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To: Members of the Senate Finance Committee and Senate Health and Human Services Committee

From: The Protect Our HealthCare Coalition

Date: March 6, 2018

Re: Budget Article 13, Section 1 (Proposed Co-payments)

Budget Article 14, Section 1 (Proposed repeal of retroactive Medicaid coverage and restructuring Unity program for seniors and adults with disabilities)

The Protect Our HealthCare Coalition is a group of 22 leading Rhode Island non-profits and consumer groups with a goal to protect and promote quality, affordable healthcare for all. The Coalition also includes hundreds of community members around the state who support the Coalition's mission.

Committees should reject the proposed co-payments

Our Coalition is strongly opposed to the Proposal in Budget Article 13 that would require adults (except for some adults with disabilities) to pay co-payments for vital health care services including:

- \$4.00 for brand name prescription drugs and \$2.50 for generics
- \$3.00 for non-preventive doctor visits for physical health care
- \$8.00 for non-emergency use of the emergency room
- \$3.00 per inpatient hospital stay

Co-payments will cause financial hardship and likely adverse health outcomes for over 150,000 adults, including parents, pregnant women, single adults and seniors who will be subject to these payments. Across these populations, more than **seven out of ten live below the poverty level**. Several thousand parents enrolled in the RI Works program -- overwhelmingly single mothers -- struggle to get by on income that is 70% below the poverty level. (A family of 3 receives yearly benefits of \$6,300.) Adults with disabilities who are enrolled in Medicaid through the "expansion category" would not be protected from the co-payment requirement.¹

Research establishes the harmful impacts of co-payments on low-income individuals. The Kaiser Family Foundation recently released a brief reviewing research from 65 papers published between 2000 and 2017 on the effects of premiums and cost-sharing. The full report can be found at:

<http://files.kff.org/attachment/Issue-Brief-The-Effects-of-Premiums-and-Cost-Sharing-on-Low-Income-Populations>

¹ Adults with disabilities who are enrolled in Medicaid as "disabled" would not be subject to co-payments. There are many adults in the "expansion" category established through the Affordable Care Act who meet the level of disability to qualify for Medicaid as disabled. If these adults choose to change their coverage category to "disabled" because co-pays are unaffordable, the state's share of health care costs would rise from 5% to 50%.

For the committees' convenience we print the most relevant section of the report here. (Footnote citations are omitted.)

Effects of Cost Sharing

A wide range of studies find that even relatively small levels of cost sharing, in the range of \$1 to \$5, are associated with reduced use of care, including necessary services.

The RAND health insurance experiment (HIE), conducted in the 1970s and still considered the seminal study on the effects of cost sharing on individual behavior, shows a reduction in use of services after cost sharing increased, regardless of income. Since then, a growing body of research has found that cost sharing is associated with reduced utilization of services, including vaccinations, prescription drugs, mental health visits, preventive and primary care, and inpatient and outpatient care, and decreased adherence to medications. In many of these studies, copayment increases as small as \$1-\$5 can effect use of care.

Some studies find that lower-income individuals are more likely to reduce their use of services, including essential services, than higher-income individuals. Research also suggests that copayments can result in unintended consequences, such as increased use of other costlier services like the emergency room. Two studies have found that copayments do not negatively affect utilization. In one case, the authors suggest that increases in provider reimbursement may have negated effects of the copayment increases, particularly if not all copayments were being collected by providers at the point of care.

Research points to varying effects of cost sharing for people with significant health needs. Some studies find that utilization among individuals with chronic conditions or significant health needs is less sensitive to copayments compared to those with fewer health needs. As such, these individuals face increased cost burdens associated with accessing care because of copayment increases. Other research finds that even relatively small copayments can reduce utilization among individuals with significant health needs.

Numerous studies find that cost sharing has negative effects on individuals' ability to access needed care and health outcomes and increases financial burdens for families.

For example, studies have found that increases in cost sharing are associated with increased rates of uncontrolled hypertension and hypercholesterolemia and reduced treatment for children with asthma.

Increases in cost sharing also increase financial burdens for families, causing some to cut back on necessities or borrow money to pay for care. In particular, small copayments can add up quickly when an individual needs ongoing care or multiple medications.

Findings on how cost sharing affects non-emergent use of the emergency room are limited. One study found that these copayments reduce non-urgent visits. Other studies find that these copayments do not affect use of the emergency room.

It is also worth emphasizing that while the state expects to save around \$3 million by implementing co-payments, it will be forfeiting \$12 million in federal funds. This is significantly higher than the usual 50% loss of federal funds because a significant number of people impacted by the co-payment proposal are “expansion” adults for whom the state receives around 95% federal share.

Committees should reject the proposed cuts to investment in rebalancing long-term care

Rhode Island has a long-standing goal of “rebalancing” long-term care by making more investments in quality community based services that help people live at home. But at least two proposals in the proposed budget would be a step backward on the road to achieve this goal.

First, we object to the proposed restructuring of the Unity managed care program designed to help seniors and people with disabilities who have both Medicare and Medicaid coverage improve their quality of health and life. It is not clear how the “savings” of \$10 - \$15 million in state and federal funds would be achieved or what the impact on access to services for these most needy individuals would be. It is premature to jump from this strategy of serving the health care and long term care needs of this population, without more data regarding outcomes in the Unity program.

We are also concerned that rather than use the “Perry Sullivan” funds to expand community-based services that are necessary if the state truly wants to “rebalance” long term care, the majority of the funds are proposed to be used to pay for the wage increase for home care providers that the Assembly adopted last year. We cannot emphasize too much how critical the wage increase is for these front-line caregivers, but we urge you to absorb that increase in the budget and dedicate the Perry Sullivan funds for additional required initiatives to expand home and community based care.

Committee should reject the proposed elimination of retroactive coverage for seniors and people with disabilities

Retroactive payments help protect our poorest and most vulnerable Rhode Islanders from financial crises. Often a hospitalization or onset of illness and accumulation of medical bills is what prompts a person to apply for Medicaid coverage. Medicaid eligibility starts on the first day of the month in which the person applies. Under current rules, bills incurred in the 3 months prior to application can also be covered if the person was eligible. Eliminating these retroactive payments will cost seniors and people with disabilities approximately \$4 million (\$2 million in state and \$2 million in federal funds).

Thank you for your consideration of our testimony.