Medicaid Cost-Sharing

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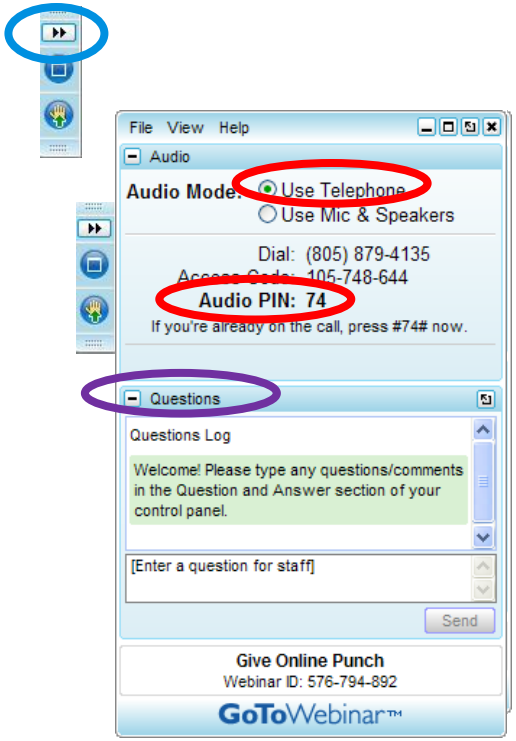

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- Non-profit law firm committed to health care access & quality for low-income individuals
- Washington D.C., Los Angeles, & North Carolina
- www.healthlaw.org
  - Medicaid Expansion toolbox on our website

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Today's Focus: Medicaid Cost-Sharing & Premiums

For Information on premiums as cost-sharing in the Marketplace:

CBPP Webinar on Marketplace Cost-Sharing
www.cbpp.org/files/**Cost-Sharing-Reductions**-Webinar-6-19-13.pdf

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Overview

- Cost-sharing Definitions and Research Review
- Medicaid Legal Requirements
- Cost-sharing Litigation
- Advocacy Tips

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What is cost-sharing?

- Payments made to *obtain services*:
  - **Copayments** – fixed dollar amount
  - **Coinsurance** – percentage of service's total cost
  - **Deductible** – fixed payment before coverage begins (rare in Medicaid)
  - **Out-of-pocket limit** – maximum amount an individual or household pays over a given time period
- Consequences for nonpayment
  - Enrollee can be held liable for incurred debt
  - Option to deny services to enrollees above poverty

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What are premiums?

- **Premium**–charge (e.g. monthly) to *obtain* coverage
  - Includes enrollment fees and similar charges
- Consequences of nonpayment
  - Disenrollment
  - Lockout
  - Hardship exception

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Why cost-sharing?

- "Shape health-seeking behavior" towards more efficient care
  - "Value-based" insurance design
  - Create smart "consumers"
  - Avoid "moral hazard" by requiring "skin-in-the-game"
- **BUT Cost-sharing is a blunt instrument**:
  - Health providers make most decisions
  - Reduces access to needed care
  - Magnifies access issues for lower-income people

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Relative Impact of Cost-sharing on Low-Income Enrollees

Sarah and Mark live with their two young children in Columbus, Ohio. Sarah works full time in retail and Mark works part time and helps with child care. Their income is **$1950/month** –just under federal poverty level. Let's look at projections for their basic monthly expenses:*

Rent & Utilities:	$ 740
Food:	$ 650
Childcare:	$ 1050
Transportation:	$ 430
Other:	$ 330
Total:	**$ 2800**

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* Data from the National Center for Children in Poverty Basic Needs Calculator: http://www.nccp.org/tools/frs/budget.php

Relative Impact of Cost-sharing on Low-Income Enrollees

Jack is a 60-year old single man with an income of $950/month (99% FPL). He has chronic high blood pressure, heart disease and diabetes. Below are his monthly copays for significant health care needs:

Jack's Monthly Medical Expenses:

2 specialist visits:	$8
1 primary care visit:	$4
5 prescriptions (2 non-preferred):	$28
Total:	$40

