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MEDICAID CO-PAYS

Proposals moving ahead

The 2011 Texas Legislature is considering a range of bills that would make major changes to Medicaid, from block granting the program along with Medicare and all other federal health funding, to using Medicaid as the laboratory for testing new models of care delivery and payments. Several bills, including the House and Senate budget bills, assume provisions to start charging some level of co-payments in Texas Medicaid. Given the current extreme revenue shortfall, the pressure to introduce co-payments is greater than ever before; for example, adoption of co-payments for visits to the emergency room that involve non-emergency medical care is considered likely. This ***Policy Page*** describes the Health and Human Services Commission's (HHSC) proposals for Medicaid and the Children's Health Insurance Program (CHIP) co-payments, the changes proposed in current bills, and the federal law and rules that Texas must comply with when imposing Medicaid and CHIP co-payments.

Co-Payment Proposals Today—and How We Got Here

State law has authorized HHSC to implement general Medicaid co-payments since 2003, and co-payments for visits to the emergency room for non-emergency medical care since 2007;[1] but that option has not been exercised. In the 2011 Legislature, both chambers' budget bills and several bills moving through the legislative process direct HHSC to implement Medicaid co-payments for the first time since a very brief experiment in 1982 (more history below). HHSC's co-pay proposals are described in presentations to the Senate Finance Committee, (http://www.hhsc.state.tx.us/news/presentations/2011/sfc-co-pay-0211.pdf) and include:

- adoption of a new co-payment for emergency room (ER) visits for non-emergency medical care which will apply to all Medicaid enrollees;
- co-payments applied to adults on Medicaid for prescription drugs and office visits; and
- higher co-payments for CHIP children.

HHSC estimates that implementing the Medicaid co-payments will have a *net cost* of $2.7 million in general revenue to the state budget in 2012-13, because the state will need to build computer systems to keep track of how much a person has spent on co-payments to ensure it does not exceed 5 percent of their income. For CHIP, HHSC projects increased co-payments will offset program costs with about $8 million in revenues.

HHSC's Rider 61 in the House and Rider 58 in the Senate committee substitute call for "maximizing co-payments in all Medicaid and non-Medicaid programs." Senate Bill (SB) 7 by Nelson would amend current Texas Medicaid co-payment law to direct HHSC to adopt cost-sharing for Medicaid and CHIP in consultation with a new Quality-Based Payment Advisory Committee, with a specific instruction to adopt co-payments for patients who seek care in the ER for non-emergency medical conditions. In SB 7, this provision is matched with new policies designed to improve Medicaid clients' access to urgent care outside the ER, as well. In addition, House Bill (HB) 2368 by Parker and HB 2478 by Perry also call for adopting co-payments for ER visits for non-emergent care.

A Look Back

1982

Texas Medicaid had a brief experiment with copayments in 1982, when a 50 cent prescription co-payment was adopted. Pharmacists were expected to collect, track, and report co-payments, and it was quickly determined that the administrative cost to the state would eliminate any net savings. The policy was repealed after one month. Of course, information technology supporting Medicaid providers was still quite limited in 1982. Although the practical considerations for tracking and reporting co-payments are very different in 2011, concerns about creating barriers to needed care are unchanged today.

Federal Law on Medicaid Co-Pays

- No co-payments allowed for children, pregnant women, kids in foster care, or adoption assistance, hospice patients, breast and cervical cancer patients, or those whose income has already been used to pay for care (e.g., nursing home residents)
- Exception to above is allowed for ER visits for non-emergency care
- There are upper limits on co-payments by service type and by income tiers, updated for inflation
- Total cost-sharing in cannot exceed 5 percent of family income in any month
- No one below 100 percent federal poverty level can be *denied* care if they cannot pay
- No co-payments allowed for true emergency care, family planning, or well-child care

For a detailed summary of cost-sharing rules in Medicaid and CHIP: see *Cost Sharing for Children and Families in Medicaid and CHIP* at: http://ccf.georgetown.edu/index/cms-filesystem-action?file=strategy%20center/cost_sharing_final.pdf

2002

A rider in the budget bills for 2002-03 reduced overall Medicaid appropriations by $205 million general revenue, and directed HHSC to achieve these savings through a list of cost-saving proposals, including Medicaid co-payments. Though the required savings had already been identified, HHSC announced in March 2002 that the agency would promulgate a co-payment policy, convened a stakeholder workgroup (hospital, physician, pharmacy, HMO, and consumer advocates) to comment on the agency proposal (http://www.hhsc.state.tx.us/medicaid/reports/Cost_Sharing_Sum_042102.html), and issued proposed rules in October 2002. A State District Court granted a temporary restraining order in December 2002, and the rules were never implemented.

