

# THE FACTS ON MEDICAID COPAYMENTS

## Considerations for Arkansas



February 2013



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### EXECUTIVE SUMMARY

- If Arkansas extends Medicaid to 250,000 uninsured adults, the state has flexibility to design cost-sharing policies to meet the needs of Arkansans within federal guidelines.
- Research shows that cost-sharing reduces access to care for low-income families who already struggle to make ends meet, especially if a family member has special health needs.
- Copayments do not reduce unneeded emergency care – Medicaid patients use the same amount of emergency room care as privately-insured people.
- Value-based insurance design or incentives such as chronic disease management services can help consumers seek high-quality, cost effective care and follow care plans. This can result in long-term cost-reduction in Medicaid.
- Cost-sharing must be evaluated to ensure it does not restrict access to care for low-income families.

### INTRODUCTION

Arkansas has an opportunity to strengthen its Medicaid program and stimulate economic activity statewide by extending coverage to an estimated 250,000 uninsured Arkansans, including 10,000 children.<sup>1</sup> Arkansas can cover parents and other adults with incomes up to 138 percent of the Federal Poverty Level (FPL), which is about \$31,800 for a family of four.<sup>2</sup> The federal government will pay the full cost for newly eligible adults until 2017 and no less than 90 percent after that.<sup>3</sup> Arkansas's current Medicaid eligibility limit for adults is one of the most restrictive in the country, permitting few non-elderly eligible adults who are not disabled, pregnant, or parents/caretakers to enroll.<sup>4</sup> As a result, strengthening Medicaid could have an immense impact on the state's health. Arkansas's 89th General Assembly will decide whether Arkansas will take advantage of this opportunity that is projected to benefit the state's budget, the economy, job creation, and, most importantly, families.<sup>5</sup>

Once Arkansas decides to extend Medicaid, the state will continue to have flexibility to determine program details that affect the success of Medicaid. The federal government sets basic parameters aligned with Medicaid's goal to provide medical services for vulnerable and low-income persons. However, states have broad flexibility within those limits to customize Medicaid to their state's needs.<sup>6</sup> The design of coverage can affect access to care. Fiscally responsible policies can be implemented that do not enact barriers to coverage and care or shift costs to families who cannot afford it.

This brief outlines current rules for cost-sharing in Medicaid, reviews research on cost-sharing and its relationship to access to care, and provides recommendations for structuring cost-sharing without negatively impacting outcomes.

## COST-SHARING RULES IN ARKANSAS MEDICAID

One area in which states have flexibility is cost-sharing. There are several types of cost-sharing.

- **Copayments** or **coinsurance** are charges that beneficiaries pay when they receive a service.
- **Premiums** are periodic payments beneficiaries must pay to be enrolled in health coverage.<sup>7</sup>

The ACA did not change cost-sharing rules, so existing federal cost-sharing policies apply to the newly-covered population (adults up to 138 percent FPL). The Centers for Medicare and Medicaid Services released proposed rules in January 2013 to modernize and simplify federal cost-sharing guidelines.<sup>8</sup> **Federal rules do not allow cost-sharing for several groups** including low-income children, foster children, and individuals in hospice care.

Additionally, cost-sharing cannot be imposed for emergency services, family planning services, preventive care for children, or pregnancy-related care. Federal limitations on cost-sharing are changed annually based on the cost of medical care. While the proposed rules have not yet received final approval, proposed limitations on cost-sharing and Arkansas's current policies are summarized below.<sup>9</sup>

Medicaid Cost Sharing for Adults <sup>10</sup>				
	Income under 100 % FPL		Income 100-138 % FPL	
	Arkansas Amount	Federal Maximum	Arkansas Rules	Federal Rules
Preventive Services	None	\$4 <sup>11</sup>	None	10% of cost
Outpatient Services	None	\$4	None	10% of cost
Institutional Services	10% of first day of charges	Up to 50% of first day of charges	10% of first day of charges	Up to 50% of first day of charges, or 10% of cost
Emergency Services	None	Not Allowed	None	Not Allowed
Non-Emergency use of ER	None	\$8	None	\$8
Prescription Drugs	\$0.50 to \$3.00	\$4 Preferred \$8 Non-Preferred	\$0.50 to \$3.00	\$4 Preferred Drugs 20% of cost Non-Preferred
Premiums	None	Not Allowed	None	Not allowed

