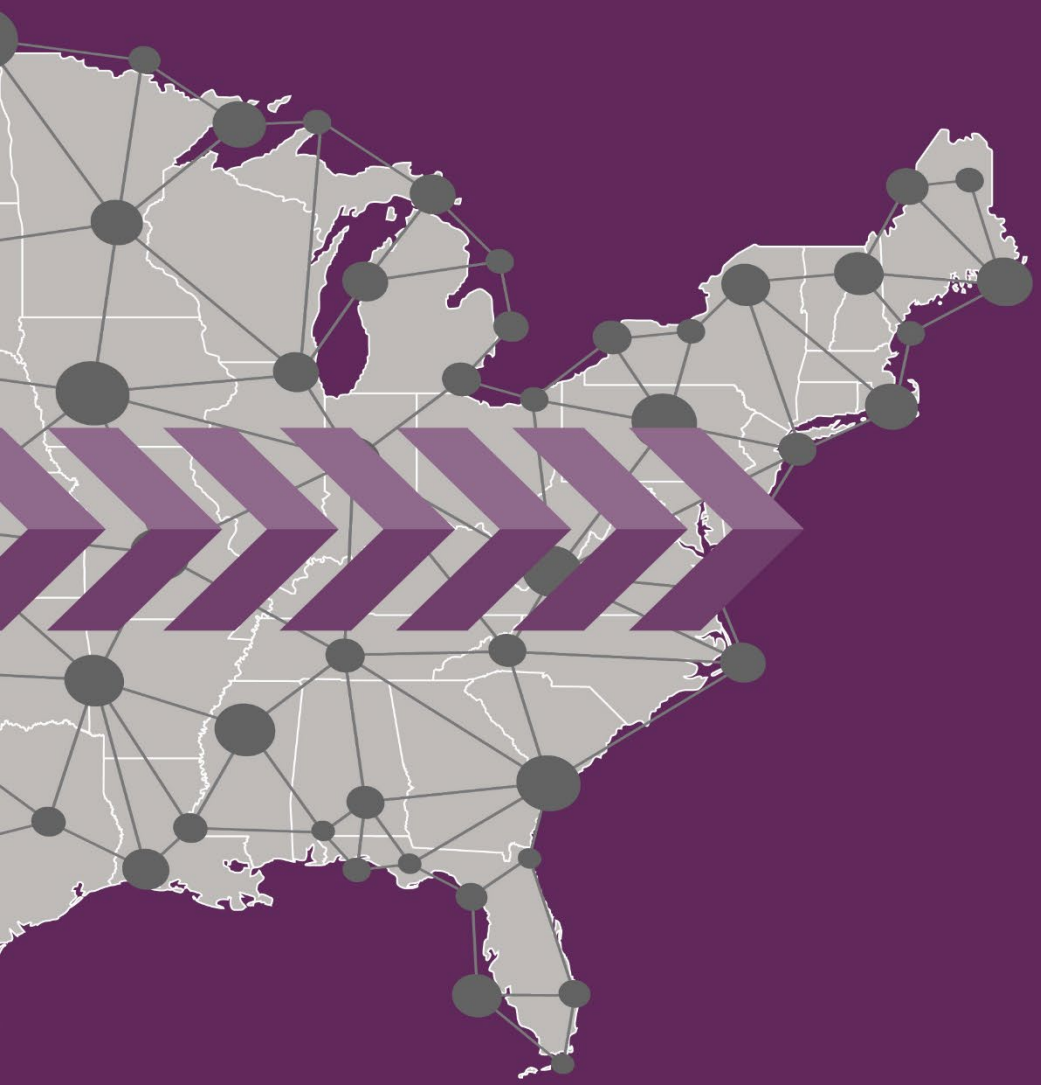

Operationalizing New H.R.1 Medicaid Copay Requirements: A Toolkit for States

Prepared by Manatt Health

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STATE Health & Value STRATEGIES

Driving Innovation Across States

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Questions? Email Heather Howard at heatherh@princeton.edu.

