IDAPA 16 – IDAHO DEPARTMENT OF HEALTH AND WELFARE

Division of Medicaid

16.03.18 – Medicaid Cost-Sharing

Who does this rule apply to?
For those receiving medical assistance under Idaho Medicaid who are subject to cost-sharing.

What is the purpose of this rule?
These rules describe the general requirements regarding the administration of the cost-sharing provisions for participation in a medical assistance program providing direct benefits in Idaho.

What is the legal authority for the agency to promulgate this rule?
This rule implements the following statutes passed by the Idaho Legislature:

Public Assistance and Welfare -
Public Assistance Law:
- Section 56-202(b), Idaho Code – Duties of Director of State Department of Health & Welfare
- Section 56-253, Idaho Code – Powers and Duties of the Director
- Section 56-257, Idaho Code – Copayments

Where can I find information on Administrative Appeals?
Administrative appeals and contested cases are governed by the provisions of IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings."

How do I request public records?
Unless exempted, all public records are subject to disclosure by the Department that will comply with Title 74, Chapter 1, Idaho Code, upon requests. Confidential information may be restricted by state or federal law, federal regulation, and IDAPA 16.05.01, "Use and Disclosure of Department Records."

Who do I contact for more information on this rule?

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Webpages: Medicaid: https://medicaid.idaho.gov
https://healthandwelfare.idaho.gov/providers/idaho-medicaid-providers/information-medicaid-providers
(see Public Schedule of Premiums and Cost-Sharing)

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000. LEGAL AUTHORITY.
Under Section 56-202(b), Idaho Code, the Legislature has delegated to the Department of Health and Welfare the responsibility to establish and enforce such rules as may be necessary or proper to administer public assistance programs within the state of Idaho. Under Sections 56-253 and 56-257, Idaho Code, the Department of Health and Welfare is to establish enforceable cost-sharing requirements within the limits of federal Medicaid law and regulations. Furthermore, the Idaho Department of Health and Welfare is the designated agency to administer programs under Title XIX and Title XXI of the Social Security Act. (7-1-21)T

001. TITLE AND SCOPE.

01. Title. These rules are titled IDAPA 16.03.18, "Medicaid Cost-Sharing." (7-1-21)T

02. Scope. These rules describe the general requirements regarding the administration of the cost-sharing provisions for participation in a medical assistance program providing direct benefits in Idaho. (7-1-21)T

002. WRITTEN INTERPRETATIONS.
This agency may have written statements which pertain to the interpretation of the rules of this chapter. These documents are available for public inspection. (7-1-21)T

003. -- 009. (RESERVED)

010. DEFINITIONS.

01. Copayment (Copay). The amount a participant is required to pay to the provider for specified services. (7-1-21)T

02. Cost-Sharing. A payment the participant or the financially responsible adult is required to make toward the cost of the participant's health care. Cost-sharing includes both copays and premiums. (7-1-21)T

03. Creditable Health Insurance. Creditable health insurance is coverage that provides benefits for inpatient and outpatient hospital services and physicians' medical and surgical services. Creditable coverage excludes liability, limited scope dental, vision, specified disease or other supplemental-type benefits. (7-1-21)T

04. Department. The Idaho Department of Health and Welfare, or a person authorized to act on behalf of the Department. (7-1-21)T

05. Family Income. The gross income of all financially responsible adults who reside with the participant, as calculated under IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children." (7-1-21)T

06. Family Size. Family size is the number of people living in the same home as the child. This includes relatives and other optional household members. (7-1-21)T

07. Federal Poverty Guidelines (FPG). The federal poverty guidelines issued annually by the U. S. Department of Health and Human Services (HHS). The federal poverty guidelines are available on the U.S. Health and Human Services website at http://aspe.hhs.gov/poverty. (7-1-21)T

08. Financially Responsible Adult. An individual who is the biological or adoptive parent of a child and is financially responsible for the participant. (7-1-21)T

09. Medical Assistance. Payments for part or all of the cost of services funded by Titles XIX or XXI of the federal Social Security Act, as amended. (7-1-21)T

10. Participant. A person eligible for and enrolled in the Idaho Medical Assistance Program. (7-1-21)T

11. Physician Office Visit. Services performed by a physician, nurse practitioner or physician's assistant at the practitioner's place of business, including Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs). Indian Health Clinic/638 Clinics providing services to individuals eligible for Indian Health Services are not included. (7-1-21)T

