How Will Proposed Medi-Cal Cost Sharing Affect People Living With HIV in California?

Executive Summary: California Gov. Brown proposed Medicaid co-payments that would impose significant financial barriers on the receipt of medical care by persons living with HIV (PLWH), who require substantial amounts of medical care annually. This analysis quantifies those costs based on actual medical utilization experience of PLWH in California in prior years. PLWH average 10.3 outpatient visits a year. Copayments for these visits as well as for emergency room visits, medications, inpatient and dental care would impose cost-sharing on the average PLWH in California of over $312. PLWH who use the most services could face charges of up to $4760. If hard caps initially proposed by the governor were instituted, one quarter of PLWH would have been charged the full cost of all visits over the first ten each year, thereby facing average cost-sharing of $5020. The one third of PLWH who used more than six prescriptions a month would be charged $2200 on average. Charges this high will likely discourage appropriate utilization, undermine health and lead to higher Medi-Cal costs for inpatient care.

Background: Faced with a massive, projected state budget deficit in fiscal year 2011/12, Gov. Jerry Brown proposed a number of changes to California's Medicaid program, called Medi-Cal. The proposed plan would impose cost sharing on all Medi-Cal enrollees, including persons with both Medi-Cal and Medicare coverage (the dual coverage group) and Medi-Cal HMO enrollees. Patients would be charged the following fees for using Medi-Cal services:

1. $5 co-payment for each physician or FQHC/RHC visit
2. $5 co-payment for each dental office visit
3. $3 and $5 co-payments per prescription with no coverage for over-the-counter drugs
4. $50 co-payments for each emergency room visit (both emergency and non-emergency)
5. $100 co-payment per hospital inpatient day, with a maximum of $200 per stay

The Governor also proposed a "hard cap" of 10 physician office and clinic visits per year, including visits to federally qualified health centers (FQHC) and rural health centers (RHC) and a "hard cap" of 6 prescriptions per month for adult Medi-Cal enrollees. However, in February, the California Senate and Assembly rejected the caps on physician visits and prescriptions, but left Medi-Cal cost-sharing in place.

The 33,000 PLWH in California insured by Medi-Cal have extensive needs for health care. Thus, it is important to know how the proposed changes will affect this vulnerable population.

Methods: In order to forecast how the proposed new fees will impact Medi-Cal beneficiaries with HIV, we first projected expected use of Medi-Cal services in FY11/12 based on data on all Medi-Cal claims for persons living with HIV in California in 2007, the most recent year for which detailed Medi-Cal claims data are available. Although medical costs rise over time, it is reasonable to assume that quantities of services used are relatively constant from year to year. Annual estimates were based on data for Medi-Cal beneficiaries 18 years of age or older, who were eligible for Medi-Cal the entire year, and had no long-term care (LTC) stays during the year. We excluded physician claims that did not occur in an outpatient setting and claims that were exempted from cost sharing (e.g., pregnancy or EPSDT).

Findings: 33,083 persons with HIV

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were covered by Medi-Cal in 2007, of whom 22,266 were over 18, enrolled the entire year and did not have LTC stays. Forty-five percent of the full year enrollees also had Medicare coverage. Total Medi-Cal expenses for PLWH who were enrolled for all 12 months totaled $347 million/year, of which California's share is 50%. Medi-Cal costs averaged $23,394 for PLWH who only had Medi-Cal coverage and $6,692 for PLWH who were covered by both Medi-Cal and Medicare.

The numbers of visits to physicians or clinics paid for by Medi-Cal averaged 13.9 visits for the 74% of enrollees who had at least one physician visit during the year (see Table 1).

