SB
366

HFIN
FILE

(11)

IOUSE COMMITTEE REP⌄ ₹T

Date Referred: April 14, 1994 FURTHER REFERRALS:

Date of Committee Action: 4/30/94

The FINANCE Committee considered: CSSB 366(FIN) am(efd fld)

CSSB 366(FIN) AM(EFD FLD)

"An Act relating to medical support and health insurance coverage for children; allowing a member of the teachers' retirement system or the public emp.ɔyees' retirement system to assign to a Medicaidqualifying trust the member's right to receive a monetary benefit from the system; relating to the effect of a Medicaid-qualifying trust on the eligibility of a person for Medicaid; relating to the recovery of certain Medicaid payments from estates and trusts; requiring persons who receive Medicaid services to be liable for sharing in the cost of those services to the extent allowed under federal law and regulations."

RECOMMENDATIONS: [ ] the same title

be replaced with ______ [ ] a new title

[ ] have attached amendments(s)

[✓] do pass

[ ] do not pass

[ ] no recommendations

[ ] individual recommendations

[ ] additional referral to the ______ Committee

ADOPTS: ______ letter of Intent

ATTACHES NEW FISCAL NOTE(s): (Dept) APPROVES PREVIOUS: (Dept/Date)

[✓] fiscal impact DHSS [✓] fiscal note(s) (2) DHSS

[ ] zero fiscal note ______ [✓] zero fiscal note(s) DCED 4/12/94

SIGNING DO PASS	DP	OTHER RECOMMENDATIONS	DNP	NR	AM
Eldon P. MacLean (MacLean)	✓	Terry Martin (Martin)		✓	
Ronald L. Larson (Larson)	X	Kay Brown (Brown)		✓	
Ben Grussendorf (Grussendorf)	X	Gene Therriault (Therriault)		X	
Richard Foster (Foster)	X				
[signature]					

Ronald L. Larson / E.P. MacLean

CHAIRMAN'S SIGNATURE

CS FOR SENATE BILL NO. 366(FIN) am(efd fld)

IN THE LEGISLATURE OF THE STATE OF ALASKA

EIGHTEENTH LEGISLATURE - SECOND SESSION

BY THE SENATE FINANCE COMMITTEE

FIN

Amended: 4/11/94
Offered: 4/6/94

Sponsor(s): SENATE FINANCE COMMITTEE

A BILL

FOR AN ACT ENTITLED

1 "An Act relating to medical support and health insurance coverage for children;
2 allowing a member of the teachers' retirement system or the public employees'
3 retirement system to assign to a Medicaid-qualifying trust the member's right to
4 receive a monetary benefit from the system; relating to the effect of a Medicaid-
5 qualifying trust on the eligibility of a person for Medicaid; relating to the
6 recovery of certain Medicaid payments from estates and trusts; requiring persons
7 who receive Medicaid services to be liable for sharing in the cost of those
8 services to the extent allowed under federal law and regulations."

9 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

10 * Section 1. PURPOSES. The purposes of this Act are to
11 (1) bring the state into compliance with federal law with respect to the recovery of
12 Medicaid payments from the estates and trusts of individuals under certain circumstances and

No. 4
Bill Version CSSB 366 (FIN)
(S) Publish Date: 4-12-94

FISCAL NOTE

STATE OF ALASKA
1994 LEGISLATIVE SESSION

Revision Date:
Title: Medicaid and Medical Support Orders

Sponsor: Senate Finance Committee
Requestor:

Department Affected: Commerce and Economic Development
BRU: Insurance
Component: Operations

COMPONENT SERIAL NO. 354

Expenditures/Revenues:

OPERATING EXPENDITURES	FY 95	FY 96	FY 97	FY 98	FY 99	FY 00
PERSONAL SERVICES	0	0	0	0	0	0
TRAVEL	0	0	0	0	0	0
CONTRACTUAL	0	0	0	0	0	0
SUPPLIES	0	0	0	0	0	0
EQUIPMENT	0	0	0	0	0	0
LAND & STRUCTURES	0	0	0	0	0	0
GRANTS, CLAIMS	0	0	0	0	0	0
MISCELLANEOUS	0	0	0	0	0	0
TOTAL OPERATING	0	0	0	0	0	0

CAPITAL EXPENDITURES	0	0	0	0	0	0
CHANGE IN REVENUES ( )	0	0	0	0	0	0

FUND SOURCE

1002 Federal Receipts	0	0	0	0	0	0
1003 GF Match	0	0	0	0	0	0
1004 GF	0	0	0	0	0	0
1005 GF/Program Receipts	0.	0	0	0	0	0
1006 GF/MHTIA	0	0	0	0	0	0
Other	0	0	0	0	0	0
TOTAL	0	0	0	0	0	0

Estimate of current year (FY 94) cost: $ 0

POSITIONS

FULL-TIME	0	0	0	0	0	0
PART-TIME	0	0	0	0	0	0
TEMPORARY	0	0	0	0	0	0

ANALYSIS: (Attach a separate page if necessary.)

No fiscal impact.

Prepared by: Joan Brown, Administrative Officer
Phone: 465-2597
Division: Insurance
Date: 4/11/94

Approved by Commissioner: Paul Fuhs
Agency: Commerce and Economic Development
Date: 4-12-94

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No. 3

FISCAL NOTE

Bill Version: SB 366

(S) Publish Date: 4-6-94

STATE OF ALASKA
1994 LEGISLATIVE SESSION

Revision Date: 03/25/95
Title: An Act relating to medical child support, recovery from estates and trusts...
Sponsor: Senate Finance Committee
Requestor: Senate Finance Committee

Dept. Affecte Health and Social Services
BRU: Medical Assistance Administration
Component: Claims Processing
COMPONENT SERIAL NO. 243

Expenditures/Revenues: (Thousa..ds of Dollars)

OPERATING	FY95	FY96	FY97	FY98	FY99	FY00
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL	130.0					
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	130.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGES IN REVENUES						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	65.0					
1003 GF Match	65.0					
1004 GF						
1005 GF/Program Receipts						
1006 GF/MHTIA						
Other						
TOTAL	130.0	0.0	0.0	0.0	0.0	0.0

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

Changes in SB 366 (Fin) reflect ~~NO~~ FISCAL CHANGE from the origin fiscal note. This fiscal note is appropriate.
4-6-94 date — Comte Aide (initial)

Estimate of current year (FY94) impact: 0.0

ANALYSIS: (Attach a separate page if necessary)

Implementation of the copayment requirements will necessitate several changes to the claims processing system. The one-time contractual cost of these changes is estimated on the attached page.

Prepared by: Kevin Henderson
Phone: 465-3355
Division: Medical Assistance
Date: 03/25/94
Approved by Commissioner: Margaret R. Lowe, M.Ed., Ed.S.
Date: 3-25-94
Agency: Department of Health & Social Services

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ANALYSIS (cont.):

Estimated Cost of One-Time Claims Processing Changes

Facility Inpatient Claims	$25,000
Facility Outpatient Claims	$25,000
Identify and Separate Under Age 18 Claims	$15,000
Identify and Separate Pregnancy Claims	$15,000
Non-facility, Copayment Applied Per Line	$25,000
Non-facility, Copayment Applied Per Claim	$25,000
Total	$130,000

STATE OF ALASKA
1994 LEGISLATIVE SESSION

BILL NO. CSSB 366 (FIN)

Revision Date: 4/6/94
Title: **Medical child support, recovery from estates and trusts, and recipient cost sharing**
Sponsor: **Senate Finance Committee**
Requestor:

Dept. Affected **Health and Social Services**
BRU: **Medical Assistance**
Component: **Medicaid Facilities**

COMPONENT SERIAL NO. 230

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY95	FY96	FY97	FY98	FY99	FY00
PERSONAL SERVICES	0.0	0.0	0.0	0.0	0.0	0.0
TRAVEL	0.0	0.0	0.0	0.0	0.0	0.0
CONTRACTUAL	0.0	0.0	0.0	0.0	0.0	0.0
SUPPLIES	0.0	0.0	0.0	0.0	0.0	0.0
EQUIPMENT	0.0	0.0	0.0	0.0	0.0	0.0
LAND & STRUCTURES	0.0	0.0	0.0	0.0	0.0	0.0
GRANTS, CLAIMS	(235.4)	(530.1)	(596.9)	(672.1)	(756.8)	(852.2)
MISCELLANEOUS	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL OPERATING	(235.4)	(530.1)	(596.9)	(672.1)	(756.8)	(852.2)

	FY95	FY96	FY97	FY98	FY99	FY00
CAPITAL EXPENDITURES	0.0	0.0	0.0	0.0	0.0	0.0
CHANGES IN REVENUES	0.0	0.0	0.0	0.0	0.0	0.0

FUND SOURCE (Thousands of Dollars)

FUND SOURCE	FY95	FY96	FY97	FY98	FY99	FY00
1002 Federal Receipts	(176.7)	(327.5)	(364.9)	(406.5)	(452.9)	(505.1)
1003 GF Match	(176.7)	(327.6)	(365.0)	(406.6)	(452.9)	(505.1)
1004 GF	0.0	0.0	0.0	0.0	0.0	0.0
1005 GF/Program Receipts	118.0	125.0	133.0	141.0	149.0	158.0
1006 GF/MHTIA	0.0	0.0	0.0	0.0	0.0	0.0
Other	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL	(235.4)	(530.1)	(596.9)	(672.1)	(756.8)	(852.2)

Estimate of current year (FY94) impact: 0.0

POSITIONS:

	FY95	FY96	FY97	FY98	FY99	FY00
FULL-TIME	0	0	0	0	0	0
PART-TIME	0	0	0	0	0	0
TEMPORARY	0	0	0	0	0	0

ANALYSIS (attach a separate page in necessary)

This bill would bring DH&SS into compliance with OBRA-93 changes dealing with child medical support orders (42 U.S.C. 1396g) and medicaid qualifying trusts and estate recovery (42 U.S.C. 1396p), and with recipient liability for sharing the cost of Medicaid services. New requirements are placed on employers and insurers when a child medical support order is in effect. New statutory authority (as required by federal law) is provided to the department to seek recovery of Medicaid payments made on behalf of certain individuals in long-term care through the placing of liens on that individual's real property. Fiscal impact is categorized into three components: Facilities, Non-Facility, and Claims processing. This fiscal note shows savings in the Medicaid Facilities component. See attached sheet for details. NOTE: In the Facilities component, the House budget has already reduced the Governor's request by $550,000 in anticipation of co-pay implementation.

Prepared by: Kevin D. Henderson DW for KDH
Division: Medical Assistance
Phone: 465-3355
Date: 4/28/94

Approved by Commissioner: Margaret R. Lowe, M.Ed., Ed.S. *(signed: Margaret R. Lowe)*
Date: 4-28/94
Agency: Department of Health and Social Services

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ESTATE RECOVERY

Division of Medical Assistance historical data shows that the long-term care caseload for FY 95 is expected to be 1183 individuals. Division of Public Assistance eligibility technicians estimate that the long-term care population will experience an annual death rate of 10 percent. It is anticipated that the long-term care population (including those receiving waiver services) will grow enough to replace the 10 percent who die each year and will increase an additional 6 percent per year. The average amount of estate recovery expected from that population is estimated to be $1000 per person; this amount is multiplied by the number of cases expected to have money available for recovery (i.e., 10 percent of the caseload, based upon the death rate). The resulting estate recovery is shown in this fiscal note as program receipts.

Death rate in LTC facilities:	10%
Average recovery expected:	$1,000
Annual LTC facility growth rate	6%

	FY 95	FY 96	FY 97	FY 98	FY 99	FY 00
Nursing Home (6% growth)	926	982	1041	1103	1169	1239
Waivers (6% growth)	257	272	288	305	323	342
TOTAL Caseload	1183	1254	1329	1408	1492	1581
Estate Recovery Cases (10% of caseload)	118	125	133	141	149	158
x $1000 Total Program Receipts = (thousands)	$118.0	$125.0	$133.0	$141.0	$149.0	$158.0

MEDICAID QUALIFYING TRUSTS

The provisions of this bill that allow PERS and TERS beneficiaries to divert pension income into medicaid qualifying trusts parallels federal law which authorizes diversion of social security payments into medicaid qualifying trusts. We do not anticipate an increase in Medicaid utilization solely because of these provisions.

COST SHARING (Facilities)

PROGRAM REDUCTION DUE TO IMPOSITION OF COPAYMENT REQUIREMENTS: The facilities component will be reduced under the provisions of SB 366 by the amount of copayments for which recipients become responsible. The minimum time required to develop regulations, provider manuals changes, claims payment system changes, and provide required notices and address hearings/appeals is one-half year. For this reason, the amount realized in the facilities component for FY 95 is estimated on a half-year implementation. The cost-shifting to recipients and providers in future years will be doubled and also increased by program growth and further identification of cost-effective copayment potential. We project that Medicaid program expenditures will grow at a 6 percent rate annually for facilities. The total FY95 copayment for this component is anticipated to be $235,400 .

Under the bill the copayment for inpatient services is $50 per day up to a maximum of $200 per discharge. The claims payment history shows the following inpatient claims for the previous 12 month period: 1 day=740 claims, 2 days=596 claims, 3 days=460 claims, 4 or more days=1220 claims. Based on this information and implementation of copayments in the last half of FY95 the amount of copayment to be realized from inpatient services would be $217,100.

Outpatient hospital services produce an estimated copayment amount of $18,300. This amount assumes a $3 copayment on outpatient services and approval of a federal waiver to allow a $6 copayment per visit for non-emergency

Amount of co-pay plus annual program growth (thousands)	12.6%	$235.4	$530.1	$598.9	$672.1	$756.8	$852.2

No. 1
Bill Version: SB 366
(S) Publish Date: 4-6-94

FISCAL NOTE

STATE OF ALASKA
1994 LEGISLATIVE SESSION

Revision Date: 4/4/94
Title: Medical child support, recovery from estates and trusts, and recipient cost sharing
Sponsor: Senate Finance Committee
Requestor:

Dept. Affected: Health and Social Services
BRU: Medical Assistance
Component: Medicaid Non-Facility

COMPONENT SERIAL NO. 229

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY95	FY96	FY97	FY98	FY99	FY00
PERSONAL SERVICES	0.0	0.0	0.0	0.0	0.0	0.0
TRAVEL	0.0	0.0	0.0	0.0	0.0	0.0
CONTRACTUAL	0.0	0.0	0.0	0.0	0.0	0.0
SUPPLIES	0.0	0.0	0.0	0.0	0.0	0.0
EQUIPMENT	0.0	0.0	0.0	0.0	0.0	0.0
LAND & STRUCTURES	0.0	0.0	0.0	0.0	0.0	0.0
GRANTS, CLAIMS	(799.1)	(1,494.6)	(2,004.2)	(2,276.6)	(2,586.0)	(2,937.8)
MISCELLANEOUS	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL OPERATING	(799.1)	(1,494.6)	(2,004.2)	(2,276.6)	(2,586.0)	(2,937.8)
CAPITAL EXPENDITURES	0.0	0.0	0.0	0.0	0.0	0.0
CHANGES IN REVENUES	0.0	0.0	0.0	0.0	0.0	0.0

FUND SOURCE (Thousands of Dollars)

FUND SOURCE	FY95	FY96	FY97	FY98	FY99	FY00
1002 Federal Receipts	(399.5)	(747.3)	(1,002.1)	(1,138.3)	(1,293.0)	(1,468.9)
1003 GF Match	(399.6)	(747.3)	(1,002.1)	(1,138.3)	(1,293.0)	(1,468.9)
1004 GF	0.0	0.0	0.0	0.0	0.0	0.0
1005 GF/Program Receipts	0.0	0.0	0.0	0.0	0.0	0.0
1006 GF/MHTIA	0.0	0.0	0.0	0.0	0.0	0.0
Other	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL	(799.1)	(1,494.6)	(2,004.2)	(2,276.6)	(2,586.0)	(2,937.8)

Estimate of current year (FY94) impact: 0.0

Changes in CSSB 366 (Fin) reflect NO FISCAL CHANGE from the or[iginal] fiscal note. This fiscal note is appropriate
4-6-94 — date
[initial] — Comte Aide (initial)

POSITIONS:

FULL-TIME	0	0	0
PART-TIME	0	0	0
TEMPORARY	0	0	0

ANALYSIS (attach a separate page in necessary)

This bill would bring DH&SS into compliance with OBRA-93 changes dealing with child medical support orders (42 U.S.C. 1396g) and medicaid qualifying trusts and estate recovery (42 U.S.C. 1396p), and with recipient liability for sharing the cost of Medicaid services. New requirements are placed on employers and insurers when a child medical support order is in effect. New statutory authority (as required by federal law) is provided to the department to seek recovery of Medicaid payments made on behalf of certain individuals in long-term care through the placing of liens on that individual's real property. Fiscal impact is categorized into three components: Facilities, Non-Facility, and Claims Processing. This fiscal note shows savings in the non-facility component. See attached sheet for details. NOTE: In the Non-Facility component, the House budget has already reduced the Governor's request by $400,000 in anticipation of co-pay implementation.

Prepared by: Kevin D. Henderson [signature]
Division: Medical Assistance
Phone: 465-3355
Date: 4/4/94

Approved by Commissioner: Margaret R. Lowe, M.Ed., Ed.S. [signature]
Agency: Department of Health and Social Services
Date: 4-5-94

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MEDICAL SUPPORT ORDERS

RECIPIENT TYPE	Cost of Medicaid Per Individual		
	# of Clients (FY 93)	Cost (FY 93)	Cost Per Recipient
Children who receive AFDC	24,961	$39,259,803	$1,573
Children (non-AFDC)	3,742	$9,967,083	$2,664
Children (1-5 yrs/MCCA-88)	7,092	$12,929,757	$1,823
Total	35,795	$62,156,643	$1,736
Estimated growth in individual cost for FY 94	12.6%		$1,955

INCREASED COST AVOIDANCE THROUGH THIRD-PARTY RESOURCES: Currently, CSED has a case load in excess of 40,000 cases, 19,464 of these cases are AFDC related. As of February 1994, 6,230 of the AFDC related cases have a medical support order and, of those, 1,322 have medical insurance provided at this time. Under other federal law (not OBRA-93) CSED is currently reviewing and modifying all existing cases since 10/1/85 to add medical support orders where needed. This is an ongoing process that is expected to be completed by the end of FY 97. CSED estimates that, by the end of FY 97, all AFDC orders will include a medical support order. All new AFDC related CSED cases are required to have medical support orders. With the anticipated growth in the number of new cases, the completion of review and modification of all existing cases, and the added provisions of OBRA-93 reflected in SB 366, CSED estimates that the number of AFDC cases with medical support orders will total between 22,000 – 23,000 by the end of FY 97. After FY 97, when the backlog is eliminated, the growth in CSED/AFDC cases with medical support orders is expected to be approximately 6% per year. For FY 95, CSED estimates a base of approximately 10,430 total cases with medical support orders. The estimated number of cases in FY 96 is an even split between 10,430 in FY 95 and 22,500 in FY 97.

		FY 95	FY 96	FY 97	FY 98	FY 99	FY 00
CSED Cases per year w/ medical orders (6% increase after FY 97)	6%	10430	16465	22500	23850	25281	26798
Cases with third-party payment because of SB 366 (5% of caseload)	5%	522	823	1125	1193	1264	1340
Cost of Medicaid per individual x SB366 cases (7.6 % growth per year)	7.6%	$2,104	$2,264	$2,436	$2,621	$2,820	$3,034
Cost of deductibles, co-pay, and uncovered services (Not subject to cost collection)	50%	$1,052	$1,132	$1,218	$1,311	$1,410	$1,517
Actual cost avoidance per individual		$1,052	$1,132	$1,218	$1,310	$1,410	$1,517
INCREASED COST AVOIDANCE		$549,144	$931,636	$1,370,250	$1,562,830	$1,782,240	$2,032,780

COST SHARING (Non-Facility)

PROGRAM REDUCTION DUE TO IMPOSITION OF COPAYMENT REQUIREMENTS: The non-facility component will be reduced under the SB 366 by the amount of copayments for which recipients become responsible. The minimum time required to develop regulations, provider manuals changes, claims payment system changes, and provide required notices and address hearings/appeals is one-half year. For this reason, the amount realized in the non-facility component for FY 95 is estimated on a half-year implementation. The cost-shifting to recipients and providers in future years will be doubled and also increase by program growth and further identification of cost-effective copayment potential. Copayments for non-facility services are limited by federal regulation to nominal amounts and are, therefore, more marginal on cost-return analysis. Non-facility copayments are estimated to produce $250,000 in copayment offsets to claims for FY 95. We project that Medicaid program expenditures will grow at a 12.6 percent rate annually.