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12. Premium. A regular and periodic charge or payment for health coverage. (7-1-21)T

13. Social Security Act. 42 U.S.C. 101 et seq., authorizing, in part, federal grants to the states for medical assistance to eligible low-income individuals. (7-1-21)T

14. State. The state of Idaho. (7-1-21)T

15. Title XIX. Title XIX of the Social Security Act, known as Medicaid, is a medical benefits program jointly financed by the federal and state governments and administered by the states. This program pays for medical assistance for certain individuals and families with low income and limited resources. (7-1-21)T

16. Title XXI. Title XXI of the Social Security Act, known as the State Children's Health Insurance Program (SCHIP). This is a program that primarily pays for medical assistance for low-income children. (7-1-21)T

011. -- 024. (RESERVED)

025. PARTICIPANTS EXEMPT FROM COST-SHARING.

Native American and Alaskan Native participants are exempt from the cost-sharing provisions of Sections 200, 205, 215, 320, and 400 of these rules. The participant must declare his race to the Department to receive this exemption. Participants in the Medicaid Workers with Disabilities (MWD) program are exempt from the cost-sharing provisions of Sections 200, 205, 207, and 400 of these rules. (7-1-21)T

026. -- 049. (RESERVED)

050. GENERAL COST-SHARING.

01. Cost-Sharing Maximum Amount. A family will be required to pay out of pocket costs not to exceed five percent (5%) of the family's anticipated gross monthly income unless an exception is made as provided in Subsection 050.02 of this rule. (7-1-21)T

02. Exception to Cost-Sharing Maximum. A family will be required to pay cost-sharing amounts as provided in Sections 215 and 400 of these rules. These cost-sharing amounts may exceed the family's five percent (5%) of anticipated gross monthly income. (7-1-21)T

03. Proof of Cost-Sharing Payment. If a participant believes that their cost-sharing exceeded the five percent (5%) cost-sharing of the family's anticipated gross monthly income, they must provide proof to the Department of the copay amounts that were paid. (7-1-21)T

04. Excess Cost-Sharing. A family that establishes proof of payment for cost-sharing that exceeds the five percent (5%) of the family's anticipated gross monthly income will be reimbursed by the Department for the amount paid that exceeds the five percent (5%), except as provided in Subsection 050.02 of this rule. (7-1-21)T

05. Cost-Sharing Suspended. A family that exceeds the five percent (5%) maximum amount for cost-sharing will not be required to pay a cost-sharing portion for any family participant for the remainder of the calendar month in which proof of payment is established. (7-1-21)T

051. - 199. (RESERVED)

200. PREMIUMS FOR PARTICIPATION UNDER THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP).

01. Family Income Above 133% of FPG. Each SCHIP participant with family income above one hundred thirty-three percent (133%) and equal to or less than one hundred fifty percent (150%) of the current FPG must pay a monthly premium of ten dollars ($10) to the Department. (7-1-21)T

02. Family Income Above 150% of FPG. Each SCHIP participant with family income above one hundred fifty percent (150%) and equal to or less than one hundred eighty-five percent (185%) of the current FPG

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must pay a monthly premium of fifteen dollars ($15) to the Department. (7-1-21)T

201. -- 204. (RESERVED)

205. PREMIUMS FOR PARTICIPATION UNDER HOME CARE FOR CERTAIN DISABLED CHILDREN (HCCDC).

01. Family Income Above 150% and Equal to or Less Than 185% of FPG. Each HCCDC participant with a family income above one hundred fifty percent (150%) and equal to or less than one hundred eighty-five percent (185%) of the current FPG must pay a monthly premium of fifteen dollars ($15) to the Department. The maximum monthly premium a family must pay is limited to thirty dollars ($30). (7-1-21)T

02. Family Income Above 185% of FPG. Each HCCDC family with income above one hundred eighty-five percent (185%) of the current FPG must pay a monthly premium to the Department. The monthly premium is a fixed percent of the family's income as provided in the table below. (7-1-21)T

