COMMUNITY CATALYST

Medicaid Eligibility and Benefit Cuts: Evidence They Harm Consumers and Have Unintended Consequences on State Budgets

Medicaid provides health and economic security to millions of families and individuals with low income and limited resources. However, in numerous states across the nation, policymakers are making false assumptions that eligibility and benefit cuts to the program will close budget gaps and allow beneficiaries to seamlessly shift onto the private insurance market.

These counterproductive Medicaid cuts fall across the board, but include those in these four categories: 1) Rolling back income eligibility levels for pregnant people; 2) Reducing the scope of breast and cervical cancer emergency treatment programs; 3) Adding out-of-pocket requirements; and 4) Restricting certain benefits, such as prescription drugs and dental coverage.

These four categories of Medicaid cuts could jeopardize the care and health of vulnerable Americans and lead to higher costs in other areas of the state's budget.

1. Rolling Back Income Eligibility for Pregnant People

As of January 2015, Medicaid income eligibility for pregnant people is between 138-200 percent of the Federal Poverty Level (FPL) in 18 states and 200-250 percent FPL or higher in 33 states including DC.[1] Some state policymakers are looking to roll back eligibility to the federal minimum level of 138 percent FPL with the intention of shifting those beneficiaries to the Marketplace.[2] However, rolling back eligibility for low-income pregnant people will not result in a seamless transition to the Marketplace nor will it help state budgets due to several reasons:

- **Pregnant people and newborns risk losing critical coverage.**
  - Pregnancy does not trigger a Special Enrollment Period for enrollment in the Marketplaces. An uninsured person who becomes pregnant outside of open enrollment may have no options for coverage if the person cannot get Medicaid.
  - Even with tax credits, premiums and cost-sharing in the Marketplace may still be out of reach for low-income pregnant people. A study in Connecticut showed that as many as 29 percent of a proposed scaled back parent population (from 138 to 185 percent FPL) would forgo Marketplace coverage due to affordability issues.[3]

[1] Kaiser Family Foundation. (2015). Where are State Today? Medicaid and CHIP Eligibility Levels as of January 2015. Retrieved from http://kff.org/medicaid/fact-sheet/where-are-states-today-medicaid-and-chip/

[2] Some states have a higher income standard of 185 percent FPL for pregnant people. To view the list see Table 1 from http://www.nga.org/files/live/sites/NGA/files/pdf/MCHUPDATE0190.pdf

[3] London, K., Seifert, R. & Gershon, R. (2013). Consequences of Proposed Eligibility Reduction of HUSKY A Parents. *Connecticut Health Foundation.* Retrieved from https://www.cthealth.org/wp-content/uploads/2013/03/Consequences-of-Proposed-Eligibility-Reduction-of-HUSKY-A-Parents.pdf

- A pregnant person with an offer of employer sponsored insurance (ESI) may be ineligible for tax credits in the Marketplace - even if the offer of ESI is not affordable .
- Pregnant people on Medicaid can access prenatal and postpartum care at little to no cost. As a result, their newborns are more likely to be born healthy and will automatically receive Medicaid for one year. Even if newborns born to uninsured mothers are Medicaid eligible, their enrollment may be delayed. They are also less likely to be healthy, since they may not have had all recommended prenatal care – translating to higher health care costs eventually absorbed by Medicaid.[4]

- **Cutting Medicaid may increase uncompensated care.** Pregnancy and delivery makes up the largest portion of uncompensated care costs.[5] Since state and local governments pay for about 40 percent of uncompensated care, reducing eligibility for pregnant people on Medicaid may lead to higher uncompensated care costs for the state.[6]

2. Reducing the Scope of Screening Programs

Under the National Breast and Cervical Cancer Early Detection Program (NBCCEDP), low-income people up to 250 percent FPL are given breast and cervical cancer screening services in all 50 states. All states also contribute funding to the program and chose to provide emergency, temporary Medicaid treatment for people who are diagnosed with cancer through NBCCEDP. However, some state leaders are proposing to reduce funding to the screening portion of the program or pull out of providing cancer treatment on NBCCEDP. Doing so will result in sicker Americans who may put off treatment and cost the state more long-term. Taking treatment and screening away from low-income people will:

- **Negatively impact coverage and the marketplaces**
  - Similar to uninsured people becoming pregnant outside of a SEP, people diagnosed with breast or cervical cancer cannot sign up for Marketplace coverage outside of open enrollment. Nevertheless, if these people purchase health plans only after they find out they are sick, it can destabilize the Marketplace risk pool and drive up premiums for everyone in the state's individual market. Special

[4] Brooks, T. & Duong, S. (2015). Cuts to Medicaid Pregnancy Coverage: Penny Wise and Pound Foolish. *Center for Children and Families.* Retrieved from http://ccf.georgetown.edu/all/cuts-medicaid-pregnancy-coverage-penny-wise-pound-foolish/ and American College of Obstetricians and Gynocologists. (2008). People and Health Insurance: By the Numbers. Retrieved from http://www.acog.org/~/media/Departments/Government%20Relations%20and%20Outreach/hcfwhcfa-numbers.pdf?dmc=1&ts=20120624T1105550955

