kaiser commission on medicaid and the uninsured

THE HENRY J. KAISER FAMILY FOUNDATION

POLICY BRIEF

February 2013

Premiums and Cost-Sharing in Medicaid

Executive Summary

Medicaid, the nation's public health insurance program for low-income people, now covers over 60 million Americans, including many working families, low-income elderly, and individuals with disabilities. Medicaid beneficiaries tend to be poorer and sicker than those enrolled in private insurance. Given these characteristics, federal law limits the extent to which states can charge premiums and cost-sharing, particularly for pregnant women, children and adults but allows flexibility for individuals with incomes above 100% of the federal poverty level (FPL).

Over the years, Medicaid premiums and cost sharing have been used to limit state program costs, encourage more personal responsibility over health care choices and to better align public coverage with private coverage where states have expanded coverage. However, a large body of research shows that premiums and cost-sharing can act as barriers in obtaining, maintaining and accessing health coverage and health care services, particularly for individuals with low incomes and significant health care needs. These barriers can result in increases in uninsured, unmet health care needs and adverse health outcomes. State savings from cost-sharing and premiums may accrue due to declines in coverage and utilization more so than from increases in revenues. These changes can strain the health care safety-net and effectively reduce reimbursement for providers serving the Medicaid program. A more detailed description of the research can be found here.

This brief reviews three key questions:

1. **What are the current rules about cost-sharing?**

States have flexibility to impose cost-sharing on certain children and adults with incomes between 100% and 150% FPL and to impose premiums and higher cost-sharing for beneficiaries with incomes above 150% FPL. Federal law limits the amounts states can charge Medicaid beneficiaries for premiums and cost-sharing, with stronger limits for pregnant women, children, and adults with incomes below 100% FPL. Cost-sharing for individuals under 100% FPL is generally limited to "nominal" amounts established in federal regulations. Cost-sharing for emergency services and family planning services and supplies is prohibited for all populations.

2. **What is the status of premiums and cost-sharing in Medicaid today?**

As of FY 2013, 40 states charged premiums for at least one beneficiary group in Medicaid, most commonly for working individuals with disabilities and adults eligible for Medicaid under Section 1115 waivers. Maintenance of Eligibility (MOE) requirements in the ACA prohibit states from imposing new premiums and also from increasing existing premiums, except for inflation adjustments. However, the MOE provisions do not prohibit states from increasing or imposing new cost-sharing requirements in Medicaid. A total of 45 states (including DC) currently require copayments. In recent years, some states implemented increased or new copayments, most often for prescription drugs, non-emergency use of the ED, and physician or clinic services.

3. **What are the new proposed rules for premiums and cost-sharing?**

On January 14, 2013 HHS released a Notice of Proposed Rulemaking (NPRM), or proposed rule, that includes proposed changes to streamline Medicaid premium and cost-sharing regulations and to give states additional flexibility. Some specific proposed changes include increases in the nominal cost-sharing amounts and authority to charge differential cost-sharing for preferred and non-preferred drugs and nonemergency use of the emergency department (ED). The NPRM requests comment and input on a number of issues, including potential changes in the maximum cost-sharing for institutional services, the proposed definition of non-emergent care in the ED, and separate nominal cost-sharing amounts for community-based long-term services.

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1. What are the current rules around Medicaid premiums and cost-sharing?

Federal law limits the amounts that states can charge poor Medicaid beneficiaries for premiums and cost-sharing. States have flexibility to impose cost-sharing on certain children and adults with incomes between 100% and 150% FPL and to impose premiums and higher cost-sharing for beneficiaries with incomes above 150% FPL. Federal law limits the amounts states can charge Medicaid beneficiaries for premiums and cost-sharing, with stronger limits for pregnant women, children, and adults with incomes below 100% FPL. Cost-sharing for individuals under 100% FPL is generally limited to "nominal" amounts established in federal regulations. Cost-sharing for emergency services and family planning services and supplies is prohibited for all populations. States must ensure that the total cost of Medicaid premiums and cost-sharing for a family does not exceed 5% of the family's income on a quarterly or monthly basis. (Table 1)

The Deficit Reduction Act of 2005 (DRA) provided states with new flexibility to implement cost-sharing in their Medicaid programs. Beyond existing authority to charge higher cost-sharing for those with incomes over 150% FPL, states were given additional authority to vary their cost-sharing requirements by eligibility group and to make cost-sharing enforceable (i.e., allow a provider to deny services if the cost-sharing is not paid).

