



Policy Brief

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MEDICAID COST-SHARING FOR MATERNAL AND CHILD HEALTH UNDER THE DEFICIT REDUCTION ACT OF 2005 (DRA)

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Overview

Congressional passage of the Deficit Reduction Act of 2005 (DRA) on February 1, 2006 provides states with new options for reducing Medicaid costs, including the increased use of cost-sharing.

There is significant concern about whether or not and how states will choose to implement the newly allowed changes to their Medicaid programs.

One provision makes it easier for states to charge pregnant women and children enforceable, and potentially non-nominal, co-payments for certain prescription drugs.

This brief discusses states' options under the DRA to use cost-sharing to control Medicaid costs by reducing health care utilization. In making a recommendation, state budget concerns are balanced against prioritizing the health of women and children.

What Clinicians Can Do:

- Understand the various types of cost-sharing and their potential impact on reducing the utilization of health care
- Familiarize themselves with the changes in Medicaid law introduced by the passage of the Deficit Reduction Act of 2005, primarily that pregnant women and children may become subject to certain co-pays at state option
- Contact their state representatives and Governor to find out what actions the state is considering taking, and urge them to maintain cost-sharing protections for pregnant women and children
- If your state should make co-pays enforceable, protest this decision by refusing to deny services to individuals based on their ability/inability to pay a co-payment
- Visit the advocacy section of our website to get involved in ACU's state-based network to learn more about how you can get involved in efforts to protect the Medicaid program in your home state

Background

Enacted in 1965, Medicaid is the largest public insurance program in the United States, covering over 52 million low-income and vulnerable Americans, at a cost of over \$300 billion.¹ The federal and state governments jointly finance Medicaid, paying for services delivered via the private health care system by reimbursing participating providers for services delivered to enrollees. Medicaid costs are shared based on the Federal Medical Assistance Percentage (FMAP), which is calculated for each state by comparing a state's per capita income to the national average.²

Each state administers its own program and can tailor it to the specific needs of the population. The Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services (HHS), establishes mandatory minimum benefits and eligibility levels based on income and specific categories (e.g., children, pregnant women, disabled, etc.). All states must provide this mandatory coverage. The federal government also allows states to cover optional populations and benefits, and still receive the federal match.

Medicaid coverage, like all health insurance, is an important determinant for obtaining medical care. Medicaid is perhaps the most comprehensive insurance available for pregnant women and children. Being uninsured leads to delaying or foregoing needed medical care, which has the potential to harm health outcomes. For pregnant women early and adequate prenatal care can prevent later costly complications of pregnancy.³ In fact, every \$1 spent on prenatal care saves the Medicaid program a total of \$3.⁴

For children, the consequences of foregoing early care can be detrimental to growth, learning, and development. Preventive care is particularly essential to detecting problems early and intervening before they worsen.⁵ Medicaid's Early and Periodic Screening, Diagnosis, and Treatment Program provides comprehensive benefits to all children under age 21, including preventive care and other services which are typically excluded from other insurance coverage.⁶

Medicaid is an entitlement program, meaning that all who meet the eligibility requirements are entitled to services and funding does not run out. Consequently, the cost of the Medicaid program has increased significantly, for both the federal and state

¹ Vernon Smith, Neva Kaye, Debbie Chang, Jennie Bonney, Charles Milligan, Dann Milne, Robert Mollica, and Cynthia Shirk. "Making Medicaid Work for the 21st Century: Improving Health and Long-Term Care Coverage for Low-Income Americans." National Academy of State Health Policy. Available: http://www.nashp.org/Files/Making_Medicaid_Work_for_the_21st_Century.pdf

² For instance, in a state receiving a 60% FMAP, the federal government pays 60% and the state pays the other 40%.

³ Nancy Green. March of Dimes Senate Testimony. "Uninsured Pregnant Women: Impact on Infant and Maternal Mortality."

