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Striking a Balance: Financial Contributions and Access to Care in the New Hampshire Health Protection Program

The State of New Hampshire recently opened coverage for the New Hampshire Health Protection Program (NHHPP), the state's public health insurance program for low-income adults.[i] This flagship program will provide health insurance through New Hampshire Medicaid until 2016. The state is concurrently building the framework for the next component of the NHHPP, the Premium Assistance Program, in which coverage will be provided through commercial insurance carriers in the federal Marketplace starting in 2016. While New Hampshire must structure this private market coverage within the parameters of the federal Medicaid program, the state has the opportunity to design a unique program that addresses Granite State goals.

Whether to require financial contributions, such as premium payments or cost sharing, from enrollees is a question that requires careful analysis. A substantial body of literature suggests that low-income people are very sensitive to even the most modest costs in relation to health insurance. Imposing such financial obligations on low-income enrollees may be counterproductive to the state's overarching goals of achieving sustained health insurance coverage for New Hampshire residents and encouraging effective use of health care resources by those who are newly insured.

This paper examines the premiums and cost sharing currently allowed within Medicaid, trends in imposing out-of-pocket costs on low-income adults covered by Medicaid, and potential risks of imposing out-of-pocket costs on financially vulnerable adults.

States Can Use Premiums and Cost Sharing in Limited Ways within Medicaid Programs

Under federal law, states can require Medicaid enrollees to pay premiums for Medicaid coverage and can impose other forms of cost sharing, but only to a limited degree. In general, cost sharing and premiums are supposed to be "nominal" and may not exceed an aggregate cap, equal to 5 percent of the enrollee's household income.[ii] Within that cap, however, states may mandate financial contributions that vary according to enrollees' income levels, the services they receive, or the eligibility category into which they fall. This system gives states some flexibility to impose cost sharing and premiums without having to seek additional authority from the federal government.

Premiums

Premiums are financial contributions paid monthly by the enrollee for coverage of insurance benefits for a distinct period of time. These fees are usually introduced at the point of enrollment into insurance. In general, states cannot require Medicaid enrollees to pay premiums for their coverage if their household incomes are below 150 percent of the federal poverty level (FPL), or $17,505 for an individual in 2014. Furthermore, states cannot require some groups of enrollees, such as the terminally ill or those residing in an institution, to pay premiums even if their incomes exceed this threshold. In any event, total enrollee out-of-pocket costs cannot exceed the cap of 5 percent of household income. Of note, only adults with incomes under 138 percent of FPL are eligible to participate in the NHHPP; as a result, New Hampshire cannot impose premiums on enrollees without seeking special permission, known as a "waiver", from the Centers for Medicare and Medicaid Services (CMS), the federal agency that oversees the Medicaid program.

Medicaid Premiums and Cost Sharing Allowed under Current Law

Income Level	Up to 100% FPL	101-150% FPL	Over 150% FPL
Premiums	Not allowed	Not allowed	Allowed
Maximum Copayments			
Outpatient services	$4	10% of service cost	20% of service cost
Inpatient services	$75 per admission	10% of total agency cost of stay per admission	20% of total cost of stay per admission
Preferred drugs	$4	$4	4
Non-preferred drugs	$8	$8	20% of agency cost of drug
Nonemergency use of emergency departments	$8	$8	No limit

Aggregate cap on premiums and cost sharing

5 percent of household income calculated quarterly or monthly

Eligibility groups exempt from premiums and cost sharing

Most children, people in institutions who only have a personal needs allowance, women eligible through breast and cervical cancer treatment programs, individuals receiving hospice care, Indians who have ever been served through the Indian health service program

Services exempt from cost sharing

Services to pregnant women unless identified as not pregnancy related, emergency services, family planning services, provider preventable services, and preventive services

Cost Sharing

Cost sharing refers to additional payments required of the enrollee to meet costs not covered by the insurance and can include copayments, coinsurance, or deductibles. Copayment is the type of cost sharing to which this paper most commonly refers and is a flat amount paid at the point of medical service, such as at an office visit. The degree to which states can impose cost-sharing requirements on Medicaid enrollees

varies significantly with an enrollee's income level. For instance, cost-sharing maximums for outpatient services can range from as little as $4 per person, per service, to as much as 20 percent of the cost to the Medicaid agency for the service. Inpatient cost-sharing ranges from $75 per admission up to 20 percent of the total cost to the state of the stay. Cost sharing is subject to the aggregate cap of 5 percent of household income. The figure above summarizes the current maximum allowable premiums and cost sharing within Medicaid, in the absence of a waiver.

