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Mexico's water debt

Behind the U.S.-Mexico Water Treaty Dispute

Mexico owes the United States about 450 billion gallons of water under the terms of a 1944 treaty to share the waters of the Rio Grande. Since 1992, Mexico has fallen behind on its required deliveries. Texas farmers in the Lower Rio Grande Valley, who depend on water from the river to irrigate their crops, have been hit hard by the accumulation of Mexico's water debt.

Parched fields and dusty irrigation ditches have caught the attention of state officials. In a letter to U.S. Secretary of State Colin Powell, Texas Gov. Rick Perry outlined a plan for Mexico to provide enough water to meet Texas' immediate water needs, as well as cooperative efforts to prevent future deficits. In April, Agriculture Commissioner Susan Combs and Valley growers met with State Department officials to present evidence from satellite imagery that Mexico has enough water available to meet its commitments. In February, Attorney General John Cornyn announced the creation of an in-house task force to investigate legal and diplomatic avenues to resolve the dispute and to secure water for users in the Valley.

Aware of the growing crisis in the Valley, Congress included in its agricultural appropriations act for fiscal 2002 (H.R. 2330) a provision, introduced by Rep. Henry Bonilla of Texas, requiring the U.S. Department of Agriculture (USDA) to report on the economic loss to agricultural producers and on USDA's authority and plans to assist Valley farmers with the financial impact of the water debt. USDA is expected to issue the report in early May.

President Bush and Mexican President Vicente Fox met in March during a United Nations conference in Monterrey, Mexico. The White House confirms that the two leaders discussed the fulfillment of Mexico's obligations under the water treaty, but there has been no official announcement on the outcome of the discussion.

Treaty provisions

In 1944, the United States and Mexico signed a treaty aimed at

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HHSC Work Group Presents Options for Cost Sharing by Medicaid Clients

Medicaid, the state-federal health-care program for the poor, elderly, and disabled, has been a major driver of state budget increases in recent years. Budget writers in the 77th Texas Legislature, facing growth in state Medicaid costs, asked the Health and Human Services Commission (HHSC) to find $205 million in general-revenue savings for fiscal 2002-03 and adjusted the appropriation for Medicaid accordingly through a rider to the general appropriations act.

Rider 33 under Special Provisions Relating to All Health and Human Services Agencies lists 17 initiatives that HHSC could implement to achieve the targeted cost savings. The list includes $3 million in general-revenue savings by establishing sliding-scale copayments for Medicaid recipients. Following the legislative session, HHSC formed a work group of agency representatives and stakeholders to develop a plan whereby Medicaid recipients would share the cost of their medical care.

On April 11, the work group recommended two cost-sharing options to HHSC: an annual enrollment fee for families with incomes above the federal poverty level (FPL) and

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sharing the waters of the Rio Grande between Fort Quitman in Hudspeth County, southeast of El Paso, and the Gulf of Mexico, as well as the waters of the Colorado and Tijuana Rivers along the California-Mexico border. Downstream from Fort Quitman, the treaty generally allots to each country all the waters of their respective tributaries to the Rio Grande, except from Mexico's Rio Conchos, Rio San Diego, Rio San Rodrigo, Rio Escondido, Rio Salado, and Las Vacas Arroyo. (See map, page 3.)

The treaty allots to the United States one-third of the water flowing into the Rio Grande from these six tributaries. In return, Mexico is to receive 1.5 million acre-feet of water each year from the Colorado River, which drains into Mexico at the California-Arizona border after flowing through the southwestern United States. (An acre-foot is the volume of water that would cover one acre of land to a depth of one foot, or about 326,000 gallons.)

The International Boundary and Water Commission (IBWC) oversees the distribution of water from the Rio Grande between the two countries. The IBWC, comprising a U.S. and a Mexican section, operates gauging stations in the river to measure the amount of water flowing through. Stream gauges also indicate the amount of water entering the river from individual tributaries, such as those identified in the 1944 treaty. Downstream from Fort Quitman, the Pecos and Devil's Rivers flow into the Rio Grande on the Texas side, but the majority of the river's flow comes from Mexican tributaries. The IBWC's U.S. and Mexican sections meet weekly to compare and reconcile stream and river flow data and to account for water stored in international reservoirs on the Rio Grande.