- For **children receiving ARKids First A or Medicaid**, the federal law allows cost-sharing only for non-emergency use of the emergency room (up to \$8) or non-preferred prescription drugs (up to \$4). Today, Arkansas does not require any cost-sharing for these services.
- Children from higher-income families who have ARKids First B have unique cost-sharing rules set in the terms of a waiver. Most services have a \$10 copayment; prescriptions are \$5 and inpatient services are 10 percent of the first day of charges.<sup>12, 13</sup>

Based on Arkansas's current rules, providers may not deny services to any Medicaid beneficiary because of the individual's inability to pay cost-sharing charges. The proposed federal rules would allow providers to deny services to some adults with income above the poverty level.<sup>14</sup> **Regardless, a family's total cost-sharing in Medicaid and/or ARKids First is capped at five percent of their income.**<sup>15</sup> If a family meets the out-of-pocket limit, they can no longer be charged any cost-sharing fees. Arkansas does have a system in place to track this automatically and notify families if they meet the maximum; it should be used across all Medicaid programs. Only a handful of states have systems that track out-of-pocket spending and notify providers not to charge copayments or coinsurance; Arkansas is lucky to be among those states that take the burden off of families to track spending.<sup>16</sup>

## WHAT ARE THE OPTIONS FOR COST-SHARING IF ARKANSAS EXTENDS MEDICAID?

Research shows that **copayments can be a barrier to enrollment and care for Medicaid beneficiaries**. Arkansas has flexibility to set cost-sharing limits within the federal maximums. Attempting to increase cost-sharing beyond the federal limits would be difficult. California was recently denied a request to impose enforceable, significant copayments on its Medicaid patients because the Centers for Medicare and Medicaid Services was “unable to identify the legal and policy support” for the request.<sup>17</sup> Significant research on copays outlines the drawbacks of cost-sharing for Medicaid recipients, lending doubt to future waivers for this program design.

## WHAT DOES RESEARCH SAY ABOUT COST-SHARING’S IMPACT ON FAMILIES?

In short, **cost-sharing in Medicaid reduces access to care** for low-income enrollees and can worsen their health outcomes. When individuals cannot access preventive care and early treatment, it often means they use the costly emergency room or let health issues worsen before they finally receive treatment.

- In one example, Medicaid-enrolled cancer patients had more emergency room visits when copayments were added and each patient’s total costs were \$2,000 higher in a six-month period than they were for those without copayments.<sup>18</sup>
- Prescription drug copayments led to a 78 percent increase in emergency room use in Quebec.<sup>19</sup>
- Oregon’s experiment with cost-sharing caused nearly half of adults to drop coverage, with most citing cost-sharing as a reason.<sup>20</sup>

**Cost-sharing is more likely to affect children negatively**, with low-income children being less likely than adults to receive effective care.<sup>21</sup>

- Even with no cost-sharing, families with children who have special health care needs spent \$141 more on premiums and \$432 more on out-of-pocket costs than other families did; increased cost-sharing would worsen this disparity.<sup>22</sup>

**Medicaid enrollees use the same average amount of care as people with private health coverage.**

- They are no more likely to go to the emergency room for non-urgent care than anyone else.<sup>23,24</sup>
- Requiring copayments for nonemergency visits was not shown to decrease Medicaid recipients’ emergency room use.<sup>25</sup>
- Copayments would not be likely to limit “unnecessary” health care use.

