

§ 447.66

the consequences for an individual who does not pay.

[73 FR 71851, Nov. 25, 2008, as amended at 75 FR 30262, May 28, 2010]

§ 447.66 General alternative premium protections.

(a) States may not impose alternative premiums upon the following individuals:

(1) Individuals under 18 years of age that are required to be provided medical assistance under section 1902(a)(10)(A)(i) of the Act, and including individuals with respect to whom child welfare services are made available under Part B of title IV of the Act on the basis of being a child in foster care and individuals with respect to whom adoption or foster care assistance is made available under Part E of that title, without regard to age.

(2) Pregnant women.

(3) Any terminally ill individual receiving hospice care, as defined in section 1905(o) of the Act.

(4) Any individual who is an inpatient in a hospital, nursing facility, intermediate care facility, or other medical institution, if the individual is required, as a condition of receiving services in that institution under the State plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs.

(5) Women who are receiving Medicaid on the basis of the breast or cervical cancer eligibility group under sections 1902(a)(10)(A)(ii)(XVIII) and 1902(aa) of the Act.

(6) Disabled children who are receiving medical assistance by virtue of the application of sections 1902(a)(10)(A)(ii)(XIX) and 1902(cc) of the Act.

(7) An Indian who is eligible to receive or has received an item or service furnished by an Indian health care provider or through referral under contract health services.

(b) States may exempt additional classes of individuals from premiums.

(c) Nothing in this subsection shall be construed as restricting the application of any other limitations on the imposition of premiums that may

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apply to an individual receiving Medicaid who is an Indian.

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§ 447.68 Alternative copayments, coinsurance, deductibles, or similar cost sharing charges: State plan requirements.

When a State imposes alternative copayments, coinsurance, deductibles, or similar cost sharing charges on individuals, the State plan must describe the following:

(a) The group or groups of individuals that may be subject to the cost sharing charge.

(b) The methodology used to determine family income, for purposes of the limitations on cost sharing related to family income level that are described in § 447.78(c) of this chapter, including the period and periodicity of those determinations.

(c) The schedule of the copayments, coinsurance, deductibles, or similar cost sharing charges imposed for each item or service for which a charge is imposed.

(d) The methodology used by the State to identify beneficiaries who are subject to premiums or cost sharing for specific items or services and, if families are at risk of reaching the total aggregate limit for premiums and cost sharing under Medicaid defined at § 447.78, track beneficiaries' incurred premiums and cost sharing through a mechanism developed by the State that does not rely on beneficiaries, in order to inform beneficiaries and providers of beneficiaries' liability and notify beneficiaries and providers when individual beneficiaries have incurred family out-of-pocket expenses up to that limit and are no longer subject to further cost sharing for the remainder of the family's current monthly or quarterly cap period.

(e) The process for informing beneficiaries, applicants, providers, and the public of the schedule of cost sharing charges for specific items and services for a group or groups of individuals in accordance with § 447.76.

(f) The methodology used to ensure that:

(1) The aggregate amount of premiums and cost sharing imposed under