Strategy	Premiums and Cost Sharing
Background:	The Deficit Reduction Act of 2005 (DRA) provides state Medicaid agencies with new options as of March 31, 2006, to impose increased premiums and cost sharing upon certain Medicaid recipients above 100 percent of the federal poverty level (FPL). It allows states to make the payment of premiums a condition of Medicaid eligibility and payment of cost sharing a condition of receiving services. In addition, the DRA allows states to vary the premiums and cost sharing charged based on income, eligibility category, and type of service. States must submit a state plan amendment to the Centers for Medicare and Medicaid Services (CMS) to implement cost sharing options allowed under the DRA. CMS has not yet filed regulations on these provisions. DRA cost sharing provisions have limited applicability in Texas because of the restrictions on cost sharing imposed for most populations served by Medicaid in Texas. A premium is an enrollment fee or similar charge, such as a monthly fee. Cost sharing is any deduction, co-payment or similar charge required to use Medicaid services. The DRA restricts the total amount of premiums and cost sharing to not more than 5 percent of the family's income (applied quarterly or monthly at the option of the state). Attachment 1 includes a table that outlines premium and cost sharing allowances and restrictions by Texas Medicaid eligibility category and income. States are required to exempt the following services from cost sharing: preventive services for children, family planning services, and emergency services. The DRA includes cost sharing provisions intended to limit utilization of certain prescription drugs and inappropriate use of emergency room services. Attachment 1 provides detailed information on cost sharing allowances and restrictions for these services by eligibility category and income. **Prescription Drugs** States may impose varied cost sharing amounts depending on whether the drug is a preferred drug or a non-preferred drug. In Texas, preferred drugs would be those drugs reviewed by the Pharmaceutical and Therapeutic Committee and approved by the Health and Human Services Commission (HHSC) to be on the Medicaid preferred drug list based on cost effectiveness, clinical efficacy, and safety. The DRA allows states to impose lesser cost sharing requirements for use of preferred drugs. However, the DRA also stipulates that cost sharing for a non-preferred drug is limited to preferred drug cost sharing amounts if a physician determines a preferred drug would not be as effective as a non-preferred drug, would have an adverse effect on the individual, or both. Because Texas requires a prior authorization before non-preferred drugs can be dispensed, the DRA requirement effectively limits cost sharing for all drugs to the limits defined in the DRA for preferred drugs. The DRA allows states to require beneficiaries to pay cost sharing before receiving prescription drugs, and it requires states to reduce the amount of reimbursement to pharmacies by the amount of beneficiary cost sharing obligations.[i]

<table>
<tr><td>Strategy</td><td>Premiums and Cost Sharing</td></tr>
<tr><td></td><td>Non-Emergency Use of Emergency Rooms
States may permit a hospital to impose cost sharing for non-emergency services furnished to an individual in the hospital emergency department, if the following conditions are met:
• The individual has access to a non-emergency room provider.
• The hospital performs an appropriate medical screening, determines the individual does not have an emergency medical condition, and informs the individual of the following before providing the non-emergency care:
➢ The hospital may require payment before the service is provided.
➢ The name/location of an alternate non-emergency services provider who is available and accessible.
➢ That the alternate provider can provide the services without imposing cost sharing.
➢ The hospital provides a referral to coordinate scheduling of the treatment.
Cost savings that could be generated in Texas through the implementation of DRA provisions for premiums and cost sharing are very limited. Texas may want to consider premium and cost sharing options if a federal waiver is pursued to expand Medicaid eligibility to higher income individuals or groups not traditionally served by Medicaid, such as families, or if Texas pursues a waiver to provide or subsidize coverage of the uninsured outside of Medicaid.</td></tr>
<tr><td>Other States:</td><td>Kentucky has implemented cost sharing with its DRA-related reform effort.
CMS has approved a number of Section 1115 Research and Demonstration Waivers, including Health Insurance Flexibility and Accountability (HIFA) waivers[ii] in other states that expand Medicaid coverage to higher income or new categories of individuals and include premium and/or cost sharing amounts above those allowed under the DRA. A non-exhaustive list includes the following states:
Arkansas
The Arkansas HIFA waiver, implemented October 1, 2006, offers a limited benefit package of six physician service days per year, seven inpatient acute care hospital days per year, two outpatient hospital services per year (e.g., outpatient surgery, radiology, and/or emergency room visits), and two prescription drugs per month to adults under age 65 and at 200 percent FPL or less. Enrollees pay up to $15 per month in premiums. Cost sharing includes a $100 deductible, 15 percent coinsurance for all services except pharmacy, and a $1,000 out-of-pocket maximum per year for the deductible and coinsurance.

