

## Cost-Sharing Implementation for Children Among State Medicaid Programs

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### **Abstract**

Cost containment and quality service delivery through Medicaid programs are a top priority in the United States. In order to curb costs, the Deficit Reduction Act (DRA) of 2005 allowed states to impose cost-sharing, including copays, on previously exempt groups, such as children. Research on the implementation of the DRA among states has been limited. This study surveyed 50 states and the District of Columbia to identify state copay policies for children on Medicaid receiving behavioral health services (a group who was exempt from copays before the DRA). Analysis of state Medicaid policies revealed that Illinois, Wisconsin, and Idaho implemented copays for this group of children. These states had variable policies impacting children with different family income levels, age requirements, and service needs. The findings of this study issue a call for additional research on the impact of these copays on service utilization and actual cost savings observed by states.

## Introduction

From 2001-2004, the United States experienced an economic decline which caused budget concerns and catalyzed federal priorities to reduce spending.<sup>1</sup> In order to provide states with additional cost containment options, the Deficit Reduction Act 2005 (DRA) was signed into law in February of 2006 by President George W. Bush.<sup>2</sup> The DRA included provisions for cost-sharing, or “any contribution consumers make towards the costs of their healthcare as defined in their health insurance policy” within public health insurance (Medicaid) programs.<sup>3,4</sup> The DRA opened new mechanisms for states to consider savings within Medicaid by cost-shifting both during the immediate economic downturn and longer term. In addition to a focus on increased state flexibility, the DRA was simultaneously geared toward reducing the federal deficit.<sup>5</sup>

The DRA created a new atmosphere for considering mechanisms for cost-sharing. Cost-sharing fees can be structured to be paid at a set time (e.g. monthly) before individuals receive services, such as enrollment fees or sliding-scale premiums, or “at the time of service” with fees such as copayments (“copays”).<sup>6</sup> Before the DRA was passed, states were not permitted to charge premiums or enrollment fees to certain Medicaid beneficiaries.<sup>7</sup> For example, children and pregnant women did not have cost-sharing requirements.<sup>8</sup> Certain services were also exempt from cost-sharing fees, including emergency room use, family planning services and hospice care.<sup>9</sup> The modified provisions instituted by the DRA permitted state-determined “new options for instituting cost-sharing and premiums for children’s coverage.”<sup>10</sup>

Under the DRA, states are able to implement cost-sharing for those with a family income above 100% of the Federal Poverty Line (FPL) and to use other premiums and enrollment fees the states determine necessary.<sup>11</sup> For families with an income above 100% but at or below 150% FPL, the cost-sharing fees for individuals could not be greater than “10% of the cost of the service, or item, and total cost-sharing...may not exceed 5% of family income.”<sup>12</sup>

Through the DRA, optional services provided by state Medicaid programs can include cost-sharing, even for children under age 18. Optional services include prescription drugs, home health care, physical therapy, speech therapy, occupational therapy, mental health services, and case management.

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<sup>1</sup> Henry J. Kaiser Family Foundation. "State Fiscal Conditions and Medicaid." In *The Kaiser Commission on Medicaid and the Uninsured*, 2007, 1-2.

<sup>2</sup> Henry J. Kaiser Family Foundation. "Deficit Reduction Act of 2005: Implications for Medicaid." In *The Kaiser Commission on Medicaid and the Uninsured*, 2006, 1-2.

<sup>3</sup> Ibid.

<sup>4</sup> Agency for Healthcare Research and Quality. "Cost-Sharing Definition." Agency for Healthcare Research and Quality, [http://archive.ahrq.gov/chip/text/content/cost\\_sharing/cost\\_sharing.htm](http://archive.ahrq.gov/chip/text/content/cost_sharing/cost_sharing.htm).

<sup>5</sup> Henry J. Kaiser Family Foundation. *Deficit Reduction Act of 2005*, 2006, 1.

<sup>6</sup> Agency for Healthcare Research and Quality. 2012. "Cost-sharing definition."

