NATIONAL COUNCIL
FOR COMMUNITY BEHAVIORAL HEALTHCARE

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FINAL RULE ON CHANGES TO FEDERAL COST SHARING RULES

Medicaid Program; Premiums and Cost Sharing

A new federal rule , titled "Medicaid Program; Premiums and Cost Sharing (42 CFR Parts 447 and 457), gives states broader authority to charge premiums and higher co-payments for non-"institutional services"(including doctors' services, hospital care, prescription drugs, and behavioral health services) provided to low-income people under Medicaid. States may now deny services or medications to beneficiaries if they cannot pay co-payments or premiums (a provision that is also included in The Medicare Prescription Drug, Improvement, and Modernization Act). This fact sheet provides details about the populations and services impacted by the rule, briefly discusses implications, and provides recommendations for community behavioral healthcare organizations to protect access to Medicaid services for clients.

Under the Final Rule, the Centers for Medicare & Medicaid Services estimates that Medicaid recipients will pay more than $1.3 billion in co-payments over five years, resulting in savings of $1.4 billion to the federal government and $1.1 billion to the states. The Congressional Budget Office estimates that eighty percent of the expected savings will result from decreased use of services, and the other 20 percent from people who lose Medicaid coverage because they are unable to pay the new premiums.[i] Many public health experts and even some federal officials warn that low-income people may delay or forgo care because of the higher charges, resulting in higher acute care costs and increased rates of chronic diseases. States that already have waivers in order to require premiums for Medicaid coverage find that these changes almost always lead to enrollment declines.

Background

Prior to the Deficit Reduction Act (DRA), the Medicaid law prohibited states from charging Medicaid enrollees premiums or enrollment fees outside of a Section 1115 waiver or various Medicaid "buy-in" programs that have been introduced for working individuals with disabilities who do not have access to affordable employer based insurance. Additionally, beneficiaries could not be denied health care or medications if they were unable to afford the co-payments. Co-payments were limited to no more than $3 for any service, and Medicaid statewideness and comparability rules prohibited states from imposing different co-payments on distinct Medicaid populations or geographical regions of the State.

The DRA gave states the authority (as of March 31, 2006) to vary the premiums and cost sharing by and within groups (as defined by a state), by geographic area, and by type of service. The Final Rule, released November 25, 2008 in the Federal Register (Volume 73, Number 228), clarifies and implements sections of the Deficit Reduction Act of 2005 (DRA) and the Tax Relief and Health Care Act of 2006 (TRHCA). Section § 447.64 of the Federal Rule describes the State Plan requirements to implement alternative premiums, enrollment fees, and other similar fees. Below are examples of allowable cost sharing as a result of this rule:

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- A state that requires counties to contribute to the cost of Medicaid may allow cost sharing (within federal guidelines) to vary by county.
- States are allowed to require prepayment of premiums before individuals enroll and to terminate coverage if the individual (or, in the case of a child, his or her parent) does not pay within 60 days.
- In addition, States have the option to require payment of alternative premiums as a condition of eligibility and alternative cost-sharing as a condition of receipt of the service or drug, or cost-sharing for non-emergency services in the ER. As part of the ER provision, the DRA sets up a grant program that provides $50 million in funding for States to establish non-emergency alternative providers.
- The DRA contains special rules on cost-sharing for prescription drugs and non-emergency care provided in emergency rooms (ER).
- Copayments are adjusted annually for medical care component of the Consumer Price Index for All Urban Consumers (CPI-U). For 2009, copayments cannot exceed $3.40 per visit, and for individuals referenced in an approved State child health plan under title XXI pursuant to § 457.70(c), $5.70 per visit.

	Mandatory Children (under 6 with income < 133% FPL; 6- 17 <100% FPL) *	**Income < 100% FPL***	**Income 100 to 150 % FPL***	**Income > 150 %FPL***
Most services	Not allowed	Nominal cost-sharing	Up to 10 % of the cost of service	Up to 20% of the cost of service
Prescription drugs	Nominal for non-preferred; None for preferred	Nominal cost-sharing	Nominal cost-sharing	Up to 20% of the cost for non-preferred drugs
Non-emergency use of the emergency room	Nominal	Nominal cost-sharing	Two times nominal	No limit
Enforceability of co-payments	No	No	Yes	Yes

***Federal Poverty Level (FPL) is $10,400 for an Individual, $21,200 for a family of four**

Protections and Exemptions

Although some groups are exempt from premiums, none are exempted from cost-sharing. People who live in an institution, are receiving hospice care, children in mandatory coverage categories under age 18, very-low-income children and pregnant women, and people who qualify for Medicaid under the breast and cervical cancer eligibility category are exempt from premiums and cost-sharing under the DRA, but they do face a charge of up to $3 for a non-preferred drug or for non-emergency use of an emergency room. Children and adults who qualify on the basis of their disability, including individuals with serious mental illness, are subject to the new rules. Some services are exempt, but mental health services are generally subject to cost-sharing.[ii]

