



## What Makes Medicaid, Medicaid? Affordability

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- Medicaid provides important protections to reduce barriers to enrollment, keep necessary services affordable, and prevent financial ruin due to medical bills.
- Under current law, states may customize their Medicaid programs, including the option to impose premiums for some enrollees and cost sharing for services.
- Research consistently shows that imposing premiums and cost-sharing on low income persons create barriers to care and coverage and are not associated with substantial cost savings.
- Cost sharing is a blunt tool to shape health care seeking behavior, especially when the costs of medical services are nearly impossible to find out ahead of time.
- Proposals to change Medicaid financing to a per capita cap or block grant would result in budget pressures and push states to raise cost sharing and create more barriers to care for low income persons on Medicaid.

### Background

Affordable care is foundational to accessible care. High premiums keep people from getting insured, increase uncompensated care in hospitals and emergency departments, and lead to medical bankruptcies. High cost sharing leads people to delay and forgo needed care, even when they know this often leads to worse outcomes and expensive treatments down the road.<sup>1</sup>

At low incomes, people have to decide between medicine and food or medicine and rent. Medicaid, the nation's largest health insurance program, is designed specifically to meet the needs of such low-income individuals. And because affordability is so fundamental to access, Congress included robust affordability protections in the Medicaid program to keep out-of-pocket expenses low and encourage utilization of the most cost-effective services. This brief explores the program's affordability protections.

Consumers' out-of-pocket costs for health insurance can be loosely divided into two categories: up-front costs, which are mainly premiums, and back-end costs, which include cost sharing enrollees pay when they use services. Premiums are based on the projected cost of providing care for a given pool of enrollees, including administration, profits and other related costs, minus the expected share that the enrollee would pay for care. As anyone with health insurance knows, actually using care almost always involves additional out-of-pocket costs – a \$10 copay for a medication, 20% coinsurance for an x-ray, a \$1000 deductible. So premiums are only a price for admission; they do not cover all the costs of the show. In fact, premiums and cost sharing are inversely connected – a plan with higher back-end cost sharing typically has lower up front premiums. Because of this relationship, any discussion of affordability has to address both types of out-of-pocket expenses.

### Medicaid Law Prohibits Premiums for Most Low-Income Enrollees

Requiring low-income individuals to pay premiums or similar enrollment fees for health coverage keeps some people from enrolling. Low-income people face great financial strain and in many cases simply cannot afford even small premiums. For those with no credit cards or checking accounts, simply making a premium payment can be significant challenge. Evidence shows that when Medicaid enrollees have been subjected to premiums, substantial numbers drop out sooner rather than later.<sup>2</sup> As one might expect, this effect is greater as income decreases or as premiums increase.<sup>3</sup> Recognizing these barriers, Congress enacted provisions that generally prohibit Medicaid premiums on individuals with incomes below 150% of the federal poverty level (FPL).<sup>4</sup> Other provisions exempt certain groups, such as Native Americans, from premiums at any income level.

In the late 1990s and early 2000s, the Centers for Medicare & Medicaid Services (CMS) approved a number of demonstrations that charged premiums for limited-service benefit packages intended for non-elderly adults. Oregon, for example, charged sliding scale premiums to enrollees below the FPL and implemented a lock-out for nonpayment in 2003.<sup>5</sup> In the first year, enrollment dropped by nearly half for the affected population. A number of other states, including Washington, Rhode Island, Maryland, Vermont, and Utah also experienced substantial disenrollment after implementing premiums or enrollment fees on lower-income individuals.<sup>6</sup> In response to such experiences, at least four states reconsidered, abandoned or ultimately discontinued policies to implement premiums in Medicaid or CHIP.<sup>7</sup>

### Key Affordability Terms

**Premium:** fees paid, typically monthly, for coverage of a defined set of health care benefits for a defined period of time.

**Cost sharing:** the portion of expenses for covered health care services and supplies that the patient must pay out-of-pocket.

**Deductible:** the amount a patient must pay out-of-pocket before the insurer covers any expenses during a given benefit period.

**Coinsurance:** a percentage of the costs of any covered health care that an enrollee must pay after they receive that care

**Copayment:** a flat fee paid upon receipt of a covered service or item.

**Out-of-pocket maximum:** a cap on total patient spending per benefit period. The OOP maximum typically does not include premiums for private insurance, but does in Medicaid.

