United States General Accounting Office

GAO

Report to Congressional Requesters

March 2004

MEDICAID AND SCHIP

States' Premium and Cost Sharing Requirements for Beneficiaries

GAO-04-491

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GAO Accountability • Integrity • Reliability

Highlights

Highlights of GAO-04-491, a report to congressional requesters

Why GAO Did This Study

Over 50 million low-income adults and children receive health insurance coverage through Medicaid and the State Children's Health Insurance Program (SCHIP). Federal law allows states to require beneficiary contributions, such as premiums and cost sharing (coinsurance, copayments, and deductibles), for at least some Medicaid and SCHIP beneficiaries. GAO was asked to (1) identify and compare states' Medicaid and SCHIP beneficiary contribution requirements for children, (2) identify states' Medicaid beneficiary contribution requirements for adults, and (3) determine the extent to which states' Medicaid and SCHIP beneficiary contribution requirements have changed since 2001.

GAO surveyed Medicaid and SCHIP program offices in the 50 states and the District of Columbia about their beneficiary contribution requirements as of August 2003, including their requirements for specific population groups and for six selected services, such as inpatient hospital, physician services, and prescription drugs. For each population group covered, states were asked to indicate the portion of the group charged beneficiary contributions by selecting "all," "most," "some," or "none." GAO also interviewed officials of the Centers for Medicare & Medicaid Services (CMS) regarding the Medicaid and SCHIP statutory requirements for beneficiary contributions.

www.gao.gov/cgi-bin/getrpt?GAO-04-491.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Kathryn G. Allen at (202) 512-7118.

What GAO Found

GAO's survey found that children were more likely to be subject to beneficiary contributions, specifically premiums and cost sharing, in SCHIP than in Medicaid. Overall, 26 states reported charging premiums for a portion of children—"some," "most," or "all"—in SCHIP, compared to 9 states in Medicaid. Twenty-five states charged cost sharing for some portion of children in SCHIP, compared to 6 states for Medicaid. States used copayments as the primary form of cost sharing for children. Most states that reported charging cost sharing applied copayment requirements to the six health care services.

Most states reported requiring beneficiary contributions from adults enrolled in Medicaid. Twenty-five states charged premiums, generally charging portions of certain populations, such as adults with disabilities. Over 40 states charged cost sharing to most, if not all, adults, including those with disabilities, noninstitutionalized elderly persons, and parents. Copayments were the predominate form of cost sharing. States most frequently reported copayments for prescription drugs and physician services.

States with Copayments for Selected Services and Populations, as of August 1, 2003

	Number of states		
Population	Inpatient hospital	Physician services	Prescription drugs
Children			
Medicaid	4	5	4
SCHIP	12	21	22
Medicaid adults			
Pregnant women	2	2	2
Noninstitutionalized elderly	18	25	35
Adults with disabilities	19	26	36
Parents	16	22	31

Source: GAO analysis of state survey responses.

From the beginning of their 2001 state fiscal years through August 1, 2003, 34 states reported increasing and 10 states reported decreasing the amount of beneficiary contributions required in Medicaid, SCHIP, or both. For the 33 states that provided information on the amount of increases, premium increases to existing requirements ranged from $2 a month to $39 a month. Other states added new premium requirements, some of which were as much as several hundred dollars a month. In most instances, reported copayment increases were generally limited to $5 or less.

GAO asked CMS officials to provide technical comments on the statutory and regulatory information on Medicaid and SCHIP beneficiary contributions, which were incorporated as appropriate.

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Abbreviations

ADL	activity of daily living
AHRQ	Agency for Healthcare Research and Quality
CMS	Centers for Medicare & Medicaid Services
ER	emergency room
FPL	federal poverty level
IADL	instrumental activity of daily living
HHS	Department of Health and Human Services
MEPS	Medical Expenditures Panel Survey
SCHIP	State Children's Health Insurance Program

GAO
Accountability * Integrity * Reliability

United States General Accounting Office
Washington, DC 20548

March 31, 2004

The Honorable John D. Dingell
Ranking Minority Member
Committee on Energy and Commerce
House of Representatives

The Honorable Sherrod Brown
Ranking Minority Member
Subcommittee on Health
Committee on Energy and Commerce
House of Representatives

The Honorable Henry A. Waxman
Ranking Minority Member
Committee on Government Reform
House of Representatives

Over 50 million low-income adults and children receive health insurance coverage largely through two federal-state programs—Medicaid and the State Children's Health Insurance Program (SCHIP). Medicaid generally covers low-income families and individuals who are aged or disabled, while SCHIP provides health care coverage to children in families whose incomes, while low, are above Medicaid's eligibility requirements. Health insurance often includes beneficiary contribution requirements of some type, which require the insured individual to pay some portion of medical expenses. The most common types of beneficiary contribution requirements are premiums—a payment required for insurance coverage for a given period of time—and cost sharing—an out-of-pocket payment for part of the cost of services used by a beneficiary. Medicaid and SCHIP limit the use of beneficiary contribution requirements. The Medicaid statute limits the amount of the premiums that can be charged and prohibits states from instituting cost sharing provisions for certain categories of individuals, such as children under age 18 and pregnant women. Under SCHIP, federal law caps the amount of beneficiary contributions that can be charged for certain children and exempts preventive services for certain children from any cost sharing. States must seek authority from the federal government to waive these requirements to implement beneficiary contributions beyond Medicaid and SCHIP limits.

Opinions differ over the extent to which beneficiary contributions are appropriate and useful tools for managing health care utilization among low-income populations. Premiums are sometimes viewed as promoting personal responsibility by having the beneficiary participate in the cost of coverage. Proponents of cost sharing believe that copayments can make individuals more price-conscious consumers of health care services, which may reduce the use of unnecessary services. Others believe that cost sharing requirements may limit service use, such as physician visits, causing individuals to defer necessary treatment, resulting in more severe conditions and potentially higher expenses. Concerns have been expressed that, as states seek to increase the use of beneficiary contributions for Medicaid, SCHIP, or both programs, eligible individuals may reduce their program participation or use of services.

You asked us to (1) identify and compare states' Medicaid and SCHIP beneficiary contribution requirements for children, (2) identify states' Medicaid beneficiary contribution requirements for adults, and (3) determine the extent to which states' Medicaid and SCHIP beneficiary contribution requirements have changed since 2001.

To identify the beneficiary contribution requirements in states' Medicaid and SCHIP programs, we surveyed offices of each program in the 50 states and the District of Columbia.[1] The survey asked which beneficiary contribution requirements existed in the state as of August 1, 2003, the populations subject to each requirement, and changes made to the requirements since the beginning of the state's 2001 fiscal year.[2] For Medicaid, states were asked to report on requirements for nine population groups—children, children with special needs, pregnant women, individuals in nursing homes and institutions, noninstitutionalized elderly persons, adults with disabilities, medically needy,[3] parents, and any other populations defined by the state. We divided these categories into two

[1]Throughout this report, the term "states" refers to the 50 states and the District of Columbia.

[2]The time periods for states' fiscal years were different: most used a fiscal year that began July 1 and others used either the federal fiscal year (Oct. 1 through Sept. 30) or another time period.

[3]Medically needy individuals are generally people who fall into one of the eligibility categories that are composed of broad groups—children, individuals with disabilities, or the elderly—and who incur medical expenses such that their income, less these expenses, makes them eligible for Medicaid.

groups—children and adults.[4] For SCHIP, states were asked to report on requirements for children, children with special needs, and any other populations defined by the state. For each population group covered, such as children or individuals in nursing homes, the state was asked to indicate the portion of the group charged each of the four types of beneficiary contributions (premiums, copayments, coinsurance, and deductibles) by selecting "all," "most," "some," or "none." States were also asked to indicate if their Medicaid or SCHIP program did not cover a specific population. The survey asked states about their cost sharing requirements for six selected services (inpatient hospital, outpatient hospital, physician services, prescription drugs, nonemergency use of the emergency room (ER), and dental). In addition to their survey responses, states submitted documentation of the amounts of their beneficiary contribution requirements. We corroborated survey responses with documentation provided by states and other available data on states' Medicaid and SCHIP programs. We also contacted officials from the Centers for Medicare & Medicaid Services (CMS), the agency within the Department of Health and Human Services (HHS) that oversees states' Medicaid and SCHIP programs, regarding the Medicaid and SCHIP statutory requirements for beneficiary contributions. We performed our work from July 2003 through March 2004 in accordance with generally accepted government auditing standards.

Results in Brief

Our state survey showed that children were more likely to be subject to beneficiary contributions, specifically premiums and cost sharing, in SCHIP than in Medicaid. Overall, 26 states reported charging premiums for some portion of children—either "some," "most," or "all"—in SCHIP compared to 9 states in Medicaid. Twenty-five states charged cost sharing for some portion of children in SCHIP, while 6 states had cost sharing requirements for some portion of children in Medicaid. States used copayments as the primary form of cost sharing for children. Most states that reported charging cost sharing applied copayment requirements to the six health care services that we considered. The amount of beneficiary contributions required for children varied on the basis of factors such as

[4]The adult population group can include both children and adults. For example, a child (aged 18 or younger) may be placed in a nursing home or institution, be pregnant, or be considered medically needy. However, since the majority of the individuals in this group were likely to be over the age of 18, we categorized pregnant women, individuals in nursing homes and institutions, and medically needy population groups as adults for purposes of our report.

family income. For example, two states' Medicaid programs limited yearly premium amounts to a percentage of annual family income; SCHIP copayments for most services in one state were $2 or $5 depending on family income.

Nearly half of the states reported assessing premiums for some adults enrolled in Medicaid and the majority of the states required cost sharing for some portion of adults, primarily in the form of copayments for services. Twenty-five states charged premiums, generally limiting the charges to portions of certain population groups, such as working adults with disabilities. Over 40 states charged cost sharing to most, if not all, adults, including adults with disabilities, noninstitutionalized elderly persons, and parents. Copayments were the predominate form of cost sharing. The services for which states most frequently required copayments were physician services and prescription drugs. Copayment amounts varied depending on the service and the state. For example, across states, copayments ranged from $.50 to $25 for physician services and prescription drugs.

Thirty-four states reported increasing the amount of beneficiary contributions required in Medicaid, SCHIP, or both programs, while 10 states reported decreasing such requirements during states' fiscal years 2001 through August 1, 2003. Amounts of beneficiary contributions for children increased in 18 states—3 states in Medicaid, 12 states in SCHIP, and 3 states in both programs—and increased for adults in Medicaid in 30 states. The requirement most often increased was the copayment requirement, and the increases generally were targeted to noninstitutionalized elderly persons, adults with disabilities, and parents. Across the 33 states that provided us information on the amount of beneficiary contribution increases, premium increases to existing requirements ranged from $2 a month to $39 a month. Other states added new premium requirements, some of which were as much as several hundred dollars a month. Copayment increases were generally limited to $5 or less; in a small number of instances, increases were higher. For the 10 states that decreased beneficiary contribution requirements during the time period we reviewed, 5 states decreased requirements for some portion of children in SCHIP and 5 states decreased requirements for some portion of adults in Medicaid.

Officials in CMS provided technical comments on the statutory and regulatory information on Medicaid and SCHIP beneficiary contributions, which we incorporated as appropriate.

Background

Health insurance coverage often includes beneficiary contributions, which require an insured individual to pay some portion of medical expenses. The medical expenses charged to an individual—particularly for certain types of beneficiary contributions—can vary depending on the amount and type of services used. The two most common forms of beneficiary contribution requirements—health insurance premiums and cost sharing—differ in the method and frequency with which they are applied. Premiums are charged at regular intervals, such as monthly, and generally the same amount is charged each time. In contrast, cost sharing charges can vary depending on the amount and type of services used. There are three types of cost sharing arrangements: coinsurance, copayments, and deductibles (see table 1).

Table 1: Common Health Care Cost Sharing Arrangements

Type of cost sharing	Definition
Coinsurance	A percentage of the cost of health care services, such as physician visits and prescriptions filled.
Copayment	A fixed amount for each service paid at the time of service. Examples include payments for each physician visit and for each prescription filled.
Deductible	An amount that must be paid by the insured before the insurer will begin paying. For example, a covered individual with a $50 deductible would have to pay the first $50 of health care charges, after which the insurer would begin paying.

Source: Slee, Vergil N. et al., Slee's Health Care Terms: Third Comprehensive Edition (St. Paul, Minn.: Tringa Press, 1996).

Among low-income populations, approximately 40 percent of children and nondisabled adults had at least one nonpreventive physician visit during 2000.[5] Among these individuals, children averaged close to three nonpreventive physician visits per year, while nondisabled adults averaged fewer than five visits per year. Similarly, for individuals who filled at least one prescription, the average number of filled prescriptions ranged from approximately 4 per year for children to over 32 per year for adults with

[5]The Medical Expenditure Panel Survey (MEPS) provides national data on individuals' annual utilization of medical services. MEPS, conducted by the Agency for Healthcare Research and Quality (AHRQ), consists of four surveys, including the Household Component, which provides nationally representative data and expenditures for the U.S. civilian noninstitutionalized population.

disabilities.[6] (See app. I for more information on beneficiary service utilization.)

Medicaid and SCHIP generally limit the use of beneficiary contribution requirements. The following sections contain specific information about the programs and the federal laws pertaining to their use of beneficiary contributions.