Trends in Financial Contributions and Medicaid Coverage

The most common form of financial responsibility within Medicaid programs is cost sharing such as copayments, coinsurance, or deductibles. Forty-five states required cost sharing of at least one portion of their Medicaid enrollees in 2013.[iii] Five of those states, including New Hampshire, impose copayments only for prescriptions drugs. Increased or new copayment requirements have been most common for pharmacy, non-emergency use of the Emergency Department, and physician and clinic visits.[iv]

Requiring premium payments is slightly less common in Medicaid programs, with 39 states employing some form of premiums. The most common Medicaid programs that use premiums are those that have expanded Medicaid coverage by allowing individuals with disabilities to continue to receive Medicaid coverage by paying premiums, when their earnings increase to a level at which they would otherwise be ineligible for Medicaid. New Hampshire's Medicaid for Employed Adults with Disabilities program (known as NH MEAD) is an example of this type of program. NH MEAD currently charges nominal premiums to enrollees with incomes at or above 150 percent FPL.

As of January 1, 2013, only five states charged premiums for Medicaid coverage for children, but only for those families with incomes at 150 percent FPL or above.[v] During that same time, only one state, Wisconsin, charged premiums to parents in Medicaid.[vi] That being said, premiums and enrollment fees are more commonly charged in Medicaid expanded adult coverage programs; that is, programs in which the state has sought special permission to exceed the traditional income eligibility limitations for adults and thereby expand insurance coverage to a broader group of low-income adults. As of FY 2013, premiums and enrollment fees were charged to adults eligible under expanded coverage programs in 19 of 34 Medicaid waivers; of those 19 programs, 14 charged premiums to adults with incomes below the federal threshold of 150 percent FPL.

Other States with Premium Assistance Have Sought Modest Increases in Cost-Sharing

Like New Hampshire, two other states have incorporated premium assistance – the use of federal Medicaid funds to purchase health insurance through the federal Marketplace – into their efforts to extend health insurance coverage to low-income adults. These coverage expansions' unique private-market designs have required waivers from CMS. Similar to other adult expanded coverage programs, one of these states has obtained permission to impose out-of-pocket costs on enrollees beyond the

particular limits described in federal statute and regulation. Michigan, while not using the federal Marketplace to provide expanded Medicaid to low-income adults, has modified an existing waiver to be able to impose financial obligations beyond those currently allowed. Each of these states' recently approved waiver provisions related to cost sharing and premiums is examined below.

Arkansas

Arkansas has created the Health Care Independence Program, more commonly known as the Private Option, which is the model of coverage most similar to the NHHPP. The Private Option provides low-income adults with health insurance policies purchased through the federal Marketplace using Medicaid funds. Within Arkansas' Private Option coverage, enrollees are not responsible for any premium payments. However, in 2014, enrollees with incomes between 100 and 138 percent FPL will have cost-sharing responsibilities in the form of copayments. Moreover, for 2015 and 2016, Arkansas will impose cost-sharing requirements on enrollees with incomes between 50 and 100 percent FPL as well. In all instances, cost sharing will be consistent with Medicaid's overall cap of 5 percent household income.[vii] Arkansas' cost-sharing obligations are within the existing federal parameters described earlier and therefore did not require additional federal authority.

Iowa

Iowa's Premium Assistance program, known as Marketplace Choice, covers only those adults with incomes between 100 and 138 percent FPL. Similar to Arkansas' approach, Iowa's Marketplace Choice program offers health insurance policies available through the federal Marketplace and paid for with Medicaid funds. All Marketplace Choice enrollees will pay monthly premiums that may not exceed $10 per month and 2 percent of the enrollees' annual household income. All premiums are waived for the first year of enrollment. In the following years, enrollees will be able to avoid premium payment requirements if they complete health improvement or wellness activities, such as an annual wellness exam or a health risk assessment. The state must grant premium waivers to those enrollees who attest to financial hardship.