Despite that experience, yet another iteration of charging premiums to Medicaid enrollees began in the wake of the Supreme Court's decision that permitted states to reject the Medicaid expansion without penalty. In a handful of states, CMS has permitted premiums up to 2% of household income (about \$27/month for an individual at 138% FPL) through 1115 demonstrations.<sup>8</sup> Indiana has the harshest requirements of any state, with an approved waiver requiring premium payment prior to full enrollment and allowing a 6-month lockout penalty for failure to pay premiums.

*Early evaluations of Indiana's Health Indiana Plan suggest premiums and other cost sharing mechanisms may be creating barriers to coverage for low income enrollees.<sup>9</sup>*

These policies affect only the "least vulnerable" segment of Indiana's Medicaid expansion: individuals with incomes from 101-138% FPL who are not medically frail or otherwise exempt. This group comprised no more than 12% of the enrolled expansion population (roughly 45,000 individuals) in October 2016.<sup>10</sup> Within that group, state data shows that disenrollment more than tripled from 2,677 closures for nonpayment in the demonstration's first year to 9,384 through just the first three quarters of year two.<sup>11</sup> Data

estimating the total participation rates for eligible individuals in this income group is not available, and data that would enable meaningful comparisons across expansion states with or without premium policies, such as uninsured rates by income level, is also scarce. Still, Indiana's early evaluation raises serious concerns that premiums in Indiana's new demonstrations may be creating barriers to coverage. Such barriers are exactly what Congress sought to avoid when it enacted the Medicaid premium prohibition below 150% FPL.

### Cost Sharing's Impact on Low-Income Individuals and Families

The back-end cost sharing associated with actually using covered services can be substantial. In its simplest expression, cost sharing seeks to reduce the use or overuse of ineffective or less cost-efficient medical care, though there is a wide gap between intent and reality in this arena.<sup>12</sup> Research on cost sharing consistently supports several key conclusions regarding its impact on Medicaid enrollees:<sup>13</sup>

- **Untailored cost sharing, in practice, is not "smart."** As currently structured, the most common mechanisms, especially deductibles and coinsurance, are too broad and imprecise to shape more efficient health seeking behavior or effectively reduce systemic health costs without negatively impacting low-income beneficiaries' health and financial well-being. Research *over the last four decades* has consistently concluded that the imposition of cost sharing on low-income and vulnerable populations reduces use of both essential and less essential care in roughly equal proportions and correlates with increased risk of poor health outcomes.<sup>14</sup>
- **Cost sharing substantially impedes access to care for individuals with lower incomes.** At lower incomes, even small copays substantially and significantly reduce access to needed care.<sup>15</sup> The financial burden of cost sharing increases as household income decreases, magnifying this effect.

- **Increased cost sharing reduces utilization across many types of services.** In particular, cost sharing reduces adherence to medications, frequency of office visits, access to preventive services and utilization of mental health services.<sup>16</sup>
- **Decreased utilization due to cost sharing often increases the likelihood of adverse health events.** Evidence is strongest that reduced prescription adherence increases adverse events. This effect seems to increase with age, poorer health status, and lower income.
- **Cost sharing disproportionately impacts individuals with chronic illness and mental health and substance use disorders.** These individuals have higher health expenses and face higher risk of adverse events. On top of that, cost sharing for mental health services and substance use disorder treatment historically exceeds cost sharing for general medical care, though mental health parity laws aim to reduce such discrepancies.<sup>17</sup>
- **Cost sharing may not reduce overall costs by much, but it does *shift* health care costs.** In the Medicaid program, cost sharing shifts costs from state and federal governments to low-income enrollees and, to some extent, their providers.<sup>18</sup>

To help protect low income enrollees, Congress established limits on out-of-pocket expenses, as well as state flexibility. The following section explains these flexibilities, limitations, and several recent proposals by states to increase cost sharing beyond the federal limits.

