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Q&A
Limiting the Cost Sharing in Medicaid-Funded Programs

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Q. My state is considering implementing cost sharing for Medicaid beneficiaries, arguing that this will save money. The state wants to implement cost sharing above the nominal amounts listed in federal Medicaid regulations and to make payment of the copayments mandatory. It also wants to impose premiums on some Medicaid populations that exceed the premium amounts currently allowed in the Medicaid laws. We understand that the state is going to ask the federal Medicaid agency for approval of these changes. Are there arguments we can make against these cuts? Can you suggest evidentiary support for our legal position?

A. Yes. A recent decision from the Ninth Circuit Court of Appeals casts doubt on the state's plan to impose the heightened cost sharing. Moreover, numerous studies have demonstrated that Medicaid cost sharing reduces utilization of necessary services and lowers enrollment. The imposition of premiums also implicates the maintenance of efforts requirements of the Affordable Care Act.

Discussion

Medicaid cost sharing rules

Cost sharing requires a patient to pay part of the cost of health care services, such as enrollment fees, premiums, deductibles, coinsurance, copayments, or similar charges. Congress has been very clear about the options that it intends to make available to states that are implementing cost sharing. In fact, two Medicaid Act provisions deal exclusively with premiums and cost sharing.[2]

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[2] Congress first added substantive cost sharing provisions to the Medicaid Act in 1982. *See* Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 97-248, § 133 (adding 42 U.S.C. § 1396o). At the time, the House of Representatives Committee on Energy and Commerce noted: "[A] large number of States have sought waivers of current law relating to the imposition of cost-

The first provision, 42 U.S.C. § 1396o, allows states to impose cost sharing within set limits.[3] For the most part, enrollment fees, premiums and similar charges may not be imposed on categorically needy Medicaid beneficiaries.[4] Nominal copayments or similar charges are allowed.[5] Some coverage groups or services must be excluded, including children under age 18, pregnant women (for pregnancy-related services), outpatient drugs when used to promote cessation of tobacco use, family planning services, hospice services, services for institutionalized individuals who contribute most of their income to the cost of care, and services furnished to Indians through the Indian Health Services.[6] Participating Medicaid providers cannot deny care because the deduction, cost sharing, or similar charge cannot be paid up front.[7]

States also have the option of imposing cost sharing pursuant to 42 U.S.C. § 1396o-1. This provision authorizes states to amend their state plans to impose premiums and cost sharing on certain groups of individuals and most types of services and to vary premiums without regard to Medicaid's comparability requirements.[8] It specifically allows states to establish higher cost sharing on non-preferred prescription drugs and non-emergency use of the emergency department.[9] States may allow Medicaid providers to condition the provision of care on payment of the cost sharing amount.[10] There are limits on states' authority under this section. For example, individuals with family incomes at or below the federal poverty level can only be charged nominal copayments.[11] In addition, premiums and cost sharing (other than for non-preferred prescription drugs) may not be imposed on certain vulnerable groups, including many categories of children, pregnant women, terminally ill individuals receiving hospice, and Native Americans, and for certain services, such as emergency and preventive services.[12]

If a state wants to impose cost sharing that differs from the rules outlined above, it must obtain permission from the Secretary of the U.S. Department of Health and Human Services (Secretary).[13] The Secretary can approve heightened copayments through a waiver, only after public notice and comment, and only if the waiver meets five circumscribed criteria, including a

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sharing under the demonstration authority at section 1115 of the Act. The Committee believes that this bill gives the States sufficient flexibility in this regard to make further exercise of the Secretary's demonstration authority unnecessary." H. R. Rep. No. 97-757 (1982), Report on Medicaid and Medicare Part B Budget Reconciliation Amendments of 1982 (August 17, 1982).

[3] 42 U.S.C. § 1396o. For in-depth discussion of the law and relevant cases, *see* National Health Law Program, *The Advocate's Guide to the Medicaid Program* at 4.12-4.14 (May 2011) (available at www.healthlaw.org).

[4] *Id.* § 1396o(a); 42 C.F.R. §§ 447.51, 447.53.