TABLE 1. CURRENT RULES FOR MEDICAID PREMIUM AND COST-SHARING STANDARDS, JANUARY 2013

	≤100% FPL	101% - 150% FPL	>150% FPL
Premiums	Not allowed	Not allowed	Allowed
Cost-Sharing (may include deductibles, copayments, or coinsurance)			
Most Services	Nominal*	Up to 10% of the cost of the service or a nominal charge	Up to 20% of the cost of the service or a nominal charge
Institutional Services	Per admission, 50% of the cost the agency pays for the first day of care	Per admission, 50% of the cost the agency pays for the first day of care or 10% of the total cost the agency pays for the stay	Per admission, 50% of the cost the agency pays for the first day of care or 20% of the total cost the agency pays for the stay
Prescription Drugs	Preferred / Non-Preferred – Nominal	Preferred / Non-Preferred – Nominal	Preferred - Nominal Non-Preferred - Up to 20% of the cost of the drug
Non-Emergency Use of ED**	Nominal	Up to twice the nominal amount	No limit (5% family cap applies)
Preventive Services	Nominal	Up to 10% of the cost of the service or a nominal charge	Up to 20% of the cost of the service or a nominal charge
Aggregate Cap	5% of family income (Cap on Total Premium and Cost Sharing Charges for all family members)		
Cost-Sharing is Enforceable	No	Yes	Yes
Populations Exempt from Premiums and Most Cost-Sharing	Children under age 18 and most pregnant women with incomes <150% FPL, terminally ill individuals, individuals residing in an institution, American Indians who either are eligible to receive or have received an item or service furnished by an Indian health care provider or through referral to contract health services and individuals covered under the Breast and Cervical Cancer Treatment Program		
Exempt Services	Emergency services, family planning services and supplies, preventive services for children under age 18 and tobacco cessation services for pregnant women are exempt from cost sharing.		

*"Maximum Nominal Out of Pocket Costs" are $2.65 deductible, $3.90 copayment, or 5% coinsurance. The maximum copayment that Medicaid may charge is based on what the state pays for that service.

**Cost-sharing is only allowed if a beneficiary has been provided with a referral to an alternative provider.

2. What is the status of premiums and cost-sharing in Medicaid today?

As of FY 2013, forty states reported that they have at least one group subject to a premium. The most common premium programs (in 36 states) are used to expand Medicaid coverage by allowing individuals with disabilities receiving Medicaid to remain on the program by paying premiums as earnings or assets increase which would otherwise make them ineligible for Medicaid. Generally, these programs are called Ticket to Work, Medicaid for Employed Persons with Disabilities, or Medicaid Buy-In Programs. Four states impose premiums under the Family Opportunity Act (FOA), which allowed families with uninsured children with disabilities who do not qualify for Medicaid to "buy in" to Medicaid for their children by paying a premium and two states also enable higher-income families to pay a premium for Medicaid under their Medically Fragile Persons with Disabilities (MFPD) waivers.[i] Premiums and enrollment fees are charged to adults covered in 19 of 34 Medicaid waivers.[ii] These premiums may apply to parents who could otherwise be covered without any premiums under a state plan option as well as childless adults who would not have been eligible for Medicaid coverage without a waiver prior to the ACA.

Because of the Maintenance of Effort (MOE) provisions, premiums have been stable. The MOE provisions in the ACA require states to maintain eligibility standards, methodologies, and procedures in their programs that are no more restrictive than those in effect when the ACA was enacted until Exchanges are certified (expected in 2014) for adults and 2019 for children. Under the MOE requirement, states cannot implement or increase premiums, other than inflationary increases. In 2012, Wisconsin increased premiums for adults above 133% FPL under a limited budget deficit exception to the MOE requirements. The MOE requirements do not prohibit states from increasing or imposing new cost-sharing requirements in Medicaid.