### **Medicaid Limits Cost sharing to Maintain Access for Enrollees**

Medicaid allows states to impose cost sharing on services. Deductibles are generally not allowed, but limited copayments and coinsurance are permitted depending on the service, eligibility group, and income level of the enrollee. Individuals with incomes below the FPL have the lowest copayments – currently listed as no more than \$4.00 for a doctor visit or a preferred prescription drug.<sup>19</sup> States can charge these individuals higher amounts for a few services, such as \$8.00 for a non-emergency emergency department (ED) visit or a non-preferred prescription drug and up to \$75 for an inpatient visit.<sup>20</sup> Additional protections apply to ED and non-preferred drug copays, such as an exceptions process for those who have a clinical benefit from selecting a non-preferred drug.<sup>21</sup> States can also set considerably higher limits on individuals with incomes above the poverty line – up to 10% of Medicaid costs for most services for individuals between 100-150% FPL (See Appendix for a chart summarizing Medicaid cost sharing rules).

In addition to the general limits, Congress exempted certain vulnerable populations and services from cost sharing altogether. Most children, women eligible through the breast and cervical cancer option, Native Americans, and certain individuals receiving long-term supports and services may not be charged cost sharing. Exempt services include recommended preventive services, emergency services, and some reproductive health services described below.

These cost sharing limits and exemptions are an essential part of Medicaid's design. Without doubt, high cost sharing leads low-income people to delay or forego needed care.<sup>22</sup>

## Cost Sharing Protections for Women and Families

Recognizing the key role preventive screening and prenatal care play in successful pregnancy, childbirth, and early childhood development, Congress established additional protections for children and pregnant woman. Medicaid encourages states to increase access to coverage and care for children and pregnant women. Over half of the states provide full Medicaid coverage for pregnant women with incomes up to at least twice the federal poverty level. In all, Medicaid helps cover almost half the births in the United States and provides immediate coverage to infants born to a Medicaid-enrolled mother.<sup>23</sup> To enhance access to regular prenatal screening, which can lower the risk of later health complications, Medicaid law also exempts pregnancy-related services. Medicaid also excludes most children under the age of 18 from cost sharing.<sup>24</sup> This attention to enhancing access at critical life developmental stages may help explain the growing body of research showing that Medicaid coverage improves children's educational and occupational success later in life.<sup>25</sup>

Likewise, recognizing the importance and value of family planning services and supplies, Congress prohibited states from imposing cost-sharing on these services.<sup>27</sup> Research shows that eliminating cost-sharing obligations increases contraceptive use, improves women's ability to choose the contraceptive method that best suits their needs, and ultimately allows women to avoid unintended pregnancies.<sup>28</sup>

*Eliminating cost-sharing obligations increases contraceptive use, improves women's ability to choose the contraceptive method that best suits their needs, and ultimately allows women to avoid unintended pregnancies.<sup>26</sup>*

### Additional Cost Sharing Protections

Medicaid also includes three additional affordability protections to ensure access to care for the lowest-income populations. First, Medicaid law requires that anyone who is living at or below the FPL cannot be denied treatment due to their inability to pay the copayment.<sup>29</sup> Notably, while such a person cannot, for example, be denied a prescription at the pharmacy, that person is not absolved of their obligation to repay the debt.

Second, Medicaid law specifically allows providers to waive copays for their patients.<sup>30</sup> Again this statutory right recognizes the fact that cost sharing can present a serious barrier for low-income enrollees and shows Medicaid's expectation that personal responsibility be implemented as Congress intended to minimize these barriers.

Third, Medicaid law requires that no individual in poverty can be charged aggregate cost sharing in excess 5% of their household income in a month or quarter.<sup>31</sup> For an adult in a family of three at 138% FPL – the high end of Medicaid expansion – the quarterly aggregate cap would be \$335 per household. This out-of-pocket limit differs in important ways from the limits found in private insurance. The aggregate cap includes both Medicaid premiums and cost sharing for the whole household, while most private insurance limits exclude premiums and set separate individual and family caps. Most private insurance also calculates limits annually. But costly health events typically cluster together in the same month or quarter, so having a lower quarterly cap helps mitigate the impact of these one-time events on low income enrollees and their families.<sup>32</sup>

Taken together, these Medicaid protections dramatically improve the affordability of care for low-income individuals, particularly those who have more extensive and ongoing health care needs, meaning they can actually afford to use their insurance and get treatment. It comes as no surprise that a controlled study in Oregon comparing similar populations with and without Medicaid found that Medicaid coverage nearly eliminated catastrophic medical expenses and substantially reduced financial strain for the Medicaid group.<sup>33</sup> After two years, positive screens for depression were 30% lower in the Medicaid group, while Medicaid enrollees also displayed better medication adherence for diabetes and reported improved overall health.<sup>34</sup>

