THE POLICY PAGE
An Update on State and Federal Action

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CO-PAYMENTS FOR ADULTS IN MEDICAID: WILL THE JUICE BE WORTH THE SQUEEZE?

Comments on Proposed Rules Due by Nov. 12

The Texas Health and Human Services Commission (HHSC) published proposed rules pertaining to "Cost Sharing Requirements for Medicaid Recipients" in the October 11, 2002, issue of the *Texas Register*. The proposed rules would create co-pay requirements (described below) for most adult Texas Medicaid recipients. A firm start date for the co-payment policy does not appear to have been set, but HHSC has indicated the earliest possible date would be December 16, 2002.

BASICS

Comments on the co-payment proposed rules must be submitted by 5:00 p.m. C.S.T. Tuesday, November 12, to Dee Sportsman, Program Development, Medicaid/CHIP Division, Texas Health and Human Services Commission, 1100 W. 49th Street, MC Y-997, Austin, Texas 78756-3199 or via facsimile at (512) 794-6818. The text of the proposed rules can be found in the *Texas Register* at 27 TexReg 9514 October 11, 2002, or viewed online at http://lamb.sos.state.tx.us/texreg/issues.html. A public hearing on the rules was held on October 21, 2002, but it is not too late to voice your position on this proposal. This *Policy Page* describes the proposed rules, the political and legal Texas context for their development, federal policy governing the topic, and research on how co-payments affect access to care. The proposal can be viewed at http://www.hhsc.state.tx.us/Medicaid/reports/102002__ProposedCoPay.html.

BENEFITS SUBJECT TO CO-PAYMENTS.

The proposed co-payments would be required for two types of benefits:

1. Non-emergency services provided in an emergency department in the amount of $3 per non-emergency visit.
2. Prescription medicines. Co-pay requirements will be 50 cents for generic prescription medications, and $3 for each brand name prescription (even if no generic substitute for that brand name exists). Over-the-counter drugs prescribed by a physician will not be subject to co-payments, nor will birth control pills or other contraceptives (federal Medicaid rules prohibit co-payment for family planning supplies).

Monthly Cap. Total co-payments for an individual will be limited to $8 for any single month. Medicaid currently does not have the computer system capacity to keep track of co-payments, so for the foreseeable future, it will be up to each client to keep track of his own spending. Clients will be required to keep receipts and should expect to provide proof that the $8.00 maximum has been met. No additional payments will be due after the cap is reached.

Access to Benefits Guaranteed. Under federal law and rule, hospital and pharmacy providers cannot deny services on the basis of the recipient's inability to pay. HHSC has clarified that under federal rule, pharmacies and hospitals can choose to bill Medicaid enrollees for unpaid co-payments, or to attempt collection from the patient via other means at a later time. Services or prescriptions can never be denied due to unpaid co-payments, however.

Who will be subject to co-payments? Federal Medicaid law and policy prohibit co-payments for children (under age 18, but Texas will exempt children through their 19th birthday) or pregnant women (see summary of federal requirements, below). Also exempt from the Texas proposal are: adults living in state schools, nursing homes, or other institutions, adults "spending down" for Medically Needy coverage, and adults using hospice services.

Groups proposed to be subject to co-payments in Texas Medicaid are those adults not prohibited by federal law. In 2003 HHSC estimates about 583,000 adults will be subject to co-pays; of whom 74.6% are aged, blind or disabled persons on SSI; 19.7% are adults with dependent children at TANF income levels; and 5.7% are seniors and people with disabilities with incomes above SSI in community care waiver programs. More specifically:

- seniors and adults with disabilities who receive Supplemental Security Income (SSI). SSI provides

cash assistance to seniors (age 65 and older) and disabled adults with incomes not exceeding $545 per month in 2002 (74% of the poverty income for an individual). An unknown number of seniors and disabled persons on SSI in Texas live in informal "board and care" settings where they turn over most or all of their monthly check to the landlord. How they will fare under co-payments is a special concern.

- adults receiving Temporary Assistance for Needy Families (TANF), and adults who meet TANF income limits but do not receive TANF ("section 1931" adults). Texas TANF provides cash assistance (plus limited employment preparation services and child care) to parents with dependent children for a limited time period (not to exceed 3 years), who have incomes less than 32% of the federal poverty line, or $395 per month for a working parent with 2 children. A parent working more than 19 hours per week at minimum wage ($5.15/hour) would have income too high to continue receiving TANF and Medicaid.