[5] *Id.* §§ 1396o(a)(3), 1396o(b)(3); 42 C.F.R. § 447.53.

[6] 42 U.S.C. §§ 1396o(a)(2), 1396o(b)(2), 1396o(j)(1); 42 C.F.R. § 447.53.

[7] 42 U.S.C. § 1396o(e).

[8] *Id.* § 1396o-1(a)(2).

[9] *Id.* § 1396o-1; 42 C.F.R. §§ 447.62-447.82.

[10] 42 U.S.C. § 1396o-1(d)(2).

[11] *Id.* §§ 1396o-1(a)(2), 1396o-1(b)(1)-(2).

[12] *Id.* §§ 1396o-1(b)(3).

[13] *See* 42 U.S.C. § 1396o(f).

two year time limit and testing of a previously untested use of copayments.[14] In addition, the Secretary has granted states permission to impose heightened cost sharing under section 1115 of the Social Security Act, which authorizes the Secretary to approve "experimental, pilot, or demonstration" projects that are "likely to assist in promoting the objectives of the Medicaid Act."[15] Section 1115 authorizes the Secretary to waive Medicaid Act provisions contained in 42 U.S.C. § 1396a. The Secretary also claims a broader section 1115 authority, variously labeled by the Secretary as an "expenditure authority" or "expansion authority," to allow states to use Medicaid funds to implement projects that the Secretary and a state agree upon, including projects that ignore the Medicaid Act cost sharing provisions.[16]

The Maintenance of Effort (MOE) Requirement of the ACA

The imposition of new premiums would appear to violate the MOE provisions which require the continuation of "eligibility standards, methodologies and procedures" that are no more restrictive than those in effect on March 23, 2010. [17] A February 25, 2011 "Dear State Medicaid Director" letter specifically addresses the question of premiums under MOE requirements and states that in general the imposition of new premiums is prohibited.[18] For adult populations, the MOE lasts until the date on which the U.S. Department of Health and Human Services Secretary determines that a fully operational Exchange has been established in the state. For children under age 19 (or such higher age as the state may have elected), the MOE runs through September 30, 2019.[19]

The Newton-Nations Ruling from the Ninth Circuit

On August 24, 2011, the Ninth Circuit Court of Appeals decided *Newton-Nations et al. v. Betlach and Sebelius*.[20] *Newton-Nations* concerns the authority of the Secretary and the State of Arizona to impose heightened, mandatory copayments on poverty-level people with disabling conditions and medically needy people with incomes below 40% of the 2000 federal poverty level. The Secretary approved the copayments as part of an ongoing section 1115 demonstration project.

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[14] *Id.*

[15] 42 U.S.C. § 1315 (§ 1115 of the Social Security Act).

[16] *See Newton-Nations v. Betlach*, _ F.3d _, 2011 WL 3689241 (9th Cir. 2011) (holding that § 1396o cost sharing limits to not apply to medically needy populations who were covered through a section 1115 project rather than the state Medicaid plan); *Spry v. Thompson*, 483 F.3d 1272 (9th Cir. 2007) (authorizing heightened cost sharing on non-disabled adults and couples not described in the Medicaid Act).

[17] 42 U.S.C. §§ 1396a(a)(74), 1396a(gg)(1).

[18] *See* DHHS, Dear State Medicaid Director at Question 13 (Feb. 25, 2011), at https://www.cms.gov/smdl/downloads/SMD11001.pdf.

[19] 42 U.S.C. § 1396a(gg)(2).

[20] _ F.3d _, 2011 WL 3689241 (9th Cir. 2011). The case is co-counseled by the William E. Morris Institute for Justice and the National Health Law Program.

The Ninth Circuit's opinion includes a significant, potentially far-reaching reversal of the Secretary's approval of the copayments. The Secretary had argued that the 1115 "project" under review was the entire demonstration project (originally approved in the early 1980s as a Medicaid managed care experiment), not the copayment project that was approved in 2004. According to the Secretary, the copayments would "continue to ensure wider health benefit coverage to low-income people." The State argued that the copayments would save money.

