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Medicaid
Medicaid Copayments

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I. Introduction

A few states have proposed legislation in 2019 to impose copayment or cost sharing on Medicaid services. As in the past, nonemergent use of emergency room services and prescription drugs are the primary targets.

Kaiser Family Foundation Survey Reports State Cost-Sharing Reductions

According to a recent Kaiser Family Foundation survey, [FN1] eleven states reported policies to eliminate or reduce a cost-sharing requirement for FY 2019 or FY 2020. However, five states reported new or increased cost-sharing requirements.

According to the report, states were more likely to report policies to eliminate or reduce cost-sharing than report new or increased cost-sharing requirements. Eleven states reported policies to eliminate or reduce a cost-sharing requirement and five states reported new or increased cost-sharing in FY 2019 or FY 2020. Key changes include:

• Illinois, Montana, North Dakota, and New Mexico reported eliminating or plans to eliminate copayments on all services for some or all populations. For example, an approved Section 1115 waiver in New Mexico would have imposed a number of new copayments and other cost-sharing requirements, but the new administration did not implement the waiver's changes and allowed existing copayments, including for people with disabilities, to sunset.

• The District of Columbia and Oklahoma are eliminating cost-sharing on medication-assisted treatment (MAT) and Michigan eliminated cost-sharing for all drugs used in the treatment of mental health conditions and SUD.

• Two states (Virginia and Wisconsin) reported new or increased copayments for non-emergency use of a hospital emergency department (ED) for certain populations.

• Kentucky reported changes that will prohibit MCOs from waiving copayments that apply in the Medicaid FFS program.

II. 2019 State Activity

Illinois

• 2019 IL S.B. 646 (NS), introduced January 31, makes a technical change in a section regarding Medicaid copayments.

• 2019 IL H.B. 2288 (NS), filed February 8, provides that the Department of Healthcare and Family Services shall not require any person committed to the custody of the Department of Corrections who is eligible for medical assistance to pay a fee as a co-payment for services.

New Kentucky Medicaid Copay Policy Begins

A new Medicaid copay policy will take effect on January 1, 2019. Although many people are already paying copays, under the new policy, everyone who is not otherwise exempt will start paying copays for some services.

Those who are exempt include: foster children, children enrolled in Medicaid, pregnant women, beneficiaries who have reached their cost sharing limit for the quarter and individual receiving hospice care.

Some services are exempt from copays including, but not limited to: emergency services, some family planning services and preventive services.

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Medicaid recipients will not be charged more than 5 percent of their household income during the same three-month quarter.

Providers cannot refuse services to individuals whose income is 100 percent or below the FPL. However, if a beneficiary's income is over 100 percent, providers have the option to refuse services.

Kentucky

The Cabinet for Health and Family Services, Department for Medicaid Services has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed, or opportunity presented, by federal law to qualify for federal Medicaid funds. KRS 205.6312(5) requires the cabinet to promulgate administrative regulations that implement copayments for Medicaid recipients. This administrative regulation establishes the provisions relating to Medicaid Program copayments. See 2019 KY REG TEXT 522876 (NS).

Minnesota

2019 MN S.F. 2874 (NS), introduced May 9, relating to medical assistance (MA) copayments and deductibles modification.

Mississippi

2019 MS H.B. 542 (NS), introduced January 15, to require insurers, Medicaid and the State Health Plan to cover contraceptives without cost sharing.

New Mexico Governor Announces Plan to Reverse Medicaid Copay Policies

Gov. Michelle Lujan Grisham on February 13 directed the Human Services Department to seek federal approval to reverse several policy decisions previously made on the Medicaid program that would have impacted nearly 700,000 New Mexicans.

A letter to the Federal Centers for Medicare and Medicaid Services (CMS) has been sent by HSD requesting approval to reverse the following policy decisions submitted as part of New Mexico's Centennial Care 2.0 demonstration waiver last year, which have been implemented or are scheduled to be implemented this year:

• Eight-dollar co-payments for Centennial Care members for non-emergency use of the hospital emergency department and non-preferred prescription drugs, impacting approximately 645,000 Medicaid members – scheduled for implementation March 1, 2019.