Individual at 25% FPL:	16.8% (5% cap may apply)
Individual at 50% FPL:	8.4% (5% cap may apply)
Jack's Medicaid expenses (99% FPL):	4.2% of monthly income
Individual at 200% FPL:	2.1%

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Cost-Sharing Literature

- Rand Health Insurance Experiment in 1970s
  - *The Effect of Co-Insurance on the Health of A*dults
  - Only large-scale, randomized "gold standard" study on cost-sharing
  - Conclusion: Cost-sharing led to reduced use of services with no significant adverse consequences on health
    - NOTE: effects primarily in patient-initiated care seeking.
  - IMPORTANT EXCEPTION: Cost sharing caused low income people to forego necessary care

+35 years of research: Cost-sharing in Medicaid

- Copayments most heavily studied
  - Consistent, redundant conclusions
- Cause low-income people to use substantially fewer *essential* and *effective* medical services or medications
  - Cause enrollees to self-ration or delay seeking care
  - Decrease adherence to prescription regimens
  - Force choice between health care and other basic necessities of life
- Result in costly emergency and inpatient care
  - Not associated with significant program savings
- Depress enrollment in Medicaid

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COST-SHARING & THE LAW

What are the legal limits in Medicaid?

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Protections with flexibilities

- Statute and regulations authorize, limit, and protect
- States have lots of flexibility within those limits
- Critical to enforce current limits and protections, especially for people below poverty

Why is cost-sharing so complicated in Medicaid?

- Levels can vary by:
  - Income of beneficiary
  - “Groups of individuals”
  - Cost or type of service
- Exceptions, and exceptions to the exceptions
- Two overlapping statutory provisions:
  - Social Security Act § 1916 = 42 U.S.C. § 1396o
  - Social Security Act § 1916A = 42 U.S.C. § 1396o-1
- July 2013 final regulations make significant changes
  - 42 C.F.R. §§ 447.50-57, effective 10/1/2013

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Cost-sharing Authority in Medicaid

§ 1916 – "Original"

- Added in 1982
- Generally prohibits premiums, with exceptions
- "Nominal" cost-sharing
- Exempts certain services and groups
- Tightly circumscribed waivers

§ 1916A – "Alternative"

- Deficit Reduction Act (2005)
- Increases state "flexibilities"
  - "Targeted" cost sharing
  - Higher limits on some services
  - Premiums above 150% FPL
  - "Enforceable" cost sharing
- 5% out-of-pocket limit
- Additional exemptions, protections for people below poverty line
- Tightly circumscribed waivers

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Six key rules on cost-sharing and premiums in Medicaid

1. Certain groups and services exempted
2. “Nominal” cost-sharing generally permitted
3. Higher limits permitted for “targeted” groups, non-emergency use of ER, and non-preferred medications
4. Premiums allowed above 150% FPL with exceptions for a couple of eligibility groups
5. 5% “aggregate cap” on cost-sharing and premiums
6. State option for “enforceable” cost-sharing – provider can deny service if you can’t pay

#1: Key cost-sharing exceptions

- For certain populations and certain services cost-sharing is not generally allowed
- Recently finalized rule makes clear that cost-sharing for non-emergency use of ER and for non-preferred drugs can be applied to otherwise exempt groups
- Medicaid expansion must comply with exceptions and all other Medicaid cost-sharing rules

Cost-sharing Exceptions

Exempt from Cost-sharing

Populations	Services
• Children and adolescents in mandatory categories • Institutionalized individuals with only a personal needs allowance • Individuals in hospice care • Individuals eligible through Breast and Cervical Cancer Treatment Program • Indians/Alaska Natives ever served through Indian Health Services	• Pregnancy-related services (broad interpretation), including tobacco cessation outpatient drugs • Emergency services • Certain family planning services and supplies • Well-baby and well-child services and immunizations for children under 18 • Provider-preventable services

Exempt from Premiums

- Children under age 18 in mandatory coverage categories
- Persons in institutions with only a personal needs allowance
- Persons eligible through the Breast and Cervical Cancer Treatment Program
- Terminally ill individuals receiving hospice care
- Indians/Alaska Natives ever served through Indian Health Services programs

42 C.F.R. § 447.56(a)

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#2: What is “nominal” cost-sharing?

