MEDICAID TOPICS

State-By-State Comparisons
Cost Sharing (Co-Pays)

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Issue Summary

Recent policy discussions about finding new ways to contain Medicaid costs increasingly mention the idea of allowing states to increase the amounts that low-income Medicaid beneficiaries are charged in the form of cost-sharing. In a June 15, 2005 preliminary report issued by the National Governors Association (NGA), NGA proposed giving states broad flexibility for setting premiums, deductibles, co-payments and other forms of cost-sharing on any and all Medicaid beneficiaries as well as on services used by Medicaid beneficiaries. The only federal limit on cost sharing proposed by NGA would be a requirement that a family's cost sharing payments cannot exceed 5% of total income.

Proponents of increased cost sharing argue that it would make Medicaid more like private health insurance and promote "personal responsibility." This argument is based on the premise that Medicaid beneficiaries are using unnecessary services at greater rates than people with private insurance. Research on this topic, however, shows that Medicaid beneficiaries use approximately the same amount of services as people with private insurance. One study showed no statistically significant differences in the number of doctor visits, emergency room visits, hospital stays or dental visits. There is substantial evidence in the research, however, that indicates that even modest increases in cost sharing will have an immediate and negative effect on the ability of Medicaid beneficiaries to use health care services and can trigger the subsequent use of more expensive forms of care such as emergency room care or hospitalization. Low-income people with chronic health conditions are the most vulnerable from cost-sharing since they use the most health services. A person who requires five prescription drugs per month must pay five times as much in co-payments as someone who has one prescription, for example.

There is research that indicates that out-of- pocket medical expenses have been rising more rapidly for Medicaid beneficiaries than for other Americans, and that poor Medicaid beneficiaries actually spend a considerably larger share of their incomes on out-of-pocket medical expenses than do middle-class people with private health insurance. This is due to increases in cost-sharing by state Medicaid programs, and the increases in the cost of health care services that Medicaid does not cover. Poor Medicaid beneficiaries aged 19-64 who are not disabled spent more than two-thirds more of their income on such costs in 2002 than the non-elderly privately insured.

A research study in Quebec published in the *Journal of the American Medical Association* found that after imposing co-payments on prescription drugs on adults receiving welfare, fewer prescriptions were filled for essential medications. The co-payments led to a 78% increase in the occurrence of adverse events, including death, hospitalization and nursing home admissions. Co-payments also led to an eighty-eight percent increase in emergency room use. Another study in the United States found that co-payments for substance abuse services led to initial reductions in treatment cost but ultimately led to higher rates of relapse that required more treatment and drove

up long term costs. A recent small study in Minnesota found that more than half of the patients studied had been unable to get their prescriptions at least once in the last six months because of co-payments. The inability to afford co-payments had serious health consequences and led to the use of more expensive forms of medical care.

The RAND Health Insurance Experiment, which is considered the definitive study of this issue, found that co-payments led to a much larger reduction in the use of medical care by low-income adults and children than by those with higher incomes. The RAND study found that co-payments led to reductions in medical care that the researchers rated as being "effective" as well as in care viewed as "less effective." The study also found that co-payments did not significantly harm the health of middle and upper income people but did lead to poorer health for those with lower incomes. Health status was considerably worse for those who had to make co-payments than for those who did not. (In the Rand study, low income was defined as living below 200% of poverty).

In Utah, when small co-payments were imposed on Medicaid beneficiaries with incomes below the poverty line, a significant reduction in physician visits and access resulted. About two-fifths of those affected in Utah reported that they had to resort to such strategies as reducing the amount they spent on food or housing or "stretching out" their prescriptions.

Several states charge monthly premiums to low-income Medicaid or SCHIP beneficiaries. The result is that Medicaid participation is reduced. The higher the premium the greater proportional reduction in participation occurred. Oregon requested and received a waiver to increase premiums for its Medicaid expansion program. Enrollees included people with incomes below the poverty line. The premium levels were raised to $6 per month for those without any income to $20 per month for people at the poverty line. After the state increased the premiums, about half of those enrolled lost coverage. About three-quarters of those who dropped from the program became uninsured. Those who disenrolled in Oregon were four to five times more likely to report the emergency room as their usual source of care than people who remained enrolled.