Mexico's average annual delivery from the six tributaries identified in the treaty must be at least 350,000 acre-feet, accounted for in five-year cycles. If Mexico cannot deliver the required minimum for a five-year accounting cycle because of extraordinary drought or serious accident to the water infrastructure of the six measured tributaries, Mexico must make up the deficit during the following five-year cycle. The treaty does not define "extraordinary drought."

The treaty allots to each country one-half of the water in the Rio Grande from tributaries not identified in the 1944 treaty. Often called "50/50 water," this portion of the Rio Grande consists primarily of unmeasured stormwater runoff entering the river from arroyos and creeks during periods of significant rainfall.

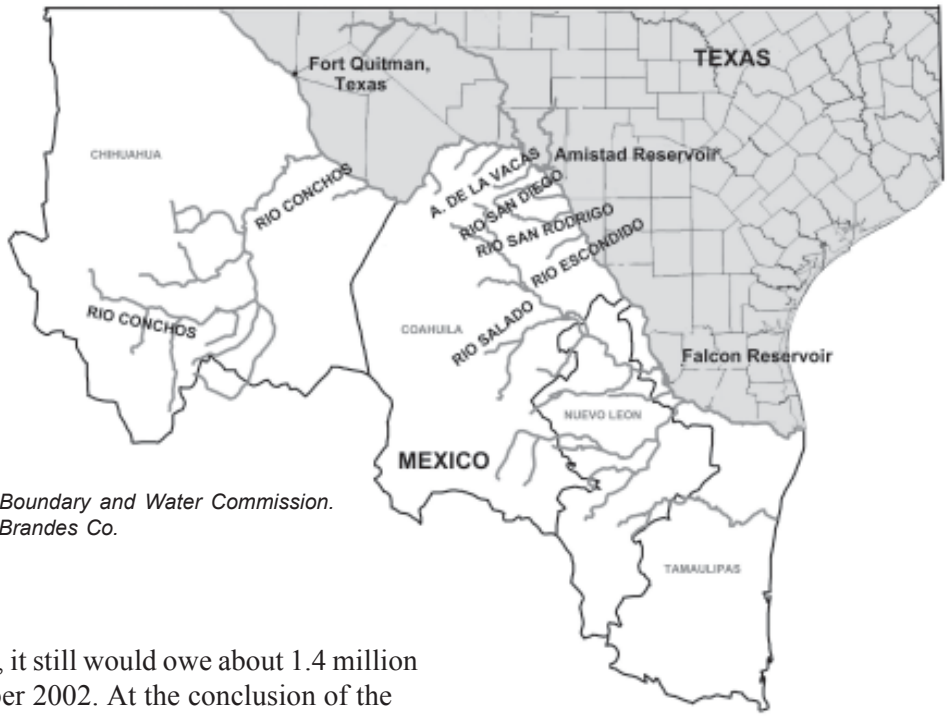
The treaty also calls for the joint construction of at least two storage dams along the river. These dams now form Falcon and Amistad reservoirs, completed in 1953 and 1969 respectively. The United States and Mexico each have water storage capacity in both reservoirs. The IBWC operates the dams and accounts for each country's share of the water stored in the reservoirs. The treaty stipulates that a new five-year accounting cycle begins when the U.S. portion of both reservoirs is filled to capacity. That occurred last in October 1992, the beginning of the 1992-1997 accounting cycle.

Without significant rainfall or the repayment of a substantial part of Mexico's water debt, the Valley could suffer an economic disaster.

Mexico owed the United States about 1 million acre-feet of water at the end of the 1992-1997 accounting cycle. Under the exception for extraordinary drought, the treaty requires the deficit to be made up by October 2002. However, Mexico's water debt has continued to grow during the current accounting cycle. By October 2001, Mexico was in arrears for nearly 400,000 additional acre-feet of water.

Mexico's Foreign Secretariat asserts that the treaty does not require Mexico to repay the total 1.4 million acre-feet by 2002. According to the secretariat, only the deficit from the 1992-1997 accounting cycle must be repaid by October 2002, and any deficit incurred during the current cycle would be due at the end of the next cycle, in 2007. The United States disputes that interpretation, arguing that Minute No. 234 to the treaty requires that the deficit from the current cycle be made up along with the deficit from the 1992-1997 cycle by the 2002 deadline. Thus, even if Mexico meets the required minimum of 350,000

Tributaries Covered by 1944 U.S.-Mexico Treaty



Source: International Boundary and Water Commission. Map courtesy of R.J. Brandes Co.

acre-feet this year, it still would owe about 1.4 million acre-feet in October 2002. At the conclusion of the current cycle in October, the IBWC's U.S. and Mexican sections are expected to make a final determination of the amount of debt accrued during 1997-2002.