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About Manatt Health

This toolkit was prepared by Manatt Health. Manatt Health, a division of Manatt, Phelps & Phillips, LLP, is an integrated legal and consulting practice with over 160 professionals in nine locations across the country. Manatt Health supports states, providers, and insurers with understanding and navigating the complex and rapidly evolving healthcare policy and regulatory landscape. Manatt Health brings deep subject matter expertise to its clients, helping them expand coverage, increase access, and create new ways of organizing, paying for, and delivering care. For more information, visit https://www.manatt.com/health.

Toolkit Objectives

This toolkit is intended to support states in understanding and implementing H.R.1's new copay* requirements for certain Medicaid expansion enrollees that meet specific income requirements. The toolkit:

Provides an overview of H.R.1's new Medicaid copay requirements.

Proposes a practical and feasible operational approach to ensure compliance with federal requirements and reduce states' administrative burden and potential barriers for members.

*Referred to in H.R.1 (Sec. 71120) as "cost-sharing."

Background on H.R.1's Medicaid Co-Payments

Medicaid Co-Payments Under H.R.1

Beginning October 1, 2028, H.R.1 requires states to impose co-payments for services provided to Medicaid expansion adults with income above 100% of the federal poverty level (FPL) ($15,560 per year).

- **States decide copay amounts** (< $35 per service) and which services to apply co-payments.
- **Services <u>not</u> subject to co-payments include** *(list below reflects statutory language in H.R.1)*:
  - Pregnancy-related services
  - Inpatient services
  - Hospice services
  - Family planning services
  - Emergency services
  - Approved/recommended adult vaccines
  - Primary care services
  - Mental health/Substance Abuse Disorder services
  - Federally Qualified Health Center services
  - Rural Health Clinic services
  - Certified Community Behavioral Health Clinic services

Newly exempt services under H.R.1

Sources: 42 U.S.C. 1396o(k)(2).

States May Have Flexibility When Determining Copay Amounts and Which Services

Section 71120 of H.R.1 generally requires states to impose co-payments for "specified individuals," defined as individuals between 100-138% FPL enrolled in expansion or under a waiver.

- For services subject to co-payments, the statute requires states to impose co-payments "with respect to **certain** care, items, or services furnished to such an individual, **as determined by the State**." *(Section 1916(k)(2)(A) of the Social Security Act.)*
  - This language likely gives states the flexibility to define the scope of services subject to co-payments. Notably, the statute does *not* require states to impose co-payments on *all* services except the excluded ones.
- **As further background, the House-passed language looked different on this question.** The House required co-payments "with respect to medical assistance furnished to such an individual," which could have broadly applied co-payments to all non-exempt services. That language changed and became narrower (applying only to "certain care, items, or services") in the Senate. This reinforces the notion that Congress specifically did not apply these new copay requirements to all non-exempt services.

Note: CMS has not yet issued guidance on how states will be required to implement co-payments under H.R.1. As such, this analysis may be subject to change.

Operational Considerations

States must adhere to the following federal copay requirements:

- Medicaid co-payments **incurred by all individuals in the Medicaid household may not exceed an aggregate limit of 5%** of the family's income applied on a quarterly or monthly basis.
- **If a state imposes co-payments that could place enrollees at risk of reaching the aggregate family limit, the State Plan must indicate a process to track each family's incurred co-payments through an effective mechanism that does not rely on enrollee documentation**–which may be administratively complex and costly to implement.
- State Medicaid agencies must inform enrollees and providers of the enrollees' aggregate limit and **notify enrollees and providers when an enrollee has incurred out-of-pocket expenses up to the aggregate family limit** and individual family members are no longer subject to co-payments for the remainder of the family's current monthly or quarterly cap period.

Sources: 42 U.S.C. 1396o(k)(B)(iii); 42 C.F.R. 447.56(f)(1),(2),(3).

Affordability and Access Impact

Research shows that co-payments may create affordability barriers that deter individuals from pursuing necessary care, which can translate into higher healthcare costs in the future.