Amount of co-pay plus yearly program gro	12.6%	250,000	563,000	633,938	713,814	803,755	905,028

TOTAL COST AVOIDANCE (Non-Facility)	$799,144	$1,494,636	$2,004,188	$2,276,644	$2,585,995	$2,937,808

FISCAL NOTE

No. 4

Bill Version: CSSB 366 (FIN)

(S) Publish Date: 4-12-94

STATE OF ALASKA
1994 LEGISLATIVE SESSION

Revision Date:
Title: Medicaid and Medical Support Orders

Sponsor: Senate Finance Committee
Requestor:

Department Affected: Commerce and Economic Development
BRU: Insurance
Component: Operations

COMPONENT SERIAL NO. 354

Expenditures/Revenues:

OPERATING EXPENDITURES	FY 95	FY 96	FY 97	FY 98	FY 99	FY 00
PERSONAL SERVICES	0	0	0	0	0	0
TRAVEL	0	0	0	0	0	0
CONTRACTUAL	0	0	0	0	0	0
SUPPLIES	0	0	0	0	0	0
EQUIPMENT	0	0	0	0	0	0
LAND & STRUCTURES	0	0	0	0	0	0
GRANTS, CLAIMS	0	0	0	0	0	0
MISCELLANEOUS	0	0	0	0	0	0
TOTAL OPERATING	0	0	0	0	0	0
CAPITAL EXPENDITURES	0	0	0	0	0	0
CHANGE IN REVENUES ( )	0	0	0	0	0	0

FUND SOURCE

FUND SOURCE	FY 95	FY 96	FY 97	FY 98	FY 99	FY 00
1002 Federal Receipts	0	0	0	0	0	0
1003 GF Match	0	0	0	0	0	0
1004 GF	0	0	0	0	0	0
1005 GF/Program Receipts	0.	0	0	0	0	0
1006 GF/MHTIA	0	0	0	0	0	0
Other	0	0	0	0	0	0
TOTAL	0	0	0	0	0	0

Estimate of current year (FY 94) cost: $ 0

POSITIONS

POSITIONS	FY 95	FY 96	FY 97	FY 98	FY 99	FY 00
FULL-TIME	0	0	0	0	0	0
PART-TIME	0	0	0	0	0	0
TEMPORARY	0	0	0	0	0	0

ANALYSIS: (Attach a separate page if necessary.)

No fiscal impact.

Prepared by: Joan Brown, Administrative Officer
Division: Insurance
Phone: 465-2597
Date: 4/11/94

Approved by Commissioner: Paul Fuhs
Agency: Commerce and Economic Development
Date: 4-12-94

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No. 3

FISCAL NOTE

Bill Version: SB 366

(S) Publish Date: 4-6-94

STATE OF ALASKA
1994 LEGISLATIVE SESSION

Revision Date: 03/25/95

Title: An Act relating to medical child support, recovery from estates and trusts...

Sponsor: Senate Finance Committee

Requestor: Senate Finance Committee

Dept. Affecte Health and Social Services

BRU: Medical Assistance Administration

Component: Claims Processing

COMPONENT SERIAL NO. 243

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY95	FYS6	FY97	FY98	FY99	FY00
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL	130.0					
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	130.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGES IN REVENUES						

FUND SOURCE (Thousands of Dollars)

FUND SOURCE						
1002 Federal Receipts	65.0					
1003 GF Match	65.0					
1004 GF						
1005 GF/Program Receipts						
1006 GF/MHTIA						
Other						
TOTAL	[illegible]0.0	0.0	0.0	0.0	0.0	0.0

POSITIONS:

POSITIONS						
FULL-TIME						
PART-TIME						
TEMPORARY						

Changes in CS SB 366 (Fin) reflect ~~NO~~ a FISCAL CHANGE from the origin fiscal note. This fiscal note is appropriate.

4-6-94 date — [initials] Comte Aide (initial)

Estimate of current year (FY94) impact: 0.0

ANALYSIS: (Attach a separate page if necessary)

Implementation of the copayment requirements will necessitate several changes to the claims processing system. The one-time contractual cost of these changes is estimated on the attached page.

Prepared by: Kevin Henderson [signature]

Phone: 465-3355

Division: Medical Assistance

Date: 03/25/94

Approved by Commissioner: Margaret R. Lowe, M.Ed., Ed.S. [signature: Margaret R. Lowe]

Date: 3-25-94

Agency: Department of Health & Social Services

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ANALYSIS (cont.):

Estimated Cost of One-Time Claims Processing Changes

Facility Inpatient Claims	$25,000
Facility Outpatient Claims	$25,000
Identify and Separate Under Age 18 Claims	$15,000
Identify and Separate Pregnancy Claims	$15,000
Non-facility, Copayment Applied Per Line	$25,000
Non-facility, Copayment Applied Per Claim	$25,000
Total	$130,000

STATE OF ALASKA
1994 LEGISLATIVE SESSION

FISCAL NOTE

No. 1
Bill Version: SB 366
(S) Publish Date: 4-6-94

Revision Date:	4/4/94	Dept. Affected	Health and Social Services
Title:	Medical child support, recovery from estates and trusts, and recipient cost sharing	BRU:	Medical Assistance
		Component:	Medicaid Non-Facility
Sponsor:	Senate Finance Committee		
Requestor:		COMPONENT SERIAL NO.	229

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY95	FY96	FY97	FY98	FY99	FY00
PERSONAL SERVICES	0.0	0.0	0.0	0.0	0.0	0.0
TRAVEL	0.0	0.0	0.0	0.0	0.0	0.0
CONTRACTUAL	0.0	0.0	0.0	0.0	0.0	0.0
SUPPLIES	0.0	0.0	0.0	0.0	0.0	0.0
EQUIPMENT	0.0	0.0	0.0	0.0	0.0	0.0
LAND & STRUCTURES	0.0	0.0	0.0	0.0	0.0	0.0
GRANTS, CLAIMS	(799.1)	(1,494.6)	(2,004.2)	(2,276.6)	(2,586.0)	(2,937.8)
MISCELLANEOUS	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL OPERATING	(799.1)	(1,494.6)	(2,004.2)	(2,276.6)	(2,586.0)	(2,[illegible]7.8)
CAPITAL EXPENDITURES	0.0	0.0	0.0	0.0	0.0	0.0
CHANGES IN REVENUES	0.0	0.0	0.0	0.0	0.0	0.0

FUND SOURCE (Thousands of Dollars)

	FY95	FY96	FY97	FY98	FY99	FY00
1002 Federal Receipts	(399.5)	(747.3)	(1,002.1)	(1,138.3)	(1,293.0)	(1,468.9)
1003 GF Match	(399.6)	(747.3)	(1,002.1)	(1,138.3)	(1,293.0)	(1,468.9)
1004 GF	0.0	0.0	0.0	0.0	0.0	0.0
1005 GF/Program Receipts	0.0	0.0	0.0	0.0	0.0	0.0
1006 GF/MHTIA	0.[illegible]	0.0	0.0	0.0	0.0	0.0
Other	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL	(799.1)	(1,494.6)	(2,004.2)	(2,276.6)	(2,586.0)	(2,937.8)

Estimate of current year (FY94) impact: 0.0

POSITIONS:

FULL-TIME	0	0	0
PART-TIME	0	0	0
TEMPORARY	0	0	0

Changes in CSSB 366 (Fin) reflect ~~NO~~ FISCAL CHANGE from the orig fiscal note. This fiscal note is appropriate.
4-6-94 date — Comte Aide (initial)

ANALYSIS (attach a separate page in necessary)

This bill would bring DH&SS into compliance with OBRA-93 changes dealing with child medical support orders (42 U.S.C. 1396g) and medicaid qualifying trusts and estate recovery (42 U.S.C. 1396p), and with recipient liability for sharing the cost of Medicaid services. New requirements are placed on employers and insurers when a child medical support order is in effect. New statutory authority (as required by federal law) is provided to the department to seek recovery of Medicaid payments made on behalf of certain individuals in long-term care through the placing of liens on that individual's real property. Fiscal impact is categorized into three components: Facilities, Non-Facility, and Claims Processing. This fiscal note shows savings in the non-facility component. See attached sheet for details. NOTE: In the Non-Facility component, the House budget has already reduced the Governor's request by $400,000 in anticipation of co-pay implementation.

Prepared by:	Kevin D. Henderson	Phone:	465-3355
Division:	Medical Assistance	Date:	4/4/94
Approved by Commissioner:	Margaret R. Lowe, M.Ed., Ed.S.	Date:	4-5-94
Agency:	Department of Health and Social Services		

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MEDICAL SUPPORT ORDERS

Cost of Medicaid Per Individual

RECIPIENT TYPE	# of Clients (FY 93)	Cost (FY 93)	Cost Per Recipient
Children who receive AFDC	24,961	$39,259,803	$1,573
Children (non-AFDC)	3,742	$9,967,083	$2,664
Children (1-5 yrs/MCCA-88)	7,092	$12,929,757	$1,823
Total	35,795	$62,156,643	$1,736
Estimated growth in individual cost for FY 94	12.6%		$1,955

INCREASED COST AVOIDANCE THROUGH THIRD-PARTY RESOURCES: Currently, CSED has a case load in excess of 40,000 cases, 19,464 of these cases are AFDC related. As of February 1994, 6,230 of the AFDC related cases have a medical support order and, of those, 1,322 have medical insurance provided at this time. Under other federal law (not OBRA-93) CSED is currently reviewing and modifying all existing cases since 10/1/85 to add medical support orders where needed. This is an ongoing process that is expected to be completed by the end of FY 97. CSED estimates that, by the end of FY 97, all AFDC orders will include a medical support order. All new AFDC related CSED cases are required to have medical support orders. With the anticipated growth in the number of new cases, the completion of review and modification of all existing cases, and the added provisions of OBRA-93 reflected in SB 366, CSED estimates that the number of AFDC cases with medical support orders will total between 22,000 – 23,000 by the end of FY 97. After FY 97, when the backlog is eliminated, the growth in CSED/AFDC cases with medical support orders is expected to be approximately 6% per year. For FY 95, CSED estimates a base of approximately 10,430 total cases with medical support orders. The estimated number of cases in FY 96 is an even split between 10,430 in FY 95 and 22,500 in FY 97.

		FY 95	FY 96	FY 97	FY 98	FY 99	FY 00
CSED Cases per year w/ medical orders (6% increase after FY 97)	6%	10430	16465	22500	23850	25281	26798
Cases with third-party payment because of SB 366 (5% of caseload)	5%	522	823	1125	1193	1264	1340
Cost of Medicaid per individual x SB366 cases (7.6 % growth per year)	7.6%	$2,104	$2,264	$2,436	$2,621	$2,320	$3,034
Cost of deductibles, co-pay, and uncovered services (Not subject to cost collection)	50%	$1,052	$1,132	$1,218	$1,311	$1,410	$1,517
Actual cost avoidance per individual		$1,052	$1,132	$1,218	$1,310	$1,410	$1,517
INCREASED COST AVOIDANCE		$548,144	$931,636	$1,370,250	$1,562,830	$1,782,240	$2,032,780

COST SHARING (Non-Facility)

PROGRAM REDUCTION DUE TO IMPOSITION OF COPAYMENT REQUIREMENTS: The non-facility component will be reduced under the SB 366 by the amount of copayments for which recipients become responsible. The minimum time required to develop regulations, provider manuals changes, claims payment system changes, and provide required notices and address hearings/appeals is one-half year. For this reason, the amount realized in the non-facility component for FY 95 is estimated on a half-year implementation. The cost-shifting to recipients and providers in future years will be doubled and also increase by program growth and further identification of cost-effective copayment potential. Copayments for non-facility services are limited by federal regulation to nominal amounts and are, therefore, more marginal on cost-return analysis. Non-facility copayments are estimated to produce $250,000 in copayment offsets to claims for FY 95. We project that Medicaid program expenditures will grow at a 2.6 percent rate annually.

		FY 95	FY 96	FY 97	FY 98	FY 99	FY 00
Amount of co-pay plus yearly program gro	12.6%	250,000	563,000	633,938	713,814	803,755	905,028

	FY 95	FY 96	FY 97	FY 98	FY 99	FY 00
TOTAL COST AVOIDANCE (Non-Facility)	$799,144	$1,494,636	$2,004,188	$2,276,644	$2,585,995	$2,937,808

STATE OF ALASKA ★ DEPARTMENT OF HEALTH & SOCIAL SERVICES

POSITION PAPER

Senate Bill 366

"An Act relating to medical support for children; ..."

Under the federal Omnibus Budget Reconciliation Act of 1993 (OBRA 93), state Medicaid programs must implement provisions to obtain and enforce medical support orders for noncustodial parents on behalf of Medicaid-eligible children and to recover Medicaid expenditures on long term care and related expenditures for Medicaid recipients age 55 and older. Implementation of these provisions is necessary to avoid loss of federal financial participation in the Alaska Medicaid program.

In addition, OBRA 93 amended federal law to allow individuals to assign their Social Security payments to certain kinds of trusts created for the purpose of qualifying for Medicaid. Senate Bill 366 amends Alaska statutes to allow individuals to assign their payments from the Teachers' Retirement System and the Public Employees Retirement System to these Medicaid qualifying trusts.

Senate Bill 366 also requires the Medicaid program to impose copayments for Medicaid-funded services to the maximum extent possible. This provision will reduce Medicaid expenditures and shift costs to Medicaid recipients and providers.

Position

The department supports the provisions bringing the Alaska Medicaid program into compliance with federal law; these provisions will avoid federal sanctions and result in savings to the Medicaid program. The department also supports allowing individuals to assign TRS or PERS benefits to Medicaid qualifying trusts. The department does not have a position on the implementation of copayments.

Recommended by: Kimberly B. Busch
Kimberly B. Busch, Director
Division of Medical Assistance

Date: 3-25-94

Approved by: Margaret R. Lowe
Margaret R. Lowe, M.Ed., Ed. S.
Commissioner

Date: 3/25/94

SB 366

whether the agency has shown good faith, the Administrator will consider whether the agency has received an unusually high volume of claims which are not clean claims, and whether the agency is making diligent efforts to implement an automated claims processing and information retrieval system.

(2) The agency's request for a waiver must contain a written plan of correction specifying all steps it will take to meet the requirements of this section.

(3) The Administrator will review each case and if he approves a waiver, will specify its expiration date, based on the State's capability and efforts to meet the requirements of this section.

(f) *Prepayment and postpayment claims review.* (1) For all claims, the agency must conduct prepayment claims review consisting of—

(i) Verification that the recipient was included in the eligibility file and that the provider was authorized to furnish the service at the time the service was furnished;

(ii) Checks that the number of visits and services delivered are logically consistent with the recipient's characteristics and circumstances, such as type of illness, age, sex, service location;

(iii) Verification that the claim does not duplicate or conflict with one reviewed previously or currently being reviewed;

(iv) Verification that a payment does not exceed any reimbursement rates or limits in the State plan; and

(v) Checks for third party liability within the requirements of § 433.137 of this chapter.

(2) The agency must conduct postpayment claims review that meets the requirements of parts 455 and 456 of this chapter, dealing with fraud and utilization control.

(g) *Reports.* The agency must provide any reports and documentation on compliance with this section that the Administrator may require.

(Secs. 1102 and 1902(a)(37) of the Social Security Act (42 U.S.C. 1302, 1396a(a)(37)))

[44 FR 30344, May 25, 1979, as amended at 55 FR 1434, Jan. 16, 1990]

Cost Sharing

§ 447.50 Cost sharing: Basis and purpose.

(a) Section 1902(a)(14) of the Act permits States to require certain recipients to share some of the costs of Medicaid by imposing upon them such payments as enrollment fees, premiums, deductibles, coinsurance, co-payments, or similar cost sharing charges. For States that impose cost sharing payments, §§ 447.51 through 447.59 prescribe State plan requirements and options for cost sharing, specify the standards and conditions under which States may impose cost sharing, set forth minimum amounts and the methods for determining maximum amounts, and prescribe conditions for FFP that relate to cost sharing requirements.

Enrollment Fee, Premium or Similar Cost Sharing Charge

§ 447.51 Requirements and options.

(a) The plan must provide that the Medicaid agency does not impose any enrollment fee, premium, or similar charge upon categorically needy individuals, as defined in §§ 435.4 and 436.3 of this subchapter, for any services available under the plan.

(b) The plan may impose an enrollment fee, premium, or similar charge on medically needy individuals, as defined in §§ 435.4 and 436.3 of this subchapter, for any services available under the plan.

(c) For each charge imposed under paragraph (b) of this section, the plan must specify—

(1) The amount of the charge;

(2) The period of liability for the charge; and

(3) The consequences for an individual who does not pay.

(d) The plan must provide that any charge imposed under paragraph (b) of this section is related to total gross family income as set forth under § 447.52.

§ 447.52 Minimum and maximum income-related charges.

For the purpose of relating the amount of an enrollment fee, premium, or similar charge to total gross

— Federal Regs. Re: Medicaid Copayments —

family income, as required under § 447.51(d), the following rules apply:

(a) *Minimum charge.* A charge of at least $1.00 per month is imposed on each—

(1) One- or two-person family with monthly gross income of $150 or less;

(2) Three- or four-person family with monthly gross income of $300 or less; and

(3) Five- or more-person family with monthly gross income of $350 or less.

(b) *Maximum charge.* Any charge related to gross family income that is above the minimum listed in paragraph (a) of this section may not exceed the standards shown in the following table:

MAXIMUM MONTHLY CHARGE

Gross family income (per month)	Family size		
	1 or 2	3 or 4	5 or more
$150 or less	$1	$1	$1
$151 or $200	2	1	1
$201 to $250	3	1	1
$251 to $300	4	1	1
$301 to $350	5	2	1
$351 to $400	6	3	2
$401 to $450	7	4	3
$451 to $500	8	5	4
$501 to $550	9	6	5
$551 to $600	10	7	6
$601 to $650	11	8	7
$651 to $700	12	9	8
$701 to $750	13	10	9
$751 to $800	14	11	10
$801 to $850	15	12	11
$851 to $900	16	13	12
$901 to $950	17	14	13
$951 to $1,000	18	15	14
More than $1,000	19	16	15

(c) *Income-related charges.* The agency must impose an appropriately higher charge for each higher level of family income, within the maximum amounts specified in paragraph (b) of this section.

[43 FR 45253, Sept. 29, 1978, as amended at 45 FR 24889, Apr. 11, 1980]

DEDUCTIBLE, COINSURANCE, CO-PAYMENT OR SIMILAR COST-SHARING CHARGE

§ 447.53 Applicability; specification; multiple charges.

(a) *Basic requirements.* Except as specified in paragraph (b) of this section, the plan may impose a nominal deductible, coinsurance, copayment, or similar charge upon categorically and medically needy individuals for any service under the plan.

(b) *Exclusions from cost sharing.* The plan may not provide for imposition of a deductible, coinsurance, copayment, or similar charge upon categorically or medically needy individuals (except as specified in paragraph (b)(6) of this section) for the following:

(1) *Children.* Services furnished to individuals under 18 years of age (and, at the option of the State, individuals under 21, 20, or 19 years of age, or any reasonable category of individuals 18 years of age or over but under 21) are excluded from cost sharing.

