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COST-SHARING AND PREMIUMS IN MEDICAID

What Rules Apply?

By Judith Solomon

A substantial body of research shows that higher co-payments are likely to cause low-income people to decrease their use of necessary health care services. Low-income people with chronic health conditions are the most vulnerable to harm from cost-sharing, as they use the most health care services. Research also shows that premiums can make it difficult for low-income people to enroll in Medicaid and keep their coverage. When low-income people are unable to pay premiums or cost-sharing charges, they may end up using more expensive forms of care such as emergency room or inpatient hospital care.¹

The Deficit Reduction Act of 2005 (DRA) added a new provision to the Medicaid statute that gives states the option to impose cost-sharing charges and premiums on Medicaid beneficiaries in certain circumstances. The new provision did not repeal an existing section of the Medicaid law that also provides authority to states to impose cost-sharing.²

Aspects of the Medicaid rules on cost-sharing were then clarified in the Tax Relief and Health Care Act of 2006 (TRHCA), which was signed into law on December 20, 2006. The result is a confusing array of rules that provide for different treatment based on a beneficiary's income, Medicaid coverage category, and the type of services being provided. This paper attempts to unravel these rules by summarizing how all the rules on cost-sharing and premiums apply to children and adults.³ Because of the potential harm cost-sharing and premiums can cause for low-income people, it is essential that these rules, which include a number of exemptions, limitations, and protections, be understood and followed by states.⁴

¹ The research on cost-sharing and premiums is summarized in Leighton Ku and Victoria Wachino, "The Effect of Increased Cost-Sharing in Medicaid: A Summary of Research Findings," Center on Budget and Policy Priorities, July 7, 2005.

² The DRA provision is section 1916A of the Social Security Act, while the prior provision is at section 1916.

³ As used in this paper and in the DRA, premiums are payments that are required to enroll and to maintain coverage while cost-sharing refers to co-payments, co-insurance, deductibles or similar charges for a particular service. Section 1916A(a)(3).

⁴ So far only one state, Kentucky, has used the authority allowed under the DRA in adopting new rules for cost-sharing. Elicia J. Herz, "Medicaid Cost-Sharing under the Deficit Reduction Act of 2005 (DRA)," Congressional Research Service, January 25, 2007.

Cost-sharing and Premiums for Children

Most children under the age of 18 are exempt from premiums and from cost-sharing on most services. However, new rules allow states to impose co-payments for prescription drugs and use of the emergency room for non-emergency care on all children in certain circumstances. The DRA also allows states to impose premiums and cost-sharing charges on some children in families with income above the poverty line. The total amount of premiums and cost-sharing charges cannot exceed a cap of five percent of family income, which is calculated on a monthly or quarterly basis at the option of the state.

- The exemption from cost-sharing and premiums applies to children under 18 in “mandatory” Medicaid coverage groups. These groups include children under the age of six in families with income below 133 percent of the poverty line and children from age 6 to 18 in families with income below 100 percent of the poverty line. While children under 18 at these income levels are always exempt, states have the option of exempting older youth.⁵
- Children in state foster care and adoption assistance programs are exempt from cost-sharing regardless of their age.
- Children with disabilities who are eligible for Medicaid under the Family Opportunity Act are exempt from cost-sharing.⁶

Special rules for prescription drugs and the use of the emergency room for non-emergency services allow nominal cost-sharing charges to be imposed on the children who are otherwise exempt from cost-sharing. (The DRA requires that the Secretary increase the standards for nominal cost-sharing each year beginning in 2006 by the annual percentage increase in the medical care component of the Consumer Price Index. The medical CPI rises about twice as quickly as the overall CPI.⁷)

- The DRA allow states to vary cost-sharing charges based on whether a drug is preferred or non-preferred.⁸ Children who are otherwise exempt from cost-sharing can be charged nominal co-payments for non-preferred drugs.
- Children who are otherwise exempt from cost-sharing can be charged nominal co-payments for use of the emergency room for non-emergency services. Co-payments for the use of the emergency room for non-emergency services can be imposed only if the beneficiary has

⁵ Section 1916 explicitly allows states to exempt “individuals under 21, 20, or 19 years of age,” and section 1916A allows states to vary cost-sharing among groups of individuals.

⁶The Family Opportunity Act is a new option in the DRA that allows states to provide Medicaid eligibility to children with special health care needs whose families have income above the usual Medicaid eligibility level in the state. States have the option of charging premiums to families of children eligible under the Family Opportunity Act with family income above 200 percent of the poverty line.

⁷ The Secretary of Health and Human Services continues to have discretion to define nominal co-payments. Current regulations define a range of nominal co-payments from fifty cents to \$3 depending on the Medicaid payment for the service.

⁸ As amended by the TRHCA, the statute defines preferred drugs as the most cost-effective drugs within a class.

access to an alternative provider such as a physician’s office or community health center. The hospital must provide the beneficiary with the name of the alternative provider along with a referral to coordinate scheduling of an appointment.⁹

When applying these special rules to children in families with income below the poverty line, the TRHCA makes it clear that providers cannot turn these beneficiaries away when they cannot afford to pay a cost-sharing charge.

