F I S C A L I M P A C T R E P O R T

SPONSOR HCPAC **ORIGINAL DATE** 03/03/09 **LAST UPDATED** 03/06/09 **HB** 438/HCPACS/ aHHGAC

SHORT TITLE Medicaid Cost Sharing for Emergency Room Services **SB**

ANALYST Earnest

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY09	FY10	FY11	3 Year Total Cost	Recurring or Non-Rec	Fund Affected
Total		$175.0*	$175.0*	$350.0*	Recurring	General Fund and Federal Funds

(Parenthesis ( ) Indicate Expenditure Decreases)

*See Fiscal Implications

SOURCES OF INFORMATION
LFC Files

Responses Received From
Human Services Department (HSD)
Health Policy Commission (HPC)

SUMMARY

Synopsis of HHGAC amendment

The House Health and Government Affairs Committee amendment makes technical adjustments to the bill to specify cost sharing amounts for individuals with incomes "greater than" 150 percent FPL.

Synopsis of Original Bill

The House Consumer and Public Affairs Committee Substitute for House Bill 438 enacts a new section of the Public Assistance Act that requires Medicaid recipients to pay a co-payment for the unnecessary use of hospital emergency room (ER) services.

There bill specifies copayments for individuals at certain income levels based on the federal poverty level (FPL), as follows:

- Child with household income between 100% and 150% of FPL: $6.00
- Adult with household income between 100% and 150% of FPL: $25.00

- Child with household income above 150% of FPL: $20.00
- Adult with household income above 150% of FPL: $50.00

For individuals with incomes under 100% of FPL the cost sharing requirements would not apply.

The bill requires HSD to apply for a federal grant to establish a program to provide for non-emergency services to serve as an alternative to emergency rooms as providers of heath care.

FISCAL IMPLICATIONS

HSD reports that requiring cost sharing for Medicaid recipients for use of emergency room services in non-emergency situations could reduce expenditures in the Medicaid program. However, these reductions could simply be shifted to Medicaid providers or offset by costs associated with implementing the cost sharing. HSD finds that due to these unknown factors and unsettled policies, it is not currently possible to determine the costs and potential cost savings of this bill.

In addition, HSD estimates the need for 2 FTE and $175 thousand per year to apply for and oversee the federal grant, as required by the bill.

The ISD2 system (the system that determines Medicaid eligibility) will require some changes that will cost about $60,000 to implement. For the MMIS system, the changes will be minimal and will be accommodated within the current maintenance contract.

SIGNIFICANT ISSUES

HSD reports that the federal Deficit Reduction Act (DRA) of 2005 provided states new options in designing benefit and eligibility packages for public assistance programs. As this relates to HB438/HCPACS, Section 1916A of the DRA allows states to use premiums and cost sharing such as co-payments or deductions, subject to certain limitations. However, even with this added flexibility, premiums and most other forms of cost sharing may not be used with certain populations, certain services, or for families with income at or below 100% of federal poverty guidelines. The amount that may be charged to a Medicaid recipient varies by the cost of the service to the state, as well as by the income level of the family.

According to HSD, some of the copayments specified in the bill differ from the federally allowable maximum:

> CS/HB438 would dictate the specific co-payment amounts for children and adults at or above 100% of the federal poverty level. The CMS regulations, however, do not have different co-payment maximums for children and adults. The maximum payment for households (children and adults) between 100% and 150% of the federal poverty level would be twice the nominal amount listed in regulation. Assuming emergency room care fees are at or above $50.01, that amount would be $6.80 (2 X $3.40). CS/HB438 would have children paying slightly less than, and adults in this income bracket paying more than, the federally allowable maximum. For households (children and adults) above 150% of the poverty level, the maximum allowable co-payment is 20% of what the Department would pay for the service. While the Department pays a hospital a percentage of their billed charges and these charges differ by hospital, we estimate the average

> payment to be approximately $90.00. Therefore, the maximum co-payment amount for individuals with household income at this level would be $18.00. The bill would have children and adults paying more than the allowable maximum.

HSD states that cost sharing can have negative consequences for recipients, causing individuals to delay or forgo needed care. There are concerns that cost sharing can be a barrier to access, that imposing cost sharing could lead to higher costs overall, can lead to poorer health outcomes for recipients, and could increase the rate of uninsured individuals.

In addition, HSD states:

> there is also concern that cost sharing such as co-pays would create additional administrative burden for providers and could also lead to revenue losses for some providers. The first concern would arise from the need to determine which clients coming into the place of service would need to pay what amount of co-pays. If co-pay amount varies by income group, there could be several different co-pays depending on the clients' category of eligibility and income level. If cost sharing responsibilities are shifted to the provider of service, this may discourage participation, thereby increasing access problems. Providers do have the statutory authority to waive or reduce cost sharing if they believe imposing cost sharing produces a negative relationship between providers and clients, but HSD or the MCOs would make payment, in accordance with federal law, as if the provider had imposed the co-pay. This would lead to reduced provider revenue.

ADMINISTRATIVE IMPLICATIONS

HSD states that to implement any form of premiums or cost sharing, the state would need to amend the state Medicaid plan, track income and other client data to determine who would need to pay and how much, track client out-of-pocket expenditures, and enforce the cost-sharing requirements. There would also need to be changes to the Medicaid Management Information System and possibly to the program's eligibility system, ISD2.

TECHNICAL ISSUES

HSD notes that the bill cites §1903(y) of the Deficit Reduction Act on page 4 line 4. That section is actually part of the Social Security Act (SSA). The Deficit Reduction Act amended Title XIX of the SSA, but did not have a §1903.

OTHER SUBSTANTIVE ISSUES

According to HPC:

> Unnecessary visits to hospital ERs contribute to overcrowding in emergency departments (EDs). The overcrowding of EDs affects access to care. According to the American College of Emergency Physicians, crowding threatens the ability of emergency physicians to provide timely patient care and results in prolonged pain and suffering for patients, and long waits and increased transport times for ambulance patients. In 2007, two hundred emergency physicians indicated that they knew of a patient who had died because of the practice of "boarding."

Boarding occurs when hospitals hold emergency patients who have been stabilized and admitted to the hospital from the ED. This is the primary cause of overcrowding and causes patients to undergo unnecessary suffering and indignity, while putting lives at risk. When a patient is boarded, emergency physicians and nurses must continue to monitor that patient, preventing them from attending to new emergencies arriving at the hospital.

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