TABLE 205.02 SLIDING FEE SCHEDULE FOR MONTHLY PREMIUMS FOR HCCDC PARTICIPATION		
Family Income Above 185% of Current FPG		Premium Based on % of Family Income
ABOVE	LESS THAN OR EQUAL TO	
185%	250%	1.0%
250%	300%	1.5%
300%	400%	2.0%
400%	500%	2.5%
500%	600%	3.0%
600%	700%	3.5%
700%	800%	4.0%
800%	900%	4.5%
900%	No Upper Limit	5.0%

(7-1-21)T

03. Reduction of Premium for Creditable Health Insurance. A family who purchases creditable health insurance for the participant may receive a twenty-five percent (25%) reduction of the required monthly premium. (7-1-21)T

04. Failure to Provide Information. Failure to provide the Department with information needed to determine family income and household size may subject the participant to a monthly premium equal to the average monthly cost of coverage for participants receiving Medicaid Enhanced Plan Benefits through HCCDC. (7-1-21)T

05. Failure to Pay Premium. Failure to pay the premium for an HCCDC participant will not cause the participant to lose coverage or eligibility for services. A participant eligible through HCCDC is exempt from the provisions of Section 250 of these rules. (7-1-21)T

06. Waiver of Premium. The premium may be waived if the Department determines that payment of the premium would cause undue hardship on the family. Undue hardship exists when an unexpected expense would cause the family to forgo basic food or shelter in order to make a premium payment. Detailed documentation of the

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family's living and insurance expenses demonstrating such hardship must be provided to the Department. (7-1-21)T

07. Premium Recalculation. The premium amount is recalculated at each annual eligibility renewal. If a financially responsible adult reports a reduction in family income prior to renewal, the premium will be reduced to the appropriate level upon verification of the reduction to the family's income. When the family income is at a level that does not require premium payments, the premium will no longer be assessed. (7-1-21)T

206. (RESERVED)

207. PREMIUMS FOR PARTICIPATION UNDER THE YOUTH EMPOWERMENT SERVICES (YES) PROGRAM.

01. Premium Fee Schedule. Each YES program participant, as that individual is defined in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 636, is subject to assessment of a premium based on family income. The Department will establish a premium fee schedule at rates not to exceed maximums set forth in federal law and regulations governing state Medicaid programs. The fee schedule will be published on the Department's website and provided to families participating in the YES program who are subject to premiums. (7-1-21)T

02. Enforcement of Premiums. Payment of premiums will be enforced within the limitations of federal laws and regulations governing state Medicaid programs. (7-1-21)T

03. Waiver of Premium. The monthly premium described in Subsection 207.01 of this rule may be waived if the Department determines that the family is unable to participate in the cost of care. (7-1-21)T

04. Premium Recalculation. The premium amount is recalculated at each annual eligibility redetermination. If a financially responsible adult reports a reduction in family income prior to eligibility redetermination, the premium will be reduced to the appropriate level upon verification of the reduction in the family's income. When the family income is reduced to a level that does not require premium payments, the premium will no longer be assessed. (7-1-21)T

208. -- 209. (RESERVED)

210. DEPARTMENT RESPONSIBILITIES.

01. Assessed Premiums. A participant will not be assessed premiums during the time initial eligibility is determined. Obligation for premium payments does not begin for at least sixty (60) days after receipt of application, except for workers with disabilities under Section 215 of these rules. (7-1-21)T

02. Premiums Not Assessed Due to Late Review. A participant can not be assessed premiums for extra months of eligibility received due solely to the Department's late review of continuing eligibility, except for workers with disabilities under Section 215 of these rules. (7-1-21)T

03. No Retroactive Premiums Assessed. A participant can not be assessed premiums for months of retroactive eligibility. (7-1-21)T

04. Notification of Premiums. The Department is required to routinely notify a participant of their premium payment obligations including any delinquencies, if applicable. (7-1-21)T

211. -- 214. (RESERVED)

215. PREMIUMS FOR PARTICIPATION IN MEDICAID ENHANCED PLAN.

01. Workers with Disabilities. A participant in the Medicaid for Workers with Disabilities coverage group must share in the cost of Medicaid coverage, if required. Countable income is determined under IDAPA 16.03.05, "Eligibility for Aid to the Aged, Blind, and Disabled (AABD)." A participant's premium for his share of Medicaid costs under this coverage group is determined in Subsections 215.01.a. through 215.01.c. of this rule. (7-1-21)T