The only cost sharing in Iowa's Marketplace Choice program is a required copayment for non-emergency use of the Emergency Department. Enrollees' total out-of-pocket costs (including both premiums and cost-sharing responsibilities) are limited to 5 percent of their annual household income. Due to Iowa imposing premiums on those

with incomes between 100 and 138 percent FPL, Iowa did have to seek a specific waiver provision in order to charge premiums to those with incomes below 150 percent FPL as a component of its Marketplace Choice waiver.

Michigan

In December 2013, CMS approved Michigan's amendment to an existing waiver to create an alternative Medicaid expansion option called Healthy Michigan. Healthy Michigan enrolls adults with incomes up to 138 percent FPL in Medicaid managed care plans. The program requires enrollees with incomes between 100 and 138 percent FPL to pay a monthly premium of 2 percent of their income into a savings account, similar to a health savings account (HSA), which will be used to pay for out-of-pocket costs. All enrollees are required to make copayments after the first six months of coverage; however, the total copayments cannot exceed 3 percent of the enrollees' annual income. Enrollees who complete an annual health risk assessment and are deemed to have healthy behaviors will have their out-of-pocket costs – including both the required payments to their savings accounts and copayments – reduced. As required under Medicaid law, total out-of-pocket costs (including both payments to the savings accounts and cost-sharing responsibilities) cannot exceed 5 percent of the enrollees' income. The copayments that enrollees will be charged will be consistent with Marketplace rules and will be paid directly to the insurance carriers.[viii] Enrollees will not be charged copays for preventive services, emergency services, emergency hospital admissions, or high-value prescriptions. Moreover, no individual may lose eligibility or be denied access to services for failure to pay premiums or copayments.

Risks of Financial Obligations Demand Thoughtful Application

While current federal law gives states the flexibility to charge premiums and cost-sharing, and some states have sought additional flexibility through waivers to do so, New Hampshire should carefully consider the implications of imposing financial requirements in the NHHPP. A significant body of research related to the effect of premiums and copayments on low-income people suggests that imposing even modest premium or copayment requirements may increase barriers to accessing care and prevent people from enrolling or remaining enrolled. In fact, an analysis published in August 2014 showed that premium increases were associated with reductions in enrollment, with larger reductions in enrollment in public coverage among the lowest-income children.[ix] In addition, a 2013 review of more than 30 studies on this subject found other negative associations with increased cost-sharing and premium requirements, including increasing unmet needs, worsening health outcomes, and generating additional administrative cost.[x]

In one respect, the research makes it clear that cost sharing reduces utilization of health care, but not in an efficient or effective way: cost sharing reduces utilization of both essential health care and non-essential healthcare, in roughly equal proportions.[xi] In some studies, higher cost sharing has correlated with worse outcomes in several areas of health care for the poorest and sickest patients.[xii] Taken together, this suggests New Hampshire should use these financial tools sparingly and only after carefully considering the chronic conditions and socioeconomic status of those who may be affected. Moreover, decades of research suggests that instituting higher copayments does not effectively reduce health care expenditures as such an approach has been associated with decreased utilization of outpatient services and concurrent increased utilization of hospital care or hospital days. In other words, people rationed needed health care in reaction to cost sharing and that rationing ultimately resulted in more expensive health care interventions. [xiii]

In the end, the dominant lure into and out of the health insurance market is affordability. For those with low income, a monthly premium payment or threshold enrollment fee can prevent them from enrolling or being able to maintain coverage. Cost sharing can also act as a barrier to accessing care, including care that is effective and essential. New Hampshire gains more economically and fiscally by insuring as many of its residents as possible in the NHHPP. Policymakers should carefully consider whether and at what level to impose financial responsibilities on enrollees in seeking to maximize sustained enrollment in the NHHPP and the economic and fiscal benefits to the state that are anticipated to come with it.

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[i] Adults with income up to 138 percent of the federal poverty level are eligible for this program. For an individual, this is income below $16,105 in 2014.