(2) *Pregnant women.* Services furnished to pregnant women if such services related to the pregnancy, or to any other medical condition which may complicate the pregnancy are excluded from cost sharing obligations. These services include routine prenatal care, labor and delivery, routine post-partum care, family planning services, complications of pregnancy or delivery likely to affect the pregnancy, such as hypertension, diabetes, urinary tract infection, and services furnished during the postpartum period for conditions or complications related to the pregnancy. The postpartum period is the immediate postpartum period which begins on the last day of pregnancy and extends through the end of the month in which the 60-day period following termination of pregnancy ends. States may further exclude from cost sharing all services furnished to pregnant women if they desire.

(3) *Institutionalized individuals.* Services furnished to any individual who is an inpatient in a hospital, long-term care facility, or other medical institution if the individual is required (pursuant to § 435.725, § 435.733, § 435.832, or § 436.832), as a condition of receiving services in the institution, to spend all but a minimal amount of his income required for personal needs, for medical care costs are excluded from cost sharing.

(4) *Emergency services.* Services provided in a hospital, clinic, office, or other facility that is equipped to furnish the required care, after the

sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in—

(i) Placing the patient's health in serious jeopardy;

(ii) Serious impairment to bodily functions; or

(iii) Serious dysfunction of any bodily organ or part.

(5) *Family planning.* Family planning services and supplies furnished to individuals of child-bearing age are excluded from cost sharing.

(6) *HMO Enrollees.* Services furnished by a health maintenance organization (HMO) to categorically needy individuals enrolled in the HMO are excluded from cost sharing. States may further exclude copayment charges for HMO services furnished to medically needy individuals.

(c) *Prohibition against multiple charges.* For any service, the plan may not impose more than one type of charge referred to in paragraph (a) of this section.

(d) *State plan specifications.* For each charge imposed under this section, the plan must specify—

(1) The service for which the charge is made;

(2) The amount of the charge;

(3) The basis for determining the charge;

(4) The basis for determining whether an individual is unable to pay the charge and the means by which such an individual will be identified to providers; and

(5) The procedures for implementing and enforcing the exclusions from cost sharing found in paragraph (b) of this section.

[43 FR 45253, Sept. 29, 1978, as amended at 47 FR 21051, May 17, 1982; 48 FR 5736, Jan. 8, 1983; 50 FR 23013, May 30, 1985; 55 FR 48611, Nov. 21, 1990; 55 FR 52130, Dec. 19, 1990]

§ 447.54 Maximum allowable charges.

(a) *Non-institutional services.* Except as specified in paragraph (b), for non-institutional services, the plan must provide that—

(1) Any deductible it imposes does not exceed $2.00 per month per family for each period of Medicaid eligibility. For example, if Medicaid eligibility is certified for a 3-month period, the maximum deductible which may be imposed on a family for that period of eligibility is $6.00;

(2) Any coinsurance rate it imposes does not exceed 5 percent of the payment the agency makes for the services; and

(3) Any co-payments it imposes do not exceed the amounts shown in the following table:

States payment for the service	Maximum copayment chargeable to recipient
$10 or less	$.50
$10.01 to $25	1.00
$25.01 to $50	2.00
$50.01 or more	3.00

(b) *Waiver of the requirement that cost sharing amounts be nominal.* Upon approval from HCFA, the requirement that cost sharing charges must be nominal may be waived, in accordance with section 431.55(g) for nonemergency services furnished in hospital emergency room.

(c) *Institutional services.* For institutional services, the plan must provide that the maximum deductible, coinsurance or co-payment charge for each admission does not exceed 50 percent of the payment the agency makes for the first day of care in the institution.

(d) *Cumulative maximum.* The plan may provide for a cumulative maximum amount for all deductible, coinsurance or co-payment charges that it imposes on any family during a specified period of time.

[48 FR 5736, Jan. 8, 1983]

§ 447.55 Standard co-payment.

(a) The plan may provide for a standard, or fixed, co-payment amount for any service.

(b) This standard copayment amount for any service may be determined by applying the maximum copayment amounts specified in § 447.54 (a) and (b) to the agency's average or typical payment for that service. For

example, if the agency's typical payment for prescribed drugs is $4 to $5 per prescription, the agency might set a standard copayment of $0.50 per prescription.

§ 447.56 Income-related charges.

Subject to the maximum allowable charges specified in § 447.54 (a) and (b), the plan may provide for income-related deductible, coinsurance or copayment charges. For example, an agency may impose a higher charge on medically needy recipients than it imposes upon categorically needy recipients.

§ 447.57 Restrictions on payments to providers.

(a) The plan must provide that the agency does not increase the payment it makes to any provider to offset uncollected amounts for deductibles, coinsurance, copayments or similar charges that the provider has waived or are uncollectable, except as permitted under paragraph (b) of this section.

(b) For those providers that the agency reimburses under Medicare reasonable cost reimbursement principles, in accordance with subpart B of this part, an agency may increase its payment to offset uncollected deductible, coinsurance, copayment, or similar charges that are bad debts of providers.

§ 447.58 Payments to prepaid capitation organizations.

Except for HMO services subject to the co-payment exclusion in § 447.53(b)(6), if the agency contracts with a prepaid capitation organization that does not impose the agency's deductibles, coinsurance, co-payments or similar charges on its recipient members, the plan must provide that the agency calculates its payments to the organization as if those cost sharing charges were collected.

[48 FR 5736, Jan. 8, 1983]

FEDERAL FINANCIAL PARTICIPATION

§ 447.59 FFP: Conditions relating to cost sharing.

No FFP in the State's expenditures for services is available for—

(a) Any cost sharing amounts that recipients should have paid as enrollment fees, premiums, deductibles, coinsurance, copayments, or similar charges under §§ 447.50 through 447.58 (except for amounts that the agency pays as bad debts of providers under § 447.57); and

(b) Any amounts paid by the agency on behalf of ineligible individuals, whether or not the individual had paid any required premium or enrollment fee.

Subpart B—Payment Methods: General Provisions

§ 447.200 Basis and purpose.

This subpart prescribes State plan requirements for setting payment rates to implement, in part, section 1902(a)(30) of the Act, which requires that payments for services be consistent with efficiency, economy, and quality of care.

[46 FR 48560, Oct. 1, 1981]

§ 447.201 State plan requirements.

(a) A State plan must provide that the requirements in this subpart are met.

(b) The plan must describe the policy and the methods to be used in setting payment rates for each type of service included in the State's Medicaid program.

§ 447.202 Audits.

The Medicaid agency must assure appropriate audit of records if payment is based on costs of services or on a fee plus cost of materials.

§ 447.203 Documentation of payment rates.

(a) The agency must maintain documentation of payment rates and make it available to HHS upon request.

(b) The agency must record, in State manuals or other official files, the following information for increases in payment rates for individual practitioner services:

(1) An estimate of the percentile of the range of customary charges to which the revised payment structure

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICAID COST SHARING

JULY 1993 OEI-03-91-01800

EXECUTIVE SUMMARY

PURPOSE

To (1) review State Medicaid cost sharing policies and (2) determine their impact on the program.

BACKGROUND

Medicaid is one of the fastest growing programs in Federal and State budgets. Total Medicaid expenditures grew from $72.1 billion in 1990 to $94.5 billion in 1991, an increase of 31 percent. As Medicaid costs continue to rise, Federal and State officials are searching for cost containment measures.

One of the fastest growing trends in corporate health care cost containment is greater beneficiary cost sharing. Cost sharing requires beneficiaries to pay a portion of their health care costs. State Medicaid programs have also increasingly been using cost sharing as a cost containment method. States not currently using cost sharing policies may begin to reexamine the issue since Medicaid now absorbs 14 cents of every State dollar spent.

Section 1902(a)(14) of the Social Security Act provides that Medicaid may impose "enrollment fees, premiums, or similar charges, and deductions, cost sharing, or similar charges." Children, HMO enrollees, pregnancy services, emergency services, hospice services, and services provided to residents of nursing facilities or medical institutions, are exempt from cost sharing.

To examine States' cost sharing policies, we collected detailed information from State Medicaid directors. We also reviewed data collected by the Health Care Financing Administration's (HCFA) information systems.

FINDINGS

Twenty-seven States use cost sharing in their Medicaid programs.

Cost sharing programs save money.

States without cost sharing could save between $167 and $335 million annually (of which the Federal share would be $99 to $198 million) by applying cost sharing to just four services -- inpatient hospital, outpatient hospital, physician visits, and prescription drugs.

States with cost sharing do not report significant impacts on utilization of services or access to care.

AGENCY COMMENTS

The HCFA and the Assistant Secretary for Management and Budget commented on the draft report; the full text of their comments is in Appendix D. Neither agency concurred with our draft recommendation. We have made several changes in response to their suggestions. However, we believe that the available evidence supports cost-sharing as a viable cost saving mechanism for financially strapped State programs, and would have a less deleterious effect on Medicaid beneficiaries than poor payment rates to providers, or elimination of services or eligible groups

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States with cost sharing do not report significant impacts on utilization of services or access to care.

Cost sharing States have not experienced excessive administrative, recipient, or provider burdens.

Federal requirements may hinder States from designing even more effective cost sharing programs.

RECOMMENDATION

We believe that implementing or expanding cost sharing programs would allow State to (1) reduce program expenditures; (2) maintain or increase eligible populations; (3 maintain or increase covered services; and/or (4) maintain or increase reimbursemer rates.

As a result of these conclusions, we make the following recommendation.

The HCFA should promote the development of effective cost sharing programs by:

- allowing States to experiment with cost sharing programs that target n populations and reflect more substantial cost sharing amounts, and/or

- recommending changes to Federal requirements allowing for greater State flexibility in determining exempted populations and services, and allowing higher recipient cost sharing amounts.

The HCFA might also consider funding evaluation projects which formally assess co sharing programs and provide information on the most effective structure of such programs.

The HCFA should promote the use of cost sharing in States that do not currently have programs. The HCFA could choose to exercise its leadership in a number of ways. Th HCFA could:

- encourage States to implement cost sharing by providing information about State experiences with cost sharing and offering technical assistance and clarification of Federal requirements, or

- seek legislation to provide States with incentives to implement cost sharing programs, such as decreasing Federal matching to States who not implement cost sharing, or

- seek legislation to mandate cost sharing for all States.

AGENCY COMMENTS

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INTRODUCTION

PURPOSE

To (1) review State Medicaid cost sharing policies and (2) determine their impact on the program.

BACKGROUND

Cost Sharing

Medicaid is one of the fastest growing programs in Federal and State budgets. Total Medicaid expenditures grew from $72.1 billion in 1990 to $94.5 billion in 1991, an increase of 31 percent.

As Medicaid costs continue to rise, Federal and State officials are searching for cost containment measures. One of the fastest growing trends in corporate health care cost containment is greater beneficiary cost sharing. Cost sharing requires beneficiaries to pay a portion of their health care costs. State Medicaid programs have also increasingly been using cost sharing as a cost containment method.

States not currently using cost sharing policies may begin to reexamine the issue since Medicaid now absorbs 14 cents of every State dollar spent. According to Raymond Scheppach, Executive Director of the National Governor's Association, as State budgets rise and "governors are becoming more reluctant to ask for tax increases, States are likely to cut more deeply into spending and perhaps impose new 'user fees' for specific programs."[1]

Federal Cost Sharing Legislation and Regulation

Section 1902(a)(14) of the Social Security Act allows Medicaid to impose "enrollment fees, premiums, or similar charges, and deductions, cost sharing, or similar charges." Medicaid cost sharing legislation has changed since the original 1965 law. The largest change to date occurred under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA).

The TEFRA expanded cost sharing options to allow both the medically and categorically needy to pay nominal fees for almost all services. The legislation precludes providers participating under the State plan from denying service due to an eligible recipient's inability to pay the cost sharing amount. However, the provision does not extinguish the recipient's liability for the amount.

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[1]Jim Luther, "States may be forced to cut spending more despite tax increases," The Baltimore Sun, October 30, 1991, 6A.

Section 1916 of the Social Security Act was added by TEFRA and exempts the following populations and services from cost sharing : children, HMO enrollees who are categorically needy, pregnancy services, emergency services, hospice services, and services provided to residents of nursing facilities or medical institutions. In addition, specific types of cost sharing such as enrollment fees, premiums, or similar charges cannot be imposed upon the categorically needy.

The Medicaid cost sharing payment regulations outlined in 42 CFR Ch. IV sections 447.50-.59 establish minimum and maximum charges for enrollment fees and premiums based on families' gross monthly income. The maximum deductible, coinsurance, or copayment charge for institutional services cannot exceed 50 percent of the Medicaid agency's payment for the first day of service. For non-institutional services:

- deductibles may not exceed $2 per month per family per period of eligibility;
- coinsurance rates may not exceed 5 percent of the service payment; and
- maximum copayment chargeable to recipient for services is $.50 to $3.00, depending on the cost of the service.

Previous Cost Sharing Studies

The largest study to date on the effects of cost sharing was conducted by the Rand Corporation. The Health Insurance Experiment reviewed health care consumption by insured individuals at randomly assigned levels of cost sharing. Over 7,000 people were assigned coinsurance rates of 0, 25, 50 and 95 percent. The purpose was to determine the potential effects of cost sharing on service utilization and overall health status. The federally-sponsored study ran over several years in the 1970's and early 1980's.

The study found that patients with limited cost sharing used approximately one-third fewer medical services than patients receiving free care. Apart from better blood pressure control and corrected far vision, participants in free care did not have significantly better health outcomes than patients with cost sharing plans.[2]

In a review of California's 1972 cost sharing experiment, most Medi-Cal[3] beneficiaries thought that cost sharing had not affected their health care. However, 17 percent

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[2]Robert H. Brook, Robert H., John E.Ware, Jr., William H. Rogers, Emmet B. Keeler, Allyson R. Davies, Cathy A. Donald, George A. Goldberg, Kathleen N. Lohr, Patricia C. Masthay, and Joseph P. Newhouse, "Does Free Care Improve Adults' Health? Results from a Randomized Controlled Trial," The New England Journal of Medicine Vol. 309 No. 23 (December 8, 1983): 1426-34.

[3]California's Medicaid program is called Medi-Cal.

thought it had reduced the care available to them. These 17 percent were for the most part in households with chronic or significant medical needs.[4]

A more recent study on Medicaid prescription drugs found that New Hampshire's monthly limit on prescriptions caused a 30 percent drop in the number of prescriptions filled. After the limit was rescinded and a $1.00 copayment was implemented, prescriptions increased to just below pre-limit levels.[5]

For a more inclusive list of cost sharing references see Appendix A.

METHODOLOGY

State Interviews

We conducted structured telephone interviews with State Medicaid Directors or their representatives. To facilitate data collection, information sheets were sent to all States that had cost sharing programs prior to the interview. We also asked States to provide us with written material on

- the types and amounts of cost sharing,
- reported cost projections and savings, and
- cost sharing program evaluations.

We interviewed officials in 49 States and the District of Columbia. State officials in California declined to be interviewed but did provide us with written material. Whenever possible, we have included California's information in our State statistics.

Although Arizona does not have fee for service reimbursement, it was included in our interviews. Under the Title XIX demonstration project, the Arizona Health Care Cost

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[4]Carl E. Hopkins, Milton I. Roemer, Donald M. Procter, Foline Gartside, James Lubitz, Gerald A. Gardner, and Marc Moser, "Cost-Sharing and Prior Authorization Effects on Medicaid Services in California: Part I. The Beneficiaries' Reactions," Medical Care Vol. XIII No. 7 (July 1975): 582-94.

[5]Stephen B. Soumerai, Jerry Avorn, Dennis Ross-Degnan, and Steven Gortmaker, "Payment Restrictions for Prescription Drugs Under Medicaid: Effects on Therapy, Cost, and Equity," The New England Journal of Medicine Vol. 317 No. 9 (August 27, 1987): 550-56.

Stephen B. Soumerai, Dennis Ross-Degnan, Jerry Avorn, Thomas J. McLaughlin, and Igor Choodnovskiy, "Effects of Medicaid Drug-Payment Limits on Admission to Hospitals and Nursing Homes," The New England Journal of Medicine Vol. 325 No. 15 (October 10, 1991): 1072-7.

Containment System provides care through organized health plans and capitated reimbursement. However, Arizona does allow cost sharing by the health plans for a limited number of services. Therefore, we requested information on their experienc with cost sharing.

Data Reports and Information Systems

The information collected from our State interviews was compared with the HCFA' new State Profile Data System (spDATA) for inaccuracies. We found a few discrepancies and informed HCFA's Medicaid Bureau about the differences. The errors were found to lie with the data system and not our State-reported data. The were caused by time lags on newly implemented policies or data input mistakes.

To project cost savings, we used service numbers supplied by States on 1991 Form HCFA-2082. The data is based on service claims paid by State Medicaid agencies Fiscal Year 1991. See Appendix B for a detailed description of the cost savings projection.

FINDINGS

TWENTY-SEVEN STATES USE COST SHARING IN THEIR MEDICAID PROGRAMS.

Twenty-six States cited containing costs or reducing unnecessary utilization as the main reasons for implementing recipient cost sharing in their Medicaid programs. Several States implemented cost sharing to promote an active role for recipients in their health care. One State also mentioned that they use cost sharing to encourage participation in health maintenance organizations (HMO) since HMO enrolled Medicaid recipients are exempt from cost sharing. See Appendix C for a list of States with cost sharing.

States have been using cost sharing for more than two decades. Half (14 of 27) the States have implemented their programs incrementally over the years. Five States established programs in the early to mid 1970's. Most States began programs during the 1980's. Two States implemented cost sharing programs in 1992.

Of the 24 States not currently using cost sharing, almost half are now considering programs. In fact, New York plans to implement cost sharing in the early part of 1993. The main reason States are considering cost sharing is budgetary restraints.

The most frequently used form of cost sharing is copayments.

All States with cost sharing use copayments as the main mechanism for sharing costs with recipients. Copayments range from 50 cents to $3.00, with the exception of inpatient hospital copayments which range up to $50 per admission. Four States also use 2 or 5 percent coinsurance for certain services and one State recently implemented an inpatient hospital deductible of $100.

No States use enrollment fees or premiums for medically needy individuals as allowed by Federal law. Two States used premiums in the late 1970s but found them cumbersome to administer and discontinued their use. Both States recounted that local offices had difficulty administering the programs since premiums were based on recipient income. Since incomes changed monthly, the premiums had to be recalculated every month resulting in increased staff time and record keeping.

States automatically deduct cost sharing amounts from provider reimbursement.

All States[6] reduce provider reimbursement for eligible recipients and services regardless of whether the copayment is collected. The majority do not require

[6]Except Arizona, which takes copayment amounts into account when developing its capitation rates.

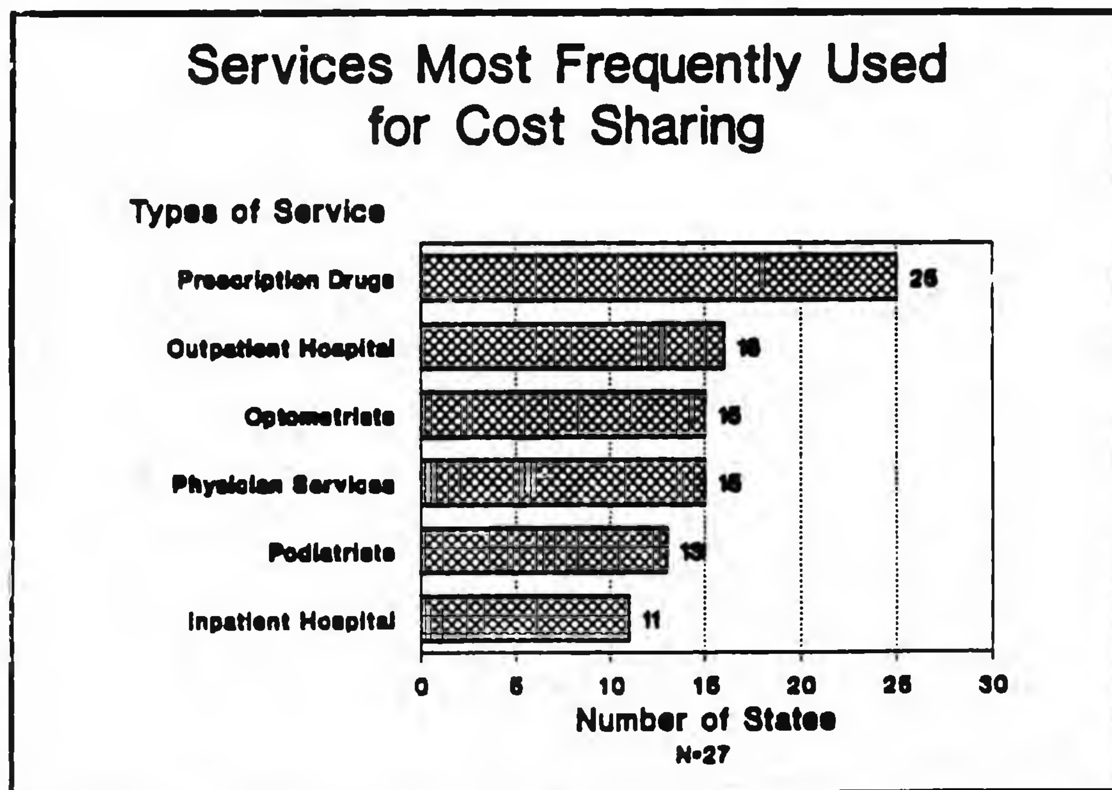
providers to indicate on the claim form whether they have collected or attempted to collect the cost sharing amount.

