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## The Vermont Legislative Research Service

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### Medicaid: Federal Copayment and Cost-Sharing Regulations

As determined by the Centers for Medicare and Medicaid Services, states can charge copayments and establish cost-sharing requirements for enrollees in state Medicaid programs. The extent to which states can implement these cost-sharing programs is limited by the federal government. Premiums and cost-sharing programs have been used to limit state Medicaid costs. Maximum out-of-pocket costs per household are limited, but higher charges can be imposed on those whose yearly income places them above the Federal Poverty Line (FPL).<sup>1</sup> Total Medicaid cost-sharing and premiums in a household cannot exceed an aggregate limit of 5% of family income. Although policies vary by state, the federal guidelines for cost sharing programs and service limitations for 2014 are listed in Table 1 below. The number of states with cost-sharing programs for adults is shown in Figure 1. The following report will outline the rules for implementing Medicaid cost-sharing programs and the various cost-sharing initiatives that have been implemented in order to reduce the costs of state run programs. To see more examples of what other states are doing in the way of cost-sharing policies, please see the VLRS report "[Medicaid Post Affordable Care Act.](#)"<sup>2</sup>

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<sup>1</sup> Centers for Medicare and Medicaid Services, "Cost Sharing," *U.S. Department of Health and Human Services*, accessed February 18, 2016, <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/cost-sharing/cost-sharing.html>.

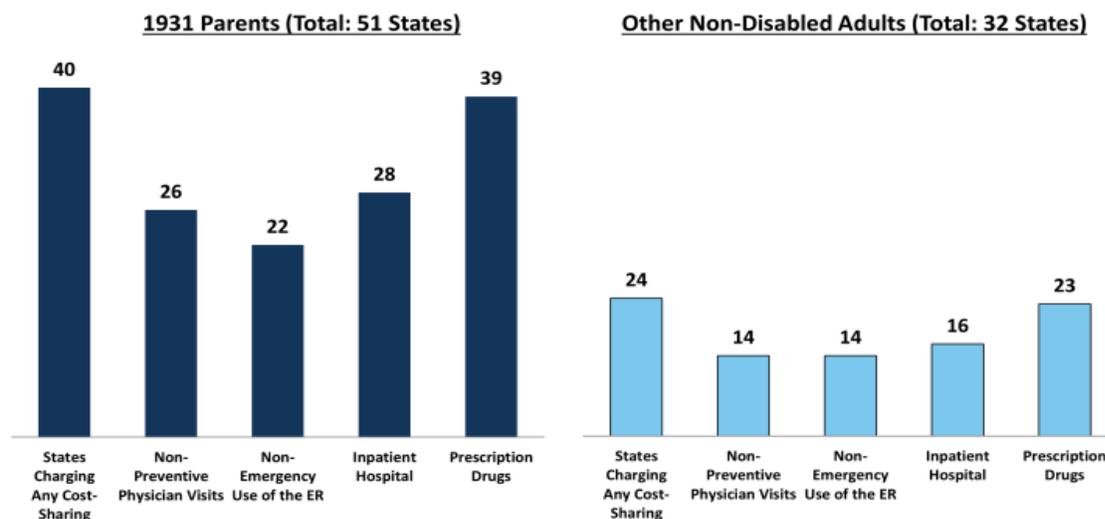
<sup>2</sup> <http://www.uvm.edu/~vlrs/Health/Medicaid Practices following ACA.pdf>

**Table 1: Federal Maximum Allowable Cost-Sharing for 2014**

Notable Cost-Sharing Changes	Individuals with family income:		
	< 100% FPL	101 – 150% FPL	> 150% FPL
Outpatient Services (physician visit, physical therapy, etc.)	\$4 (CPI-U Annual Update)	10% of cost for entire stay	20% of cost for entire stay
Inpatient Stay	\$75 (CPI-U Annual Update)		
Preferred Drugs	\$4	\$4	\$4
Non-Preferred Drugs	\$8	\$8	20% of cost
Non-emergency Use of the ER	\$8	\$8	No Limit

Source: Smith, Vernon K, Kathleen Gifford, Eileen Ellis, Robin Rudowitz, and Laura Snyder. "Medicaid in an Era of Health & Delivery System Reform: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2014 and 2015," *The Henry J. Kaiser Family Foundation*, October 14, 2014, accessed February 20, 2016, <http://kff.org/report-section/medicaid-in-an-era-of-health-delivery-system-reform-premiums-and-cost-sharing/>.

