MEDICAID COST-SHARING

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TYPES OF MEDICAID COST SHARING

 "[Medicaid] cost-sharing requirements may include participation-related cost-sharing, such as monthly premiums or annual enrollment fees, as well as point-of-services cost-sharing such as copayments – flat dollar amounts paid directly to providers for services rendered. Similar types of out-of-pocket cost-sharing can apply to individuals enrolled in private health insurance, although the amounts to which such beneficiaries may be subject can be higher than the amounts allowed in Medicaid."

- Congressional Research Service (CRS), *Out-of-Pocket Costs for Medicaid Beneficiaries: In Brief* (2015)

ISSUE

Does federal law prohibit states from imposing cost-sharing requirements on Medicaid recipients? This report updates OLR Report 2016-R-0007 with new copayment limits effective October 1, 2016.

FEDERAL COST SHARING REQUIREMENTS

According to the federal Centers for Medicare and Medicaid Services (CMS), states can impose copayments, coinsurance, deductibles, or similar charges on most Medicaid-covered services, but, except as noted below, most cost-sharing is nominal. For example, in 2013, the maximum deductible was $2.65. The amounts states can charge vary with income and are based on the state's payment for the service.

According to a Congressional Research Service (CRS) report, state Medicaid cost-sharing requirements cannot exceed 5% of the family income either on a monthly or quarterly basis, as specified by the state Medicaid agency. States may not withhold services for failure to pay the nominal costs, but they may hold beneficiaries liable for the unpaid amounts. Children, terminally ill individuals, and certain other individuals are generally exempt from cost-sharing requirements.

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Federal law (1) limits cost-sharing to nominal amounts for recipients under 100% of the federal poverty level (FPL) and (2) allows for greater, though limited, cost sharing for individuals over 100% FPL. (In 2016, 100% FPL was equivalent to $11,770 annually for an individual.) By law, states cannot impose cost-sharing for Medicaid (1) emergency services, (2) family planning services or supplies and (2) services for children under age 18 and pregnant women (42 USC § 1396o).

States may establish alternative out-of-pocket costs for certain Medicaid enrollees with incomes above 100% FPL. These costs may be higher than the nominal costs described above, but may not exceed 5% of family income. States may also charge certain limited premiums and enrollment fees on certain Medicaid enrollees with income above 150% FPL.

Generally, most of Connecticut's Medicaid recipients receive health care through one of the Department of Social Services' HUSKY programs (i.e., HUSKY A, C, and D), which do not require deductibles or copayments. To learn more about copayments and deductibles for state residents under Medicaid, see OLR Report 2015-R-0160.

Table 1 depicts maximum allowable copayments under federal law as of October 1, 2016.

Table 1: Maximum Allowable Copayments for Medicaid Recipients

Services and Supplies	Eligible Populations by Family Income		
	≤100% FPL	101-150% FPL	>150% FPL
Institutional Care (inpatient hospital care, rehab care, etc.)	$78.40	10% of the cost the agency pays for the entire state	20% of the cost the agency pays for the entire state
Non-Institutional Care	$4.20	10% of the cost the agency pays	20% of the cost the agency pays
Non-emergency use of the ER	$8.40	$8.40	No limit *within 5% aggregate limit
Preferred drugs Non-Preferred drugs	$4.20 $8.40	$4.20 $8.40	$4.20 20% of the cost the agency pays

Source: CMS

RESOURCES

CMS, *Cost Sharing Out-of-Pocket Costs*, available at:
https://www.medicaid.gov/medicaid-chip-program-information/by-topics/cost-sharing/cost-sharing-out-of-pocket-costs.html

CRS, *Out-of-Pocket Costs for Medicaid Beneficiaries: In Brief* (2015), available at:
https://www.crsreports.com/download?hash=ea8421d39526518f8706414f78cb78c7a7474adbd2124d6dfc9f20a83b1b408f

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