Arizona
The Arizona HIFA waiver provides the Medicaid benefit package to parents of</td></tr>
</table>

Strategy	Premiums and Cost Sharing
	children in the Medicaid and Children's Health Insurance Program (CHIP). Premiums are $15 to $25 per month for each covered parent. Cost sharing is $5 for the non-emergency use of the emergency room. **Hawaii** The Hawaii 1115 waiver provides a comprehensive benefit package to adults up to 300 percent FPL, with premiums ranging from $30 per month to 50 percent of the cost of the their coverage. **Minnesota** The Minnesota 1115 waiver provides Medicaid coverage for parents of children in Medicaid up to 275 percent FPL. Monthly premiums are on a sliding scale from $4 to $492. **Oregon** The Oregon 1115 waiver provides a comprehensive benefit package to adults at or under 100 percent FPL, with premiums of $9 to $20 per month. **Utah** Utah's 1115 waiver provides certain adults, ages 19 and older and eligible for Medicaid through Utah's State Plan, with a benefits package equivalent to its public employee health plan. These enrollees are charged $6 for non-emergent emergency room use, $5 for office visits, and $2 for prescriptions. They also pay $220 for an inpatient hospital stay, with a maximum out-of-pocket annual limit of $500. Uninsured adults ages 19 and older up to 150 percent FPL are also eligible to receive a preventive and primary care benefit package. Enrollees are charged an enrollment fee of between $15 -$50, and pay cost sharing for various services, including 25 percent of prescription costs for non-preferred drugs and $30 for an emergency room visit, with a maximum $1,000 out-of-pocket annual limit.
Application to Texas – Advantages & Disadvantages:	**Advantages**: • Premiums and cost sharing may promote a greater awareness of the cost of health care service, thereby reducing utilization of higher cost or inappropriate services. • If included in a larger reform effort (i.e. federal 1115 waiver) that extends coverage to new categories or higher income individuals, or provides coverage outside of Medicaid, premiums and cost sharing could help offset new costs of the initiative. **Disadvantages**: • Medicaid beneficiaries have limited incomes and may be limited in their ability to pay premiums or cost sharing. Studies show that premiums and cost sharing cause low-income people to delay or reduce their use of care, and may lead to poor health outcomes and increased costs.[iii] In addition,

Strategy	Premiums and Cost Sharing
	other states have reported drops in Medicaid enrollment after implementing cost sharing for low income populations. • Given the limited use of premiums and cost sharing allowed under the DRA, administrative costs to implement and maintain these provisions may limit, eliminate, or exceed savings.

Meets Medicaid Reform Goal(s):

Cost Reduction or Avoidance	X	Maximizes federal funds		Improves Program Sustainability		Consumer Choice/ Responsibility	X
Reduces Number of Uninsured		Supports Private Market Coverage		Improves Quality		Improves Access	
Benefit Options							

Populations Affected:

A limited number of categories of Medicaid beneficiaries currently served in Texas could be charged premiums or cost sharing as defined by the DRA. (For individuals at or below 100 percent FPL, provisions in Title XIX of the Social Security Act, Section 1916 apply.[iv]) In Texas, these provisions allow the state to charge cost sharing up to $3 for certain services to non-exempt populations, but no premiums.

The major categories of individuals that could be charged premiums in Texas include infants from 133 to 185 percent of FPL, youths under age 21 transitioning from foster care, and some people who are elderly.

The DRA prohibits premiums or cost sharing for preferred drugs to be collected for the following individuals:
- Children under age 18 in mandatory coverage categories[v].
- Children in foster or adoption care coverage.
- Pregnant women.
- Any terminally ill individual receiving hospice services.
- Individuals in hospitals, nursing facilities, intermediate care facilities for persons with mental retardation, or other institutions under the state plan, and those who as a condition of receiving services in the institution are required to spend for care costs all but a minimum amount of income needed for personal needs.
- Individuals receiving services through Medicaid breast and cervical cancer programs.