Concerns about the adverse consequences of premiums on Medicaid or SCHIP enrollment along with the administrative costs involved have led a number of states to reconsider and change their policies regarding premiums. Virginia initially imposed premiums on children with family incomes above 150 percent of poverty but when it was determined about 3,000 children would be terminated the premiums were canceled. Maryland also imposed premiums on thousands of children in its SCHIP program and enrollment declined significantly. The premiums were discontinued after one year. Connecticut planned to increase premiums significantly for Medicaid beneficiaries but repealed these requirements after an analysis indicated tens of thousands of people would lose coverage. Similarly, the state of Washington obtained a federal waiver to increase the premiums it charges for children's insurance but eventually dropped the increases.

Medicaid law exempts children and pregnant women from Medicaid co-payments as recognition that they could be a barrier to preventive and primary care and potentially have lasting adverse health consequences. Nursing home patients are also exempt because all of their income is used

to pay for their care except for a very small allowance for personal needs. States may charge other types of Medicaid beneficiaries, i.e., non-pregnant, non-institutionalized adults, senior citizens and people with disabilities, co-payments but such payments may not exceed "nominal" levels such as $3 per service or prescription. As of 2003, some 43 states charged co-payments to some or all eligible Medicaid beneficiaries. Co-pays for prescription drugs are the most common.

While co-payments can lead people to reduce their use of medical care, they do not necessarily make people "smarter" health care consumers. Research has found that when higher co-payments are imposed, patients reduce their use of both essential and less-essential services. A recent study of tiered drug co-payments in the private sector found that higher co-payments led diabetics to reduce their use of diabetes medications. Another study found that increase co-payments among hypertensive patients led to reductions in patients' use of drugs for high blood pressure and cholesterol.

The trend among states is to increase co-payments within the federal limits and some have received waivers to exceed those limits. Seventeen states increased co-payments in 2003, twenty in 2004 and nine states plan to do so in 2005 according to the Kaiser Commission on Medicaid and the uninsured. Some argue that since the allowable co-payment of $3 per service has not been raised since the 1980's an increase should be permitted.

Importance to Family Physicians

Cost sharing in Medicaid in the form of premiums, increased premiums or co-payments reduces access and utilization of health care services. Physician visits tend to go down and emergency department visits tend to increase. Children are less likely to get preventive care and adults are more likely to go without a needed service. A significant number of people become uninsured when Medicaid premiums are increased.

Higher co-payments for prescription drugs may result in patients going without necessary medications. Some states are charging Medicaid beneficiaries higher co-payments for certain prescriptions in an attempt to motivate consumers to choose less expensive drugs but the physicians often do not know which drugs have higher or lower co-payments.

Co-payments could result in a reduction in overall revenue from Medicaid for participating family physicians as payments are reduced by Medicaid to reflect the patient co-payment. Patients may not have the co-payment or not seek needed care. The cost of billing for the co-payment may exceed the payment itself.

State-by-State Tables

Table 1
Medicaid Benefits by Service: Physician Services (October 2004)

Note: Totals include 50 states and D.C.	"Benefits Covered" Totals		
Is the benefit covered?	**Yes:** 51	**No:** 0	
Is there a co-payment requirement?	**Yes:** 29	**No:** 22	

Is the Benefit Covered?	Copayment Requirement	Prior Approval Requirement	Coverage Limitations	Reimbursement Methodology	Populations Covered
Alabama					
Yes	$1/office visit - See state-specific FN		14 ambulatory or nursing facility visits/year; 16 inpatient hospital visits/year; 1 psych evaluation/year; pregnancy, family planning and mental health visits excluded from limit	Fee for service	CN
Alaska					
Yes	$3/visit			Fee for service, second and subsequent surgeries performed at same time paid at lesser rate	CN
Arizona					
Yes	$1/office or home visit			Fee for service	CN & MN
Arkansas					
Yes		Specified surgical procedures	12 visits/year irrespective of setting included in limits for other specified practitioners, 2 in-person or telemedicine consultations/year	Fee for service	CN & MN
California					
Yes	$1/visit	Specified surgical procedures including those to be performed on inpatient basis that are normally rendered on outpatient basis, respiratory therapy not personally	8 psych or allergy visits/4 months, outpatient heroin detox limited to 21 days and 28 days between episodes of treatment	Fee for service, some services performed in outpatient hospital setting paid 80% of fee	CN & MN