[5] Elixhauser, A. & Russo, C.A. (2006). Conditions Related to Uninsured Hospitalizations, 2003. *Healthcare Cost and Utilization Project and Agency for Healthcare Research and Quality.* Retrieved from http://www.hcup-us.ahrq.gov/reports/statbriefs/sb8.pdf

[6] Coughlin, T.A., Holahan, J., Caswell, K. & McGrath, M. (2014). Uncompensated Care for the Uninsured in 2013: A Detailed Examination. *Kaiser Family Foundation.* Retrieved from http://kff.org/uninsured/report/uncompensated-care-for-the-uninsured-in-2013-a-detailed-examination/

Medicaid coverage for uninsured low-income people with cancer provides needed treatment that would also protect the market from these spikes.

- **Reduce chances of survival**.
  - Uninsured people are seven times more likely to forgo preventive care than the insured, while 57 percent of uninsured people put off treatment.[7]
  - Early detection and treatment can increase five-year survival rates to as high as 98 percent. However, people who delay treatment after diagnosis have a 66-85 percent increased risk of death.[8]
  - If an uninsured person was diagnosed with cancer outside of 2015 open enrollment, he/she would have to wait until open enrollment begins in November 15, 2015 to sign up for Marketplace coverage and until January 1, 2016 for his/her first date of 2016 coverage – the wait could be up to ten and a half months.

3. Adding New or Increased Out-of-pocket Costs

New or increased out-of-pocket requirements, such as copayments and monthly premiums, are a growing trend in state Medicaid programs.[9] Some policymakers assume that shifting costs onto Medicaid beneficiaries will address state budget concerns by generating revenue, incentivizing responsible care choices and reducing total state spending. These policy discussions are especially salient given that states that have yet to close the coverage gap would likely consider cost-sharing in their proposals. Ultimately, these out-of-pocket costs that were meant to save states money will impede access to care and produce adverse downstream effects such as higher emergency room use and uncompensated care costs.

- **Medicaid premiums reduce coverage and access to care**. In Oregon, nearly half of the state's Medicaid beneficiaries lost coverage when the state increased premiums from $6 to $20 per month, imposed cost-sharing and created lockout periods for failure to pay. A third of those who dropped out of the program remained uninsured beyond 18 months of losing coverage.[10]

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[7] Riffkin, R. (November 28, 2014). Cost Still a Barrier Between Americans and Medical Care. *Gallup.* Retrieved from http://www.gallup.com/poll/179774/cost-barrier-americans-medical-care.aspx

[8] McLaughlin, J.M., Anderson, R.T., Ferketich, A.K., Seiber, E.E., Balkrishnan, R. & Paskett, E.D. (2012). Effect of Survival of Longer Intervals Between Confirmed Diagnosis and Treatment Initiation Among Low-Income People with Breast Cancer. *Journal of Clinical Oncology.* Retrieved from http://jco.ascopubs.org/content/early/2012/11/16/JCO.2012.39.7695.full.pdf+html

[9] States can impose cost-sharing on certain children and adults with incomes between 100 and 150 percent FPL and can impose premiums and higher cost-sharing for beneficiaries with incomes above 150 percent FPL. States are more limited in imposing premiums and cost-sharing for Medicaid beneficiaries under 100 percent FPL. For more information visit https://kaiserfamilyfoundation.files.wordpress.com/2013/02/8416.pdf

[10] Wright, B.J., Carlson, M.J., Smith, J. & Edlund, T. (2005). Impact of Changes to Premiums, Cost-Sharing and Benefits on Adult Medicaid Beneficiaries: Results from an Ongoing Study of The Oregon Health Plan. *Commonwealth Fund.* Retrieved from http://www.commonwealthfund.org/~/media/files/publications/fund-report/2005/jul/impact-of-changes-to-premiums--cost-sharing--and-benefits-on-adult-medicaid-beneficiaries--results-f/wright_impact_changes_premiums_medicaid_oregon-pdf.pdf

- **Medicaid copayments reduce access to essential services.** Copayments have been shown to reduce health care utilization, including *necessary* care. Almost half of beneficiaries on Oregon Medicaid cited unmet medical needs as a result of costs after copayments were imposed. After copays were eliminated, that figure dropped to about a third. [11] In Utah**,** even small copayments of $2 or $3 per service or prescription caused 13 percent of people to forgo their medication.[12]
- **Medicaid out-of-pocket costs drive up other costs borne by the state.**
    - ***Increased ER use:*** People who lost coverage on Oregon Medicaid because of out-of-pocket requirements and strict lockout policies were 4 to 5 times more likely to use the ER as a usual source of care than people who remained enrolled.[13]
    - ***Increased administrative costs:*** Systems to administer and collect out-of-pocket costs on beneficiaries are costly and complex. For every $1 raised in cost-sharing in Medicaid, states will spend more in administrative expenses ($2.77 in Arizona[14] and $1.39 in Virginia).[15] State legislators in Maryland abandoned a proposal to implement emergency room copayments after determining that it was not cost effective.[16]

4. Imposing Benefit Restrictions

In attempts to lower program costs and create incentives for efficient use of care, some state policymakers impose limits on hospital visits, prescription drugs and other benefits. Just like cost-sharing and out-of-pocket requirements, restrictions on Medicaid benefits may decrease utilization for that service, but may also lead to harmful and costly outcomes in the long-term.