**Out-of-pocket costs place a heavier burden on families living in poverty**, especially those with serious health needs.<sup>26</sup>

- Nationally, half of households have credit card debt from medical expenses, and medical debt contributes to 62 percent of bankruptcies.<sup>27</sup>
- In Arkansas, where almost half of households earn less than \$35,000 annually, extra medical costs can diminish efforts to reduce poverty.<sup>28</sup>

**Families who depend on Medicaid need financial security provided by predictable health care costs**, or they can struggle to afford necessities such as nutritious food, transportation, school supplies, or rent.<sup>29</sup>

- Cost-sharing can mean families postpone non-emergency medical care or drop coverage altogether.<sup>30</sup>



## WHAT IS THE IMPACT ON PROVIDERS, BUDGETS, AND BUSINESSES?

Providers feel a significant impact when families cannot pay cost-sharing fees. Only nineteen states have lower primary care Medicaid reimbursements than Arkansas, and more than a quarter of the population relies on Medicaid for medical care.<sup>31,32</sup> **Copayments reduce provider income if Medicaid enrollees cannot pay for care.**<sup>33</sup>

- Arkansas inpatient copayments already reduce Medicaid reimbursements to hospitals in excess of \$5.6 million annually due to a high rate of non-payment.<sup>34</sup>
- Oklahoma Medicaid providers reported that cost-sharing is paid only 29 percent of the time, leaving safety net hospitals and providers with unpaid charges.<sup>35</sup>

**Copayments and other forms of cost-sharing do not always have the money-saving effects states hope to achieve.**

- Maryland abandoned copayments for non-emergency use of the emergency room because it was not cost-effective to administer.<sup>36</sup>
- The National Bureau of Economic Research found that increased cost sharing was associated with increases in employee absences, leading to reduced productivity for businesses.<sup>37</sup>

## PAYING FOR BETTER OUTCOMES

Copayments do not necessarily ensure that consumers only receive medically necessary and appropriate services. Copays can act as a chainsaw rather than a scalpel: people delay necessary care, not just unnecessary care. For example, tiered drug copayments were shown to lead to reduced compliance with diabetes medications, which helps prevent more serious, costly complications.<sup>38</sup>

Arkansas is already working through its Payment Improvement Initiative to incentivize providers to provide high-quality, cost-effective care. Value-based insurance design (VBID), which incentivizes patients to use cost-effective health services and preventive care, is especially helpful for preventing and treating chronic diseases like diabetes or high blood pressure.

- Incentivizing consumers can save money and increase compliance with treatment plans.<sup>39,40</sup>
- One program showed a 6.5 percent increase in diabetes medication compliance and a savings of \$1.33 for every dollar spent on the program over three years.

National policy groups recommend value-based insurance design as an effective way to address spending growth in the health care sector, including in Medicaid.<sup>41</sup> It could be an innovative structure to explore within Medicaid to complement the Payment Improvement Initiative.

## RECOMMENDATIONS

Arkansas has an opportunity to structure a strengthened Medicaid program to create better health outcomes for its lower-income families. If cost-sharing is part of the discussion, a few principles should apply.

- **Model cost-sharing that works in Arkansas.** Consumers are not opposed to cost-sharing if the amounts are reasonable and affordable.<sup>42</sup> Copayments work in the ARKids First B program for middle-income families, but the state must consider lower-income families’ needs.
- **Be innovative.** Value-based insurance design or incentives such as chronic disease management services can help consumers seek high-quality, cost effective care and follow care plans. This can result in long-term cost-reduction in Medicaid.
- **Protect families’ budgets.** Automated cost-sharing calculators ensure families, especially those with special health needs, are not spending more than five percent of their income on cost-sharing.
- **Monitor the effects of cost-sharing decisions.** The impacts of cost-sharing on access to care need to be carefully studied to drive future program design and ensure needed care is available.
- **Encourage preventive care.** Take advantage of the increased federal matching rate (FMAP) for preventive services by covering adult preventive services with no cost-sharing, as private insurers now do.<sup>43</sup>

Arkansas’s legislature needs to seize this opportunity to improve the health of its residents and save more than 1,000 lives each year by extending Medicaid to low-income adults. Projections that suggest strengthening Medicaid will also benefit the state budget and support rural hospitals add to the evidence that extending Medicaid to 250,000 uninsured Arkansans is a good deal for the state. However, the structure of Medicaid is key to its success, and decisions about cost-sharing, copayments, and other program details must not be made lightly.

## NOTES

<sup>1</sup> DHS Medicaid Expansion Estimates, revised November 2011.