The major categories of individuals in Texas that could potentially be subject to cost sharing include infants from 133 to 185 percent FPL, pregnant women for non-pregnancy related services, youths under age 21 transitioning from foster care, and some elderly individuals.

The DRA prohibits cost sharing to be collected for the following services:
- Services provided to individuals at or less than 100 percent FPL.
- Services provided to children under age 18 who are in mandatory coverage categories.
- Services for children in foster or adoption care coverage.

<table>
<tr><td>Strategy</td><td colspan="6">Premiums and Cost Sharing</td></tr>
<tr><td></td><td colspan="6">
• Preventive services provided to any child under 18.
• Services provided to pregnant women if the service relates to the pregnancy or a medical condition that may complicate the pregnancy. Cost sharing may be imposed on pregnant women for non-pregnancy related services.
• Services to a terminally ill individual in hospice.
• Individuals in hospitals, nursing facilities, intermediate care facilities for persons with mental retardation, or other institutions under the state plan, and those who as a condition of receiving services in the institution are required to spend for care costs all but a minimum amount of income needed for personal needs.
• Emergency services as defined by the U.S. Health and Human Services Secretary. (The Secretary has not yet defined these services.).
• Family planning services.
• Services furnished to women receiving services through Medicaid breast and cervical cancer programs.
Texas could pursue additional premium and cost sharing options through a federal 1115 waiver if coupled with initiatives to expanded Medicaid eligibility or other health coverage.
</td></tr>
<tr><td>General Revenue Impact:</td><td colspan="6">
It is unknown at this time if revenue generated through the limited premium and cost sharing options available through the DRA would offset increased administrative costs to implement and operate premiums and cost sharing.

Administrative costs would include:
• Systems and program changes to identify beneficiaries eligible for premiums or cost sharing, to disenroll beneficiaries not meeting premium payment requirements, and to manage changes when families meet the spending cap.
• New administrative processes to bill for, collect, and track premiums.
• Rate adjustments to account for provider collection of cost sharing.
• Provider and beneficiary education.
</td></tr>
<tr><td rowspan="2">Other Considerations</td><td colspan="2">Stand Alone Option</td><td>X</td><td colspan="2">This Option should be considered in conjunction with other Medicaid Reform Strategy(ies)</td><td>X</td></tr>
<tr><td colspan="6">Texas could implement premiums and cost sharing allowed by DRA through a state plan amendment. Given the limitations imposed by the DRA on collection of premiums and cost sharing of currently eligible beneficiaries, Texas may want to consider the introduction of premiums and cost sharing within the context of more comprehensive reform, such as public/private premium assistance programs or expansion of coverage to new individuals.</td></tr>
<tr><td rowspan="2">State and Federal Approval(s) Required:</td><td rowspan="2">Federal</td><td>1115 Waiver (if premiums and cost sharing are coupled with larger reforms)</td><td>X</td><td rowspan="2">State</td><td>Rules</td><td>X</td></tr>
<tr><td>Other Waiver(s), [LIST]</td><td></td><td>Legislation</td><td></td></tr>
</table>

Strategy	Premiums and Cost Sharing				
		State Plan Amendment (if premiums and cost sharing are implemented in the current Medicaid program)	X		
Implementation Considerations & Timeframes:	**Affected Stakeholders** • Consumer groups may oppose premium provisions. • Provider and consumer groups may oppose cost sharing provisions. **Systems and Resource Considerations** • See administrative costs identified in the General Revenue Impact section. **Implementation Timeframes (in months)** • Approximately 18-24 months would be needed to implement systems and program changes, revise rules, and seek approval of a state plan amendment.				

[i] CMS, State Medicaid Director letter, June 16, 2006. Available online at http://www.cms.hhs.gov/smdl/downloads/SMD061606.pdf

[ii] Section 1115 Research and Demonstration Waivers allow states to waive a number of federal requirements in order to test policy innovations. HIFA Waivers are a type of Section 1115 waiver specifically designed to increase the number of individuals with health insurance coverage.

