ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

FISCAL IMPACT OF IMPLEMENTING COST SHARING AND BENCHMARK BENEFIT PROVISIONS OF THE FEDERAL DEFICIT REDUCTION ACT OF 2005

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Janet Napolitano
Governor

Anthony D. Rodgers
Director

REPORTING REQUIREMENTS

Arizona Session Laws 2006, Chapter 344, § 3 (HB 2863) requires the Arizona Health Care Cost Containment System (AHCCCS) to submit to the Joint Legislative Budget Committee (JLBC) a report on the fiscal impact of implementing certain provisions in the federal Deficit Reduction Act of 2005 (Public Law 109-171). The report must address the fiscal impact associated with:

1. Enacting the maximum amount of cost sharing subject to the federal limitations that aggregate cost sharing and premiums cannot exceed five percent of household income.
2. Cost sharing for prescription drugs that are not preferred drugs within a class.
3. Cost sharing for nonemergency care provided in a hospital.
4. Cost sharing for an alternative benefit package that is actuarially equivalent to federal benchmark benefit packages. As required in a September 1, 2006, letter to JLBC, AHCCCS reported that it selected the state employee health benefit plan as a benchmark.

SUMMARY AND FINDINGS

1. The Agency identified $8,865,334 in potential premiums or $8,069,380 in potential copayments. The total premiums and copayments cannot be implemented simultaneously due to the 5% limit on cost sharing under the DRA. After accounting for the 66.47% federal share, this would yield $2,972,547 in potential premiums and $2,705,663 in potential copayments. The administrative costs of implementing these cost sharing methods would be $15,838,100.
2. The Agency identified up to $1,902,678 in potential premiums or $4,373,473 in potential copayments for ALTCS members receiving home and community based services; however, imposing additional cost sharing on ALTCS members may have an adverse fiscal impact on the state. Members unable to pay cost sharing may need to forego necessary medical services, leading to poorer health and costlier care. Others may choose to move into nursing facilities to avoid going without needed services. The fiscal impact for the state could be substantial because the cost of institutional care is more than three times greater than the cost of HCBS. In addition, cost sharing would be inconsistent with Arizona's new Medicare copayment subsidy program for many of these individuals.
3. While the static analysis presented in this document potentially identifies millions of dollars in cost sharing options, it should be noted that the Agency has identified considerable infrastructure investments would be needed for implementation. The analysis does not take into account any shift in services as a result of new cost sharing.
4. New premiums may increase disenrollment, resulting in more uninsured citizens, more uncompensated care for the state's hospitals, and further increase challenges facing emergency rooms.
5. Excluding behavioral health services, AHCCCS may incur costs by implementing the state employee benefit plan instead of the AHCCCS benefit plan, due to broader services under the state employee plan and the DRA requirement to provide comprehensive wrap-around services for children.

6. Managed care is intended to shift health care from an illness-based approach to one emphasizing disease prevention and maintenance of health; cost sharing on general office visits may be inconsistent with this objective. Premiums can lead to high member turnover, which can decrease the ability of plans to manage care; therefore, longer enrollment can lead to better health outcomes.

DRA COST SHARING

DRA COST SHARING. Social Security Act § 1916A, established by §§ 6041 to 6043 of the federal Deficit Reduction Act of 2005 (DRA; Public Law 109-171), permits states to require Medicaid members to pay cost sharing that was previously prohibited by federal law. Below are DRA premium and cost sharing requirements.

1. Types of cost sharing. The DRA permits states to require premiums, enrollment fees, copayments, and similar fees, including higher cost sharing for non-preferred drugs and non-emergency use of the emergency room.
2. Return of federal share. The state must return to the federal government the federal share (66.47%) of any premiums or copayments imposed on Medicaid members.
3. Inapplicable to other cost sharing. These provisions apply only to cost sharing imposed under § 1916A. They have no effect on AHCCCS' current cost sharing.
4. Most AHCCCS members ineligible. Section 1916A does not apply to Medicaid-eligible individuals with family income at or below 100% Federal Poverty Level (FPL), or to individuals who are only eligible for Medicare cost sharing, KidsCare, or HIFA parents.
5. Denial of eligibility and services. A state may deny Medicaid eligibility or terminate eligibility for failure to pay a DRA premium, and a state may permit providers to refuse services to members who do not pay DRA copayments.
6. Exempt individuals (premiums). The following individuals cannot be charged premiums or enrollment fees:
    a. Certain mandatory groups of children under 18, including children receiving TANF or SSI-cash, SOBRA children, and foster children.
    b. Recipients of adoption or foster care assistance.
    c. Pregnant women.
    d. Hospice patients.
    e. Institutionalized individuals who are required to pay a share of cost.
    f. Women in the breast and cervical cancer treatment program.
7. Exempt services (copayments). The following services may only be subject to nominal copayments (up to $3.00) for prescription drugs and non-emergency use of the emergency room. No other cost sharing may be imposed.
    a. Services provided to exempt individuals.
    b. Preventive services for children under 18.
    c. Family planning services and supplies.

d. Emergency services.