<sup>2</sup> The law states coverage will be extended to 133% FPL with a standard 5% income “disregard” that raises the rate to 138% .

<sup>3</sup> 2012 Federal Poverty Level Guidelines are as follows, according to HHS.

Household Size	100%	138%	150%	200%	300%	400%
1	\$11,170	\$15,415	\$16,755	\$22,340	\$33,510	\$44,680
2	\$15,130	\$20,879	\$22,695	\$30,260	\$45,390	\$60,520
3	\$19,090	\$26,344	\$28,635	\$38,180	\$57,270	\$76,360
4	\$23,050	\$31,809	\$34,575	\$ 46,100	\$69,150	\$92,200
each additional person	\$3,960	\$5,465	\$5,940	\$7,920	\$11,880	\$15,840

<sup>4</sup> The ARHealthNetworks program covers adults who have been uninsured more than 12 months, who are employed or self-employed and work 30+ hours a week, whose jobs do not offer group coverage, who earn less than 200% FPL (\$46,100/year for a family of four). Only a few thousand adults are enrolled in this program today.

<sup>5</sup> See AACF brief “Strengthening Medicaid Helps Families” (2012) and RAND Corporation’s “The Economic Impact of the Affordable Care Act on Arkansas” (2013) by Price and Saltzman.

<sup>6</sup> Families USA. “State Plan Amendments and Waivers: How states can change their Medicaid Program.” (2012)

<sup>7</sup> Georgetown Center for Children and Families “Cost Sharing for Children and Families in Medicaid and CHIP” (2009).

<sup>8</sup> U.S. DHHS CMS. 42 CFR Parts 430, 431, 433, 435, 440, 447, and 457. . <http://www.gpo.gov/fdsys/pkg/FR-2013-01-22/pdf/2013-00659.pdf>.