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- No premiums are permitted for families with incomes below 100 percent of the Federal Poverty Level (FPL). Co-payments are allowed, in line with the nominal co-payments allowed prior to the DRA (typically, $3).
- Children in the lowest income groups (up to 133% of poverty for those under age 6 and up to 100% of poverty for those between 6 and 17) can only be charged $3 for non-preferred drugs or non-emergency use of the emergency room. No other cost-sharing can be imposed on this group.
- No premiums are permitted for families with income above 100 percent and at/or below 150 percent of FPL. Cost-sharing up to 10 percent of the cost of services is permitted within this group.
- Above 150 percent of the FPL, premiums are permitted and cost-sharing up to 20 percent of the cost of services is allowed.
- The DRA provides that the aggregate premium and/or cost-sharing amounts must not exceed 5 percent of the family's income for all family members for the month or quarter period.

Implications

Extensive research has shown that even moderate levels of cost sharing—of the amounts permitted by this provision—cause Medicaid beneficiaries to delay or forgo needed care. If states aggressively use the new flexibility to reduce Medicaid spending growth, low income children and adults will likely experience financials barriers to obtaining needed care or will drop out of coverage altogether. Individuals with chronic health conditions are the most vulnerable to harm from cost-sharing, as they use the most health care services. Unintended consequences, including higher rates of hospitalization or more use of emergency room care, could result.

A recent analysis by Center on Budget and Policy Priorities found that higher co-payments can make it harder for people covered by Medicaid to afford medical services they need, while premiums can make it more difficult for low-income people to enroll and maintain coverage. Providers may also experience a loss of revenue due to reduced utilization of health care or loss of coverage if beneficiaries lose eligibility when they cannot pay premiums and seek uncompensated care. [iii]

What you can do

- **Stay in contact with your state officials to watch for state plan amendments.** In some states, governors can make these changes without going to the legislature. The chart below, adapted from the National Health Law Program, lists states requiring legislative approval before implementation of a state plan amendment.[iv] If your state does not have such a requirement, and your legislature is more helpful on these issues than the Governor, consider advocating for a bill that would require legislative approval of any Medicaid change.

MEDICAID COST SHARING
States with Statutory Requirements

Data drawn from *The Role of State Law in Limiting Medicaid Changes*, National Health Law Program

State has some form of statutory requirements related to Medicaid cost-sharing
State has NO statutory requirements related to Medicaid cost-sharing

If your state chooses to pursue cost-sharing or premiums:

- **Evaluate impact of costs on client ability to access to services in your organization, and prepare fact sheets for your state and federal legislators using examples of local service costs.** Talk with your legislators and state Medicaid and mental health administrators to protect against increasing burdens on individuals who are already living on very low incomes. For data on the impact of cost sharing in Medicaid, see the Joint Statement on Medication Cost Sharing in State Medicaid Programs with the National Council, NAMI, and Mental Health America.

- **Make sure administrative and billing staff are prepared to explain co-payment and premium changes to clients who may be unaware of the new rules.** Identify strategies to ensure a client's inability to pay increased costs does not prevent access to needed services (e.g., payment plans, additional resources for financial assistance).

- **Monitor implementation of rate changes**, and work closely with your state to develop simple eligibility and payment processes that work for individuals with serious mental illness. Check that state authorities track the amount of cost-sharing and are able to advise providers when the individual has met the five percent limit, so the burden is not placed on the beneficiary. If your state has a preferred drug list, advocate for a physician override procedure that will place minimal burdens on physicians and for a monitoring process to ensure that overrides are being granted when the preferred drug is not as effective and/or would have adverse side effects.   Evaluate cost sharing changes for mental health services and bring these to the attention of your legislatures through a fact sheet.

Any Questions or Comments? Contact Christopher Loftis, PhD (202.684.7457, xt 234 or ChrisL@thenationalcouncil.org).

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[i] Congressional Budget Office Cost Estimate (January 27, 2006), S. 1932 Deficit Reduction Act of 2005, see Uhttp://cbo.gov/ftpdocs/70xx/doc7028/s1932conf.pdfU.

[ii] A complete list of populations and services exempt from premiums and cost sharing can be found in the UState Medicaid Directors letters addressing sections 6041 through 6043U of the DRA.[ii]

[iii] See the UJoint Statement on Medication Cost Sharing in State Medicaid ProgramsU with the National Council, NAMI, and Mental Health America. For reviews of impact of cost sharing, see Leighton Ku and Victoria Wachino (July 7, 2005), The Effect of Increased Cost-Sharing in Medicaid: A Summary of Research Findings, Center on Budget and Policy Priorities; Samantha Artiga and Molly O'Malley (May 2005), Increasing Premiums and Cost Sharing in Medicaid and SCHIP: Recent State Experience

[iv] *See* "The Role of State Law in Limiting Medicaid Changes (April '06)" by the National Health Law Program and the National Association of Community Health Centers at Uwww.healthlaw.orgU.