ALABAMA POLICY INSTITUTE

GUIDE TO THE ISSUES

The Costs and Benefits of Co-payments in Alabama's Medicaid Program

Background

Medicaid is a state and federal program that provides payment for medical services to low-income citizens who meet certain requirements.[i] In Alabama, Medicaid is the largest medical and health services provider to the poor – serving children, the elderly, the disabled, and those eligible for federally-assisted income maintenance payments.[ii]

Because of the increasing costs of Medicaid, some states are proposing to institute some type of co-payments for services rendered under Medicaid. California recently requested a waiver requiring Medicaid beneficiaries to pay low co-payments for certain services, in order to allow better utilization of the medical system.[iii] The state requested a demonstration waiver that is designed to give states flexibility and control to improve Medicaid programs in regards to expanding eligibility, providing more services, and using new service delivery options to improve care and efficiency, as well as lower costs. Typically, these waivers are approved for five years and are usually renewable for another three years.[iv] The Centers for Medicare and Medicaid Services denied the waiver request, claiming that the co-pays are neither temporary nor targeted at a specific population, as required by federal Medicaid law.

ISSUE SNAPSHOT

Because of increasing costs of Medicaid, some states are implementing co-payments.

If Medicaid patients had reasonable co-payments within the means of their income, Medicaid would save money as recipients would more carefully consider their needs before using medical services.

Alabama should consider developing a nominal cost-sharing plan that works to reflect the true cost of health care for Medicaid recipients.

Policy Considerations

Within the current Alabama Medicaid system, medical services may be consumed at a faster pace because there is little to no competing interest in the healthcare decision. For the typical patient covered by private insurance, the decision to seek care is balanced against the cost of a co-payment or other cost-sharing provision of the insurance coverage. Prospective patients must decide whether the benefits of care outweigh the cost from their personal funds.[v] The result is that the cost of care is focused on more significant ailments, rather than common colds and sprains. Because Medicaid beneficiaries currently receive free or low-priced services, a patient has little to weigh against seeking