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a. A participant who has countable income at or below one hundred thirty-three percent (133%) of the current federal poverty guideline is not required to pay a premium for Medicaid. (7-1-21)T

b. A participant who has countable income above one hundred thirty-three percent (133%) to two hundred fifty percent (250%) of the current federal poverty guideline is required to pay a monthly premium of ten dollars ($10) to the Department. (7-1-21)T

c. A participant who has countable income in excess of two hundred fifty percent (250%) of the current federal poverty guideline is required to pay a monthly premium to the Department. The amount due is the greater of ten dollars ($10); or seven and one-half percent (7.5%) of the participant's income above two hundred fifty percent (250%) of the current federal poverty guideline. (7-1-21)T

02. Recomputed Premium Amount. Premium amounts are recomputed when changes to a participant's countable income result in a different percentage premium calculation as determined in Subsections 215.02 through 215.04 of this rule, and at the annual re-determination. (7-1-21)T

216. -- 249. (RESERVED)

250. DELINQUENT PREMIUM PAYMENTS.

If the participant is sixty (60) days or more past due on its premium payments, the participant is contacted to determine the reason for the delinquency. If the participant's countable income is less than the amount used for the most recent eligibility determination, the participant is offered a new eligibility determination. If a participant's family income is at a level that does not require premium payments, the premium will no longer be assessed. The change is effective the month after the participant becomes eligible for such benefits. The following Subsections 250.01 through 250.03 of this rule apply to delinquent premium payments. (7-1-21)T

01. Delinquent Payments. A participant must not be approved for or renewed for coverage that requires premium payments, if their premium payments are sixty (60) days or more delinquent as of the last working day of their twelve (12) month eligibility period. (7-1-21)T

02. Reestablishing Eligibility. A participant can reestablish eligibility by paying the premium debt in full, unless one (1) of the conditions listed in Subsection 250.03 applies. (7-1-21)T

03. Premium Debt. Any premium debt assessed, but not paid, will be forgiven if one (1) of the following applies: (7-1-21)T

a. The participant reports and the Department determines that the participant's family income is below one hundred and thirty-three percent (133%) FPG. This may occur at any time during the eligibility period; or (7-1-21)T

b. A participant in the Medicaid Basic Plan has a medical condition that requires the participant to receive the benefits provided in IDAPA 16.03.10 "Medicaid Enhanced Plan Benefits." (7-1-21)T

251. -- 299. (RESERVED)

300. PARTICIPANTS EXEMPT FROM COPAYMENT.

01. Exempt Participants. Certain participants are exempt from copayments for services described in Section 320.03 through 320.10 of these rules. Exempt participants include: (7-1-21)T

a. A child under the age of nineteen (19) with family income less than or equal to one hundred and thirty-three percent (133%) of the current federal poverty guidelines (FPG); (7-1-21)T

b. An individual age of nineteen (19) or older with family income less than or equal to one hundred percent (100%) of the current federal poverty guidelines (FPG); (7-1-21)T

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c. A pregnant or post-partum woman when the services provided are related to the pregnancy; (7-1-21)T

d. An inpatient in a hospital, nursing facility, intermediate care facility for persons with intellectual disabilities (ICF/ID), or other medical institution, who is required to pay all but a nominal amount of their income to the institution for their care; (7-1-21)T

e. An adult participant who receives services provided under a waiver of Section 1915c of the Social Security Act (SSA); (7-1-21)T

f. A participant who has other health care coverage that is the primary payor for the services provided; (7-1-21)T

g. A participant receiving hospice care; (7-1-21)T

h. A child in foster care receiving aid or assistance under the Social Security Act (SSA), Title IV, Part B; (7-1-21)T

i. A participant receiving adoption or foster care assistance under the Social Security Act (SSA), Title IV, Part E, regardless of age; and (7-1-21)T

j. A woman eligible under the breast and cervical cancer eligibility group. (7-1-21)T

02. Notification of Copayment. The Department will provide notification to each participant who is not exempt from the copayment requirements in Subsections 320.03 through 320.10 of these rules. (7-1-21)T

301. -- 309. (RESERVED)