<sup>7</sup> Henry J. Kaiser Family Foundation. *Deficit Reduction Act of 2005*, 2006, 1.

<sup>8</sup> Ibid.

<sup>9</sup> Ibid.

<sup>10</sup> Agency for Healthcare Research and Quality. "Cost-sharing definition."

<sup>11</sup> Sara Rosenbaum and Anne Markus. "The Deficit Reduction Act of 2005: An Overview of Key Medicaid Provisions and Their Implications for Early Childhood Development Services." x-xi, 24: George Washington University, 2006, x-xi, 24.

<sup>12</sup> Ibid., vii.

The DRA provides states the option to exempt these additional services from cost-sharing for all beneficiaries or certain groups.<sup>13</sup>

Certain services remain exempt from cost-sharing despite the DRA, including services for children under 18 with mandatory coverage and preventive services for all children under 18, regardless of income. Mandatory service benefits include physician services, hospital services, rural and federally-qualified health center services, early and periodic screening, diagnostic, and treatment (EPSDT) services, and several others.<sup>14</sup>

The Congressional Budget Office (CBO) initially projected that the Medicaid provisions of DRA would result in a net savings of \$4.8 billion over 5 years.<sup>15</sup> CBO estimates are based on state's collective adherence to several cost-sharing initiatives of the DRA that can both directly and indirectly impact Medicaid beneficiaries. Through the DRA, 9 million people, about half of whom are children, were projected to have incurred copays for the first time or would see an increase in the copay amount they previously paid for services by 2015.<sup>16</sup>

Research has found that health care participation declines with the implementation of copays or premiums, especially among vulnerable populations such as persons with disabilities, low-income individuals, and the focus of this study, children.<sup>17,18</sup> The impact of copays may be especially detrimental on children with disabilities since early and consistent intervention is critical to improved long-term outcomes. Treatment protocols for children with disabilities can include medication management, primary care services, and behavioral services. These services are often expensive and intensive. Children may receive these services through Medicaid, if they qualify through a waiver, based on family income or through other mechanisms.

The RAND "Health Insurance Experiment" study, conducted between 1971 and 1982, is a landmark study on cost-sharing.<sup>19</sup> The study followed more than 7,700 individuals for 3-5 years and found that individuals with a copay utilized fewer services.<sup>20</sup> The study also found that cost-sharing reduced the use of nearly all health services.<sup>21</sup> This reduction in services was not found to have an adverse effect on health, except for "the poorest and sickest 6 percent of the sample."<sup>22</sup>

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<sup>13</sup> Ibid., x-xi.

<sup>14</sup> Ibid.

<sup>15</sup> Henry J. Kaiser Family Foundation. Deficit Reduction Act of 2005, 2006 1.

<sup>16</sup> Ibid, 2.

<sup>17</sup> Ibid.

<sup>18</sup> American Psychiatric Association. "Joint Statement on Medication Cost Sharing in State Medicaid Programs." edited by Mental Health America, 2008.

<sup>19</sup> Robert H. Brook, Emmett B. Keeler, Kathleen N. Lohr, Joseph P. Newhouse, John E. Ware, William H. Rogers, Allyson Ross Davies, et al. "The Health Insurance Experiment: A Classic Rand Study Speaks to the Current Health Care Reform Debate." In *RAND Corporation Research Briefs*, RAND Corporation, 2006, 1-2.

<sup>20</sup> Ibid.

<sup>21</sup> Ibid.

<sup>22</sup> Ibid, 3.