Medicaid

Established in 1965, Medicaid is a joint federal-state entitlement program that finances health care coverage for certain low-income families, children, pregnant women, and individuals who are aged or disabled. In fiscal year 2001, there were more than 46 million Medicaid enrollees, over half of whom were children, and federal and state expenditures totaled $228 billion. Medicaid eligibility is based in part on family income and assets; states set their eligibility criteria within broad federal guidelines. Eligibility criteria for each state's Medicaid program are outlined in a CMS-approved state plan.

Medicaid allows states to require certain beneficiaries to contribute to the cost of their coverage by charging premiums and requiring cost sharing.[7] The populations that can be required to make beneficiary contributions under federal law differ depending on the type of beneficiary contribution—premiums or cost sharing—and the law places limits on the amounts of the contributions states can require. Federal law generally bars states from requiring beneficiary contributions of certain populations, but exceptions do exist. Additionally, states may seek federal approval to waive certain provisions regarding beneficiary contributions.

Federal Law Governing Premiums in Medicaid

States are prohibited from requiring premiums from certain low-income individuals within certain groups, including children, pregnant women, individuals in families with dependent children, individuals with disabilities, and elderly persons, but exceptions exist.[8] Specifically, in

[6]MEPS data showed that approximately 45 percent of low-income children had a prescription filled during a year, compared to approximately 96 percent of disabled adults.

[7]Social Security Act section 1902(a)(14) (codified at 42 U.S.C. 1396a(a)(14)).

[8]Medicaid classifies certain individuals as categorically needy. Categorically needy persons are those within certain eligibility categories, including persons who are disabled, elderly, pregnant, children, beneficiaries of cash assistance programs, and whose income and resources do not exceed specified levels.

Medicaid, the law allows states to require premiums from certain populations, such as certain working individuals with disabilities and families.[9] (See table 2 for examples of these exceptions.) Additionally, states are allowed to charge premiums to medically needy individuals—generally, people who fall into one of the eligibility coverage groups indicated above, but who incur medical expenses such that their income, less these expenses, makes them eligible for Medicaid.[10] If states require premiums for medically needy individuals, the regulations specify that the premiums be assessed on a sliding scale, from $1 to $19 per person per month, on the basis of their family's total gross income.

[9]Social Security Act section 1916 (codified at 42 U.S.C. 1396o).

[10]Medically needy coverage is also termed "spend-down" coverage; as of November 2002, 36 states opted to cover Medicaid beneficiaries under the medically needy or spend-down category.

Table 2: Examples of Exceptions to Prohibitions on Premiums in Medicaid, by Population Group

Population	Exception
Children	• Children under age 1 in families with incomes equal to or exceeding 150 percent of the federal poverty level (FPL)[a] may be charged premiums at states' discretion.[b] Premiums may not exceed 10 percent of family income that is above 150 percent of the FPL.[c]
Pregnant women	• Pregnant women whose incomes are equal to or exceed 150 percent of the FPL may be charged premiums at states' discretion.[b] Premiums may not exceed 10 percent of their income that is above 150 percent of the FPL.[c]
Individuals in families with dependent children	• Under "transitional Medicaid assistance," families moving from cash assistance to employment may maintain health insurance coverage under Medicaid for up to 1 year.[d] Premiums may be charged for the final 6 months of coverage for families above a certain level of income but may not exceed 3 percent of the family's average gross monthly earnings (less the average monthly costs for child care necessary to enable the caretaker relative to engage in employment).
Individuals with disabilities	• Under the Balanced Budget Act of 1997, states may cover working individuals with disabilities who have family incomes exceeding 250 percent FPL and there is no limit to the amount of premiums states can charge. • Under the Ticket to Work and Work Incentives Improvement Act of 1999 (Ticket to Work Act), states may require premiums of up to 7.5 percent of income from working individuals with disabilities whose annual incomes do not exceed 450 percent of the FPL.

Source: GAO analysis of federal law, as of March 2004.

[a]In 2003, the FPL for an individual equated to $8,980 per year and $15,260 for a family of three in the 48 contiguous states and the District of Columbia.

[b]Population group is covered under an optional categorically needy group in states that, as of December 19, 1989, had established, or passed legislation authorizing or appropriating funds for, a minimum income eligibility level for Medicaid greater than 133 percent of the FPL.

[c]If the minimum income eligibility level in the state for the optional categorically needy group exceeds 150 percent of the FPL, premiums may not exceed 10 percent of the family income that exceeds that minimum.

[d]Authorized by section 1925 of the Social Security Act (codified at 42 U.S.C. 1396r-6 (2000)).

Federal Law Governing Cost Sharing in Medicaid

Federal law prohibits states from applying cost sharing requirements for certain individuals and certain services. Specifically, cost sharing may not be charged for categorically and medically needy children under 18 years of age,[11] and pregnant women, for services related to the pregnancy or to conditions that could complicate the pregnancy. Additionally, cost sharing may not be charged for the categorically and medically needy for

- services furnished to individuals residing in a nursing home or other institution, who were required to spend most of their income for medical care;[12]
- services furnished to individuals receiving hospice care;
- emergency services; and
- family planning services and supplies.

States may require nominal copayments, coinsurance, or deductibles within federal limits from other beneficiaries or for other services (see table 3). Beneficiaries may be charged only one type of cost sharing per service. Providers may collect cost sharing amounts from beneficiaries and generally are not to be reimbursed by the state if they are unsuccessful in collecting cost sharing from beneficiaries. Providers generally may not deny services if beneficiaries are unable to pay cost sharing amounts.

[11]States may require cost sharing for individuals aged 18 to 21 even if they are considered children by the state.

[12]States may not charge cost sharing on medical services furnished to a person who is an inpatient in a hospital, long-term care facility, or other medical institution if, as a condition of receiving those services, the person was required to spend almost all of his or her income in order to qualify for Medicaid. See 42 CFR 447.53(b)(3) (2003).

Table 3: Medicaid Cost Sharing Limits

Type of cost sharing	Limit[a]
Coinsurance	Rates may not exceed 5 percent of the amount the state pays to Medicaid providers for the services for noninstitutional care or be more than 50 percent of the Medicaid payment for the first day of institutional care per admission.
Copayment	Amount is limited—from $0.50 to $3.00—for noninstitutional care and may be no more than 50 percent of the Medicaid payment for the first day of institutional care per admission.
Deductible	Amount is limited to $2.00 per family per month for each period of eligibility for noninstitutional care and to no more than 50 percent of the Medicaid payment for the first day of institutional care per admission.

Source: GAO analysis, as of October 2003, of Medicaid regulations.

[a]States may seek authority from CMS to charge up to twice the cost sharing limit for nonemergency services delivered in a hospital emergency room provided that the state can demonstrate that alternative sources of nonemergency, outpatient services are available and accessible to beneficiaries. See Social Security Act sections 1916(a)(3) and 1916(b)(3) (codified at 42 U.S.C. 1396o(a)(3) and (b)(3)).

Waivers of Premium and Cost Sharing Law in Medicaid

States must seek permission from the federal government to charge premiums or cost sharing beyond what is allowed under Medicaid. Under section 1115 of the Social Security Act, the Secretary of Health and Human Services has broad authority to approve demonstration projects that he determines are likely to promote Medicaid objectives.[13] The Secretary may waive certain provisions of the statute if the Secretary finds it necessary for the performance of the experimental, pilot, or demonstration projects. Section 1115 waivers have been used to provide coverage to individuals not normally eligible for Medicaid—or to expand coverage to those who are eligible under Medicaid but are not included in the scope of the state's plan. Beneficiary contribution requirements for individuals who become eligible for Medicaid through an 1115 waiver may be approved at the Secretary's discretion, subject to some limitations. CMS reviews states' proposed beneficiary contribution requirements for 1115 waivers as part of the waiver approval process and specifies any terms and conditions that a state must adhere to as a condition of the waiver approval.

[13]For purposes of this report, we will refer to demonstration projects approved under section 1115 as 1115 waiver programs.

According to CMS, because the provisions of Medicaid law related to limitations on beneficiary contributions[14] are applicable only to persons eligible under the state plan, specific waivers of the beneficiary contribution provisions are not always necessary. Waivers are necessary when states want to charge premiums or cost sharing amounts that are generally prohibited under federal law for individuals who are already covered under the state's plan. As of February 2004, two states—Arkansas and Vermont—have received approval to charge individuals premiums and one state—Arizona—has received approval to charge individuals both premiums and cost sharing.

For other populations, specific waivers of requirements regarding beneficiary contributions are not necessary. In particular, states are permitted to charge beneficiary contributions in excess of what would otherwise be permitted for populations who, without a waiver, would not be eligible for coverage under the state's Medicaid plan. For these populations, states are permitted to end coverage for beneficiaries who fail to pay premiums or deny services to those who fail to pay cost sharing. As of February 2004, of the 22 states with statewide 1115 waivers, 21 states covered populations in their Medicaid program for which the Medicaid statutory provisions regarding limits on beneficiary contributions are not applicable.

SCHIP

In 1997, Congress established SCHIP, which provides health care coverage to low-income, uninsured children living in families whose incomes exceed the states' eligibility limits for Medicaid. SCHIP covered over 5.8 million children during fiscal year 2003,[15] and federal and state expenditures were approximately $6.1 billion. States have three options in designing SCHIP—expand their Medicaid program, develop a separate child health program that functions independently of Medicaid, or combine these two approaches.

The approach that a state chooses affects its beneficiary contribution policies. A state that uses its SCHIP allocation to expand Medicaid must follow Medicaid rules—thus SCHIP beneficiaries are subject to the state's Medicaid policies with regard to premiums and cost sharing. For a state

[14]See section 1916 of the Social Security Act.

[15]This number represents an unduplicated count of all beneficiaries enrolled at any time in fiscal year 2003.

with a separate SCHIP program, federal law limits the premium and cost sharing amounts it may charge. States with a separate SCHIP program are prohibited from requiring premium or cost sharing contributions together totaling more than 5 percent of family income.[16] States with separate SCHIP programs are also prohibited from charging any cost sharing on preventive services.[17] In addition, for children in families with income at or below 150 percent of the FPL, there are specific limits on the amounts of premiums and cost sharing that states may charge in a separate SCHIP program (see table 4). For these individuals, federal regulation also prohibits states from requiring more than one type of cost sharing charge on each service. Additionally, regardless of family income or a state's SCHIP design, states are prohibited from charging premiums or cost sharing to American Indians or Alaska Natives.[18]

[16]42 CFR 457.560 (2003).

[17]Regarding preventive services, federal regulations prohibit these states from charging cost sharing for well-baby and well-child services, including routine physical examinations, associated laboratory tests, immunizations, and routine preventive and diagnostic dental services. See 42 CFR 457.520 (2003).

[18]42 CFR 457.125, 457.535 (2003).

Table 4: Federal Limits on Separate SCHIP Programs' Premium and Cost Sharing for Children in Families with Income at or Below 150 Percent of the Federal Poverty Level

Type of beneficiary contribution	Limits for children in families with income at or below 100 percent of the federal poverty level (FPL)	Limits for children in families with income from 101 to 150 percent of the FPL
Premium	• May not exceed the Medicaid premium schedule for the medically needy, which operates on a sliding scale, with a maximum premium of $19 per person per month.	• Limits are the same as those for families with income at or below 100 percent of the FPL.
Coinsurance	• May not exceed 5 percent of the state payment for non-institutional services; and • may not exceed 50 percent of the state payment for the first day of institutional care per admission.	• May not exceed 5 percent of the state payment for noninstitutional services; and • may not exceed 50 percent of the state's Medicaid fee-for-service payment for the first day of institutional care per admission.
Copayment	• From $0.50 to $3 for noninstitutional services; and • may not exceed 50 percent of the state payment for the first day of institutional care per admission.	• From $1 to $5 for noninstitutional services provided under fee-for service; • may not exceed $5 per visit for noninstitutional services provided under managed care; • may not exceed 50 percent of the state's Medicaid fee-for-service payment for the first day of institutional care per admission; • may not exceed $5 for hospital emergency services; and • may not exceed $10 for nonemergency services furnished in an emergency room.
Deductible	• May not exceed $2 per family per month per period of eligibility for noninstitutional services; and • may not exceed 50 percent of the state payment for the first day of institutional care per admission.	• May not exceed $3 per family per month per period of eligibility for noninstitutional services; and • may not exceed 50 percent of the state's Medicaid fee-for-service payment for the first day of institutional care per admission.

Source: GAO analysis of SCHIP regulations, March 2004.

Similar to Medicaid, to require premiums or cost sharing in SCHIP beyond what is permissible under federal law, states must seek waivers from the Secretary of Health and Human Services. In establishing SCHIP, Congress extended the applicability of section 1115 of the Social Security Act to SCHIP "in the same manner" as it applies to states under Medicaid.[19] According to CMS, six states with SCHIP programs that are Medicaid expansions have received section 1115 waivers to require beneficiary

[19]Social Security Act section 2107(e)(2)(A) (codified at 42 U.S.C. 1397gg(e)(2)(A)(2000)).

contributions that would be allowable in a separate SCHIP program.[20] In some cases, 1115 waiver approvals have allowed states to increase cost sharing in their premium assistance programs—programs in which the state helps individuals gain access to available employer-based insurance by using SCHIP funds to pay for part of an individual's share of the cost of coverage. Specifically, two states—Illinois and Oregon—have waivers to allow for increased cost sharing for children in such premium assistance programs.

Children Were More Likely to Be Subject to Beneficiary Contributions in SCHIP than in Medicaid

In response to our survey, states reported that children were more likely to be subject to premiums and cost sharing in SCHIP than in Medicaid. Overall, 26 states charged premiums for some portion of children—"some," "most," or "all" in SCHIP, and 9 states charged premiums, through the use of 1115 waivers, for some portion of children in Medicaid. Twenty-five states charged cost sharing for children in SCHIP compared to six states for Medicaid. Most states that reported charging cost sharing applied copayment requirements to the six services we reviewed.[21] In addition, the amounts of beneficiary contributions required for children varied on the basis of factors such as family income.

