

Deficit Reduction Act Important Facts for State Policymakers

February 21, 2008

Medicaid Cost-Sharing and Premiums

States have new options to impose cost-sharing charges and premiums on certain Medicaid recipients through new flexibilities introduced in the Deficit Reduction Act of 2005 and clarified in the Tax Relief and Health Care Act of 2006.

Background

In order to obtain private health insurance, individuals are generally required to pay monthly premiums and/or enrollment fees. The premium and cost sharing provision under the Deficit Reduction Act of 2005 (DRA) gives States new options to align their Medicaid programs more closely to private insurance plans, such as requiring recipients to pay monthly premiums, deductibles, coinsurance or co-payments.

Prior to passage of the DRA, Medicaid regulations allowed States to impose nominal cost-sharing on certain Medicaid recipients. Premium charges were generally prohibited.

Under the DRA, States no longer need a waiver from the Secretary of the Department of Health and Human Services to impose cost-sharing charges and premiums on certain Medicaid recipients. States are now allowed to charge co-payments greater than the nominal amount to some Medicaid recipients and premiums to recipients with family incomes above 150% of the federal poverty level (FPL). In addition, States can require payment of any allowable cost-sharing at the point of service before providing care or services for individuals with income above 100% of the Federal poverty level.

Options for Premiums and Cost-sharing

As specified in a State Plan Amendment, States can impose premiums and cost-sharing for certain groups of individuals not exempt under the law on certain specific types of services.

- Groups exempt from paying premiums and cost sharing include, but are not limited to, children, pregnant women and individuals in hospice.
- Services that are excluded from cost sharing charges include, but are not limited to, emergency, family planning and preventive services.
- A complete list of populations and services exempt from premiums and cost sharing can be found in the State Medicaid Directors letters addressing sections 6041 through 6043 of the DRA (links below).

The amount a State may charge for premiums and/or cost sharing is based on an individual's family income. The poorest recipients cannot be required to pay any premiums or cost sharing that exceed a nominal amount. For all recipients, the total amount of premiums and cost-sharing charges cannot exceed five percent of a family's income. States may use a family's gross income or other alternative way of counting income for purposes of applying premiums and cost-sharing. Premium amounts are determined on a sliding scale and cost sharing charges can range from nominal to up to 10% or 20% of the cost of the service depending on the individual's family income.

Prescription Drugs

The DRA allows States to apply separate cost-sharing rules to prescription drugs And may vary cost-sharing amounts based on whether the drug is considered a "preferred" or "non-preferred" drug and on

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the income level of the recipient. The State may only impose nominal cost-sharing for non-preferred drugs on individuals who are otherwise exempt from cost-sharing.

Non-Emergency Use of the Emergency Department

Under the DRA, States may permit hospitals to impose cost-sharing for use of a hospital emergency department for non-emergency care. Co-payments for the use of the emergency room for non-emergency services can be imposed only if the recipient has access to an alternative provider. The hospital must provide the recipient with the name of the alternative provider along with a referral to coordinate scheduling of an appointment. The amount the State may charge an individual depends on the individual's family income.

Enforcement

The DRA allows States to permit providers to withhold care or services to individuals who do not meet their cost-sharing obligations, except for individuals at or below 100% of the FPL. States have the option to terminate coverage if a recipient fails to make premium payments for longer than 60 days. States may waive this penalty in cases where it would impose "undue hardship."

If your State is considering health reform, new demonstrations, or other innovations in Medicaid, what should you think about?

Populations and Services

- To which populations will the State charge premiums?
- To which populations will State impose cost-sharing?
- For which services will the State charge premiums and/or cost-sharing?

State Action

- What State legislative changes to the Medicaid program will be necessary to implement any program changes in cost-sharing?
- The State Plan must describe new cost-sharing requirements.
- The State Plan must describe how the State will ensure that the total premium and/or cost-sharing amounts do not exceed 5% of a family's income.
- The State Plan must indicate new cost-sharing enforcement provisions.

Important Links

For more information on how to proceed with cost-sharing, please see the following resources:

State Medicaid Directors Letter on DRA § 6041 through § 6043

<http://www.cms.hhs.gov/smdl/downloads/SMD061606.pdf>

Premiums and Cost-sharing State Plan Amendment Preprint template

<http://www.cms.hhs.gov/smdl/downloads/6041Preprint.pdf>

<http://www.cms.hhs.gov/smdl/downloads/6042Preprint.pdf>

Approved State Plan Amendments for States with New Premium and Cost-sharing Provisions

http://www.cms.hhs.gov/DeficitReductionAct/03_SPA.asp#TopOfPage