  The 1996 federal welfare law, PRWORA, required states to ensure Medicaid eligibility for persons who met each state's 1996 cash assistance standards, whether the parents get TANF cash assistance or not. Texas currently places these parents in the Medically Needy "without spend-down" category, because of computer system limitations. Income limits are the same as for TANF.

- seniors and disabled adults in Community Care waivers with incomes above the SSI level. These are limited-enrollment Medicaid programs designed to allow seniors and individuals with disabilities to remain in a home or community-based setting, rather than a nursing home. The income limit for these programs is 3 times the SSI cap, or $1,635 per month (221% of the poverty income for an individual).

It is important to note that 94% of persons subject to co-pays will have income below the poverty income line.

WHAT FEDERAL MEDICAID LAW AND RULE SAY ABOUT CO-PAYMENTS

The use of co-payments in Medicaid allowed under federal law is quite limited. The law even specifically limits what can and cannot be waived under an 1115 demonstration waiver. The Centers for Medicare and Medicaid Services (CMS – formerly HCFA) closely scrutinizes cost-sharing requirements for persons below poverty, and especially those who fall into eligibility categories that are mandatory for states to cover under Medicaid. A quick guide is provided below.

Co-Payments: Federal law limits strictly the use of co-payments in "regular" Medicaid and in standard Medicaid Managed care:

- No co-payments for anyone under age 18
- No co-payments for pregnancy-related services, or services affecting the pregnancy

This means only adults on TANF or at TANF income levels, and disabled or elderly on SSI or in Community Care waivers, can have co-payments applied.

- No co-payments for nursing homes, institutional care for mental retardation (ICF-MR), or hospice services (nursing home and ICF-MR clients are already required to give most of their income to Medicaid to help defray the costs of that care).
- No co-payments for Emergency Services.
- Co-payments for these adults must be "nominal," currently defined in federal regulations as not exceeding $3 for the most expensive services.
- Services must be provided, regardless of the client's ability to pay the co-payment.

What about 1115 waivers? Federal Medicaid statute clearly limits the scope of waivers of co-payment rules under 1115 authority. Two kinds of waivers are allowed with respect to mandatory Medicaid populations (the categories of persons states must serve in their Medicaid programs):

(1) The nominal co-payment for NON-emergency use of an E.R. can be doubled to $6 with an approved waiver, but the State must establish that beneficiaries "have actually available and accessible to them alternative sources of non-emergency, outpatient services"); and

(2) States may conduct a methodologically sound demonstration project involving control groups, etc. Among other criteria, the project must either be voluntary for beneficiaries or must make "provision for assumption of liability for preventable damage to the health of [beneficiaries] resulting from involuntary participation."

Existing Waivers. Arizona's Medicaid program (which consists entirely of an 1115 waiver) was "grandfathered" to allow co-payments for all enrollees since implementation in 1982, largely because the program was developed and negotiated before the implementation of the exemption of pregnant women and children in OBRA 1981 (implemented nationwide October 1982). No services can be denied if a client is unable to pay. Tennessee, Kentucky, and Oregon currently exempt everyone under 100% of poverty from co-payments in their 1115 waivers. Generally, under 1115 waivers states have been allowed to charge co-payments to groups above the poverty income, as well as for expansion populations and eligibility groups not mandated to be served under federal Medicaid law (e.g., childless adults). To illustrate, Oregon's waiver exempts pregnant women and children from both premiums and co-payments, and exempts other mandatory Medicaid populations (e.g., SSI beneficiaries and Section 1931 adults) from premiums, but not from co-payments. Persons not in a mandatory Medicaid category are subject to both premiums and co-payments.

Law and Rule Changes Could Change the Landscape. Many experts believe that co-payments cannot be extended under waiver authority to children or pregnant women without a change in federal law, unless the co-payment policy meets one of the two standards listed above. Still, some states have requested waiver approval of policies historically believed to be unallowable. For example, Washington has requested approval of a still-pending 1115 waiver which would impose $5 co-payments for certain brand-name drugs for all enrollees, and a $10 co-payment for all non-emergency E.R. visits. If CMS approves such a proposal, national experts expect it would face a legal challenge. Thus, changes in the populations (pregnant women, children) and services (e.g., emergency care, institutional care, family planning) currently exempt from cost sharing may require Congressional action, even for inclusion under an 1115 waiver. However, the dollar amounts defined as upper limits for "nominal" cost-sharing in Medicaid are defined in federal rules (not statute), and could be raised through a change in federal regulation. The definitions of "nominal" rates for Medicaid cost-sharing also govern CHIP cost sharing for families with incomes under 150% of poverty, so a change in the Medicaid rule would also affect CHIP programs.
For a longer discussion of federal law and rules, and recent policy developments in states' waivers and waiver requests, see:
http://www.familiesusa.org/Action%20Kit%20State%20Advocates/6_Cost%20sharing.pdf.