Premiums

Twenty-six states reported charging premiums for some portion of children in SCHIP, compared to 9 states for Medicaid: 5 states charged premiums for some portion of children in both Medicaid and SCHIP, 21 states charged premiums for SCHIP children only, and 4 states charged premiums for Medicaid children only. (See table 5.)

[20]The six states that received section 1115 waivers are Arkansas, Missouri, New Mexico, Ohio, Rhode Island, and Wisconsin. As of March 2004, Ohio had not implemented its waiver.

[21]Our survey asked states about their cost sharing requirements for six services: inpatient hospital, outpatient hospital, physician services, prescription drugs, nonemergency use of the ER, and dental.

Table 5: States' Use of Premiums for Children in Medicaid and SCHIP, as of August 1, 2003

Charge premiums in		Number of states	States
Medicaid?	SCHIP?		
No	No	21	Alaska, Colorado, District of Columbia, Idaho, Kentucky, Louisiana, Mississippi, Montana, Nebraska, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Virginia, West Virginia, and Wyoming
No	Yes	21	Alabama, California, Connecticut, Delaware, Florida, Georgia, Illinois, Indiana, Iowa, Kansas, Maine, Maryland, Michigan, Missouri, Nevada, New Hampshire, New Jersey, New York, Texas, Utah, and Washington
Yes	No	4	Arkansas,[a] Hawaii,[b] Minnesota,[c] and Tennessee[d]
Yes	Yes	5	Arizona, Massachusetts, Rhode Island, Vermont, and Wisconsin

Source: GAO analysis of state survey responses.

[a]Arkansas's 1115 waiver included premium charges for children who are receiving medical care at home that otherwise would be provided in an institution.

[b]Hawaii charged premiums for children in families with incomes above 200 percent of the FPL, which in 2003 equated to $20,660 per year for an individual and $35,100 for a family of three.

[c]Minnesota allowed individuals the choice of participating in its 1115 waiver program, which includes premium charges, or its traditional Medicaid program, which does not include premium charges for children.

[d]Tennessee did not have a SCHIP program.

Although federal law generally prohibits states from charging premiums for children in Medicaid, some states reported having received waivers from the Secretary of Health and Human Services granting them authority to do so. Of the nine states charging premiums for children in Medicaid, six states required premiums for children included in their 1115 waiver populations only. For example, Rhode Island charged premiums only for children with incomes between 150 and 250 percent of the FPL, all of whom became Medicaid eligible through its 1115 waiver. The remaining three states—Arizona, Arkansas, and Vermont—also had 1115 waivers but had received approval to waive provisions related to premium requirements. Thus, they were allowed to charge premiums for children.

States generally are not allowed to charge premiums for children in their SCHIP Medicaid expansion programs, as these programs follow the law governing the Medicaid program. According to CMS, six states have

received SCHIP 1115 waivers to require beneficiary contributions for children in their SCHIP Medicaid expansion programs. Three of those states—Missouri, Rhode Island and Wisconsin—used their 1115 waiver to implement premiums for some portion of their SCHIP beneficiaries. The remaining three states—Arkansas, New Mexico and Ohio—did not charge premiums for children in their SCHIP program.

Among states with premium requirements for children, SCHIP programs often reported charging premiums for a larger proportion of their children than did Medicaid programs (see app. II). Ten of the 26 states charging premiums for children in SCHIP required them for all or most of their SCHIP children. In contrast, all nine of the states with premiums for children in Medicaid required them for only some of the population.

The amount of premiums required for Medicaid and SCHIP children varied across and within states. (See app. III for the range in premiums for all states.) Some states reported varying premium amounts on the basis of beneficiaries' family income, and some states reported capping the amount of premiums a beneficiary could be subject to in a given year. (See table 6.) The following are examples of the variation in states' premium requirements.

- In Vermont, Medicaid premiums were assessed for eligible children in families with incomes above 185 percent of the FPL, and amounts varied from $25 to $35 a month depending on the family income.
- Medicaid programs in Rhode Island and Minnesota limited total yearly premium amounts to 4 percent and 7.5 percent of annual family income, respectively.
- In SCHIP, monthly premiums in Washington were $10 per child, with a cap of $360 per family per year. In New York, monthly premiums for families with incomes between 133 and 185 percent of the FPL were $9 per eligible child with a cap of $27 per family per month; families with incomes above 185 were charged $15 per eligible child with a cap of $45 per family per month.

Table 6: States' Premium Charges for Children in Medicaid and SCHIP, as of August 1, 2003

Characteristic	Number of states	
	Medicaid	SCHIP
States charging premiums for children	9	26
States varying premiums by income	9	20
States capping premium charges	4	11

Source: GAO analysis of state survey responses.

Cost Sharing

In requiring cost sharing amounts, states reported relying on copayments and generally did not report using the other two main types of cost sharing requirements—coinsurance and deductibles. Twenty-five states charged copayments for some portion of children in SCHIP, while six states charged copayments for some portion of children in Medicaid. (See table 7.) With regard to coinsurance, three states charged coinsurance in Medicaid; Alaska and Missouri charged only children aged 18 or over, and Arkansas charged only children in its 1115 waiver program. Additionally, four states charged coinsurance in SCHIP (Alaska, Arkansas, Colorado, and Utah). None of the states reported using deductibles as a form of cost sharing for children.

Table 7: States' Use of Copayments for Children in Medicaid and SCHIP, as of August 1, 2003

Charge copayments in		Number of states	States
Medicaid?	SCHIP?		
No	No	24	District of Columbia, Georgia, Hawaii, Idaho, Kansas, Louisiana, Maine, Maryland,[a] Massachusetts, Michigan, Minnesota, Nebraska, Nevada, New York, Ohio, Oregon, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Vermont, Washington, and Wyoming
No	Yes	21	Alabama, Arizona, California, Colorado, Connecticut, Florida, Illinois, Indiana, Iowa, Kentucky, Mississippi, Montana, New Hampshire, New Jersey, New Mexico, North Carolina, North Dakota, Texas, Utah, Virginia, and West Virginia
Yes	No	2	Delaware[b] and Tennessee[c]
Yes	Yes	4	Alaska, Arkansas, Missouri, and Wisconsin

Source: GAO analysis of state survey responses.

[a]Maryland did not charge copayments to children in Medicaid. In SCHIP, the state did not charge copayments, but SCHIP beneficiaries receiving coverage through the employer-sponsored insurance program may be charged copayments by their health plan.

[b]Although Delaware did not require a copayment in SCHIP, the state did have a fee for inappropriate use of the ER. In Medicaid, Delaware's only copayment was for nonemergency transportation.

[c]Tennessee did not have a SCHIP program.

While federal law prohibits states from charging cost sharing for children in Medicaid under age 18, some states require cost sharing to the extent it is permissible under Medicaid provisions or through an 1115 waiver. For the six states that charged copayments for some portion of Medicaid children, Alaska's, Missouri's, and Wisconsin's copayment requirements applied to children age 18 or over, and Delaware reported charging copayments for nonemergency transportation, requirements that are permissible under federal law.[22] Arkansas charged copayments only to children in its state's 1115 waiver population. Tennessee, whose entire Medicaid program operates under an 1115 waiver, charged copayments to children at or above the FPL.

[22]In Medicaid, nonemergency transportation can be considered either a service or an administrative cost. Delaware treats nonemergency transportation as an administrative cost and thus was allowed to charge a copayment for this service.

With regard to cost sharing in SCHIP, six states obtained section 1115 waivers that allowed them to require beneficiary contributions from children in their SCHIP Medicaid expansion programs.[23] Four of the states—Arkansas, Missouri, New Mexico and Wisconsin—used their 1115 waiver to implement copayments for some portion of their SCHIP beneficiaries. The remaining two states—Ohio and Rhode Island—did not charge copayments for children in their SCHIP programs. Among states with copayment requirements for children, SCHIP programs were more likely to charge a larger proportion of their population compared to Medicaid (see app. IV).

Most states that reported charging cost sharing applied copayment requirements to the six health care services that we considered. (See table 8.) In addition, the amount of cost sharing that states charged for the six selected services varied by service and state. For example, in the Texas SCHIP program, copayments varied on the basis of family income, ranging from $2 to $10 per physician visit, and from $25 to $100 per inpatient hospitalization. Across states with copayments for physician services, copayment amounts ranged from $1 per visit in Missouri's Medicaid program and Wisconsin's Medicaid and SCHIP programs to as high as $25 per visit in Tennessee's Medicaid program. (See app. V.)

[23]Section 2107(e)(2)(A) of the Social Security Act extends the Secretary's authority under section 1115 to the SCHIP statute.

Table 8: States' Use of Cost Sharing for Children for Six Services, by Program and Service, as of August 1, 2003

	Number of states					
	Copayment		Coinsurance		States using cost sharing for this service	
Service	Medicaid	SCHIP	Medicaid	SCHIP	Medicaid	SCHIP
Inpatient hospital	4	12	1	2	5	13[a]
Outpatient hospital	3	17	1	2	4	18[a]
Physician services	5	21	0	0	5	21
Prescription drugs	4	22	0	1	4	22[a]
Nonemergency use of the emergency room	4	21	1	1	5	22
Dental	4	14	1	2	4[b]	15[a]

Source: GAO analysis of state survey responses.

[a]Utah SCHIP charged a copayment for children with a family income at or below 150% FPL and charged copayment or coinsurance for children in a family with a higher income level.

[b]Missouri Medicaid charged a copayment or coinsurance, depending on the dental service. Specifically, the state charged a coinsurance for dentures and charged a copayment for all other dental services.

Some states varied cost sharing amounts for children on the basis of family income. For example, in Virginia, SCHIP copayments for children in families with income from 133 percent to below 150 percent of the FPL were $2 per physician visit or per prescription and $5 for these services for children in families with higher incomes. Of the six states that charged cost sharing for children in Medicaid, only Tennessee capped cost sharing amounts for children. In SCHIP, seven states set specific caps for cost sharing amounts for a child in a given year. (See table 9.) For example, SCHIP cost sharing was capped at $650 a year in Connecticut and $750 a year in West Virginia.

Table 9: States' Use of Cost Sharing Charges for Children in Medicaid and SCHIP, as of August 1, 2003

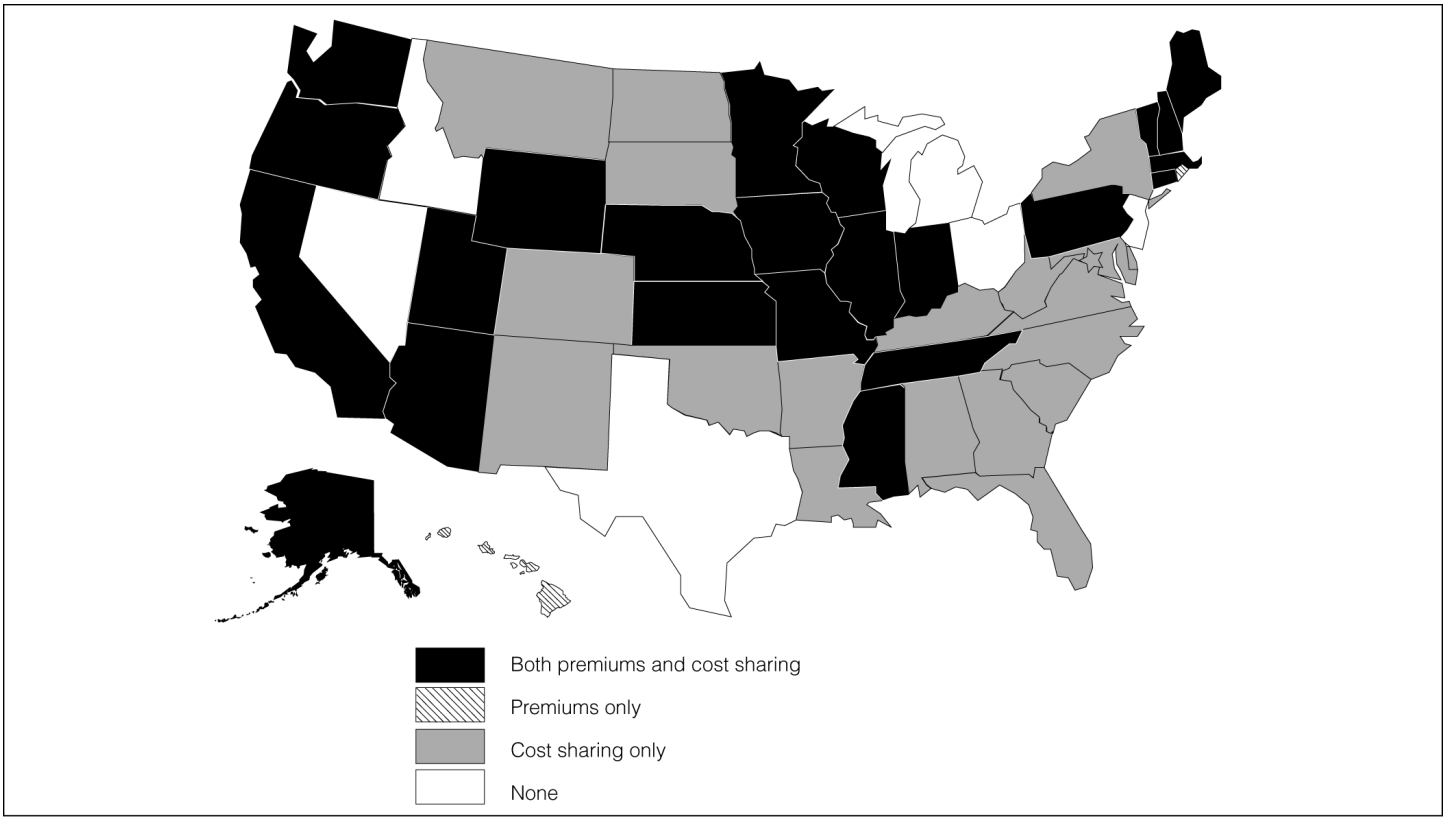
	Number of states	
Characteristics	Medicaid	SCHIP
States charging cost sharing for children	6	25
States varying cost sharing by income	1	14
States capping cost sharing charges	1	7

Source: GAO analysis of state survey responses.

