In February 2006, the President signed into law budget reconciliation legislation—the so-called Deficit Reduction Act (DRA)—that fundamentally alters many aspects of the Medicaid program. Some of these changes are mandatory provisions that states must enact and that will make it more difficult for people to either qualify for or enroll in Medicaid. Other changes are optional provisions that allow states to make unprecedented changes to the Medicaid program through state plan amendments.

This series of issue briefs is designed to inform advocates about the specifics of these changes and to highlight key implementation issues and strategies to mitigate the harm these provisions could cause to people on Medicaid.

Cost-Sharing and Premiums:
Shifting Costs to Those Who Can Afford It Least

The Deficit Reduction Act of 2006 makes sweeping changes to the rules governing how much states can charge people in Medicaid for health care. The changes in the new law are threefold:

1. The DRA increases the amount states can charge people for health care services;
2. The DRA gives states new authority to charge premiums for certain people in Medicaid;
3. The DRA gives states the ability to deny health care or coverage to people who cannot afford the cost-sharing or premiums they are charged.

Unlike some other provisions of the DRA, the cost-sharing and premium provisions are purely optional: States are not required to begin charging premiums, nor are they required to make any changes to their current cost-sharing structure. However, if states take advantage of these new options, millions of people who rely on Medicaid could be forced to delay or forgo care—or they may be unable to get Medicaid at all because they cannot afford it. This issue brief explains the new premium and cost-sharing options and offers strategies for advocates whose states choose to make changes that could harm people on Medicaid.

How Does the DRA Affect Cost-Sharing and Premiums?

- **Cost-Sharing**

Before the DRA, states were permitted to charge adults in Medicaid a “nominal” copayment or co-insurance for Medicaid services. Children were exempt from any cost-sharing. The nominal copayment was limited to between $0.50 and $3 (depending on the cost of the service) or up to 5 percent co-insurance per service.

Furthermore, providers were required to provide medical care even if the individual could not afford to pay the cost-sharing at the time of service. The DRA makes several changes to the amounts states can charge for health care services:

1. The DRA increases the maximum copayments that states can charge for people who have incomes below the federal poverty level or who are otherwise exempt from the limits described below (see “Exempt from Cost-Sharing”). States will be allowed to increase nominal copayments each year in accordance with the annual increase in the Medical Consumer Price Index (MCPI). In recent years, the MCPI has gone up by between 4 and 5 percent, rising much faster than the average American worker’s wages.[1]
2. The DRA increases the cost-sharing limit to 10 percent of the cost of the service (for people with incomes between 100 and 150 percent of poverty) or 20 percent of the cost of the service (for people with incomes above 150 percent of poverty), effective March 31, 2006.[2] See “Exempt from Cost-Sharing” for a list of people and services exempt from these higher cost-sharing limits.[3]
3. The DRA increases the cost-sharing limit for prescription drugs separately from cost-sharing for other services. This provision allows states to establish lists for “preferred” and “non-preferred” drugs, and to charge higher cost-sharing for non-preferred drugs than for preferred drugs. This mechanism is designed to encourage individuals to choose preferred drugs. States will be able to charge “nominal” copayments for non-preferred prescription medications for people with incomes below 150 percent of poverty and to those in an otherwise exempt group. They may charge up to 20 percent of the cost of the service for non-preferred prescription drugs for people with incomes above 150 percent of poverty. States may charge less for preferred drugs (even if they are more expensive drugs), or they may decide to waive the cost-sharing altogether for preferred drugs.
4. Finally, the DRA allows cost-sharing for use of the emergency room for non-emergency care, effective January 1, 2007. People otherwise exempt from cost-sharing can be charged up to the nominal copayment. People with incomes at or below poverty can be charged up to twice the nominal copayment. There is no limit to the amount that people with incomes above poverty can be charged (other than the overall cost-sharing and premium limit of 5 percent of monthly or quarterly income).