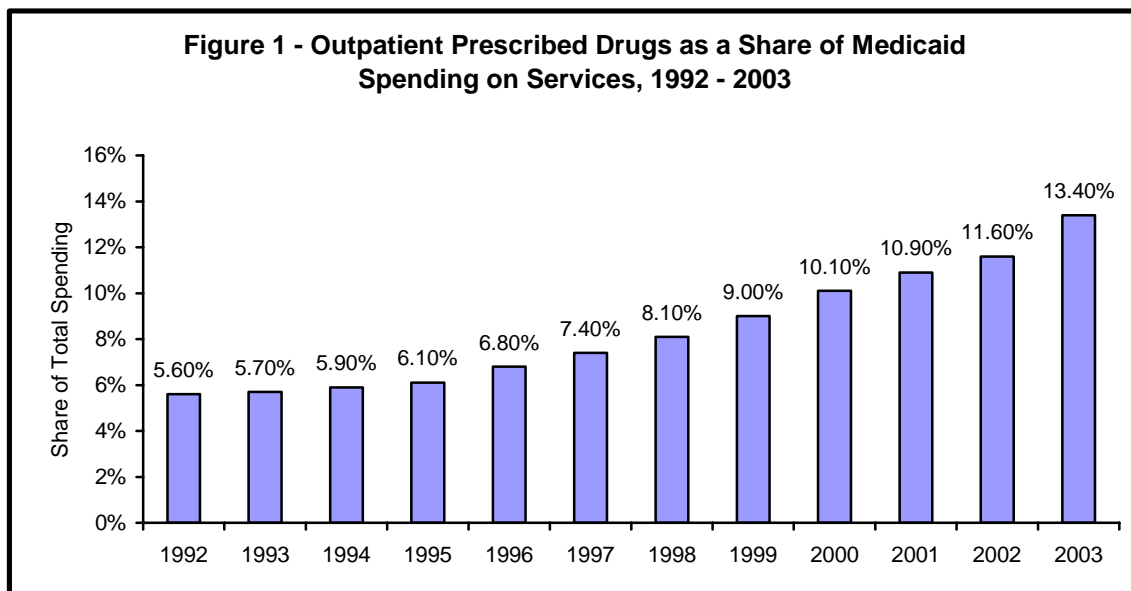
⁴ National Conference of State Legislatures. "Funding Pre-Natal Care for Unauthorized Immigrants: Challenges Lie Ahead for States." Available: <http://www.ncsl.org/programs/immig/prenatal.htm>

⁵ The National Institute of Child Health and Human Development, "Growing Up Healthy: An Overview of the National Children's Study." Available: <http://www.nichd.nih.gov/publications/pubs/guh/section8.pdf>; "Prevention: Aiming Towards Better Health." <http://preventdisease.com/prevention/prevention.html>

⁶ Denise Collins. "EPSDT: What Is It?" Protection and Advocacy for People with Disabilities, Inc. Available: <http://www.protectitonandadvocacy-sc.org/EPSDT.html>

governments. Prescription drugs are the fastest rising component of the program as shown in Figure 1.

The federal government can only control Medicaid costs by changing the law to reduce the number of eligible persons, either by lowering the income eligibility levels or eliminating certain eligibility categories. States can control costs by limiting enrollment through stricter eligibility requirements or the decision to cover fewer optional populations, limiting benefits through the elimination of optional benefits or the placing of limits on the number or amount of services to be covered in a given time period, reducing utilization through managed care, disease prevention, and cost-sharing, controlling the price of care, and decreasing administrative costs by increasing the efficiency of the program.⁷



Source: Kaiser Commission on Medicaid and the Uninsured, using data from the Medicaid Statistical Information System.

Cost-sharing refers to the practice, common to both public and private insurers, of requiring the consumer to assume some of the cost of their care. It includes premiums, deductibles, co-payments, and co-insurance. In accordance with traditional microeconomic theory, cost-sharing assumes that rational consumers of health care services, when made more price-sensitive, will make more judicious purchasing decisions. This analysis focuses specifically on the cost-sharing provisions of the Deficit Reduction Act of 2005 (DRA) that stand to affect pregnant women and children, namely co-payments for non-preferred prescription drugs (see Table 1, p. 8).

Co-payments are fixed amounts paid when the enrollee actually receives a good or service. In the case of private insurance, for example, a prescription drug might require a \$20 co-payment (more or less, depending on the plan). Medicaid law has historically

⁷ Cynthia Shirk. "Making Medicaid Work for the 21st Century: State Options to Control Costs, Issue Brief #4." National Academy for State Health Policy. November 2004. Available:

limited the allowable level of co-payments, understanding that low-income Medicaid populations are unlikely to afford higher fees. By being collected at the point-of-service, co-payments are used to make consumers more price-sensitive in seeking care. The literature strongly supports an inverse association between co-payments and the utilization of prescription drugs.⁸