THE JUICE:

How will co-payments reduce state Medicaid spending?

Pharmacy Cuts. The state is planning to reduce payments to pharmacies by 50% of the amount of co-payments they could potentially collect. In other words, though clients will be allowed to get their prescriptions regardless of whether or not they can afford to pay their 50 cents or $3, the state will assume that pharmacies are collecting at least half the time, and will reduce payments to the pharmacy based on that assumption, e.g., by 25 cents for every generic prescription, or $1.50 for each brand-name drug that was subject to co-payment. HHSC estimates $3.3 million GR (state dollars) in savings to the state budget in 2003 alone because of these reductions ($8.9 million GR for 2004 and 2005). It is not yet clear whether the state will adjust the cuts to pharmacy reimbursement to reflect the prescriptions that are not subject to co-pay because a client has reached his $8 cap.

Additional savings could result if Medicaid enrollees ask their doctors to switch them to a generic drug in order to access the lower co-payment. Texas Medicaid already enjoys nearly 100% generic substitution when prescriptions are written for which a generic substitute exists. But there are many drugs for which no generic substitute exists (a generic is literally the same chemical compound as the brand), and only by switching to a completely different drug which can be used to treat the same condition could the Medicaid recipient reduce his co-payment, and save the program money (e.g., change from Celebrex to ibuprofen for arthritis). The enrollee would have to ask his pharmacist to contact the doctor to authorize such a change, because this type of "therapeutic" (as contrasted with generic) substitution is not allowed under Texas law without the physician's specific directive. Because generics are so much cheaper on average, HHSC estimates Texas Medicaid would save $1.8 million GR annually for every 1% of prescriptions redirected from brand name to generic.

Texas pharmacy owners are less than enthusiastic about the proposed co-payments and cuts for a variety of reasons. They are not convinced that they will consistently collect at least 50% of co-payments, believe they will incur administrative costs related to the collection of the co-payments, and have concerns about clients being discouraged from getting medically necessary drugs. In addition, the co-payments are being implemented at the same time as several other payment changes for pharmacies which create concerns about the profitability of filling Medicaid prescriptions.

In response to these concerns, HHSC has announced that the agency will delay pharmacy reimbursement reductions for co-payments for six months, and work with pharmacy representatives to develop a process for pharmacies to report co-payment collection rates and other information during the six month period. HHSC has also indicated that the start date for pharmacy and E.R. co-payments will be "on or after" December 16, to allow pharmacy co-payments and other pharmacy reimbursement changes to begin at the same time.

Emergency Room. Federal Medicaid law and rule prohibit state Medicaid programs from imposing co-payments for emergency services; thus Emergency Room (E.R.) co-payments are only allowed for visits deemed to be non-emergencies. Another federal law, the Emergency Medical Treatment and Active Labor Act (EMTALA), strictly prohibits hospitals from requesting payment for E.R. services until after all medically necessary services have been provided, so this new co-payment will be requested only after patients have received any treatment. HHSC is not at this time proposing to reduce payments to hospitals based on co-payment collection. However, if the introduction of the "non-emergency" E.R. co-payment has an impact on E.R. use for primary care, HHSC estimates that the state could save $200,000 GR annually for each 1% reduction in E.R. use.

What is an emergency? Researchers have found that health care professionals do not agree on what constitutes a true emergency. Federal Medicaid law and rule set a standard which generally suggests that an emergency exists if a person in need of help has a condition with symptoms of such a severity that, without care, the person's health would be in serious jeopardy, or he would risk serious impairment to bodily functions, or serious dysfunction of any organ or body part. The rules specifically include severe pain as a reasonable cause for seeking emergency care.

HHSC has created a workgroup with hospital industry representatives to establish some guidelines for E.R.s to define which visits should be classified as non-emergency and

charged a co-payment. This will be challenging, since the bulk of the targeted co-pay group (80%) are elderly and disabled clients. For example, while it might be inappropriate for an able-bodied 24-year-old to go to the E.R. when he has the flu, influenza can of course be life-threatening for an elderly person, or a person of any age who is chronically ill. Thus, diagnosis alone will not provide a sufficient standard for a true emergency.