Since the RAND study, research has also found that out-of-pocket healthcare expenditures lower the use of health services and are detrimental to families and to children. Recent studies have investigated expenditures of Children's Health Insurance Program (CHIP). All states' CHIPs provide health insurance for children whose family incomes are higher than Medicaid requirements.<sup>23</sup> Children served through CHIP must meet family income requirements set by the state in which they reside.<sup>24</sup> Using claims data from 1999-2009 for Alabama's CHIP program entitled ALL Kids, a 2012 study found that copays reduced service use across inpatient, outpatient, and emergency services and the use of medications.<sup>25</sup> Another study also used ALL Kids data from 1999-2009 and noted that an increase of \$50 in annual premiums with a \$1 to \$3 increase in per visit copays decreased program enrollment by 6.1% to 8.3%.<sup>26</sup> Families from traditionally underserved and underrepresented groups were found to be more sensitive to shifts in prices than other families.<sup>27</sup>

In addition to the impact on individuals and families, cost-sharing incurs administrative costs for states and providers.<sup>28</sup> In 2006, the Arizona Health Care Cost Containment System (AHCCCS) published a report which demonstrated the costs to implement copay provisions allowed by the DRA.<sup>29</sup> In order to collect \$2,972,547 in potential premiums and \$2,705,663 in copays, the AHCCCS estimated over \$15 million dollars in administrative expenses, such as additional billing system infrastructure and staff.<sup>30</sup> Research on Medicaid programs has also indicated that cost-sharing could change service use but might not result in savings. A 2008 study focused on Oregon's Medicaid program after it implemented copays for low-income adult members and found they did not result in cost-savings, but impacted members' treatment trends.<sup>31</sup> The changes in treatment trends indicated that Medicaid members decreased their total service use, but increased their inpatient care service utilization.<sup>32</sup>

The impact and implementation of cost-sharing nationally is unclear and understudied. There is a dearth of research on if and how states have implemented cost-sharing, including copays for previously exempted groups, such as children and individuals with disabilities. Given the potential impact of these strategies both as cost savings mechanisms for states and the impact upon children and families, documenting changes in cost-sharing within Medicaid programs is critical. The purpose of this study was to determine if and how states were implementing new cost-sharing mechanisms within Medicaid programs for one particularly vulnerable group – children utilizing behavioral outpatient services.

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<sup>23</sup> Centers for Medicare & Medicaid Services. "Children's Health Insurance Program Eligibility." edited by Centers for Medicare & Medicaid Services, 2015.

<sup>24</sup> Ibid.

<sup>25</sup> Bisakha Sen, Justin Blackburn, Michael A. Morrisey, Meredith L. Kilgore, David J. Becker, Cathy Caldwell, and Nir Menachemi. "Did Copayment Changes Reduce Health Service Utilization among Chip Enrollees? Evidence from Alabama." *Health Serv Res* 47, no. 4 (Aug 2012): 1603-20.

<sup>26</sup> Michael A. Morrisey, Justin Blackburn, Bisakha Sen, David Becker, Meredith L. Kilgore, Cathy Caldwell, and Nir Menachemi. "The Effects of Premium Changes on All Kids, Alabama's Chip Program." *Medicare Medicaid Res Rev* 2, no. 3, 2012.

<sup>27</sup> Ibid.

<sup>28</sup> American Psychiatric Association. Joint Statement on Medication Cost Sharing, 2006.

<sup>29</sup> Arizona Health Care Cost Containment System. "The Fiscal Impact of Implementing Cost-Sharing and Benchmark Benefit Provisions of the Federal Deficit Reduction Act." 2006, 2.

<sup>30</sup> Ibid, 5-6.

<sup>31</sup> Neal T. Wallace, K. John McConnell, Charles A. Gallia, and Jeanene A. Smith. "How Effective Are Copayments in Reducing Expenditures for Low-Income Adult Medicaid Beneficiaries? Experience from the Oregon Health Plan." *Health Serv Res* 43, no. 2 (Apr 2008): 515-30.

<sup>32</sup> Ibid.

## Methods

State Medicaid cost-sharing policies, including copays, for children receiving behavioral outpatient services were surveyed to detect implementation of cost-sharing provisions. Assessment of cost-sharing status was determined by obtaining two sources for all 50 states and the District of Columbia (D.C.). These sources included at least two of the following for each state and DC: Contact with state Medicaid office, information on the state Medicaid website or Medicaid provider manual, reports from the Henry J. Kaiser Family Foundation on Medicaid, or advocacy group contacts.<sup>33,34</sup> Contact with state Medicaid offices was made by directly calling and/or emailing the state's Medicaid office and interacting directly with a representative. These representatives either confirmed the copay for their state, or provided references for online websites and provider manuals. Each state has a Medicaid provider manual, which outlines billing and service regulations for providers, and was also used as a verified source. Many provider manuals include information about copays that Medicaid beneficiaries have to pay when they receive services, age specific services, and payment exemptions. Relevant information in provider manuals were noted and linked when possible. Table 1 outlines the sources of information used to validate information for each state and the presence or absence of a copay.