States use computer edits in their information systems and provider-supplied information to administer cost sharing. Computer edits match information from eligibility files to claim forms for exemptions such as children and nursing home residents. Edits also identify exempted services by diagnostic code, e.g. emergencies. Other States use exemption codes supplied by the provider to indicate emergency, family planning, or pregnancy services.

States apply cost sharing to both mandatory and optional Medicaid services with prescription drugs being the most frequent cost sharing service.

States apply cost sharing to a wide array of services. Some States have chosen to apply cost sharing only to mandatory services (States must provide these services as required by law); others apply it only to optional services (States elect whether or not to cover these services).

Most States apply cost sharing to both mandatory and optional services. Almost all States (25 of 27) employ cost sharing on prescription or pharmacy services. The services to which States most often apply cost sharing are shown below. A complete list of cost sharing services by State is presented in Appendix C.



The number of services with cost sharing varies among States. One State (PA) applies cost sharing to all but a few exempted services while five States apply

cost sharing to only one service. Two-thirds of States have more than five services with cost sharing.

States reported a number of rationales for selecting services for cost sharing. The most common was services for which States believed there was unnecessary utilization. Twenty-five percent said they wanted to put cost sharing on all the services allowed by Federal regulation. Several said they specifically chose services where they felt there would not be a negative impact on access. Other States mentioned choosing services where cost sharing would be easier to administer and collect. Finally, three States were given specific service choices from their State legislatures.

COST SHARING PROGRAMS SAVE MONEY.

Twenty-two of the 27 States reported that their programs reduced Medicaid expenditures.[7] Three States which had recently implemented programs had no information yet. One State which had no statistical proof of savings declined to respond.

Eleven States reported annual cost savings ranging from $325,000 to $9.5 million.

Of the 22 States reporting savings, 11 provided financial data. As shown below, eight States provided statistics from their information systems or outside evaluations and the remaining three were estimated dollars.

The three remaining States provided dollar estimates of $325,000, $500,000, and $2,250,000. These savings were attributed to cost sharing applied to prescription drug services.

State	Number of Services	Number of Recipients	Cost Savings	
Colorado	9	200,000	FY 1991	$2,168,342
Maine	10	147,886	FY 1992	$432,246[1]
Montana	26	70,000	FY 1991	$917,412
North Carolina	9	751,000	FY 1992	$5,518,910
Pennsylvania	all	1,177,161	FY 1990	$9,424,585
South Dakota	10	55,000	FY 1992	$708,384
Vermont	3	68,622	FY 1992	$906,199
Wisconsin	19	416,000	FY 1988	$6,700,000

[1] *Savings are for prescription drugs only and for the 11 month period 7/91-5/92.*

[7] California's written material did not provide us with cost savings information.

Of the eight States that provided actual cost savings, only Wisconsin included $2.1 million in savings from decreased utilization. The remaining seven States' savings figures represent only reductions in provider reimbursement by the amount of recipient cost sharing.

States without financial data believe cost sharing saves money.

The 11 States whose information systems did not collect savings information nevertheless believe their programs have achieved savings. Five States believe savin come from recipient cost sharing dollars and six believe savings come from a combination of cost sharing dollars and reduced utilization.

STATES WITHOUT COST SHARING COULD SAVE BETWEEN $167 AND $3 MILLION ANNUALLY BY APPLYING COST SHARING TO FOUR SERVICES

Potential savings for 24 States without cost sharing depends on the number of eligibl beneficiaries and services to which cost sharing is applied. However, we estimate tha cost sharing on four services in these States could save the Medicaid program betwee $167 and $335 million a year. The Federal share could range from $99 to $198 million and the States could save between $68 to $137 million.

These savings are due to reductions in provider reimbursement alone and do not include savings from possible utilization changes. The savings would be even greater States implemented cost sharing on more than just these four services.

This estimate includes four services -- prescription drugs, physician visits, inpatient hospital stays, and outpatient hospital visits. These services were selected because information on their use by recipients was available from State HCFA-2082 reports f 1991.

The number of services provided by each State without cost sharing was multiplied b the most frequently used copayment amount by States with cost sharing. The cost savings projection includes savings only from reductions in service reimbursement by the amount of recipient cost sharing and not reductions in service utilization.

The high estimate of $335 million is not reduced by the number of services that woul be exempt according to Federal regulations. The $167 million estimate excludes these exempted services. See Appendix B for a more detailed description of the cost sharing projection.

STATES WITH COST SHARING DO NOT REPORT SIGNIFICANT IMPACTS ON UTILIZATION OF SERVICES OR ACCESS TO CARE

Although 15 States cited reducing inappropriate utilization as one of the reasons for implementing cost sharing, States have not experienced significant reductions in the use of services after implementation of cost sharing.

Only three States have formally evaluated their cost sharing programs. Their results have differed, but in no case did they find a strong relationship between the implementation of cost sharing and significant reductions in the use of services.

The three States that have conducted formal evaluation are Wisconsin, California, and Montana.

Wisconsin's Office of Policy and Budget reviewed the State's cost sharing program in 1989.[8] Wisconsin looked at utilization information for cost sharing services implemented over several years. For a group of copayments implemented in 1981, they found a 1.5 percent decrease in utilization for services that were not greatly affected by other program changes (chiropractic, medical equipment and supplies, and transportation). For copayments instituted or increased in 1988, Wisconsin found a 1.5 percent drop in utilization for physician services and no decrease in outpatient hospital services. The Wisconsin report cautions that

> The utilization effect statistic must be interpreted with caution since factors other than copayments may account for this change, e.g., changes in provider participation. Probably the way to interpret the 1.5 utilization percentage is as the maximum that might be due to copayments.

In 1985, under contract with HCFA, California evaluated the Medi-Cal copayment demonstration project.[9] The evaluation found no significant changes in utilization for physician office visits, emergency room visits, physical therapy, chiropractic services, and optometry after copayments were implemented.

Montana's evaluation found that after copayments were implemented for 19 services, recipient usage increased for all services except 3 -- inpatient hospital, dental, and prescription drugs.[10] The reported decreases for inpatient hospital and dental services could not be attributed solely to copayment since there had also been changes in reimbursement methodologies and coverage. However, the 15 percent decrease in utilization from 3.17 prescriptions to 2.68 prescriptions per recipient may have been attributable to copayments.

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[8]Timothy Tyson, The Impact of Copayments on Medical Assistance Recipients: A Report to the Legislature (Wisconsin: Wisconsin Department of Health and Social Services, Office of Policy and Budget, Evaluation Section, June 1989).

[9]D. Jerome Hansen, James C. Cicconetti, Terri Stackpole, and John Keith, California Statewide Copayment Project (California: California Department of Health Services, July 1985), HCFA Contract No. 11-P-98206/9-03.

[10]KPMG Peat Marwick, State of Montana, Department of Social and Rehabilitation Services: Review of the Copayment Program, (November 1990).

Almost half of the States without statistical evaluations reported no significant decrease in cost sharing services. None of the remaining States had recent information on utilization changes attributable to cost sharing.

Eleven of the 24 States without evaluation data reported no significant decreases in utilization attributable to cost sharing. These responses were based on overall utilization comparisons from year to year. Three States had just begun their cost sharing programs and therefore did not have any information.

Of the remaining States, seven did not know of any changes because they did not collect utilization impact data. Two States had no recent impact data but had writt material from over 10 years back showing decreases in utilization the year after copayment implementation. One other State had a lowering in utilization numbers but felt they couldn't attribute this to cost sharing.

Cost sharing programs are often implemented with other cost containment, reimbursement, and eligibility changes. This makes assigning utilization impact to c sharing almost impossible. In fact, 17 States implemented other program changes a the same time as cost sharing.

Most States do not believe cost sharing prevents recipients access to needed services.

Eighty percent of States (22 of 27) did not believe recipient access to necessary car was limited by cost sharing. According to respondents, the Federal requirement th providers must furnish service when the recipient is unable to pay precludes limitin access and the nominal cost sharing amounts do not put undue burdens on people requiring essential care.

Twenty percent reported that they could not say absolutely that cost sharing never interferes with access to necessary services. Two States suggested that while provid were not limiting access to care, some recipients might forego services because the aren't aware that they must be served even if they are unable to pay at the time th service is provided. However, one State also mentioned that they were hesitant to make the policy clear to recipients for fear that recipients would always say they couldn't pay.

State evaluations confirm the information collected from the States concerning recipie access to services under cost sharing.

All three State evaluations conclude that cost sharing has not limited recipients' ac to necessary services. Montana's evaluation also included a provider survey indica that cost sharing had not influenced their acceptance of Medicaid patients.

Wisconsin's evaluation further reviewed access to care by including a recipient sur Eleven of 151 respondents indicated that they had sought fewer services because t could not afford the copayment. The study also presented evidence showing that

than 2 percent of the calls to the Medicaid recipient hotline were about copayments in the 2 months preceding and the 4 months following copayment implementation. Most of these calls (95 percent) were questions and clarifications about cost sharing while 5 percent were complaints.

COST SHARING STATES HAVE NOT EXPERIENCED EXCESSIVE ADMINISTRATIVE, RECIPIENT, OR PROVIDER BURDENS.

Overall, States with cost sharing indicated they had few problems with implementation. Over 45 percent of States said they had no implementation problems. Other States mentioned working out concerns with advocacy groups and provider associations. Four States have had court cases brought against them by patient advocacy groups. All of these States have since implemented cost sharing.

Interestingly, more than half the States (15 of 24) without cost sharing believed it would be a financial burden for them to administer. They also felt cost sharing would impose too great a financial burden on recipients and providers.

The administrative expense is basically a one-time minimal cost for information system changes and information dissemination.

Five States furnished dollar estimates ranging from $2,000 to $100,000 for the information system changes. Two States estimated their staff time for rule-making and information dissemination at $15,000 and $30,000 respectively. The remaining States either could not break out the cost of their cost sharing program or estimated the cost to be "minimal" or "negligible."

New York, which is attempting to implement cost sharing, reported implementation cost of $1.5 million. Approximately $1 million was for client notification and $500,000 for information system changes including department and contractor costs.

The higher implementation costs are due to the large size of New York's program and the number of notices sent out due to court challenges and delays. However, if New York's initial cost savings projections are correct, New York should recover its expenditure in 1 month's time.

Some States reduce burden on recipients by expanding exemptions and capping cost sharing amounts.

Fifteen States have expanded the age of exempted children beyond the Federal requirement of 18 and under. Twelve States have expanded the age to 21, two increased to age 19, and one to age 20.

Fifteen States have expanded the pregnancy-related service exemption to include all pregnant women. Some States did this to alleviate administrative confusion, so that providers can exempt any woman who is pregnant. Otherwise, States require

providers to indicate that the service is pregnancy related, e.g., providers must writ "related to pregnancy" on the prescription.

At least 12 States also exclude services to severely or chronically ill individuals. Th include dialysis services, chemotherapy, radiation therapy, oxygen equipment, and home and community based services.

Five States have also tried to ensure that recipients are not overburdened by large cost sharing amounts by establishing caps on specific services or total cost sharing amounts.

- Colorado has a cost sharing cap of $150 per year.

- Maine established monthly caps for each cost sharing service that range fro $4 to $30 per month.

- Montana allows cost sharing up to $127 per year for families. It also limits cost sharing for inpatient hospital stays to $66 per admission.

- Pennsylvania caps copayments at $90 for a 6-month period. Inpatient hosp copayments may not exceed $21 per admission.

- Wisconsin caps inpatient hospital services, physician visits, and sole-provide pharmacy services at various dollars limits per year. Cost sharing for physical/occupational/speech therapy and psychotherapy ends after so many hours or dollars of service provided.

All States, except Pennsylvania, stop reducing provider payments when the dollar amount is reached. Pennsylvania rebates the amount paid over the limit to the recipient every 6 months.

Overall, among the 17 States that could estimate the number of recipients exempt from cost sharing, 9 States exempted between 40 and 50 percent and 8 exempted 50 percent.

Provider responses to cost sharing are mixed. However, provider participation in Med has not dropped due to cost sharing.

Over half the States reported little or no negative response from physicians when implemented cost sharing. Several of these States said providers were used to co sharing since it is a component of most third party health insurance.

Other States reported mixed responses, especially among different provider group Several States said specific provider groups in their State actually supported cost sharing by Medicaid recipients. Four States said provider groups were extremely opposed to cost sharing in the Medicaid program.

Provider complaints focused mainly on the administrative hassle attached to collecting cost sharing payments from recipients. Providers explain that if the amount is not collected at the time of service, the cost of billing for the amount exceeds the amount billed. Complaints were also received that providers looked at this as reducing reimbursement levels that they already consider too low.

Almost 90 percent of States (21 of 24) did not monitor collection of copayments by providers. Therefore, States don't know if recipients are making the payments. However, about one-third of the States believed that there are instances when cost sharing amounts are not being paid by recipient or collection is not being attempted by providers.

Although there is little State collected data on the impact of cost sharing on providers, provider surveys supply additional insight into the impact of cost sharing on physicians and their actions. The three State evaluations highlighted the following:

- Approximately 50 percent of all copayments went uncollected.
- Providers with high percentages of Medicaid patients were more likely to charge copayments.
- Providers felt the nominal nature of cost sharing amounts were not worth the billing or collection effort.
- Certain providers such as pharmacists more frequently collect cost sharing payments.

All except two States report no decreases in Medicaid provider participation after implementing cost sharing. One State has lost several podiatrists and they believe this might be due to a combination of copayments and declining reimbursement. Another State reported discontinuing a physician visit copayment after physicians threatened to drop out of the program. However, this same State characterized the pharmacy providers as being positive about the cost sharing program.

FEDERAL REQUIREMENTS MAY HINDER STATES FROM DESIGNING EVEN MORE EFFECTIVE COST SHARING PROGRAMS.

More than 40 percent of States with cost sharing voiced concerns about Federal cost sharing requirements. Seventy percent of these States felt that flexible Federal requirements would allow States to increase the effectiveness of their cost sharing programs. Several States also reported difficulty in preparing guidelines that allowed for effective cost sharing while maintaining compliance with Federal requirements.

States report that the Federal exemptions are too broad and the cost sharing amounts too nominal for certain services or eligible recipients.

Ten States with cost sharing responded that they would like to design more effective cost sharing programs. These States would increase cost sharing amounts or create exemptions targeted at specific vulnerable populations or services instead of broad exemption categories.

For example, States said they would increase coinsurance and copayment rates, include HMO enrollees in cost sharing, and waive certain exclusions for populations above a certain percentage of the poverty level. States speculated that this increased cost sharing would assist them in expanding eligibility to people not currently being served by their State's program.

States without cost sharing also indicated that Federal cost sharing regulations are a deterrent. Six States reported not implementing cost sharing because of restrictive Federal requirements.

States say defining a recipient's inability to pay cost sharing amounts is difficult.

Several States had difficulty in supplying guidelines to providers defining what constitutes a recipient's inability to pay for services. This is important since Federal law requires service to be provided even when a recipient is unable to pay the cost sharing amount at the time it is provided.

Most States do not have policies for handling recipients who are eligible for cost sharing but habitually do not pay. These States tell providers that verbal confirmation of inability to pay from recipients is proof of inability to pay. Only three States have outlined policies for their providers.

- Michigan's provider manual states that if the recipient fails to pay a copayment, the provider can, in the future, refuse to serve that recipient as a Medicaid patient.

- Pennsylvania advocates that providers cannot deny services because of recipient's inability to pay, unless there is "creditable evidence" that the recipient is able to pay, but refuses to do so. The policy states that a recipient found making purchases of non-essential items is an example of creditable evidence and requires the provider to document this in the record.

- Wyoming's guidance to providers states that since Medicaid copayment amounts are nominal, if a recipient regularly fails to pay the required copayment a provider may exclude the recipient from their practice.

The majority of States have not defined the difference between unwillingness to pay and inability to pay. States just refer providers to the Federal law stating that they cannot deny service but that the uncollected amount is considered a debt to providers.

RECOMMENDATIONS

The information in this report demonstrates that many States have developed cost sharing programs that reduce Medicaid expenditures. States have suggested that cost sharing allows Medicaid recipients to be a partner in their health care determinations. It also allows Medicaid recipients to become accustomed to an element common in private health insurance. States with cost sharing reported no evidence that cost sharing has a negative impact on recipients.

We believe that implementing or expanding cost sharing programs would allow States to:

- reduce program expenditures;
- maintain or increase eligible populations;
- maintain or increase covered services; and/or
- maintain or increase reimbursement rates.

As a result of these conclusions, we make the following recommendations.

The HCFA should promote the development of effective cost sharing programs by:

- allowing States to experiment with cost sharing programs that target new populations and reflect more substantial cost sharing amounts, and/or
- recommending changes to Federal requirements allowing for greater State flexibility in determining exempted populations and services, and allowing higher recipient cost sharing amounts.

The HCFA might also consider funding evaluation projects which formally assess cost sharing programs and provide information on the most effective structure of such programs.

The HCFA should promote the use of cost sharing in States that do not currently have programs. The HCFA could choose to exercise its leadership in a number of ways. The HCFA could:

- encourage States to implement cost sharing by providing information about State experiences with cost sharing and offering technical assistance and clarification of Federal requirements, or

The Assistant Secretary for Management and Budget Comments

The Assistant Secretary for Management and Budget believed that the sample size and data were insufficient to support the findings and that additional sample data needed to be collected before conclusions could be drawn on the effectiveness of cost sharing programs.

While we agree that only three States have formally evaluated their programs, testimonial evidence from 24 additional States confirms the evaluations' findings. We believe that taken together, this information provides strong enough evidence to support our findings. Certainly, we agree that additional research on cost sharing would be helpful; as a result, we have revised our recommendation to include the suggestion that HCFA direct some of its evaluation resources towards this end. In the meantime, however, we believe that the available evidence supports cost-sharing as a viable cost saving mechanism for financially strapped State programs, and would have a less deleterious effect on Medicaid beneficiaries than poor payment rates to providers, or elimination of services or eligible groups.

- seek legislation to provide States with incentives to implement cost sharing programs, such as decreasing Federal matching to States who do not implement cost sharing, or

- seek legislation to mandate cost sharing for all States.

AGENCY COMMENTS

The HCFA and the Assistant Secretary for Management and Budget commented on the draft report. The full text of their comments is in Appendix D.

The Health Care Financing Administration Comments

The HCFA did not concur with our draft recommendation that the agency promote effective cost sharing in the States. The HCFA cited their desire to have cost sharing remain a voluntary State option. This desire is not inconsistent with our draft recommendation or our revised recommendations which appear in this final report. While mandating cost sharing is one approach that HCFA may choose to consider as a way to promote cost sharing, both in our draft report and in this final report we list other approaches which HCFA could use as well to accomplish this goal.