310. COPAYMENT FEE AMOUNTS.

01. Nominal Amount. The amount of the copayment must be a nominal amount as provided in 42 CFR 447.54. This nominal amount is set by the U.S. Department of Health and Human Services. (7-1-21)T

02. Fee Amount. Beginning on November 1, 2011, the nominal fee amount required to be paid by the participant as a copayment is three dollars and sixty-five cents ($3.65). This copayment amount will be adjusted annually as determined by the Secretary of Human Services. (7-1-21)T

03. Annual Increase. The nominal fee amount will be increased annually by an adjusted percentage rate determined by the Secretary of Health and Human Services as set in the Social Security Act Section 1916. (7-1-21)T

311. -- 319. (RESERVED)

320. MEDICAID OUTPATIENT SERVICES SUBJECT TO COPAYMENTS.
Medicaid participants are responsible for making copayments for the outpatient services described in Subsections 320.01 through 320.10 of this rule, unless exempted. The amount of the copayment is provided in Section 310 of these rules. (7-1-21)T

01. Accessing Hospital Emergency Department for Non-Emergency Medical Conditions. A participant who seeks care at a hospital emergency department for services that do not meet the definition of an emergency medical condition as defined in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," may be required to pay a copayment to the provider. A participant who must access a hospital emergency department in order to receive routine services for their medical condition is exempt from this provision. (7-1-21)T

02. Accessing Emergency Transportation Services for Non-Emergency Medical Conditions. A participant who accesses emergency transportation services for a condition that is determined by the Department to be a non-emergency medical condition may be required to pay a copayment to the provider of the service.(7-1-21)T

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03. Chiropractic Services. Those services for spinal manipulation performed by a chiropractor. (7-1-21)T

04. Occupational Therapy. (7-1-21)T

05 Optometric Services. Those services performed by a optometrist that fall into the "General Ophthalmological Services" category of Current Procedural Terminology (CPT). (7-1-21)T

06. Outpatient Hospital Services. Any of the services included in Subsections 320.03 through 320.05 and Subsections 320.07 through 320.10 of this rule performed in an outpatient hospital setting. Services performed in a Hospital Emergency Department are excluded, except as provided for in Subsection 320.01 of this rule. (7-1-21)T

07. Physical Therapy. (7-1-21)T

08. Podiatry Services. Services provided by a podiatrist during an office visit. (7-1-21)T

09. Physician Office Visit. Each physician office visit, unless: (7-1-21)T

a. The visit is for a preventive wellness exam, immunizations, or family planning: (7-1-21)T

b. The visit is for urgent care provided at a clinic billing as an urgent care facility. (7-1-21)T

10. Speech Therapy. (7-1-21)T

321. -- 324. (RESERVED)

325. EXCEPTION TO CHARGING A COPAYMENT.
In order for a copay to be charged by the provider, the Medicaid payment amount for the services rendered during a visit must be equal to or greater than ten (10) times the amount of the copay described in Section 310 of these rules. The Medicaid payment amount is determined by the Department and published in the Medicaid Fee Schedule. (7-1-21)T

326. -- 329. (RESERVED)

330. COLLECTION OF COPAYMENTS.

01. Responsibility for Collection. The provider of services is responsible for collection of the copayment from the participant. (7-1-21)T

02. Denial of Services. The provider may require payment of an applicable copay prior to rendering services. (7-1-21)T

03. Waiver of Copayment. The provider may choose to waive payment of any copay. The provider must have a written policy describing the criteria for enforcing collection of copayments and when the copay may be waived. (7-1-21)T

04. Reduction in Reimbursement.When a copay is applicable, the provider's reimbursement will be reduced by the amount of the copay regardless of whether or not a copay was charged or collected by the provider. (7-1-21)T

331. -- 399. (RESERVED)

400. PARTICIPATION IN THE COST OF HOME AND COMMUNITY-BASED WAIVER SERVICES.
Medicaid participants required to participate in the cost of Home and Community-Based Waiver (HCBS) services as described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," must have their share of cost determined as described in Subsections 400.01 through 400.10 of this rule. (7-1-21)T

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01. Excluded Income. Income excluded under the provisions of IDAPA 16.03.05, "Eligibility for Aid to the Aged, Blind, and Disabled (AABD)," Sections 723 and 725, is excluded in determining participation. (7-1-21)T