- Findings suggest co-payments **create affordability challenges for consumers; and even low-to-moderate copays impede access to care.** For example:
  - Low-income Americans were found to be **twice as likely as** non-low-income Americans to report not taking medications as prescribed to reduce prescription drug costs (20% vs 10%).
  - Among individuals in low-income ZIP codes, a 10% increase in prescription co-payments was correlated with a **10% reduction in statin drug adherence.**
  - Any copay for prescribed medications was associated with an **11% reduction in medication adherence** among nearly 200,000 participants on public insurance. (Furthermore, 21% of individuals with an employer sponsored health plan stopped taking prescribed medication after a $10 increase in their prescription copay.)
  - Rural-urban **colonoscopy disparities were reduced by 40%** after co-payments for colonoscopies were eliminated by the Affordable Care Act (ACA).
- Co-payments result in all users paying the same price to access services. Therefore, **lower income individuals, larger families, and those with poorer health bear the greatest burden of out-of-pocket costs from copays.**

Recommended Implementation Approach

Practical and Feasible Operational Approach

Adopting an approach whereby the state applies a very low copay amount to certain services would reduce the risk that Medicaid expansion members will reach the 5% aggregate household limit. The approach:

Minimizes administrative burden and system complexity. Using nominal co-payments with little to no likelihood of approaching the 5% household income cap eliminates the need to:

- Track cumulative co-payments across services and time;
- Integrate Modified Gross Adjusted Income (MAGI) and household calculations into claims systems; and
- Build and track against enrollee-level individual caps.

Substantially reduces information technology (IT) costs at both the federal and state level.

- No major systems build/data exchange is required, as the household cap would not realistically be reached.
- Existing payment and claims processes could remain unchanged, avoiding reprocessing or notifications.

Promotes continuity of care: Reduces the likelihood that members delay or forgo care, while nominal co-payments limit financial burdens for the lowest-income expansion enrollees.

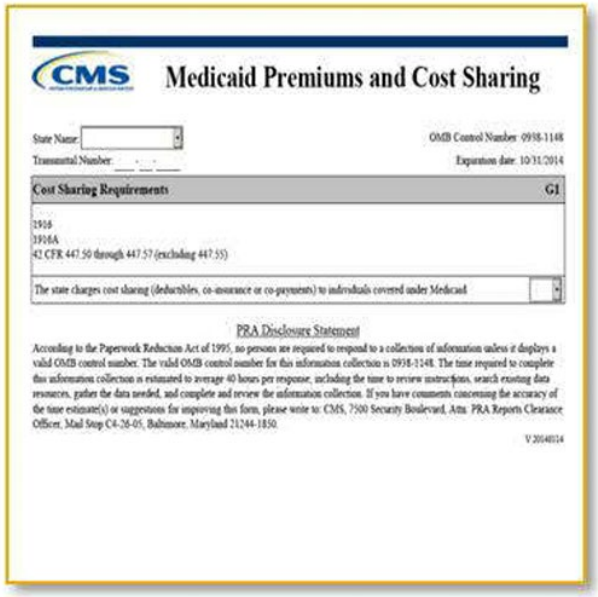
Advances program integrity by ensuring members are only paying co-payments that are less than 5% of their aggregate household limit.

Requirements of a Cost-Sharing State Plan Amendment

States may be required to develop and submit a state plan amendment (SPA) to CMS to implement H.R.1's Medicaid co-payments.

Requirements for the "Premiums and Cost-Sharing" SPA Include:

- Identification of **populations to whom the state will apply co-payments**
- Identification of **what services are subject to co-payments and the amount of co-payments**
- Affirmation that the co-payments plan properly **excludes all exempt populations and services**
- Identification of the **amount of the state's aggregate limit**, if less than 5%
- Explanation of **tracking and monitoring processes**
- Assurance that appropriate and adequate **advanced public notice was provided**



CMS Medicaid Premiums and Cost Sharing

State Name:

Transmittal Number:

OMB Control Number: 0938-1148

Expiration date: 10/31/2014

Cost Sharing Requirements	G1
1916 1916A 42 CFR 447.50 through 447.57 (excluding 447.55)	
The state charges cost sharing (deductibles, co-insurance or co-payments) to individuals covered under Medicaid	

PRA Disclosure Statement

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For more information, visit CMS' OneMAC frequently asked questions webpage.

