House Finance Committee
Testimony in Opposition to Budget Article 13, Section 1
and in Partial Opposition to Budget Article 13, Section 3
Submitted by Linda Katz, Policy Director
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Budget Article 13, Section 1 – Co-payments

The Economic Progress Institute is opposed to the proposal to require low-income Medicaid beneficiaries to pay co-pays for certain services. All adults, excluding those who are receiving Medicaid through the disability category of eligibility and pregnant women would be subject to the new co-payments, affecting 150,000 parents, parent, adults and seniors. We oppose the co-payments because:

1. All of the affected population has income only marginally above the poverty level (maximum of 138% FPL) and the vast majority have income at or below the poverty level. Seniors all have income at or below poverty. Three-quarters of adults and parents have income below poverty and parents enrolled in the RI Works cash assistance program have income that is 70% below the poverty level. There is no room in these families' budgets to contribute toward their health care costs.

2. Co-payments put these individuals at risk of foregoing medication, sick-visits and other necessary services that would put their health at risk. Substantial research, recently compiled by the Kaiser Family Foundation, shows that: "Even small levels of cost-sharing, in the range of $1 - $5, are associated with reduced use of care, including necessary services". http://files.kff.org/attachment/Issue-Brief-The-Effects-of-Premiums-and-Cost-Sharing-on-Low-Income-Populations

3. Rhode Island expects to "save" $3.2 million in general revenue through co-payments, and "save" the federal government $12 million. This $15M "savings" will be borne by poor Medicaid beneficiaries and providers, many of whom will not be able to collect the co-payments from their patients, but will still provide care.

4. Expected savings may be off-set by adults with disabilities switching from the "expansion category" of coverage to the "disability category" of coverage if they can't afford the co-payments. Because the eligibility process for Medicaid as "expansion" is simpler than that for people with disabilities, and the benefits are the same, many individuals with disabilities obtain coverage as "expansion". The state receives around 95% federal match for these individuals. For beneficiaries covered as "disabled", the state receives around 50% federal match. Medicaid beneficiaries are entitled under federal law to choose the Medicaid category in which they wish

to enroll. State costs would rise if beneficiaries switch categories from "expansion" to "disability".

5. Collecting co-payments requires resources and staff at OHHS that could be better spent on other Medicaid initiatives such as improving access to home and community based long term services and supports. Federal law limits annual cost sharing to no more than 5% of the beneficiary's income and requires OHHS to monitor expenditures and stop the co-pays when the beneficiary reaches the cap. OHHS needs to "staff up" to implement this monitoring and also needs to have policies in place so that beneficiaries who have reached the cap, as well as beneficiaries not subject to the co-payments (disabled individuals, pregnant women and children) are not inappropriately charged.

6. The proposed co-pays are more stringent that co-pays required in other New England states. Connecticut does not have co-payments. New Hampshire requires co-pays only for individuals with income above poverty. Maine, Massachusetts and New Hampshire do not require co-pays for doctors' visits and none of the New England states that have co-payments for prescriptions have different amounts for generic and brand name prescriptions. (Massachusetts also only charges $1 co-pay for generic drugs for diabetes, high blood pressure and high cholesterol). https://www.kff.org/medicaid/report/medicaid-and-chip-eligibility-enrollment-renewal-and-cost-sharing-policies-as-of-january-2017-findings-from-a-50-state-survey/

Budget Article 13, Section 3 – RIte Share

RIte Share is an effective way to ensure that employers share in the cost of health insurance coverage for their employees as well as reducing state costs for health coverage for these workers. Under current law, parents who are eligible for RIte Care (or whose children are eligible) who have access to employer sponsored insurance (ESI) may be required to enroll in that coverage as a condition of continued eligibility for Medicaid.

Article 13, Section 3 proposes several changes to the current RIte Share requirements, including requiring the "expansion population" to enroll in RIte Share if appropriate ESI is available.

While we do not object to expanding the RIte Share requirement, we want to ensure that Medicaid-eligible beneficiaries are no worse off if they are required to enroll in RIte Share instead of being enrolled in a Medicaid managed care plan.

We have the following objections to the proposed changes to the RIte Share program:

1. Do not require adults with disabilities to enroll in RIte Share. People with disabilities enrolled in Medicaid receive comprehensive services through one of three managed care plans. These services include basic health care as well as long-term services and supports that enable the person to live at home. Commercial health insurance does not provide the broad scope of

benefits that people with disabilities need. While a person enrolled in their employer's health insurance plan – or their spouse's health insurance plan, through RIte Share - would be entitled to Medicaid "wrap around" coverage for services that the commercial plan doesn't cover, the individual may not be able to find providers who accept the Medicaid fee-for-service rates for the home and community based services they require.
40-8.4-12(c), do not add "40-8.5" to Medicaid categories required to enroll in RIte Share

2. Do not require Rite Share enrollees to pay co-pays to providers. Income levels for RIte Share enrollees are the same as for RIte Care/Rhode Health Partners – three quarters have income below the poverty level. Beneficiaries cannot afford the provider co-payments that commercial insurance plans require.
40-8.4-12 (b)(11): Delete: Co-payments to providers are not covered as part of the wrap-around coverage.

3. Ensure that RIte Share participants have access to <u>all</u> benefits that they would have if they remained in RIte Care/Rhody Health Partners. This includes transportation, interpreter services and all medically necessary services without limits that might be imposed under commercial coverage.
40-8.4-12(e) Delete the word "reasonably" so that ALL benefits not available under the commercial plan that are available to Medicaid beneficiaries are provided to RIte Share enrollees.

4. Do not increase the current cost-sharing for RIte Share enrollees. Under current rules, RIte Share participants with income above 150% FPL are required to contribute to the monthly premium cost as follows:
$61/month if income is 150 – 185%FPL
$77/month if income is 185 - 200%FPL
$92/month if income is 200 – 250% FPL
The Article proposes that RIte Share enrollees will need to contribute 5% of income. This will impose higher costs on low-income families. For example, a parent with one child with income at 150% FPL (take home pay of around $1,850) who is required to enroll in RIte Share currently pays $61/month. At 5%, the parent's cost would rise to $102/month.
40-8.4-12(g) Delete or reduce the 5% requirement.

5. Do not require children to enroll in Rite Share if the non-custodial parent is the one who has access to employer-sponsored coverage. A non-custodial parent who includes his/her child in employer coverage may live in another state and the child's access to health care in Rhode Island may be limited. RIte Share enrollment should only be required if the <u>custodial parent</u> is the one who has access to employer sponsored coverage and the statute should be amended to so reflect.