Copayment requirements are used to varying degrees by most state Medicaid programs. A total of 45 states (including DC) have copayment requirements, including five states (DE, LA, MD, NH and WV) that impose copayments only on drugs. Only six states (CT, HI, NV, NJ, RI and TX) report no copayment requirements at all. A number of states proposed or implemented increases or new copayment requirements in recent years. Increased or new copayment requirements were most common for pharmacy, non-emergency use of the emergency room, physicians and clinics.[iii]

In FY 2012, CMS denied some waiver requests to implement cost-sharing that CMS determined were not consistent with federal rules. In August 2011, the U.S. Ninth Circuit Court of Appeals ruled in *Newton-Nations v. Betlach* that the Secretary's review of proposed copay changes under Arizona's prior 1115 Waiver did not satisfy the waiver test to determine whether the proposal was likely to further the goals of the Medicaid program and that the review did not adequately "consider the impact on the" persons that Medicaid "was enacted to protect."[iv] The Court questioned whether the waiver request could "demonstrate something different than the last 35 years' worth of health policy research."[v,vi] In February 2013 a federal district court held that the Secretary's approval of Arizona's current 1115 demonstration, including copays for the expansion population, was arbitrary and capricious and ordered the Secretary to re-evaluate her decision in light of expert evidence alleging that the demonstration does not test any new aspects of copayments and that copayments are not an effective cost saving measure because they lead beneficiaries to forgo preventive care and medications leading to higher incidences of serious medical conditions requiring more expensive care."

Few states currently use the broader cost-sharing flexibility included in the DRA. Only one state (PA) reported using DRA authority to impose greater than nominal copayment requirements or to vary copayment obligations by eligibility group. Pennsylvania planned to implement DRA alternative cost-sharing (20 percent coinsurance on non-exempt services) for certain children with disabilities under age 18, who have household incomes above 200 percent of poverty.[vii] Seven states (AZ, ID, KY, MS, NH, UT, and WI) reported that copayment requirements were enforceable in FY 2012 for at least one eligibility group as allowed by the DRA. Another three states (CA, IL and ME) reported plans to take advantage of the DRA authority to make copayments enforceable in FY 2013.

3. What are the new proposed rules around premiums and cost-sharing?

On January 14, 2013 HHS released a Notice of Proposed Rulemaking (NPRM), or proposed rule, that includes proposed changes to streamline Medicaid premium and cost-sharing regulations and to give states additional flexibility. Some specific proposed changes include increases in the nominal cost-sharing amounts and authority to charge differential cost-sharing for preferred and non-preferred drugs and nonemergency use of the emergency department (ED). The NPRM requests comment and input on a number of issues, including potential change in the maximum cost-sharing for institutional services, the proposed definition of non-emergent care in the ED, and separate nominal cost-sharing amounts for community-based long-term services. These changes are highlighted below.

Cost-Sharing for Outpatient Services and Inpatient Stay: For outpatient services, the NPRM increases the nominal amounts. For inpatient services, the NPRM seeks comment on alternative cost-sharing policies.

Current Rules and Proposed Changes for Outpatient and Inpatient Cost-Sharing			
	≤100% FPL	**>100 - 150%FPL**	**>150% Poverty**
Current Rules: Outpatient Services	Nominal ($3.90 Maximum for services >$50)	Up to 10% of the cost of the service or a nominal charge	Up to 20% of the cost of the service or a nominal charge
NPRM: Outpatient Services	Nominal (up to $4 Increased by CPI-U beginning in October 2015). Maximum is no longer tied to what the state pays for the service but cannot exceed the amount the agency pays for the service.	Up to 10% of cost the agency pays	Up to 20% of cost the agency pays
Current Rules: Institutional Services	Per admission up to 50% of the cost the agency pays for the first day of care	Per admission up to 50% of the cost the agency pays for the first day of care or 10% of the total cost the agency pays for the stay	Per admission up to 50% of the cost the agency pays for the first day of care or 20% of the total cost the agency pays for the stay
NPRM: Institutional Services	The NPRM seeks comments on alternatives to current policy for inpatient cost-sharing because inpatient services are high cost for low-income populations and services can generally not be avoided or prevented. Options include the $4 maximum applied to outpatient services, $50 or $100.		

