Order Code RS22578
January 25, 2007

CRS Report for Congress

Medicaid Cost-Sharing Under the Deficit Reduction Act of 2005 (DRA)

Elicia J. Herz
Specialist in Social Legislation
Domestic Social Policy Division

Summary

Under traditional Medicaid, states may require certain beneficiaries to share in the cost of Medicaid services, although there are limits on the amounts that states can impose, the beneficiary groups that can be required to pay, and the services for which cost-sharing can be charged. Prior to DRA, changes to these rules required a waiver. DRA provides states with new options for benefit packages and cost-sharing that may be implemented through Medicaid state plan amendments (SPAs) rather than waiver authority. These rules vary by beneficiary income level and for some types of service. The recently enacted P.L. 109-432 (Tax Relief and Health Care Act of 2006) modified the DRA cost-sharing rules. This report describes the new cost-sharing options and recent state actions to implement these provisions, and will be updated as additional activity warrants.

In health insurance, beneficiaries may face two types of out-of-pocket payments: (1) participation-related cost-sharing, typically in the form of monthly premiums, regardless of whether services are utilized, and (2) service-related cost-sharing, which consists of payments made directly to providers at the time of service delivery. Such beneficiary cost-sharing under Medicaid is described below.

Participation-Related Cost-Sharing

In order to obtain health insurance generally, enrollees may be required to pay monthly premiums and/or, less frequently, enrollment fees. Such charges are prohibited under traditional Medicaid for most eligibility groups. Nominal amounts set in regulations, ranging from $1 to $19 per month, depending on monthly family income and size, can be collected from (1) certain families moving from welfare to work who qualify for transitional assistance under Medicaid, and (2) pregnant women and infants with annual family income exceeding 150% of the federal poverty level (FPL), or, for example, about $19,800 for a family of two.

Premiums and enrollment fees can exceed these nominal amounts for other specific groups. For example, for certain individuals who qualify for Medicaid due to high out-of-pocket medical expenses, states may implement a monthly fee as an alternative to meeting financial eligibility thresholds by deducting medical expenses from income (i.e., the "spend down" method). Cost-sharing is not capped for workers with disabilities and income up to 250% FPL. Premiums cannot exceed 7.5% of income for other workers with disabilities and income between 250% and 450% FPL. (If a state covers both groups, the same cost-sharing rules must apply.) Finally, some groups covered by Medicaid through certain waivers can be charged premiums that exceed nominal amounts.

Under DRA authority, the general rules regarding applicable premiums are specified for three income ranges. For individuals with income under 100% FPL, and between 100% to 150% FPL, premiums are prohibited. Like traditional Medicaid, other specific groups (e.g., some children, pregnant women, individuals with special needs) are also exempt from paying premiums under the new DRA option. For persons with income above 150% FPL, DRA places no limits on the amount of premiums that may be charged.

For the most part, premiums are not used under traditional Medicaid, except for workers with disabilities and waiver populations. Among the four states (Idaho, Kansas, Kentucky, and West Virginia) with approval for alternative DRA benefit packages, only Kentucky imposes monthly premiums: (1) $20/family with children with income over 150% FPL who are enrolled in the State Children's Health Insurance Program (SCHIP; additional details below), and (2) up to $30/family (not to exceed 3% of the adjusted, average monthly income) during the last six months of transitional Medicaid for working families with income over 100% FPL.

Service-Related Cost-Sharing

Beneficiary out-of-pocket payments to providers at the time of service can take three forms. A *deductible* is a specified dollar amount paid for all services rendered during a specific time period (e.g., per month or year) before health insurance (e.g., Medicaid) begins to pay for care. *Coinsurance* is a specified percentage of the cost or charge for a specific service rendered. A *copayment* is a specified dollar amount for each item or service delivered. While deductibles and coinsurance are rarely used in traditional Medicaid, copayments are applied to some services and groups.

The **Appendix Table** provides a comparison of the maximum charges allowed for service-related cost-sharing under traditional Medicaid, DRA, and SCHIP. SCHIP is a capped federal grant that allows states to cover low-income, uninsured children in families with income above Medicaid eligibility thresholds. Children may be enrolled in separate SCHIP programs for which SCHIP rules apply (shown in the **Appendix Table**), or in Medicaid, for which traditional Medicaid or DRA rules apply. Some states (e.g., Kentucky) have both types of SCHIP programs (a Medicaid expansion and a separate SCHIP program), for which children with the highest income levels are enrolled in the separate program. Service-related cost-sharing under separate SCHIP programs generally parallels the rules under traditional Medicaid for lower-income subgroups; there are no limits specified for higher-income subgroups. Total SCHIP cost-sharing is capped at 5% of family income per eligibility period.

