)(3), 1396o-1(c)(2)(A); 42 C.F.R. §§ 447.53(b), 447.54(b).
[24] 42 C.F.R. §§ 447.53, .54.
[25] David Machledt and Jane Perkins, *supra* note 15.
[26] Anne Rossier Markus et al., *Medicaid Covered Births, 2008 Through 2010, in the Context of the Implementation of Health Reform*, 23-5 WOMEN'S HEALTH ISSUES e273, e275 (2013), http://www.whijournal.com/article/S1049-3867%2813%2900055-8/pdf; Kaiser Family Found.,

Births Financed By Medicaid (Oct. 2016), http://kff.org/medicaid/state-indicator/births-financed-by-medicaid; 42 U.S.C. § 1396a(e)(4); 42 C.F.R. § 435.117.

[27] See, e.g., Jeffrey F. Peipert et al., *Preventing Unintended Pregnancies by Providing No-Cost Contraception*, 120 OBSTETRICS & GYNECOLOGY 1291, 1291 (2012); Kelly Cleland et al., *Family Planning as Cost-Saving Preventive Health Service*, 364 NEW ENG. J. MED. e.37(1), e.37(2) (2011).

[28] 42 U.S.C. § 1396o(a)(2); 42 C.F.R. § 447.56(a); [exempting pregnant women and children from cost-sharing] Nat'l Inst. Child Health & Human Dev., *What Is Prenatal Care and Why Is It Important?*, https://www.nichd.nih.gov/health/topics/pregnancy/conditioninfo/pages/prenatal-care.aspx.

[29] Alisa Chester and Joan Alker, Georgetown Univ. Health Pol'y Institute – Ctr. for Children & Families, *Medicaid at 50: A Look at the Long-Term Benefits of Childhood Medicaid* (July 2015), http://ccf.georgetown.edu/2015/07/27/medicaid-50-look-long-term-benefits-childhood-medicaid/.

[30] 42 U.S.C. §§ 1396o(e), 1396o-1(d)(2); 42 C.F.R. § 447.52(e).

[31] 42 U.S.C. § 1396o-1(d)(2); 42 C.F.R. § §447.52(e)(3).

[32] 42 U.S.C. § 1396o-1(b)(1)(B)(ii), (b)(2)(A); 42 C.F.R. § 447.56(f).

[33] Thomas M. Selden et al., *Cost-sharing in Medicaid and CHIP: How Does It Affect Out-of-Pocket Spending?* 28 HEALTH AFF. w607, w614 (online ed. 2009). For families with children on public insurance, the average peak month accounts for 43% of annual out-of-pocket spending, while the average peak quarter accounts for 58% of annual spending.

[34] Katherine Baicker, et al., *The Oregon Experiment – Effects of Medicaid on Clinical Outcomes*, 368 NEW ENG. J. MED. 1713 (2013).

[35] *Id.* at 1717.

[36] Medicare.gov, Costs, https://www.medicare.gov/basics/costs/medicare-costs (last visited Mar. 21, 2023.)

[37] These states include Michigan, Indiana, Arizona, Arkansas, Montana, and Iowa. Pennsylvania received approval but later abandoned its demonstration in favor of a straight Medicaid expansion state plan amendment.