The Court did not accept this argument and, instead, viewed the project under review as the copayment project that was approved in 2004. It held the Secretary's scant review did not satisfy her obligation under the Social Security Act to determine whether the proposal was likely to further the goals of the Medicaid Act. Citing an earlier case, *Beno v. Shalala*, the Court also found the Secretary's review did not adequately "consider the impact of the project on the" persons the Medicaid Act "was enacted to protect."[21] The Court remanded the case to the district court, ordering it to vacate the Secretary's decision and remand to the Secretary for further consideration consistent with the opinion.

A few aspects of the analysis are particularly important—not only to low-income people in Arizona but also to low-income people in other states where heightened, mandatory cost sharing is being considered as part of a section 1115 demonstration project.

- First, the Secretary must determine that the cost sharing proposal has value as a demonstration, experimental or pilot project.

- Second, "a simple benefits cut, which might save money, but has no research of experimental goal" will not do.[22]

- Third, section 1115 obligates the Secretary to evaluate the cost sharing proposal's potential impact on the individuals that the Medicaid Act is intended to help.

- Finally, the Court questioned whether Arizona's project could have an experimental, pilot or demonstration value, expressing doubt that the copayments could "demonstrate something different than the last 35-years worth of health policy research," which consistently concludes that copayments cause low-income people to forego even medically necessary care. [23]

The Ninth Circuit vacated the district court's decision accepting the Secretary's approval of the Arizona project and remanded the case to the district court, with directions to vacate her decision and remand to Secretary for further consideration.[24]

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[21] 30 F.3d 1057, 1070 (9th Cir. 1994).
[22] *Newton-Nations*, 2011 WL 3689241, at *8 (quoting *Beno*, 30 F.3d at 1071).
[23] *Id.*
[24] *Id*. at 9. Unfortunately, the decision is not entirely favorable to Medicaid beneficiaries. The Court deferred to the Secretary's position that to be protected by 42 U.S.C. §§ 1396o and 1396o-1, the medically needy population group had to be covered in an approved state plan and that Arizona could ignore the copayment protections because it was providing coverage through a

Evidence demonstrating the negative impact of cost sharing

As noted above, *Newton-Nations* questions whether the state cost sharing project could have an experimental, pilot or demonstration value, given the 35-year track record of health policy research. Cost-sharing is one of the most frequently studied aspects of the Medicaid program. Citing past studies, the former Director of the Arizona Medicaid program and a defendant in *Newton-Nations* acknowledging that when cost sharing is applied to low-income populations, "people will tend to forgo seeing their physician and having their prescriptions filled. Use of the hospital and emergency services will increase because the use of preventative services has decreased. "[25]

Indeed, over three decades of research has overwhelmingly established that heightened copayments make it harder for beneficiaries to afford medical services, while premiums make it harder for eligible individuals to enroll and maintain coverage. There is no question that Medicaid cost sharing adds to families' financial hardship, forcing difficult choices between necessary health care and other basic necessities.[26] Further, increased cost sharing leads to

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section 1115 project. Advocates must monitor this aspect of the case, lest the Secretary and complicit states work to "flip" optional Medicaid coverage groups out of the state plan and into section1115 projects (and thereby deny them the protections of the Medicaid Act cost sharing limitation). The Plaintiffs also challenged the copayment notices as inadequate under the Medicaid Act and U.S. Constitution. The Court remanded this issue, instructing the district court to determine whether the notices have changed to the point where the plaintiffs' constitutional claims are moot. Without analysis, the Court said the Medicaid Act provision did not apply. Plaintiffs' have filed a petition for rehearing in hopes of obtaining clarification on this point.