8. Five percent aggregate cap. The aggregate amount of all premiums and cost sharing for all family members may not exceed 5% of the family's income.
9. Variable limits. Cost sharing limits depend on family income, unless the individual or service is exempt. The DRA cost sharing maximums are presented in Table 1.

Table 1. DRA Cost Sharing Maximums

Family Income or Exempt Status	**5% Cap**: The aggregate amount of premiums and cost sharing imposed on all family members cannot exceed 5% of family income			
	Premiums	**General Cost Sharing**	**Cost Sharing: Drugs**	**Cost Sharing: Non-emergency ER**
0 - 100% FPL	$0	$0	$0	$0
100% - 150% FPL	$0	10% of service cost	$3.00	$6.00
Above 150% FPL	Unspecified	20% of service cost	20% of drug cost	Unspecified
Exempt individuals and services (regardless of family income)	$0	$0	$3.00	$3.00

DRA COST SHARING ANALYSIS

Groups impacted. In analyzing the fiscal impact of implementing DRA cost sharing for AHCCCS members, the following groups were excluded.

- Groups to which DRA cost sharing provisions do not apply.
- Groups with fewer than 1,120 members, pursuant to actuarial guidelines for achieving credible projections and because the cost of administering cost sharing for small coverage groups can be disproportionate to fiscal savings.
- Institutionalized members of the Arizona Long Term Care System (ALTCS), who already contribute all but a small portion of their income to the cost of care.
- Non-institutionalized children in ALTCS, due to DRA exemptions and because AHCCCS was mandated to implement new cost sharing for developmentally disabled children with family income at or above 400% FPL.

DRA cost sharing can, however, be applied to the following groups. See Table 2 for applicable limits.

- Transitional Medical Assistance (TMA) families with income over 100% FPL. Federal law requires the state to provide temporary Medicaid coverage as families transition away from TANF and poverty. Eligible families are those whose employment income is between 100% FPL and 185% FPL. AHCCCS eligibility ends after two six-month periods. DES determines eligibility.
- SOBRA children with income over 100% FPL. Federal law requires the state to cover children:
    i. Under age one with family income up to 140% FPL,
    ii. Age one to five with family income up to 133% FPL, and
    iii. Age six to 18 with income up to 100% FPL.

  SOBRA children under age six with income between 100% FPL and 140% FPL can be subject to DRA cost sharing.

- Non-institutionalized adult ALTCS members with income over 100% FPL. ALTCS covers long term care services for individuals who are institutionalized or at risk of institutionalization. Non-institutionalized members receive home and community based services (HCBS).

  The two ALTCS groups include individuals who are elderly or physically disabled (EPD) or developmentally disabled (DD). AHCCCS analyzed each group separately due to significant differences in service utilization. As stated above, this analysis excludes children and institutionalized members. Adult ALTCS members receiving HCBS with income over 100% FPL can be subject to DRA cost sharing.

Table 2. Cost Sharing Maximums for Groups Analyzed.

Coverage Group or Exempt Status	**5% Cap**: The aggregate amount of premiums and cost sharing imposed on all family members cannot exceed 5% of family income			
	Premiums	**General Cost Sharing**	**Cost Sharing: Drugs**	**Cost Sharing: Non-emergency ER**
TMA 100% - 150% FPL (unless exempt)	$0	10% of service cost	$3.00	$6.00
TMA 150% - 185% FPL (unless exempt)	Unspecified	20% of service cost	20% of drug cost	Unspecified
SOBRA Children 100% - 140% FPL	$0	$0	$3.00	$3.00
ALTCS HCBS 100% - 150% FPL (unless exempt)	$0	10% of service cost	$3.00	$6.00
ALTCS HCBS Over 150% (unless exempt)	Unspecified	20% of service cost	20% of drug cost	Unspecified
Exempt individual or service (regardless of income or group)	$0	$0	$3.00	$3.00

The following services, which account for the vast majority of expenditures, were included in this fiscal impact analysis.

- Inpatient hospital.
- Outpatient hospital.
- Physician visits.
- Prescription drugs.
- Non-emergency use of the emergency room.

Fiscal analysis: premiums and copayments. AHCCCS established standard copayments by applying the DRA cost sharing maximums to the average cost for that service. See Table 4.