For more information, see: http://www.cppp.org/files/3/pp172.pdf
http://www.cppp.org/files/3/PP176.pdf

2003

HB 2292 cut just under $1 billion general revenue ($2.6 billion All Funds) from the Medicaid and CHIP programs, and among its hundreds of provisions was a mandate for HHSC to impose Medicaid cost sharing to the extent allowed under federal law. The cost-sharing options listed in the bill, however, were neither allowed or even "waiveable" under federal law. The HB 2292 provision was never implemented due to a number of factors including the ongoing reluctance of providers to collecting co-payments and/or have their fees reduced, and the HHSC administrative costs of implementing the new policy at the same time as dozens of other major policy changes.

For more information, see: http://www.cppp.org/research.php?aid=35
http://www.cppp.org/research.php?aid=61

2007

SB 10 included authorization for Texas Medicaid to implement co-payments for ER visits for non-emergency medical care, consistent with federal law. A 2006 federal law had just established this new co-payment option, applied to all Medicaid enrollees under these specific circumstances:

1. the hospital must provide the client with the name and location of an alternate provider that is available and accessible; and
2. make a referral to help with scheduling of the treatment. If a client still chooses to seek the treatment of the non-emergent care in the Emergency Room, they may be charged a limited co-payment.

SB 10 also called on HHSC to make a determination that the new co-pay would be "feasible and cost effective" before implementing, and the analysis commissioned by the HHSC and completed in 2008 concluded that the policy would *not* meet that test.

For more information, see: http://www.hhsc.state.tx.us/reports/HospitalEmergencyRoomsAnalysis_0708.pdf

2011

Several bills in the current legislative session call for Medicaid co-payments with the budget bills including a general reference to co-payment and three other bills promoting a new co-payment for ER visits for non-emergency medical care. Of these, SB 7 by Nelson is notable for several reasons. First, it stops rewarding high volume of services or denials of care, and provides financial incentives for improved health outcomes and quality, and reductions in "potentially preventable events." In addition, it recognizes that Medicaid patients often seek ER care because little attention has been paid in the past to creating alternative and accessible sources of urgent care for Medicaid enrollees. The bill requires that health providers who want to be reimbursed as "quality-based health homes" must provide for access to care outside of regular business hours. It also requires HHSC to study the cost-effectiveness of Medicaid HMOs' physician incentive programs designed to reduce hospital ER use for non-emergent conditions, to identify cost-effective approaches and any statutory changes needed to apply those models across Medicaid, and then to implement a cost-effective physician incentive program for the entire Texas Medicaid program. These provisions are based in part on recommendations in the Legislative Budget Board's (LBB) 2011 Government Effectiveness and Efficiency Report.

Presumably because the earlier HHSC evaluation (required by SB 10 from 2007) found that implementing co-payments would not be cost-effective, SB 7 also *removes* from Texas the requirement that co-payment implementation be determined "feasible and cost effective." In contrast many other provisions in SB 7 remain conditioned on meeting that test.[2] The bill also removes the 2007 provision that prohibited HHSC from reducing hospital reimbursement for ER visits to account for the assumed collection of a new co-payment.

HB 2368, 2478, and 13 also address Medicaid co-payments. HB 2368 by Representative Parker calls for co-payments for non-emergency conditions treated in the ER similar to the SB 7 provisions, and proposes upper limits of $5 per hospital outpatient department, $5 per physician visit, and $7.50 per prescription. HB 2478 by Representative Perry directs HHSC to adopt policies that will encourage federally qualified health centers and other health clinics to offer evening hours. The bill also provides for denial of care to Medicaid enrollees seeking care for a non-emergent condition in the ER unless there is no alternative source for the care being sought within 50 miles; however, this would conflict with the 2006 federal law and would not be allowed. HB 13 by Chairman Kolkhorst would direct HHSC to seek a major waiver of federal Medicaid law that

would include "co-payment requirements similar to private sector principles for all eligibility groups." Presumably, HB 13 intends to add co-payments for prenatal care and children's well and sick care which are not allowed under federal law, and it is important to note that federal Medicaid law may not allow these provisions to be waived, even under section 1115 demonstration waiver authority.