Service-related cost-sharing under traditional Medicaid is prohibited for the following specific groups and services: (1) children under 18, (2) pregnant women for pregnancy-related services, (3) services provided to certain institutionalized individuals, (4) individuals receiving hospice care, (5) emergency services, and (6) family planning services and supplies. For most other groups and services, nominal amounts are allowed. For example, nominal copayments specified in regulations range from $0.50 to $3, depending on the payment for the item or service. These nominal amounts will be increased by medical inflation beginning in 2006 (regulations not yet released).

Under the DRA option, certain groups and services are also exempt from the service-related cost-sharing provisions. These exemptions are nearly identical to those under traditional Medicaid. However, under traditional Medicaid, all children under 18 are exempt, while under DRA, only children covered under mandatory eligibility groups (the lowest income categories) and certain foster care/adoption assistance youth are exempt. Also, groups exempted from the general service-related cost-sharing provisions under DRA may nonetheless be subject to cost-sharing for non-emergency services provided in a hospital emergency room (ER), and/or for prescribed drugs (see the **Appendix Table**). Under SCHIP, only American Indian and Alaskan Native children are exempt from cost-sharing, and cost-sharing is also prohibited for well-baby and well-child services.

Among the four states with approval for alternative benefit packages via DRA, only Kentucky includes cost-sharing for participants, summarized in **Table 1**. For many services across the four Kentucky plans, there is no cost-sharing for beneficiaries. When applicable, copayments for selected non-institutional services, acute inpatient hospital care, and for generic and preferred brand-name drugs are very similar to the maximums allowed under traditional Medicaid. For non-preferred brand-name drugs and for non-emergency care in an ER, a 5% coinsurance charge will be applicable in most cases. For all four Kentucky plans, the maximum annual out-of-pocket expense per member is $225 for health care services and $225 for prescriptions. Additionally, under DRA, the total aggregate amount of all cost-sharing (premiums plus service-related charges) cannot exceed 5% of family income applied on a monthly or quarterly basis as specified by the state. Under Kentucky's DRA SPA, this limit is applied on a quarterly basis.

Consequences for Failure to Pay Cost-Sharing

The rules governing consequences for failure to pay premiums differ somewhat under traditional Medicaid and DRA. Under traditional Medicaid, for certain groups of pregnant women and infants for whom monthly premiums may be charged, states cannot require prepayment, but may terminate Medicaid eligibility when failure to pay such premiums continues for at least 60 days. In contrast, under DRA, states may condition Medicaid coverage on the payment of premiums, but like traditional Medicaid, states may terminate Medicaid eligibility only when nonpayment continues for at least 60 days. States can apply this DRA provision to some or all applicable groups. Under both traditional Medicaid and DRA, states may waive premiums in cases of undue hardship. In Kentucky, benefits are terminated after two months of non-payment of premiums for children in the separate SCHIP program. Upon payment of a missed premium, re-enrollment is allowed. After 12 months of non-payment, payment of the missed premium is not required for re-enrollment. Also, working families with transitional Medicaid will lose coverage after two months of missed premiums unless good cause is established.

There are more differences between traditional Medicaid and DRA with respect to rules for failure to pay service-related cost-sharing. Under traditional Medicaid, providers cannot deny care to beneficiaries due to an individual's inability to pay a cost-sharing charge. However, this requirement does not eliminate the beneficiary's liability for payment of such charges. In contrast, under DRA, states may allow providers to require payment of authorized cost-sharing as a condition of receiving services. Providers may be allowed to reduce or waive cost-sharing on a case-by-case basis. P.L. 109-432 exempts individuals in families with income below 100% FPL from the DRA failure to pay rules for both premiums and service-related cost-sharing. According to state regulations, Kentucky requires all providers to collect applicable cost-sharing from Medicaid beneficiaries at the time of service delivery or at a later date. No provider can waive cost-sharing, but only pharmacy providers can deny services for failure to pay (as per a state law). Finally, under SCHIP, states must specify consequences applicable to nonpayment of premiums and/or service-related cost-sharing, and must institute disenrollment protections (e.g., providing both reasonable notice and an opportunity to pay policies).