### **Protections for Older Adults – Medicare Savings Programs (MSPs)**

Medicaid helps low-income Medicare enrollees to pay for Medicare out-of-pocket costs. While Medicare is nearly universally available for older adults, premiums and back-end cost sharing can be steep, including hospital visit deductibles (\$1316/visit), Part B premiums (\$109/month for most), prescription drug expenses, and outpatient deductibles and coinsurance (\$183/year and the standard 20% of costs for most services). Those costs can add up quickly for an enrollee population that typically has care needs. To reduce the burden, Medicaid covers nearly all Medicare cost sharing for Medicare beneficiaries under the FPL with low assets. For Medicare enrollees with slightly higher incomes, MSPs cover the Medicare Part B premiums. That alone saves enrollees over \$1,300 over the course of a year.

These programs increase affordability for millions of older adults and people with disabilities and offer people the chance to access the care they may need to stay healthy and maintain active and integrated lives in their communities.

### **Threats to Medicaid Cost Sharing Protections**

A spate of recent proposals in Congress would repeal the Affordable Care Act and establish federal funding caps in Medicaid. If enacted, these policies would increasingly shift financial responsibility for Medicaid to the states and to enrollees. Coupled with the relinquishing of federal financial responsibility for this low-income health insurance program, Congress or the administration would likely have to find ways to allow states to curb enrollment or reduce services. *Proposals that would create such “additional flexibilities” for states may undermine Medicaid’s critical affordability protections.*

One likely way states will pursue such flexibilities is through 1115 demonstrations. Even without the added budget pressures a federal funding cap would create, several states have already successfully petitioned the federal government to conduct premium and cost sharing “demonstrations” on their adult Medicaid expansion groups. Six states now charge premiums to at least some portion of this population, and, as noted above, Indiana imposes both a waiting period for those who do not prepay premiums and a 6-month lockout for enrollees over the FPL who do not pay premiums on time.<sup>35</sup> Indiana is also conducting an “experiment” on the effects of charging copays more than triple the Medicaid legal limit for nonemergency use of the ED, despite evidence showing that ED copays are not effective at reducing nonemergency use of the ED.<sup>36</sup> The full impact of these policies is not yet known; but based on past experience, they will increase barriers to care.

Proposals to impose per capita caps will drastically cut federal Medicaid funding and shift costs onto states. States already facing budget constraints will likely reduce access to enrollment and services through increased cost sharing, lock outs, and other measures.

### **Conclusion**

For more than 50 years, Medicaid has provided access to affordable health services that would otherwise be unavailable to many. Medicaid's strong affordability protections provide states flexibility to customize their programs while assuring that those services remain accessible. Federal funding caps now threaten to roll back these critical design features that have helped make Medicaid such a success.

## ENDNOTES

<sup>1</sup> David Grande et al., *Life Disruptions for Midlife and Older Adults with High Out-of-Pocket Health Expenditures*, 11 ANN. FAM. MED. 37 (2013); Jeffrey Kullgren et al., *Health Care Use and Decision Making Among Lower-Income Families in High-Deductible Health Plans*, 170 ARCHIVE OF INTERNAL MED. 1918 (2010).

<sup>2</sup> Salam Abdus et al., *Children's Health Insurance Program Premiums Adversely Affect Enrollment, Especially Among Lower-Income Children*, 33 HEALTH AFF. 1353 (2014); Leighton Ku & Teresa A. Coughlin, *Sliding-Scale Premium Health Insurance Programs: Four States' Experiences*, 36 INQUIRY 471 (1999); Bill J. Wright et al., *The Impact of Increased Cost Sharing on Medicaid Enrollees*, 24 HEALTH AFF. 1106 (2005); Samantha Artiga & Molly O'Malley, HENRY J. KAISER FAM. FOUND., *Increasing Premiums and Cost Sharing in Medicaid and SCHIP: Recent State Experiences* (2005), <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/increasing-premiums-and-cost-sharing-in-medicaid-and-schip-recent-state-experiences-issue-paper.pdf>.

<sup>3</sup> Leighton Ku & Teresa A. Coughlin, *Sliding-Scale Premium Health Insurance Programs: Four States' Experiences*, 36 INQUIRY 471 (1999).