Impact on the Valley

Water shortages have a significant negative impact on agriculture in the Rio Grande Valley. Economists have estimated that each acre-foot of irrigation water used in the Valley is worth an average $652 to the area economy. Without significant rainfall or the repayment of a substantial portion of Mexico's water debt, Valley irrigation officials predict a major economic and agricultural disaster for the Valley this year.

As Mexico's water debt has grown, irrigated agricultural acreage in the Valley has decreased. The number of acres of irrigated cropland in Cameron, Hidalgo, Starr, and Willacy counties fell by 14 percent between 1992 and 1997, the period when Mexico's debt began.

Below-average rainfall also has contributed to the Valley's water shortage. In Brownsville, 2000 and 2001 ranked as the ninth and tenth driest years since 1871. Rainfall totals for 2001 in other cities in deep South Texas ranged from five to ten inches below normal.

Currently, water from the Rio Grande does not reach the Gulf of Mexico. The drought, exacerbated by Mexico's water debt, has reduced the amount of water flowing in the river. An accumulation of silt at the mouth of the Rio Grande blocks the river from flowing into the Gulf. This blockage has jeopardized the Rio Grande estuary, a confluence of freshwater and saltwater stretching from the mouth of the river to about 30 miles upstream. Located in the transition between tropical and temperate climates, the estuary is the northernmost breeding place on the western Gulf Coast for snook, a fish popular among sportfishing enthusiasts. White shrimp, one of the three main species of Gulf Coast shrimp, are found in the Rio Grande estuary before they mature and migrate to the Gulf. In addition, Texas' most commercially important crab, the blue crab, thrives in the estuary.

A water-rights system specific to the lower and middle Rio Grande governs the distribution of water from Amistad and Falcon reservoirs. Domestic, municipal, and industrial (DMI) water users have priority over holders of water rights for irrigation or mining purposes. The U.S. portion of the reservoirs includes a reserve of 225,000 acre-feet for DMI water users and a 75,000-acre-feet operating reserve. The remaining water is allocated for irrigation or mining. If the amount of water in the U.S. portion of the reservoirs decreases, water allocations for irrigation or mining are curtailed to maintain the DMI and operating reserves.

Valley irrigation officials attribute Mexico's water debt to inadequate management of the water in the six tributaries specified by the treaty.

Without enough incoming water to replenish withdrawals, the amount of U.S. water stored in the reservoirs has dropped to the lowest level since the dams were built. In January 2002, the combined amount of U.S. water stored in both reservoirs had dropped to 32 percent of capacity, down from 43 percent a year earlier.

Valley water officials say they have been concerned about the accumulation of Mexico's water debt since 1996, when a few of the Valley's 28 irrigation districts first began to receive a limited allocation of irrigation water. The number of districts receiving limited allocations had grown significantly by 1998. This year, with only a minimal amount of U.S. water stored in the reservoirs, farmers in most districts will receive enough water for only one watering. Farmers in the two districts with the highest concentration of agricultural activity probably will receive less than half of the water needed for a single watering.

Sugarcane and citrus crops offer a high return on a farmer's investment but also require more water than low-return row crops, such as grain sorghum and cotton. With farmers likely to receive only enough water for a single watering, Valley irrigation officials expect that most farmers will opt to plant cotton and grain sorghum as dryland crops — a method that relies solely on rainfall to provide water — to preserve irrigation water for the high-return crops. However, most farmers probably will be unable to provide the seven to ten waterings needed to produce sugarcane and citrus crops. In fact, a single watering is barely enough to keep a citrus orchard alive through the growing season.

Reasons for the shortfall

Valley irrigation officials attribute Mexico's water debt to inadequate management of the water in the six tributaries specified by the treaty. They say that Mexico lacks a coordinated policy to manage tributary water to meet local agricultural, municipal, and industrial needs in addition to the country's obligations under the treaty. An April 2000 report by consulting firm R.J. Brandes analyzed runoff and reservoir levels in the six tributary basins and concluded that Mexico should have been able to deliver to the United States enough water to meet all but 115,000 acre-feet of the minimum amount for the 1992-1997 cycle and should not have incurred a deficit during the first two years of the 1997-2002 cycle.

