

Increased Medicaid Cost-sharing Will Increase Healthcare Costs

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The introduction or increase of Medicaid cost-sharing for persons with mental illnesses will discourage them from seeking or continuing treatment. This will result in significant burden and costs to the general healthcare system.

- **Implementation of cost-sharing has the potential to raise administrative costs to states.**

While the Deficit Reduction Act (DRA), signed into law last year by President Bush, gives states greater leeway to impose co-payments and other cost-sharing, implementing these provisions does not guarantee increased revenue for states. According to study by Arizona's state Medicaid agency, while the state could expect to collect over \$5.6 million in co-payments and other cost-sharing measures after taking out the federal share, the state would incur almost \$16 million in administrative costs to collect that amount. This projected administrative cost does not take into account the potential for increased healthcare costs based on changes in consumer behavior (e.g., cutting back on medication, failing to fill prescriptions) that could lead to an increase in emergency room visits and other expensive services.¹

As an Oregon study concluded, if states are to save money by increasing co-payments and other cost-sharing mechanisms, the savings will come not from increased revenue but because beneficiaries choose to go without services.

- **Cost-sharing reduces the total amount of state expenditure on Medicaid, thus reducing the federal matching funds received by the state.**

When cost-sharing is used, only a portion of the funds benefit the state government, while the rest of the savings are passed on to the federal government.

- **Increased cost-sharing leads to poor health outcomes, increased emergency room visits, hospital care, and institutionalization.**

A recent study examining the impact of the implementation of the Medicare Part D prescription drug benefit found that participants whose medication was discontinued or temporarily stopped were six times more likely to have a significant adverse event and almost eight times as likely to have an emergency room visit compared to participants with other types of problems accessing needed medications

Rates of Significant Adverse Clinical Events Reported After Medication Access and Continuity Problems for 579 Patients

Variable	Patients with Event	
	%	SE (%)
Any adverse event	27.3	2.6
Increase in suicidal ideation/behavior	21.7	2.7
Emergency room visit	19.8	2.9
Increase in violent ideation/behavior	14.5	2.5
Psychiatric hospitalization	11.0	2.1
Became homeless for more than 48 hours	3.1	1.3

Source: J. West et al., 2007



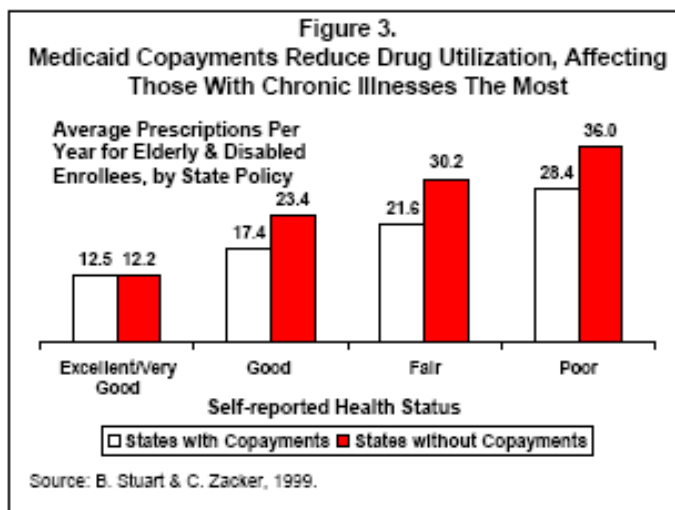
(e.g., not being able to access refills, having to switch to a different medication).

Another large study looking at the situation before and after coinsurance was introduced found that emergency department (ED) use increased by 88% and poor outcomes such as hospitalization, institutionalization and death increased by 78%.

- **Increased cost-sharing for prescription drugs reduces the use of essential drugs that are vital to disease management and prevention.**

A focus group found that participants had “difficulty affording co-payments and described instances in which they were unable to obtain prescription drugs because they could not pay. As one participant remarked, ‘Being able to afford \$2 is a lot of money when you have absolutely nothing.’”

In 2001, it was estimated that people with mental illness on Supplemental Security Income (SSI) received, on average, \$517 per month. This money is often used to cover housing, food, and medical needs.



- **Reduction in medication usage results in increased Emergency Department visits by people with mental illnesses, increasing the burden on the healthcare system.**

In a recent national survey, 60% of the physicians surveyed said that the increase in psychiatric patients seeking care at emergency departments (ED) is negatively affecting access to emergency care for all patients by generating longer waiting times and limiting the availability of ED staff and ED beds for other patients.

References:

¹ Information on the studies referenced in this fact sheet is available upon request. For a copy of the list of sources or for other questions, call Allison Fort at 301.984.6200, ext. 235 or email HAllisonF@nccbh.org.

The National Council for Community Behavioral Healthcare is a not-for-profit, 501(c)(3) association of 1,300 behavioral healthcare organizations. Our members offer medical, social, psychological, and rehabilitation services in community settings to help people with mental illnesses and addiction disorders recover and lead productive lives. Medicaid pays for up to 75 percent of the services our members provide to six million adults, children, and families in communities across the country.



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