• Ten-dollar premiums for members of the Medicaid Adult Expansion Group, impacting approximately 50,000 Medicaid members – scheduled for implementation July 1, 2019.

• Limitations on retroactive eligibility – first phase implemented January 1, 2019.

“These policy changes would limit access to emergency services, prescription services, and disrupt continuity of coverage for hundreds of thousands New Mexicans who rely on Medicaid for their health care needs,” said Gov. Lujan Grisham. “I have no intention of implementing policies that put a financial strain on low-income New Mexicans as well as administrative hardship on our health care provider network.”

“New Mexico sees value in reducing unnecessary use of the health care system and we will work with our hospital partners to examine alternative options for reducing unnecessary emergency department use. However, we do not believe that co-payments are an effective strategy in driving changes in provider or member behavior,” said David R. Scrase, HSD Secretary. “In addition, New Mexico's rate of preferred/generic drug utilization already exceeds 85 percent, indicating that the Centennial Care program already is very effective in managing the Medicaid pharmacy benefit.”

Gov. Lujan Grisham expressed serious concerns about the $10 monthly premiums for members in the Medicaid Adult Expansion category who have income above 100 percent of the Federal Poverty Level. “For an individual who is making just over $1,000 month, adding a $10 premium for health coverage will likely result in no coverage, eventually creating pent-up demand for services over the long term,” said Governor Lujan Grisham.

Instead of implementing premiums, HSD is interested in pursuing other policy strategies that will help keep eligible individuals enrolled to avoid lapses in coverage and needed medical care.

Retroactive eligibility for a three-month period has been a mainstay in the Medicaid program, which helps income qualified people get coverage after they have applied, usually due to a medical emergency. Limitations on retroactive eligibility have already begun to be phased in, with a maximum one-month retroactive eligibility period for affected individuals. Phase two would completely eliminate retroactive eligibility by January 2020.

“This is a policy that puts financial strain on low-income New Mexicans and on an already fragile health care workforce through additional costs, uncompensated care, and unmet medical needs,” said Nicole Comeaux, HSD Medical Assistance Division Director. “We want to find the best and fastest way to reverse this decision and have no intention of eliminating retroactive coverage for Medicaid clients.”

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“HSD will work with the federal CMS to quickly reach a solution to best reverse these policy changes, and review others that will be in the best interest of New Mexicans,” Secretary Scrase said.

Vermont

2019 VT H.B. 114 (NS), introduced January 29, to require individuals enrolled in the Medicaid program with incomes between 100 and 138 percent of the federal poverty level to pay the maximum amount of co-payments for their health care services as are allowed under federal law. It would also increase the amount of financial assistance available to income-eligible individuals enrolled in health insurance plans offered through the Vermont Health Benefit Exchange.

Virginia

• 2018 VA H.B. 2530 (NS), introduced January 9, requires the Department of Medical Assistance Services to require individuals receiving medical assistance pursuant to the state plan for medical assistance whose household income is greater than 100 percent of the federal poverty level for a household the size of the individual's household to participate in cost-sharing to the greatest extent allowed under federal law and to require individuals receiving medical assistance pursuant to the state plan for medical assistance whose household income is equal to or less than 100 percent of the federal poverty level for a household the size of the individual's household to participate in cost-sharing for nonemergency services delivered in a hospital emergency department to the greatest extent allowed by federal law. The bill also requires hospitals with emergency departments to develop a protocol for patients who receive medical assistance pursuant to the state plan for medical assistance to whom a service other than an emergency service will be provided to (i) inform the patient as to the amount of the cost-sharing obligation for such nonemergency services for which the patient may be responsible; (ii) provide the patient with information, including name and location, about available nonemergency health care providers; and (iii) provide a referral to such nonemergency health care provider to facilitate treatment of the patient by the nonemergency health care provider.