In states that recently implemented co-payments in Medicaid through waivers, co-payments significantly reduced utilization and disproportionately impacted lower-income populations. For example, after implementing co-payments (ranging from \$3 to \$250 depending on service) the state of Oregon observed a 44% decrease in Medicaid enrollment, with 68.2% of those with “zero income” citing cost-sharing as their reason for disenrolling versus 38.7% for those with incomes between 26-100% of FPL, and 23.9% for those with incomes over 100% of FPL.⁹ Some respondents even noted that they had to forego food or another necessity in order to finance their health care.¹⁰ Furthermore, there was a noticeable increase in the number of persons utilizing emergency rooms and other safety net providers to receive care while circumventing the co-payment barrier. Similar findings came out of Washington and Utah.¹¹ The RAND Health Insurance Experiment concluded that co-payments resulted in poorer health outcomes (e.g., anemia, dental problems) among low-income children.¹²

Medicaid law prior to 2006 exempted certain groups (e.g., pregnant women, children ages 18 and under) and certain services (e.g., EPSDT, emergency services, hospice care) from co-payments.¹³ Even for the non-exempt, co-payments were capped at a nominal level between \$0.50 and \$3, which has not been raised since 1982.

Under the DRA, states may use a state plan amendment (SPA), rather than an 1115 waiver, to impose new—or increase current—co-payment levels. Both SPAs and 1115 waivers require the approval of HHS, although approved SPAs are easier to obtain. Previously exempt populations and services (e.g., mandatory children, pregnant women,

⁸ Anis et al. “When patients have to pay a share of drug costs: Effects on frequency of physician visits, hospital admissions and filling of prescriptions.” *CMAJ*, 173(11) 2005; T.B. Gibson et al. “A copayment increase for prescription drugs: The long-term and short-term effects on use and expenditures.” *Inquiry* 42(3): 293-310, 2005; Leibowitz et al. “The demand for prescription drugs as a function of cost sharing.” *Social Science and Medicine*, 21(10): 1063-9, 1985; J.T. Lurk et al. “Effects of changes in patient cost sharing and drug sample policies on prescription drug costs and utilization in a safety-net-provider setting.” *American Journal of Health System Pharmacy*, 61(3): 267-72, 2004; Nelson et al. “The effect of a Medicaid drug copayment program on the utilization and cost of prescription services.” *Medical Care*, 22(8): 724-36, 1984; Roemer et al. “Copayments for ambulatory care: Penny-wise and pound-foolish.” *Medical Care*, 13(6): 457-66, 1975; Stuart and Zacker, “Who bears the burden of Medicaid drug co-payment policies?” *Health Affairs*, 18(2): 201-12, 1999.

⁹ B. Wright, et al. “The impact of increased cost sharing on Medicaid enrollees.” *Health Affairs*, 24(4): 1106-1116.

¹⁰ Artiga article Oregon something something.

¹¹ Samantha Artiga, David Rousseau, Barbara Lyons, Stephen Smith, and Daniel S. Gaylin. “Can States Stretch the Medicaid Dollar Without Passing the Buck? Lessons from Utah.” *Health Affairs*, 25(2): 532-40.

¹² Leighton Ku. “Charging the poor more for health care: Cost-sharing in Medicaid.” Center on Budget and Policy Priorities. May 7, 2003 Available:

¹³ § 1916(a) of Title XIX of the Social Security Act.

EPSDT, emergency services, and hospice care) remain exempt from most co-payments in the DRA.

The DRA allows states to charge higher co-payments for non-preferred prescription drugs than for less expensive generics to steer consumers towards the lower cost drugs. In fact, all Medicaid enrollees, including pregnant women and children, are subject to co-payments for non-preferred drugs. This can pose potential problems in cases where the non-preferred drug is the best or only option for the patient. Thus, the DRA allows states to waive or reduce co-payments for non-preferred drugs if a physician verifies that the drug is needed, and that the preferred drug would be insufficient for any reason. By permitting states to charge higher and enforceable co-payments, even for currently exempt populations such as pregnant women and children, the hope is to steer beneficiary choices and reduce costs by reducing inappropriate utilization of services. Yet, Medicaid beneficiaries already utilize more generic prescription drugs than other populations (54% versus 42%).¹⁴

The Congressional Budget Office (CBO) has scored the federal savings of the cost-sharing provisions of the DRA, and found them to be quite substantial. Figure 2, below, depicts a projected reduction in annual spending that cumulatively amounts to \$1.9 billion over 5 years and nearly \$10 billion over 10 years from co-payments and premiums in Medicaid. Overall, CBO projects federal Medicaid savings from the DRA to reach \$11.5 billion in five years, and \$43.2 billion over ten years. Thus, the cost-sharing provisions of the DRA account for some 16.5% of federal Medicaid savings over the 5 year window and 22.9% over 10 years.¹⁵ However, these figures represent only federal spending, and it is possible that states could still see rising costs. CBO predicts that the majority of the savings will come from reduced utilization, estimating that some 6.6 million children will be affected by cost-sharing for prescription drugs in Medicaid nationwide, with over 3 million of these children below poverty.¹⁶

States are under significant pressure to reduce Medicaid program costs, and are considering a number of options to achieve cost-control. The roles of Governors and the State Legislatures are extremely important in the wake of passage, because the federal law does little to mandate changes to Medicaid, instead giving states the flexibility to pursue a wide number of previously unavailable options.