Certain services are also exempt from cost-sharing regardless of a child’s income. States cannot impose cost-sharing on preventive services such as check-ups and immunizations that are provided

Cost-sharing and Premiums for Children			
	Mandatory (under 6 with income < 133% of the poverty line; 6-17 <100%)	Other children – Income to 150 percent of the poverty line	Income > 150 % of the poverty line
Most Services	Not allowed	Up to 10 percent of the cost of the service	Up to 20 percent of the cost of the service
Prescription drugs	Nominal for non-preferred; 0 for preferred	Nominal for non-preferred	Up to 20 percent of the cost for non-preferred
Non-emergency use of the ER	Nominal	Two times nominal	Any amount
Enforceability of co-payments	No	Yes	Yes
Premiums	Not allowed	Not allowed	Allowed

to children under 18, emergency services, and family planning services and supplies.

The DRA allows cost-sharing and premiums for some children in families with income above the poverty line.

- Children who are not exempt and whose families have income between 100 and 150 percent of the poverty line cannot be charged premiums, but can be charged up to 10 percent of the cost of the service for services other than prescription drugs and non-emergency use of the emergency room. They can be charged nominal co-payments for non-preferred prescription drugs and up to twice the nominal amount for use of the emergency room for non-emergency services.

⁹ Emergency services remain exempt from cost-sharing, and the new provision makes it clear that it does not modify a hospital’s obligation to provide screening and stabilizing treatment of an emergency medical condition under the Emergency Medical Treatment and Labor Act (EMTALA) at section 1867 of the Social Security Act.

- Children whose families have income above 150 percent of the poverty line can be charged premiums and cost-sharing up to 20 percent of the cost of the service for non-preferred prescription drugs¹⁰ and other services. There is no limit on cost-sharing for use of the emergency room for non-emergency services.

Cost-sharing and Premiums for Adults

Like children, cost-sharing and premium rules for adults depend on their income. Many adults are exempt from premiums and most cost-sharing, and limits on cost-sharing vary based on income for those who are not exempt.

- Beneficiaries who are in a hospital, nursing home or other any other medical institution that requires them to contribute all but a nominal amount of their income for their care are exempt from cost-sharing as are patients who are receiving hospice care. Women who are eligible under the Breast and Cervical Cancer Screening and Treatment program are also exempt from cost-sharing.
- Pregnant women are exempt from cost-sharing for services relating to their pregnancy or for any other medical condition which may complicate their pregnancy.
- States can impose nominal cost-sharing charges for non-preferred drugs and non-emergency use of the emergency room on beneficiaries who are otherwise exempt from cost-sharing.
- States cannot impose cost-sharing on emergency services, and family planning services and supplies.

Cost-sharing and Premiums for Non-Exempt Adults			
	Income < 100 percent of the poverty line	Income 100 to 150 percent of the poverty line	Income > 150 percent of the poverty line
Most services	Nominal cost-sharing	Up to 10 percent of the cost of the service	Up to 20 percent of the cost of the service
Prescription drugs	Nominal cost-sharing	Nominal cost-sharing	Up to 20 percent of the cost of the drug for non-preferred
Non-emergency use of the emergency room	Nominal cost-sharing	Two times nominal	No limit
Enforceability of co-payments	No	Yes	Yes
Premiums	Not allowed	Not allowed	Allowed

¹⁰ The maximum cost-sharing charges are set in relation to non-preferred drugs with the expectation that the state would waive or reduce cost-sharing for preferred drugs although this is not expressly required in the law. If the state does have different levels of cost-sharing, it must provide the non-preferred drug at the lower cost-sharing level when a physician

- Health care providers cannot refuse services to beneficiaries with income below the poverty line who cannot afford to pay a cost-sharing charge.

Cost-sharing and Premiums Cannot Exceed Five Percent of a Family's Income

States that want to impose cost-sharing and premiums on Medicaid beneficiaries must make sure that the total amount of premiums and cost-sharing does not exceed a cap of five percent of family income. States can choose whether to calculate the cap based on charges imposed each month or each quarter. The TRHCA makes it clear that the cap applies to all Medicaid beneficiaries, including beneficiaries with income below the poverty line.

In calculating the cap, states must take into account premiums and cost-sharing imposed on all members of a family enrolled in Medicaid. States can decide how to calculate family income for the purpose of the cap. For example, they can use the same deductions or disregards of income that they use in determining a family's eligibility for benefits or they can use the family's gross income without any deductions.

Conclusion

While the DRA gives states new flexibility to impose cost-sharing on Medicaid beneficiaries, it also provides a number of important protections for beneficiaries. As amended by the TRHCA, the DRA prohibits states from requiring that beneficiaries pay more than 5 percent of their income toward the cost of care. Moreover, if a state decides to allow providers to turn beneficiaries away when they cannot afford to pay a cost-sharing charge, the state must ensure that providers do not apply this rule to beneficiaries with income below the poverty line. States that want to impose cost-sharing on Medicaid beneficiaries will have to develop mechanisms to follow these rules and all the other rules that now govern cost-sharing in Medicaid.

determines that the preferred drug would not be as effective or would have adverse side effects for the beneficiary.