Coalition for a Moral Budget

Fighting to ensure that Medicaid beneficiaries, seniors, and people with HIV/AIDS are protected from cost sharing.

Medicaid and ADDP Co-Pays Will Harm the Most Vulnerable New Jerseyans

The Governor's proposed FY'10 budget includes co-pays on Medicaid beneficiaries who use prescription drugs, including seniors and others who are dually eligible for Medicare. The Medicaid co-pay would be $2 a prescription with a monthly cap of $10. The budget also includes a co-pay for the AIDS Drug Distribution Program (ADDP). The ADDP co-pay is on a sliding fee scale based on the person's income.

Imposing co-payments on Medicaid beneficiaries and individuals with HIV/AIDS will harm the most vulnerable New Jerseyans and will not result in actual savings to the State. Co-payments make health care less affordable for individuals with limited incomes, forcing people to choose between needed health care services and other necessities such as rent, food, or heating. If beneficiaries choose the latter, there is a greater risk that they will require more costly hospital services. As these services will be ultimately billed to Medicaid anyway, this would clearly defeat the intended cost reduction to the State. Medicaid and ADDP co-pays would result in individuals with significant disabilities and those living in poverty not seeking care, exacerbating their illnesses, and cost the State even more in hospitalizations and more Emergency Room visits.

This is a synopsis of a white paper, developed last year, that discusses the arguments for and against instituting Medicaid co-pays in New Jersey and synthesizes many of the national studies that have been conducted that demonstrate the problems associated with Medicaid co-pays. Some of the study findings are:

- The Rand Health Insurance Experiment, which is considered the definitive study on co-payments, found that low-income individuals reduce their medical visits by 41% when they were responsible for co-payments.

- When Utah imposed nominal co-payments on Medicaid beneficiaries, 40% of beneficiaries reported the co-payments caused serious financial harm and there was a significant reduction in health care access.

- A study in Minnesota found that more than half of beneficiaries reported that they had been unable to get their prescription drugs at least once in the last six months dues to co-payments.

Over the past few years, while New Jersey debated over Medicaid co-payments, several states with co-payments have recognized the negative impact on their citizens and have taken action. For example, in FY 2008, Oregon eliminated co-payments for generic drugs and other drugs on their preferred drug list.

The most vulnerable citizens of New Jersey will bear the brunt of Medicaid and ADDP co-pays. Some examples:

- Jorge is 56 years old with developmental disabilities. He has diabetes and high blood pressure and takes six prescription drugs. He is barely able to make ends meet each month and does not know what he will do if he has co-payments for his six prescriptions and doctors visits.

- Joanne is the caregiver of her 27 year old son, who is HIV positive. Due to the stage of his AIDS virus, if Joanne's son is unable to routinely take his medication or receive treatment from his doctor, he will most certainly deteriorate and die.

- Joe is dually diagnosed with mental illness and developmental disabilities. He takes 23 different prescriptions to manage his mental illness, diabetes, asthma, allergies, high blood pressure, low potassium, gastrointestinal issues, cholesterol, inflammation, iron deficiency, seizures and water retention. Joe is afraid that he will not be able to afford his prescriptions if he has co-payments.

The proposal to impose co-pays on Medicaid prescription drugs and the AIDS Drug Distribution Program (ADDP) will harm the most vulnerable New Jerseyans and will not result in actual savings to the State.

Co-payments makes health care even less affordable for individuals with limited incomes, forcing beneficiaries to choose between needed health care services and other necessities such as rent, food, or heating.

If beneficiaries choose the latter, there is greater risk that they will require more costly hospital services. As these services will ultimately be billed to Medicaid anyway, this would clearly defeat the intended cost reduction to the state.

Conversely, if a beneficiary chooses their health over other necessities, other state funded programs (such as the Low Income Home Energy Assistance Program or the Universal Service Fund) may be more heavily relied upon, thus increasing the cost for those programs.

Either way, the state will not save money

Health services research has consistently shown that co- payments cause low-income people to forgo health care services, including essential services which can lead to costly consequences such as increased use of emergency rooms.

A study examining the impact of Medicaid drug co-payments policies in thirty-eight states found, that after controlling for other factors, the primary effect of co-payments is to reduce the likelihood that Medicaid beneficiaries fill any prescriptions during the year.

A study in Minnesota found that more than half reported that they had been unable to get their prescription drugs at least once in the past six months because of co-payments of $3 for brand name drugs and $1 for generics.

Research found that when Utah imposed small co-payments ($2 or $3 per service or prescription); this led to significant reductions in health care access and utilization. Even though the co-payments were "nominal" forty-percent (40%) of beneficiaries reported that it caused "serious" financial hardships.

One study found that higher co-payments led to reductions in patients' use of drugs for high blood pressure and cholesterol reduction, which can lead to the disease progressing and to more severe consequences such as heart attacks.

Some argue that cost-sharing encourages responsible use of health care services. However, the research does not support this argument.

Two studies by the Urban Institute found that after controlling for health characteristics, people on Medicaid used the same average amount of care as similar individuals with private insurance.

Other research has found that while co-payments lead people to reduce their medical care, they do not necessarily make people "smarter" health care consumers. When co-payments are imposed, patients reduce their use of essential and less-essential services.