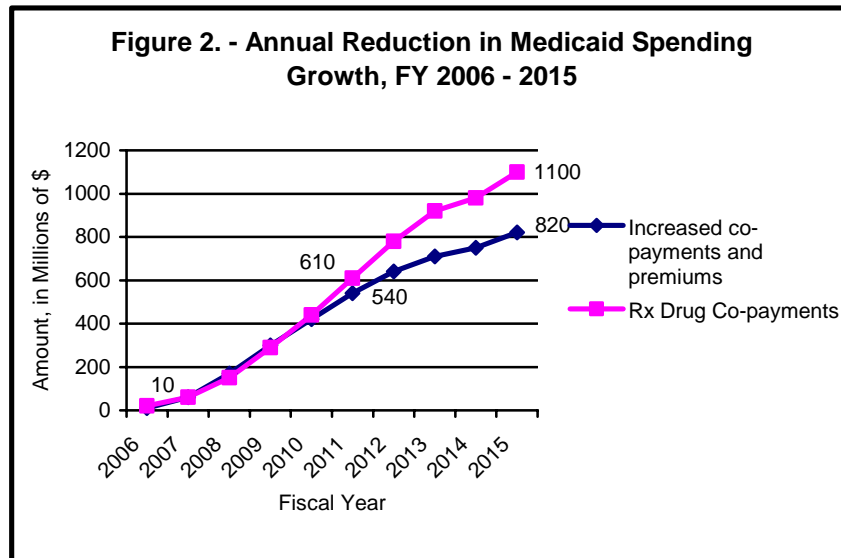
Consumer interest organizations, especially those who serve, or whose members serve, a large proportion of Medicaid enrollees, face two risks in increased Medicaid cost-sharing. First, the patients they serve may seek less care, and thus their health may suffer – which will increase costs to the system when these patients are finally treated somewhere (e.g., emergency rooms). Second, reduced utilization by Medicaid patients

¹⁴ G.E. Miller and J.F. Moeller. “Outpatient prescription drug prices and insurance coverage: An analysis of therapeutic drug class and user characteristics from the 1996 Medical Expenditure Panel Survey.” in *Investing in Health: The Social and Economic Benefits of Health Care Innovation*, 2001, pp. 23-57.

¹⁵ “Cost Estimate of S.1932 The Deficit Reduction Act of 2005.” Congressional Budget Office. January 27, 2006. Available: <http://www.cbo.gov/ftpdocs/70xx/doc7028/s1932conf.pdf>

¹⁶ Jennifer Tolbert. National Overview of Medicaid Issues. Kaiser Commission on Medicaid and the Uninsured. Presentation to the National Rural Health Association, April 18, 2006.

means reduced revenues, especially for primary care and safety net providers, for whom Medicaid reimbursement represents an even greater proportion of total revenues.



Source: “Cost Estimate of S.1932 The Deficit Reduction Act of 2005.” Congressional Budget Office. January 27, 2006. <http://www.cbo.gov/ftpdocs/70xx/doc7028/s1932conf.pdf>

Making co-payments enforceable also raises questions. For instance, who is responsible for ensuring that co-payments are collected? Imagine a pharmacist who fills prescriptions for 10 Medicaid patients in a day, each of whom is required to pay a \$5 co-payment. On the one hand, if the pharmacist turns away those patients who, despite truly needing medication, are unable to pay the \$5, then the cost-sharing has become a very significant barrier to accessing services, not just a cost-control measure that causes patients to spend more wisely. Conversely, if the pharmacist fills the prescriptions anyway, and does not seek to collect the co-payments at all, he or she loses \$50 a day (\$5 x 10). Furthermore, if the pharmacist then asks his or her office staff to contact and/or bill the patients in order to receive the co-payment, he or she stands to lose even more money, because the cost of a staff person’s time and other associated costs will far outweigh the revenue brought in through any co-payments that are collected. “Typically cost sharing does not increase fees paid to providers. Rather it shifts some of the fee to patients. As these co-payments are so often difficult or expensive for dentists and other providers to collect, they have been characterized by opponents as a ‘hidden provider tax.’”¹⁷