Table 1. Cost-Sharing Under Kentucky's DRA Alternative Benefit Packages

Type of service	Global Choices (general Medicaid population)	Family Choices (most children including SCHIP)	Optimum Choices (MR/DD needing ICF/MR level of care)	Comprehensive Choices (disabled needing NF level of care)
Most non-institutional services (e.g., OPD, MD visits, dental, PT)	Copays of $1 to $3	Copays of $2	Copays of $2 to $3	Copays of $2 to $3
Acute inpatient hospital services	$50/admission	NA	$10 copayment	$10 copayment
Generic drugs	$1 per Rx	$1 per Rx	$1 per Rx	$1 per Rx
Preferred brand-name drugs	$2 per Rx	$2 per Rx	$2 per Rx	$2 per Rx
Non-preferred brand-name drugs	5% coinsurance per Rx	$3 per Rx	5% coinsurance per Rx	5% coinsurance per Rx
Non-emergency care in an ER	5% coinsurance	5% coinsurance (higher income groups only)	5% coinsurance	5% coinsurance

Source: [http://chfs.ky.gov/dms/kyhealthchoices.htm] (downloaded on Dec. 18, 2006). See the tab labeled "KyHealth Choices Benefit Packages."

Notes: Only non-zero cost-sharing amounts are shown. For children in Global Choices and Family Choices, either no cost-sharing applies, or cost-sharing varies by income (i.e., lowest cost-sharing for lowest income). Definitions for abbreviations: (1) MR/DD - persons with mental retardation or developmental disabilities, (2) ICF/MR - intermediate care facilities for the mentally retarded, (3) NF - nursing facility, (4) OPD - hospital outpatient department or clinic, (5) MD - physician, (6) PT - physical therapy, (7) NA - not applicable, and (8) Rx - prescription. Kentucky will also allow some Medicaid beneficiaries (excluding the lowest income groups and those with special needs) to purchase employer-sponsored insurance (ESI) that is actuarially equivalent to a specific state employee health plan. Beneficiaries with ESI will be subject to the benefit package and cost-sharing provisions of those plans, and Medicaid will not "wrap-around" this coverage (i.e., provide additional benefits).

Appendix Table. Comparison of Service-Related Cost-Sharing Rules — Traditional Medicaid, DRA Options, and SCHIP

	Exempt groups [a]			Income < 100% FPL			Income 100% - 150% FPL			Income > 150% FPL		
	Medicaid	**DRA**	**SCHIP**	**Medicaid**	**DRA [b]**	**SCHIP**	**Medicaid**	**DRA**	**SCHIP**	**Medicaid**	**DRA**	**SCHIP**
Non-institutional services in general												
Maximum deductible	$0	$0	$0	Nominal= $2 per family per month	Nominal=$2 per family per month	$2 per family per month	Nominal= $2 per family per month	NA	$3 per family per month	Nominal=$2 per family per month	NA	No limit
Maximum coinsurance	$0	$0	$0	Nominal=5% of payment for item or service	Nominal=5% of payment for item or service	5% of payment for item or service	Nominal= 5% of payment for item or service	10% of cost of item or service	5% of payment for item or service	Nominal=5% of payment for item or service	20% of cost of item or service	No limit
Maximum copayments	$0	$0	$0	Nominal= $0.50 - $3 based on payment for item or service	Nominal=$0.50 - $3 based on payment for item or service	$0.50 - $3 based on payment for item or service	Nominal= $0.50 - $3 based on payment for item or service	NA	For FFS, $1 - $5 based on total cost of services during a visit; for managed care, $5 per visit	Nominal=$0.50 - $3 based on payment for item or service	NA	No limit
Institutional services in general												
Maximum charge	$0	$0	$0	Nominal=50% of payment for 1st day of care per admission	Nominal=50% of payment for 1st day of care per admission	50% of payment for 1st day of care per admission	Nominal= 50% of payment for 1st day of care per admission	10% of cost of item or service	50% of payment applicable under Medicaid FFS for 1st day of care per admission and $5 for emerg. services	Nominal=50% of payment for 1st day of care per admission	20% of cost of item or service	No limit
Special rule: non-emergency care in an ER												
Maximum charge	$0	Nominal, if no cost-sharing for alternative providers	$0	Nominal; can be twice nominal (via waiver) when alternative providers are available	Nominal, if no cost-sharing for alternative providers	Nominal; can be twice nominal (via waiver)	Nominal; can be twice nominal (via waiver) when alternative providers are available	Twice nominal when alternate providers are available	Twice the charges for non-instit. services, up to $10	Nominal; can be twice nominal (via waiver) when alternative providers are available	No limit, when alternate providers are available	No limit