For Adults in Medicaid, Nearly Half the States Assessed Premiums and a Majority Required Cost Sharing

Nearly half the states (25) reported assessing premiums for some adults enrolled in Medicaid, and a majority of the states (43) reported requiring cost sharing for some portion of adults, primarily in the form of copayments. Overall, 45 states required some portion of adults to share in the cost of their care by charging premiums, cost sharing, or both. (See fig. 1.) The states that required premiums generally did so on a limited basis, targeting portions of particular population groups, such as certain adults with disabilities. In contrast, the states with cost sharing requirements for adults in Medicaid charged several population groups and a larger portion of each group.

Figure 1: States' Use of Premiums and Cost Sharing for Adults in Medicaid, as of August 1, 2003



Source: GAO analysis of state survey responses.

Premiums

Twenty-five states reported assessing premiums for some portion of their adult Medicaid populations. States mainly charged premiums to adults with disabilities (23 states)[24] and parents (9 states), but a few states charged premiums to other adults, such as pregnant women (4 states) and noninstitutionalized elderly individuals (2 states). (See table 10.) (App. VI contains details on the portion of the populations charged premiums in each state.)

Table 10: States' Use of Premiums for Adults in Medicaid, by Population Group, as of August 1, 2003

	Number of states charging all, most, or some of this population		
Population[a]	**All**	**Most**	**Some**
Pregnant women	0	0	4
Individuals in nursing homes and institutions	0	0	0
Noninstitutionalized elderly	0	0	2
Adults with disabilities	0	0	23
Medically needy	0	0	0
Parents	0	1	8

Source: GAO analysis of state survey responses.

Note: In our survey, states were asked to indicate what portion of a specific population group was charged premiums by selecting "all," "most," "some," or "none."

[a]Five states reported charging premiums to other adult populations, such as childless adults.

Generally, states are not permitted to require certain individuals to pay premiums, including elderly persons, individuals with disabilities, and pregnant women. However, certain exceptions exist, for example:

- Four states (Hawaii, Minnesota, Rhode Island, and Vermont) reported charging premiums to pregnant women through their states' 1115 waiver

[24]In many cases, these states only charged working individuals with disabilities. In 2003, the following states provided Medicaid coverage to working individuals with disabilities: Alaska, Arizona, Arkansas, California, Connecticut, Illinois, Indiana, Iowa, Kansas, Maine, Massachusetts, Minnesota, Mississippi, Missouri, Nebraska, New Hampshire, New Jersey, New Mexico, Oregon, Pennsylvania, South Carolina, Utah, Vermont, Washington, Wisconsin, and Wyoming. See U.S. General Accounting Office, *Medicaid and Ticket to Work: States' Early Efforts to Cover Working Individuals with Disabilities*, GAO-03-587 (Washington, D.C.: June 13, 2003) and Jennifer Hess and Karen Tritz, *Ticket to Work and Work Incentives Improvement Act of 1999: Implementation Status* (Washington, D.C.: Congressional Research Service, June 3, 2003).

programs. Vermont had a waiver of the specific Medicaid provision regarding premium requirements, while the other three states charged pregnant women in their 1115 waiver programs. Hawaii, Rhode Island, and Vermont charged premiums only to pregnant women with incomes exceeding 185 percent of the FPL. In the fourth state, Minnesota, pregnant women with incomes at or below 275 percent of the FPL could choose whether to enroll in the state's regular Medicaid program or the state's 1115 waiver program. Only those enrolled in the 1115 waiver program were charged premiums, and failure to pay the required premiums did not result in the women's disenrollment from the program.

- As allowed under federal law, states may charge premiums in Medicaid to certain individuals with disabilities, primarily those who are employed. For example, Connecticut reported charging premiums to working individuals with disabilities with incomes above 200 percent of the FPL. These individuals were required to pay a monthly premium equivalent to 10 percent of their income that exceeded 200 percent of the FPL, minus the amount the individuals or their spouses paid for any other health insurance.

Premium amounts and requirements varied significantly across the 25 states. For example, in Massachusetts, monthly premiums ranged from $15 for families with incomes at the poverty level to over $928 for families with incomes over 1,000 percent of the FPL. Maine charged premiums equal to 3 percent of families' net incomes for eligible parents with incomes above 150 percent of the FPL. (See app. VII for the income thresholds and ranges in amounts for premiums charged to adults in each state.) Twelve states capped the amount of premiums that beneficiaries could be subject to in a given year. For example, premiums for working individuals with disabilities in Mississippi were capped at 5 percent of annual income, and in Maine, premiums for some adults were capped at 3 percent of annual income. (See table 11.)

Table 11: States' Premium Charges for Adults in Medicaid, as of August 1, 2003

Characteristic	Number of states
States charging premiums	25
States varying premiums by income	25
States capping premium charges	12[a]

Source: GAO analysis of state survey responses.

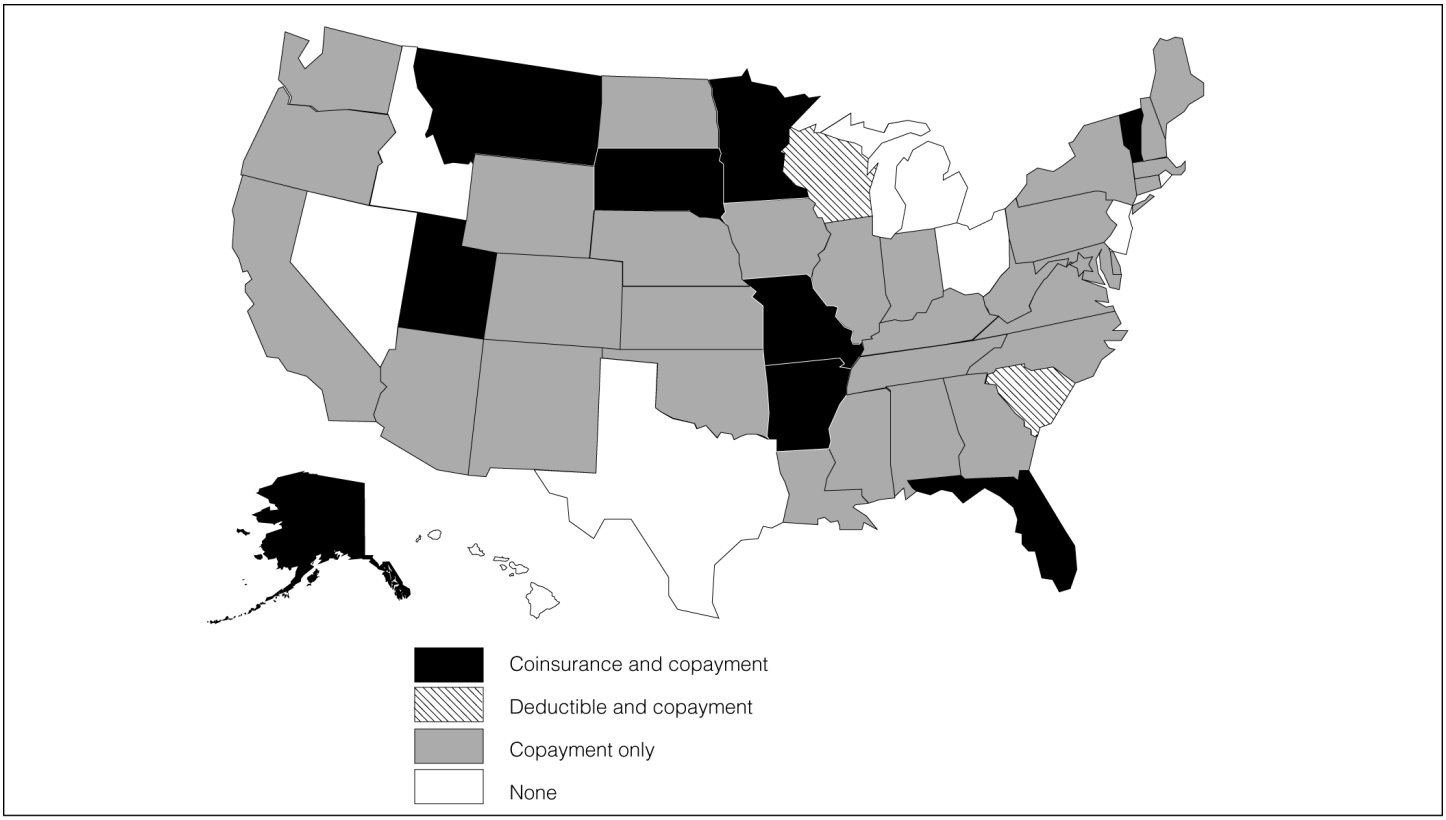
[a]Three of these states reported that premium charges were capped for some beneficiaries.

Cost Sharing

Forty-three states reported requiring adult populations to share in the cost of their care by charging copayments, coinsurance, or deductibles. (See fig. 2.) All 43 states charged copayments for selected services to some portion of adults. Nine of these states also charged coinsurance to some portion of adults.[25] Two of the 43 states—South Carolina and Wisconsin—required a deductible for elderly individuals who received pharmacy—but no other—benefits from the states' Medicaid program. For example, all participants in South Carolina's Medicaid pharmacy program were required to pay a $500 deductible for prescription drugs.

[25]The nine states are Alaska, Arkansas, Florida, Minnesota, Missouri, Montana, South Dakota, Utah, and Vermont.

Figure 2: States' Use of Cost Sharing for Adults in Medicaid, as of August 1, 2003



Source: GAO analysis of state survey responses.

Copayments were the predominate form of cost sharing for adults, with states most frequently reporting copayments for adults with disabilities, noninstitutionalized elderly persons, and parents. (See table 12 and app. VIII.) Three states required copayments for pregnant women (Delaware, Virginia, and Wisconsin) for services unrelated to the pregnancy.[26] While states generally are prohibited from charging cost sharing, including copayments, for medical services for individuals residing in institutions, Delaware considers nonemergency transportation to be an administrative cost and thus was allowed to charge a $1 copayment.

[26]Delaware charged a copayment for nonemergency transportation and Wisconsin charged a copayment for dental services. Virginia charged a copayment for inpatient hospital services, outpatient hospital services, physician services, and prescription drugs when the services were unrelated to the pregnancy.

Table 12: States' Use of Copayments for Adults in Medicaid, as of August 1, 2003

	Number of states and portion of population charged		
Population[a]	**All**	**Most**	**Some**
Pregnant women[b]	1	0	2
Individuals in nursing homes and institutions[c]	1	0	0
Noninstitutionalized elderly persons	21	8	11
Adults with disabilities	21	9	11
Medically needy	14	7	8
Parents	16	11	9

Source: GAO analysis of state survey responses.

Note: In our survey, states were asked to indicate what portion of the population were charged copayments by selecting "all," "most," "some," or "none." They were also asked to designate if a population was not covered by their state's Medicaid program.

[a]Ten states reported charging copayments to other adult populations, such as childless adults.

[b]Three states required copayments for services unrelated to the pregnancy.

[c]One state charged individuals in institutions for nonemergency transportation.

The services for which states most frequently reported charging copayments were physician services and prescription drugs. (See table 13.) Copayment amounts varied depending on the service and the state. Across states, copayments ranged from $.50 to $25 for physician services and prescription drugs. Across the services, most states that required copayments for inpatient hospital services charged higher copayment amounts for this service compared to the other five services. For example, Montana's copayment requirement for inpatient hospital services was $100 per stay, whereas its copayment requirements for the five remaining services we reviewed were $1 to $5. (See app. IX for details on the cost sharing amounts, including copayments, for adults, by state.)

Table 13: States' Use of Copayments for Adults for Six Services, by Population Group, as of August 1, 2003

	Number of states charging copayment					
Population[a]	Inpatient hospital	Outpatient hospital	Physician services	Prescription drugs	Nonemergency use of the ER	Dental
Pregnant women	2	2	2	2	0	1
Noninstitutionalized elderly persons	18	21	25	35	16	13
Adults with disabilities	19	22	26	36	16	14
Medically needy	11	13	16	25	8	9
Parents	16	19	22	31	12	14

Source: GAO analysis of state survey responses.

[a]No states required copayments for individuals in nursing homes and institutions for any of the six services; thus, this population is excluded from the table.

In five states, the amount of cost sharing charged varied by income for some portion of adults. For example, copayment amounts for physician services in Utah varied from $3 or $5 per visit depending on income. Six states reported placing a cap on the amount of cost sharing an individual could be subject to in a given year. For example, in Pennsylvania cost sharing expenses were capped at $90 per beneficiary every 6 months, and in New Mexico cost sharing amounts for working individuals with disabilities were capped at 3 to 5 percent a year depending on income.

