FactSheet

MACPAC

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Advising Congress on Medicaid and CHIP Policy

Federal Requirements and State Options: Premiums and Cost Sharing

States have the flexibility under Sections 1916 and 1916A of the Social Security Act (the Act) to require certain individuals to pay premiums or enrollment fees in order to enroll in Medicaid or cost sharing associated with the receipt of particular services, including copayments, deductibles, or similar charges (Table 1). (For definitions of cost sharing terms, see Box 1.) There are specific guidelines regarding who may be charged these fees, the services for which and the amounts they may be charged, and the penalties they may face if amounts owed are not paid.

BOX 1. Cost Sharing Definitions

Premium: A fee, generally due on a monthly basis, that an enrollee must pay to remain in Medicaid.

Enrollment fee: A fee required prior to enrolling and reenrolling in Medicaid. Under federal Medicaid regulations, enrollment fees are considered to be a type of premium.

Cost sharing: The portion of health care costs that is the enrollee's responsibility. Cost sharing can include coinsurance, copayments, and deductibles.

Coinsurance: The percentage of a medical bill that the enrollee must pay. For example, if Medicaid pays for 80 percent of a certain service, the enrollee is responsible for paying the remaining 20 percent (coinsurance charge).

Copayment: A fixed amount that the enrollee must pay the provider at the point of service. For example, an enrollee may be required to pay $4 for an office visit with a physician.

Deductible: The amount of medical expenses for covered services per benefit period (usually one year) that the enrollee must incur before Medicaid will pay for care. Some services may be fully covered regardless of whether the enrollee has reached the deductible (this is referred to as exempt from the deductible).

Populations exempt from premiums and cost-sharing charges. Certain populations are exempt from any premium or cost sharing charges, including most children under age 18; children receiving child welfare services; certain American Indians and Alaska Natives; certain beneficiaries in institutions such as nursing facilities and intermediate care facilities; beneficiaries receiving hospice care; and individuals eligible for Medicaid under the Breast and Cervical Cancer Treatment Program (42 CFR 447.56(a)(1)).

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Premiums and other cost sharing can be imposed on adults, parents, and certain aged, blind, and disabled beneficiaries. However, premiums can only be charged for individuals whose income exceeds 150 percent of the federal poverty level (FPL) (42 CFR 447.55(a)). As many states do not cover individuals with incomes above 150 percent FPL, premiums are not common in Medicaid.

Premiums. States may charge certain pregnant women premiums of up to 10 percent of the amount by which their income exceeds 150 percent FPL. Individuals eligible through a medically needy pathway may be charged on a sliding scale up to $20 per month. Individuals eligible under certain pathways for children and working adults with disabilities may be charged on a sliding scale based on income (42 CFR 447.55). The amount and range of premiums for such populations varies across states. For example, monthly premiums range from $25 to $200 for working individuals with disabilities in Colorado, while North Carolina charges workers with disabilities an annual enrollment fee and a monthly premium that ranges from $139 to $283 (HCPF 2014, NCDHHS 2017).

Cost sharing. In Medicaid, cost sharing can vary based on enrollee income, type of provider, and the cost of the service (MACPAC 2014a, MACPAC 2014b). States may impose cost sharing for outpatient services, inpatient hospital stays, non-emergency use of the emergency department, and prescription drugs (42 CFR 447.52–54). For example, 27 states require parents to pay cost sharing for non-preventive physician services and 38 states require cost sharing for prescription drugs (Brooks et al. 2017).

Cost sharing is prohibited for emergency services, family planning services and supplies, preventive services provided to children under 18 (regardless of family income), and services for provider-preventable conditions (42 CFR 447.56(a)(2)). Although pregnant women may be charged cost sharing for services not related to the pregnancy, all pregnancy-related services must be provided at no cost to the beneficiary (42 CFR 447.56(a)(1)(vii), 42 CFR 447.56(a)(2)(iv)).

For populations with household income at or below 100 percent FPL, only nominal cost-sharing charges are permitted. For individuals with income over 100 percent FPL, states may target higher cost-sharing amounts to specific populations.[1] While the amount charged may vary by income, lower-income individuals cannot be charged more than higher-income individuals (42 CFR 447.52(g)).

Nominal levels of cost sharing are defined in regulation and range from $4 for outpatient services to $75 for inpatient services. These maximum levels are increased annually by the percentage increase in the medical care component of the Consumer Price Index for All Urban Consumers (CPI-U) (42 CFR 447.52(b)). States may also establish differential cost sharing for preferred and non-preferred drugs (42 CFR 447.53).

Consequences for non-payment. A state may permit providers to deny service to a beneficiary with income above 100 percent FPL who does not pay required cost sharing, but also must permit providers to reduce or waive cost sharing on a case-by-case basis (42 CFR 447.52(e)). States may terminate categorically needy beneficiaries for failure to pay premiums after a grace period of 60 days; coverage for medically needy beneficiaries, however, may not be terminated for failure to pay premiums (42 CFR 447.55(b)(2)). States cannot bar an individual terminated for failure to pay premiums from re-applying and enrolling in coverage if otherwise eligible (42 CFR 447.55(b)(5)).