[ii] 42 U.S.C. §1396(o)(a)(3)(b)(3); 42 C.F.R. 447.53

[iii] Heberlein, Martha et al. *Getting into Gear for 2014: Findings from a 50-State Survey of Eligibility, Enrollment Renewal, and Cost-Sharing Policies in Medicaid and CHIP, 2012-2013*. Kaiser Commission on Medicaid and the Uninsured, January 2013, pp. 20.

[iv] Smith, Vernon et al. *Medicaid Today; Preparing for Tomorrow: A Look at State Medicaid Program Spending, Enrollment and Policy Trends*, Kaiser Commission on Medicaid and the Uninsured, October 2012.

[v] Heberlein, Martha et al. *Getting into Gear for 2014: Findings from a 50-State Survey of Eligibility, Enrollment Renewal, and Cost-Sharing Policies in Medicaid and CHIP, 2012-2013*. Kaiser Commission on Medicaid and the Uninsured, January 2013, Table 16, pp. 58.

[vi] Because Medicaid coverage for adults is generally limited to those with extremely low income levels, and given Medicaid's prohibition against charging premiums to those with incomes below 150 percent FPL, it makes sense that few Medicaid programs would charge premiums to the adults typically eligible for Medicaid.

[vii] These caps will be calculated annually and consistent with Marketplace rules regarding out-of-pocket caps. For example, within the federal Marketplace, customers are protected by a cap that limits out-of-pocket costs to $6,340 for an individual and $12,700 for a family in 2014. This is a cap that cannot be exceeded, not a deductible amount that must be first paid. Additionally, within the Marketplace, customers with income up to 138 percent FPL will not pay more than 2 percent of their income toward premium payments. These same enrollees are also eligible for cost-sharing reduction plans (silver level plans), which may significantly reduce the deductible and co-payment amounts for which they are responsible.

[viii] See note vii.

[ix] Abdus S, Hudson J, Hill SC, Selden TM. *Children's Health Insurance Program Premiums Adversely Affect Enrollment, especially Among Lower- Income Children*. HEALTH AFFAIRS 33, No 8 (2014) 1353-1360.
[x] *Premiums and Cost-Sharing in Medicaid: A Review of Research Findings*. Kaiser Commission on Medicaid and the Uninsured, January 2013.
[xi] *Id.* pp. 8-10, Table 2.
[xii] For example, a mounting string of research shows that uniform increases in cost sharing for prescription drugs without consideration of the value of the medication or the clinical or socioeconomic status of the affected patients can have deleterious effects on health. Soumerai SB, McLaughlin TJ, Ross-Degnan D, Casteris CS, Bollini P. *Effects of a limit on Medicaid drug-reimbursement on the use of psychotropic agents and acute mental health services by patients with schizophrenia*. New England Journal of Medicine, 1994; 331:650-5. Goldman DP, Joyce GF, Escarce JJ, et al. *Pharmacy benefits and the use of drugs by the chronically ill.* JAMA 2004; 291:2344-50. Hsu J, Price M, Huang J, t al. *Unintended consequences on caps of Medicare drug benefits*. New England Journal of Medicine, 2006; 354: 2349-59. Tanblyn R, Laprise J, Hanley JA et al. *Adverse events associated with prescription drug cost sharing among poor and elderly persons*. Journal of the American Medical Association, 2001; 285: 421-9.
[xiii] Helms, LJ, Newhouse JP, Phelps CE. *Copayments and demand for medical care: the California Medicaid experience*. Santa Monica, CA: Rand, 1978. Chandra A, Gruber J, McKnight R. *Patient cost-sharing, hospitalization offsets, and the design of optimal health insurance for the elderly*. NBER Working Paper 12972. Cambridge, MA: National Bureau of Economic Research; 2007. Trivedi, AN, Moloo, H, Mor V. *Increased ambulatory care Copayments and hospitalizations among the elderly*. New England Journal of Medicine, 2010; 362-320-8. . Wallace et al. 2008. *How effective are copayments in reducing expenditures for low-income adult Medicaid beneficiaries? Experience from the Oregon health Ppan*. Health Research and Educational Trust.