Thirty-Four States Increased and Ten States Decreased the Amount of Beneficiary Contributions

From the beginning of their 2001 state fiscal years through August 1, 2003, 34 states reported increasing and 10 states reported decreasing the amount of beneficiary contributions they required in Medicaid, SCHIP, or both.[27] We considered states to have increased beneficiary contribution requirements if they either raised the amount of existing contributions or instituted new contribution requirements for certain populations or services. For children, 18 states increased the amount of beneficiary contributions required in Medicaid, SCHIP, or both. For adults in Medicaid, 30 states increased the amount of beneficiary contributions. For the states that provided us information on the amount of beneficiary

[27]The time periods for states' fiscal years were different: most used a fiscal year that began July 1 and others used either the federal fiscal year (Oct. 1 through Sept. 30) or another time period.

contribution increases,[28] premium increases to existing requirements ranged from $2 a month to $39 a month. Other states added new premium requirements, some of which were as much as several hundred dollars a month. In contrast, states primarily increased copayment requirements by $5 or less. For a small number of states, however, copayment increases were more significant. New Hampshire SCHIP, for example, increased copayments for ER visits from $25 to $50 per visit. While no states reported decreasing their beneficiary contribution requirements for children in Medicaid, five states decreased these requirements (premiums, cost sharing, or both) for some portion of children in SCHIP, and five other states decreased cost sharing requirements for some portion of adults in Medicaid.

Eighteen States Increased and Five States Decreased Beneficiary Contributions for Children

From the beginning of their 2001 state fiscal years through August 1, 2003, 18 states reported increasing the amount of beneficiary contributions required for children in Medicaid, SCHIP, or both. Beneficiary contribution requirements were increased solely in Medicaid by 3 states, solely in SCHIP by 12 states, and in both Medicaid and SCHIP by 3 states. During the same period, 5 states decreased the amount of beneficiary contributions required for children, with all decreases occurring in states' SCHIP programs.

Premiums

Of the 9 states charging premiums for children in Medicaid, 5 reported increases in premiums. Eleven of the 26 states charging premiums for children in SCHIP also reported increased premium amounts. (See table 14.) Some states increased existing premiums, while other states added new premiums, as shown in the following examples.

- Vermont increased its existing Medicaid monthly premiums by $5 or $9 per household depending on income;[29] it increased its SCHIP monthly premiums by $20 per household.[30]

[28]Thirty-three of the 34 states that increased beneficiary contributions in Medicaid, SCHIP or both provided us with information on the amount of increases.

[29]In some states, such as Vermont, premiums are charged for a household—individuals living together in the same house.

[30]In Vermont, monthly premiums for Medicaid increased from $20 to $25 for children in households with income from 185 percent through 225 percent of the FPL and from $24 to $35 for children in households with higher income. In SCHIP, monthly premiums increased by $20—from $50 to $70.

- Premiums for newly covered populations of children were added in Arizona's Medicaid program and Maryland's SCHIP program.[31]

Table 14: Changes in States' Premiums for Children in Medicaid and SCHIP, State Fiscal Year 2001 through August 1, 2003

	Number of states	
Premium changes	**Medicaid[a]**	**SCHIP**
States that increased	5 (Arizona, Arkansas, Massachusetts, Rhode Island, and Vermont)	11 (Florida, Georgia, Kansas, Massachusetts, Maryland, Missouri, New Jersey, New Hampshire, Rhode Island, Utah, and Vermont)
States that decreased	0	2 (Kansas and Utah)
States with no changes	3 (Hawaii, Minnesota, and Wisconsin)	15 (Alabama, Arizona, California, Connecticut, Delaware, Iowa, Illinois, Indiana, Maine, Michigan, Nevada, New York, Texas, Washington, and Wisconsin)

Source: GAO analysis of state survey responses.

[a]One of the states charging premiums for some portion of children in Medicaid, Tennessee, did not report whether changes were made to the state's premium requirements.

While no states decreased their premiums for children in Medicaid, two states—Kansas and Utah—decreased SCHIP premium amounts. For example, in February 2003, Kansas increased its monthly premium amounts by $20 or $30, depending on family income, and then decreased them by $10 or $15 dollars a few months later.

Cost Sharing

Delaware was the only state of the 6 states charging copayments for children in Medicaid that reported increasing copayment amounts, compared to 6 of the 25 states charging copayments for children in SCHIP that reported increasing copayment amounts. (See table 15.) Delaware added a copayment in Medicaid for nonemergency transportation services

[31]Since state fiscal year 2001, Arizona has implemented a program under the Ticket to Work Act that provides Medicaid coverage to certain working individuals with disabilities, including some children aged 18. Maryland implemented a separate SCHIP program in July 2001, which raised the state's SCHIP income eligibility level from 200 percent to 300 percent of the FPL. Both states' new programs included a premium requirement.

in 2002. As described in the following, of the six states that reported increasing SCHIP copayment requirements, two increased existing copayments, and four both increased existing copayments and added new copayment requirements.

- Missouri and New Hampshire increased existing copayments. For example, New Hampshire increased copayments for nonemergency use of the ER from $25 per visit to $50 per visit and increased copayments for physician visits from $5 to $10.
- Kentucky, Texas, Utah, and West Virginia made multiple changes to their copayment requirements. For example, Utah added a copayment for dental services for children in families with incomes at or below 150 percent of the FPL and increased copayment amounts for children in families with incomes above 150 percent of the FPL.

Table 15: Changes in States' Copayments for Children in Medicaid and SCHIP, State Fiscal Year 2001 through August 1, 2003

Copayment changes	Medicaid[a]	SCHIP
States that increased	1 (Delaware)	6 (Kentucky, Missouri, New Hampshire, Texas, Utah, and West Virginia)
States that decreased	0	4 (Colorado, Texas, Utah, and Virginia)
States with no changes	4 (Alaska, Arkansas, Missouri, Wisconsin)	17 (Alabama, Alaska, Arizona, Arkansas, California, Connecticut, Florida, Illinois, Indiana, Iowa, Mississippi, Montana, New Jersey, New Mexico, North Carolina, North Dakota, Wisconsin)

Source: GAO analysis of state survey responses.

[a]One of the states charging copayments for some portion of children in Medicaid, Tennessee, did not report whether changes were made to the state's copayment requirements.

While no states reported decreasing copayment amounts for children in Medicaid, four states did so for SCHIP. Colorado decreased the SCHIP copayment for nonemergency use of the ER from $5 to $3, and Virginia decreased copayments for vision exams from $25 to either $2 or $5, depending on family income. In addition to decreasing copayment amounts, the remaining two states, Texas and Utah, also increased copayments during the same period. Texas' changes to copayments varied by service and family income. For example, the state decreased the copayment for generic prescription drugs by $1 or $2 for certain SCHIP beneficiaries, while increasing the copayment for brand name prescription drugs by between $3 and $10 for these and other beneficiaries. Copayment

increases for other services in Texas ranged from $3 to $50. Utah decreased SCHIP copayment amounts for children in families with incomes at or below 150 percent of the FPL by $2 for physician services, inpatient and outpatient hospital services, and ER services. The state also increased copayments by $5 for physician and ER services, and $1 for certain prescription drugs for children in families with incomes above 150 percent of the FPL.

While none of the states changed coinsurance requirements for children in Medicaid,[32] one of the four states (Alaska, Arkansas, Colorado, and Utah) that charged coinsurance in SCHIP (Colorado) increased its coinsurance requirements.

Thirty States Increased and Five States Decreased Beneficiary Contributions for Adults

Thirty states reported increasing the amount of beneficiary contributions charged to some portion of adults in Medicaid. Most of these states (24) increased copayment amounts; fewer states increased premiums (12) and coinsurance amounts (2). Five states decreased beneficiary contribution requirements, specifically with respect to cost sharing.

Premiums

From the beginning of their 2001 state fiscal years through August 1, 2003, 12 states reported increasing premiums for some portion of adults in Medicaid. Half of these states increased the amount of existing premium requirements.[33] For example, Rhode Island increased monthly premiums from approximately 3 percent of a family's income to approximately 4 percent,[34] and Vermont increased premiums for certain working individuals with disabilities by $25 to $36 a month, depending on the individual's income and whether he or she had other insurance. The other half of these states added new premium requirements.[35] For example, in January 2003, Arizona began covering working individuals with

[32]The three states that charged coinsurance to children in Medicaid were Alaska, Arkansas, and Missouri.

[33]The six states were Massachusetts, Mississippi, New Hampshire, Oregon, Rhode Island, and Vermont.

[34]In Rhode Island, monthly premiums for certain parents with incomes from 150 percent through 185 percent of the FPL increased from $43 to $61. Monthly premiums for pregnant women increased from $53 to $77 for those with incomes from 185 percent through 200 percent of the FPL, and from $53 to $92 for those with incomes at or above 200 percent of the FPL.

[35]The six states were Arizona, Illinois, Kansas, Minnesota, Missouri, and Washington.

disabilities, requiring the new beneficiaries to pay monthly premiums of $15 or $25, depending on their income. In 2002, Washington added a premium for certain families covered under transitional Medicaid assistance.[36] While a few states increased premiums for pregnant women, adults with disabilities, and parents, no states increased premiums for noninstitutionalized elderly beneficiaries. (See table 16.) No states decreased premium amounts for adults during this period.

Table 16: States' Changes to Premiums for Adults in Medicaid, State Fiscal Year 2001 through August 1, 2003

	Number of states		
Population	**Increased premiums**	**Decreased premiums**	**No change**
Pregnant women	2	0	2
Individuals in nursing homes and institutions	0	0	0
Noninstitutionalized elderly	0	0	2
Adults with disabilities	10	0	13
Medically needy	0	0	0
Parents	3	0	6

Source: GAO analysis of state survey responses.

Cost Sharing

With regard to cost sharing, 25 states reported increasing requirements for some portion of Medicaid adults. Twenty-two of these states increased only copayment requirements, one state increased only coinsurance requirements, and two states increased a combination of cost sharing requirements.[37] States' cost sharing increases were generally targeted to noninstitutionalized elderly persons, adults with disabilities, parents and medically needy individuals. (See table 17.) Some states increased the amount of existing cost sharing requirements, while other states added cost sharing requirements for new services, as shown in the following examples:

[36]The premium was equal to 1 percent of income after deducting certain child care expenses.

[37]For the two states increasing charges in more than one cost sharing category, one state (Utah) increased both copayment and coinsurance requirements, while the other state (South Carolina) increased both copayment and deductible requirements.

- Both Nebraska and South Carolina increased prescription drug copayments by $1, and Utah increased copayments for drugs by $2.
- In North Dakota, copayments for inpatient hospitalization increased from $50 to $75 per stay, and copayments for nonemergency visits to the ER increased from $3 to $6 per visit.
- Washington implemented a $3 copayment for nonemergency visits to the ER in July 2002, while Oklahoma added $1 to $3 copayments for certain services, such as outpatient hospital services.

Table 17: States' Changes to Cost Sharing for Adults in Medicaid, State Fiscal Year 2001 through August 1, 2003

	Number of states					
	Copayment			Coinsurance		
Population	Increased	Decreased	No change	Increased	Decreased	No change
Pregnant women	2	0	1	0	0	1
Individuals in nursing homes and institutions	1	0	0	0	0	0
Noninstitutionalized elderly persons	24	4	15	2	1	4
Adults with disabilities	24	4	16	2	1	4
Medically needy	17	4	11	2	1	2
Parents	21	3	14	2	1	4

Source: GAO analysis of state survey responses.

During this same time period, five states reported decreasing copayment or coinsurance requirements for portions of their adult population. Specifically, Illinois, Indiana, Maryland, and Montana decreased copayment amounts for some portion of adults. For example, both Illinois and Maryland eliminated their $1 copayments for generic prescription drugs.[38] Only Arkansas decreased coinsurance requirements for adults. In November 2001, the state decreased the coinsurance amount for inpatient hospitalization for most adults by 12 percent, from 22 percent of the cost of the first day of hospitalization to 10 percent.[39]

[38]Maryland eliminated its generic prescription drug copayment in November 2002, and Illinois made its change in July 2003. Both states still required some portion of adults to pay copayments for brand-name prescriptions.

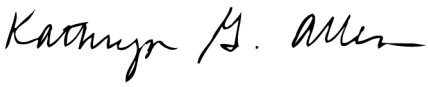
[39]In Arkansas, the cost sharing requirements for working individuals with disabilities were different from those of other Medicaid adults. The state did not change cost sharing requirements for working individuals with disabilities during the period under review.

Agency Comments

We asked CMS officials to verify the technical accuracy of the statutory and regulatory information on Medicaid and SCHIP beneficiary contributions presented in the background section of this report. These officials provided technical comments, which we have incorporated as appropriate. Because we did not evaluate CMS's management of the Medicaid and SCHIP programs, we did not ask CMS to comment on other sections of this report.

As agreed with your offices, we plan no further distribution of this report until 30 days from its date of issue, unless you publicly announce its contents. At that time, we will send copies of this report to the Administrator of the Centers for Medicare & Medicaid Services. We will also make copies available to others upon request. In addition, the report will be available at no charge on the GAO Web site at http://www.gao.gov.

Please call me on (202) 512-7118 or Carolyn Yocom on (202) 512-4931 if you have questions about this report. Major contributors to this report are listed in appendix X.