Some irrigation officials also point to increased agricultural production in the Rio Conchos basin and Chihuahua. The Rio Conchos contributes the bulk of the tributary water allotted to the United States under the treaty. Since signing the treaty, Mexico has built five reservoirs in the Rio Conchos basin. During the 1992-1997 cycle, when Mexico accumulated a deficit of 1 million acre-feet, irrigation releases from the largest reservoir on the river totaled about 3.2 million acre-feet, according to the Brandes report. Farmers in this region use an average of more than five acre-feet of water per acre of irrigated cropland each year, a figure twice as large as the maximum possible allotment of irrigation water for Texas farmers in the Valley. In November 2001, the governor of Chihuahua announced plans to build a pipeline to divert more water from the Rio Conchos for use by local factories.

A report by the Texas A&M Agricultural Extension Service shows increased agricultural production in Chihuahua during recent years of drought. The study found a 37 percent increase in agricultural output and a 36 percent increase in yield (tons per acre) from 1990

through 1999, a period in which the number of irrigated acres increased by less than 1 percent. The report notes a decrease in planting of low-return crops, coupled with an increase in planting of high-return and water-intensive crops such as alfalfa, corn, and pecans. The combination of these trends indicates increased use of irrigation water in Chihuahua agricultural production and local farmers' confidence in the availability of a consistent water supply, according to the report.

Before the 1990s, a water surplus allowed Mexico to meet its internal needs and its obligations under the treaty without implementing water management policies. But as demand for water in the tributary basins has grown and recent annual rainfall amounts have been below average, Mexico finds itself unable to meet its own needs while complying with the treaty. To some, it appears that Mexico pinned its hopes on receiving a significant rainfall that would fill the reservoirs and alleviate its water debt.

Mexican officials attribute the water deficit to a severe drought — the most severe in the region's recorded history — that has gripped the tributary watersheds for more than a decade. Mexico's water storage in its portion of the international reservoirs has dropped to less than 10 percent of capacity. Water storage in the Rio Conchos basin is down to less than 20 percent of capacity. Like their counterparts on the U.S. side of the border, Mexican farmers are suffering heavy agricultural losses due to drought conditions and reduced irrigation water.

Mexico rejects allegations that it has used water allotted to the United States to increase its own agricultural production.

Mexican representatives concede that an abundance of steady rainfall in previous decades delayed their recognition of the drought's onset and its severity. With rainfall replenishing creeks, rivers, and reservoirs and supplementing irrigation water for agriculture, the need to develop a sustainable water management plan was not apparent. Indeed, they say, during some years of plentiful rainfall, the United States received more than its allotted share of tributary water.

Mexican officials admit that when the drought first appeared, Mexico did not act quickly enough to implement water management strategies. They also say, however, that the IBWC did not act quickly enough to warn either government of the emergence of the drought and the need to implement measures in response. They argue that strengthening the IBWC's authority during emergency situations to react to impending water shortages would help to prevent similar situations in the future.

Mexico rejects allegations that it has used water allotted to the United States to increase its own agricultural production. Mexican officials say there is no evidence to support such claims. They point out that farmers in the Rio Conchos basin have received less irrigation water each year since the drought has taken hold. Although Mexico has a policy supporting expanded industrial development in northern Mexico as part of the North American Free Trade Agreement, the industries involved use only a fraction of the water used by agriculture. The drought, they say, is responsible for Mexico's inability to repay the water debt or to meet its own needs.

Dispute resolution efforts

In March 2001, following discussions between Presidents Bush and Fox, the two governments announced an agreement under which Mexico would repay 600,000 acre-feet of water by July 31, 2001. The agreement, Minute No. 307 to the 1944 treaty, included a contingency plan under which the repayment deadline could be extended to September 30. The 600,000 acre-feet was to come from Mexico's share of the "50/50 water," the United States' one-third allotment of water from the six measured tributaries, and an additional release of water from a reservoir on Mexico's Rio Salado.

Minute No. 307 also called for the two governments to reach an agreement by the end of 2001 under which Mexico would repay the remainder of the debt. By September 30, the extended payment deadline under Minute No. 307, Mexico had repaid about 348,000 acre-feet of water.

In August 2001, an agricultural union in northern Tamaulipas state filed suit in a Mexican federal court to stop repayment of the water. Other agricultural groups also filed suit. The groups claimed that using Mexico's share of the 50/50 water to repay the debt would damage northern Tamaulipas' farming industry. Farmers in that region depend on scant rainfall and on water from Mexico's share of the 50/50 water. In response, a Mexican federal judge issued an injunction suspending repayment of the water.

