Protect Medicaid Funding Issue #2: Affordability

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Introduction

Medicaid helps people live healthier and more economically secure lives. It increases the diagnosis and early treatment of chronic conditions, enhances educational achievement and future earnings for covered children, reduces health care inequities, and provides comprehensive, high-quality, and cost-effective care.[1] Medicaid coverage is tailored to the unique needs of individuals and families with low incomes, but still costs less per beneficiary than private insurance.[2] Medicaid's core beneficiary protections make the program work for enrolled populations, including children, parents, pregnant people, low-income workers, older adults, and people with disabilities. Despite Medicaid's proven success and efficient use of funds, detractors repeatedly seek to cut or cap funding for the program. These proposals seriously jeopardize the health and financial security of the over 80 million people who benefit from Medicaid and CHIP.[3]

This fact sheet explains how Medicaid cost-sharing standards keep beneficiaries' 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 150% of the federal poverty level, or $38,730 for family of three in 2024) because even small premiums reduce enrollment.[4] Medicaid allows states to apply copays and coinsurance, but strictly limits cost-sharing because even small required payments reduce access to needed services.[5] Medicaid also prohibits providers from denying care to individuals below the federal poverty level if they cannot afford to pay.

Medicaid cost-sharing limits help low-income and underserved individuals access services they rely on. Medicaid prohibits cost-sharing for key services, such as pregnancy-related services, preventive care, and emergency services. Medicaid also completely exempts some underserved populations from out-of-pocket costs, including Native Americans and most children and adolescents, to reduce common barriers to needed care.

Medicaid's affordability protections improve health outcomes. Medicaid beneficiaries are less likely to skip medications or delay care due to cost.[6] Lower out-of-pocket costs improve access to primary and preventive care and increase the likelihood of treatment for chronic conditions such as diabetes and mental health conditions.[7] One study shows that depression rates declined after individuals began Medicaid coverage.[8]

Medicaid improves people's financial security. States must limit all Medicaid cost-sharing to no more than five percent of household income **per month or quarter**.[9] Medicaid's cap is almost universally lower than the **annual** out-of-pocket caps in private insurance. The shorter increment also shields individuals with low incomes from incurring debilitating medical debt from a single expensive event or complication.[10] Medicaid sharply reduces medical bankruptcies and interactions with debt collection agencies.[11] Several studies show that Medicaid makes it easier for people to work and increases employment for people with disabilities.[12]

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. Higher cost-sharing discourages people from using both essential and non-essential services.[13] The result: worse health outcomes and more expensive care needs down the road, especially for populations with higher health risks, like older adults and people with disabilities.[14]

Funding caps would likely erode Medicaid affordability protections. With less federal funding under funding caps, states would likely push to reverse long-standing federal affordability standards. Prior funding cap proposals would have granted states broader flexibility to raise premiums and cost-sharing. Even if Congress makes no changes, states may seek to impose premiums and eliminate cost-sharing limits. After Medicaid expansion, several states aggressively sought exceptions to Medicaid's rules prohibiting premiums. These exceptions included charging premiums, terminating people for failure to pay, and locking them out for months after termination. Budget pressures resulting from funding caps would

likely increase such requests. States may also undermine other core protections, such as out-of-pocket maximum limits and rules requiring providers to treat patients below the federal poverty level who cannot afford copayments.

Funding caps will worsen health inequities. Black, Indigenous, and other people of color are more likely to have low incomes and be enrolled in Medicaid. Weakening the affordability protections in Medicaid will reduce their access to care and exacerbate health and wealth inequities.[15] Lower-income communities will see a reduction in their health security and an increase in debt and medical bankruptcies.

Funding caps would lead to more uncompensated care, increased medical debt, and worse outcomes. With funding caps, states would likely shift more costs to beneficiaries, leading to more frequent terminations and delayed care.[16] The individuals who drop out of coverage due to unaffordable premiums may not find other coverage and would later appear in the health care system with more advanced illnesses and emergency conditions. Individuals with unaffordable cost-sharing would simply skip medical treatments, resulting in worse health outcomes and more expensive treatments later. Those uncompensated care costs can bankrupt individuals and harm the entire system.

ENDNOTES

[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), https://diabetesjournals.org/care/article/38/5/833/ (Medicaid coverage improves diabetes screening and treatment initiation); Owen Thompson, *The Long-Term Health Impacts of Medicaid and CHIP*, 51 J. HEALTH ECON. 26 (2017), https://www.sciencedirect.com/science/article/abs/pii/S0167629616305136?via%3Dihub; Sarah Miller & Laura R. Wherry, *The Long-Term Effects of Early Life Medicaid Coverage*, 54 J. HUMAN RES. 785-824 (2019), http://jhr.uwpress.org/content/54/3/785 (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), https://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2016.303155 (Medicaid expansion reduced health care disparities); Robin Rudowitz et al., Kaiser Fam. Found., *10 Things to Know about Medicaid: Setting the Facts Straight* (March 6, 2019), https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-setting-the-facts-straight/; Hannah Katch, Ctr. on Budget & Pol'y Priorities, *Medicaid Works: Millions Benefit from Medicaid's Effective, Efficient Coverage* (June 2, 2017), https://www.cbpp.org/research/health/medicaid-works-millions-benefit-from-medicaids-effective-efficient-coverage.

[2] Hannah Katch et al., Ctr. on Budget & Pol'y Priorities, *Frequently Asked Questions about Medicaid* (Nov. 22, 2019), https://www.cbpp.org/research/health/frequently-asked-questions-about-medicaid (Private insurance costs twenty-two percent more than covering the same low-income individual with Medicaid).