More on the HHSC Co-pay Proposal

As noted above, the HHSC presentation to the Senate Finance committee provides a well-detailed description of their concept for adding Medicaid co-payments. HHSC does not intend that co-payments adopted for Medicaid adults as allowed under federal law be linked with a reduction in provider payment rates, with the exception of the non-emergency use of the ER. Federal law (see box on page 2) will not allow a service to be denied to a person who cannot afford a Medicaid co-payment and who has below-poverty income.[3] According to the HHSC testimony, more than 90 percent of Texas Medicaid enrollees have income below the federal poverty line. The agency rationale is that it is not reasonable to reduce provider fees based on expected collection of co-payments for this population.

HHSC must build a system for tracking co-payments paid by Medicaid enrollees, to ensure that they or no family is required to make further Medicaid co-payments after they reach 5 percent of their family income, a requirement of federal law. HHSC estimates that implementing the Medicaid co-payments will have a net cost to the state budget in 2012-13 of about $2.7 million general revenue for this reason.

While the non-emergent medical care ER co-payments can be implemented relatively soon by hospitals—if they can meet the federal standard for directing clients to alternative care locations—the agency will not expect to have the tracking system for other client co-payments (e.g., office visits and prescriptions) ready to support the system before state fiscal year 2013. That target date assumption is contingent on continued on-time roll-out of and modifications to the TIERS system.

HHSC's Medicaid Co-payment Proposal (Adult Enrollees)

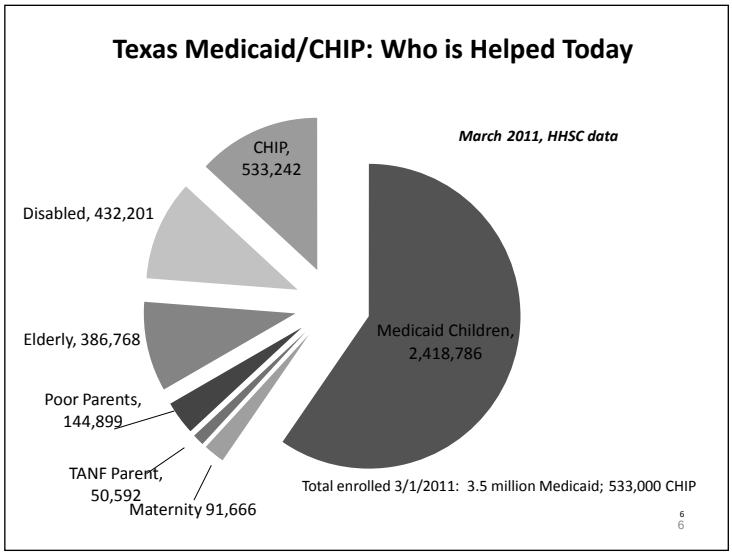
	Less Than 100 Percent of the Federal Poverty Line		101-150 Percent of the Federal Poverty Line	
	Legal Maximum*	**HHSC proposed**	**Legal Maximum***	**HHSC proposed**
Non-Emergency Care in ER	$3.65	$3	$7.30	$5
Generic Medication	$1.25	$0	$2.27	$2
Brand-Name Medications	$3.65	$3	$19.59	$5
Office Visits	$2.45	$2	$3	$3

*** Updated annually for inflation**

Source: HHSC 2/23/2011 presentation to Senate Finance Committee
http://www.hhsc.state.tx.us/news/presentations/2011/sfc-co-pay-0211.pdf

CPPP Recommendations

- **Co-payments for ER use for non-emergency medical care** should be carefully implemented, ensuring full compliance with federal law. This means they can *only* be implemented in hospitals where an available alternative site for care (with no or a lower co-pay than the ER) exists, and where the hospital will refer the patient for that care. CPPP supports this implementation in large part because SB 7 takes meaningful steps to improve access to after-hours and urgent care, through the physician pay incentives and HMO standards described above. Federal regulations are clear that these co-payments are not allowed where no alternative care site is available. The new co-payment's financial incentive will work best to redirect families to less costly sites only if it is matched—and thereby reinforced—with strong good-faith-efforts by Texas Medicaid to increase ease of access to those sites.