By February 2002, legal issues surrounding the 50/50 water had been resolved, allowing the transfer of about 92,000 acre-feet of water. (This estimate is based on preliminary estimates and is expected to be 101,000 acre-feet when the water accounting is finalized.) Including the most recent transfer, about 440,000 acre-feet of water has been credited to the United States under Minute 307.

Environmental concerns. Environmental groups say repayment of the debt could alleviate the Valley's immediate water shortage but would do little to solve the border region's long-term water problems. Drought and Mexico's water debt have magnified the demands on the river to meet the needs of a rapidly growing population and to provide irrigation water for agriculture. The river's severed connection with the Gulf eliminates the confluence of freshwater and saltwater that is essential to a healthy estuary and the life cycle of many forms of aquatic life.

Resolving the dispute, environmentalists say, presents an opportunity to develop a long-term plan for managing water resources in the Rio Grande basin on both sides of the U.S.-Mexico border. A basin-wide plan, they say, would ensure that planning to meet future municipal, industrial, and agricultural demand for water took into account the needs of the estuary and river ecosystem. Drought management strategies and improved water monitoring under the plan could lead to better use of existing water resources. Also, modernizing the Valley's irrigation system, much of which was built in the 1920s, could increase irrigation efficiency by reducing the estimated 25 percent of water lost to evaporation and through cracks in the canals. Implementation of a Rio Grande basin water management plan, they argue, could help prevent problems like the water crisis facing the Valley today.

Governor's plan. In March 2002, Gov. Perry released a plan calling for Mexico to provide immediately 200,000 acre-feet of water to meet Texas' existing agricultural needs and an additional 447,000 acre-feet by the end of the irrigation season, August 31. Under the plan, the total 647,000 acre-feet would come from transfers of water stored in the international reservoirs, deliveries from water held in tributary reservoirs, and Mexico's share of the 50/50 water.

The plan calls for Mexico to develop and implement a plan for managing its reservoirs to ensure the regular delivery of treaty water to the United States. It also recommends the joint development of drought management and sustainable management strategies for the Rio Grande basin, as well as completion by the IBWC of a joint hydrologic model of the river basin.

Regional water plan

Mexico's water debt also may have repercussions for the Valley's regional water plan, a component of the state's regional water-planning process required by the 75th Legislature under SB 1 by Brown. In 2001, the Rio Grande Regional Water Planning Group submitted to the Texas Water Development Board (TWDB) a plan for meeting the region's water needs through 2050. The plan's estimates of the water supply available to the region assume that Mexico will meet its treaty obligations.

SB 1 requires the regional planning groups to update their plans every five years. In developing its 2006 update, the water planning group has requested $344,000 in additional funds to study the impact of Mexico's failure to comply with the treaty. TWDB is expected to consider the request in June 2002.

— by Travis Phillips

(Medicaid, from page 1)

copayments by certain Medicaid recipients. Both options would be voluntary. The work group generally did not favor development of a copayment policy but considered these options less onerous than others discussed. The group specifically ruled out concurrent implementation of both models.

The work group's discussion focused on whether Texas should have a cost-sharing policy and on important considerations in developing that policy, including access to services, appropriate use of services, impact on health-care providers, and administrative complexity.

In most cases, federal regulations prohibit imposing cost sharing on specified categories of Medicaid recipients.

HHSC will review these options and the policy considerations raised by the work group in light of the agency's cost-containment efforts. Because the agency had a legislative directive to implement cost savings under Rider 33, it could make rule changes to implement a cost-sharing program or could proceed to apply for a federal waiver if needed.

Restrictions on cost sharing

Federal Medicaid regulations allow few options to establish cost sharing. Because Medicaid is an entitlement program, a state cannot limit enrollment in or use of the program by those who are eligible. Medicaid primarily serves the poor, elderly, and disabled, and the majority of recipients are children. The federal regulations specify mandatory eligibility groups, including infants born to Medicaid-eligible women, children in low-income families, pregnant women whose family income is at or below 133 percent of the FPL, recipients of Supplemental Security Income, and others. The FPL is now $17,650 for a family of four. States may choose to extend Medicaid eligibility to other groups.

Federal regulations prohibit a state from imposing cost sharing on specified groups of Medicaid beneficiaries. As a result, about 70 percent of Texas Medicaid recipients would be exempt from cost sharing. Also, federal law prohibits requiring cost sharing for certain services, including pregnancy-related services, emergency services, family planning services, hospice care, and institutional services for which clients already must apply their own income.