Illustrative Example: $1 Copay for a Household of One

If a state applies $1 co-payments to a limited number of services (e.g., prescription drugs):

A "high" but plausible utilization pattern for an individual adult may be four to six copay eligible services per month (e.g., a few prescriptions).

- 5% of aggregate household income at 100% of the FPL is ≈ $65 monthly cap:
  - At six copay eligible services per month, an individual would pay $6 per month in co-payments.
  - The individual would need greater than 10 times that volume (65+ copay events in a single month) to hit the monthly cap.

An "extremely high" utilization pattern for an individual adult might be 10 to 12 copay eligible services per month (approximately double the "high" scenario).

- Even at this level, the individual would still need greater than five times more use to reach the 65 services per month needed to hit the cap.

Conclusion:

With **$1 co-payments on a narrow set of services**, a member at **100% of the FPL** is **very unlikely** to come close to the 5% aggregate cap under any reasonable utilization pattern.

Illustrative Example: The 5% Cap for a $1 Copay

A one-person household at 100% of the FPL would need about 65 copay events in a single month, or 196 copay events in a quarter, to bump up against the cap.

Household Size	Family Income (100% FPL)[1]	5% Monthly Cap	Approximate Number of $1 Co-Payments to Reach Monthly Cap	Approximate Number of $1 Co-Payments to Reach Quarterly Cap
1	$15,650	**$65.21**	65 copays	196 copays
2	$21,150	**$88.12**	88 copays	264 copays
3	$26,650	**$111.04**	111 copays	333 copays
4	$32,150	**$133.96**	133 copays	402 copays

1: Based on 2025 guidelines for 100% of the FPL.

Operational Considerations

Decision-Making Framework for Selecting Services Subject to Co-Payments

There is no mandatory number of services on which a state must apply Medicaid co-payments. States may elect to apply co-payments to a select number of services to mitigate impact on members.

Key Evaluation Considerations When Selecting the Service(s) That Will be Subject to Co-Payments:

- Could adding a copay for this service lead to potential unintended harm or equity risks in the near- or long-term?
    - For example, applying a copay on dental services may deter members from seeking care in the near-term but research shows that untreated oral health issues have an association with chronic, high-cost health conditions.
- Does the state intend to set co-payments on services to change member behavior and/or provider behavior (e.g., generic prescription drugs) in an intended direction?
- Can the copay be operationalized relatively cleanly (e.g., a service that is in managed care versus a carve out)?
- Does the state have a clear policy rationale for the copay?

Key Steps for the Operational Approach in Practice

1. The state's eligibility system identifies a Medicaid expansion member with income above 100% of the FPL that is subject to new Medicaid co-payments.
2. State sends a notification to the member, plan, and providers that the individual is subject to Medicaid co-payments.
3. The member receives a service subject to a copay; and the member is flagged as needing to pay a copay amount.
4. Member pays the copay. Considering the copay is so minimal that it is virtually impossible it will contribute to hitting the 5% family income cap, the incurred copay is not tracked by the state.

Additional Operational Considerations

Member Notices

- Member notices should **include an explanation of co-payments that members are required to pay.**
- Given high rates of low health literacy among consumers, communications should **be clear and accessible and occur early and often** to prepare Medicaid users for any potential changes.

Notices should be written using plain language to ensure members understand the upcoming changes. States should also consider validating draft communications with their Beneficiary Advisory Councils (BACs) to obtain member input and update communications accordingly. *See SHVS' resources, linked here and here, for more information on communications best practices.*

Provider Communication

- States should **notify providers of members' new copay obligations.** For example, states may leverage their Eligibility Verification Systems to indicate whether a member is subject to co-payments.

Managed Care Plan Notification

- If co-payments are applied to services that are covered under Medicaid managed care organizations (MCOs), **states will need to amend their MCO contracts to reflect these changes.**
- MCOs will need to **update their member information** to reflect the new co-payments.