- **Cutting dental benefits increases uncompensated care.** In Maryland, cutting Medicaid dental coverage decreased dental office visits by 8 percent, but also increased dental-related claims in the emergency department by 12 percent.[17] As a result of eliminating dental coverage from Massachusetts' Medicaid program in 2002, uncompensated care costs paid by Massachusetts to free-standing Community Health Centers for dental

[11] Wright, et al., 2005
[12] Ku, L., Deschamps, E. & Hilman, J. (2004). The Effects of Copayments in the Use of Medical Services and Prescription Drugs in Utah's Medicaid Program," *Center on Budget and Policy Priorities*. Retrieved from http://www.cbpp.org/cms/index.cfm?fa=view&id=1398
[13] Ku, L. & Wachino, Victoria. (2005). The Effect of Increased Cost-Sharing in Medicaid. *Center on Budget and Policy Priorities.* Retrieved from http://www.cbpp.org/cms/?fa=view&id=321
[14] Napolitano, J. & Rodgers, A. (2006). Fiscal Impact of Implementing Cost Sharing and Benchmark Benefit Provisions of the Federal Deficit Reduction Act of 2005. Retrieved from http://www.azahcccs.gov/reporting/Downloads/CostSharing/FINAL_Cost_Sharing_Report.pdf.
[15] Dickson, V. (2014). Medicaid cost-sharing seen as deterring enrollment *Georgetown University*. Retrieved from http://ccf.georgetown.edu/media/medicaid-cost-sharing-seen-as-deterring-enrollment/
[16] Handel D.A., McConnell K.J., Wallace N.T. & Gallia C.A. (2008). How much does emergency department use affect the cost of Medicaid programs? *Ann Emerg Med*, 51(5), 614–21. Retrieved from http://content.healthaffairs.org/content/29/9/1643.full
[17] Cohen, L.A., Manski, R.J., Magder, L.S. & Mullins, C.D. (2003). A Medicaid Population's Use of Physicians' Offices for Dental Problems. *American Journal of Public Health*. 93(8), 1297-1301. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1447960/

services rose by 54 percent between 2002 and 2003 – while savings from eliminating that benefit was less than one percent of total state Medicaid spending in 2004. [18]

- **Limits on prescription drug coverage do not always save money**. States may limit the number of prescriptions covered**,** adopt preferred drug lists (PDLS) that require prior authorization or exclude certain drugs. These limits can reduce access, encourage harmful substitutions and hurt overall health. In a multi-state study, restrictions neither decreased overall drug use nor spending because of equal or greater uses of newer and more costly drugs or other health services.[19]
- **Benefit cuts hurt providers as well as patients.** Limits can result in substantial loss of revenue and increases in uncompensated care. Community Health Centers (CHCs) will be hit especially hard when patients continue to use CHCs for their benefits, but the services will not be reimbursed by Medicaid.
    - When dental coverage was cut from Massachusetts Medicaid, CHCs picked up more uncompensated care while losing Medicaid reimbursements, resulting in revenue shortfalls. Private dentists faced a 14 percent decline in MassHealth reimbursements from 2001-2004. One dentist reported his revenue from MassHealth reimbursements declined by about 40 percentage points of total revenue and led to reduced staff. [20]
    - When former Missouri Governor Blunt proposed drastic Medicaid cuts (including elimination and reduction of optional benefits, scaling back eligibility for elderly and disabled, eliminating dental and eyeglasses benefits) health centers estimated losing half of their Medicaid revenue ($16-20 million).[21]

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[18] Pryor, C. & Monopoli, M. (2005). Eliminating Adult Dental Coverage in Medicaid: An Analysis of the Massachusetts Experience. *Kaiser Family Foundation.* Retrieved from https://kaiserfamilyfoundation.files.wordpress.com/2013/01/7378.pdf
[19] Soumerai, S.B. (2004). Benefits and Risks of Increasing Restrictions on Access to Costly Drugs in Medicaid. *Health Affairs*, 23(1), 135-146. Retrieved from http://content.healthaffairs.org/content/23/1/135.full
[20] Pryor & Monopoli, 2005.
[21] Wilensky, S. & McDermott, M. (2005). Unkindest Cuts: The Impact of State Medicaid Reductions on Health Centers and Their Patients. *The National Association of Community Health Centers, Inc.* Retrieved from https://www.nachc.com/client/documents/issues-advocacy/state-issues/add-medicaid-info/statepolicyreport5.pdf