[25] Defendant Rodgers' Answers to Plaintiffs' Interrogatories, Interrogatory No. 3, at 4 (available from NHeLP-NC). The Director also stated: "If you are going to put co-payments and co-insurance on … [managed care organization] … members it will work against the health plans medical management programs. The reason that AHCCCS has one of the lowest PMPM [per member per month payments] of all state Medicaid programs is our managed care model. Health plan[s] manage the utilization of members better than any cost sharing program would do. Cost sharing is for States that do not have Medicaid managed care." E-mail from Director of Arizona Health Care Cost Containment System to staff (Feb. 21, 2007) (available from NHeLP-NC). Moreover, evidence in *Newton-Nations* showed that approximately 18.6 percent of covered generic drugs had an average cost of $3.50, meaning that low-income Medicaid beneficiaries obtaining these drugs would actually be subsidizing the State when paying the mandatory $4.00 copayment.

[26] Thomas M. Seldon *et al., Cost sharing in Medicaid and CHIP: How Does It Affect Out-of-Pocket Spending?* 28 HEALTH AFF. W607 (online ed. 2009), http://content.healthaffairs.org/content/28/4/w607.full.

poorer health and increased use of high-cost services like emergency rooms.[27] The following study results are indicative of the robust body of research:

Women living in areas with lower median incomes have been disproportionately affected by cost sharing and are more likely to forgo breast cancer screening than women from more affluent areas. An analysis of Medicare plans also found that breast-cancer screening rates, among women who should be screened according to clinical guidelines, were 77.5% in full coverage plans, compared to only 69.2% in cost sharing plans.[28]

The primary effect of copayments is to reduce the likelihood that beneficiaries will fill their doctors' prescriptions. Increased drug copayments make it more likely that low-income patients will be unable to adhere to medication instructions, worsening health disparities. A 10% increase in copayment for certain drugs (statins) decreased medication adherence by more than 12% for patients living in an area with median household incomes of less than $30,000 compared with a decrease of less than 2% for patients living in areas with a median income of more than $62,000.[29]

Elderly Medicaid beneficiaries and beneficiaries with disabilities who reside in states that charge copayments have lower rates of prescription drug use. This burden falls disproportionately on beneficiaries in poor health.[30] When a prescription coinsurance and deductible cost-sharing policy was introduced in Quebec, Canada, the use of essential drugs decreased by 14% for cash assistance beneficiaries. Emergency room visits increased by 78%, and serious adverse health events increased by 88%.[31]

State-specific studies of cost sharing have also demonstrated the negative impact on Medicaid enrollees. For example :

- In Missouri, 100,000 people lost Medicaid coverage because the state tightened eligibility standards, imposed higher premiums, and expanded copayments to nearly all Medicaid-covered services and prescription drugs. After Missouri implemented these changes, the

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[27] Leighton Ku & Victoria Wachino, *The Effect of Increased Cost Sharing in Medicaid: A Summary of Research Findings* (2005), *available at* http://www.cbpp.org/cms/?fa=view&id=321.

[28] Amal Trivedi *et al*, *Effect of Cost Sharing on Screening Mammography in Medicare Health Plans*, 358 NEW ENG. J. MED. 375 (2008), *at* http://*www.nejm.org/doi/full/10.1056/NEJMsa070929#t=article.*

[29] Michael Chernew et *al*, *Effects of Increased Patient Cost Sharing on Socioeconomic Disparities in Health Care*, 23 J. GEN. INTERN. MED. 1131, (2008), *at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2517964/?tool=pubmed.

[30] Stuart B, Zacker C., *Who Bears the Burden of Medicaid Drug Co-payment Policies?* 18 HEALTH AFF. (online ed., March/April 1999), http://content.healthaffairs.org/content/18/2/201.long.

