F I S C A L   I M P A C T   R E P O R T

ORIGINAL DATE 1/24/08
SPONSOR Gardner **LAST UPDATED** **HB** 268

SHORT TITLE Medical Assistance Beneficiary Cost Sharing **SB**

ANALYST Weber

REVENUE (dollars in thousands)

Estimated Revenue			Recurring or Non-Rec	Fund Affected
FY08	**FY09**	**FY10**		
	Undetermined but Minimal		Recurring	Other State Funds

(Parenthesis ( ) Indicate Revenue Decreases)

SOURCES OF INFORMATION
LFC Files

Responses Received From
Human Services Department (HSD)

SUMMARY

Synopsis of Bill

House Bill 268 would amend the Public Assistance Act to require that the HSD and the Medicaid program promulgate rules that would implement cost-sharing measures for recipients of Medicaid. A premium assessment would be imposed on recipients and it would it would also require rules leading to emergency room and pharmacy co-payments by Medicaid recipients. Emergency room copayments would be in amounts comparable to those charged by commercial health insurers and copayments for prescription drugs would be designed to provide incentives for greater use of generic prescription drugs.

It would allow that these cost sharing measures be for recipients that meet criteria determined by the department and be in compliance with federal requirements, but would require that the Department apply for any waivers that the Federal government may require to institute these coverage cost-sharing measures.

FISCAL IMPLICATIONS

Human Services offers the following regarding federal regulation of premiums and co-pays for the Medicaid populations.

Only certain Medicaid recipients in non-mandatory coverage groups could be required to share in premium and service costs in accordance with federal law. Co-payments currently are prohibited for children under 18 and for pregnancy related services, for institutional care, and for emergency services. Co-payments for adults must be nominal, defined as not to exceed $3.00.

The Department explored the possibility of this kind of cost sharing in 2005 when cost containment measures were necessary. At that time, the Department found cost-sharing measures, particularly premium payments, to not be a significant cost savings after administrative costs were accounted for.

The Deficit Reduction Act of 2005 allows cost sharing for some Medicaid populations and services, using the State Plan as authority rather than a demonstration waiver from the federal government. Individuals or households with incomes at 100% of the federal poverty level (FPL) or below are exempt from cost-sharing. For those families between 101-150% FPL, no premiums are permitted and coinsurance is allowed, up to 10% of the cost of service. There is a cap of 5% of family income per year. Nominal co-payments may be charged. For those at or above 151% FPL, premiums are permitted as is coinsurance, up to 20% of the cost of the service.

The DRA also exempts certain groups from premiums. These include children who are mandatorily eligible for Medicaid (ages birth through 5 up to 133% FPL and ages 6-18 up to 100% FPL), pregnant women, institutionalized individuals, terminally ill individuals receiving hospice, and women in breast or cervical cancer eligibility group. Certain services are exempt from coinsurance. These include services used by mandatory children to age 18; preventive services; family planning; pregnancy-related services to pregnant women; services to terminally ill or institutionalized persons; women in breast or cervical cancer eligibility group. Importantly in terms of this bill, emergent use of the Emergency Room is exempt.

The Department's current Preferred Drug List (PDL) requires that a generic drug be used when available.

Some recipients, such as those participating in the State Children's Health Insurance Program (SCHIP) and Working Disabled Individuals (WDI) program now are required to pay co-pays. Some recipients under the State Coverage Insurance (SCI) program, a waiver under the SCHIP program, pay both co-pays and premiums.

The demographics of the Medicaid population is not supplied to determine the potential cost savings, but the limited amount of co-pays seem to minimize this as a potential revenue source for the program.

MW/mt