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A Summary of Federal Medicaid Cost-Sharing and Premium Standards: Current Law v. the House Budget Bill

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The attached table summarizes the federal Medicaid rules governing premiums and cost-sharing under current law versus the budget bill approved by the House on November 17, 2005. In addition to the population-specific changes that are summarized in the table, the House bill would change current rules in the following ways:

- **New state flexibility to vary premium and cost-sharing charges by group.** Under current law, states generally must provide comparable treatment to all Medicaid beneficiaries (e.g., a state that imposes a co-payment on prescription drugs cannot opt to do so for people with HIV, but not for those with multiple sclerosis). Under the House bill, states would be allowed to vary the premiums and cost-sharing that they charge by group (as defined by a state), as well as to vary charges by type of service.

- **New state flexibility to deny care for non-payment.** Under a provision often referred to as the "enforceability" provision, current law prohibits states from denying care to Medicaid beneficiaries who are unable to meet a cost-sharing obligation (although they remain liable for the charge). The House bill would allow states to permit providers to deny care to someone who does not meet a cost-sharing obligation. On premiums, states would be allowed to require prepayment and/or to terminate the coverage of someone who fails to pay within 60 days.

In general, the new federal premium and cost-sharing standards proposed by the House would go into effect on January 1, 2006. However, the new rules governing co-payments for the use of non-preferred drugs would be effective on October 1, 2006 and for non-emergency use of the ER would be effective on the date of enactment.

Table-Specific Notes

- "FPL" refers to the federal poverty level. In 2005, the FPL for a family of three is set at $16,090 a year or $1,341 a month.
- "Cost-sharing" refers to a deduction, deductible, co-payment, or similar charge. "Premiums" refer to monthly premium charges, an annual enrollment fee, or other similar charge.
- A "non-preferred drug" is one that a state has decided is not "preferred" because it is not the least (or less) costly effective prescription drug within a class of drugs. States would define what constitutes a drug class. States, however, cannot classify a drug as "non-preferred" if it currently is treated as a preferred drug by the TRICARE pharmacy benefit program.
- The "Current Law" column of the table summarizes the key premium and cost-sharing rules affecting the applicable population group. In some cases, there are minor exceptions to the rules that are not noted in the table due to space constraints. For an exhaustive review of current law in this area, see Chapter 2 of *The Medicaid Resource Book* prepared by Andy Schneider for the Kaiser Commission on Medicaid and the Uninsured, July 2002.

Federal Medicaid Standards for Cost-Sharing and Premiums: Current Law v. the House Budget Bill		
	Current Law	**House Budget Bill** *(Note: The allowable charges described below cannot in the aggregate exceed 5% of a family's annual income)*
Children		
Under age 6 with income <= 133% of FPL and ages 6 to 17 <= 100% FPL	• No premiums • No cost-sharing	• No premiums • Co-payments up to $3 (indexed to medical inflation) for non-preferred drugs and for non-emergency use of the ER. • No cost-sharing for other services
Under age 6 with income > 133% FPL and ages 6 to 17 with income >100% FPL	• No premiums • No cost-sharing	• Premiums allowed • Cost-sharing allowed for nearly all services except preventive care* • No upper limit on premiums or charge per service except 5% cap • Specific authority to charge up to $6 to $9 (depending on income; amount indexed to medical inflation) for a non-preferred drug
Pregnant Women		
	• No premiums • No cost-sharing for pregnancy-related services • Co-payments up to $3 for other services	• No premiums • No cost-sharing for pregnancy-related services except up to $3 (indexed to medical inflation) for non-preferred drugs and non-emergency use of the ER • Co-payments up to $3 (indexed to medical inflation) for other services*
Parents, Seniors, and People with Disabilities**		
At or below 100% FPL ***	• No premiums • Co-payments up to $3 per service	• No premiums • Co-payments up to $3 (indexed to medical inflation) for nearly all services*
Above 100% FPL	• No premiums • Co-payments up to $3 per service	• Premiums allowed • Cost-sharing can be charged for nearly all services* • No upper limit on premiums or charge per service except 5% cap • Specific authority to charge up to $9 to $12 (depending on income; amount indexed to medical inflation) for use of a non-preferred drug and for non-emergency use of the ER

*States are required to exempt from cost-sharing preventive services for children, services provided to someone in hospice care or an institution, family planning services, and emergency services.

**People who are receiving hospice care or residing in an institution are exempt from premiums and cost-sharing except that they can face charges of up to $3 (indexed to medical inflation) for a non-preferred drug or for non-emergency use of an ER.

***States have the flexibility to define income as they like when evaluating whether someone falls below 100% FPL (e.g., they can use gross income rather than the net income measure used in Medicaid eligibility determinations) and they are not required to reassign people if their incomes change between scheduled evaluations.