<sup>4</sup> Social Security Act § 1916(c). Although Medicaid law is very clear about this premium policy, HHS has recently given a few states questionable permission to apply premiums below 150% FPL – the states have been allowed to apply mandatory premiums for individuals from 100-150% FPL and voluntary premiums for individuals below 100%. Both of these policies fly in the face of clear evidence that such premiums are harmful and represent a serious departure from the carefully calculated design of Medicaid, which prohibits premiums for individuals that the evidence clearly shows cannot afford to pay those premiums. Medicaid law on premiums, if correctly applied, is uniquely designed to protect the needs of Medicaid beneficiaries.

<sup>5</sup> Samantha Artiga & Molly O'Malley, KAISER FAM. FOUND., *Increasing Premiums and Cost Sharing in Medicaid and SCHIP: Recent State Experiences*, 2 (2005), <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/increasing-premiums-and-cost-sharing-in-medicaid-and-schip-recent-state-experiences-issue-paper.pdf>

<sup>6</sup> *Id.*

<sup>7</sup> Leighton Ku & Victoria Wachino, CENTER ON BUDGET & POLICY PRIORITIES, *The Effect of Increased Cost-Sharing in Medicaid: A Summary of Research Findings* (2005), <http://www.cbpp.org/cms/?fa=view&id=321>. The states were VA, MD, CT, and WA. Leighton Ku & Victoria Wachino, *The Effect of Increased Cost-Sharing in Medicaid: A Summary of Research Findings* (Center on Budget and Policy Priorities) (2005), <http://www.cbpp.org/files/5-31-05health2.pdf>.

<sup>8</sup> CMS has not allowed disenrollment for nonpayment for anyone below the FPL.

<sup>9</sup> David Machledt, NAT'L HEALTH LAW PROGRAM, *Indiana Medicaid Expansion Raises Concerns* (Feb. 2017), <http://www.healthlaw.org/publications/browse-all-publications/indiana-medicaid-demonstration-raises-concerns>.

<sup>10</sup> Enrollment for the 101-138% FPL group reached 45,081 in October 2016, or roughly 11.5 % of total enrollment (389,205). Note that some individuals in this income group would have been declared medically frail or otherwise exempt from closure for nonpayment. So the actual number of enrollees subject to this policy would have been lower. IND. FAMILY AND SOCIAL SERVS. ADMIN. ("FSSA"), *Healthy Indiana Plan Demonstration Quarterly Report, Demonstration Yr. 2, Qtr. 3, 4* (Dec. 30, 2016).

<sup>11</sup> LEWIN GROUP, *Indiana Healthy Indiana Plan 2.0: Interim Evaluation Report*, 44 (July 6, 2016), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-interim-evl-rpt-07062016.pdf>. Nearly half of the second year disenrollments came in the third quarter. FSSA, *Healthy Indiana Plan Demonstration Quarterly Report, Demonstration Yr. 2, Qtr. 3, 4* (Dec. 30, 2016).

<sup>12</sup> David Machledt and Jane Perkins, NAT'L HEALTH LAW PROGRAM, *Medicaid Premiums and Cost Sharing* (Mar. 2014), available at: <http://www.healthlaw.org/publications/search-publications/Medicaid-Premiums-Cost-Sharing#>.

<sup>13</sup> *Id.*

<sup>14</sup> Ku & Wachino, *supra* note 7.

<sup>15</sup> *Id.*

<sup>16</sup> See Machledt & Perkins, *supra* note 12.

<sup>17</sup> Dominic Hodgkin et al., *Cost Sharing for Substance Abuse and Mental Health Services in Managed Care Plans*, 60 MED. CARE RES. REV. 101, 108 (2003). Note: The Mental Health Parity and Addiction Equity Act of

2008, expanded under the ACA, significantly limits the capacity for health plans to charge higher cost sharing for mental health and substance abuse disorder services. For more details on the scope and limitations of mental health parity law, see Elizabeth Edwards, NAT'L HEALTH LAW PROGRAM, *The Mental Health Parity and Addiction Equity Act of 2008* (Jan. 2014), <http://www.healthlaw.org/publications/browse-all-publications/issue-brief-mhpaea2008#.UxYyYYWGdNg>

<sup>18</sup> See Neal T. Wallace et al., *How Effective Are Copayments in Reducing Expenditures for Low-Income Adult Medicaid Beneficiaries Experience from the Oregon Health Plan*, 42 Health Res. & Educ. Trust 515 (2008). Many providers never collect copayments due and absorb an effective cut in rates equivalent to the amount of cost sharing. See Laura Snyder & Robin Rudowitz, KAISER FAM. FOUND., *Premiums and Cost-Sharing in Medicaid: A Review of Research Findings*, 11 (2013), <http://kaiserfamilyfoundation.files.wordpress.com/2013/02/8417.pdf>.