WHY CO-PAYMENTS ARE BEING PROPOSED NOW

History. Texas Medicaid had a brief experiment with co-payments 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 to the state. The policy was repealed after one month.

Current State Budget. HHS Special Provisions Rider 33 in the state budget for 2002-2003 reduced overall Medicaid appropriations by $205 million GR — more than the amount allocated for physician, professional and outpatient fee increases — and directed HHSC to achieve these savings through a variety of approaches including (but not limited to) a list of cost-saving proposals which included Medicaid co-payments. All of the required Rider 33 savings had already been identified prior to the HHSC's announcement in March 2002 that the agency would promulgate a co-payment policy. The agency has indicated that, because a shortfall remains in the current 2002-2003 budget for Medicaid, officials intend to pursue these and other savings proposals from Rider 33, despite having met the target. Several cost-saving proposals listed in Rider 33 are not being implemented, including statewide implementation of primary care case management (PCCM: state-administered Medicaid Managed Care), and mandatory Medicaid Managed Care participation by SSI clients. These were not implemented because of strong objections from some health care provider groups to the former, and because the PCCM coverage of SSI clients was anticipated to actually cost more than the current arrangement.

HHSC process. HHSC convened a stakeholder group in April to comment on (but not decide on) a co-payment proposal. This group included hospital, physician, pharmacy, HMO, and consumer advocates (including CPPP staff). A summary of the workgroup's recommendations can be found at

http://www.hhsc.state.tx.us/Medicaid/reports/Cost_Sharing_Sum_042102.html. As the summary notes, "the workgroup generally did not favor development of a co-pay policy for Medicaid; however, the workgroup developed two models members considered less onerous than other models discussed." The concerns voiced by the group are reprinted below from the HHSC summary.

> Workgroup Concerns. The workgroup generally did not favor implementation of co-pays or cost sharing for the Medicaid population. Specifically, the workgroup members expressed the following concerns:
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> - Co-pays can serve as a barrier to services, even if they are voluntary, and can induce enrollees to skip medically needed care, not just unnecessary care.
> - Co-pays place an additional administrative burden and administrative costs on providers.
> - Co-pays may discourage utilization of medically necessary care.
> - The additional administrative burden of co-pays will decrease provider participation in the program.
> - Co-pays are not proven to influence more appropriate utilization.
> - Federal regulations that limit co-pays to "non-emergency" ER services are not consistent with EMTALA requirements on hospitals. Often, hospitals cannot prospectively determine "non-emergency" ER services from genuine ER services because of the nature of emergencies.
> - Recipients residing in areas with poor physician access must utilize the ER for services and that co-pays penalize these individuals for a failing in the health care system.
> - Recipients will be embarrassed if they are unable to make a co-pay, even if it is voluntary. *(CPPP Note: More importantly, workgroup members were concerned that embarrassment or pride will prevent some enrollees from accessing medically necessary care. In addition, there are concerns that, due to confusion or misinformation, Medicaid enrollees may not understand that they cannot be denied care if they cannot pay, and may defer filling prescriptions or seeking legitimate emergency care.)*
> - The greatest financial burden for co-pays will be placed on the sickest recipients, most at risk of nursing home/institutional placement and with the greatest need for medically necessary ER services and high cost brand-name drugs (without therapeutic alternatives).
> - Recipients may not have enough information or education to make an informed decision re: appropriate ER brand-name drug usage, even with a concerted educational program for providers and recipients.
> - The precedent of Medicaid co-pays, even without provider reimbursement reductions, will eventually lead to legislated changes that do result in provider reimbursement reductions and increased levels of state audits and administrative complexity.

Inquiry Submitted to Federal Officials. In June, HHSC officials submitted a letter of inquiry to the Centers for Medicare and Medicaid Services (CMS – formerly HCFA) asking for guidance on how the state might get approval for a policy of imposing the E.R. and prescription co-payments on all Texas Medicaid enrollees except those in institutions (e.g., nursing homes, state schools). The proposal sent to the federal officials also contemplated higher co-payments for the small number of Medicaid enrollees with incomes from 100-150% of the federal poverty income level (FPL), and higher still for those 151% FPL and above.