- This is a static analysis. It does not account for decreases in utilization and enrollment resulting from imposition of premiums or cost sharing. Nor does this analysis calculate the financial impact of other consequences of cost sharing. Members' inability to afford cost sharing may result in higher costs of care, such as increased hospitalization or use of emergency services.
- The federal share (66.47%) of all amounts collected must be returned to the federal government; this is not reflected in Table 4.

Fiscal analysis: administration. These are preliminary estimates. If new copayments or premiums are implemented, AHCCCS will need to further refine these estimates. See Table 3.

- AHCCCS' current premium billing system is operating at capacity; the system must be replaced or completely redesigned to expand capacity to include new programs. AHCCCS estimates that it would take up to three years to develop such a system, at a cost of up to $5 million, excluding hardware costs.
- DES does not currently have a premium billing system. If premiums are imposed on groups for which DES determines eligibility, DES may need to build a similar premium billing system, with costs up to an additional $5 million, excluding hardware and ongoing support and maintenance.
- AHCCCS currently does not have a system for tracking copayments to ensure that the Agency complies with the DRA requirement that cost sharing not exceed 5% of family income. Building such a system for AHCCCS and each health plan may cost up to $2 million, excluding ongoing support and maintenance.
- AHCCCS could not estimate personnel costs associated with a copayment system.
- AHCCCS estimates new premiums would add approximately 15 minutes to the eligibility determination process for calculation and management of premiums, requiring 25 new FTE at a total fund cost of $923,900.

Table 3. Administrative Expenses Associated with Implementing New Premiums and Copayments

Expense	Cost
AHCCCS Premium Billing System	Up to $5,000,000
DES Premium Billing System	Up to $5,000,000
Copayment Tracking System	Up to $2,000,000
Hardware	$100,000
Ongoing support	Up to $2,444,000
Premium billing staff (one-time costs)	$26,800
Premium billing staff (ongoing costs)	$343,400
Eligibility Determination	$923,900
Total	Up to $15,838,100 (total funds)

Table 4. AHCCCS Analysis of DRA Premiums and Copayments. See Table 3 for the breakdown of up to $15.8 million in administrative expenses. Also, note that AHCCCS must reimburse the federal government for the federal share (66.47%) of premiums and cost sharing.

	TMA		SOBRA	HCBS EPD		HCBS DD	
	100% - 150% FPL	Over 150% FPL	Over 100% FPL	100% - 150% FPL	Over 150% FPL	100% - 150% FPL	Over 150% FPL
	11,717 households	4,837 households	19,919 children	5,153 households	1,654 households	1,059 households	149 households
Maximum Premium							
Amount Per Household Per Month	$0.00	$119.97	$0.00	$0.00	$83.62	$0.00	$136.12
Amount Per Household Per Year (PHPY)	$0.00	$1,439.59	$0.00	$0.00	$1,003.41	$0.00	$1,633.39
Total Collected for Premiums	$0.00	$6,962,656	$0.00	$0.00	$1,659,369	$0.00	$243,309
Maximum Copayment for Prescriptions							
Amount PHPY	$23.64	$68.33	$7.20	$27.36	$113.97	$32.40	$122.95
Total Collected for Prescriptions	$276,996	$330,462	$143,417	$140,977	$188,483	$34,303	$18,315
Maximum Copayments for Services							
Inpatient amount PHPY	$58.47	$116.95	$0.00	$277.11	$554.22	$62.26	$124.51
Outpatient amount PHPY	$25.09	$50.18	$0.00	$113.23	$226.47	$11.65	$23.30
Physician amount PHPY	$54.12	$108.23	$0.00	$72.02	$144.04	$27.90	$55.81
Maximum PHPY for Services	$137.68	$275.36	$0.00	$462.36	$924.73	$101.81	$203.62
Maximum Copayments Prescriptions and Services							
Maximum Per Household Per Year for Prescriptions and Services	$161.32	$343.69	$7.20	$489.72	$1,003.41	$134.21	$326.57
Total Collected for Drugs and Services	$1,890,235	$1,662,255	$143,417	$2,523,366	$1,659,369	$142,092	$48,646

DRA BENCHMARK BENEFIT PLANS

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Social Security Act § 1937, established by DRA § 6044, permits states to create mandatory "benchmark" benefit plans for certain healthy children and adults. Below are requirements for DRA benchmark benefit plans.