Kathryn G. Allen
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and Private Health Insurance Issues

Appendix I: Service Utilization Rates for Low-Income Individuals

The medical expenses charged to an individual—particularly for cost sharing provisions—can vary depending on the amount and type of services used. The Medical Expenditure Panel Survey (MEPS) provides data on individuals' annual utilization of medical services. MEPS, conducted by the Agency for Healthcare Research and Quality (AHRQ), consists of four surveys, including the Household Component, which provides nationally representative data and expenditures for the U.S. civilian noninstitutionalized population. The MEPS Household Component is a survey of individuals regarding their demographic characteristics, health insurance coverage, and health care use. At the time of our analysis, the 2000 version of the MEPS household component was the most recent version with all of the necessary data available.

To determine service utilization for low-income populations, we included individuals with incomes below 200 percent of the FPL.[1] For this cohort, we analyzed data for the following five population groups: (1) children (defined as individuals under age 18), (2) pregnant women aged 18 and over, (3) elderly persons—individuals aged 65 and over, (4) adults aged 18 to 64 with disabilities,[2] and (5) nondisabled adults aged 18 to 64. For each of these population groups, we calculated the proportion of the population that used the following five services—(1) inpatient hospital, (2) outpatient hospital, (3) physician, (4) prescription drug, and (5) dental—at least once during the year (see table 18).[3] For example, approximately 38 percent of children had a nonpreventive physician visit during the year, and almost 79 percent of adults with disabilities visited the physician for nonpreventive care.

[1]In 2000, the FPL for an individual equated to $8,350 per year and $14,150 for a family of three in the 48 contiguous states and the District of Columbia.

[2]MEPS defines individuals with disabilities as individuals who identified needing assistance with at least one activity of daily living (ADL) or instrumental activity of daily living (IADL). MEPS identifies ADLs as basic physical activities such as bathing, dressing, or getting around the house and IADLs as cognitive or social functions such as using the telephone, paying bills, taking medications, preparing light meals, doing laundry, or going shopping. MEPS offers a relatively expansive definition of disability in that it does not distinguish the number of ADLs or IADLs with which an individual may require assistance.

[3]For physician services, we did not include services provided by non-physician practitioners. We excluded orthodontia from our analysis of dental services, and nonemergency use of the emergency room because there was no MEPS category for these services.

Table 18: Percentage of the Population Below 200 Percent of the FPL Who Used Selected Services during 2000

Services	Children	Pregnant women	Noninstitutionalized elderly	Adults with disabilities	Nondisabled adults
Inpatient hospital (discharges)	3.9	50.5	19.3	26.8	6.4
Outpatient hospital (visits)	4.8	29.5	27.2	28.1	9.2
Office-based physician visits					
Nonpreventive	38.1	60.5	68.7	78.7	39.7
Nonemergency	56.0	89.7	87.3	86.8	51.2
Prescription drugs (prescriptions filled)	44.8	83.2	89.4	96.0	54.2
Dental (visits)					
Nonpreventive	4.6	11.9	14.2	13.1	9.2
Nonemergency	25.9	25.0	27.3	28.4	23.1

Source: GAO analysis of AHRQ's MEPS household component, 2000.

Note: For each service, the data represent the percentage of the population below 200 percent of the FPL who used that particular service at least once during the year.

For the individuals in each population group who used a service, we calculated their average utilization rates for each of the selected services. The utilization rates for each service, displayed in table 19, represent the average use among individuals who used that particular service at least once during the year. Additionally, since federal law generally does not allow states to charge Medicaid cost sharing for emergency services, we calculated the utilization rates for nonemergency physician and dental visits by excluding visits classified in MEPS as emergencies. Similarly, since SCHIP generally does not allow states with separate SCHIP programs to require cost sharing for preventive medical or dental visits, we excluded certain types of visits we considered as preventive, such as well-child exams and dental visits for teeth cleaning.

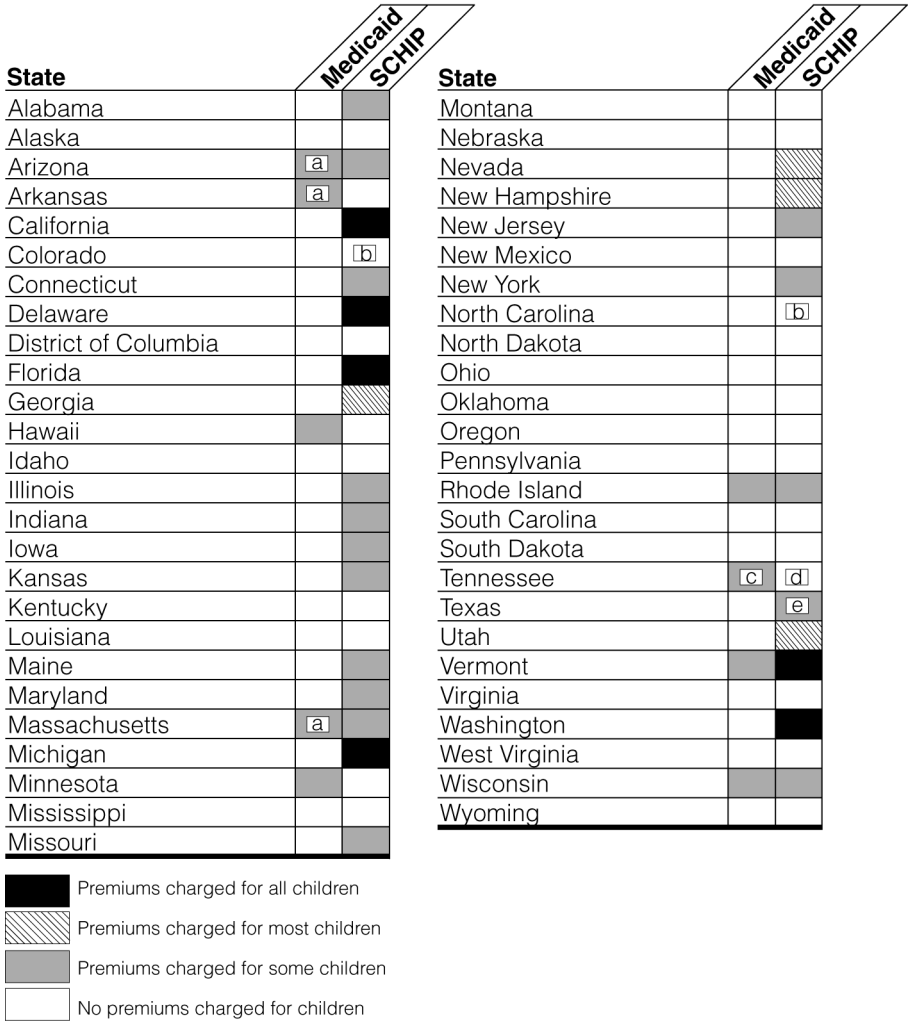
Table 19: Average Utilization Rates for Individuals Below 200 Percent of the FPL Who Used Selected Services during 2000, by Population

Service	Children	Pregnant women	Noninstitutionalized elderly	Adults with disabilities	Nondisabled adults
Inpatient hospital (discharges)	1.18	1.17	1.43	1.86	1.26
Outpatient hospital (visits)	1.99	3.21	5.73	7.79	3.51
Office-based physician visits					
Nonpreventive	2.94	6.58	5.39	8.42	4.55
Nonemergency	3.17	8.91	7.11	9.37	4.63
Prescription drugs (prescriptions filled)	4.22	15.68	25.71	32.69	11.85
Dental (visits)					
Nonpreventive	1.58	2.31	2.26	2.62	2.73
Nonemergency	1.60	2.43	2.61	2.58	2.28

Source: GAO's analysis of AHRQ's MEPS household component, 2000.

Note: For each service, the data represent the average utilization of individuals who used that particular service at least once during the year. For example, among the children who had at least one outpatient hospital visit during the year, the average was 1.99 visits during the year.

Appendix II: Premium Requirements for Children in Medicaid and SCHIP, by State, as of August 1, 2003



Source: GAO analysis of state survey responses.

Note: In our survey, states were asked to indicate what portion of the population was charged premiums by selecting "all," "most," "some," or "none."

[a]State only charged premiums to some portion of children with special needs.

[b]State did not charge premiums, but had an enrollment fee.

[c]Tennessee, which operates its entire Medicaid program under an 1115 waiver, charged premiums for some children in families with incomes at or above the FPL.

[d]Tennessee did not have a SCHIP program.

[e]Texas also had an enrollment fee.

Appendix III: Premium Amounts for Children in Medicaid and SCHIP, by State, as of August 1, 2003

State	Lowest percentage of the FPL at which state charged premiums[a]	Range of premium amounts[b]	Unit charged[c]
Medicaid			
Arizona	100	$15 or $25	Individual
Arkansas	Varied[d]	$21 to $458[e]	Family
Hawaii	>200	$60	Individual
Massachusetts	>150	$12 per child with $36 family maximum; or $15 to over $928; or 60% to 85% of full premium[f]	Individual and family
Minnesota	[g]	$4 to $300 per individual; $8 to $900 per family[h]	Individual or family
Rhode Island	150	$61 to $92	Family
Tennessee	100	$20 to $550 for an individual; $40 to $1,375 for a family[i]	Individual or family
Vermont	185	$25 or $35	Household
Wisconsin	>150	$30 to over $360[j]	Individual
SCHIP			
Alabama	>150	$50 annual premium per child with a $150 family maximum	Individual and family
Arizona	>150	$10 per child; $15 for more than 1 child	Family
California	>100[k]	$4 or $9	Individual
Connecticut	>235	$30 per child, with a $50 per family maximum	Individual and family
Delaware	101	$10 or $25	Family
Florida	≤200	$20	Family
Georgia	>100	$10 to $20	Household
Illinois	150	$15 to $30	Individual
Indiana	>150	$11 to $25	Family
Iowa	>150	$10 per child with a $20 family maximum	Individual and family
Kansas	151	$10 or $15	Family
Maine	>150	$5 to $20 for 1 child; $10 to $40 for more than 1 child	Individual or household
Maryland	>185	$37 to $50	Family
Massachusetts	>150	$12 per child with a $36 family maximum; or $15 to $35; or 60% of full premium	Individual or family
Michigan	>150	$5	Family
Missouri	226	$59 to $225[l]	Family
Nevada	100	$10 to $50	Household
New Hampshire	185	$25 to $100	Individual

State	Lowest percentage of the FPL at which state charged premiums[a]	Range of premium amounts[b]	Unit charged[c]
New Jersey	200	$16.50 to $110	Family
New York	133	$9 or $15 per individual; $27 or $45 per family	Individual or family
Rhode Island	150	$61 to $92	Family
Texas	151	$15 to $18	Family
Utah	≤150	$13 to $25 per quarter	Family
Vermont	>225	$70	Household
Washington	>200[m]	$10 per individual with $30 family maximum	Individual or family
Wisconsin	≥150	$30 to $360[j]	Family

Source: GAO analysis of state survey responses and documentation provided by states.

[a]In 2003, the FPL for an individual equated to $8,980 per year and $15,260 for a family of three in the 48 contiguous states and the District of Columbia.

[b]Premiums were paid on a monthly basis unless otherwise noted.

[c]In Medicaid and SCHIP, states determine premium charges for an individual, family unit, or household (individuals living in the same house).

[d]Arkansas charged premiums to children in a family of any size with an income above $25,000. The estimated equivalent percentage of FPL at which the state began charging children could have ranged from 120 percent for a family of five to 300 percent based on a family size of 1.

[e]In Arkansas, the highest premium amount, $458 per month, would be charged to a child from a family whose income exceeded $200,000 per year.

[f]In Massachusetts, premiums of $928 or more per month would be charged to a child from a family whose income exceeded 1,000 percent of the FPL, which equated to approximately $153,000 per year for a family of three. Other individuals with other health insurance coverage can be charged a percentage of premiums in order to obtain supplemental coverage.

[g]In Minnesota, families could choose to enroll their children in either the state's regular Medicaid program or its 1115 waiver program – both of which covered children from families with incomes up to 275 percent of the FPL. Children in families that chose to enroll in the 1115 waiver program were charged premiums regardless of their family income. Thus, families with incomes less than 1 percent of the FPL could choose to pay premiums.

[h]In Minnesota, the highest premium amount, $900 per family per month, would be charged to a family whose income was at least 275 percent of the FPL, which equates to approximately $42,000 per year for a family of three.

[i]In Tennessee, the highest premium amount, $1,375 per month, would be charged to a family of three whose income was at least 600 percent of the FPL, which equated to approximately $91,600 per year.