Cost sharing for the rest of the Medicaid population and for nonexempt services must be nominal and may not result in denial of services. Federal regulations define "nominal" copayments as between $0.50 and $3 for most office-based services. The maximum copayment for hospital services is half of the rate paid by the Medicaid program for the first day of hospital care. If a state can prove that adequate and accessible alternatives to emergency-room care exist, the state may require a copayment of up to $6 for nonemergency use of the emergency room, although the regulations do not define "nonemergency."

Federal regulations allow some cost sharing by exempt groups in two cases. (1) A state may establish a monthly premium for infants under age 1 and for pregnant women with incomes above 150 percent of the FPL. The premium may not exceed 10 percent of the amount by which the family income exceeds 150 percent of the FPL. (2) A state may collect a sliding-scale premium from some disabled workers for whom the state pays Medicare Part A premiums (the hospital benefit portion of Medicare). No state has implemented either type of cost-sharing program, in part because such programs would apply to few recipients and would carry high administrative costs.

In 1982, Texas initiated a $0.50 copayment on Medicaid prescriptions. However, one month after the program began, federal regulations took effect that exempted children and nursing home residents — about three-quarters of the eligible population — from cost sharing. After this exemption, the program was projected to result in a net cost to the state, and the copayment was repealed by rule on October 1, 1982.

Waivers allow flexibility

A state can deviate from some federal regulations by obtaining a waiver. Two types of waivers may apply to Medicaid cost sharing: research and demonstration (1115) waivers, for use in conducting a pilot or demonstration project that otherwise would be prohibited, and Health Insurance Flexibility and Accountability (HIFA) waivers, a type of 1115 waiver designed to increase health insurance coverage for low-income people in a state.

Arizona obtained an 1115 waiver to implement a statewide Medicaid managed-care program in 1982, prior to which the state had no Medicaid program at all. The state's waiver has not expanded eligibility but includes the eligibility groups mandated by federal law. Under the waiver, Arizona requires all recipients to enroll in a health maintenance organization and requires each patient to pay $1 for physician services, $5 for elective surgery, and $5 per nonemergency visit to an emergency room. The copayment is collected at the point of service and is accounted as a reduction in reimbursement to the provider. Other states with 1115 waivers and managed care include Hawaii, Kentucky, Oregon, and Tennessee.

In the current fiscal climate, the federal government may be more likely to consider initiatives outside the established waivers.

HIFA waivers, introduced in August 2001, have been granted only in Arizona and California to expand coverage under the Children's Health Insurance Program (CHIP) to families with up to 200 percent of the FPL. Because HIFA waivers are designed to expand eligibility for health coverage, Texas would be unlikely to obtain one of these waivers to implement cost sharing unless the state planned to expand eligibility as a result.

Meaningful cost sharing could require an alternate form of approval by the federal government. Many states facing tight budgets have attributed some of their problems to rising Medicaid costs. In this fiscal climate, state Medicaid officials believe that the federal government may be more likely to consider initiatives outside the established waivers.

Cost-sharing options

In developing options for Medicaid cost sharing, the HHSC work group considered goals that members felt were important to the success of such a policy, including:

- equity and appropriateness;
- no barrier to services;
- encouragement of appropriate utilization;
- no additional administrative burden;
- no connection between the policy and provider reimbursement; and
- maintaining the dignity of recipients.

The group considered which services and populations cost sharing would include; what impact the policy would have on program costs, provider reimbursement, recipients' use of services, and access to care; and what level of administrative complexity and costs the policy would entail. HHSC will evaluate the work group's recommendations in light of the agency's cost-containment goals.

The first option, an *annual enrollment fee*, would apply to recipients in families with income above 100 percent of the FPL. The voluntary fee, to be paid upon certification or recertification to the program, would range from $5 to $10, with a cap of $15 to $20 per family. The work group suggested that a recipient who chose to pay the fee might receive a different card or some other form of recognition designating the recipient as a partner with the state in the Medicaid program. Cost savings from this option would come entirely from the collection of the enrollment fee.