[31] Robyn Tamblyn, et al., *Adverse Events Associated with Prescription Drug Cost-Sharing among Poor and Elderly Persons*, J. AM. MED. ASS'N. (online ed. January 2001), *at* http://jama.ama-assn.org/content/285/4/421.long.

number of uninsured individuals increased, hospitals were burdened with more uncompensated care, and revenue shortfalls forced community health centers to charge patients more and obtain larger state grants.[32]

- A dramatic reduction in Medicaid enrollment occurred in Oregon after the state imposed new copayments, ranging from $5 for outpatient physician visits and $250 for inpatient hospital admissions, and new premiums ranging from $6 to $20 a month. Those who left the program because of the heightened cost sharing had inferior access to needed care, were significantly less likely to visit a primary care physician, and used the emergency room more often than those who left the program for other reasons. [33] The Oregon Medicaid program's copayment policies did not provide the expected cost savings because individuals skipped preventive care and used more costly hospital emergency care.[34]

- Another study of the imposition of prescription drug copayments in the Oregon Medicaid program, set at $2 for generics and $3 for brand name drugs, found utilization of prescription drugs declined by 17%. Reductions in prescription drug use was observed in every therapeutic category studied, with the greatest reductions occurring for drugs treating depression and respiratory diseases.[35]

- Families, outreach workers, and providers in Washington State all reported that immigrant families had significant difficulty paying for prescription drugs when new copayments were imposed.[36]

- A Utah study found that instituting a Medicaid copayment of $2 per prescription led to 13% of enrollees not filling their prescriptions because they could not afford the co-pay.

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[32] Stephen Zuckerman *et al., Missouri's 2005 Medicaid Cuts: How Did They Effect Enrollees and Providers?* 28 HEALTH AFF. (online ed. Feb. 2009), *at* http://content.healthaffairs.org/content/early/2009/02/18/hlthaff.28.2.w335.full.pdf+html.

[33] Bill Wright, et al., *The Impact of Increased Cost Sharing on Medicaid Enrollees*, 25 HEALTH AFF. (online ed., July/August 2005), *at* http://www.healthaffairs.org/RWJ/Wright.pdf.

[34] Neal T. Wallace *et al., How Effective Are Copayments in Reducing Expenditures for Low-Income Adult Medicaid Beneficiaries? Experience from the Oregon Health Plan,* 43 HEALTH SERV. RES. 515 (2008), *at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2442363/.

[35] Daniel Hartung *et al., Impact of a Medicaid Copayment Policy on Prescription Drug and Health Services Utilization in a Fee-for-Service Medicaid Population*, 46 MED. CARE 565, (2008), *at* http://www.ncbi.nlm.nih.gov/pubmed/18520310.

[36] Mark Gardner & Janet Varon, *Moving Immigrants from a Medicaid Look-Alike Program to Basic Health in Washington State: Early Observations* (May 2004), *at* www.nohla.org/pdf-downloads/Moving- Immigrants-from-a-Medicaid-Look-Alike-Program-to-Basic-Health-in-Washington-State-Early-Observations.pdf.

When the state increased copayments to $3 copayments for doctor visits, 11% of enrollees did not to go to the doctor because they could not afford it.[37]

- The imposition of $1.00 copayments for services in California in the 1970's caused affected Medicaid beneficiaries to reduce their use of necessary care, decreasing immunizations by 45%, Pap smears by 21.5%, and obstetrical care by 58%.[38]

Conclusion

Despite abundant evidence that cost sharing hurts beneficiaries and does not save money, states have and will likely continue to seek ways to impose it on beneficiaries. As noted in *Newton-Nations,* even when a state wants to use an 1115 project to circumvent the Medicaid Act's cost sharing limits, it must show that the project is consistent with the goals of the Medicaid program, that the , and that the project is not simply to save money. And, the state cannot violate the MOE requirements of the ACA. Advocates should closely monitor developments related to cost sharing, and contact NHeLP for advice and assistance.

[37] Office of the Executive Director, Utah Department of Health, *Medicaid Benefits Change Impact Study*, UTAH PUBLIC HEALTH OUTCOMES MEASURE REPORT, (December 2003), *at* http://health.utah.gov/hda/reports/MedicaidBenefitsChangeSummary.pdf.

[38] As described by Julie Hudman and Molly O'Malley, *Health Insurance Premiums and Cost-Sharing: Findings from the Research on Low-Income Populations*, (March 2003), *at* http://www.kff.org/medicaid/upload/Health-Insurance-Premiums-and-Cost-Sharing-Findings-from-the- Research-on-Low-Income-Populations-Policy-Brief.pdf.