## Number of States with Cost-Sharing for Selected Services for Adults, January 2016



**Figure 1: States with Cost-Sharing**

Source: The Henry J Kaiser Family Foundation, "Medicaid and CHIP Eligibility, Enrollment, Renewal, and Cost-Sharing Policies as of January 2016: Findings from a 50-State Survey," The Henry J Kaiser Family Foundation, Last Modified January 21, 2016, <http://kff.org/report-section/medicaid-and-chip-eligibility-enrollment-renewal-and-cost-sharing-policies-as-of-january-2016-premiums-and-cost-sharing/>.

## Medicaid Cost-Sharing Rules

Any cost-sharing in the state Medicaid plan applies to all categories of eligibility with the exception of certain targeted cost-sharing, which can only be applied to individuals with incomes above the Federal Poverty Level (over 100% of the FPL).<sup>3</sup>

Emergency services, family planning services, preventive services provided to children, pregnancy related services, and provider preventable services (services resulting from possible preventable events) are all exempt from cost-sharing.<sup>4</sup>

Cost-sharing may be implemented for the following services: outpatient services, inpatient services, non-emergency use of the ER, and prescription drugs.<sup>5</sup> Non-married, childless adults, parents, and the aged, blind, and disabled are all subject to imposition of cost-sharing as well.

There are authorized variations in cost-sharing amounts under the State Plan Amendment (SPA). States may vary cost-sharing levels based on provider type. To encourage utilization, a state may impose lower cost-sharing levels for primary care services. States may not vary cost-sharing levels based on delivery system and “whether an individual enrolls in managed care or fee-for service.”<sup>6</sup>

### Preferred vs. Non-Preferred Drugs

If the state does not differentiate between two classes of drugs, name brand or generic, it is considered to be a preferred drug. If a state wishes to impose differential cost-sharing for generic brands over name brand drugs, it must be “implemented within the framework of preferred and non-preferred drugs.”<sup>7</sup>

### Non-Emergency Use of the Emergency Room

Cost-sharing may only be imposed if a hospital, prior to providing care, provides a screening at the ER (required by the Emergency Medical Treatment and Active Labor Act).<sup>8</sup> The hospital is required to inform the beneficiary of the amount of the cost-sharing obligation and provide him or her with the name and location of a non-emergency service provider. The hospital then has to determine that the alternate provider can provide services with lesser or no cost-sharing, and provide a referral.<sup>9</sup>

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<sup>3</sup> Medicaid and Chip Learning Collaborative, “Overview of Medicaid Cost Sharing and Premium Requirements,” *Medicaid.gov*, last modified November 25, 2014, <https://www.medicaid.gov/state-resource-center/mac-learning-collaboratives/learning-collaborative-state-toolbox/downloads/cost-sharing-premium-requirements.pdf>.

<sup>4</sup> Medicaid and Chip Learning Collaborative, “Overview of Medicaid Cost Sharing and Premium Requirements.”

<sup>5</sup> Medicaid and Chip Learning Collaborative, “Overview of Medicaid Cost Sharing and Premium Requirements.”

<sup>6</sup> Medicaid and Chip Learning Collaborative, “Overview of Medicaid Cost Sharing and Premium Requirements.”

<sup>7</sup> Medicaid and Chip Learning Collaborative, “Overview of Medicaid Cost Sharing and Premium Requirements.”

<sup>8</sup> Medicaid and Chip Learning Collaborative, “Overview of Medicaid Cost Sharing and Premium Requirements.”

<sup>9</sup> Medicaid and Chip Learning Collaborative, “Overview of Medicaid Cost Sharing and Premium Requirements.”