Exempt from Cost-Sharing

People

- Children under age 6 with family incomes up to 133 percent of the federal poverty level
- Children ages 6-18 with family incomes up to 100 percent of the federal poverty level
- Foster children
- Hospice patients
- Institutionalized patients
- Women in the breast or cervical cancer eligibility category

Services

- Preventive services provided to any children
- Pregnancy-related services
- Emergency services
- Family planning services

Premiums and Enrollment Fees

States can require people in Medicaid with incomes above 150 percent of poverty to pay a fee or a premium to get Medicaid coverage, effective March 31, 2006. This is the first time that states have been permitted to charge premiums or enrollment fees for most people in Medicaid.[4] There is no limit to the amount of this premium or fee, except that it may not—combined with other cost-sharing expenses—exceed 5 percent of a family's monthly or quarterly income. See "Exempt from Premiums" for a list of groups exempt from the new option to charge premiums and enrollment fees.[5]

Exempt from Premiums

- Children under age 6 with family incomes up to 133 percent of the federal poverty level
- Children ages 6-18with family incomes up to 100 percent of the federal poverty level
- Foster children
- Pregnant women
- Hospice patients
- Institutionalized patients
- Women in the breast or cervical cancer eligibility category

Enforceability

The DRA allows states for the first time to deny Medicaid coverage to anyone who cannot pay a premium or enrollment fee, and it gives states the explicit right to allow providers to turn people away without giving them health care if they cannot pay a copayment or other cost-sharing amount. This new provision turns the premise of Medicaid—to provide medically necessary health care to people who otherwise cannot afford it—on its head. The DRA allows states to decide to make cost-sharing "mandatory" or "enforceable" separately from any decision to raise or not to raise their current cost-sharing amounts. This means that, even in states that do not elect to raise cost-sharing amounts, advocates may face efforts to allow providers to refuse service for people who cannot afford existing cost-sharing in the state.

Comparability

An important rule in Medicaid requires states generally to treat people comparably with regard to the coverage that they get through Medicaid. Applied to cost-sharing, for example, this rule has meant that states exercising the ability to charge copayments had to charge everybody enrolled in Medicaid the same copayment or other cost-sharing amount for similar services. A state could not charge one copayment in one part of the state and a different copayment in another part of a state. Likewise, a state could not charge a person with a heart condition a different copayment than a person with diabetes for the same prescription drug.

The DRA eliminates this protection for cost-sharing and premiums. If a state decides to charge a new premium for people with incomes above 150 percent of poverty, for instance, it can then decide to charge different premiums for different groups—and those groups can be determined by geography, by health care condition, by age, or by any other defining characteristic the state chooses to use. Moreover, a state could allow certain providers to turn people away if they cannot pay a copayment but require

other providers to serve all Medicaid enrollees. Or it could decide to require certain people in Medicaid to pay copayments or risk not receiving health care but not apply this rule to all Medicaid enrollees.

- **Income Calculation**

The DRA specifically allows states to calculate income amounts separately for the purposes of premiums or cost-sharing than for eligibility determinations. This means that states could decide to use a gross income test for premiums and cost-sharing rather than a net income test (what most states use for determining eligibility for Medicaid), which could mean that more people would "qualify" to pay higher amounts of cost-sharing. By allowing the use of different income calculations, the DRA would make an already complicated system vastly more complicated for caseworkers and for families alike, and it would increase administrative costs for states.

What Are the Implications of Higher Cost-Sharing and Premiums for Medicaid Enrollees?

- **Cost-Sharing**

The Congressional Budget Office (CBO), in its analysis of the budget reconciliation bill, developed estimates of the consequences of the cost-sharing provisions.[8] According to the CBO, some 13 million people—a third of them children—could face new or increased cost-sharing over the next 10 years. Around 80 percent of the savings expected to result from new cost-sharing would be due to decreased use of services—not from the actual collection of cost-sharing payments from people on Medicaid.