- **Proposed co-payments for adults on prescription drugs and office visits, so long as they are consistent with federal law can be a reasonable component of Texas Medicaid.** Of course, relatively few Texas Medicaid enrollees are subject to these co-pays today, since children and maternity patients are excluded. But given that federal law would expand Medicaid to a much larger group of adults in 2014, it makes sense to begin building the system for tracking enrollee cost sharing now. Today 2.4 million Texas children but fewer than 200,000 of their parents are enrolled, because only parents with incomes below 12 -20 percent of the poverty line qualify, but in 2014 U.S. citizen parents (and other equally poor citizen adults) will qualify up to 133 percent of the Federal Poverty Line (FPL). HHSC projects December 2012 as the earliest date for a co-payment tracking system to be available, which presumably means that would be the earliest date for non-ER co-pays for adults to be launched.

- **CHIP co-payment increases proposed by HHSC are generally reasonable in the context of the current revenue shortfall, with some exceptions.** Federal CHIP laws require a protection similar to Medicaid's that cost sharing not exceed 5 percent of family income. CHIP children with incomes below poverty[4] (about 10% of Texas CHIP-enrolled children according to HHSC) have upper limits similar to those in Medicaid, and there are tiered limits for children in families between 101-150 percent FPL, 151-185 percent, and 186-200 percent FPL. Texas already imposes CHIP co-payments close to the federal limits; HHSC proposed changes are to:

  (1) increase co-payments for generic drugs

  (2) allow cost-sharing up to the federal maximum (capped now at a lower percentage); and

  (3) increase co-payments for hospital stays.

CPPP has concerns that HHSC-proposed prescription drug co-pays may not reward generic use strongly enough, but the overall proposal is appropriate in the context of deep across-the-board spending reductions for health care programs across the state budget.

Co-payments in Perspective. In closing, legislative and agency Medicaid and CHIP co-payment proposals must be weighed in the current context: our current state revenue crisis, and the good-faith attempts to change financial incentives, require health systems to provide alternative access to urgent care, and to reduce perverse incentives that may make it financially advantageous for some hospitals to allow continued non-emergency traffic in the ER.

At the same time, in our national determination to get health care spending and government deficits under control, we must not make the mistake of targeting only Medicaid spending. Solutions to control the U.S. health spending growth must not be pursued on the backs of the poorest and weakest among us. Health care costs for Medicare and privately insured Americans are growing faster than for Medicaid. Focusing cost controls on Medicaid alone isn't just wrong—it won't work.

Federal laws provide strong protections against undue hardship for Medicaid enrollees for cost-sharing. Advocates for Medicaid beneficiaries should give those protections a chance to work: trust, but verify. Skeptics who wish those legal protections weren't there at all should also give co-payments *under the law* a chance. After all, Texas Medicaid has only one month of co-payment experience back in 1982 under its belt, and it cannot be plausibly argued that unlimited co-payments are needed when we have not even tested co-payments as in current law.

Endnotes

[1] Human Resources Code, Sec. 32.064 and Sec. 32.0641.

[2] See for example in Section 1 of the bill subsections 536.102, 536.202; 536.203; 536.086; 536.0861.

[3] One area of potential confusion in the HHSC presentation is that the agency used the term "not required to pay" co-payment to indicate populations who cannot be denied care for non-payment. The populations described as "not required" to pay co-pays will (1) be asked for a co-pay, and (2) the unpaid co-payment can be pursued by the provider as a debt, but (3) the patient may not be denied medical care.

[4] Texas is one of only 3 US states with an asset limit for Medicaid children (with UT and SC); this pushes some children in poverty into CHIP.

Other CPPP reports dealing with Medicaid co-payments and not already linked above can be found at:
http://www.cppp.org/files/3/pp132.pdf (2001);
http://www.cppp.org/files/3/POP%20287%20MEDICAID%20REFORM%20BILLS.pdf (2007); and
http://www.cppp.org/files/3/HHSC%20320.pdf (2008).