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COPAYMENTS AND DEDUCTIBLES IN MEDICAID AND HEALTH INSURANCE PLANS

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DEDUCTIBLES AND COPAYMENTS

A deductible is the amount of money a policyholder pays out-of-pocket before insurance coverage begins.

A copayment is a fixed amount a policyholder pays out-of-pocket each time he or she receives a specific health care service.

Deductibles and copayments are both common forms of health insurance cost sharing.

ISSUE

This report provides information on copayments and deductibles for (1) Medicaid, (2) state employee medical plans, and (3) other private health insurance plans. It also includes general income limits for eligibility for Connecticut's Medicaid-funded health care programs.

SUMMARY

Generally, Medicaid enrollees in Connecticut do not pay deductibles or copayments, though some enrollees in a smaller Medicaid-funded program may pay a premium based on their income.

State employee medical plans require annual deductibles of $350 for individuals and $350 per person up to $1,400 for families, but this requirement can be waived if the employees participate in the Health Enhancement Program. State employee medical plans do not require copayments for in-network preventative care or immunizations, but do generally require $15 copayments for in-network outpatient visits, walk-in centers, and urgent care centers. The plans pay 80% of the allowable charges for such visits out-of-network.

The Connecticut Insurance Department does not track average deductibles or copayments included in private health insurance plans, but it does set maximum allowable copayment amount (e.g., $40 for a primary care provider office visit).

Plans available on the state's health insurance exchange (Access Health CT) have in-network deductibles ranging from $0 to $5,000 per person and may also have separate deductibles for prescription drugs. Copayments for in-network office visits range from $10 to $40 for primary care and $30 to $50 for specialists, and may also require policyholders to pay a percentage of the allowable cost (i.e., coinsurance). Copayments for prescription drugs vary by plan and by type of drug.

MEDICAID

Deductibles and Copayments

Generally, most of the state's Medicaid recipients receive health care through one of the Department of Social Services' (DSS) HUSKY programs (i.e., HUSKY A, C, and D), which do not require deductibles or copayments. Med-Connect, a much smaller Medicaid-funded health program for working individuals with disabilities, has a premium requirement based on income, but no deductibles or copayments. The Medicare Savings Program provides Medicaid-funded assistance with certain Medicare cost sharing requirements.

Income Limits

Table 1 shows general income limits for Medicaid eligibility for individuals and families in Connecticut. These limits do not reflect changes in the state budget bill (PA 15-244) passed by the legislature, but not yet signed by the governor.

Table 1: Annual Income Limits for Medicaid Programs (HUSKY A and D)

Category	*Family of 2*	*Family of 3*	*Family of 4*	*Family of 5*
Children and parents or caregivers (HUSKY A)	$32,060	$40,381	$48,743	$57,105
Pregnant women (HUSKY A)	$41,896	$52,837	$63,778	$74,719
Individuals age 19-65 who do not qualify for other coverage (HUSKY D)	$21,984 ($16,243 for single individual)	$27,725	$33,466	$39,206

Source: DSS

HUSKY C provides health care coverage for individuals who are elderly, blind, or living with a disability. Monthly income limits for this program vary based on (1) marital status and (2) region, as shown in Table 2. Region A covers southwestern Connecticut, while region B covers the rest of the state. Certain income is not included when determining eligibility for HUSKY C, which does not use the same

methodology for income calculation as HUSKY A and D. Table 2 shows net income limits after allowed deductions.

Table 2: Monthly Net Income Limits for Medicaid Programs (HUSKY C)

Status	*Region A*	*Region B*
Single individual	$610.61	$506.22
Married couple	$777.92	$672.10

Source: DSS

Recipients of Med-Connect, a much smaller Medicaid-funded health program for working individuals with disabilities, may earn up to $75,000 annually and pay premiums based on that income.