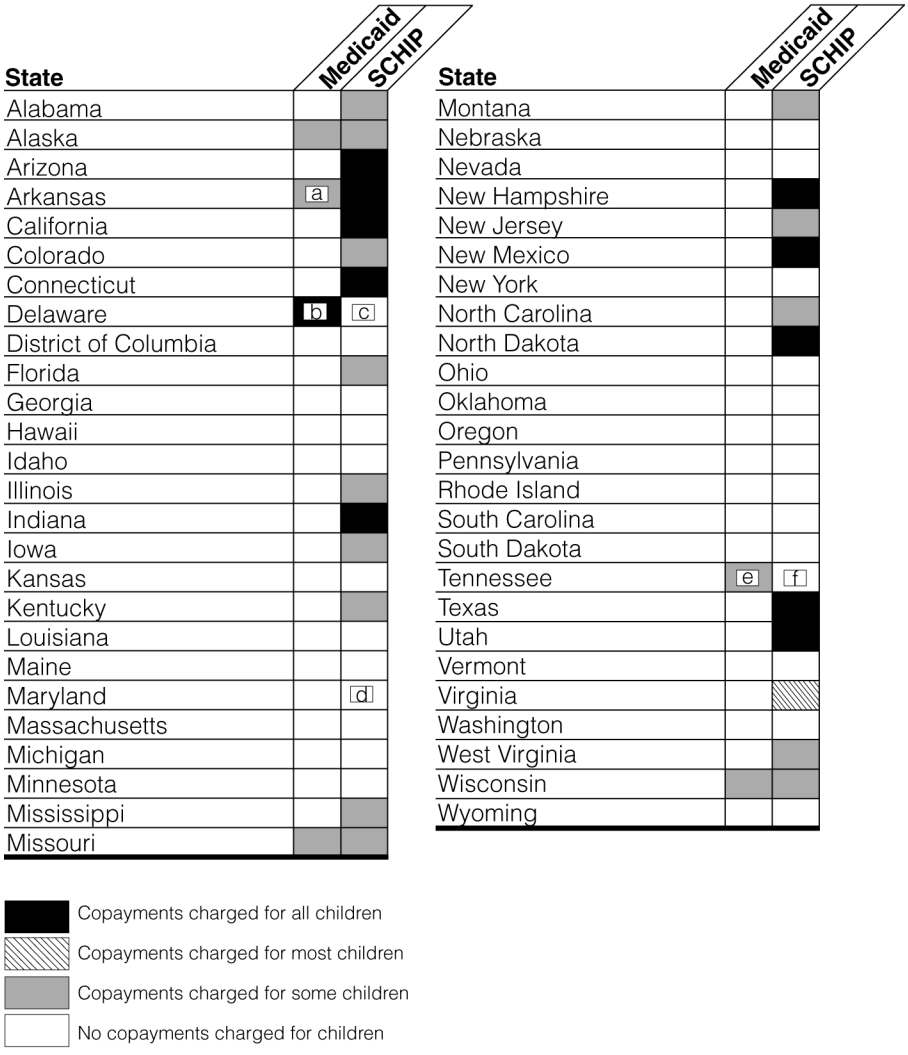
[j]In Wisconsin, monthly premiums of $360 and above would be charged to a child from a family whose annual income was at least $144,000.

[k]The percentage represents an estimated equivalent for the monthly income figures that California provided based on one family member in 2003.

[l]In Missouri, the highest premium amount, $225 per month, would be charged to a family of six or more whose income exceeds $61,700 per year.

[m]The percentage represents an estimated equivalent for the monthly income figures that Washington provided based on one family member in 2003.

Appendix IV: Copayment Requirements for Children in Medicaid and SCHIP, by State, as of August 1, 2003



Source: GAO analysis of state survey responses.

Note: In our survey, states were asked to indicate what portion of the population was charged copayments by selecting "all," "most," "some," or "none."

[a]Arkansas charged copayments to all children in its 1115 waiver program, but did not charge copayments to other children.

[b]Delaware's only copayment, which the state charged to all populations in its Medicaid program, was for nonemergency transportation services.

[c]Although Delaware did not charge copayments to children in SCHIP, the state did charge a fee for inappropriate use of the emergency room.

[d]Maryland's SCHIP program did not charge copayments, but SCHIP beneficiaries receiving coverage through Maryland's employer-sponsored insurance program may be charged copayments by their health plan.

[e]Tennessee, which operates its entire Medicaid program under an 1115 waiver, charged copayments for some children in families with incomes at or above the FPL.

[f]Tennessee did not have a SCHIP program.

Appendix V: Cost Sharing Amounts for Children in Medicaid and SCHIP, by State, as of August 1, 2003

State	Inpatient hospital[a]	Outpatient hospital[a]	Physician services[a]	Prescription drugs[b]	Nonemergency use of emergency room[a]	Dental services[a]
Medicaid						
Alaska	$50 per day (maximum of $200 per discharge)	5% of allowable charges	$3	$2	5% of allowable charges	NA
Arkansas	20% of the cost of the first day	$10	$10	$5	$10	$10
Delaware[c]	NA	NA	NA	NA	NA	NA
Missouri	$10	$2	$1	[d]	$1 or $2	5% for dentures; $0.50 to $3 for other services
Tennessee	$100 or $200	NA	$5 to $25	$5 or $10	$25 or $50	$15 or $25
Wisconsin	$3	$3	$1 to $3	$0.50 or $1	$3	$0.50 to $3
SCHIP						
Alabama	$5	$5	$5	$1 or $3	$5	$5
Arizona	NA	NA	NA	NA	$5	NA
Alaska	$50 per day (maximum of $200 per discharge)	5% of allowable charges	$3	$2	5% of allowable charges	NA
Arkansas	20% of the cost of the first day	$10	$10	$5	$10	$10
California	NA	$5	$5	$5	$5[e]	$5 per service
Colorado	NA	$2 or $5	$2 or $5	$1 to $5	$3 or $15	coinsurance not to exceed $5 per non-routine service
Connecticut	NA	$5	$5	$3 to $6	$25	$5
Florida	NA	$3	$3	$3	$10	NA
Illinois	$2 or $5	$2 or $5	$2 or $5	$2 to $5	$25	$2 or $5
Indiana	NA	NA	NA	$3 or $10	NA	NA
Iowa	NA	NA	NA	NA	$25	NA
Kentucky	NA	NA	$2	$1	NA	$2
Mississippi	$5	$5	$5	NA	$15	$5
Missouri	NA	$5 or $10	$5 or $10	$9	$5 or $10	$5 or $10
Montana	$25	$5	$3	$3 or $5	$5	NA
New Hampshire	NA	NA	$10	$5 or $10	$50	NA
New Jersey	NA	$5	$5 or $10	$1 to $10	$1 to $10	NA
New Mexico	$25	$5	$5	$2	$15	$5

State	Inpatient hospital[a]	Outpatient hospital[a]	Physician services[a]	Prescription drugs[b]	Nonemergency use of emergency room[a]	Dental services[a]
North Carolina	NA	$5	$5	$6	$20	$5
North Dakota	$50	NA	NA	$2	$5	NA
Texas	$100	NA	$10	$3 to $20	$3 to $50	NA
Utah	$3 or 10% of allowable charges[f]	$3 or 10% of allowable charges[f]	$3 or $15[f]	$1 to $5 or 50% of allowable charges[f]	$3 or $35[f]	$3 or 20% of allowable charges[f]
Virginia	$15 or $25	$2 or $5	$2 or $5	$2 or $5	$10 or $25	$5
West Virginia	$25	$25 per procedure	$15	$5 to $15	$35	NA
Wisconsin	$3	$3	$1 to $3	$0.50 to $1	$3	$0.50 to $3

Source: GAO analysis of state survey responses and documentation provided by states.

NA = Not applicable. The state did not charge cost sharing for this service.

Note: This appendix reflects cost sharing amounts charged by states for the portion of the Medicaid and SCHIP populations subject to cost sharing charges. The amount of cost sharing and the services subject to cost sharing may vary within a state by population. See Appendix IV for details on the portion of children subject to copayment requirements in Medicaid and SCHIP.

[a]Cost sharing amount is on a per visit or per admission basis unless otherwise noted.

[b]Cost sharing amount is on a per prescription basis unless otherwise noted.

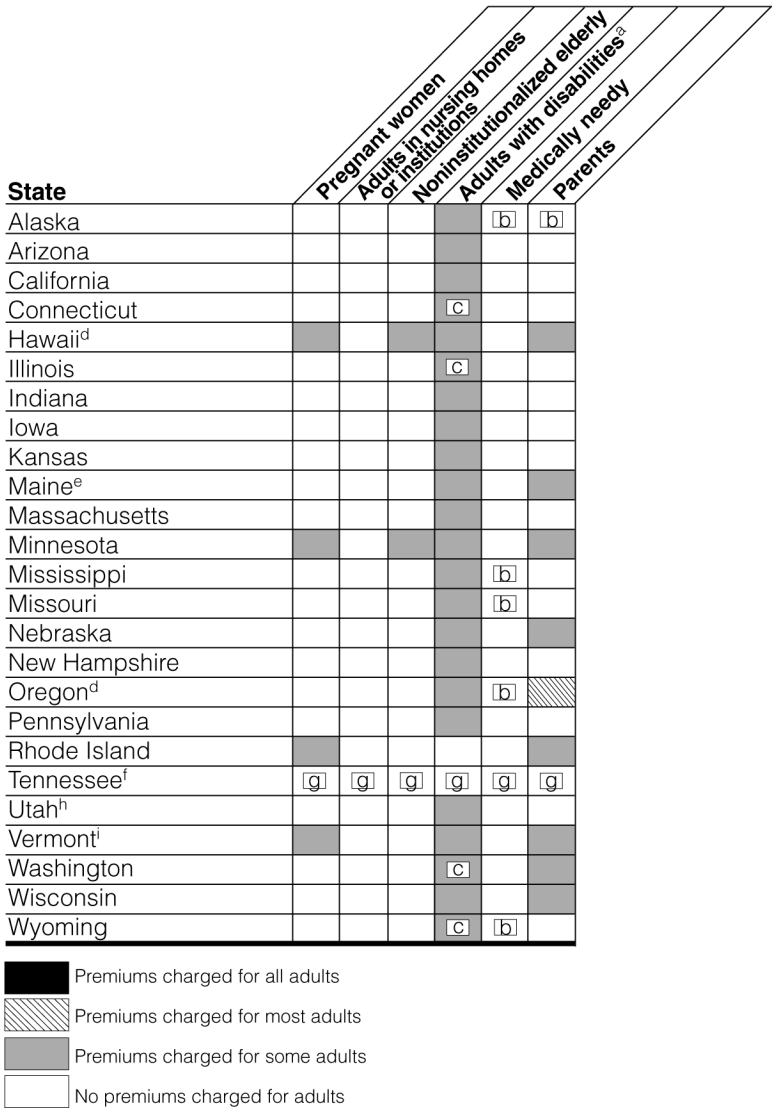
[c]Delaware charged a $1 copayment for nonemergency transportation.

[d]Missouri did not have a copayment for prescription drugs in Medicaid, but some children were charged a dispensing fee for prescriptions.

[e]California charged a $5 copayment for emergency services, which is waived if the beneficiary is hospitalized. However, the state did not cover nonemergency services provided in the emergency room.

[f]Utah SCHIP charged a copayment for children with a family income at or below 150 percent FPL and charged copayment or coinsurance for children in a family with a higher income level.

Appendix VI: Premiums for Adult Populations in Medicaid, by State, as of August 1, 2003



Source: GAO analysis of state survey responses.

Notes: In our survey, states were asked to indicate what portion of the population was charged premiums by selecting “all,” “most,” “some,” or “none.” They were also asked to designate if Medicaid did not cover a population in their state.

The following states did not charge premiums to any adults in Medicaid: Alabama, Arkansas, Colorado, Delaware, District of Columbia, Florida, Georgia, Idaho, Kentucky, Louisiana, Maryland, Michigan, Montana, Nevada, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Texas, Virginia, and West Virginia.

[a]This population includes working adults with disabilities. States may require premiums from certain working adults with disabilities who received Medicaid coverage under the Balanced Budget Act of 1997 or the Ticket to Work and Work Incentives Improvement Act of 1999.

[b]Population not covered in the state's Medicaid program.

[c]State charged premiums to all working individuals with disabilities, but did not charge premiums to other adults with disabilities.

[d]State charged premiums to some portion of childless adults.

[e]Maine charged premiums to individuals in the state's HIV/AIDS waiver program.

[f]Tennessee, which operates its entire Medicaid program under an 1115 waiver, charged premiums to some adults enrolled in the state's 1115 waiver program who had incomes at or above the poverty level.

[g]Not applicable: Tennessee did not report information based on these population groups.

[h]Utah charged an enrollment fee to all adults enrolled in the state's primary care waiver program.

[i]Vermont charged premiums to some adults enrolled in the state's 1115 waiver program.

Appendix VII: Premium Amounts for Adults in Medicaid, by State, as of August 1, 2003

State	Lowest percentage of the FPL at which state charged premiums[a]	Range of premium amounts[b]	Unit charged
Alaska	100	Formula based on family income	Individual
Arizona	100	$15 or $25	Individual
California	[c]	$20 to $250 for an individual; $30 to $375 for a couple	Individual or couple
Connecticut	>200	10% of monthly income exceeding 200% of the FPL	Individual and spouse
Hawaii	[c]	$30, $60, or amount varied[d]	Individual
Illinois	>250	$6 to $100	Individual
Indiana	150	$48 to $187 for an individual; $65 to $254 for a couple	Individual or couple
Iowa	>150	$20 to $201	Individual
Kansas	100	$55 to $152 for an individual; $74 to $205 for a couple	Individual or couple
Maine	150[e]	$10 to $40; 3% of family income[e]	Individual or family
Massachusetts	>100[e]	$15 to over $928; 60 to 85% of full premium[f]	Individual or family
Minnesota	[c]	$4 to $900[g]	Individual, family, or household
Mississippi	150	$55 to $91 for an individual; $75 to $122 for a couple	Individual or couple
Missouri	>150	Formula based on income	Individual
Nebraska	100[e]	$31 to $183 for an individual; $41 to $247 for a couple; $22 to $139 for a household	Individual, couple, or household
New Hampshire	150	$80 to $220	Individual
Oregon	[c]	$6 to $20	Individual
Pennsylvania	[h]	5% of income	Individual
Rhode Island	150[e]	$61 to $92	Family
Tennessee	100	$20 to $550 for an individual; $40 to $1,375 for a family[i]	Individual or family
Utah	100	15% of income	Individual
Vermont	> 50[e]	$10 semi-annually to $75 per month	Individual or household
Washington	11[e]	Formula based on income	Individual or household
Wisconsin	>150	$25 to $1000[j]; $30 to $300	Individual or family
Wyoming	100	Formula based on income	Individual

Source: GAO analysis of state survey responses and documentation provided by states.