The second option, a *copayment schedule* in accordance with federal regulations, would apply to adult recipients of Temporary Assistance to Needy Families (TANF), aged, blind, and disabled people, and recipients who live in the community rather than an institution through a Medicaid waiver program. This option also would be voluntary; that is, services would not be denied to those who did not or could not pay. Copayments would apply to emergency room use and branded prescriptions, with certain exceptions, and would be collected at the

Cost Sharing: Medicaid Options vs. CHIP

	CHIP program				Medicaid program	
	Family income relative to federal poverty level					
Cost sharing item:	100%	101-150%	151-185%	186-200%	Option A	Option B
Enrollment fee (per year per family)	$0	$15	$15	$18	$5-10	$0
Monthly premium (per family)	$0	$0	$15	$18	$0	$0
Office visit	$0	$2	$5	$10	$0	$0
Emergency room	$3	$5	$50	$50	$0	$3 (non-emergency)
Generic drug	$0	$0	$5	$5	$0	$0
Branded drug	$3	$5	$5	$20	$0	$1-3 (with exceptions for certain drugs)
Facility copayment, inpatient (per visit)	$0	$25	$25	$100	$0	$0
Facility copayment, outpatient (per visit)	$0	$0	$0	$0	$0	$0
Cap on cost sharing	$100	$100	5% of net income	5% of net income	$15-20	$100 per family

Note: Medicaid Option A would apply to all families with income above the federal poverty level; Option B would apply only to non-pregnant adults who live in the community.

Source: Texas Health and Human Services Commission.

point of service and retained by the health-care provider. Copayment amounts would be capped by the number of prescriptions and annual amounts paid. The state would save costs under this option through use of lower-cost services, such as by diverting patients from emergency rooms to doctor's offices.

For and against cost sharing

In the commercial insurance market, insurers assign copayments to different services and products to encourage the insured to use the most cost-effective services. For example, an office visit typically requires a lower copayment than does a visit to an emergency room. Texas' CHIP program employs this model with a sliding scale to ensure access to appropriate services at all income levels. (See box, page 10.)

Supporters of Medicaid cost sharing say that it can help prepare recipients for future self-sufficiency. Requiring recipients to pay a small monthly cost or copayments, supporters say, prepares them to manage higher monthly costs for health care once they are no longer eligible for Medicaid. Other supporters say that contributing to the cost of health care may remove the "welfare" stigma often associated with Medicaid and encourage recipients to work toward greater self-sufficiency.

Supporters note that other public assistance programs are moving toward requiring greater participation by recipients. TANF, the federal-state cash assistance program, carries work requirements that have been strengthened in recent years. Only Medicaid provides unlimited benefits without some form of participation by the client. Supporters of cost sharing say the state should bring Medicaid in line with other types of assistance.

Some opponents say that cost sharing runs counter to the spirit of Medicaid, which was designed to ensure that medical care is available to all residents whose family income falls below certain levels. By requiring recipients to help pay for their medical care, opponents say, the state would shirk its responsibility to ensure access to care. Even voluntary cost sharing, they say, could prevent some of the intended population from receiving care, because some recipients may feel that, if the state asks them to contribute, they should not use health-care services unless they can help pay for them.

Opponents also note that the majority of Medicaid recipients are children and that most adults in the program are pregnant women, elderly, or disabled people who are unlikely to become more financially self-supporting. Programs such as TANF require job training or education that leads to greater self-sufficiency. However, opponents say, paying part of a Medicaid bill does not teach recipients additional skills that will help them become more self-sufficient. Also, they argue, the Medicaid population is fundamentally different from the CHIP population, in which most families have at least one employed adult, so while the self-sufficiency argument may apply to CHIP, it does not apply to Medicaid.

Policy considerations

Beyond the general question of whether Texas should implement a cost-sharing program, stakeholders discussed the possible impact of certain aspects of a cost-sharing program on parts of the Medicaid system. The work group recommended that HHSC evaluate these concerns in crafting any cost-sharing policy.

Access to care. One area in which states have tried to rein in expenses through cost containment is prescription drugs. Strategies include copayments, limiting the number of prescriptions, generic substitution, prior authorization, and step-therapy protocols that require a physician to try lower-cost alternatives before prescribing expensive drugs. A recent study by the nonpartisan Center for Studying Health System Change found that one-quarter of adult Medicaid recipients said they could not afford to have a prescription filled in the previous year. Recipients living in states with multiple cost-containment strategies faced the greatest difficulties, while recipients in states with a single cost-containment strategy reported no impact on access. Texas already imposes a three-prescription limit for TANF adults not in managed care and for disabled adults living in the community. Also, the state requires substitution of generic drugs for branded drugs. Given that copayments may influence the behavior of recipients who feel obligated to pay, some may go without needed care or inappropriately use emergency rooms, where patients generally obtain treatment before payment is discussed.

