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COST-SHARING TO REDUCE MEDICAID COSTS IN MARYLAND

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In February of 2005, the Deficit Reduction Act (DRA) was signed into law by President Bush. Among the many features included in the bill were provisions allowing states to take steps to reduce Medicaid spending. Unlike some other states, Maryland has not yet utilized these opportunities to help control its rising Medicaid expenditures.

One of the most significant provisions in the DRA is the allowance of limited cost-sharing for Medicaid beneficiaries. States that choose these cost-sharing options will recoup some of the costs for providing Medicaid services. More importantly, these states will also reduce utilization of services. Some may view this reduction as a negative consequence of cost-sharing, but evidence indicates that the reduction in services is not accompanied by a reduction in a person's health quality. Instead, the reduction in services will reduce over-utilization.

Maryland's Governor and General Assembly should consider implementing the cost-sharing provisions in the DRA. Although this should not replace movements to fundamentally reform Maryland's Medicaid program, it would help to slow its growth and would provide lawmakers with more opportunities to pursue further reforms.

MEDICAID IN MARYLAND

Medicaid in Maryland is known as the Maryland Medical Assistance Program (MAP). According to various sources, from 10 to 14 percent of Marylanders receive assistance from the program,[1] which is lower than the national average of 19 percent. However, according to the National Association of State Budget Officers, in 2004 approximately 27.1 percent of the state budget was devoted to Medicaid—which is higher than the national average of 22.3 percent. This is more than any other budget category in Maryland, including spending for elementary and secondary education.

In 2004, Maryland spent $2.1 billion in state funds and $2.4 billion in federal funds—a total of more than $4.5 billion—on MAP recipients. In 2005, those numbers are expected to grow to $2.54 billion in state funds and $2.55 billion in federal funds, a total of more than $5 billion. That translates to a 19 percent increase in state spending from 2004 to 2005.

COST-SHARING

The Deficit Reduction Act allows states to implement cost-sharing in three areas:

- For beneficiaries whose incomes are more than 1.5 times the federal poverty level, states can charge up to 20 percent of the cost of services,

1. Various sources differ on the number of MAP recipients and on the exact amount Maryland spends on this program. Unless otherwise noted, the author is using numbers from the Kaiser Family Foundation.

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as well as unlimited premiums. For beneficiaries whose incomes are between one and 1.5 times the federal poverty level, co-payments can only be up to 10 percent of the cost of services. For beneficiaries whose incomes are below the poverty level, the DRA set no limits on cost-sharing (although it is unlikely that any state will impose cost-sharing on this group). Cost-sharing is not allowed for some beneficiary populations—such as children required to be covered under federal law, pregnant women, and terminally ill patients in hospice care—and some services (mainly services utilized by the mandatory children and pregnant women). Cost-sharing cannot exceed 5 percent of a family's income.

- Hospitals can impose cost-sharing on non-emergency services delivered in emergency rooms if patients had access to another source of medical care.
- Cost-sharing can also be applied if a state has compiled a list of preferred drugs and a Medicaid beneficiary chooses a drug not on that list (unless the patient's doctor certifies the patient needed that specific drug).

BENEFITS OF COST-SHARING

Introducing co-payments and other cost-sharing measures would reduce Maryland's Medicaid expenditures in two ways: beneficiaries would pay part of the costs currently paid by the states, and beneficiaries would use fewer services.

Exactly how much the state would save depends on the level of co-payments imposed. Because Medicaid users are primarily low-income earners, it is doubtful that these co-payments would add up to a significant amount of income for the state. The real savings would come from reductions in over-utilization of the system.

As the state's Medical Assistance Program currently operates, most services are essentially free for Medicaid patients. Therefore, these patients have the option to use any and all available services without limit, because there is no cost associated with using services unnecessarily. However, with co-payments, a financial consequence for using unneeded services would be introduced to the system, although the actual amount paid by the beneficiary would be small.

Critics will argue that cost-sharing could result in Medicaid beneficiaries forgoing necessary medical services, but evidence indicates that this will not happen. The most comprehensive study of the differences in the quality of health that result from free health care, such as Maryland's Medical Assistance Program, as opposed to health care where patients pay some cost (as would be the case with co-payments) shows that there is no significant difference in patients' health care outcomes.[2]

Another criticism is that it would be unfair to ask people on Medicaid to pay even a small share of the medical costs they incur. Critics contend that because people on Medicaid are often at or below the poverty level they have very little income with which to meet co-payments.

This concern can easily be addressed, because the General Assembly is able to design cost-sharing measures in any way it sees fit. If the Assembly is concerned with how cost-sharing would affect the poorest Marylanders, it can exempt them from it. The Assembly could also designate an emergency fund to help meet the needs of Medicaid beneficiaries who are truly in need of assistance.

CONCLUSION

Other states are using the authority given them by the Deficit Reduction Act to begin controlling their Medicaid costs through cost-sharing. Maryland legislators need to consider doing the same. Medicaid expenditures are an increasingly large portion of the state's budget, and cost-sharing is an easy step that can be taken toward reducing the growth rate of this program.

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2. *Effects of Coinsurance in the Health Insurance Experiment*, Rand Corporation, p. viii, at *www.rand.org/pubs/reports/2006/R3055.pdf*.