Notes:The following states did not charge premiums to any adults in Medicaid: Alabama, Arkansas, Colorado, Delaware, District of Columbia, Florida, Georgia, Idaho, Kentucky, Louisiana, Maryland, Michigan, Montana, Nevada, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Texas, Virginia, and West Virginia.

This appendix reflects the range in premiums states charged across their entire adult population.

[a]In 2003, the FPL for an individual equated to $8,980 per year and $15,260 for a family of three in the 48 contiguous states and the District of Columbia.

[b]Unless otherwise noted, premiums were paid on a monthly basis. Additionally, states have discretion in defining income for purposes of eligibility determination.

[c]The lowest income level at which an adult could be charged premiums in this state's Medicaid program equated to less than one percent of the FPL. However, for certain populations, there were higher income thresholds at which the state began charging premiums.

[d]In Hawaii, the premium amount for certain individuals varied based on the individual's age, gender, geographic location and health plan.

[e]Represents the lowest income level at which an adult could be charged premiums in this state's Medicaid program. However, for certain populations there were higher income thresholds at which the state began charging premiums.

[f]In Massachusetts, premiums of $928 or more per month would be charged to a child from a family whose income exceeded 1,000 percent of the FPL, which equated to approximately $153,000 per year for a family of three. Other individuals with other health insurance coverage can be charged a percentage of premiums in order to obtain supplemental coverage.

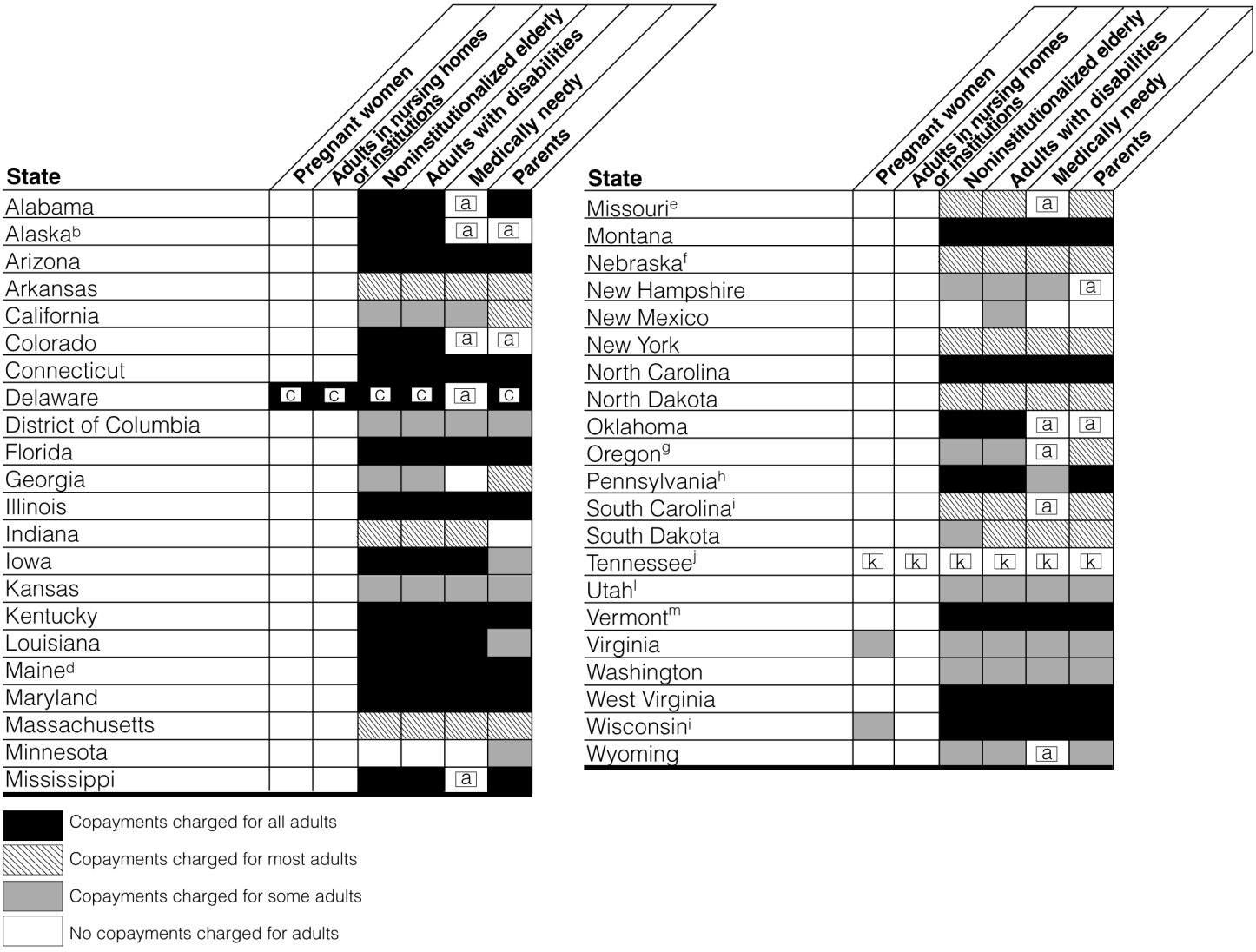
[g]In Minnesota, the highest premium amount, $900 per family per month, would be charged to a family whose income was at least 275 percent of the FPL, which equated to approximately $42,000 per year for a family of three.

[h]Pennsylvania charged premiums only for working individuals with disabilities whose incomes were below 250 percent of the FPL.

[i]The highest premium amount, $1,375 per month, would be charged to a family whose income was at least 600 percent of the FPL, which equated to approximately $91,600 per year.

[j]The highest premium amounts were for certain working individuals with disabilities. The premium amount charged was approximately three percent of the individual's earned income and all of the individual's unearned income after disregarding certain living and medical expenses.

Appendix VIII: Copayment Requirements for Adults in Medicaid, by State, as of August 1, 2003



Source: GAO analysis of state survey responses.

Notes: In our survey, states were asked to indicate what portion of the population was charged cost sharing by selecting "all," "most," "some," or "none." They were also asked to designate if a population was not covered by their states' Medicaid program.

The following states did not charge copayments to any adults in Medicaid: Hawaii, Idaho, Michigan, Nevada, New Jersey, Ohio, Rhode Island, and Texas.

[a]Population not covered in the state's Medicaid program.

[b]Alaska also charged copayments to all individuals qualifying for transitional Medicaid assistance.

[c]Delaware's only copayment, which the state charged to all populations in its Medicaid program, was for nonemergency transportation services.

[d]Maine also charged copayments to all individuals enrolled in its HIV/AIDs waiver program and all individuals in its comprehensive 1115 waiver program.

[e]In addition, individuals participating in the Missouri's 1115 waiver program, which extends 12 months of additional coverage to working parents or caretakers, were also charged copayments. As of January 2004, this program had approximately 2,400 beneficiaries.

[f]Nebraska also charged copayments to most individuals in its refugee resettlement program.

[g]Oregon also charged copayments to most childless adults.

[h]Pennsylvania also charged copayments to most adults in its general assistance program.

[i]State also charged copayments to all individuals in its state's Medicaid pharmacy program.

[j]Tennessee, which operates its entire Medicaid program under an 1115 waiver, charged copayments to some adults enrolled in the state's 1115 waiver program who had incomes at or above the poverty level.

[k]Not applicable: Tennessee did not report information based on these population groups.

[l]Utah also charged copayments to all individuals enrolled in its primary care waiver program.

[m]Vermont also charged copayments to all individuals enrolled in its 1115 waiver program.

Appendix IX: Cost Sharing Amounts for Adults in Medicaid, by State, as of August 1, 2003

State	Inpatient hospital[a]	Outpatient hospital[a]	Physician services[a]	Prescription drugs[b]	Nonemergency use of the emergency room[a]	Dental services[a]
Alabama	$50	$3	$1	$0.50 to $3	$3	NA
Alaska	$50 per day ($200 maximum per discharge)	5% of allowable charges	$3	$2	5% of allowable charges	NA
Arizona	NA	NA	$1	NA	$5	NA
Arkansas	10% to 25% of per diem amount	$10	$10	$0.50 to $15	$10	$10
California	NA	$1	$1	$1	$5	NA
Colorado	$15	$3	$2	$0.75 or $3	$3	NA
Connecticut	NA	NA	NA	$1	NA	NA
Delaware[c]	NA	NA	NA	NA	NA	NA
District of Columbia	NA	NA	NA	$1	NA	NA
Florida	$3	$3	$2 per day per provider	NA	NA	5% of charges
Georgia	$12.50	$3	$2	$0.50	$3	NA
Illinois	$2 or $3 per day[d]	NA	$2	$1 to $3	NA	NA
Indiana	NA	NA	NA	$0.50 to $3	$1 to $2	NA
Iowa	NA	NA	$3	$0.50 to $3	NA	$3
Kansas	$48	$3	$2	$3	NA	$3
Kentucky	NA	NA	$2	$1	NA	$2
Louisiana	NA	NA	NA	$0.50 to $3	NA	NA
Maine	$0.50 to $3[e]	$0.50 to $3[e]	$0.50 to $3[e]	$2.50 to $10	NA	NA
Maryland	NA	NA	NA	$2 to $7.50	NA	NA
Massachusetts	NA	NA	NA	$2	NA	NA
Minnesota	NA	NA	NA	$3	NA	50% of payment rate
Mississippi	$10 per day (maximum of one-half of first day per diem)	$3	$3	$1 or $3	$3	$3
Missouri	$10	$2 or $10[f]	$1[g] or $10[f]	$0.50 to $2 or $5[f]	$1 or $2	$0.50 to $3 or 5% of charges or $10[f]
Montana	$100	$5	$4	$1 to $5	$5	$3

State	Inpatient hospital[a]	Outpatient hospital[a]	Physician services[a]	Prescription drugs[b]	Nonemergency use of the emergency room[a]	Dental services[a]
Nebraska	NA	$3	$2	$2 per person	NA	$3 per service
New Hampshire	NA	NA	NA	$0.50 or $1	NA	NA
New Mexico	$25	$5	$5	$2	$15	$5
New York	$25 per visit with an overnight stay	$3	NA	$0.50 or $2	$3	NA
North Carolina	NA	$3	$3	$1 or $3	NA	$3 per service
North Dakota	$50	$1 or $2	$2	$3 (brand name only)	$3	$2
Oklahoma	$3 per day	$3 per day	$1 per service	$1 or $2	NA	NA
Oregon	$250	$3 to $20	$3 to $5	$2 to $15	$50	$10 to $100
Pennsylvania	$3 per day; maximum of $21 per admission	$0.50 to $3	$0.50 to $3	$1	$1 to $6	$0.50 to $3
South Carolina	NA	NA	NA	$3 to $21[h]	NA	NA
South Dakota	NA	5% of payment; maximum of $50	$2	$2	5% of payment; maximum of $50	$1
Tennessee	$100 or $200	NA	$5 to $25	$5 or $10	$25 or $50	$15 or $25
Utah	$220	$2 or $3	$3 or $5	$2 to $5 or 25% of cost	$6 or $30	10% of allowable Medicaid payment
Vermont	$50 or $75	$3 or $25 per day	$7	$1 to $10 or 50% to 60%	$60	$3
Virginia	$100	$3	$1	$1	NA	NA
Washington	NA	NA	NA	NA	$3	NA
West Virginia	NA	NA	NA	$0.50 to $3	NA	NA
Wisconsin	$3 per day; maximium of $75	$3	$1 to $3	$.50 to $15[i]	$3	$.50 to $3
Wyoming	NA	$6	$2	$2 to $25	$6	NA

Source: GAO analysis of state survey responses and documentation provided by states.

NA = Not applicable. The state did not charge cost sharing for this service.

Notes: The following states did not charge cost sharing to any adults in Medicaid: Hawaii, Idaho, Michigan, Nevada, New Jersey, Ohio, Rhode Island, and Texas.

Appendix IX: Cost Sharing Amounts for Adults in Medicaid, by State, as of August 1, 2003

This appendix reflects cost sharing amounts charged by states for the services and portions of the Medicaid adult populations subject to cost sharing charges. The amount of cost sharing and the services subject to cost sharing may vary within a state by population. See Appendix VIII for details on the adult populations subject to copayment requirements in Medicaid.

[a]Cost sharing amount is on a per visit or per admission basis unless otherwise noted.

[b]Cost sharing amount is on a per prescription basis unless otherwise noted.

[c]Delaware's only cost sharing was a $1 copayment for nonemergency transportation.

[d]Illinois did not require cost sharing for all procedures within this service.

[e]Maine had a $3 daily limit and a $30 monthly limit for these services.

[f]Copayment is for individuals participating in the Missouri's 1115 waiver program, which extends 12 months of additional coverage to working parents or caretakers. As of January 2004, this program had approximately 2,400 beneficiaries.

[g]Missouri's copayment for physician services is only for services rendered in a hospital outpatient clinic or emergency room.

[h]South Carolina had a $500 deductible for elderly individuals enrolled in the state's pharmacy waiver.

[i]Wisconsin also had a deductible—either $500 or $850, depending on income levels—for elderly individuals enrolled in the state's pharmacy waiver program.

Appendix X: GAO Contact and Staff Acknowledgments

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