• 2018 VA S.B. 1167 (NS), enrolled February 18, prohibits health care providers licensed by the Board of Medicine from requesting or requiring a patient who is a recipient of medical assistance services pursuant to the state plan for medical assistance to whom health care services involving (i) the prescription of an opioid for the management of pain or (ii) the prescription of buprenorphine-containing products, methadone, or other opioid replacements approved for the treatment of opioid addiction by the U.S. Food and Drug Administration for medication-assisted treatment of opioid addiction.

• 2018 VA H.B. 2558 (NS), adopted March 5, prohibits health care providers licensed by the Board of Medicine from requesting or requiring a patient who is a recipient of medical assistance services pursuant to the state plan for medical assistance to pay out-of-pocket costs associated with the provision of service involving (i) the prescription of an opioid for the management of pain or (ii) the prescription of buprenorphine-containing products, methadone, or other opioid replacements approved for the treatment of opioid addiction by the U.S. Food and Drug Administration.

Wyoming

2019 WY H.B. 194 (NS), adopted March 8, providing for air ambulance transport coverage under Medicaid as specified; requiring a copay; creating an account; imposing a premium assessment on certain insurers for the purposes of this act; requiring reimbursements from state agencies for air ambulance transport services; authorizing the submission of federal Medicaid state plan amendments and other necessary waivers and agreements; classifying air ambulance subscription plans as disability insurance; and other related provisions.

III. Other Copayment Activity

Drugmakers Jazz, Alexion, Lundbeck to Pay $123 million to Resolve Charity Kickback Probe

(Reuters) - Three drugmakers will pay $122.6 million to resolve claims they used charities that help cover Medicare patients' out-of-pocket drug costs as a way to pay kickbacks aimed at encouraging use of their medications, including some expensive ones. [FN2]

The U.S. Justice Department on Thursday said Jazz Pharmaceuticals Plc, Lundbeck and Alexion Pharmaceuticals Inc were the latest companies to settle claims stemming from an industry-wide probe of drugmakers' financial support of patient assistance charities.

The government in an earlier settlement said drugmakers used such charities as a means to improperly pay the copay obligations of Medicare patients using their drugs, in violation of the Anti-Kickback Statute.

The investigation came amid growing attention to soaring U.S. drug prices. Copays are partly meant to serve as a check on healthcare expenses by exposing patients to some of a drug's cost.

Jazz will pay $57 million, Lundbeck will pay $52.6 million and Alexion will pay $13 million.

None of the companies admitted wrongdoing, a fact Lundbeck and Jazz noted in separate statements. Alexion said the settlement recognized “significant” positive changes at the company.

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Drug companies are prohibited from subsidizing copayments for patients enrolled in the government's Medicare healthcare program for those aged 65 and older. Companies may donate to non-profits providing copay assistance as long as they are independent.

But according to the settlement agreements, the drugmakers used certain charities as “conduits” to pay patients' copays.

The government alleged Alexion in 2010 asked a foundation to set up a fund to support patients using Soliris, a treatment for two rare blood disorders that costs over $500,000 annually.

While such funds are typically set up to help patients afford treatments for a given disease or condition, the government said Alexion discussed wanting the fund to support only patients using Soliris.

The department said Jazz asked a foundation to set up funds to cover copays for patients using its narcolepsy treatment Xyrem and its Prialt pain medication.

The foundation's funds almost exclusively assisted patients using those two drugs through 2014 and referred pain patients seeking help paying for drugs other than Prialt elsewhere, the government said.

The department said Lundbeck, beginning in 2011, donated to a charity's fund that ostensibly covered only copays for patients with Huntington's Disease.

The fund actually helped patients who used its Xenazine drug for any condition, including unapproved ones, the government said. Medicare and a health care program for veterans subsequently paid claims for Xenazine.

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[FN1]

. The full survey report is available at: http://files.kff.org/attachment/Report-A-View-from-the-States-Key-Medicaid-Policy-Changes.

[FN2]

. Nate Raymond, Drugmakers Jazz, Alexion, Lundbeck to pay $123 million to resolve U.S. charity kickback probe, Reuters (April 4, 2019).

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