Increased cost-sharing is not a judicious way to reduce Medicaid spending. It will not automatically make Medicaid enrollees better-informed consumers of health care, as the supporters of this policy often suggest. Nor is it likely to discourage people from seeking unneeded health care services. In fact, there is scant evidence to suggest that such over-utilization of services is driving up Medicaid costs. Rather, increased cost-sharing will mean that people seeking medical care will be turned away if they cannot pay their coinsurance at the time of service. Or they will avoid seeking care at all if they fear they cannot pay. Extensive research has shown that even moderate levels of cost-sharing cause low-income people to delay or forgo needed care, even if seeking care early on could prevent serious and costly complications down the road.

Lessons from the States about the Effects of Cost-Sharing

- **Tennessee:** Nearly 40 percent of enrollees in TennCare said they were unable to afford copayments that were between $3 and $5.[6]
- **Oregon:** A survey of people who lost Medicaid coverage after cost-sharing increases in 2003 found that among those with unmet health needs, 72 percent claimed that the main barrier to getting that care was cost. This survey also found that those who lost coverage were significantly more likely to have an emergency room visit over the following six months than were those who retained coverage.[7]

While the DRA prohibits cost-sharing for preventive care for children, it includes no such exemption for adults. Paying more for an annual checkup is almost certain to discourage low-income people from getting this kind of care. There is already evidence of this among the uninsured, who are much less likely to have a routine checkup than those with insurance because of the cost of such care.[9] Unfortunately, denying people access to preventive care—like cancer screenings, cardiovascular health screenings, and diabetes care—only delays the diagnosis and treatment of conditions that will be more complicated and more expensive to treat down the road.

Increasing cost-sharing is a perfect example of the old saying "penny-wise and pound-foolish." In the short-term, denying patients care may save money, but patients who go without needed care will eventually show up in the emergency room with complicated, costly conditions that could have been prevented with earlier medical attention.

The harmful effects of the cost-sharing provisions of the DRA may be exacerbated by harsh policies that allow providers to turn people away if they cannot afford a copayment. There will be significant pressure in states to make cost-sharing "mandatory" or "enforceable," even in states that do not choose to raise the amounts that Medicaid enrollees must pay out of pocket. Moreover, in states that do increase cost-sharing, there will likely be even more pressure on providers who may have been willing to forget about a $0.50 or $2 copayment but who will be much harder-pressed to write off higher copayments.

• Premiums

The CBO has estimated that 20 percent of the savings expected from allowing states to charge premiums ($594 million) would accrue from people who lose Medicaid because they are unable to pay the new premiums.[10] According to the CBO, around 1.3 million people could face new Medicaid premiums over the next 10 years, and 65,000 of these people will lose Medicaid coverage as a result. More than half of those losing coverage will be children.

In recent years, several states—including Oregon, Rhode Island, and Vermont—have experimented with imposing Medicaid premiums through Section 1115 waivers. Evidence from these states suggests that when premiums are either increased or implemented for the first time, many people are unable to pay them and lose coverage, often becoming uninsured.[11]

Lessons from the States about the Impact of Premiums

- **Oregon:** When new Medicaid premiums were introduced and existing premium amounts were raised in 2003, almost half of all enrollees lost Medicaid coverage. People with the lowest incomes were the most likely to lose coverage.
- **Rhode Island:** New premiums introduced in 2002 led to an 18 percent decline in enrollment. Nearly half of those who lost coverage said it was because they could not afford the premium.
- **Vermont:** New premiums introduced in 2004 led to a 15 percent decline in enrollment. The majority of those who lost coverage cited cost as their main reason for disenrollment.

What Can Advocates Do?