The HCFA agreed that there is sufficient evidence to show that cost sharing saves money for the Medicaid program. However, HCFA expressed concerns regarding the impact that cost sharing has on Medicaid recipients and providers of care.

We agree that the literature shows that certain vulnerable populations such as children, people with disabilities, and the chronically ill may be more adversely affected by cost sharing. And in this report, we outline some of the policies that States with cost sharing have implemented to protect these populations. These policies include capping cost sharing amounts, excluding certain services from cost sharing, and exempting children up to 21 years of age.

We also agree that cost sharing must be reviewed for its impact on providers. Although we found that cost sharing had not caused providers to leave the Medicaid program, we recognize that States with low provider participation must be concerned about recipients' access to providers.

In response to these concerns, we have decided to create two recommendations. The first addresses effectiveness of cost sharing programs and the second addresses the promotion of cost sharing in the Medicaid program. We believe that some of HCFA's concerns could be alleviated by allowing States to experiment with cost sharing programs. More flexibility would enable States to determine the needs of their individual program and populations and then develop a cost sharing program that fits those needs. States, for example, could choose to exempt specific vulnerable populations from cost sharing while targeting other populations like HMO enrollees for cost sharing.

APPENDIX A

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APPENDIX B

COST SAVINGS ESTIMATE

Data Source

The data was taken from information reported to the Health Care Financing Administration (HCFA) by all States and the District of Columbia. The States report their data on the *Statistical Report on Medical Care: Eligibles, Recipients, Payments and Services*, Form HCFA-2082. The data is based on claims paid for services provided in Fiscal Year 1991 (October 1, 1990 - September 30, 1991).

In the Annotations for the HCFA-2082 Data Tables, HCFA states that it does not guarantee the accuracy of the data provided by State Medicaid Agencies. However, HCFA does correct obvious errors and will estimate certain values when appropriate.

Savings Methodology

Of the service types available from the HCFA-2082 Data Tables, we selected services using two main criteria: (1) States frequently apply cost sharing to the service and (2) most of the services would not be exempted by Federal regulations. Utilizing this criteria, we selected three mandatory services and one optional service.

The three mandatory services include inpatient hospital, outpatient hospital, and physician visits. The optional service is prescription drugs. Although optional services vary by State, all States include prescription drugs as a covered service.

Whenever possible, we applied the most commonly used cost sharing amount when estimating our cost savings. For outpatient hospital, we selected $3 as the copayment amount since 8 of 16 States used it. For the remaining States, three other States used variable payments of $.50 to $3, 3 used $1, 1 used $2, and one had a coinsurance of 5 percent.

We selected $1.00 for physician visits. Out of 15 States using cost sharing on this service, 8 used $1, 3 varied between $.50 and $3, 2 used $2, 1 used $3, and 1 used $1 or $3 depending on the type of service. We chose $1 for prescription drugs also. For the 25 States applying cost sharing, 14 used $1, 8 used varying amounts from $.50 to $3, 2 used $.50, and 1 used $1.50.

For inpatient hospital services, we selected the most conservative cost sharing amount since States' methodology for applying cost sharing varies. Six of the States with cost sharing impose a one time copayment (or deductible for one State) per admission. Those payments range between $10 and $100 per hospital admission. Five State apply copayment charges on a per day basis. Three of the five States use a $3 cost share per day, one uses $5, and one varies between $2 and $3 depending on the cost of

service. After reviewing this information, we felt the most conservative choice would be a $3 copayment per total inpatient hospital days.

In order to estimate the cost savings to the Medicaid program if States without cost sharing implemented cost sharing on these four services, we extracted the number of paid service claims for the States without cost sharing. However, Rhode Island data was unavailable. Therefore, the cost savings estimates are based on 23 States without cost sharing.

We calculated the cost savings estimate in three steps. (1) The number of services for each State was multiplied by the cost sharing amount we selected. (2) Each State's service cost sharing amount was added to arrive at a total cost sharing amount. (3) The total service amounts for the four services were then added to project the total cost savings if States were to implement cost sharing on these four services. The numeric equations for this calculation follows:

<u>STEP 1</u>

$$S_i \times \$3.00 = ST_i$$
$$S_o \times \$3.00 = ST_o$$
$$S_p \times \$1.00 = ST_p$$
$$S_d \times \$1.00 = ST_d$$

<u>STEP 2</u>

$$ST_i^1 + ST_i^2 + ST_i^3 + \ldots ST_i^{23} = TAS_i$$
$$ST_o^1 + ST_o^2 + ST_o^3 + \ldots ST_o^{23} = TAS_o$$
$$ST_p^1 + ST_p^2 + ST_p^3 + \ldots ST_p^{23} = TAS_p$$
$$ST_d^1 + ST_d^2 + ST_d^3 + \ldots ST_d^{23} = TAS_d$$

<u>STEP 3</u>

$$TAS_i + TAS_o + TAS_p + TAS_d = \text{Total Cost Savings Estimate}$$

S = number of services
ST = each State's total cost sharing amount by service type
TAS = Total of all States' cost sharing amounts by service type
$_{1\text{-}23}$ = Each number 1 through 23 equals one State's total
$_i$ = inpatient hospital days
$_o$ = outpatient hospital
$_p$ = physician visits
$_d$ = prescription drugs

We presented two dollar amounts for cost savings -- total cost sharing estimates with and without exempted populations. To estimate the number of services that would be excluded under Federal regulation, we used State reported data on exclusions.

States were asked how many of their recipients would be exempted from cost sharing. Out of the 17 States able to answer the question, 9 estimated 40 to 50 percent and 8 estimated over 50 percent.

Using this information, we selected 50 percent as the number of services to exempt for the exempted populations calculation. However we realize that the number of beneficiaries exempted may not equal the number of services exempted, since exempted populations may use a greater or lesser percentage of certain services.

Cost Savings Tables

The following four tables illustrate the cost savings calculations for each service type. The fifth table provides the total cost savings estimate with and without exemptions and the last table divides total savings into Federal and States shares.

Savings Calculation for Inpatient Hospital Days

States	Total Services	Services x $3	Non-Exempt Services	Non-exempt x $3
Alaska	53,417	$160,251	26,708	$80,124
Connecticut	379,891	$1,139,673	189,945	$569,835
Delaware	61,255	$183,765	30,627	$91,881
Georgia	1,069,789	$3,209,367	534,894	$1,604,682
Hawaii	70,456	$211,368	35,228	$105,684
Idaho	71,993	$215,979	35,996	$107,988
Indiana	609,076	$1,827,228	304,538	$913,614
Kentucky	593,995	$1,781,985	296,997	$890,991
Louisiana	694 894	$2,084,682	347,447	$1,042,341
Minnesota	361,285	$1,083,855	180,642	$541,926
Nebraska	117,623	$352,869	58,811	$176,433
Nevada	115,865	$347,595	57,932	$173,796
New Jersey	933,760	$2,801,280	466,880	$1,400,640
New Mexico	131,393	$394,179	65,696	$197,088
New York	4,473,440	$13,420,320	2,236,720	$6,710,160
North Dakota	55,068	$165,204	27,534	$82,602
Ohio	1,202,638	$3,607,914	601,319	$1,803,957
Oklahoma	195,918	$587,754	97,959	$293,877
Oregon	155,606	$466,818	77,803	$233,409
Rhode Island	NA	NA	NA	NA
Tennessee	754,690	$2,264,070	377,345	$1,132,035
Texas	1,599,687	$4,799,061	799,843	$2,399,529
Utah	96,990	$290,970	48,495	$145,485
Washington	406,366	$1,219,098	203,183	$609,549
Total	14,205,095	$42,615,285	7,102,542	$21,307,628

Savings Calculation for Outpatient Hospital Services

States	Total Services	Services x $3	Non-Exempt Services	Non-exempt x $3
Alaska	73,064	$219,192	36,532	$109,596
Connecticut	1,111,299	$3,333,897	555,649	$1,666,947
Delaware	892,655	$2,677,965	446,327	$1,338,981
Georgia	5,148,675	$15,446,025	2,574,337	$7,723,011
Hawaii	2,647,094	$7,941,282	1,323,547	$3,970,641
Idaho	37,470	$112,410	18,735	$56,205
Indiana	2,204,139	$6,612,417	1,102,069	$3,306,207
Kentucky	1,384,708	$4,154,124	692,354	$2,077,062
Louisiana	133,228	$399,684	66,614	$199,842
Minnesota	1,048,055	$3,144,165	524,027	$1,572,081
Nebraska	85,311	$255,933	42,655	$127,965
Nevada	203,386	$610,158	101,693	$305,079
New Jersey	995,812	$2,987,436	497,906	$1,493,718
New Mexico	72,110	$216,330	36,055	$108,165
New York	8,078,562	$24,235,686	4,039,281	$12,117,843
North Dakota	67,354	$202,062	33,677	$101,031
Ohio	2,440,571	$7,321,713	1,220,286	$3,660,855
Oklahoma	115,459	$346,377	57,729	$173,187
Oregon	92,043	$276,129	46,021	$138,063
Rhode Island	NA	NA	NA	NA
Tennessee	1,717,441	$5,152,323	858,720	$2,576,160
Texas	826,138	$2,478,414	413,069	$1,239,207
Utah	1,021,588	$3,064,764	510,794	$1,532,382
Washington	4,191,245	$12,573,735	2,095,622	$6,286,868
Total	34,587,407	$103,762,221	17,293,698	$51,881,094

Savings Calculation for Physician Visits

States	Total Services	Services x $1	Non-Exempt Services	Non-exempt x $1
Alaska	196,529	$196,529	98,264	$98,264
Connecticut	1,831,991	$1,831,991	915,996	$915,996
Delaware	377,440	$377,440	188,720	$188,720
Georgia	5,976,371	$5,976,371	2,988,185	$2,988,185

States	Total Services	Services x $1	Non-Exempt Services	Non-exempt x $1
Hawaii	4,967,763	$4,967,763	2,483,881	$2,483,881
Idaho	232,423	$232,423	116,211	$116,211
Indiana	1,542,287	$1,542,287	771,143	$771,143
Kentucky	2,383,344	$2,383,344	1,191,672	$1,191,672
Louisiana	9,151,352	$9,151,352	4,575,676	$4,575,676
Minnesota	2,292,306	$2,292,306	1,146,153	$1,146,153
Nebraska	917,483	$917,483	458,741	$458,741
Nevada	364,945	$364,945	182,472	$182,472
New Jersey	3,352,290	$3,352,290	1,676,145	$1,676,145
New Mexico	394,014	$394,014	197,007	$197,007
New York	6,470,838	$6,470,838	3,235,419	$3,235,419
North Dakota	472,104	$472,104	236,052	$236,052
Ohio	5,143,620	$5,143,620	2,571,810	$2,571,810
Oklahoma	740,794	$740,794	370,397	$370,397
Oregon	393,261	$393,261	196,630	$196,630
Rhode Island	NA	NA	NA	NA
Tennessee	4,065,459	$4,065,459	2,032,729	$2,032,729
Texas	9,627,597	$9,627,597	4,813,798	$4,813,798
Utah	1,666,551	$1,666,551	833,275	$833,275
Washington	3,651,570	$3,651,570	1,825,785	$1,825,785
Total	66,212,332	$66,212,332	33,106,160	$33,106,160

Savings Calculation for Prescription Drugs

States	Total Services	Services x $1	Non-Exempt Services	Non-exempt x $1
Alaska	299,039	$299,039	149,519	$149,519
Connecticut	3,449,149	$3,449,149	1,724,574	$1,724,574
Delaware	479,796	$479,736	239,898	$239,898
Georgia	8,841,481	$8,841,481	4,420,740	$4,420,740
Hawaii[1]	600,000	$600,000	300,000	$300,000
Idaho	750,107	$750,107	375,053	$375,053
Indiana	3,261,632	$3,261,632	1,630,816	$1,630,816
Kentucky	7,254,476	$7,254,476	3,627,238	$3,627,238
Louisiana	8,187,936	$8,187,936	4,093,968	$4,093,968
Minnesota	4,573,505	$4,573,505	2,286,752	$2,286,752

States	Total Services	Services x $1	Non-Exempt Services	Non-exempt x $1
Nebraska	1,979,626	$1,979,626	989,813	$989,813
Nevada	493,239	$493,239	246,619	$246,619
New Jersey	8,427,969	$8,427,969	4,213,984	$4,213,984
New Mexico	1,454,448	$1,454,448	727,224	$727,224
New York	26,168,221	$26,168,221	13,084,110	$13,084,110
North Dakota	607,885	$607,885	303,942	$303,942
Ohio	15,319,466	$15,319,466	7,659,733	$7,659,733
Oklahoma	2,373,168	$2,373,168	1,186,584	$1,186,584
Oregon	2,100,122	$2,100,122	1,050,061	$1,050,061
Rhode Island	NA	NA	NA	NA
Tennessee	8,239,598	$8,239,598	4,119,799	$4,119,799
Texas	11,474,997	$11,474,997	5,737,498	$5,737,498
Utah	1,253,431	$1,253,431	626,715	$626,715
Washington	5,270,693	$5,270,693	2,635,346	$2,635,346
Total	122,859,984	$122,859,984	61,429,986	$61,429,986

[1] *Since Hawaii provided number of pills instead of prescriptions, the 1991 prescription number was obtained from the National Pharmaceutical Council's Pharmaceutical Benefits Under State Medical Assistance Programs, September 1992, p. 77.*

Total Cost Savings Calculation

Types of Service	Savings without Exemptions	Savings with Exemptions
Inpatient Hospital Days	$42,615,285	$21,307,623
Outpatient Hospital Services	$103,762,221	$51,881,094
Physician Visits	$66,212,332	$33,106,160
Prescription Drugs	$122,859,984	$61,429,986
Total	$335,449,822	$167,724,366

Table 3

STATE COPAYMENT POLICIES IN EFFECT AS OF JANUARY 1, 1991

STATE	SERVICE	CO-PAY AMOUNT *	APPLICABLE TO **
Alabama	Ambulatory surgical center services	$3.00	
	Durable medical equipment	$3.00	
	Federally qualified health centers	$1.00	
	Inpatient hospital	$50/admission	
	Outpatient hospital***	$3.00	
	Supplies/appliances	$1.00	
	Physician office visits (incl. optometric)	$1.00	
	Prescription drugs	Varies	Age 19+; pregnant women for non-pregnancy related prescriptions.
	Rural health clinic***	$1.00	
Alaska	None		
Arizona	Office visits	$1.00	
	Elective surgery	$5.00	
	Non-emergency use of ER	$5.00	
Arkansas	None		
California	Prescription drugs	$1.00	Age 19+.
	Emergency room (inappropriate use)	$5.00	
	Outpatient hospital	$1.00	
Colorado (1)	Physician services	$2.00	
	Community mental health centers	$2.00	
	Inpatient hospital	$15/stay	
	Outpatient hospital	$3.00	
	Prescription drugs	$1.00	
	Physician visit	$2.00	
	Rural health clinics	$2.00	
Connecticut	None		
Delaware	None		
DC	Prescription drugs	$0.50	Age 21+; pregnant women for non-pregnancy related prescriptions.
	Eyeglasses	$2.00	
Florida	Dentures	Varies (2)	Age 21+.
	Prosthetic devices - hearing aids	Varies (2)	Age 21+.
Georgia	None		
Hawaii	None		
Idaho	None		
Illinois	Inpatient hospital	Varies (3)	
Indiana	None		
Iowa	Chiropracty	$1.00	
	Dental	$3.00	Age 21+.
	Prescription drugs	$1.00	
	Eyeglasses - optician services	$2.00	
	Medical equipment & supplies	$2.00	
	Optometry	$2.00	
	Podiatry	$1.00	
	Prosthetic devices		
	—hearing aids	$3.00	
	—orthopedic shoes	$2.00	
	Psychology	$2.00	
	Psychotherapy (CMHC only)	$2.00	
	Rehabilitation agency	$2.00	
	Transportation - ambulance	$2.00	

Table 3 con't.

STATE COPAYMENT POLICIES IN EFFECT AS OF JANUARY 1, 1991

STATE	SERVICE	CO-PAY AMOUNT *	APPLICABLE TO **
Kansas	Ambulatory surgery center services	$3.00	
	Audiology	$3.00	
	Chiropracty	$0.50	
	Dental	$2.00	
	Prescription drugs	$1.00	
	Freestanding psychiatric hospital (private)	$25.00/stay	
	Home health agency (skilled nursing)	$2.00	
	Hospital - inpatient	$25.00	
	- non-emergency outpatient	$1.00	
	- outpatient surgery	$3.00	
	Medical equipment	$3.00	
	Mental health center	$2.00	
	Optometrist	$2.00	
	Physician office visit	$1.00	
	Podiatry	$1.00	
	Psychology	$2.00.	
	Transportation - non-emer. ambulance	$1.00	
Kentucky	None		
Louisiana	None		
Maine	Prescription drugs	0.75 [4]	
Maryland	Prescription drugs	$0.50	
Massachusetts	None		
Michigan [6]	Chiropracty	$1.00	
	Dental	$3.00	Age 21+.
	Prescription drugs	$0.50	
	Optometry	$2.00	
	Podiatry	$2.00	
	Prosthetic devices - hearing aids	$3.00	
Minnesota	None		
Mississippi	Dental	$2.00	
	Prescription drugs	$1.00	
	Home health visit	$2.00	
	Hospital - emergency room	$2.00	
	- inpatient	$5.00	Age 18+; pregnant women for non-pregnancy related prescriptions.
	Optometry	$2.00	
	Rural health clinics - office visits	$1.00	
	Transportation - ambulance	$2.00	
Missouri	Audiology	Varies [5]	Age 18+.
	Dental	Varies [5]	
	Dentures	Varies [2]	
	Prescription drugs	Varies [6]	
	Hospital - inpatient	$10.00	
	- outpatient	$3.00	
	Optometry	Varies [5]	
	Podiatry	Varies [5]	
Montana	Audiology	$0.50	Age 21+.
	Clinic services	$1.00	
	Clinical social worker	$0.50	
	Dental	$1.00	
	Prescription drugs	$1.00	
	Eyeglasses	$1.00	
	Home dialysis for ESRD	$0.50	
	Home health (not including DME)	$1.00	
	Hospital - inpatient	$3.00/day [7]	
	- outpatient	$1.00	
	Nurse specialist services	$1.00	
	Occupational therapy	$0.50	
	Optometry	$1.00	
	Physical therapy (outpatient)	$0.50	
	Physician	$1.00	
	Podiatry	$1.00	

SOURCE: NATIONAL GOVERNORS' ASSOCIATION, 1991 CRSCOPAY

Table 3 con't.