CHIP: A Possible Model for Cost Sharing

The Children's Health Insurance Program (CHIP) and its counterpart serving children of state employees, the State Kids Insurance Program, are state-federal programs in which the federal government matches state spending at a 3:1 ratio, higher than that for Medicaid. These programs were established to provide health insurance to children who live in families with incomes too high to qualify for Medicaid but too low to afford private health insurance.

CHIP requires cost sharing in the form of an enrollment fee, monthly premiums, and copayments for certain services. As in the employer-sponsored commercial market, where the insured shares the cost with the employer, the state contracts with CHIP insurers and pays part of the cost. The level of required financial participation in CHIP is set on a sliding scale, with caps on the amount a family must pay over a specified period of time. According to the Health and Human Services Commission, fewer than 1 percent of families who drop out of CHIP have reported that cost sharing prohibited their continuing in the program. The effect of recent increases in Texas CHIP cost sharing, implemented in March 2002, has not yet been evaluated.

Administrative burden. A cost-sharing program would require an investment in education to explain the policy and could require issuance of new cards or other materials to document the cost-sharing arrangement. The program also could involve accounting for payment of the fee, either upon enrollment or at the point of service. In CHIP, the cost-sharing schedule is high enough to cover the administrative cost, and nonpayment of the enrollment fee or premium can result in denial of coverage. However, the voluntary nominal enrollment fees considered appropriate for the Medicaid program would be unlikely to cover the administrative cost of collecting the fee.

Voluntary copayments for Medicaid services would be collected at a doctor's office, emergency room, or pharmacy through methods already established for the collection of private insurance copayments. As long as Medicaid copayments were not accompanied by a reduction in provider reimbursement rates, this type of cost sharing would not increase the administrative burden to providers. However, some providers and stakeholders foresee that copayments could result in reduced reimbursement in the future and that additional documentation and audits required to account for collection of the copayments could increase the administrative burden. Any additional burden could discourage provider participation in a system for which services already are stretched.

Influencing behavior. Representatives of commercial insurers say that copayments have not changed patient behavior substantially unless set at high levels, such as $50 per visit. Some stakeholders maintain that the low copayments deemed appropriate for the Medicaid population are unlikely to influence behavior in a positive way. For example, they say, a copayment of a few dollars is unlikely to deter a determined recipient from using an emergency room or branded drugs. If recipients did not understand that the copayment was voluntary or were embarrassed that they could not pay in the doctor's office or pharmacy, some recipients might use emergency rooms inappropriately because they cannot be held liable for copayments there and, in practice, the subject of copayments does not arise until after service is rendered. This would result in higher cost to the Medicaid program and could add to the burden of hospitals, who are required by federal law to treat each patient who walks into a emergency room.

Appropriately influencing behavior may be difficult with a diverse Medicaid population. In some areas, the local emergency room is the only health service available after hours and on weekends. Some stakeholders argue that patients in those areas should have access to care without a required copayment. Others point out that some groups of Medicaid recipients may need greater access to branded drugs, such as new-generation antipsychotics, and should not be encouraged to switch medications.

State costs. Because the computer system that Texas' Medicaid program uses to track funds and client eligibility is expensive to modify, some stakeholders say the cost of tracking copayments could be prohibitive. Proposals that do not include tracking, such as those in which the provider would retain the copayment, still would require the state to print new material and cards for the Medicaid population.

Some steps could reduce potential drawbacks of cost sharing. The Families USA Foundation's recommendations for a cost-sharing policy include:

- Set caps on total out-of-pocket expenses and on the amount of cost sharing for certain services. This would ensure that recipients with legitimately high use of the Medicaid program, such as the sickest or those with large families, are not overburdened.
- Prohibit cost sharing on preventative services, specified prescription drugs, home health services, and durable medical equipment. Use of these services can save money in the Medicaid program by averting use of higher-cost services, such as emergency rooms.
- Prohibit or limit cost sharing for nonemergency services provided in an emergency room. Defining nonemergency use is difficult and could result in blocking access to care.
- Prohibit the sale or transfer of cost-sharing debt to a bill collection agency. Even though providers would be unlikely to pursue nominal copayments, some might send unpaid bills automatically to collection agencies. Changing their accounting systems would be a cost to these providers, and not changing it could result in recipients being pursued for voluntary payments.

— by Kelli Soika

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