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Department of Human Services
Division of Medical Assistance Programs
Communications Unit, 3rd Fl.,
DHS Bldg., 500 Summer St. NE-E35
Salem, OR 97301-0177

RE: Comment on Notice of Rulemaking, “Reimbursement method for non-contracted hospitals; definitions, RVU weights, copayments and recoupment from providers,” Ref#: 120jan-n1007

Dear Ms. Nelson:

We are writing to express our concern regarding the above-referenced Notice of Rulemaking, specifically 410-120-1230, which imposes \$3 copayments on Medicaid recipients for non-preferred brand name prescription medications. While we understand the argument of responsibility and client participation in their wellness, many of the people our members serve simply will not get their medications if there is any co-pay requirement.

The National Council for Community Based Healthcare is a national, non-profit association of over 1,300 behavioral health provider organizations. Our members serve over 6 million adults, children and families with mental health and addictions disorders. A great majority of their clients depend on Medicaid for their mental health care.

While we applaud the state’s efforts to make efficient use of resources, restricting access to medications may have serious unintended consequences to both individuals’ health and to overall healthcare costs. Without appropriate access to the most effective and well-tolerated medications, persons with mental illness may experience instability—and at a high personal and fiscal cost: increased risk of hospitalization and emergency room visits, loss of employment, homelessness, and, too frequently, incarceration.

Mental health medications play an important role in recovery for many individuals who live with mental illness. While psychiatric medications may have similar effectiveness overall, they are unique in their mechanisms of action and affect each person and a range of symptoms differently. Since effectiveness and side effects vary significantly, finding the most helpful medications and doses can take multiple trials and should be based on clinical judgment and informed consumer choice. According to the National Institute of Mental Health, individuals have unique responses to psychiatric medications and need more, not fewer, choices.

Studies have demonstrated that copays are not cost-effective and actually have the unintended consequence of discouraging individuals from taking needed medication. In response to the Deficit Reduction Act of 2005 (DRA), which allowed changes to

prescription copays for Medicaid recipients, the Arizona state Medicaid agency, Arizona Health Care Cost Containment System (AHCCCS), produced an analysis challenging the cost effectiveness of copays. (study attached)

The Arizona study focuses primarily on the costs of imposing copays. Although the state could expect to collect over \$5.6 million in copays and other cost-sharing measures after taking out the federal share, AHCCCS predicted that the state would incur almost \$16 million in administrative costs to collect that sum. Amazingly, the cost projection does not include the potential for increased costs based on changes in consumer behavior (e.g., cutting back on medication, failing to fill prescriptions) that could lead to emergency room visits and other expensive services. The AHCCCS study acknowledged as much:

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 [home- and community-based services].

In addition to citing high administrative costs associated with collecting copays, the Arizona study identifies reasons why the cost-sharing components of the DRA yield less of a pay-off than state officials might expect. For instance, states must return to the federal government the federal share of any premiums or copayments imposed on Medicaid members. In addition, the DRA does not allow states to impose copays on most Medicaid beneficiaries, exempting for example Medicaid-eligible individuals with family income at or below 100% FPL. Certain services are also exempted from co-pays, such as preventive services for children under 18 and emergency services (except for non-emergency use of an emergency room). The DRA's cap on total cost-sharing also limits how much states will collect. If states are to save money by increasing copays and other cost-sharing mechanisms, the savings come not from increased revenue but because beneficiaries choose to go without services.

Most of the research on the impact of copays has examined consumer behavior, and these studies confirm the concerns raised, but not quantified by, the Arizona Medicaid agency. Prescription drug copays, in particular, have an adverse effect on consumer use of medication as prescribed. A study in Utah, for example, found that newly imposed copays produced statistically significant decreases in utilization of prescription drugs. Similarly, when Oregon increased copays in a waiver program, one in four adults responding to a survey reported that they did not fill prescriptions because they could not afford the copay.

Evidence shows that uniform copays—e.g., \$3 per prescription, regardless of the medication's purpose—results in across the board reductions in all service usage, not just less important services or products. While this might not harm the average person,

research demonstrates that people at risk of poor health are adversely affected by copays; people at risk of poor health who are also low-income face an even greater chance of being harmed by copays.

Since the landmark Rand Health Insurance Experiment (HIE) study in the 1970s, more research has been done on the impact of copays, especially in the area of prescription drugs. For example, two 2004 studies use survey data on patient “cost-related prescription drug underuse” to show that people who report underusing medications because of cost have poorer health than those who use the medications as prescribed. While a 2006 study found that increases in copays had “little effect on hospital use for the average elderly person,” they resulted in a “significant offsetting rise in hospital admissions” for chronically ill patients.

States may not worry about the consumer impact of prescription copays because many providers ensure that their clients never have to choose between their medication or groceries. Prior to the DRA, Medicaid beneficiaries could not be denied services because of a failure to pay copays. The DRA explicitly allows states to permit providers to deny services for failure to pay, but the DRA also allows providers to reduce or waive the copays on a “case-by-case basis,” regardless of the state’s position. Such is the case in Oregon, where the Notice of Rulemaking states that “DHS will deduct the amount of the copayment from the amount paid to the Provider (*whether or not Provider collects the copayment from the Client*). (emphasis added) Providers are notoriously reluctant to deny needed medication to their clients, knowing that most would decompensate and lose whatever degree of stability and independence they have achieved.

Because providers refuse to withhold medication, the burden of copays often falls on their shoulders. A 2007 National Council survey confirmed this trend. The CEO of one state association observed, “[W]e would have continued to provide services to the clients, so [copays were] a cut to providers.” Other associations confirm that experience. As another CEO described, “[c]overage losses and affordability problems stemming from increased out-of-pocket costs led to increased pressures on providers and the health care safety-net.” Given the historic underfunding of behavioral healthcare services, copays are a cost provider can little afford to absorb.

We urge DHS to reconsider the imposition of copays, especially for this vulnerable population.

Sincerely,

/s/

Tammy Seltzer
Director of State Policy