STATE COPAYMENT POLICIES IN EFFECT AS OF JANUARY 1, 1991

STATE	SERVICE	CO-PAY AMOUNT *	APPLICABLE TO **
Wisconsin (cont.)	Dental	Varies [13]	
	Prescription drugs	$0.50 [14]	
	Durable medical equipment	$1.00	
	Eyeglasses	Varies [15]	
	Hospital - inpatient, general	$3.00/day [16]	
	- inpatient, mental diseases	$3.00/day [16]	
	- outpatient	$3.00	
	- surgery	$3.00	
	Optometry	Varies [5]	
	Oral surgery	$1.00	
	Orthodonty	Varies [17]	
	Physician visits [18]		
	- consultations	$3.00	
	- diagnostic procedure in office	$1.00	
	- eye exams	$2.00	
	- home	$1.00	
	- lab procedure performed in office	$1.00	
	- radiology procedure in office	$2.00	
	- office	$1.00	
	- outpatient hospital	$1.00	
	Prosthetic devices - hearing aids	Varies [5]	
	Prosthodontic appliance	$3.00	
	Psychotherapy	Varies [15], [19]	
	Rural health clinics	$2.00	
	Speech/hearing/language	Varies [20]	
	Therapy, physical & occupational, per 15 minutes	$0.50 [21]	
	Transportation, ambulance/ non-emergency	$2.00/trip	
Wyoming	Prescription drugs	$1.00	

KEY:

CMHC = Community Mental Health Center
DME = Durable medical equipment.
ESRD = End stage rural disease.
* Unless otherwise specified, co-pay amounts are paid per service visit.
** This column refers to specific groups of people for whom states have opted to impose charges through provisions of law. Source: US Department of Health & Human Services; Health Care Financing Adminstration Analysis of State Medicaid Program characteristics. 1986, Aug. 1987, p. 75-79.
*** For these services the state requires the copayment be paid per claim for all Medicaid beneficiaries who are also Medicare-eligible. All other Medicaid beneficiaries - the copayment is per visit.
1 Medicaid recipients are subject to a maximum of $120.00 in copayments per year.
2 Co-pay is 5% of reimbursement for these services.
3 $2.00 for per diem of $275 to $325; $3.00 for per diem over $325.
4 $4.50 per month limit on prescriptions.
5 $.50 to $3.00.
6 These co-pay policies are not applicable to individuals who enroll in the physician-sponsored plan.
7 Maximum copay charge of $66.00 per stay.
8 Maximum copay charge of $21.00 per stay
9 In Pennsylvania the copays for services range from $1.00 - $6.00 depending on the Medicaid fee for the services provided. If the Medicaid fee is:
$ 1.00 - $10.00 the copay is $1.00
$10.00 - $25.00 the copay is $2.00
$25.01 - $50.00 the copay is $4.00
$50.01 - more the copay is $6.00
10 For all other services Pennsylvania has established a copay based on the Medicaid fee for that service
Medicaid fee of $ 1.00 - $10.00 copay is $0.50
Medicaid fee of $10.01 - $25.00 copay is $1.00
Medicaid fee of $25.01 - $50.00 copay is $2.00
Medicaid fee of $50.01 - or more copay is $3.00
11 Virginia's copayments are applicable to beneficiaries age 21+ and to pregnant women for non-pregnancy related service
12 $.50 on $10.00 or less; $1.00 on $10.01 and over.
13 $.50 to $1.00.
14 Copayment limited to $5.00 per month, per pharmacy.
15 $.50 to $2.00.
16 Maximum copay charge of $75 per stay.
17 $2.00 to $3.00.
18 A cap of $30 cumulative limit per calendar year per physician for all physcian services (physician visits, surgery, lab & X-ray services, and diagnostic tests).
19 Copayment may be charged only on the first 15 visits or $500.00 per year
20 $.50 per 15 minutes for some services; $1.00 per procedure for others
21 Copayment is limited to the first 30 hours or $1,500 of accumulated services, per beneficiary, per calendar year

SOURCE: NATIONAL GOVERNORS' ASSOCIATION, 1991 CRSCOPAY

APPENDIX C

COST SHARING ON MANDATORY SERVICES

State	Inpatient Hospital	Outpatient Hospital[1]	Physician Services[2]	Rural Health Clinic	Federally Qualified Health Center	Certified Nurse Practitioner
AL	50.00 a	3.00	1.00	1.00	1.00	1.00
AZ		5.00 n-e	1.00			
AR		.50-3.00	.50-3.00	.50-3.00	.50-3.00	.50-3.00
CA		1.00/5.00 n-e	1.00			
CO	15.00 a	3.00	2.00	2.00		
DC						
FL		1.00 n-e	1.00			
IL	2.00/3.00 d					
IA						
KS	25.00 a	1.00	1.00			
ME		.50-3.00				
MD						
MA		3.00 n-e				
MI						
MS	5.00 d	2.00	1.00	2.00	1.00	
MO	10.00 a	3.00[3]				
MT	3.00 d	1.00	1.00	1.00	1.00	
NH						
NC		3.00	3.00			
PA	3.00 d	.50-3.00	.50-3.00	.50-3.00	.50-3.00	.50-3.00
SC						
SD		5 percent	2.00			
VT	50.00 a	3.00				
VA	100.00 a[4]	3.00	1.00/3.00			
WV						
WI	3.00 d	3.00	.50-3.00	2.00-3.00		.50-3.00
WY		3.00/3.00 n-e	1.00			
Total States	11	16 / 5 n-e	15	7	5	4

1 For ease of charting, we compressed non-emergency use of emergency room (n-e) with outpatient services.
2 Some States include specialized services, e.g., ophthalmology or medical psychotherapy, under physician services.
3 Includes 2.00 for outpatient service and 1.00 for physician service
4 Inpatient hospital deductible
a = cost sharing per inpatient hospital admission
d = cost sharing per inpatient hospital day

COST SHARING ON OPTIONAL SERVICES

State	Prescription Drugs	Optometric/ Optician/ Vision Services[1]	Podiatric Services	Dental Services or Treatment/ Oral Surgery[2]	Chiropractic Services	Durable Medical Equipment
AL	.50-3.00	1.00				3.00
AZ						
AR	.50-3.00	.50-3.00	.50-3.00			
CA	1.00	1.00	1.00	1.00	1.00	
CO	.50 g/2.00 b	2.00	2.00			
DC	.50					
FL	1.00	1.00	1.00	1.00 s	1.00	
IL						
IA	1.00	2.00/2.00 o	1.00	3.00	1.00	2.00
KS	1.00	2.00	1.00			3.00
ME	1.00 g/2.00 b		.50-2.00			.50-3.00
MD	1.00					
MA	.50					
MI	1.00	2.00	2.00	3.00 s	1.00	
MS	1.00			2.00		
MO	.50-2.00	.50-3.00	.50-3.00	.50-3.00		
MT	1.00	1.00	1.00	1.00		.50
NH	.50 g/1.00 b					
NC	1.00	2.00/2.00 o	1.00	3.00	1.00	
PA	1.00	.50-3.00	.50-3.00	.50-3.00	.50-3.00	.50-3.00
SC	1.50					
SD	1.00			1.00	.50	5 percent
VT	1.00-2.00					
VA	1.00	1.00				
WV	.50-1.00					
WI	1.00	1.00	1.00-3.00	.50-3.00	.50/1.00	.50-3.00
WY	1.00	1.00				
Total States	25	15 / 2 o	13	9 / 2 s	8	8

1 For ease of charting, we compressed optometric/vision and optician services.
2 For ease of charting, we compressed dental services/treatment with oral surgery.
b = brand name
g = generic
o = optician services
s = oral surgery

Calculation for Federal and State Share of Savings

States	FMAP 1991[1]	Savings without Exemptions[2]	Federal Share[3]	State Share[4]	Savings with Exemptions[5]	Federal Share	State Share
AK	50.00	$875,011	$437,506	$437,505	$437,503	$218,752	$218,751
CT	50.00	$9,754,710	$4,877,355	$4,877,355	$4,877,351	$2,438,676	$2,438,675
DE	50.00	$3,718,966	$1,859,483	$1,859,483	$1,859,480	$929,740	$929,740
GA	61.34	$33,473,244	$20,532,488	$12,940,756	$16,736,618	$10,266,241	$6,470,377
HI	54.14	$13,720,413	$7,428,232	$6,292,181	$6,860,206	$3,714,118	$3,146,090
ID	73.65	$1,310,919	$965,492	$345,427	$655,457	$482,744	$172,713
IN	63.24	$13,243,564	$8,375,230	$4,868,334	$6,621,780	$4,187,614	$2,434,166
KY	72.96	$15,573,929	$11,362,739	$4,211,190	$7,786,963	$5,681,368	$2,105,595
LA	74.48	$19,823,654	$14,764,658	$5,058,996	$9,911,827	$7,382,329	$2,529,498
MN	53.43	$11,093,831	$5,927,434	$5,166,397	$5,546,912	$2,963,715	$2,583,197
NE	62.71	$3,505,911	$2,198,557	$1,307,354	$1,752,952	$1,099,276	$653,676
NV	50.00	$1,815,937	$907,969	$907,968	$907,966	$453,983	$453,983
NJ	50.00	$17,568,975	$8,784,488	$8,784,487	$8,784,487	$4,392,244	$4,392,243
NM	73.38	$2,458,971	$1,804,393	$654,578	$1,229,484	$902,195	$327,289
NY	50.00	$70,295,065	$35,147,533	$35,147,532	$35,147,532	$17,573,766	$17,573,766
ND	70.00	$1,447,255	$1,013,079	$434,176	$723,627	$506,539	$217,088
OH	59.93	$31,392,713	$18,813,653	$12,579,060	$15,696,355	$9,406,826	$6,289,529
OK	69.65	$4,048,093	$2,819,497	$1,228,596	$2,024,045	$1,409,747	$614,298
OR	63.50	$3,236,330	$2,055,070	$1,181,260	$1,618,163	$1,027,534	$590,629
RI	53.74	NA	NA	NA	NA	NA	NA
TN	68.57	$19,721,450	$13,522,998	$6,198,452	$9,860,723	$6,761,498	$3,099,225
TX	63.53	$28,380,069	$18,029,858	$10,350,211	$14,190,032	$9,014,927	$5,175,105
UT	74.89	$6,275,716	$4,699,884	$1,575,832	$3,137,857	$2,349,941	$787,916
WA	54.21	$22,715,096	$12,313,854	$10,401,242	$11,357,546	$6,156,926	$5,200,620
Total	——	$335,449,322	$198,641,450	$136,808,372	$167,724,866	$99,320,697	$68,404,169

[1] Federal Medical Assistance Percentage (FMAP) - Rate of Federal Financial Participation in a State's Medicaid Program for FY 1991.

[2] Each State's total savings for inpatient, outpatient, physician, and prescription drug services, assuming no recipients are exempted.

[3] The Federal share is arrived at by multiplying each State's total savings by the FMAP.

[4] The State share is arrived at by multiplying each State's total savings by (1 - FMAP), e.g. the calculation for Ohio would be savings multiplied by (1 - .5993) or .4007.

[5] Each State's total savings for inpatient, outpatient, physician, and prescription drug services, assuming 50 percent of the recipients are exempted.

Table 3 con't.

STATE COPAYMENT POLICIES IN EFFECT AS OF JANUARY 1, 1991

STATE	SERVICE	CO-PAY AMOUNT *	APPLICABLE TO **
Montana con't.	Private duty nursing	$0.50	
	Prosthetic devices	$0.50	
	- hearing aids	$0.50	
	- medical equip. & supplies	$0.50	
	Psychological	$0.50	
	Speech pathology	$0.50	
Nebraska	None		
Nevada	None		
New Hampshire	Prescription drugs:		
	- generics	$0.50	
	- brand names	$1.00	
New Jersey	None		
New Mexico	None		
New York	None		
North Carolina	Chiropracty	$0.50	
	Clinic	$0.50	
	Dental	$2.00	Age 18+
	Eyeglasses (each pair and repair of $4+)	$2.00	
	Hospital - outpatient	$1.00	
	Optometry	$1.00	
	Physician	$0.50	
	Podiatry	$1.00	
	Prescription drugs	$0.50	
North Dakota	Eyeglasses - replacement lenses & frames within 1 yr. of original prescription.	$3.00	
Ohio	None		
Oklahoma	None		
Oregon	None		
Pennsylvania	Prescription drugs	$0.50	
	Inpatient	$3.00/day [8]	
	Non-emergency service in a hospital	Varies [9]	
	Emergency room	Varies [9]	
	All other allowable services	Varies [10]	
Rhode Island	None		
South Carolina	Prescription drugs	$1.00	Age 21+; and pregnant women for non-pregnancy related prescriptions.
South Dakota	Ambulatory surgery center	Varies [2]	
	Chemical dependency treatment	Varies [2]	
	Chiropracty	$0.50	
	Dental	$1.00	
	Dentures	$3.00	
	Durable medical equipment	Varies [2]	
	EPSDT screening	$1.00	
	Hospital - outpatient (except lab)	Varies [2]	
	Mental health centers	Varies [2]	
	Optometry	$0.50	
	Physician	$3.00	
	Podiatry	$2.00	
	Prescription drugs	$1.00	Pregnant women for non-pregnancy related prescription drugs.
	Psychotherapy	$2.00	
	Rehab hospital outpatient (except lab)	Varies [2]	
Tennessee	None		
Texas	None		
Utah	None		
Vermont	Prescription drugs	$1.00	
Virginia [11]	Clinic	$1.00	
	Hospital - inpatient	$30.00	
	- outpatient, nonemergency	$2.00	
	Optometry - eye exams	$1.00	
	Physician	$1.00	
	Prescription drugs	$1.00	
Washington	None		
West Virginia	Prescription drugs	Varies [12]	
Wisconsin	Audiological testing	$1.00	
	Chiropracty	$1.00	
	Day treatment service	$0.50	

SOURCE: NATIONAL GOVERNORS' ASSOCIATION 1991 CRSCOPAY

COST SHARING ON OPTIONAL SERVICES

State	Psychiatry/ Psychology/ Psycho-therapy[1]	Audiology Services	Ambulance/ Transport Services	Eyeglasses	Medical Supplies	Prosthetic Device
AL					1.00	
AZ						
AR			.50-3.00			.50-3.00
CA	1.00	1.00				
CO	.50/15 min.					
DC				2.00		
FL						
IL						
IA	2.00	2.00	2.00		2.00	2.00
KS	2.00	3.00	1.00			3.00
ME		.50-2.00	.50-2.00		.50-3.00	
MD						
MA						
MI						
MS			2.00	2.00		
MO		.50-3.00		.50-3.00		.50-3.00 ae
MT	.50/1 hour	.50		1.00	.50	.50
NH						
NC				2.00		
PA	.50		.50-3.00	.50-3.00	.50-3.00	.50-3.00
SC						
SD					1.00	5 percent
VT						
VA						
WV						
WI	.50-2.00	1.00	.50-3.00	.50-3.00	.50	
WY	1.00					
Total States	8	7	7	7	7	7

1 For ease of charting, we compressed psychiatric, psychological, and psychotherapy services.
ae = artificial eye

COST SHARING ON OPTIONAL SERVICES

State	Hearing Aids/ Hearing Aid Services	Home Health Services	Physical Therapy	Clinic Services	Dentures/ Denture Services	Occupational Therapy
AL						
AZ						
AR		2 percent				
CA			1.00	1.00		1.00
CO						
DC						
FL	5 percent				5 percent	
IL						
IA	3.00		1.00			
KS		2.00				
ME		.50-2.00	.50-2.00			.50-2.00
MD						
MA						
MI	3.00					
MS		2.00		1.00 s		
MO	.50-3.00				5 percent	
MT	.50	1.00	.50	1.00 d		.50
NH						
NC						
PA				.50-3.00	.50-3.00	
SC						
SD					3.00	
VT						
VA		3.00	3.00	1.00		3.00
WV						
WI	.50/1.00/3.00		1.00/30 min.		3.00	1.00/30 min.
WY						
Total States	6	6	6	5	5	5

s = State clinic
d = diagnostic clinic

COST SHARING ON OPTIONAL SERVICES

State	Speech Therapy	Ambulatory Surgical Centers	Community/ Mental Health Centers	Private Duty Nurse/ Personal Care	Other
AL		3.00			
AZ					a
AR				2 percent	
CA	1.00	1.00			b
CO			2.00		
DC					
FL					
IL					
IA					c,d/2.00
KS		3.00	2.00		d/3.00,e/3.00
ME	.50-2.00			.50-3.00	
MD					
MA					
MI					
MS					
MO					
MT	.50		1.00	.50	e/1.00,f
NH					
NC					
PA		.50-3.00			g
SC					
SD			5 percent		h
VT					
VA	3.00				
WV					
WI	1.00/30 min.				i
WY					
Total States	5	4	4	3	11

a = non-emergency surgery/5.00, diagnostic/rehabilitative x-ray and lab services/1.00
b = acupuncture/1.00
c = rehabilitation agency services/2.00
d = orthopedic shoes or orthotics
e = outpatient surgery
f = home dialysis/.50, free standing dialysis center/1.00, social worker/.50 per hour, licensed counselor/.50 per hour
g = diagnostic radiology/nuclear medicine/radiation therapy/medical diagnostic services (when billed in total or only technical component is billed)/1.00, all other covered services/.50-3.00
h = EPSDT screening/dental procedures/optometric, or optical procedures for those over age 18/1.00
i = Medical day treatment and assessment/.50 per day

APPENDIX D

AGENCY COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Memorandum

Date	JUN 11 1993
From	Bruce C. Vladeck Administrator
Subject	Office of Inspector General (OIG) Draft Report: "Medicaid Cost Sharing" (OEI-03-91-01800)
To	Bryan B. Mitchell Principal Deputy Inspector General

We have reviewed the above-mentioned draft report which presents findings on the impact of State cost sharing policies on the Medicaid program.

The Health Care Financing Administration nonconcurs with the recommendation contained in the report. Our specific comments are attached for your consideration.

Thank you for the opportunity to review and comment on this draft report. Please advise us if you agree with our position on the report's recommendation at your earliest convenience.

Attachment

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DATE SENT 6/14

Comments of the Health Care Financing Administration (HCFA) on the Office of Inspector General (OIG) Draft Report: Medicaid Cost Sharing, OEI-03-91-01800

Recommendation

The HCFA should promote the development of effective cost sharing programs within States.

(1) The HCFA could encourage States to implement cost sharing. The HCFA could accomplish this by:

- o providing the States with technical assistance and information about State experiences with cost sharing;
- o allowing States to experiment with cost sharing programs that target new populations and reflect more substantial cost sharing amounts; and/or
- o recommending changes to Federal requirements allowing for greater State flexibility in determining exempted populations and services, and allowing higher recipient cost sharing amounts.

(2) The HCFA could seek legislation to provide States with incentives to implement cost sharing programs, such as decreasing Federal matching to States who do not implement cost sharing.

(3) The HCFA could seek legislation to mandate cost sharing for all States.

Response

HCFA nonconcurs with this recommendation. We believe cost sharing should remain a voluntary State option.

The legislative history of section 1916 of the Social Security Act indicates that it was designed to allow States greater flexibility in the use of cost sharing without imposing unnecessary hardships on Medicaid recipients. Current regulations provide the States with a wide variety of options, and, thus, a considerable degree of program and administrative flexibility. Some of these options are as follows: (1) use of enrollment fees or premiums for the medically needy rather than copayments; (2) use of deductibles rather than copayments; (3) ability of States to relate recipient cost sharing to income (within maximum amount specified in regulations) and to charge different amounts to medically needy and categorically needy recipients; and (4) optional use of cumulative maximums for all deductibles, coinsurance, or

copayments charged to a family. While we agree that there is sufficient evidence to suggest that cost sharing saves money for the State Medicaid program and the Federal government, we believe that any changes in cost sharing policies should also be viewed in terms of its effect on Medicaid recipients.

There are significant variations of the Medicaid program among States. Consequently, advocating cost sharing may have differing effects on Medicaid recipients. Since States are looking at ways to decrease welfare payments, increased cost sharing may mean increased copayments for recipients who, in turn, will have even less money for other basic maintenance needs which have also risen in cost.

There are also potential difficulties with the implementation of cost sharing for outpatient prescription medications. One potential difficulty is that access to drugs may be limited, and the dollar savings on drugs may be outweighed by the use of high cost services, emergency rooms and potentially avoidable hospitalizations because of adverse complications experienced by persons who do not obtain their prescriptions. Any recommendation that includes prescription drugs should be reviewed to ensure that it does not conflict with other State options for limiting access to outpatient drugs for Medicaid, such as limits on the number of prescription transactions per month or on the supply (e.g., 30-day supply, 6-month supply), or a State's option to totally exclude certain drugs from reimbursement. These other limitations can also cause high-cost adverse health care needs. Furthermore, the added demand for a copayment, particularly if it is based on a percentage of total charge for the drug which is already high, can place an added burden on the Medicaid recipient.