## Requirements of a Cost-Sharing State Plan Amendment (SPA)

In order for a state to have an SPA there are a number of requirements. There must be an identification of populations that can be affected and a decision as to which services the state will assign cost-sharing programs.<sup>10</sup> There must be an affirmation that the plan properly excludes all exempt services and populations, and an explanation of the tracking and monitoring process. The final requirement is an assurance that appropriate advanced public notice is provided. In implementing cost-sharing, incentivizing and accessing care should be considered, as well as the expenses that would be incurred by tracking and monitoring the various cost-sharing populations.<sup>11</sup>

## Medicaid Optional Benefit Coverage and Copayments

To see tables that indicate the copayment requirements, limits on service days, and the reimbursement methodology for dental services, optometry services, prescription drugs, and ambulance services, please see the VLRs report titled "[Medicaid Post Affordable Care Act.](#)"

## Section 1115 Waivers

The purpose of Section 1115 Waivers is to expand eligibility to individuals who are not otherwise Medicaid or CHIP eligible, provide services not typically covered by Medicaid, or use delivery systems that improve care, efficient, and costs.<sup>12</sup> More information on Section 1115 Waivers can be found in "[Medicaid Post Affordable Care Act.](#)" With a Section 1115 waiver, states can implement monthly contributions or premiums for adults that would not be allowed without a Section 1115 waiver.<sup>13</sup> Five states charge premiums or monthly contributions under Section 1115 waivers as of January 2016. The waivers must be designed to improve health outcomes for beneficiaries and be cost-neutral.<sup>14</sup> Cost-neutral means that "during the course of the project Federal Medicaid expenditures will not be more than Federal spending without the waiver."<sup>15</sup> There have been few changes in state cost-sharing programs since 2015.

One of these changes is an increase in copayments for New Hampshire Medicaid beneficiaries. The state of New York also implemented a cost-sharing programs for individuals who earn more than 100% FPL.<sup>16</sup>

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<sup>10</sup> Medicaid and Chip Learning Collaborative, "Overview of Medicaid Cost Sharing and Premium Requirements."

<sup>11</sup> Medicaid and Chip Learning Collaborative, "Overview of Medicaid Cost Sharing and Premium Requirements."

<sup>12</sup> Centers for Medicare & Medicaid Services. "Section 1115 Demonstrations."

<sup>13</sup> The Henry J Kaiser Family Foundation, "Medicaid and CHIP Eligibility, Enrollment, Renewal, and Cost-Sharing Policies as of January 2016: Findings from a 50-State Survey."

<sup>14</sup> The Henry J Kaiser Family Foundation, "Medicaid and CHIP Eligibility, Enrollment, Renewal, and Cost-Sharing Policies as of January 2016: Findings from a 50-State Survey."

<sup>15</sup> Centers for Medicare & Medicaid Services, "Section 1115 Demonstrations," U.S. Department of Health and Human Services, accessed Feb. 10, 2016, <https://www.medicaid.gov/medicaid-chip-program-information/bytopics/waivers/1115/section-1115-demonstrations.html>.

<sup>16</sup> The Henry J Kaiser Family Foundation, "Medicaid and CHIP Eligibility, Enrollment, Renewal, and Cost-Sharing Policies as of January 2016: Findings from a 50-State Survey," *The Henry J Kaiser Family Foundation*, last modified

## Key Provisions in Approved or Pending Section 1115 Waivers

Table 2, shown below, illustrates some key provisions in approved or pending Section 1115 waivers. As is shown, various states are enacting various strategies in order to reduce the costs associated with their state Medicaid programs. Under premium assistance, QHP indicates a qualified health plan. As stipulated by the ACA, a qualified health plan is an insurance plan that is certified by the Health Insurance Marketplace. It provides essential benefits and establishes cost-sharing.<sup>17</sup> ESI is the abbreviation for employer sponsored insurance.<sup>18</sup> States also offer healthy behavior incentives for curtailing smoking, losing weight, and accessing timely child immunizations.<sup>19</sup> This “patient engagement” helps Medicaid beneficiaries to be in control of their health.<sup>20</sup> Reasonable promptness is required according to the Medicaid Act, which states “that all individuals wishing to make application for medical assistance under the [State] plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals.”<sup>21</sup> Reasonable promptness is in place because recipients of Medicaid often face long delays or waiting lists before obtaining certain services.

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January 21, 2016, <http://kff.org/report-section/medicaid-and-chip-eligibility-enrollment-renewal-and-cost-sharing-policies-as-of-january-2016-premiums-and-cost-sharing/>.