STATE EMPLOYEES

State employees may select medical plans from Anthem BlueCross and BlueShield or United Health Group. The state employee medical plans require annual deductibles and copayments for prescription drugs and certain services.

Annual Deductibles

Individuals covered by a state employee medical plan must pay a $350 annual deductible, while families pay $350 per person up to a $1,400 maximum. The medical plans waive these required deductibles for those employees who participate in the Health Enhancement Program (HEP), which requires policyholders and their families to get regular wellness exams, early diagnosis screenings, and other preventative care.

Copayments

Table 3 shows office visit copayment requirements in state employee medical plans.

Table 3: State Employee Office Visit Copayments

Category	*In-Network*	*Out-of-Network*
Outpatient visits, walk-in centers, and urgent care centers	$15	Plan pays 80% of allowable charge after deductible
Preventative care and immunizations	None	Plan pays 80% of allowable charge after deductible
Emergency care	$35 copayment (waived if patient is admitted for care)	

Source: Office of the State Comptroller (OSC)

Table 4 shows prescription drug copayment requirements in state employee medical plans. For employees who participate in HEP, copayments for certain medications used to treat chronic conditions are $0 for generic drugs, $5 for preferred brand-name drugs, and $12.50 for non-preferred brand-name drugs.

Table 4: State Employee Prescription Drug Copayments

Category	*Copayment*
Generic drug	$5
Preferred brand-name drug	$10 for a 90-day supply of maintenance drugs $20 for a 30-day supply of non-maintenance drugs
Non-preferred brand-name drugs	$25 for a 90-day supply of maintenance drugs ($10 if a physician certifies that use of the non-preferred drug is medically necessary) $35 for a 30-day supply of non-maintenance drugs ($20 if a physician certifies that use of the non-preferred drug is medically necessary)

Source: OSC

OTHER PRIVATE HEALTH INSURANCE PLANS

The Connecticut Insurance Department does not track average deductibles or copayments across private health insurance plans. It does limit the amount health insurance policies sold in the state may charge for copayments (Bulletin HC-94). Maximums are:

1. $40 for a primary care provider office visit,
2. $50 for a specialist office visit,
3. $75 for urgent care,
4. $200 for emergency room visits,
5. $5 for generic prescription drugs, and
6. $60 for brand-name prescription drugs.

State Health Insurance Exchange

Table 5 shows deductibles for plans offered on the state's health exchange for 2015. Health insurance plans sold through Access Health CT provide coverage in benefit tiers based on the actuarial value of the coverage shown in parentheses in Table 5. Actuarial value is the percentage of total average costs a plan will cover (e.g., a 90% actuarial value would cover 90% of costs for an average individual).

Table 5: Deductibles for Health Insurance Exchange Plans

Plan Name		*In-Network*	*Out-of-Network*
Platinum	Standard Platinum Plan (90%)	$0	$2,000 per person or $4,000 per family
Gold	Standard Gold Plan (80%)	$1000 per person or $2000 per family	$3,000 per person or $6,000 per family; separate drug deductible of $350 per person or $700 per family
Silver	Standard Silver Plan (70%)	$2,600 per person or $5,200 per family; separate drug deductible of $25 per person or $50 per family	$6,000 per person or $12,000 per family; separate drug deductible of $350 per person or $700 per family
	Standard Silver Cost Sharing Reduction (94%)	$0	
	Standard Silver Cost Sharing Reduction (87%)	$400 per person or $800 per family; separate drug deductible of $25 per person or $50 per family	
	Standard Silver Cost Sharing Reduction (73%)	$1,900 per person or $3,800 per family; separate drug deductible of $25 per person or $50 per family	
Bronze	Standard Bronze Plan (60%)	$5,000 per person or $10,000 per family	$10,000 per person or $20,000 per family
	Standard Bronze Health Savings Account Plan (60%)	$4,600 per person or $9,200 per family	$9,200 per person or $18,400 per family

Source: Access Health CT

Table 6 shows copayments for office visits for plans offered on the state's health insurance exchange. In many cases, the plans require coinsurance rather than a copayment. Coinsurance is a requirement that the insured pay a fixed percentage of the approved cost of the visit. In all cases below, the coinsurance percentage (1) is the amount paid by the insured before the plan provides coverage and (2) takes effect after the insured pays the deductible.