02. Base Participation. Base participation is income available for participation after subtracting all allowable deductions, except for the incurred medical expense deduction in Subsection 400.07 of this rule. Base participation is calculated by the participant's Self Reliance Specialist. The incurred medical expense deduction is calculated by the Division of Welfare. (7-1-21)T

03. Community Spouse. Except for the elderly or physically disabled participant's personal needs allowance, base participation for a participant with a community spouse is calculated under IDAPA 16.03.05, "Eligibility for Aid to the Aged, Blind, and Disabled (AABD)," Section 725. A community spouse is the spouse of an HCBS participant who is not an HCBS participant and is not institutionalized. The HCBS personal needs allowance for a participant living in adult residential care equals the federal Supplemental Security Income (SSI) benefit rate for an individual living independently. (7-1-21)T

04. Home and Community Based Services (HCBS) Spouse. Except for the elderly or physically disabled participant's personal needs allowance (PNA), base participation for a participant with an HCBS spouse is calculated and specified under IDAPA 16.03.05, "Eligibility for Aid to the Aged, Blind, and Disabled (AABD)," Section 723. An HCBS spouse is the spouse of a participant who also receives HCBS. (7-1-21)T

05. Personal Needs Allowance. The participant's personal needs allowance depends on whether the participant has a legal obligation to pay rent or mortgage. The participant's personal needs allowance is deducted from any countable income after income exclusions and before other allowable deductions. To determine the amount of the personal needs allowance, use Table 400.05 of this rule:

TABLE 400.05 - PERSONAL NEEDS ALLOWANCE	
Amount of Personal Needs Allowance (PNA) for Participation	
Not Responsible for Rent or Mortgage	Responsible for Rent or Mortgage
One hundred percent (100%) of the federal SSI benefit for a person with no spouse	One hundred and eighty percent (180%) of the Federal SSI benefit for a person with no spouse

(7-1-21)T

06. Developmentally Disabled Participants. These allowances are specified in IDAPA 16.03.05, "Eligibility for Aid to the Aged, Blind, and Disabled (AABD)." The HCBS personal needs allowance for adult participants receiving waiver services under the Developmentally Disabled Waiver is three (3) times the federal SSI benefit amount to an individual in his own home. (7-1-21)T

07. Incurred Medical Expenses. Amounts for certain limited medical or remedial services not covered by the Idaho Medicaid Plan and not paid by a third party may be deducted from the base participation amount. The Department must determine whether a participant's incurred expenses for such limited services meet the criteria for deduction. The participant must report such expenses and provide verification in order for an expense to be considered for deduction. Costs for over-the-counter medications are included in the personal needs allowance and will not be considered a medical expense. Deductions for necessary medical or remedial expenses approved by the Department will be deducted at application, and changed, as necessary, based on changes reported to the Department by the participant. (7-1-21)T

08. Remainder After Calculation. Any remainder after the calculation in Subsection 400.05 of this rule is the maximum participation to be deducted from the participant's provider payments to offset the cost of services. The participation amount will be collected from the participant by the provider. The provider and the

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participant will be notified by the Department of the amount to be collected. (7-1-21)T

09. Recalculation of Participation. The participant's participation amount must be recalculated annually at redetermination or whenever a change in income or deductions becomes known to the Department. (7-1-21)T

10. Adjustment of Participation Overpayment or Underpayment Amounts. The participant's participation amount is reduced or increased the month following the month the participant overpaid or underpaid the provider. (7-1-21)T

401. -- 999. (RESERVED)

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- Recomputed Premium Amount 7
- Workers with Disabilities 6

Premiums For Participation Under Home Care For Certain Disabled Children (HCCDC) 5
- Failure to Pay Premium 5
- Failure to Provide Information 5
- Family Income Above 150% & Equal to or Less Than 185% of FPG 5
- Family Income Above 185% of FPG 5
- Premium Recalculation 6
- Reduction of Premium for Creditable Health Insurance 5
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Premiums For Participation Under The State Children's Health Insurance Program (SCHIP) 4
- Family Income Above 133% of FPG 4
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Premiums For Participation Under The Youth Empowerment Services (YES) Program 6
- Enforcement of Premiums 6
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- Premium Recalculation 6
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