Another consideration is the impact of cost sharing on providers of care for the Medicaid population. The burden for collection of "shared cost" is shifted to the provider. In some parts of the Medicaid program, provider reimbursement for care to Medicaid eligibles functions more as a disincentive than an incentive. The need for the provider to collect a copay from the Medicaid population may well function simply as another cap on provider fees rather than a true recipient share in the cost of medical care. Although OIG mentions that the burden is on the provider to collect the copay, this report would be enhanced by showing how copay is related to physician fees, especially the new HCFA physician fee schedule. For crossover patients covered by Medicare and Medicaid, the physician is subject to the Medicare physician fee schedule and the limits of State Medicaid program reimbursement rates. Cost sharing should not serve as a barrier to receiving necessary medical services. The question of whether providers deny medical care because of a failure to collect the patient's shared portion of cost is possibly important, but reportedly unknown to those in the State Medicaid offices.

Lastly, we believe that no further action should be taken pending the development and announcement of the Administration's health care proposal. However, if OIG decides to issue this report in final, we suggest that the report be shared with the States.

Technical Comments

The section of the report entitled, "Previous Cost Sharing Studies" could be improved by referencing the studies and adding caveats about the serious methodological flaws or shortcomings in them. We would not want them presented as useful testimony for current day practices or future program and policy recommendations.

In the Executive Summary Findings, the potential savings are shown as being between $167 to $335 million annually. We suggest adding a statement to explain that variance, *e.g.*, ". . . . savings of $167 million under current law, and $335 million if existing exemptions for covered populations and services were to be legislatively repealed."

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

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MAR 30 1993

MEMORANDUM TO: Bryan B. Mitchell
Principal Deputy Inspector General

FROM : Elizabeth M. James
Acting Assistant Secretary for
Management and Budget

SUBJECT : OIG Draft Report on Medicaid Cost Sharing
OEI-C3-91-0'8 ?0

Thank you for the opportunity to review this draft report. Focusing on the area of cost containment is important and the report obtained soma good information through the executive interviews. We are, however, concerned with the conclusion that "the report demonstrates that States have developed cost sharing programs that reduce Medicaid expenditures."

We wish to raise two issues concerning your findings and the ensuing recommendations. First, the sample size and data are insufficient to support the findings. This conclusion is based on the following:

- Of the 27 states, only three provided program evaluation data (two of which were inconclusive).
- 22 states said that the cost sharing programs had reduced Medicaid expenditures. However, only 11 provided financial data depicting estimated savings.
- Only one of the state's estimates of savings included reductions in utilization. The remainder represented reductions in provider payments.
- The calculated savings estimates may be overly simplified. The maximum value was calculated simply by multiplying the number of 1991 claims by a "frequently used" copayment. A 50 percent exemption of services was assumed to arrive at the minimum value. A 50 percent recipient exemption is not necessarily equal to a 50 percent service exemption.

Second, the analyses of the sample data do not cover the interactions between cost sharing and other cost containment polices which could have influenced the observed Medicaid savings. For example,

- No analysis of changes in provider participation has been done. The only state with conclusive program evaluation data indicated that provider participation had remained stable not because recipients were paying the copayment but mainly because pursuit of the nominal amount was more expensive than the value of the copayment.

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- 17 states implemented other cost containment programs at the same time as their cost sharing and thus were unable to truly measure the effect of cost sharing.

- There is no attention to the burden incurred by recipients and providers from cost sharing programs. States are uncertain whether recipients are actually paying the copayments.

We believe additional sample data needs to be collected and analyzed before conclusions can be drawn as to the effectiveness of cost sharing programs. Perhaps a primary recommendation of this report should be that HCFA pursue further analysis in this area.

Legislative Research Agency

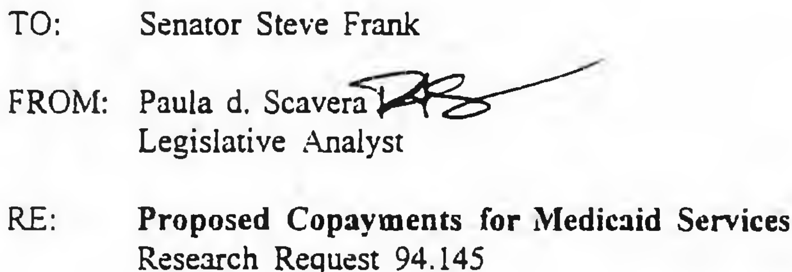
Alaska State Legislature

130 Seward Street, Suite 218
Juneau, Alaska 99801-2196

Phone: (907) 465-3991
Fax: (907) 463-3351

March 10, 1994

MEMORANDUM



TO: Senator Steve Frank

FROM: Paula d. Scavera
Legislative Analyst

RE: **Proposed Copayments for Medicaid Services**
Research Request 94.145

You requested an analysis of how much the state would save if Alaska medicaid patients were required to pay a small amount for their medical care. Copayments for certain medicaid services are allowed under federal regulations and used in 25 states and the District of Columbia.

A copayment may be imposed for most, but not all medicaid services. Federal regulations shield certain groups from requirements for copayments (attached). Among the groups excluded from being charged copayments are children under 18 years of age (and at the option of the state, individuals under 21, 20 or 19 years of age) and pregnant women seeking care for services related to their pregnancy. Institutionalized individuals who must "spend-down" (spend all but a minimal amount of their income required for personal needs) as a condition of receiving services are excluded from copayments. Emergency and family planning services are also exempt from copayment as are enrollees in health maintenance organizations (HMOs; there are no HMOs in Alaska).

Attached is a table that shows the amount of money that would have been saved in FY 93 by the medicaid program if a $2 or $3 copayment had been required. The data used in the table to compute these estimates are from a variety of sources. The Alaska Department of Health and Social Services (H&SS) provided the number of recipients, total payments and visits for FY 93, except for hospital outpatient, and mental hospital inpatient categories. These latter numbers were obtained from a previous Legislative Research Agency memorandum and represent FY 92 numbers. Excluded from the table are data about ambulance and transport services, as they were unobtainable from H&SS or other sources at hand.

To estimate the FY 95 recipients, visits, and savings, the FY 93 figures were increased 39.42 percent, which is the amount of increase in the medical assistance budget from FY 93 actual expenditures to the proposed FY 95 budget. The source for this percentage increase was Legislative Finance.

Column 11 (>20) represents the percentage of medicaid recipients that H&SS assumes would be required to make a copayment. This assumption exceeds minimum federal requirements. The department excludes all services for pregnant women, for all children under 21, for all institutionalized persons, for all persons under a prepaid health plan, and those served under home and community-based services. Thus, the percentages in column 11 are a conservative estimate. As a result, the estimated copayments in the final column are likely underestimated.

If you have questions or need further assistance, please contact us.

Attachment

Proposed Copayments for Medicaid Services in Alaska
Comparison of FY 93 with FY 95

		FY 93				FY 95 Estimated					
(1) Type of Visit/Service	(2) Provider Type	(3) Total Recipients	(4) Payments	(5) Visits	(6) Estimated Copayments	(7) Total Recipients	(8) Payments	(9) Visits	(10) Copay Amount	(11) % >20	(12) Estimated Copayments
Physician Service Visits	Physician-Individual	33,237	$24,745,658	137,035	$172,664	46,339	$34,500,396	191,054	$3.00	42%	$240,728
	Physician-Group	33,226	$16,539,099	120,511	$151,844	46,324	$23,058,812	168,016	$3.00	42%	$211,701
Certified Nurse Practitioner Services	Nurse Practitioner	864	$79,907	1,081	$1,913	1,205	$111,406	1,507	$3.00	59%	$2,668
Optometric/Option/Vision Service Visits	Optometrist	8,294	$859,909	11,192	$19,810	11,563	$1,198,865	15,604	$3.00	59%	$27,619
	Optician	2,162	$230,680	3,313	$5,864	3,014	$321,614	4,619	$3.00	59%	$8,176
	Vision Group	2,108	$230,970	2,987	$5,287	2,939	$322,018	4,164	$3.00	59%	$7,371
Dental Services or Treatment Visits	Dentist-Individual	14,796	$5,734,834	25,551	$52,124	20,629	$7,995,506	35,623	$3.00	68%	$72,671
	Dentist-Group	5,650	$1,697,504	7,567	$15,437	7,877	$2,366,660	10,550	$3.00	68%	$21,522
Chiropractic Services Visits	Chiropractor-Ind.	1,734	$374,552	3,505	$4,311	2,418	$522,200	4,887	$3.00	41%	$6,011
	Chiropractor-Group	539	$121,644	854	$1,050	751	$169,596	1,191	$3.00	41%	$1,464
Physical Therapy Visits	Outpatient Patient	305	$189,107	4,952	$4,061	425	$263,653	6,904	$2.00	41%	$5,661
	Independent Patient	465	$196,155	6,418	$5,263	648	$273,479	8,948	$2.00	41%	$7,337
Private Duty Nurse/Personal Care Visits	PC Attendant	88	$986,221	2,608	$7,824	123	$1,374,989	3,636	$3.00	100%	$10,908
	PC Agency	539	$1,273,157	4,706	$5,647	751	$1,775,035	6,561	$3.00	40%	$7,873
	PC Nurse	60	$3,285	94	$133	84	$4,580	131	$2.00	71%	$186
Generic Drug Prescriptions Filled	Pharmacy	37,230	$14,492,682	219,901	$310,060	51,906	$20,205,697	306,586	$3.00	47%	$432,286
Brand-Name Prescriptions Filled	Included in Generic										
Rural Health Clinic Visits	Rural Health Clinic	405	$66,275	1,342	$1,181	565	$92,401	1,871	$2.00	44%	$1,646
Podiatric Services Visits	Podiatry-Individual	97	$4,012	130	$153	135	$5,594	181	$2.00	59%	$214
Durable Medical Equipment Purchased	DME Supplier	1,804	$2,179,482	4,587	$8,119	2,515	$3,038,634	6,395	$3.00	59%	$11,319
Psychiatry/Psychology/Psychotherapy Visits	Psychologist	8	$7,995	46	$81	11	$11,147	64	$3.00	59%	$114
Audiology Services Visits	Audiologist	963	$122,997	2,292	$4,057	1,343	$171,482	3,196	$3.00	59%	$5,656
Prosthetic Devised Purchased	P & O Supplier	435	$396,161	900	$1,593	606	$552,328	1,255	$3.00	59%	$2,221
Hearing Aids/Hearing Aid Services	Hearing Aid Supplies	423	$186,419	1,373	$2,430	590	$259,905	1,914	$3.00	59%	$3,388
Home Health Services Visits	Home Health Agency	307	$513,098	776	$1,653	428	$715,361	1,082	$3.00	71%	$2,304
Occupational Therapy Visits	Occupational Ther.	1	$347	24	$14	1	$484	33	$1.00	59%	$20
Speech Therapy Visits	Cert. Speech Path.	151	$247,488	2,872	$5,083	211	$345,048	4,004	$3.00	59%	$7,087
Ambulatory Surgical Center Visits	Amb. Surgical Center	1,434	$678,865	1,589	$2,813	1,999	$946,474	2,215	$3.00	59%	$3,921
Community/Mental Health Center Visits	M. Health Agency	4,989	$6,961,008	94,420	$167,123	6,956	$9,705,037	131,640	$3.00	59%	$233,003
Hospital	Inpatient	7,913	Not Available	11,750	$352,500	11,032	$0	16,382	$100.00	30%	$491,456
Hospital (FY 92)	Outpatient	23,131	$10,739,954	23,131	$34,697	32,249	$14,973,644	32,249	$3.00	50%	$48,374
Mental Hospital (FY 92)	Inpatient	643	$8,293,110	643	$19,290	896	$11,562,254	896	$100.00	30%	$26,894
	Total Estimated Medicaid Copayments				***$1,364,08[illegible]***						***$1,901,801***

Source: Alaska Department of Health and Social Services, Division of Medical Assistance: FY 93 data
Division of Legislative Finance: Percentage increase
Hospital Outpatient and Mental Hospital Inpatient data: Legislative Research Agency Memorandum 93.103 "Medicaid: Where the Money Goes"

Prepared by the Legislative Research Agency, March 1994 (94.145)

Under Food and Drug Administration procedures, manufacturers may obtain changes in a drug's labeling after the drug is approved. These changes may include information about new uses of the drug or advantages that the drug has over other therapies. For this reason, the Committee expects that the formulary committee will periodically review its decisions to exclude drugs from its formulary to determine whether those drugs continue to have no significant therapeutic advantage over drugs listed on the formulary.

Sec. 5107. Elimination of the special ez ption from prior authorization for new drugs

Under current law, States are prohibited from subjecting a covered outpatient drug to prior authorization during the first six months after a drug is approved by the Food and Drug Administration. The Committee bill eliminates this prohibition so that a State will be able to impose the prior authorization requirement at any time after a drug is approved.

Sec. 5108. Technical corrections relating to section 4401 of OBRA–1990

The Committee bill makes technical corrections to section 4401 of the Omnibus Budget Reconciliation Act of 1990, P.L. 101–508, relating to reimbursement for prescribed drugs.

Part 3—Restrictions on divestiture of assets and estate recovery

Sec. 5111. Transfer of assets

Under current law, individuals residing in nursing facilities who dispose (or whose spouses dispose) of resources for less than fair market value during the 30-month period prior to application for Medicaid are subject to a delay in eligibility for nursing facility care (and home and community based services). If the individual is eligible for Medicaid at the time of institutionalization, the 30-month "look-back" period runs from the date of institutionalization. The period of ineligibility begins with the month in which the resources are transferred and lasts for the number of months equal to the lesser of (1) 30 or (2) the total uncompensated value of the resources transferred divided by the average cost to a private patient of nursing facility services in the State. This penalty does not apply in certain circumstances, including transfers to or from a spouse, to a disabled child, or to the extent that the State determines that denial of eligibility would work an undue hardship.

Under the Committee bill, individuals who, during the period 36 months prior to the first day of application for Medicaid benefits as an institutionalized individual, have transferred assets for less than fair market value will be subject to a denial of eligibility for Medicaid coverage for nursing facility (and home and community-based waiver services). The period during which benefits are denied will begin with the date on which the prohibited transfer occurred and will run for the number of months determined by dividing the total uncompensated value of the resources transferred by the average monthly cost, to a private patient, of nursing facility services in the State. The penalties for different transfers occurring within

the 36-month "look-back" period will run consecutively, not concurrently.

The Committee bill requires that individuals will not be ineligible for Medicaid coverage to the extent that the State agency determines, under procedures established by the State (in accordance with standards specified by the Secretary) that the denial of eligibility would work an undue hardship (in accordance with criteria established by the Secretary). Under the current law "undue hardship" provision, there is no Federal guidance on either the procedures a State should follow in making such determinations or the types of circumstances that should be regarded as working a hardship. States are simply required to include a definition of "undue hardship" in their State Medicaid plans. The Committee is concerned that some States may not be extending to all individuals facing hardship the protections of existing law. The Committee bill therefore amends current law to require the Secretary (1) to specify standards that State hardship determination procedures must meet, and (2) to establish criteria States must apply in determining whether a hardship exists.

The Committee expects the Secretary, in developing standards for the determination process, to address at least the following issues: notice to the institutionalized individuals that a hardship exception exists; adequate representation of the interests of such individuals; the timeliness of the determination process; protections for institutionalized individuals from transfer by a nursing facility while a determination is pending; and the ability to appeal an adverse determination.

The Committee expects the Secretary, in developing criteria for use by States in determining whether an "undue hardship" exists, will provide for special consideration of at least the following: cases in which the individual has no way to pay for the necessary care; cases in which the transfer was not knowingly authorized by the individual; and cases in which the individual assigns rights of recovery she or he may have in a cause of action against the transferee to the State or where the State has such rights pursuant to State law. In order to ensure that the standards and criteria are based on as much information as possible, the Committee expects the Secretary to develop them through a process that provides for notice and a period for public comment.

Under the Committee bill, an asset held by an individual in common with another person or persons in a joint tenancy or similar arrangement is considered to be transferred when any action is taken, by the individual or by any other person, that eliminates or reduces the individual's ownership or control of the asset.

Under the Committee bill, the following rules apply to assets placed in trust, without regard to the purposes of the trust, whether the trustees have (or exercise) any discretion, or any restrictions on distributions from the trust: With respect to revocable trusts, the corpus is considered a resource available to the individual; payments from the trust to or for the benefit of the individual are considered income to the individual; and any other payments from the trust are considered a transfer of assets by the individual.

With respect to irrevocable trusts which may benefit the grantor, the corpus of the trust is considered a resource available to the in-

dividual; payments from the trust to or for the benefit of the individual are considered income to the individual; and any other payments from the trust are considered a transfer of assets by the individual. Any portion of such an irrevocable trust from which no payment can under any circumstances be made to the individual shall be considered a transfer of assets by the individual as of the date of establishment of the trust.

With respect to irrevocable trusts which cannot benefit the grantor, the corpus shall be considered a transfer of assets by the individual as of the date of the establishment of the trust and payments from the trust after this date shall be disregarded.

Under the Committee bill, these rules do not apply to the following types of trusts: (1) trusts established for the benefit of a disabled individual by a parent, grandparent, or other representative payee (including a court or administrative body) of the individual; and (2) trusts composed only of pension, Social Security, and other income to the individual (plus accumulated income) under which the State receives any amounts remaining upon the death of the individual and which are established in States that limit nursing home eligibility to individuals with incomes below an amount set by the State no higher than 300 percent of the benefit rate under the Supplemental Security Income (SSI) program.

The Committee bill requires State Medicaid agencies to establish procedures (in accordance with standards specified by the Secretary) under which the agency waives the application of these rules relating to "Medicaid qualifying trusts" with respect to an individual if the individual establishes (under criteria established by the Secretary) that the application of these rules would work an undue hardship on the individual.

Sec. 5112. Medicaid estate recoveries

Under current law, a State has the option of seeking recovery of amounts correctly paid on behalf of an individual under its Medicaid program from the individual's estate if the individual was 65 years or older at the time he or she received Medicaid benefits. The State may not seek recovery from the beneficiary's estate until the death of the surviving spouse, if any, and only if the individual has no surviving minor or disabled child.

Under the Committee bill, States are required to establish an estate recovery program that meets certain requirements. The program must identify and track resources (whether or not excluded for eligibility purposes) of individuals who receive nursing facility, home and community-based services, and other specified long-term care services. The program must promptly ascertain when the individual and the surviving spouse, if any, dies, and must provide for the collection of the amounts correctly paid by Medicaid on behalf of the individual for long-term care services from the estate of the individual or the surviving spouse. The term "estate" is defined as all real and personal property of a deceased individual and all other assets in which the individual had any legally cognizable title or interest at the time of his death, including assets conveyed to a survivor, heir, or assign through joint tenancy, survivorship, life estate, living trust, or other arrangement.

The Committee bill requires the State agency to establish procedures (in accordance with standards specified by the Secretary) under which the agency waives recovery if it would work an undue hardship (in accordance with criteria established by the Secretary). The Committee expects that, in developing standards for State recovery procedures, the Secretary will address adequacy of notice to, and representation of, affected parties; the timeliness of the process; and the availability of appeals and other issues. With respect to the establishment of criteria for use by States in determining whether to waive recovery, the Secretary should provide for special consideration of cases in which the estate subject to recovery is (1) the sole income-producing asset of survivors (where such income is limited), such as a family farm or other family business, or (2) a homestead of modest value or (3) other compelling circumstances. The Committee also expects the Secretary to provide guidance to States on how to address situations where recovery is not waived and beneficiaries of the estate from which recovery is sought wish to satisfy the State's recovery claim without selling a non-liquid asset subject to recovery.

Sec. 5113. Closing loophole permitting wealthy individuals to qualify for Medicaid

Under the Committee bill, Section 1902(r)(2) of the Social Security Act is amended to prohibit State plans from disregarding assets in cases where an individual has received or is eligible to receive payments under a long-term care policy. The provision does not apply to State plan provisions that are approved by the Secretary as of May 14, 1993. This provision prevents States from disregarding assets of individuals seeking Medicaid eligibility on the basis that individuals have purchased long-term care insurance policies. Certain states and the Secretary have interpreted section 1902(r)(2) as permitting such disregards.