		rendered			
Colorado					
Yes	$2/office or home visit, $.50/15 minute psych service			Fee for service	CN
Connecticut					
Yes		Specified surgical procedures	1 psych evaluation/year, 1 psych therapy/day	Fee for service	CN & MN
Delaware					
Yes				Fee for service	CN
District of Columbia					
Yes		Specified surgical procedures		Fee for service	CN & MN
Florida					
Yes	$2/day for office or non-emergency outpatient hospital visit		1 non-emergency visit/day, 1 routine physical exam/year, 10 prenatal visits/year, 2 postpartum visits/year	Fee for service or prospective cost based rate	CN & MN
Georgia					
Yes	$2/office visit	Specified surgical procedures	12 office visits/year, 1 inpatient hospital visit/day, 12 nursing facility visits/year	Fee for service	CN & MN
Hawaii					
Yes			2 nursing facility visits/month	Fee for service	CN & MN
Idaho					
Yes			Naturopathic services not covered	Fee for service	CN
Illinois					
Yes	$2/visit	Specified surgical procedures	Home visits limited to homebound	Fee for service, certified cost for certain government-employed practitioners	CN & MN
Indiana					
Yes		Specified surgical procedures, procedures exceeding specified	20 office visits/year	Fee for service, services performed with assistance of second surgeon or	CN

		cost limits		in outpatient setting rather than office paid reduced fee	
Iowa					
Yes	$3/day	Specified surgical procedures		Fee for service	CN & MN
Kansas					
Yes	$2/service - See state-specific FN		12 office visits/year, 32 hours psychotherapy/year, 1 inpatient hospital visit/day, 1 nursing facility visit/month, 1 office consultation/2 months, 1 inpatient hospital consultation/10 days	Fee for service	CN & MN
Kentucky					
Yes	$2/visit for specified vision services only		4 psychotherapy visits/year	Fee for service	CN & MN
Louisiana					
Yes		Specified surgical procedures including those to be performed on inpatient basis that are normally rendered on outpatient basis	12 ambulatory visits/year irrespective of setting, 1 inpatient hospital visit/day	Fee for service	CN & MN
Maine					
Yes		Specified procedures Specified procedures and services		Fee for service	CN & MN
Maryland					
Yes		Specified surgical procedures		Fee for service	CN & MN
Massachusetts					
Yes		Specified surgical procedures	1 office, inpatient hospital or home visit/day, 1 nursing facility visit/month	Fee for service	CN & MN
Michigan					
Yes			1 nursing facility visit/month, 5 psych visits/year by general practitioner and 10	Fee for service	CN & MN

			visits/year by psychiatrist		
Minnesota					
Yes	A - $3/visit for non-preventive services except mental health		3 telemedicine consultations/week	Fee for service	A & B - See state-specific FN
Mississippi					
Yes	$3/visit		12 office, clinic or outpatient hospital visits/year, 36 nursing facility visits/year	Fee for service using a percentage of Medicare allowable payment as ceiling	CN
Missouri					
Yes	$1/visit (non-emergency outpatient hospital service only) - See state-specific FN		Specified procedures require a second opinion	Fee for service	CN
Montana					
Yes	$4/visit	Specified services		Fee for service	A & B - See state-specific FN
Nebraska					
Yes	$2/visit (specialist only) - see state-specific FN		Telemedicine consultations require minimum 30 mile distance	Fee for service	CN & MN
Nevada					
Yes			2 office visits/month	Fee for service	CN
New Hampshire					
Yes			18 ambulatory visits/year irrespective of setting, 12 psych visits/year, surgical procedures include pre- and post-operative care	Fee for service with payment ceiling for transplants	CN & MN
New Jersey					
Yes			Psych services up to $900/year or $400 for nursing facility residents	Fee for service, cost based payment for vaccines	CN & MN
New Mexico					
Yes	B - $7/visit with annual	Specified surgical procedures, allergy	2 inpatient hospital or NF visits/day, 3 physical	Fee for service, some services	CN