Two graduate students obtained at least two sources for each state and DC under the direction of a doctoral level researcher trained in policy research between April and June of 2013. Any form of cost-sharing that applied to Medicaid-covered services provided to a child was documented on a project tracking spreadsheet with the source of the information. States vary in their classification of the age of adulthood. This information was noted in the spreadsheet (also included in Table 1) to determine cost-sharing policies for children in each state based on their respective classification of childhood and adulthood.

State/ District	Copay or Cost for Services	Age of Adult Classification	Copay Information Source		
			Direct Medicaid Office Contact	State Medicaid Website/ Provider Manual	Kaiser Report
Alabama <sup>b</sup>	Not Present	18	X		
Alaska	Not Present	18	X	X	X
Arizona	Not Present	19		X	X
Arkansas	Not Present	18 <sup>a</sup>	X	X	
California <sup>b</sup>	Not Present	18	X		
Colorado	Not Present	19	X	X	
Connecticut	Not Present	19	X	X	X

<sup>33</sup> Henry J. Kaiser Family Foundation. "Medicaid Today; Preparing for Tomorrow: A Look at State Medicaid Program Spending, Enrollment and Policy Trends." In The Kaiser Commission on Medicaid and the Uninsured, 2012.

<sup>34</sup> Henry J. Kaiser Family Foundation. "Getting into Gear for 2014: Findings from a 50-State Survey of Eligibility, Enrollment, Renewal and Cost-Sharing Policies in Medicaid and Chip, 2012-2013." 2013.

Delaware	Not Present	18 <sup>a</sup>	X	X	
District of Columbia	Not Present	18 <sup>a</sup>	X		X
Florida	Not Present	21	X	X	
Georgia <sup>b</sup>	Not Present	21		X	
Hawaii <sup>b</sup>	Not Present	18 <sup>a</sup>			X
Idaho	Present	18 <sup>a</sup>	X	X	
Illinois	Present	18 <sup>a</sup>	X	X	
Indiana	Not Present	18	X	X	X
Iowa	Not Present	21	X	X	
Kansas	Not Present	18	X	X	
Kentucky <sup>b</sup>	Not Present	18 <sup>a</sup>	X		
Louisiana <sup>b</sup>	Not Present	18	X		
Maine	Not Present	21	X	X	X
Maryland	Not Present	18	X		X
Massachusetts	Not Present	19	X	X	X
Michigan	Not Present	21	X	X	X
Minnesota	Not Present	21	X	X	X
Mississippi	Not Present	18	X	X	
Missouri	Not Present	19	X	X	X
Montana	Not Present	18 <sup>a</sup>	X	X	
Nebraska	Not Present	18	X	X	X
Nevada	Not Present	18	X		X
New Hampshire	Not Present	19	X		X
New Jersey	Not Present	18	X	X	X
New Mexico <sup>b</sup>	Not Present	18	X		
New York	Not Present	21	X	X	X
North Carolina	Not Present	21	X	X	
North Dakota	Not Present	21	X	X	
Ohio	Not Present	21	X	X	X
Oklahoma	Not Present	18	X		X
Oregon	Not Present	19	X	X	
Pennsylvania	Not Present	18	X	X	
Rhode Island	Not Present	19	X		X
South Carolina	Not Present	19	X	X	X
South Dakota	Not Present	21	X		X
Tennessee	Not Present	18	X	X	
Texas <sup>b</sup>	Not Present	18 <sup>a</sup>	X		
Utah	Not Present	18	X	X	
Vermont	Not Present	21		X	X
Virginia	Not Present	21	X	X	