[iii] A number of these studies are cited in the report, *Health Coverage for Low-Income Americans: An Evidence-Based Approach to Public Policy,* The Kaiser Commission on Medicaid and the Uninsured, November 2006. Available online at http://kff.org/uninsured/upload/7476.pdf

[iv] Clarified by Section 405, HR 6111, *Tax Relief and Health Care Act of 2006*, passed by Congress on December 9, 2006.

[v] Mandatory children's categories include children 0 through 5 years of age at or below 133 percent FPL, and children 6 through 18 years of age at or below 100 percent FPL.

ATTACHMENT 1
Deficit Reduction Act (DRA) – Allowable Premiums and Cost Sharing[v], by Risk Group

Categories	DRA *Unless otherwise noted, the allowable charges described below cannot in the aggregate exceed 5 percent of a family's income as applied on a monthly or quarterly basis.*
Mandatory children In Texas, this category includes: • Children ages 0 through 5 years at or below 133 percent of the federal poverty level (FPL) • Children ages 6 through 18 years at or below 100 percent FPL	• No premiums. • No cost sharing for services. • No cost sharing for preferred prescription drugs. • Cost sharing for non-preferred drugs up to the nominal amount[v]. Not subject to the 5 percent aggregate cap. • Cost sharing for non-emergency use of the ER up to the nominal amount. Not subject to the 5 percent aggregate cap.
Optional children with incomes from 100-150 FPL In Texas, this category includes: • Infants ages 0 through 1 year between 134 percent FPL and 150 percent FPL	• No premiums. • Cost sharing for services (for example, a doctor's visit or inpatient hospital stay) up to 10 percent of the cost of the item or service. • Cost sharing for preferred prescription drugs – states may waive payment or charge less than the nominal amount. • Cost sharing for non-preferred drugs – up to the nominal amount. • Cost sharing for non-emergency use of the ER – up to two times the nominal amount.
Optional children with incomes more than 150% FPL In Texas, this category includes: • Infants ages 0 through 1 year between 151 percent FPL and 185 percent FPL	• Premiums allowed. • Cost sharing for services – up to 20 percent of the cost of the item or service. • Cost sharing for preferred prescription drugs – states may waive payment or charge less than the nominal amount. • Cost sharing for non-preferred drugs – up to 20 percent of the cost of the drug. • Cost sharing for non-emergency use of the ER – no upper limit on charges.
Pregnant Women	• No premiums. • No cost sharing for pregnancy-related services. For non-pregnancy-related services: o If income is less than 100 percent FPL – no apparent upper limit and 5 percent aggregate cap does not apply. o If income is between 100-150 FPL – up to 10 percent of the cost of the item or service. o If income is more than 150 percent FPL – up to 20 percent of the cost of the item or service. • No cost sharing for preferred prescription drugs. • Cost sharing for non-preferred drugs – up to the nominal amount. • Cost sharing for non-emergency use of the ER– up to the nominal amount.

Categories	***DRA*** *Unless otherwise noted, the allowable charges described below cannot in the aggregate exceed 5 percent of a family's income as applied on a monthly or quarterly basis.*
Adults with incomes less than 100 percent FPL	The DRA does not address premiums or cost sharing for individuals with income below 100 percent FPL. HR 6111, *Tax Relief and Health Care Act of 2006*, Section 405, passed by Congress on December 9, 2006, clarified that for individuals at or below 100 percent FPL, provisions in Title XIX of the Social Security Act, Section 1916, apply. In Texas, these provisions would allow the state to charge cost sharing up to $3 for certain services, but no premiums, and services can not be denied for failure to pay cost-sharing.
Adults with incomes between 100-150 percent FPL[v] In Texas, this includes some people who are elderly or have disabilities.	• No premiums. • Cost sharing for services up to 10 percent of the cost of the item or service. • Cost sharing for preferred prescription drugs – states may waive payment or charge less than the nominal amount. • Cost sharing for non-preferred drugs – up to the nominal amount. • Cost sharing for non-emergency use of the ER up to two times the nominal amount.
Adults with incomes more than 150 percent FPL In Texas, this includes some people who are elderly or have disabilities.	• Premiums allowed. • Cost sharing for services up to 20 percent of the cost of the item or service. • Cost sharing for preferred prescription drugs – states may waive payment or charge less than the nominal amount. • Cost sharing for non-preferred drugs – up to 20 percent of the cost of the drug. • Cost sharing for non-emergency use of the ER – no upper limit on charges.