	maximum across all services based on income, see state-specific FN	testing and treatment	medicine or manipulative therapy visits/month	performed in hospital setting paid 60% of fee	
New York					
Yes			10 visits/year	Fee for service	CN & MN
North Carolina					
Yes	$3/visit	Specified services	24 ambulatory visits/year included in limits with other specified practitioners, 1 routine health assessment exam/year	Fee for service	CN & MN
North Dakota					
Yes	$2/visit		40 psychotherapy visits/year	Fee for service	CN & MN
Ohio					
Yes			24 ambulatory visits/year irrespective of setting, 20 physical medicine visits/year	Fee for service	CN
Oklahoma					
Yes	$1/service		1 inpatient hospital visit/day up to 24, 4 non-emergency ambulatory visits/month irrespective of setting	Fee for service	CN
Oregon					
Yes	A - $3/visit	Specified surgical and therapy procedures	A & B - specified procedures require a second opinion, B - osteopathic manipulative therapy not covered	Fee for service, second and subsequent surgeries performed at same time paid a reduced fee	A & B - See state-specific FN
Pennsylvania					
Yes	$.50-$3/specified service, depending on payment		Specified limits dependent upon care setting	Fee for service with maximums/day dependent on setting, second and subsequent surgeries performed at same time paid a reduced fee	CN & MN
Rhode Island					

Yes		Specified surgical procedures, MN only - multiple visits for chronic and acute diagnoses, psych visits after evaluation	3 patients/home visit, 6 patients/group care facility, MN limited 37 inpatient hospital visits/year	Fee for service	CN & MN - see state-specific F
South Carolina					
Yes	$2/visit		12 visits/year including initial psych visits and specified services provided by nurse practitioners	Fee for service	CN
South Dakota					
Yes	$2/visit		Substance abuse treatment not covered	Fee for service for high volume procedures, percentage of charge for low volume procedures and for supplies	CN
Tennessee					
Yes	B1 - $5/visit except preventive care and $15/specialty care visit, B2 - $10/visit except preventive care and $25/specialty care visit				A & B - See state-specific FN
Texas					
Yes		Specified services		Fee for service	CN & MN
Utah					
Yes	A & B - $3/visit, C - $5/visit		Circumcision not covered, C - primary care only, including routine physical exams	Fee for service, second and subsequent surgeries performed at same time paid a reduced fee, rural physicians may be paid higher fees	A, B & C - See state-specific F
Vermont					
Yes			5 office or home visits/month, 1 inpatient hospital visit/day, 1 nursing facility visit/week, $500/year limit on psychotherapy with some exceptions	Fee for service	A & B - See state-specific FN

Virginia					
Yes	$1/visit including refractive eye exams, $3/service other than visits		Elective surgical procedures must restore body function, inpatient hospital admissions for specified surgical procedures normally rendered on outpatient basis must be medically justified, routine physical exams not covered	Fee for service, some services performed in outpatient hospital setting paid 50% of fee, assistant surgeons paid 20% of fee	CN & MN
Washington					
Yes		Specified surgical procedures	1 inpatient hospital visit/day unless payment is all-inclusive fee, 2 nursing facility visits/month, routine physical exams limited	Fee for service	CN & MN
West Virginia					
Yes		Specified surgical procedures		Fee for service	CN & MN
Wisconsin					
Yes	$.50-$3, depending on service, $1/EPSDT screening for beneficiary over age 18, maximum $30/year/provider except copayment for psychotherapy limited to 15 hours or $500		Specified surgical procedures require second opinion, 1 nursing facility visit/month	Fee for service	CN & MN
Wyoming					
Yes	$1/office or home visit		12 non-emergency visits/year, therapies must be restorative	Fee for service	CN
American Samoa					
Yes					See territory-specific FN
Guam					
Yes			1 inpatient hospital visit/day, 20 psych visits/year, routine physical exams and acupuncture not covered	Fee for service	CN
Northern Mariana Islands					

Yes					CN & MN - See territory-speci FN
Puerto Rico					
Yes			Specialist care requires primary care physician referral	Fee for service for contracted staff, cost based payment for public health staff	CN & MN
Virgin Islands					
Yes				Fee for service	CN