Washington	Not Present	18 <sup>a</sup>	X		X
West Virginia	Not Present	18	X	X	
Wisconsin <sup>b</sup>	Present	19		X	
Wyoming	Not Present	21	X	X	X
<sup>a</sup> States in which no definition of age of adult classification was found, it was assumed to be 18					
<sup>b</sup> States in which 2 separate sources were acquired in one source format					

This study does not account for cost-sharing within CHIP in states where it is administered separately from Medicaid. Some states have combined Medicaid and CHIP programs, while in other states, the programs are separate. CHIP was not examined in states with separate CHIP programs because it differs from Medicaid in qualification requirements for family income.

## Results

The vast majority of states (total of 47, and DC) did not have cost-sharing policies in place for children. This result suggests that states did not keep pace with early estimates of cost-sharing uptake for state Medicaid programs. The three states (Idaho, Illinois, and Wisconsin) that did implement cost-sharing used varying strategies outlined below.

### *Idaho: Flat Fee*

In Idaho, cost-sharing was implemented through copays in November 2011 and January 2012.<sup>35</sup> Copays for services were phased in by service types. Copays for podiatry, optometry, and chiropractic services were implemented on November 1, 2011 and copays for physician, occupational, physical, and speech therapy services were implemented on January 1, 2012.<sup>36</sup> The copay for all service types at both time points of implementation was \$3.65 and they applied to children eligible for Medicaid through the Katie Beckett waiver.<sup>37,38</sup> Through this waiver, children with disabilities can qualify for Medicaid, based on their own income and assets, instead of their family income.<sup>39</sup> After implementation in 2011 and 2012, the Idaho copay amounts did not change.

### *Illinois: Sliding Scale Copay*

Illinois was among the first states to implement cost-sharing after the DRA, on July 1<sup>st</sup>, 2006.<sup>40</sup> Illinois has several Medicaid health insurance plan options that children can qualify for based on their families' income. The first two levels are All Kids Assist and All Kids Share. There are also 8 levels known as the "All Kids Premium Levels"; each level also has an income eligibility requirement, outlined in Table 2.<sup>41,42,43</sup> In 2006, behavioral and medical encounters were classified together under the code T1015.<sup>44</sup> All

<sup>35</sup> Henry J. Kaiser Family Foundation. Medicaid today; Preparing for tomorrow, 2012, 85.

<sup>36</sup> Ibid.

<sup>37</sup> Ibid.

<sup>38</sup> Idaho Department of Health and Welfare. "Administrative Code." 2012, 7-8.

<sup>39</sup> Idaho Department of Health and Welfare. "Katie Beckett Medicaid." 2014.

<sup>40</sup> Illinois Department of Healthcare and Family Services. "Informational Notice: All Kids Health Insurance Program – Cost Sharing." edited by Illinois Department of Healthcare and Family Services, 2006.

<sup>41</sup> Illinois Department of Healthcare and Family Services. All Kids Final Report. 2010.

<sup>42</sup> Ibid.

<sup>43</sup> Illinois Department of Human Services. Illinois Health Insurance Plans. 2011.

<sup>44</sup> Illinois Department of Healthcare and Family Services. Informational notice: All Kids Health Insurance Program. 2006.

Kids Assist, All Kids Share, and All Kids Premium Level 1 had no copay charge for children who had an encounter.<sup>45</sup> Subsequent levels have varying copay costs, also outlined in Table 2.<sup>46</sup> In July 2011, All Kids Premium Levels 3-8 were discontinued and Illinois limited their program eligibility to families with incomes less than 300% FPL.<sup>47</sup>