The good news is that the cost-sharing and premium provisions of the DRA are optional: States do not have to raise the amounts people must pay out of pocket, and they don't have to make cost-sharing a condition of getting health care services. The bad news is that, as states experience additional fiscal pressure from the federal government to reduce Medicaid expenditures, they may be more likely to take up the new cost-sharing or premium options available to them. But even if a state does move down the path of charging low-income people more for the health care they get from Medicaid, there are ways that advocates can ameliorate some of the harm. The following is a short list of options for advocates and state policy makers to consider:

- **Oppose cost-sharing, premiums, and enrollment fees in Medicaid.** The DRA does not require states to charge cost-sharing, premiums, or an enrollment fee in Medicaid, and states do not have to take up the new option. Many reports cite arguments against cost-sharing and premiums for low-income people and present evidence about the harm that cost-sharing and premiums can cause. Advocates can use these reports when making a case against such harmful changes. (See, for example, *Cost Sharing in Medicaid: It's Not about "Skin in the Game"—It's about Lives on the Line* [12] and *Preserving Medicaid in Tough Times*[13] from Families USA.)
- **Enact special protections for prescription drugs.** Prescription drug cost-sharing will likely be one of the more popular options among states seeking to generate savings in Medicaid through increased cost-sharing. However, as early implementation of Medicare Part D has shown, changes to the ways people get their prescription drugs can often hamper access and lead to disastrous, life-threatening results. Given that context, here are some ways to mitigate the harm done by additional prescription drug cost-sharing:
  - Require pharmacies to dispense a temporary supply of medication for those unable to pay at the time they (re)fill their prescription.
  - Allow hardship exemptions for people unable to pay the cost-sharing required for their medications because of financial hardship.
  - Protect certain classes of drugs from any cost-sharing. [14]
- **Encourage states to track families' out-of-pocket expenses so families don't have to do it themselves.** The "shoebox method"—saving receipts from all expenses and keeping a running tally of the total cost—adds a significant burden for enrollees. It could also cause people to delay or forgo care if they are unaware that they have hit their out-of-pocket maximum or if they have not received documentation from the state proving that they are exempt from further cost-sharing.

- **Modify premium or enrollment fee proposals to include protections for enrollees.** Some states with premiums or enrollment fees in their State Children's Health Insurance Programs (SCHIPs) have developed policies to help families maintain coverage, even if they have difficulty affording the premium.
    - *Minimize the amount of the fee.* There are no federal rules about how high a premium or enrollment fee has to be, and states will have wide latitude to decide how much to charge. Clearly, the smaller the amount, the more likely low-income families will be able to afford it.
    - *Extend the grace period.* The DRA allows states to disenroll people if they fail to pay a premium within 60 days of the due date, but there is no federal rule that imposes a maximum grace period. Urge your state to make the grace period longer. It can be as long as a state wishes to make it, even up to a year.
    - *Avoid "lock-outs" or reapplication requirements.* Urge your state to allow people who have been cut off Medicaid for failure to pay a premium to get back into Medicaid without an unnecessary wait and without additional paperwork burdens.
    - *Pay for performance.* Encourage your state to reward timely payment of premiums with a reduced premium during the last quarter or month of the year.

Conclusion

Most of the cost-sharing and premium provisions became effective on March 31, 2006.[15] However, as of the date this document was published, the Centers for Medicare and Medicaid Services (CMS) had not yet issued any guidance to states about the parameters for implementing these provisions. We expect that such guidance will be forthcoming, and it will provide additional information about the scope of the new state authority. As states begin to examine new cost-sharing and premium options, Families USA stands ready to assist state advocates as proposals move forward.

Endnotes

[1] MCPI data are from Bureau of Labor Statistics, *Consumer Price Index March 2006*, available online at http://www.bls.gov/news.release/cpi.nr0.htm, accessed on May 10, 2006. Data on employee wages are from Bureau of Labor Statistics, *Employment Cost Index March 2006*, available online at http://www.bls.gov/ncs/ect/home.htm, accessed on May 10, 2006.