The state has not received a formal written response from CMS, but clearly communications have taken place. Because, as explained above, federal law and rule define the limits of what can and cannot be waived in terms of co-payment restrictions, application of co-payments to children and pregnant women in the "mandatory" Medicaid eligibility categories is generally believed to be prohibited even under an 1115 waiver. Presumably because of this, HHSC has moved ahead with the current proposal which exempts children and pregnant women. The proposal in the current rule requires only a simple Medicaid State Plan Amendment, not a waiver of federal law, and approval is nearly automatic.

THE SQUEEZE: *Research on Co-payments for Seniors and People with Disabilities*

The sick get sicker. The benchmark study of co-pay impact was the RAND Health Insurance Experiment, conducted in the 1970s and 1980s, which found that cost-sharing for poor people in poor health (such as many of the elderly and disabled on Texas Medicaid) resulted in worse health outcomes (e.g., high blood pressure, anemia), reduced use of preventive care, and delayed medically necessary treatment. The study also found that cost sharing for the poor reduced the use of highly effective healthcare treatments by 41%, more than the 30% reduction in less-effective treatment. Overall, they found that persons in poor health are the most affected by co-payments.[i]

Essential Medicine Use Down, Hospitalizations (and Worse) Up. More recently, studies have looked at the impact of prescription drug co-payments on below-poverty adults, elderly and children. A 2001 study published in the Journal of the American Medical Association analyzed the impact of a new co-payment policy on of 120,000 poor adults.[ii] The population studied had a $16 per month cap on out-of-pocket costs (twice the cap proposed for Texas), so the impact observed was despite this cap. Comparing the population before and after the implementation of co-payments, the researchers found daily use of medically essential drugs dropped by 14%, a substantial 78% increase in adverse health events (hospitalizations, institutionalizations, E.R. visits, and deaths), and an 88% increase in E.R. visits. The authors concluded, "increased cost-sharing for prescription drugs had the desired effect of reducing the use of less essential drugs, but also the unintended effect of reducing the use of drugs that are essential for disease management and prevention. As a result, in the post-policy period, there was an increase in the rate of adverse events and ED visits related to reductions in essential drug use."

Seniors, adults in poor health hit the hardest. A 1996 study of TennCare enrollees with incomes <u>above</u> 100% of poverty found that 22% reported they were unable to pay the co-payment for a medication, and 62% went without the prescribed drug.[iii] Access problems are not only for seniors on Medicaid; a 2002 study of adult Medicaid enrollees found that 41% of adult Medicaid patients <u>under age 65</u> with 2 or more chronic conditions have not filled a prescription because of cost.[iv] Overall, however, cost-sharing will fall hardest on over-65 Medicaid enrollees. Nationally, seniors on Medicaid use 26 prescriptions per year on average, compared to 14 for non-elderly adults. But among the non-elderly adults, adults in fair or poor health — which would be the case for many Texans with disabilities on SSI or in waivers — actually have higher prescription drug use rates than seniors overall, at 29 per year.[v]

<u>Next Steps</u>

Readers are encouraged to make comments to HHSC before the November 12 deadline. Some specific positions which have been adopted by Texas organizations include the following:

- Opposition to any co-payments for persons below the poverty income (100% FPL).
- Eliminate the 50 cent co-payment for generic drugs, to provide a stronger incentive for their use, and to be consistent with Texas CHIP policy (CHIP has no co-payment for generics for those below 150% FPL).
- Support for the $8 monthly cap if co-payments <u>are</u> applied to the below-poverty group.
- Recognition of cost-sharing already paid to other programs; for example Texans with HIV on Medicaid get 3 free prescriptions monthly from Medicaid, but must make $5 co-payments to the HIV drug program for additional prescriptions they need to survive.
- Support for strong outreach to enrollees to encourage them not to defer medically necessary care due to inability to pay.

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[i] Joseph Newhouse, Free For All? Lessons from the Rand Health Insurance Experiment. Cambridge: Harvard University Press, 1996.

[ii] Robyn Tamblyn, et al. "Adverse Events Associated with Prescription Drug Cost-Sharing among Poor and Elderly Persons." JAMA, 285(4): 421-429, Jan. 2001.

[iii] C. Larson, "TennCare and Enrollee Cost-Sharing: A Survey of the Previously Uninsured and Uninsurable Enrollees in Davidson County." Sept 1996. Survey conducted by the Metropolitan Health Dept. of Nashville and Davidson County.

[iv] P. Cunningham, "Prescription Drug Access: Not Just a Medicare Problem," Issue Brief 51, Center for Studying Health System Change, April 2002.

[v] 1997 Medical Expenditure Panel Survey, Center on Budget and Policy Priorities analysis.