<b>Year</b>	<b>Eligibility group</b>	<b>Federal Poverty Level</b>	<b>Copay/ Visit</b>	<b>Annual Copay Maximum</b>
2006	All Kids Assist	0-133%	\$0	\$0
	All Kids Share	133%-150%	\$0	\$100 per family for all services
	All Kids Premium Level 1	150%-200%	\$0	\$100 per family for all services
	All Kids Premium Level 2	200%-300	\$10.00	\$500 per child for hospital services
	All Kids Premium Level 3	300%-400%	\$15.00	\$750 per child for hospital services
	All Kids Premium Level 4	400%-500%	\$20.00	\$1,000 per child for hospital services
	All Kids Premium Level 5	500%-600%	\$25.00	\$5,000 per child for hospital services
	All Kids Premium Level 6	600%-700%	\$25.00	\$5,000 per child for hospital services
	All Kids Premium Level 7	700%-800%	\$25.00	\$5,000 per child for hospital services
2012	All Kids Assist	1-133%	\$0	\$0
	All Kids Share	133%-150%	\$3.65	\$100 per family
	All Kids Premium Level 1	150%-200%	\$5.00	\$100 per family
	All Kids Premium Level 2	200%-300%	\$10.00	\$500 per child

The outlined copay structure remained the same in Illinois until an increase in 2012, which occurred under the Save Medicaid Access and Resources Together (SMART) Act.<sup>50</sup> The SMART Act was implemented to reduce Illinois's Medicaid spending and to support program sustainability.<sup>51</sup> After SMART Act implementation, children were no longer included in the groups listed for copay exemptions.<sup>52</sup> In 2012, behavioral and medical encounters were also differentiated, although they have the same copay rates.<sup>53</sup> All Kids Assist had no copay for both behavioral and medical encounters; subsequent levels had increasing copays and annual copay maximums, outlined in Table 2.<sup>54</sup>

In April 2013, the copay amounts for behavioral health encounters were removed for all levels for services administered in an Encounter Rate Clinic, Federally Qualified Health Center, or Rural Health

<sup>45</sup> Illinois Department of Healthcare and Family Services. Copayments for children enrolled in All Kids. 2006.

<sup>46</sup> Ibid.

<sup>47</sup> Illinois Department of Human Services. All Kids Premium Level 3-8 Notice. 2012.

<sup>48</sup> Illinois Department of Healthcare and Family Services. Copayments for children enrolled in All Kids. 2006.

<sup>49</sup> Illinois Department of Healthcare and Family Services. Cost-sharing for Participants. 2012.

<sup>50</sup> Illinois Department of Healthcare and Family Services. Informational notice: Cost-sharing. 2012.

<sup>51</sup> Illinois Government News Network. "Governor Pat Quinn Signs Laws to Save Medicaid: Restructuring Package Stabilizes Medicaid and Preserves Care for the Most Vulnerable." Illinois Government News Network, 2012.

<sup>52</sup> Illinois Department of Healthcare and Family Services. Cost-sharing for Participants. 2012.

<sup>53</sup> Illinois Department of Healthcare and Family Services. Informational notice. 2012.

<sup>54</sup> Ibid.



Clinic.<sup>55,56</sup> In an Informational Notice on this change, the Illinois Department of Healthcare and Family Services noted that children under the age of 19 are exempt from copays.

*Wisconsin: Sliding Scale Copay*

Wisconsin’s Medicaid program, known as BadgerCare Plus, offers Medicaid beneficiaries two plans. The Standard Plan is for families with income at or below 200% FPL.<sup>57</sup> The Benchmark Plan provides more limited services than the Standard Plan, and is for families with income above 200% FPL, and for self-employed parents.<sup>58</sup> BadgerCare Plus has copay exemptions for children under age 1 with a family income of 150% FPL, children ages 1 to 5 with family income up to 185% FPL, and children ages 6 to 18 years with family incomes at or below 100% FPL.<sup>59</sup> Based on this policy, all children on the Benchmark Plan and some children on the Standard Plan incur copays. Wisconsin also has a copay exemption for children served through the Katie Beckett Waiver.<sup>60</sup>

Wisconsin did not change copay rates from 2008 to the time of this study. For occupational, physical, and speech therapy services, the copay amounts for children range from \$0.50-3.00, depending on the service cost(outlined in Table 3).<sup>61</sup> The copay charge is restricted to the first 30 hours, or \$1,500, based on which limit occurs first, for each year.<sup>62</sup>