Part 4—Improvement in identification and collection of third party payments

Sec. 5116. Liability of third parties to pay for care and services

Under current law, State Medicaid agencies are required to take all reasonable measures to ascertain the legal liability of third parties (including health insurers) to pay for covered services provided to Medicaid beneficiaries.

(a) Liability of ERISA plans.—The Committee bill includes group health plans as defined in section 607(1) of the Employee Retirement Income Security Act of 1974, service benefit plans, and health maintenance organizations among the third parties the legal liability of which States are required to ascertain with respect to services provided to Medicaid eligibles.

(b) Requiring States to prohibit insurers from taking Medicaid status into account.—The committee bill requires States to prohibit any health insurer, group health plan under ERISA, service benefit plan, or HMO from taking into account an individual's eligibility for Medicaid in enrolling the individual for coverage or making any payments for benefits to (or on behalf of) the individual.

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(c) State right to subrogation.—The Committee bill provides that, in any case where a third party has a legal liability to make payment for services provided to a Medicaid beneficiary, a State is subrogated to the right of any other party to payment for such services to the extent that payment has been made by the Medicaid program.

Section 5117. Health coverage clearinghouse

The Committee bill directs the Secretary of Health and Human Services to establish and operate a Health Coverage Clearinghouse for the purpose of identifying indemnity insurers, service benefit plans, group health plans under ERISA, health maintenance organizations, and other third parties which may be liable for payment for services provided to Medicaid, Medicare, or Indian Health Service beneficiaries (or individuals receiving services funded under the Maternal and Child Health Block Grant). The bill directs State Medicaid agencies to request information from the Clearinghouse concerning the employment and group health coverage of a Medicaid beneficiary, the beneficiary's spouse, or, if the beneficiary is a dependent child, the beneficiary's parents. The bill sets forth procedures under which State Medicaid programs may obtain this information from the Clearinghouse as well as procedures for the maintenance of a data bank by the Clearinghouse. The bill also directs employers to provide information relating to coverage of individuals (and spouse and dependent children) under the employer's group health plan to the Clearinghouse and provides a civil monetary penalty for willful and repeated failure to comply.

Sec. 5118. Medical child support

Under current law, State Medicaid agencies must enter into cooperative arrangements with the State's Child Support Enforcement agency under Title IV–D of the Social Security Act with respect to the enforcement and collection of rights of payment for medical care by or through a parent. States must also require individuals, as a condition of Medicaid eligibility, to assign to the State any rights to support for the purpose of medical care by a court or administrative order.

The Committee bill requires States to have in effect the following laws relating to medical child support: (1) a law that prohibits an insurer from denying enrollment of a child under the health coverage of the child's parent on the ground that the child was born out of wedlock, cannot be claimed as a dependent on the parent's Federal income tax return, or does not reside with the parent or in the insurer's service area; (2) a law that requires an insurer, in any case in which a parent is required by a court or administrative order to provide health coverage for a child and the parent is eligible for family coverage through the insurer, to permit the parent and/or child to enroll regardless of enrollment season restrictions; (3) a law that requires any employer doing business in the State that provides health coverage to a child pursuant to court or administrative order to withhold the employee's share of the premium (up to the maximum permitted by the Consumer Credit Protection Act); (4) a law that prohibits an insurer from imposing special requirements on a State agency acting as a subrogee or agent of a

Medicaid beneficiary; (5) a law that requires an insurer to facilitate payment for services to a child in cases where the child has health coverage through the noncustodial parent; and (6) a law that requires the State Medicaid agency to garnish wages, or withhold amounts from State tax refunds, to individuals who are subject to a medical child support order, have received payment from a third party of the costs of services to the child, and have not reimbursed the provider or the other parent or guardian.

For purposes of these laws, the term "insurer" includes an entity offering a service benefit plan, a health maintenance organization, and a group health plan under ERISA.

Part 5—Assuring proper payments to disproportionate share hospitals

Sec. 5121. Assuring proper payments to disproportionate share hospitals

Under current law, States are required to make adjustments to payments for inpatient services provided to Medicaid patients at hospitals serving disproportionate numbers of Medicaid and other low-income patients with special needs. States have broad authority to designate "disproportionate share" (DSH) hospitals. However, a hospital is deemed to be a DSH hospital, and is entitled to receive payment adjustments, if (1) its Medicaid inpatient utilization rate is at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the State, or (2) the hospital's low-income utilization rate exceeds 25 percent. There is no restriction on the amount of DSH payment adjustments any DSH facility can receive; however, the total amount of DSH payment adjustments in any State may not exceed the higher of (1) 12 percent of the total Medicaid expenditures in the State during the fiscal year or (2) the total amount of DSH payment adjustments made by the State during FY 1992.

The Committee is concerned by reports that some States are making DSH payment adjustments to hospitals that do not provide inpatient services to Medicaid beneficiaries. The purpose of the Medicaid DSH payment adjustment is to assist those facilities with high volumes of Medicaid patients in meeting the costs of providing care to the uninsured patients that they serve, since these facilities are unlikely to have large numbers of privately insured patients through which to offset their operating losses on the uninsured. It is difficult for the Committee to understand how the payment of a Medicaid DSH payment adjustment to a facility that has no Medicaid inpatients can be justified on statutory or policy grounds. The Committee bill therefore prohibits States from designating a hospital as a Medicaid disproportionate share hospital unless at least 1 percent of the facility's inpatient days are attributable to Medicaid patients.

The Committee is also concerned by reports that some States have made DSH payment adjustments to State psychiatric or university hospitals in amounts that exceed the net costs, and in some instances the total costs, of operating the facilities. According to such reports, once received by the State hospital, these excess Medicaid DSH payments are transferred to the State general fund,

Alaska State Senate

Senate Finance Committee

Official Business

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SENATE FINANCE COMMITTEE
LETTER OF INTENT
TO ACCOMPANY
CSSB 366 (Finance)

It is the intent of the Legislature that the Department of Health and Social Services shall impose cost sharing charges on eligible persons under the state Medicaid plan to the maximum extent allowed under federal law and regulations; however, if the department has clear and compelling reason to believe that application of this policy to a specific Medicaid service would not promote the purpose of reducing state expenditures or would generate savings that are insignificant in relation to the total cost containment possible, then the department shall have minimal flexibility to waive application of this policy. Furthermore, it is the intent of the Legislature that the department present a report to the first session of the Nineteenth Legislature, describing the status of implementation of this cost sharing policy, indicating any specific Medicaid service for which this policy was waived, and presenting the rationale for such a waiver. The report shall include a listing of waivers sought from the federal government and an indication of those granted.

adopted 4/12 by the Senate

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Senate

Senate Bill 366: Sponsor Statement
26 March, 1994

Senate Bill 366 was introduced by the Senate Finance Committee at the request of the Division of Medical Assistance within the Department of Health and Social Services.

In large part, the statutory changes proposed in this bill relating to medical child support orders, estate recoveries by Medicaid, and Medicaid-qualifying trusts are required by the federal Omnibus Budget Reconciliation Act of 1993 (OBRA '93), and DHSS will face a penalty--loss of federal financial Medicaid participation--if legislation is not adopted by July 1, 1994. Additionally, SB 366 directs the Division of Medical Assistance to implement a copayment policy under Alaska's Medicaid plan.

MEDICAL CHILD SUPPORT

Certain mandates imposed by OBRA '93 relate to children who are subject to a judicial or administrative medical support order. Section 7 of the Bill sets forth the requirements of a medical support order; Sections 4 and 5, respectively, require the CSED and the courts to ensure that a medical support order meets these requirements.

The Division of Medical Assistance is currently required by federal law to maintain a cooperative arrangement with the Child Support Enforcement Division with respect to the enforcement and collection of medical care payment by or through a parent (see Section 4). Federal law also mandates that Alaska must require individuals, as a condition of Medicaid eligibility, to assign to the State any rights to medical care support by a court or administrative order (see Section 18).

With regard to medical child support, OBRA '93 requires Alaska to implement laws that will:

(1) prohibit an insurer from denying enrollment of a child under the health coverage of the child's parent on the ground that the child was born out of wedlock, cannot be claimed as a dependent on the parent's federal income tax return, or does not reside with the parent or in the insurer's service area (see Section 3);

(2) require an insurer, in any case in which a parent is required by a court or administrative order to provide health coverage for a child

and the parent is eligible for family coverage through the insurer, to permit the parent and/or child to enroll regardless of enrollment season restrictions (see Section 3);
(3) require any employer doing business in Alaska that provides health coverage to a child pursuant to court or administrative order to withhold the employee's share of the premium (see Section 6);
(4) prohibit an insurer from imposing special requirements on a State agency acting as a subrogee or agent of a Medicaid beneficiary (see Section 3);
(5) require an insurer to facilitate payment for services to a child in cases where the child has health coverage through the noncustodial parent (see Section 3); and
(6) require the Division of Medical Assistance to garnish wages of individuals who are subject to a medical support order, have received payment from a third party of the costs of services to the child, and have not reimbursed the provider or the other parent or guardian (see Section 18).

With regard to these new laws, Section 3 provides that the term "insurer" includes a writing carrier, an entity offering a service benefit plan, a health maintenance organization, and a group health plan under ERISA.

MEDICAID ESTATE RECOVERIES

Under current law, Alaska's Division of Medical Assistance may opt to seek recovery of expenditures made on behalf of an individual under its Medicaid program from the individual's estate if the individual was 65 years of age or older at the time of receiving Medicaid benefits, has no surviving spouse, and has no surviving minor or disabled child.

OBRA '93 mandates that Alaska establish an estate recovery program that: (a) identifies and tracks resources of individuals who receive nursing facility, home and community-based services, and other specified long-term care services; (b) promptly ascertains when the individual and the surviving spouse, if any, dies; and (c) provides for the collection of the amounts paid by Medicaid on behalf of the individual for long-term care services from the estate of the individual or the surviving spouse. OBRA '93 also requires that the Division of Medical Assistance establish procedures under which the estate recovery is waived if it would work an undue hardship. Section 20 of the Bill implements these requirements.

TRANSFER OF ASSETS TO MEDICAID-QUALIFYING TRUSTS

Federal law currently provides that individuals residing in nursing facilities who dispose of resources for less than fair market value within 30 months prior to applying for Medicaid are subject to a delay in eligibility for nursing facility care and home- and community-based services.

OBRA '93 specifies that such individuals will not be ineligible for Medicaid coverage if the Division of Medical Assistance procedurally determines that the denial of eligibility would work an undue hardship. With respect to the consideration of personal resources for the purpose of determining Medicaid eligibility, OBRA '93 exempts from consideration Medicaid-qualifying trusts which are composed only of pension, Social Security, and other income to the individual under which the State receives any amounts remaining upon the death of the individual. Section 17 incorporates these two provisions, while Sections 2 and 16, respectively, allow an individual to assign TERS and PERS benefits to a Medicaid-qualifying trust.

MEDICAID COPAYMENTS

Section 1902(a)(14) of the Social Security Act permits States to require certain recipients to share some of the costs of Medicaid by imposing upon them such payments as deductibles, copayments, and similar cost-sharing charges. The charges must be nominal, and certain groups and types of services are excluded from the payments (children under 18, pregnant women receiving pregnancy-related services, institutionalized individuals, emergency services, family-planning services, and HMO enrollees).

Section 19 of the Bill directs that Alaska's Medicaid plan shall impose deductible, coinsurance, and copayment requirements on eligible persons to the maximum extent allowed under federal law; Section 21 provides that such charges apply to services performed on or after July 1, 1994. This policy will reduce State expenditures on Medicaid by reducing inappropriate utilization and by shifting costs to recipients and providers.

Alaska State Senate

Senate Finance Committee

Official Business

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MEMORANDUM

TO: Senator Steve Frank, Co-Chair
Senator Drue Pearce, Co-Chair
Senate Finance Committee

FROM: David Skidmore, Staff Aide

RE: Sectional Analysis of CS SB 366 (Finance)

DATE: 7 April 1994

This document was prepared in response to your request for a sectional analysis of Committee Substitute for Senate Bill 366 (Finance). In large part, the statutory changes proposed in this bill are required by the federal Omnibus Budget Reconciliation Act of 1993, and the Department of Health and Human Services will face a penalty if the necessary legislation is not adopted. Beyond this, CS SB 366 directs the Division of Medical Assistance to implement a copayment policy with regard to Alaska's Medicaid plan.

Section 1 of the Bill establishes the purposes of the Act. The purposes of the Act are to (1) bring the state into compliance with federal law with respect to the recovery of Medicaid payments from the estates and trusts of individuals under certain circumstances and with respect to the establishment of medical support orders for children; (2) allow diversion of certain employee pension payments into Medicaid-qualifying trusts if the trusts provide that Medicaid payments made on behalf of the individual may be recovered from the trust after the individual's death. There is actually a third purpose of the Bill in Section 20: to provide that the State Medicaid plan shall impose copayment requirements on eligible persons to the maximum extent allowed under federal law.

Section 2 of the Bill amends AS 14.25.200(a). This amendment provides that a teacher's or member's right to receive benefits from the Teachers' Retirement System of Alaska may be assigned to a trust or similar legal device that meets the requirements for a Medicaid-qualifying trust under AS 47.07.020(f) and 42 U.S.C. 1396p(d)(4).

Section 3 of the Bill amends AS 21.36 (TRADE PRACTICES AND FRAUDS) by adding a new section 095 (COVERAGE OF CHILDREN). This new section imposes certain requirements on providers of insurance, relating to coverage of children of the insured who are not in the custody of the insured.

Section 4 of the Bill amends AS 25.27.020(a). This amendment establishes a duty on the Child Support Enforcement Agency to ensure that a medical support order meet the requirements of AS 25.27.063 (see Section 7) and to act on behalf of DH&SS in the enforcement of AS 47.07.025(b) (see Section 18).

Section 5 of the Bill amends AS 25.27.060(c). This amendment establishes a duty on the court to ensure that a medical support order meet the requirements of AS 25.27.063 (see Section 7).

Section 6 of the Bill amends AS 25.27.062(i). This amendment extends the duty of an employer to withhold current child support obligation from an obligor's wages, adding to this amount the obligor's share of any premium for health coverage required to be withheld under AS 25.27.063(c)(4) (see Section 7).

Section 7 of the Bill amends AS 25.27 (CHILD SUPPORT ENFORCEMENT AGENCY) by adding a new section 063 (MEDICAL SUPPORT ORDER). This section sets forth the requirements of a medical support order which requires that the obligor provide health care coverage for the child to whom the duty of support is owed.

Section 8 of the Bill amends AS 25.27.065(b). This amendment is necessary for the sake of conformity. Under current statute, an agreement between an obligor and a person who is entitled to receive support on behalf of an obligee to waive past or future child support is not effective when the obligee is receiving public assistance and the right to receive child support has been assigned to a governmental agency (unless such an agreement has been adopted as an administrative order of the agency). This amendment extends this provision to include an obligee who is receiving medical assistance.

Section 9 of the Bill amends AS 25.27.120(a). This amendment is necessary for the sake of conformity. Under current statute, an obligor is liable to the state in the amount of public assistance granted to a child to whom the obligor owes a duty of support with the exception that if a support order has been entered, the liability of the obligor may not exceed the amount of support provided for in the support order. This amendment extends this provision to include an obligee who is receiving medical assistance.

Section 10 of the Bill amends AS 25.27.120(d). This amendment is necessary for the sake of conformity. Under current statute, if the Child Support Enforcement Agency fails to notify the obligor of the liability accruing due to

the obligee's receipt of public assistance, interest does not accrue on the liability to the state unless a support order has been entered. This amendment extends this provision to include an obligee who is receiving medical assistance.

Section 11 of the Bill amends AS 25.27.130(b). This amendment is necessary for the sake of conformity. Under current statute, if the Child Support Enforcement Agency is establishing or enforcing an order of support, the agency is not limited to the amount of public assistance being granted to the minor child. This amendment extends this provision to include an obligee who is receiving medical assistance.

Section 12 of the Bill amends AS 25.27.130(c). This amendment is nece sary for the sake of conformity. Under current statute, if the Child Support Enforcement Agency recovers any amount for which the obligor is liable that exceeds the total public assistance granted, the excess amount shall be granted to the obligee. This amendment extends this provision to include an obligee who is receiving medical assistance.

Section 13 of the Bill amends AS 25.27.130(d). This amendment is necessary for the sake of conformity. Under current statute, if the obligee is not receiving public assistance at the time the Child Support Enforcement Agency recovers money from the obligor for which the obligor is liable, the amount recovered shall be distributed to the obligee for support payments that have become due and unpaid since the termination of public assistance. This amendment extends this provision to include an obligee who is receiving medical assistance.

Section 14 of the Bill amends AS 25.27.130(e). This amendment is necessary for the sake of conformity. Under current statute, if the Child Support Enforcement Agency has recovered an amount for which the obligor is liable and the obligee is no longer receiving public assistance, the agency may not retain an amount in excess of the total unreimbursed public assistance. This amendment extends this provision to include an obligee who is receiving medical assistance.

Section 15 of the Bill amends AS 25.27.130(f). This amendment is necessary for the sake of conformity. Under current statute, if required by federal law, the state shall have first claim on any amount recovered through offset of the obligor's federal tax refund for unreimbursed public assistance received by the obligee. This amendment extends this provision to include an obligee who is receiving medical assistance.

Section 16 of the Bill amends AS 39.35.500. This amendment provides that a public employee's right to receive benefits from the Public Employee's Retirement System of Alaska may be assigned to a trust or similar legal device that meets the requirements for a Medicaid-qualifying trust under AS 47.07.020(f) and 42 U.S.C. 1396p(d)(4).

Section 17 of the Bill amends AS 47.07.020 (MEDICAID ELIGIBLE PERSONS) by adding new subsections (f) and (g). Subsection (f) provides that a person may not be denied eligibility for Medicaid on the basis of a diversion of income into a Medicaid-qualifying trust. Subsection (g) provides that a person's eligibility for Medicaid may not be denied or delayed on the basis of a transfer of assets for less than fair market value if the person establishes to the satisfaction of the department that the denial or delay would work an undue hardship on the person.

Section 18 of the Bill amends AS 47.07 (MEDICAL ASSISTANCE FOR NEEDY PERSONS) by adding a new section 025 (ASSIGNMENT OF MEDICAL SUPPORT RIGHTS). This new section provides that an applicant for or recipient of Medicaid is considered to have assigned to the state all rights to medical support that the applicant or recipient may have from all sources. In addition, this new section establishes the authority of DH&SS--through the CSEA or on its own behalf--to garnish the wages, salary, or other employment income of persons to whom this section applies. OBRA '93 requires that the Title XIX agency have the authority to pursue collection of medical support debt.

Section 19 of the Bill amends AS 47.07.030 (MEDICAL SERVICES TO BE PROVIDED) by adding new subsection (d). This subsection provides authorization for the department to utilize a case management system under which prior authorization for Medicaid services may be required of certain individuals.

Section 20 of the Bill amends AS 47.07 by adding a new section 042 (RECIPIENT COST-SHARING). Subsection (a) provides: that the State Medicaid plan shall generally impose cost-sharing requirements on eligible persons to the maximum extent allowed under federal law; that health care providers shall collect the allowable charge; that the department shall reduce payments to each provider by the amount of the allowable charge; that a provider may not deny services because a recipient is unable to share costs; and that an inability to share costs does not relieve the recipient of liability for the costs. Subsection (b) provides that the copayment for inpatient hospital services shall $50 a day, up to a maximum of $200 per discharge, unless such a copayment exceeds the maximum allowed under federal law. Subsection (c) directs the department to seek waivers from the federal government, allowing the State to disregard the requirement that cost-sharing amounts be nominal.

Section 21 of the Bill amends AS 47.07 by adding a new section 055 (RECOVERY OF MEDICAL ASSISTANCE FROM ESTATES). This new section provides that the estate of an individual who received Medicaid assistance is subject to a claim for recovery of the medical assistance after the individual's death, given the fulfillment of certain circumstances.

Section 22 of the Bill provides that the copayment charges imposed under Section 20 apply only to services performed on or after July 1, 1994.

Section 23 of the Bill provides that the effective date is July 1, 1994.