- <sup>9</sup> Different cost-sharing rules apply for adults with incomes above 150 percent of the poverty level.
- <sup>10</sup> Some groups of adults are exempt from cost-sharing, including pregnant women who earn less than 150% FPL, terminally ill individuals receiving hospice care, institutionalized spend-down individuals, and breast/cervical cancer patients. These adults can only be charged copayments for non-emergency use of an ER or use of non-preferred prescription drugs. Very few adults over 100% FPL are currently eligible for Medicaid. Working Disabled who earn over 100% FPL are subject to cost-sharing as outlined in the AR Medicaid provider manual.
- <sup>11</sup> Cost-sharing can be imposed for adult preventive services. States can receive a 1% FMAP increase not to require cost-sharing for prevention.
- <sup>12</sup> Medicaid.gov “Cost Sharing Out of Pocket Costs” (2013); Georgetown Center for Children and Families “Cost Sharing for Children and Families in Medicaid and CHIP” (2009); Solomon “Cost-Sharing and Premiums in Medicaid: What Rules Apply?” (2007)
- <sup>13</sup> Cost-sharing for 18-year olds is at adult level for ARKids First A although these children qualify for ARKids First or Medicaid. Federal rules apply to children receiving ARKids First A or another Medicaid category such as disabled children or foster care below the poverty level. Federal rules do not apply to cost-sharing for ARKids B. Arkansas’s CHIP program is an waiver rather than a CHIP program which gives the state flexibility to impose copayments as part of the experimental program. TEFRA covers higher-income families with disabled children under age 19 and imposes copayments and premiums based on family income. Cost-sharing limits, if the waiver did not include cost-sharing exemptions, would align with Medicaid rules for populations above 100/150% FPL. If AR had a traditional CHIP program, the cost-sharing limitations would be different. Georgetown Center for Children and Families “Cost Sharing for Children and Families in Medicaid and CHIP”(2009).
- <sup>14</sup> Email correspondence with Arkansas DHS officials, 11/12. Federal rules allow denial of care for adults above the poverty level (Medicaid.gov) AND DHHS CMS 42 CFR Parts 430, 431, 433, 435, 440, 447, and 457” (2013).
- <sup>15</sup> Medicaid.gov: Keeping America Healthy. Cost Sharing Out of Pocket Costs. (2013).
- <sup>16</sup> Selden, Kenney, Pantell, Ruhter. Cost Sharing in Medicaid and CHIP: How does it affect out-of-pocket spending? Health Affairs, 28, 4 (2009).
- <sup>17</sup> Bloomberg. “Obama Blocks CA from Charging for Care in Medicaid.”
- <sup>18</sup> Subramanian. Impact of Medicaid Copayments on patients with cancer: Lessons for Medicaid Expansion under Health Reform. Medical Care, 49, 9. (2011).
- <sup>19</sup> Ku and Wachino. The Effect of Increased Cost-Sharing in Medicaid: A Summary of Research Findings. (2005).
- <sup>20</sup> Wright, Carlson, Edlund, DeVoe, Gallia, and Smith. The Impact of Increased Cost Sharing on Medicaid Enrollees. Health Affairs, 24, 4. (2005).
- <sup>21</sup> Kaiser Family Foundation. Health Coverage for Low-Income Americans: An Evidence-Based Approach to Public Policy. (2007).
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- <sup>23</sup> Ku and Wachino. The Effect of Increased Cost-Sharing in Medicaid: A Summary of Research Findings. (2005).
- <sup>24</sup> Garcia, Bernstein, Bush. Emergency Department Visitors and Visits: Who Used the Emergency Room in 2007? National Center for Health Statistics Data Brief. (2010)
- <sup>25</sup> Mortensen. Copayments did not reduce Medicaid Enrollees’ Nonemergency use of Emergency Departments. Health Affairs 29(9). (2010).
- <sup>26</sup> Kaiser Family Foundation. Health Coverage for Low-Income Americans: An Evidence-Based Approach to Public Policy. (2007).
- <sup>27</sup> Arkansas Center for Health Improvement. Expanding Health Care Coverage for Arkansas: The Facts. (2012)
- <sup>28</sup> Source: U.S. Census Bureau, 2009-2011 American Community Survey
- <sup>29</sup> Perkins and Somers. Q&A: Limiting the cost sharing in Medicaid-funded programs. National Health Law Program. (2011).
- <sup>30</sup> Families USA. Increasing Cost-Sharing in Medicaid: A Bad Solution to Budget Issues. (2012)
- <sup>31</sup> Kaiser Family Foundation. State Health Facts Medicaid Physician Fee Index, 2008.
- <sup>32</sup> AR Department of Human Services, Medicaid Program Overview: SFY 2012 (2012).
- <sup>33</sup> Kaiser Family Foundation. Health Coverage for Low-Income Americans: An Evidence-Based Approach to Public Policy. (2007).
- <sup>34</sup> Email Correspondence, AR Hospital Association. .
- <sup>35</sup> Georgetown Center for Children and Families. Cost sharing for children and families in Medicaid and CHIP. (2009).
- <sup>36</sup> Mortensen. Copayments did not reduce Medicaid Enrollees’ Nonemergency use of Emergency Departments. Health Affairs 29(9). (2010).
- <sup>37</sup> Gibson, Fendrick, Chernew. National Bureau of Economic Research. Cost-Sharing and Productivity. (2012).
- <sup>38</sup> Ku and Wachino. The Effect of Increased Cost-Sharing in Medicaid: A Summary of Research Findings. (2005).
- <sup>39</sup> Chernew, Rosen, and Fendrick. Value based Insurance Design. Health Affairs, 26, no 2. (2007).
- <sup>40</sup> Gibson, Wang, Kelly, Brown, Turner, Frech-Tamas, Doyle, and Mauceri. A Value-Based Insurance Design Program at a Large Company Boosted Medication Adherence for Employees with Chronic Illness. Health Affairs, 30, no. 1 (2011).
- <sup>41</sup> Antos et. al. Bending the Curve: Effective Steps to Address Long-term Health Care Spending Growth. Brookings Institute. (2009).
- <sup>42</sup> Georgetown Center for Children and Families. Cost sharing for children and families in Medicaid and CHIP. (2009).
- <sup>43</sup> Kaiser Family Foundation. State Coverage of Preventive Services for Women under Medicaid: Findings from a state-level survey. (2012).



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