Aggregate limit. Total expenses for premiums and cost sharing for all individuals in a Medicaid household are capped at 5 percent of monthly or quarterly household income.[2] If a state imposes premiums or cost sharing that could put beneficiaries at risk of reaching this cap, the state must have a process in place to track expenditures that does not rely on the beneficiary. In addition, states must inform beneficiaries and their providers when the beneficiaries reach their 5 percent cost sharing cap. In such instances, individuals are no longer subjected to further cost sharing obligations for the remainder of the month or quarter (42 CFR 447.56(f)).

Waivers

Section 1916(f) of the Act imposes certain limits on waivers of cost sharing rules that apply even under Section 1115 demonstrations. Under 1916(f) requirements, a waiver of Medicaid copayment and deductible rules will only be approved if it:

- tests a unique and previously untested use of copayments;
- is limited to a period of two years or less;
- can reasonably expected to provide benefits to beneficiaries that equal the risks;
- is based on a reasonable hypothesis and is designed to test it in a methodologically sound manner, including the use of control groups; and
- is either voluntary or assumes liability for preventable damage to the health of beneficiaries resulting from their involuntary participation in the demonstration.

In addition, any waiver authority provided must be limited to a period of two years or less. These conditions have generally dissuaded states from pursing a waiver of cost-sharing limits, with only one state (Indiana) meeting these conditions. Under its waiver, Indiana is authorized to charge above-nominal amounts for non-emergency use of the emergency room ($8 for the first instance and $25 for subsequent instances), to test the theory that graduated copayments will decrease non-emergency use of the emergency room (CMS 2015).

The limitations in section 1916(f) of the Act do not apply to premiums, and CMS has approved some states to charge premiums for adults with incomes below 150 percent FPL under Section 1115 waivers. Some states have also received waivers to charge lower cost sharing for beneficiaries who engage in certain healthy behaviors, or waivers to adopt an approach similar to a health savings account in which enrollees make monthly or quarterly contributions toward payment for services (MACPAC 2017). Indiana has also received permission to impose a lock-out period on adults with incomes above 100 percent FPL who fail to make premium contributions, following a 60-day grace period (CMS 2015).

TABLE 1. Federal Requirements and State Options: Summary of State Flexibilities Related to Premiums and Cost Sharing

Type of out-of-pocket cost	Federal statutory and regulatory requirements	State plan options
Premiums: Enrollees	States cannot impose premiums on: • most children under age 18 (regardless of income)[1] • children with disabilities • children receiving Title IV-B or IV-E child welfare services • enrollees with incomes below 150 percent FPL • beneficiaries receiving hospice care • certain beneficiaries in institutions such as nursing facilities and intermediate care facilities • American Indian and Alaska Natives who are eligible to receive services from an Indian Health Service provider, even if they never received services • individuals eligible for Medicaid under the Breast and Cervical Cancer Treatment Program (§§ 1916(a), 1916(b)(2), 1916A(b) 1916(j), 42 CFR 447.55, 42 CFR 447.56(a)).	• States may impose premiums on individuals above 150 percent FPL (§ 1916(c), 42 CFR 447.55(a)). • States may impose premiums based on a sliding scale for: – certain pregnant women and infants – medically needy individuals – Children with disabilities eligible under the Family Opportunity Act – certain working individuals with disabilities[2] (§§ 1916(c), 1916(d), 1916(g) 1916(i), 42 CFR 447.55(a)).
Premiums: Amounts	• States may charge non-exempt pregnant women up to 10 percent of the amount by which their income exceeds 150 percent FPL (§ 1916(c), 42 CFR 447.55(a)(1)). • States may charge medically needy individuals up to $20 per month (42 CFR 447.55(a)(5)). • States may charge non-exempt children and working adults with disabilities on a sliding scale based on income (§§ 1916(d), 1916(g), 1916(i), 42 CFR 447.55(a)).	• States may choose to charge a lower premium, or no premium. • States may waive premiums on a case-by-case basis if payment would impose an undue hardship (42 CFR 447.55(b)(4)).

TABLE 1. (continued)

Type of out-of-pocket cost	Federal statutory and regulatory requirements	State plan options
Premiums: Consequences of nonpayment	• Medically needy beneficiaries may not be terminated for failure to pay premiums (42 CFR 447.55(b)(2)). • Individuals terminated due to failure to pay premiums may not be barred from re-applying or re-enrolling in coverage if otherwise eligible (42 CFR 447.55(b)(5)).	• States may terminate Medicaid for failure to pay premiums after a 60-day grace period (§ 1916A(d)(1), 42 CFR 447.55(b)(2)).
Cost sharing: Populations	States cannot impose cost sharing on the following groups: • most children under age 18 (regardless of income)[1] • children receiving Title IV- B or IV-E child welfare services • hildren with disabilities • beneficiaries receiving hospice care • certain beneficiaries in institutions such as nursing facilities and intermediate care facilities • American Indians and Alaska Natives who have ever received care from an Indian Health Service care provider • individuals eligible for Medicaid under the Breast and Cervical Cancer Treatment Program (§§ 1916(a), 1916(b)(2), 1916(j), 42 CFR 447.56(a)).	• States may charge cost sharing to adults, parents, and certain aged, blind, and disabled beneficiaries (§ 1916A, 42 CFR 447.52(a). • States may charge otherwise exempt populations cost sharing for non-preferred drugs and non-emergency use of the emergency department (42 CFR 447.53 (d), 42 CFR 447.54(c)).
Cost sharing: Services	States cannot impose cost sharing for the following services: • emergency services • family planning services and supplies • preventive services for children under 18 regardless of family income • pregnancy-related services	• States may charge nominal cost sharing for any state plan service other than those that are exempted ((§§ 1916(a)(3), 1916(b)(3)42 CFR 447.52) • States may target cost sharing to populations with incomes above 100 percent FPL (42 CFR 447.52(d)).