- Original cost-sharing statute, states are only allowed to charge “nominal” cost-sharing
- Secretary of HHS to define nominal limits and, as of 2005, adjust annually for inflation
- Amount of cost-sharing tied to amount Medicaid pays for the service
- Final rule changes:
  - Eliminates the “cost of services” tiers
  - Sets a $4.00 maximum for most services
  - $8.00 nominal limit for non-preferred drugs and non-emergency ER use

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Current Nominal Cost-sharing Limits

FY 2013 Maximum Allowable Nominal Copayments			
Type of Service	**Household Income (% FPL)**		
	< 100%	**101-150%**	**151%+**
Institutional Care (inpatient hospital, rehab care, etc.)	50% of 1st day cost		
Non-institutional Care (physician visits, physical therapy, etc.)	$0.65-$3.90		
Non-emergency ER use*	$3.90#	$7.80#	
Preferred Drugs	$0.65-$3.90	$0.65-$3.90	$0.65-$3.90
Non-preferred Drugs*	$0.65-$3.90	$0.65-$3.90	

§ 1916
§ 1916A

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Under §1916, states may apply for waivers to charge up to twice the nominal limit ($3.90) for this service.
* For these services, states may apply cost-sharing to otherwise exempt groups.

New Limits for Nominal Cost-sharing

FY 2014 Maximum Allowable Copayments			
Type of Service	**Household Income (% FPL)**		
	< 100%	**101-150%**	**151%+**
Institutional Care (inpatient hospital, rehab care, etc.)	$75		
Non-institutional Care (physician visits, physical therapy, etc.)	$4		
Non-emergency ER use*	$8#	$8#	
Preferred Drugs	$4	$4	$4
Non-preferred Drugs*	$8	$8	

§ 1916
§ 1916A

Under §1916, states may apply for waivers to charge up to twice the nominal limit ($4) for this service.
* For these services, states may apply cost-sharing to otherwise exempt groups.

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#3: Higher limits for certain services and incomes

- Non-emergency use of ER (§ 1916A(e))
  - No federal copay limit for beneficiaries >150% FPL
    - 5% aggregate cap applies
  - Nominal limits for groups normally excepted
  - Provider must first screen patient and identify an "actually available and accessible" alternative
- Non-preferred drugs (§ 1916A(c))
  - 20% of cost for beneficiaries >150% FPL
  - Final rule doubles limit to $8 for under 150% FPL
  - Nominal limits for groups normally excepted
  - Provider-authorized exception
- "Targeted" cost sharing permits higher limits on other services, based on beneficiary income

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Summary of New Limits (10/2013)

FY 2014 Maximum Allowable Copayments			
Type of Service	**Household Income (% FPL)**		
	< 100%	**101-150%**	**151%+**
Institutional Care (inpatient hospital, rehab care, etc.)	$75	10% total cost	20% total cost
Non-institutional Care (physician visits, physical therapy, etc.)	$4	10% total cost	20% total cost
Non-emergency ER use*	$8#	$8#	No Limit**
Preferred Drugs	$4	$4	$4
Non-preferred Drugs*	$8	$8	20% total cost

42 C.F.R. §§ 447.52-54

§ 1916
§ 1916A

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\# Under §1916, states may apply for waivers to charge up to twice the nominal limit ($4) for this service
* For these services, states may apply cost-sharing to otherwise exempt groups
** While there is no fixed limit to the ER copay, the 5% family income cap would apply

#4: Premiums in Medicaid

Income	Below 150%	Above 150%
Premiums permitted?	No	Yes
Exceptions	Limited premiums allowed for: • Medically needy (not above $20/month) • Certain people with disabilities with earned income (sliding scale) • Certain children with disabilities	Premiums *not* allowed for: • Mandatory children • Enrollees in hospice • Institutionalized individuals with only a personal needs allowance • Enrollees eligible through the Breast & Cervical Cancer Program option • American Indians and Alaska Natives

- Disenrollment after 60 days of nonpayment (§ 1916A(d))
- Medicaid expansion enrollees should not be subject to premiums under Medicaid cost-sharing rules