Cost-Sharing for Prescription Drugs: The NPRM would allow differential cost-sharing for preferred and non-preferred drugs.

	≤150% FPL	**>150% Poverty**
Current Rules: Prescription Drugs	Preferred / Non-Preferred - Nominal	Preferred: Nominal Non-preferred: 20% of payment
NPRM for Prescription Drugs*	Preferred – Nominal (up to $4) Non-preferred – Nominal (up to $8)	Preferred – Nominal (up to $4) Non-preferred - 20% of drug cost
	The NPRM maintains existing policy under which all drugs are considered preferred drugs if so identified or if the agency does not differentiate between preferred and non-preferred drugs. If an individual's doctor determines that the preferred drug would be less effective or have adverse effects, cost-sharing for the non-preferred drug is limited to the preferred drug cost-sharing amount. Cost-sharing for non-preferred drugs would be subject to maximum limits for preferred drugs for individuals who are otherwise exempt from cost-sharing.	

*Beginning 10/2015, states can increase Medicaid cost-sharing amounts by the medical CPI-U.

Cost-Sharing for Non-Emergency Use of the ED: The NPRM would increase allowable cost-sharing amounts for non-emergency use of the ED while strengthening the requirement that states cannot impose this cost-sharing without first screening and referring beneficiaries to an appropriate alternative provider.

Current Rules and Proposed Changes for Non-Emergency Use of the ED			
	≤100% FPL	**>100 - 150%FPL**	**>150% Poverty**
Current Rules: Non-Emergent Care in ED	Nominal	Twice Nominal	No limit (subject to 5% cap)
NPRM: Non-Emergent Care in ED*	$8	$8	No limit (subject to the 5% cap)
	Strengthens current regulatory language by establishing that states cannot impose cost-sharing for non-emergency use of the ED unless a beneficiary has been provided with an appropriate referral to an alternative provider. A hospital could not impose cost-sharing for non-emergency use of the ED until it has conducted an appropriate medical screening to determine that the individual does not need emergency services; provided the individual with the name and location of an available and accessible alternative provider of non-emergency services; ensured that the alternative provider can serve the individual in a timely manner with less cost-sharing, or no cost-sharing if the individual is otherwise exempt from cost-sharing; and coordinated scheduling and provided a referral for treatment by this provider. The Secretary of HHS will collect processes by which states define services as non-emergent and share effective methods with other states.		

*Beginning 10/2015, cost-sharing amounts can increase by the medical CPI-U. For individuals otherwise exempt from cost sharing, cost-sharing for non-emergency use of ED may not exceed the maximum for those with income at or below 150% FPL.

Other Key Changes in the NPRM

Community-Based Long-Term Services: The NPRM considers establishing separate cost-sharing amounts for community-based long-term services delivered over an extended period of time pursuant to a coordinated plan of care. Comments are requested regarding how to define long-term services and supports and the unit of service for which separate cost-sharing could be charged.

Premiums: The NPRM clarifies that premiums are allowed for pregnant women and infants in families with incomes exceeding 150% FPL, but not equal to or below 150% FPL. The NPRM provides states with flexibility to determine an income-related scale for premiums for medically needy populations up to a maximum of $20 (instead of $19), and removes the requirement that premiums be based on gross income since, beginning in 2014, income will be based on Modified Adjusted Gross Income (MAGI).

Tracking Cost-Sharing Expenses: Under the NPRM, states would be required to have an automated process for tracking premiums and cost-sharing if their policies place beneficiaries at risk of reaching the cost-sharing cap. The NPRM seeks comment about efficient alternatives to an automated system for tracking.

Exempt Populations / Services: The NPRM proposes to broaden the exemption of Indians from cost-sharing so that Indians who have ever received an item or service furnished by the Indian Health Service or Indian Health Facilities[viii] or through a contract health services referral are exempt from all cost-sharing. The NPRM considers and seeks comment about requiring that states apply a periodic renewal process for exempting Indians from cost-sharing, limiting exemptions to a certain period of time following utilization of services at an Indian Health Facility or under a contract health services referral. The proposed rule also revises the cost-sharing exemption for pregnancy-related services to include all services provided to pregnant women.