[3] CMS, *May 2024 Medicaid & CHIP Enrollment Data Highlights* (Aug. 30, 2024), https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html.

[4] Betsy Q. Cliff et al., Nat'l Bureau of Econ. Research, *Adverse Selection in Medicaid: Evidence from Discontinuous Program Rules* (May 2021), https://www.nber.org/system/files/working_papers/w28762/w28762.pdf; David Machledt & Jane Perkins, Nat'l Health Law Prog., *Medicaid Premiums and Cost Sharing* (March 25, 2014), https://healthlaw.org/resource/medicaid-premiums-and-cost-sharing/.

[5] 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 health care 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 copayment is a flat amount paid upon receipt of care, and coinsurance is a percentage amount paid upon receipt of care); Madeline Guth et al., Kaiser Fam. Found., *Understanding the Impact of Medicaid Premiums & Cost-Sharing: Updated Evidence from the Literature and Section 1115 Waivers* (Sept. 9, 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/; Marisa Elena Domino et al., *Increasing Time Costs and Copayments for Prescription Drugs: An Analysis of Policy Changes in a Complex*

Environment, 46 HEALTH SERV. RES. 900 (2011), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3087836/; Leighton Ku et al., Ctr. on Budget & Pol'y Priorities, *The Effects of Copayments on the Use of Medical Services and Prescription Drugs in Utah's Medicaid Program* (Nov. 2, 2004), https://www.cbpp.org/sites/default/files/archive/11-2-04health.pdf; Uriel Kim et al., *Access and Affordability in Low- to Middle-Income Individuals Insured Through Health Insurance Exchange Plans: Analysis of Statewide Data*, 34 J. GEN. INT. MED. 792 (2019), https://link.springer.com/article/10.1007/s11606-019-04826-w.

[6] 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), https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2542420.

[7] *Id. See also,* Katherine Baicker et al., *The Oregon Experiment – Effects of Medicaid on Clinical Outcomes*, 368 NEJM 1713 (2013), https://www.nejm.org/doi/full/10.1056/nejmsa1212321 (Medicaid reduces depression and increases treatment initiation for diabetes); Judith Dey et al., HHS Asst. Sec. Planning & Eval., *Benefits of Medicaid Expansion for Behavioral Health* 2 (March 28, 2016), https://aspe.hhs.gov/sites/default/files/migrated_legacy_files//143986/BHMedicaidExpansion.pdf.

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

[9] For a person with income at the federal poverty level, the aggregate cap in 2023 would be $182.25/quarterly or $60.75/monthly. For a family of three with income at the federal poverty level in 2023, the aggregate cap would be $310.75/quarterly or $103.58/monthly. Most states elect quarterly caps. Medicaid also counts any premiums toward the cap.

[10] 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), https://www.healthaffairs.org/doi/10.1377/hlthaff.28.4.w607.

[11] Luojia Hu et al., Nat'l Bureau of Econ. Research, *The Effect of the Patient Protection and Affordable Care Act Medicaid Expansions on Financial Wellbeing* (2018), https://www.nber.org/papers/w22170; Sarah Miller et al., Nat'l Bureau of Econ. Research, *The ACA Medicaid Expansion and Financial Health* (2018), https://www.nber.org/papers/w25053; Katherine Baicker et al., *supra* note 7.

[12] Renuka Tipirneni *et al.*, Inst. for Healthcare Pol'y & Innovation at Univ. of Mich., *Medicaid Expansion Helped Enrollees Do Better at Work or in Job Searches* (June 27, 2017), http://ihpi.umich.edu/news/medicaid-expansion-helped-enrollees-do-better-work-or-job-searches; Ohio Dept. Medicaid, *Ohio Medicaid Group VIII Assessment: A Report to the Ohio General Assembly*, 21 (Aug. 2018), https://medicaid.ohio.gov/static/Resources/Reports/Annual/Group-VIII-Final-Report.pdf (Survey shows 83.5 percent of employed enrollees reported Medicaid made it easier to continue working, while sixty percent of unemployed enrollees reported Medicaid made it easier to look for work); Jean P. Hall et al., *Medicaid Expansion as an Employment Incentive Program for People with Disabilities*, 108 AM. J. PUB. HEALTH 1235 (2018), https://ajph.aphapublications.org/doi/10.2105/AJPH.2018.304536 (Medicaid expansion correlated with increases in employment for people with disabilities compared to non-expansion states).

[13] Emmett B. Keeler, *Effects of Cost Sharing on Use of Medical Services and Health*, 8 MED. PRACTICE MANAGEMENT 317 (1992), https://www.rand.org/pubs/reprints/RP1114.html; Rajender Agarwal et al., *High-Deductible Health Plans Reduce Health Care Cost and Utilization, Including Use of Needed Preventive Services*, 36 HEALTH AFFS. 1762 (2017), https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.0610.

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[15] Andre M. Perry et al., Brookings Inst., *The Racial Implications of Medical Debt: How Moving toward Universal Health Care and Other Reforms Can Address Them* (Oct. 5, 2021), https://www.brookings.edu/research/the-racial-implications-of-medical-debt-how-moving-toward-universal-health-care-and-other-reforms-can-address-them/.

[16] Benjamin D. Sommers et al., *New Approaches in Medicaid: Work Requirements, Health Savings Accounts, and Health Care Access*, 37 HEALTH AFFS. 1099 (2018), https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.0331.