<sup>19</sup> Social Security Act §§ 1916(a)(3), 1916(b)(3), and 1916A(c)(2); 42 C.F.R. §§ 447.52(b)(1) and 447.53(b). See also further restrictions at 42 C.F.R. §§ 447.56(a). Note that beginning in October 2015 the cost sharing maximums for copays were indexed annually to the medical care component of the Consumer Price Index. Updated maximums have not been posted on CMS's website.

<sup>20</sup> Social Security Act §§ 1916(a)(3), 1916(b)(3), and 1916A(c)(2)(A); 42 C.F.R. §§ 447.53(b) and 447.54(b).

<sup>21</sup> 42 C.F.R. § 447.53 and 54.

<sup>22</sup> David Machledt and Jane Perkins, *supra* note 12 at note 13.

<sup>23</sup> Anne Rossier Markus et al., *Medicaid Covered Births, 2008 Through 2010, in the Context of the Implementation of Health Reform*, 23-5 WOMEN'S HEALTH ISSUES e273, e275 (2013), <http://www.whijournal.com/article/S1049-3867%2813%2900055-8/pdf>; KAISER FAMILY FOUNDATION, BIRTHS FINANCED BY MEDICAID (Oct. 2016), <http://kff.org/medicaid/state-indicator/births-financed-by-medicaid>; 42 U.S.C. § 1396a(e)(4); 42 C.F.R. § 435.117.

<sup>24</sup> 42 U.S.C. § 1396o(a)(2); 42 C.F.R. § 447.56(a); [exempting pregnant women and children from cost sharing] NAT'L INSTITUTE OF CHILD HEALTH AND HUMAN DEVELOPMENT, WHAT IS PRENATAL CARE AND WHY IS IT IMPORTANT?, <https://www.nichd.nih.gov/health/topics/pregnancy/conditioninfo/pages/prenatal-care.aspx>.

<sup>25</sup> Alisa Chester and Joan Alker, GEORGETOWN UNIVERSITY HEALTH POLICY INSTITUTE – CTR. FOR CHILDREN & FAMILIES, *Medicaid at 50: A Look at the Long-Term Benefits of Childhood Medicaid* (July 2015), <http://ccf.georgetown.edu/2015/07/27/medicaid-50-look-long-term-benefits-childhood-medicaid/>.

<sup>26</sup> See, e.g., Jeffrey F. Peipert et al., *Preventing Unintended Pregnancies by Providing No-Cost Contraception*, 120(6) OBSTETRICS & GYNECOLOGY 1291, 1291 (2012); Kelly Cleland et al., *Family Planning as Cost-Saving Preventive Health Service*, 364 NEW ENG. J. MED. e.37(1), e.37(2) (2011).

<sup>27</sup> 42 U.S.C. 1396o(a)(2)(d); 42 C.F.R. 447.56(a)(2)(ii).

<sup>28</sup> See, e.g., Jeffrey F. Peipert et al., *Preventing Unintended Pregnancies by Providing No-Cost Contraception*, 120(6) OBSTETRICS & GYNECOLOGY 1291, 1291 (2012); Kelly Cleland et al., *Family Planning as Cost-Saving Preventive Health Service*, 364 NEW ENG. J. MED. e.37(1), e.37(2) (2011).

<sup>29</sup> Social Security Act §§ 1916(e) and 1916A(d)(2); 42 C.F.R. § 447.52(e).

<sup>30</sup> Social Security Act § 1916A(d)(2); 42 C.F.R. §. §447.52(e)(3).

<sup>31</sup> Social Security Act § 1396o-1(b)(1)(B)(ii) and (b)(2)(A); 42 C.F.R. § 447.56(f).

<sup>32</sup> Thomas M. Selden et al., *Cost sharing in Medicaid and CHIP: How Does It Affect Out-of-Pocket Spending?* 28 HEALTH AFF. w607, w614 (online ed. 2009), <http://content.healthaffairs.org/content/28/4/w607>. For families with children on public insurance, the average peak month accounts for 43% of annual out-of-pocket spending, while the average peak quarter accounts for 58% of annual spending.