Public Notice Requirements: The NPRM clarifies that prior to submitting a state plan amendment to establish or significantly modify existing premiums and cost-sharing, or change the consequences of non-payment of cost-sharing, the agency must provide the public with advance notice and the opportunity to comment.

Looking Ahead

Under current law states have considerable flexibility to charge premiums and cost-sharing in their Medicaid programs. To date, there is a lot of variation in the extent to which states use this authority and few states currently use broader cost-sharing flexibility included in the DRA. Six states have no cost-sharing requirements and another five states charge cost-sharing only for prescription drugs. The proposed changes to cost-sharing would provide states with increased flexibility to impose cost-sharing in Medicaid, particularly for non-emergency use of the ED and for non-preferred drugs, areas in which states have been looking for additional flexibility. These new rules could affect those currently eligible for coverage as well as many adults who may gain coverage under the ACA Medicaid expansion.

Over the years, Medicaid premiums and cost-sharing have been used to limit state program costs, encourage more personal responsibility over health care choices and to better align public coverage with private coverage where states have expanded coverage. However, a large body of research shows that premiums and cost sharing can act as barriers in obtaining, maintaining and accessing health coverage and health care services, particularly for individuals with low incomes and significant health care needs. These barriers can result in increases in uninsured, unmet health care needs and adverse health outcomes. State savings from cost-sharing and premiums may accrue due to declines in coverage and utilization more so than from increases in revenues. These changes can strain the health care safety-net and effectively reduce reimbursement for providers serving the Medicaid program.[ix] (For a more detailed review of the research, see the following brief.) As states consider changes to premium and cost-sharing policies by using flexibility under current rules or if the proposed rules go into effect, policy makers will need to carefully consider the research that shows potential savings to states related to these measures, but also the potential risk of increased barriers to access care, increased unmet needs, worse health outcomes, substitution of more expensive care for more efficient care, increased burdens for safety-net providers and increased administrative costs.

This brief was prepared by Robin Rudowitz and Laura Snyder of the Kaiser Commission on Medicaid and the Uninsured.

[i] Smith, Vernon, et al. *Medicaid Today; Preparing for Tomorrow: A Look at State Medicaid Program Spending, Enrollment, and Policy Trends*. Kaiser Commission on Medicaid and the Uninsured, October 2012. http://www.kff.org/medicaid/8380.cfm.

[ii] Heberlein, Martha, et al. *Getting into Gear for 2014: Findings form a 50-State Survey of Eligibility, Enrollment, Renewal, and Cost-Sharing Policies in Medicaid and CHIP, 2012-2013.* Kaiser Commission on Medicaid and the Uninsured, January 2013. http://www.kff.org/medicaid/8401.cfm.

[iii] Smith, Vernon, et al. *Medicaid Today; Preparing for Tomorrow: A Look at State Medicaid Program Spending, Enrollment, and Policy Trends*. Kaiser Commission on Medicaid and the Uninsured, October 2012. http://www.kff.org/medicaid/8380.cfm.

[iv] The Newton-Nations case subsequently was dismissed as moot after the expiration of Arizona's 1115 demonstration in September, 2011.

[v] Since that court ruling, CMS has approved several Section 1115 waiver requests related to premium and cost-sharing increases in Arizona and Wisconsin in cases where coverage otherwise could have been eliminated, but denied other requests in Arizona, California and Florida.

[vi] Artiga, Samantha. *An Overview of Recent Section 1115 Medicaid Demonstration Waiver Activity*, Kaiser Commission on Medicaid and the Uninsured, May 2012. http://www.kff.org/medicaid/8318.cfm.

[vii] The Department has since indicated that it has delayed implementation of this copay for this population; the state is working with stakeholders to potentially pursue a premium for this population instead. *Department of Public Welfare Releases Statement on Co-payment Initiative.* Department of Public Welfare, October 5, 2012. http://www.dpw.state.pa.us/.

[viii] Indian Health Facilities include Indian Health Service Facilities, Tribally-Operated 638 Health Programs, and Urban Indian Health Programs (ITUs).

[ix] *Premiums and Cost-Sharing in Medicaid: A Review of Research Findings.* Kaiser Commission on Medicaid and the Uninsured, February 2013. http://www.kff.org/medicaid/8417.cfm.

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