1. Type of benefits. Instead of the traditional Medicaid benefits, a state may require certain Medicaid members to enroll in alternative benchmark benefit plans or employer-sponsored insurance that meets the benchmark standard.
2. Most AHCCCS members ineligible. A state may not make participation in a benchmark benefit plan mandatory for ALTCS members, pregnant women, Medicare eligible members, many low-income families, members receiving only family planning or emergency services, spend-down populations, women in the cancer treatment program, and most elderly, disabled or other special needs members. Some excluded members may be eligible to participate on a voluntary basis.
3. Benchmarks. Each of the following is considered a benchmark.
    - The standard Blue Cross/Blue Shield benefit plan offered under the Federal Employees Health Benefit Program.
    - The state employee benefit plan.
    - The benefit plan offered by the largest commercial, non-Medicaid, health maintenance organization in the state.
    - Any other appropriate benefit plan approved by CMS.

    In the alternative, a state may develop a benefit plan that is substantially actuarially equivalent to one of the benchmarks.
4. EPSDT wrap-around for children under 19. While some children may be enrolled in mandatory benchmark benefit plans, the state must provide a wrap-around benefit of full services available under the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program. EPSDT includes any Medicaid covered service, whether or not the service is covered under Arizona's Medicaid State Plan.
5. Variable benefits. The state may vary benefits based on member characteristics or geographic location.
6. Cost sharing. The DRA cost sharing limits under § 1916A continue to apply to members enrolled in benchmark plans.

DRA BENCHMARK BENEFIT ANALYSIS

Benchmark selected. AHCCCS developed this analysis using the state employee benefit plan as the benchmark. This selection is appropriate because, at times, the AHCCCS benefit plan has been viewed as more extensive than the state employee benefit plan. In addition, data and benefits associated with the state employee benefit plan are readily available, ensuring a more accurate, comprehensive, efficient, and timely comparison.

Actuarial analysis. AHCCCS contracted with Milliman USA to determine the actuarial value of the AHCCCS benefit plan compared to the state employee benefit plan. Milliman analyzed both benefit packages and, using the current AHCCCS per member per month rate (PMPM; the monthly amount paid to contractors for each enrolled member), determined the change in the

PMPM if AHCCCS provided the state employee benefit plan instead of the AHCCCS benefit plan.

Two AHCCCS benefits are more generous than the benefits available to state employees: prescription lenses for children and non-emergency transportation. Several state employee benefits are more generous than those available to AHCCCS members, particularly notable are chiropractic and infertility treatment. The change in the PMPM resulting from these differences is represented in Table 5.

Table 5. Actuarial comparison of state employee and AHCCCS plans, excluding EPSDT. The average PMPM is $250.

Change in AHCCCS PMPM if State Employee Benefits Replace AHCCCS Benefits			
Benefit	Range of Impact		EPSDT
	Low	High	
Chiropractic	+ $0.25	+ $0.30	X
Hearing Aids	+ $0.05	+ $0.08	X
Infertility Treatment	+ $0.13	+ $0.26	
Mammography	+ $0.09	+ $0.13	
Occupational/Speech Therapy	+ $0.08	+ $0.13	X
Orthotics	+ $0.00	+ $0.04	X
Prescription Lenses for Children	– $0.27	– $0.35	X
Non-Emergency Transportation	– $0.45	– $0.60	X
Total	– $0.12	– $0.01	

AHCCCS did not quantify the impact of the DRA requirement to provide EPSDT wrap-around benefits for children under 19. EPSDT requires AHCCCS to provide prescription lenses and non-emergency transportation for children, even if they are not provided under the benchmark plan. Therefore, AHCCCS could not save the $0.27 to $0.35 PMPM for prescription lenses and a portion of the PMPM for non-emergency transportation. Likewise, a small portion of the increased cost associated with such services as chiropractic, hearing aids, and occupational and speech therapy would not be incurred because these services are currently available to AHCCCS children as required by EPSDT. With these adjustments, it appears that implementing the state employee health plan would result in a modest increase in the PMPM for children.

Milliman also analyzed AHCCCS behavioral health benefits. Because respite services (short term care of a member to provide necessary relief for the member's caregiver) and residential mental health benefits are not included in the state employee benefit plan, the AHCCCS plan costs $6.46 PMPM more than the state employee benefit plan. As discussed above, AHCCCS would not realize the full savings under the benchmark plan because EPSDT requires the state to cover these services for children. Due to its role as a safety net for individuals with a range of disabling and chronic conditions, AHCCCS likely covers a disproportionate number of individuals with chronic behavioral health conditions requiring more intensive treatment when compared to workers enrolled in the state employee benefit plan. Without these services, the health of members with chronic behavioral health conditions may deteriorate, leading to greater costs for the state.

It must be noted that changes to AHCCCS behavioral health services are subject to court oversight as a result of two pending suits, *Arnold v. Sarn* and *J.K v. Eden*. This oversight could impact the state's ability to eliminate these services for some populations.

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