<b>Table 3</b>	
Wisconsin Co-payment Variation by Service <sup>63</sup>	
<b>Cost of Service</b>	<b>Co-payment</b>
Up to \$10.00	\$0.50
From \$10.01 to \$25.00	\$1.00
From \$25.01 to \$50.00	\$2.00
Over \$50.00	\$3.00

**Discussion**

This is the first research study to systematically document the use of copays for all states after the DRA. This type of research study is challenging because it requires surveying all states to ascertain their Medicaid policy and identifying multiple sources to validate information. However, these efforts are critical to documenting changes in Medicaid policy that impact service access and use. This study provides a state-by-state-comparison, which can be a useful basis for additional research to inform future policy development.

<sup>55</sup> Illinois Department of Healthcare and Family Services. Cost-sharing for Participants. Handbook for Providers. 2013.

<sup>56</sup> Illinois Department of Healthcare and Family Services. Informational Notice: Cost-Sharing Effective April 1, 2013. Edited by Illinois Department of Healthcare and Family Services. 2013.

<sup>57</sup> Wisconsin Department of Health Services. "Badgercare Plus Standard Plan Training." University of Wisconsin-Oshkosh, 2010.

<sup>58</sup> Ibid.

<sup>59</sup> Wisconsin Department of Health Services. Claims Manual-Podiatry. 2013, 235.

<sup>60</sup> Ibid.

<sup>61</sup> Wisconsin Department of Health Services. "Covered Services and Copays-Standard Plan."2013.

<sup>62</sup> Ibid.

<sup>63</sup> Ibid.

Data from this study indicates that the use of copays by states to offset budget issues is lagging far behind initial estimates of implementing copays for previously exempted groups. States that did enact copays applied them to different Medicaid income eligibility groups and services. Illinois instituted copays on a sliding scale for behavioral and medical encounters for certain Medicaid income eligibility groups in 2006. They were increased in 2012 and then eliminated in 2013. Wisconsin also implemented a sliding scale copay system for certain services. Under Wisconsin's Medicaid, families face copays for their children's services depending on their income level and child's age. The cost of the copay in Wisconsin is determined by the cost of the service. From the study, Idaho was the only state that implemented a flat fee copay amount for certain services for children enrolled in Medicaid through the Katie Beckett Waiver, which did not consider age of the child, cost of the service, or different income eligibility groups.

This study focused on identifying states which successfully implemented copay policies for children served through Medicaid. Other states may have attempted to implement copays, but faced opposition, including political issues, that presented a barrier. In 2012, Pennsylvania approved a copay for families served under Medicaid, with incomes 200% above FPL.<sup>64</sup> This copay was meant to improve the sustainability of the Pennsylvania Medicaid program.<sup>65</sup> Advocates, including families of children with disabilities, voiced their opposition and the copay was not implemented.<sup>66</sup>

Children and individuals with disabilities who require behavioral health services may be at particular risk for copays. These individuals have chronic care needs that continue throughout the lifespan. For instance, past research has noted increased healthcare utilization among children with Autism Spectrum Disorder (ASD), compared to children without ASD. A higher percentage of children with ASD had at least 1 inpatient hospitalization, for both psychiatric and non-psychiatric reasons.<sup>67</sup> The study found that 15-18 year olds with ASD had higher overnight hospitalizations and inpatient hospital days than individuals without ASD, a difference that researchers largely attribute to psychiatric hospitalizations.<sup>68</sup> These higher healthcare utilization rates may cause a focus on children with disabilities with behavioral health needs for copay implementation to decrease costs.

Currently, there is limited literature on cost-sharing and copays, especially for children with behavioral health service needs. No recent research on copays has focused on children on Medicaid, the largest health insurance program in the United States which serves 31 million children and 16 million adults in low income families, and 16 million elderly and persons with disabilities, as of 2013.<sup>69</sup> Overall, most of the research on copays has been preliminary and cannot provide the evidence needed to drive policy development and implementation.