	Exempt groups [a]			Income < 100% FPL			Income 100% - 150% FPL			Income > 150% FPL		
	Medicaid	**DRA**	**SCHIP**	**Medicaid**	**DRA [b]**	**SCHIP**	**Medicaid**	**DRA**	**SCHIP**	**Medicaid**	**DRA**	**SCHIP**
Special rule: prescribed drugs												
Maximum charge for non-preferred drugs	$0	Nominal	$0	Same as non-instit. services in general (e.g., $3/Rx or 5% of payment)	Nominal	Same as non-instit. services in general (e.g., $3/Rx or 5% of payment)	Same as non-instit. services in general (e.g., $3/Rx or 5% of payment)	Nominal	Same as non-instit. services in general (e.g., $3/Rx or 5% of payment)	Same as non-instit. services in general (e.g., $3/Rx or 5% of payment)	20% of cost of the drug	No limit
Maximum charge for preferred drugs	$0	$0	$0	Same as non-instit. services in general (e.g., $3/Rx or 5% of payment)	$0	Same as non-instit. services in general (e.g., $3/Rx or 5% of payment)	Same as non-instit. services in general (e.g., $3/Rx or 5% of payment)	waive or reduce	Same as non-instit. services in general (e.g., $3/Rx or 5% of payment)	Same as non-instit. services in general (e.g., $3/Rx or 5% of payment)	waive or reduce	No limit
Aggregate cap on all cost-sharing												
Maximum (as a % of income)	0%	5% of monthly or quarterly income	0%	State may specify cumulative maximum	5% of monthly or quarterly income	5% of income for eligibility period	State may specify cumulative maximum	5% of monthly or quarterly income	5% of income for eligibility period	State may specify cumulative maximum	5% of monthly or quarterly income	5% of income for eligibility period

Note: In 2006, the FPL ranges from $9,800 for a family of one to $33,600 for a family of eight. (Different guidelines apply to Alaska and Hawaii.) For a family of one, 150% FPL would equal $14,700, and for a family of eight, 150% FPL would equal $50,400. For the DRA column representing rules applicable to the under-100% FPL income group, provisions under P.L. 109-432 are shown. Medicaid cost-sharing regulations can be found at 42 CFR 447.52 (for nominal premium and enrollment fee amounts) and 42 CFR 447.54 (for nominal service-related cost-sharing amounts). Regulations for the DRA cost-sharing provisions, including indexing of the Medicaid nominal amounts by medical inflation, have not been released, but are expected in mid-2007. SCHIP cost-sharing regulations can be found at 42 CFR 457, Subpart E.

NA = not applicable.

a. Specified groups are classified as "exempt" with respect to service-related cost-sharing charges. However, under the DRA options, groups generally designated as exempt may be subject to some cost-sharing for non-emergency care in an ER and for non-preferred prescription drugs. For both traditional Medicaid and the DRA options, the following groups are identified as exempt: (1) pregnant women for pregnancy-related services, (2) individuals receiving hospice care, and (3) residents of nursing facilities (NFs) or intermediate facilities for the mentally retarded (ICF/MRs) and certain inpatients in hospitals and other medical institutions. Also, under traditional Medicaid, all children under age 18 are exempt from service-related cost-sharing, while under the DRA options, only children under age 18 in mandatory coverage groups and certain foster care and adoption assistance children, regardless of age, are exempt. Also, under the DRA options only, women covered under the breast and cervical cancer group are exempt from service-related cost-sharing. Under SCHIP, only American Indian and Alaskan Native children are exempt from such cost-sharing.

b. The original DRA legislation (P.L. 109-171) was silent with respect to premiums and service-related cost-sharing for individuals with income below 100% FPL. Senator Grassley and Representative Barton, Chairmen of the Senate Finance and House Energy and Commerce Committees, respectively, sent a letter to the federal Centers for Medicare and Medicaid Services, or CMS (dated March 29, 2006), stating that the congressional intent of DRA was that the cost-sharing rules under traditional Medicaid should apply to this income group. In a subsequent letter to state Medicaid directors (dated June 16, 2006), CMS concurred. P.L. 109-432 modified DRA by specifying cost-sharing rules for individuals with income under 100% FPL.