Table 1: Use of Medi-Cal Services by Full-Year Eligibles and Predicted Cost Sharing

		Number of Services		Predicted Cost Sharing		
Service Type	**Number of Users**	**Users Mean**	**All Mean**	**Users Mean**	**Users Max**	**All Mean**
Physician Visits	16,447	13.9	10.3	$70	$900	$51
Emergency Room Visits	5,186	3.3	0.76	$163	$1250	$38
Medications (#)	17,780	44.1	35.2	$220	$1350	$176
Hospital Days	2,382	2.2	0.23	$397	$2000	$43
Dental Visits	8,000	2.5	0.89	$12	$50	$4
Total	20,608			$337	$4760	$312

Considering the entire population of PLWH, whether or not they visited a physician, the average number of visits is 10.3. In addition to visiting physician offices and clinics, almost a quarter of eligibles also sought care in an Emergency Department, averaging 3.3 Emergency visits annually. Medications are central to maintaining the health of PLWH and medication use was substantial, averaging 35 drugs per year. Among the 11% of the Medi-Cal enrollees who were hospitalized, the average number of stays was 2.2, and average number of days hospitalized during the year was 12.8. Thirty-six percent of Medi-Cal enrollees visited the dentist, averaging 2.5 visits.

Applying the proposed cost-sharing amounts, we calculate that, on average, PLWH covered by Medi-Cal would be required to pay $312 a year for medical and dental care. More than half of this charge is medication expense.

Those who filled any prescriptions averaged 44 medications per year, which will result in projected costs of over $220. PLWH with high medication use could be charged as much as $1350. A person who used as much medical care as the highest user in 2007 would have been charged $4760. Average expenditures for those in the top 25% would exceed $900.

If caps on annual numbers of visits and monthly prescriptions were instituted as originally proposed by the Governor, Medi-Cal beneficiaries would face even higher costs. The mean numbers of visits calculated above combine the experience of some who had fewer and some who had more visits. More than one-quarter of the enrollees (27%) had more than 10 physician or clinic visits. In creating these estimates, we used a conservative definition of "visit", which excluded encounters for laboratory or x-rays that occurred independent of a physician or clinic visit. Since Medi-Cal would no longer pay for the visits over the cap, the 5927 beneficiaries who exceeded the cap during the year would have been charged an average of $4970 for these visits in addition to the $50 cost-sharing for their first 10 visits.

Patient costs for medications exceeding the proposed cap of six per month would also have imposed very substantial expenses on Medi-Cal enrollees. Fully one-third of enrollees had at least one month over the year in which they used more than six prescriptions. The average numbers of drugs used by persons who exceeded the cap in at least one month was 86. They would have been charged $274 as copayments for drugs that were under the cap and $1929 for drugs that Medi-Cal would

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no longer cover because they were in excess of the monthly cap. Thus, the one-third of Medi-Cal beneficiaries (7412 people) who exceeded the cap in at least one month would have been expected to pay an average of $2200.

Discussion: Proposed co-payments for Medi-Cal services present a significant financial barrier for the average PLWH because only persons with low levels of income qualify for Medi-Cal coverage. The challenge will be even more severe for PLWH who require large amounts of medical care over the year. For example, for the person with the most use, projected fees amount to about 60% of the income established by the government as the "federal poverty level."

If the "hard caps" on physician visits and on prescriptions were enacted, costs imposed on patients would balloon to an average of $5019 for a patient who exceeded 10 visits a year and an additional $2200 for the average person who had at least one month in which the number of prescriptions exceeded 6.

If these significant fees discourage appropriate use of medical care, state costs may rise rather than fall. Research shows that increasing copayments discourages medication adherence among chronic disease patients (Chernew, 2008; Goldman, 2007; Maciejewski, 2010). Antiretroviral medication, while expensive, lowers annual costs because lower inpatient costs more than offset the medication expense (Bozzette, 2001). PLWH on appropriate ARV regimens are less likely to transmit HIV to others, thereby reducing the numbers of new HIV infections. Thus, the proposed co-payments not only impose heavy costs on persons with low income and serious illness and undermine public health efforts to reduce HIV transmission, but they may also ultimately raise California's Medi-Cal spending on HIV disease. We conclude that Medi-Cal cost sharing requirements for PLWH are harmful to individual health, harmful to public health and harmful to public expenditures.

References

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