¹⁷ CDHP August 2005 Special Medicaid Report. “Pressure Builds to Cut \$10B: Policy Shifts in Medicaid Programs for Children.” Available:

Comparison of Medicaid Cost-Sharing Law on Prescription Drugs

	Medicaid Law Prior to the Deficit Reduction Act of 2005	Medicaid Law After the Deficit Reduction Act of 2005
Co-Payment Amounts	<ul style="list-style-type: none"> States could charge nominal co-payments ranging from \$0.50 to \$3 	<ul style="list-style-type: none"> Allows states to impose higher than nominal co-payment amounts
Exempt Populations	<ul style="list-style-type: none"> Children 18 and under, pregnant women, and institutionalized persons were exempt from co-pays, as were certain services, including: hospice care, emergency care, and family planning 	<ul style="list-style-type: none"> Children 18 and under, pregnant women, and institutionalized persons are exempt from co-pays for preferred drugs, as are certain services, including: hospice care, emergency care, and family planning. However, no group is exempt from co-pays for non-preferred drugs.
Income Limits	<ul style="list-style-type: none"> None 	<ul style="list-style-type: none"> For families earning 150% of FPL or below, non-preferred drug cost-sharing must be nominal For families earning above 150% of FPL, non-preferred drug cost-sharing must be no more than 20% of the actual cost of the drug
Formularies	<ul style="list-style-type: none"> States could set different levels of nominal co-pays for preferred versus non-preferred drugs States could require prior authorization for prescription drugs 	<ul style="list-style-type: none"> Co-pays may be higher for non-preferred drugs and waived or reduced co-pays are allowed for preferred drugs
Implementation	<ul style="list-style-type: none"> Higher cost-sharing was permissible only with an approved 1115 waiver 	<ul style="list-style-type: none"> States may impose cost-sharing via Medicaid state plan amendments
Enforceability	<ul style="list-style-type: none"> Non-enforceable 	<ul style="list-style-type: none"> Providers may deny care, at their option, for failure to pay a co-pay (enforceable)
Indexing to Inflation	<ul style="list-style-type: none"> None 	<ul style="list-style-type: none"> Cost-sharing is to be indexed to medical inflation and adjusted annually

Source: National Conference of State Legislatures. "Deficit Reduction Act of 2005: Summary of Medicaid/Medicare/Health Provisions. February 3, 2006.

Recommendations

Maintain Current Cost-Sharing Exemptions for Pregnant Women and Children

ACU urges states to maintain all current cost-sharing exemptions for pregnant women and children. Ultimately, because the DRA maintains most exemptions for these populations anyway, this option primarily refrains from charging co-payments for non-preferred drugs.

Maintaining all current cost-sharing exemptions for pregnant women and children is likely to present moderate costs to both the federal government and the states for several reasons. Essentially, this makes no changes to the Medicaid program, so if enrollment and utilization trends remain constant, Medicaid costs will continue to grow. However, other cost-containment strategies could be used on other more costly populations (e.g. the elderly and disabled) to mitigate this, as pregnant women and children are the two least expensive populations covered by Medicaid.

This option is highly beneficent, as it maintains open access to all prescription drugs for pregnant women and children. However, this option is only moderately equitable, the result of two perspectives, one highly just and the other hardly just at all. On the one hand, all pregnant women and children are exempt from co-payments under this option, a highly equitable position. On the other hand, all other groups remain subject to co-payments, which by contrast to the exemption for pregnant women and children only, makes this option highly inequitable. This problem is countered by our second recommendation:

Keep All Co-Pays Non-Enforceable

Co-pays, when made enforceable do two things. First, they make the ability to pay a condition of receiving health care. Second, they require someone to enforce (i.e., collect) them, which is often easier said than done. The cost of enforcing the co-payments, which could be considerable, would be borne by providers. Providers may voice relatively strong opposition to the notion of having to enforce co-payments, which represents a potential for financial loss in various ways as described earlier in this analysis.

Furthermore, an enforceability provision introduces the potential for inequity. Individual clinicians are likely to vary in their willingness to provide a health care good or service to a patient who cannot afford the co-payment. By keeping all co-pays for all Medicaid beneficiaries non-enforceable, the ability to pay a co-pay will never be grounds for making the decision of whether or not to provide care. Medicaid enrollees are some of our nation's most vulnerable, and we owe it to them and ourselves to treat them with compassion.