42 C.F.R. § 447.55

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#5: 5% aggregate cap

- Includes *all* Medicaid premium and cost-sharing expenses for the household
- Calculated monthly or quarterly, at state option
- State must have a mechanism to track all household cost-sharing expenses
- **Final Rule applies 5% cap to all Medicaid enrollees**

42 C.F.R. § 447.56(f)

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#6: “Enforceable” cost-sharing

- Provider can deny care if the beneficiary is unable to pay
- Default Medicaid rule, § 1916(e), prohibits “enforceable” cost sharing
  - Enrollee can still be liable for the debt
- § 1916A(d) allows states to:
  - Allow providers to “enforce” cost-sharing on non-excepted groups above 100% FPL
  - Terminate eligibility if premiums are not paid for 60 days
- 2012: 7 states reported using enforceable cost sharing

42 C.F.R. §§ 447.52(e), 55(b)

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Medicaid cost-sharing rules: Flexibility with protections

Key Protections

- Certain services and groups excepted
- “Nominal” cost-sharing below 100% FPL
- 5% aggregate cap
- No premiums below 150%

Flexibilities

- Higher limits for higher income beneficiaries
- “Enforceable” cost-sharing above 100%
- Premiums above 150%
- “Target” by income, group or type of service
- § 1115 demonstrations

Best Policy: Lower cost-sharing is better cost-sharing

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COST-SHARING LITIGATION

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The Effect of 1115 Demonstrations: A different world

- Experimental, pilot or demonstration project
- Secretary finds:
  - Likely to assist in promoting the objectives of the Medicaid Act
    - furnish medical assistance to limited income families with dependent children and the aged, blind, and disabled
    - furnish rehabilitation and other services to help them attain/retain independence or self-care
- Secretary may:
  - Waive compliance with requirements of 1396a
  - To extent and for period needed
- Requirements for transparency and public input
- REMEMBER: 42 U.S.C. § 1396o(f) cost sharing waivers

1115 Demonstrations: A different world

- Congress has said:
  - "Expected to be selectively approved"
  - "Test out a unique approach"
  - "Detailed research methodology and comprehensive evaluation"
- Authority limited to Medicaid Act, not e.g.
  - Americans with Disabilities Act
  - Title VI of the Civil Rights Act
  - Due process clause of the U.S. Constitution
- Common law of Medicaid??
  - *Quiding v. Hegstrom* (D. Ore. 1981)

1115 copay demonstrations: In the courts

- *Spry v. Thompson*, 487 F.3d 1272 (9th Cir. 2007)
  - "expansion" populations of non-disabled, non-pregnant adults are not describe in Medicaid Act & copay rules don't apply
- *Newton-Nations v. Betlach*, 660 F.3d 370 (9th Cir. 2011)
  - Secretary cannot ignore section 1115 requirements
  - Recognized 35-year history of copay research
- *Wood v. Betlach*, 2013 WL 474369 (D. Ariz. Feb. 7, 2013), after remand, 2013 WL 3871414 (D. Ariz. Jul 26, 2013)
  - Applying *Newton-Nations* to vacate copayment approval & remand to the Secretary

Advocacy Tips: Demonstration waivers

- Goal: Strong *evidence* base + state *option*= *limit* use
- Section1396o(f) waivers required for all populations "described in" Medicaid Act
- Note lack of experimental purposes & inconsistency with the objectives of Medicaid Act (in writing to the Sec.)
- Line in the sand: Only nominal, non-mandatory copayments for individuals with income below FPL
- Regardless of state labels, assess how the assessment works
  - Health Indiana Program (HIP)
    - Seeks to require all enrollees to make a monthly payment based on annual household income into a Personal Wellness and Responsibility (POWER) account
    - Nonpayment results in disenrollment & 12-month lockout

Advocacy Tips: State plan options

- Goal: Strong *evidence* base + state *option*= *limit* use
  - Services, amounts, non-mandatory
- SPA Content (42 C.F.R. § 447.52(i))
- SPA Public notice and comment (§ 447.57)
- Tracking the 5% cap
- Minimizing terminations/lock outs for premium non-payment

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COMING SOON:
NHeLP Issue Brief on Medicaid Premiums and Cost-Sharing

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