<sup>33</sup> Katherine Baicker, et al., *The Oregon Experiment – Effects of Medicaid on Clinical Outcomes*, 368 NEW ENG. J. MED. 1713 (2013).

<sup>34</sup> *Id.* at 1717.

<sup>35</sup> The six states are Michigan, Indiana, Arizona, Arkansas, Montana, and Iowa. Pennsylvania received approval but later abandoned its demonstration in favor of a straight Medicaid expansion state plan amendment.

<sup>36</sup> Medicaid law forbids charging copays for emergency care. 42 U.S.C. § 1396o(a)(2)(D); 42 U.S.C. § 1396o-1(b)(3)(B). Medicaid ED copays differ from private insurance in that they require providers to first screen patients to identify their needs are not emergent *prior* to charging a copay for treatment. Multiple studies have shown substantial inconsistencies in this screening process, while other studies have found that nonemergency ED copays have not significantly affected ED utilization in the Medicaid context.

<b>Appendix: Rules for Medicaid Premiums and Cost Sharing<sup>***</sup></b>			
	<b>≤ 100% FPL</b>	<b>101% - 150% FPL</b>	<b>&gt;150% FPL</b>
<b>Premiums</b>	Not allowed*	Not allowed*	Allowed
<b>Maximum Allowable Copayments</b>			
Outpatient services	\$4	10% of the service cost	20% of the service cost
Institutional services	Per admission, \$75	Per admission, 10% of the total agency cost of stay	Per admission, 20% of the total cost of stay
Preferred drugs	\$4	\$4	\$4
Non-preferred drugs <sup>#</sup>	\$8 (nominal)	\$8 (nominal)	20% agency cost of drug
Nonemergency use of ED <sup>#,**</sup>	\$8	\$8	No limit <sup>+</sup>
<b>Aggregate cap</b>	5% of household income calculated monthly or quarterly (cap includes all Medicaid premiums and cost sharing, state chooses periodicity)		
<b>May deny care if no prepayment?</b>	No	Yes <sup>++</sup>	Yes <sup>++</sup>
<b>Groups exempt from premiums and cost sharing</b>	<ul style="list-style-type: none"> <li>• Mandatory eligible children under age 19 (§ 435.118), except for infants under age 1 with incomes above 133%</li> <li>• Children in federally funded foster care</li> <li>• Disabled children, except those eligible under the Family Opportunity Act with incomes above 150% FPL</li> <li>• Persons in institutions who have only a personal needs allowance, and at state option, persons receiving HCBS who are subject to share-of-cost</li> <li>• Women eligible through the Breast and Cervical Cancer Treatment Program</li> <li>• Individuals receiving hospice care</li> <li>• Indians who have ever been served through Indian Health Services programs</li> </ul>		
<b>Services exempt from cost sharing</b>	<ul style="list-style-type: none"> <li>• Services furnished to pregnant women, including counseling &amp; pharmacotherapy for tobacco use cessation, unless listed in State Plan as not pregnancy-related</li> <li>• Emergency services</li> <li>• Provider-preventable services</li> <li>• Family planning services and supplies</li> <li>• Preventive services, including at least well-baby and well-child services and immunizations for children under 18, regardless of income<sup>##</sup></li> </ul>		

\* 42 U.S.C. § 1396o allows states to charge premiums on individuals below 150% FPL in certain eligibility categories. These include the Medically Needy, extended Transitional Medical Assistance, and several optional categories for people with disabilities. See also 42 C.F.R. § 447.55.

\*\* Cost sharing is allowed only if the beneficiary has been screened and receives proper notice, with a referral to an actually available and accessible alternative provider.

\*\*\* These figures reflect FY 2015 maximums. Copays are now annually indexed to the medical care component of the Consumer Price Index, but updated maximums are not posted.

# This cost sharing can also be applied to individuals normally exempt from cost sharing.

## States have the option to exempt additional preventive services from cost sharing. Preventive services recommended by the U.S. Preventive Services Task Force may not be subject to cost sharing in Alternative Benefit Plans, such as those available to adults in the ACA Medicaid expansion group.

+ While the regulations set no federal limit, the 5% aggregate household cap still applies.

++ Individuals normally exempt from cost sharing are not subject to enforceable cost sharing.