TABLE 1. (continued)

Type of out-of-pocket cost	Federal statutory and regulatory requirements	State plan options
	• services related to provider-preventable conditions (§ 1916(b)(2), 1916A(b)(3)(B), 42 CFR 447.56(a)(2))	• States may require cost sharing for non-emergency use of the emergency room if enrollees are screened by a medical professional (to confirm that the care is non-emergent), notified about the cost sharing charges, and provided with the name and location of an available and accessible alternative non-emergency services provider (42 CFR 447.54(d)).
Cost sharing: Amounts	Cost sharing for particular benefits may not exceed the following limits, based on the income of the enrollee: • outpatient services: – less than or equal to 100 percent FPL: $4 (the maximum allowable nominal amount); – 101–150 percent FPL: 10 percent of the cost the agency pays; – above 150 percent FPL: 20 percent of the cost the agency pays (42 CFR 447.52). • inpatient stay: – less than or equal to 100 percent FPL: $75 (maximum allowable nominal amount); – 101–150 percent FPL: 10 percent of the total cost the agency pays for the entire stay; – above 150 percent FPL: 20 percent of total cost the agency pays for the entire stay (42 CFR 447.52). • drugs: – preferred o less than or equal to 150 percent FPL: $4 (maximum allowable nominal amount) o above 150 percent FPL: $8 (maximum	• States may choose to charge a lower level of cost sharing, or no cost sharing.

TABLE 1. (continued)

Type of out-of-pocket cost	Federal statutory and regulatory requirements	State plan options
	allowable nominal amount) – non-preferred o less than or equal to 150 percent FPL: $4 (maximum allowable nominal amount) o above 150 percent FPL for non-preferred drugs, 20 percent of the cost the agency pays (42 CFR 447.53). • non-emergency use of the emergency department: – less than or equal to 150 percent FPL: $8 (twice the maximum allowable nominal amount) – above 150 percent FPL: no limit (42 CFR 447.54). Nominal amounts are defined in statute and updated annually when there are changes to the consumer price index (1916(h), 42 CFR 447.52, CMS 2013).	
Cost sharing: Consequences of nonpayment	• Enrollees with incomes below 100 percent FPL and those exempt from cost sharing cannot be denied access to services for non-payment (§§ 1916(e), 1916A(d)(2), 42 CFR 447.52(e)). • States must permit providers to waive cost sharing on a case-by-case basis (§1916A(d)(2), 42 CFR 447.52(e)(3)).	• States may permit a provider to deny service to a beneficiary (with incomes above 100 percent FPL) who does not pay required cost sharing (42 CFR 447.52(e)(1)).
Overall cap on out-of-pocket spending	• The total amount of premiums and cost sharing incurred by all individuals in a Medicaid household may not exceed 5 percent of the family's monthly or quarterly household income (42 CFR 447.56(f)). • The state must implement a process to track cost sharing that does not rely on the beneficiaries (42 CFR 447.56(f)(2)).	• States determine whether to calculate the cap on a quarterly on monthly basis (42 CFR 447.56(f)).

TABLE 1. (continued)

Type of out-of-pocket cost	Federal statutory and regulatory requirements	State plan options
	• The agency must also inform beneficiaries and their providers when the aggregate limit has been reached, so that enrollees are not subject to further cost sharing for the remainder of the month or quarter (42 CFR 447.56(f)(3)).	

Notes: FPL is federal poverty level.
[1] Children eligible under the mandatory eligibility group described in 42 CFR 435.118 (regardless of income).
[2] Individuals provided medical assistance under sections 1902(a)(10)(A)(ii)(XV) or 1902(a)(10)(A)(ii)(XVI) of the Act and the Ticket to Work and Work Incentives Improvement Act of 1999, may be charged premiums on a sliding scale based on income (42 CFR 447.55). Qualified disabled and working individuals described in section 1905(s) of the Act, whose income exceeds 150 percent of the FPL, may also be charged premiums on a sliding scale based on income.

Sources: MACPAC analysis of the Social Security Act and the Code of Federal Regulations.

Endnotes

[1] In determining whether to charge cost sharing, states have the flexibility to define the particular populations to target, but targeting may not be based on diagnosis (CMS 2013).

[2] States have the option of calculating the aggregate limit of 5 percent of the family's income is applied on a quarterly or monthly basis.

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