Table 6: Office Visit Copayments for Health Insurance Exchange Plans

Plan Name		*In-Network*	*Out-of-Network (primary care and specialists)*
Platinum	Standard Platinum Plan (90%)	$10 for primary care, $30 for specialists	20% coinsurance
Gold	Standard Gold Plan (80%)	$20 for primary care, $45 for specialists	30% coinsurance
Silver	Standard Silver Plan (70%)	$30 for primary care, $50 for specialists	40% coinsurance
	Standard Silver Cost Sharing Reduction (94%)	$20 for primary care, $35 for specialists	
	Standard Silver Cost Sharing Reduction (87%)	$20 for primary care, $35 for specialists	
	Standard Silver Cost Sharing Reduction (73%)	$30 for primary care, $50 for specialists	
Bronze	Standard Bronze Plan (60%)	$40 for primary care, $50 (after deductible is met) for specialists	50% coinsurance
	Standard Bronze Health Savings Account Plan (60%)	$0 after deductible is met	

Source: Access Health CT

Table 7 shows copayments for 30-day supplies of prescription drugs for plans offered on the state's health insurance exchange for 2015. Insurers may place drugs into different "tiers" based on each plan's specific benefits and cost-sharing arrangements. In general, a higher tier results in a higher out-of-pocket expense for the insured. In all cases below, the coinsurance percentage is the amount covered by the plan and takes effect after the insured pays the deductible.

Table 7: Prescription Drug Copayments for Health Insurance Exchange Plans

Plan Name		*In-Network*	*Out-of-Network*
Platinum	Standard Platinum Plan (90%)	Tier 1: $5 Tier 2: $15 Tier 3: $30 Tier 4: 20% coinsurance	20% coinsurance
Gold	Standard Gold Plan (80%)	Tier 1: $5 Tier 2: $25 Tier 3: $50 Tier 4: $60	30% coinsurance

Plan Name		*In-Network*	*Out-of-Network*
Silver	Standard Silver Plan (70%)	Tier 1: $5 Tier 2: $30 Tier 3: $55 Tier 4: $60 after deductible is met	40% coinsurance
	Standard Silver Cost Sharing Reduction (94%)	Tier 1: $5 Tier 2: $20 Tier 3: $35 Tier 4: $50	
	Standard Silver Cost Sharing Reduction (87%)	Tier 1: $5 Tier 2: $20 Tier 3: $35 Tier 4: $50 after deductible is met	
	Standard Silver Cost Sharing Reduction (73%)	Tier 1: $5 Tier 2: $30 Tier 3: $55 Tier 4: $60 after deductible is met	
Bronze	Standard Bronze Plan (60%)	Tier 1: $5 Tier 2: 50% coinsurance Tier 3: 50% coinsurance Tier 4: 50% coinsurance	50% coinsurance
	Standard Bronze Health Savings Account Plan (60%)	Tier 1: $5 after deductible Tier 2: $35 after deductible Tier 3: 40% coinsurance Tier 4: 40% coinsurance	

Source: Access Health CT

HYPERLINKS

Department of Social Services, *Connecticut HUSKY Health Program Annual Income Guidelines – effective March 1, 2015* http://www.huskyhealth.com/hh/lib/hh/pdf/HUSKYAnnualIncomeChart.pdf, last visited June 24, 2015

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Connecticut Insurance Department, *Bulletin HC-94, Maximum Copays and Filing Issues* http://www.ct.gov/cid/lib/cid/Bulletin-HC-94.pdf, last visited June 25, 2015

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