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<sup>64</sup> Mackenzie Carpenter, "Pennsylvania Delays Plan Requiring Copay in Care of Autistic Children." *Pittsburgh Post-Gazette*, 2012.

<sup>65</sup> *Ibid.*

<sup>66</sup> *Ibid.*

<sup>67</sup> Lisa A. Croen, Daniel V. Najjar, G. Thomas Ray, Linda Lotspeich, and Pilar Bernal. "A Comparison of Health Care Utilization and Costs of Children with and without Autism Spectrum Disorders in a Large Group-Model Health Plan." [In eng]. *Pediatrics* 118, no. 4 (Oct 2006): e1203-11.

<sup>68</sup> *Ibid.*

<sup>69</sup> Henry J. Kaiser Family Foundation. "Medicaid: A Primer – Key Information on the Nation's Health Coverage Program for Low-Income people." 2013.

Research on cost-sharing is especially relevant as states deal with rising healthcare costs, Affordable Care Act implementation, and costs associated with Medicaid expansion. In 2014, 23 states and D.C. reported over-spending their budget in at least one domain.<sup>70</sup> Out of these states, 14 states had reported over budget spending for Medicaid programs.<sup>71</sup> With Medicaid expansion, states are working to improve quality and control costs. For 2014-2015 fiscal years, there was an increase in how many states were planning to pass or already implemented new cost-sharing policies for their Medicaid programs, compared to previous years.<sup>72</sup> This application of copays without a parallel mechanism to study their impact is concerning as there is a lack of evidence about their effect, especially across different groups. New cost-containment strategies should be investigated before or in tandem with implementation, to avoid additional strain and barriers to care for individuals.

Low-income families and individuals with disabilities served through Medicaid are vulnerable groups and copays could be especially detrimental to their care and quality of life. Copays may also be applied to groups where political feasibility to approval and implementation could be most easily achieved. For example, when copays were almost implemented in Pennsylvania, families of children with disabilities were vocal in their opposition and successfully advocated to have the copay revoked.<sup>73</sup> However, other groups may not have an organized advocacy base and could face a higher risk of having a copay. As a result, states could strategically implement copays for the most vulnerable groups served through Medicaid. Past research has not adequately identified the effects of applying copay policies to these groups. These policies could deter individuals from receiving needed services and result in negative health outcomes.

This study provided a snapshot of copay status for 50 states and D.C. in 2013. Therefore, it cannot account for copays passed and repealed in states in years prior to or since the study. If copays for children who received behavioral health services were found in states' Medicaid policies in 2013 during the course of this study, such as Illinois and Wisconsin, more research was conducted to establish a timeline for copay implementation. This study also cannot account for copays that were implemented after Spring 2013. Copay status was also more difficult to determine in certain states that had combined Medicaid and CHIP because the programs are administered together.

## **Conclusions**

In the United States, Medicaid is a vital system of healthcare coverage for those who are financially vulnerable, elderly, and/or have disabilities. Although the DRA was put in place to try to help states stabilize financially, the implications of cost-sharing in states have yet to be thoroughly tested. The efficacy of cost-sharing policies is currently unknown due to the limited research base. This study represents a first attempt to capture the implementation of copays for a particularly at-risk group. Through this study, case states were identified where future research can focus and provide findings to

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<sup>70</sup> National Conference of State Legislatures. "State Budget Update: Fall 2014." 2014.

<sup>71</sup> Ibid.

<sup>72</sup> Vernon K. Smith, Kathleen Gifford, Eileen Ellis, Robin Rudowitz, and Laura Snyder. "Medicaid in an Era of Health & Delivery System Reform: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2014 and 2015." Henry J. Kaiser Family Foundation, 2014.

<sup>73</sup> Carpenter, 2012.

inform policy and program planning for service delivery. Additional research is needed to fully understand the impact of these copays on the service utilization of beneficiaries and if they produce cost-savings. This research is essential as states work to expand their Medicaid programs and make them sustainable.

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