[2] The DRA makes no mention of limits on cost-sharing or premiums for people with incomes below the federal poverty level. This failure has led many to conclude that, due to a drafting error, the law does not include any restrictions on cost-sharing or premiums for this group. However, a letter from Senator Grassley and Congressman Barton to Secretary Leavitt disputes this reading and urges the Secretary to make clear in guidance to the states that the silence of the statute with regard to cost-sharing and premiums for those below the federal poverty level indicates that states may charge only nominal cost-sharing amounts (as amended by the DRA) for individuals in that income group.

[3] The statute treats cost-sharing for prescription drugs separately from cost-sharing for other services. States will only be able to charge "nominal" copayments for people with incomes below 150 percent of the federal poverty level or in an otherwise "exempt" group for non-preferred prescription medications. They may charge up to 20 percent of the cost of the service for non-preferred prescription drugs for people with incomes over 150 percent of poverty. States will be able to decide which drugs are preferred and which are non-preferred.

[4] Prior to the passage of the DRA, states were permitted to charge premiums to a few people who qualified for Medicaid through the Ticket-to-Work program, which allows people with disabilities who have jobs to "buy in" to Medicaid if they do not have employer-sponsored health insurance coverage. Some states have also experimented with imposing premiums through Section 1115 waivers.

[5] See endnote 2.

[6] Celia Larson, *TennCare and Enrollee Cost-Sharing: A Survey of Previously Uninsured and Uninsurable Enrollees in Davidson County*, prepared by the Health Care Services Evaluation Division of the Metropolitan Health Department of Nashville and Davidson County, September 1996, as cited in Geri Dallek, *A Guide to Cost-Sharing and Low-Income People* (Washington: Families USA, October 1997).

[7] Bill Wright and Matthew Carlson, *The Impact of Program Changes on Health Care for the Oregon Health Plan Standard Population: Early Results from a Prospective Cohort Study* (Portland, OR: Office for Oregon Health Policy and Research, March 2004), available online at http://www.oregon.gov/DAS/OHPPR/RSCH/docs/Cohortbrief2.pdf.

[8] Congressional Budget Office, Letter to the Honorable John M. Spratt Jr. regarding Medicaid provisions in S. 1932, the Deficit Reduction Act of 2005, January 27, 2006, available online at http://www.cbo.gov/ftpdocs/70xx/doc7030/s1932updat.pdf.

[9] John Z. Ayanian, Joel S. Weissman, Eric C. Schneider, Jack A. Ginsburg, and Alan M. Zaslavsky, "Unmet Health Needs of Uninsured Adults in the United States," *JAMA*, Vol. 284, October 25, 2000, pp. 2061-2069.

[10] Congressional Budget Office, op. cit.

[11] Samantha Artiga and Molly O'Malley, *Increasing Premiums in Medicaid and SCHIP: Recent State Experiences* (Washington: The Kaiser Commission on Medicaid and the Uninsured, May 27, 2005), available online at http://www.kff.org/medicaid/7322.cfm.

[12] *Cost-Sharing in Medicaid: It's Not about 'Skin in the Game'—It's about Lives on the Line* (Washington: Families USA, September 2005), available online at http://www.familiesusa.org/assets/pdfs/Cost-sharing-in-Medicaid-Sept-2005.pdf.

[13] *Increased Premiums and Cost-Sharing* (Washington: Families USA, January 2003), available online at http://www.familiesusa.org/assets/pdfs/4a_IncreasedCostSharingc33a.pdf.

[14] For example, guidance from CMS for Medicare Part D formularies specifies that medications in "six classes of clinical concern" should not be subject to certain utilization controls (such as prior authorization) because the drugs are so immediately vital to patients' well-being that administrative barriers could discourage them from enrolling in Part D. The classes are immunosuppresants, antidepressants, antipsychotics, anticonvulsants, antiretrovirals, and antineoplastics. These same categories could serve as guidelines for drugs that states could exempt from cost-sharing.

[15] The provision related to emergency rooms is effective January 2007.