<sup>17</sup> Healthcare.gov, “Glossary: Qualified Health Plan,” *Healthcare.gov*, <https://www.healthcare.gov/glossary/qualified-health-plan/>.

<sup>18</sup> The Henry J Kaiser Family Foundation, “Premium Assistance in Medicaid and CHIP” An Overview of Current Options and Implications of the Affordable Care Act,” *Kaiser Commission on Medicaid and the Uninsured*, last modified March, 2013. <http://ccf.georgetown.edu/wp-content/uploads/2013/03/premium-assistance.pdf>.

<sup>19</sup> The Commonwealth Fund, “Public Programs Are Using Incentives to Promote Healthy Behavior,” *States in Action Archive*, last modified October 9, 2007. <http://www.commonwealthfund.org/publications/newsletters/states-in-action/2007/oct/september-october-2007/feature/public-programs-are-using-incentives-to-promote-healthy-behavior>.

<sup>20</sup> The Commonwealth Fund, “Public Programs Are Using Incentives to Promote Healthy Behavior,” *States in Action Archive*, last modified October 9, 2007. <http://www.commonwealthfund.org/publications/newsletters/states-in-action/2007/oct/september-october-2007/feature/public-programs-are-using-incentives-to-promote-healthy-behavior>.

<sup>21</sup> Oregon Advocates, “Reasonable Promptness and the Provision of Services Under Medicaid,” *Oregon Advocates.org*, accessed April 19, 2016. <http://www.oregonadvocates.org/geo/search/download.67697>.

**Table 2: Key Themes in Approved and Pending ACA Expansion Waivers**

Waiver Provision	Approved Waivers						Pending Waivers	
	AR	IA*	MI	IN*	NH*	MT	MI*	AZ
Premium Assistance	QHP	ESI		ESI	QHP		QHP	
Premiums / Monthly Contributions	X	X	X	X		X	X	X
Healthy Behavior Incentives		X	X	X			X	X
Waive Required Benefits (NEMT)		X		X				X
Reasonable Promptness				X				
Waive Retroactive Eligibility				X	X			
Co-payments Above Statutory Limits				X			X	X
12-Month Continuous Eligibility						X		
Time limit on Coverage							X	X
Work Requirement								X

NOTES: \* New Hampshire will transition from a SPA to a waiver in 2016. Cost-sharing waiver approved in IN under Section 1916(f), not Section 1115. IA has approval for mandatory QHP enrollment with premium assistance for new adults from 101-138% FPL but has a waiver amendment pending to instead require mandatory Medicaid managed care due to the loss of both QHPs. MI's pending amendment would apply to beneficiaries from 101-138% FPL after 48 months of coverage; MI's state legislation requires the Medicaid expansion to end on 4/30/16 if the new provisions are not approved by 12/31/15. PA transitioned from a waiver to a SPA in 2015 (so it is not included in the table).

SOURCE: The Henry J Kaiser Family Foundation, "The ACA and Medicaid Expansion Waivers," *The Henry J Kaiser Family Foundation*, last modified November 20, 2015, <http://kff.org/medicaid/issue-brief/the-aca-and-medicaid-expansion-waivers/>

## Medicaid Premium Rules

Income Below 150% Federal Poverty Level (FPL): For most eligibility groups, the state may not impose premiums under the state plan without a waiver, and the state may impose premiums on the medically needy and the working disabled on a scale based on income through a state plan amendment.<sup>22</sup> If the working disabled fails to pay premiums, the state may terminate. The state may not terminate the medically needy beneficiaries for failing to pay premiums.<sup>23</sup>

Income Above 150% FPL: The state may impose premiums on this population. They are included in the 5% cap. If an individual fails to pay premiums for more than 60 days, the state may terminate the individual (excluding the medically needy).<sup>24</sup> Table 3 below shows the Medicaid Premium Rules and the aggregate cost-sharing cap.

Table 3: Medicaid Premium Rules			
	<100% FPL	100%-150% FPL	>150% FPL
Premiums	Not permitted	Not permitted	Permitted, subject to aggregate cap
Aggregate cost sharing cap	5% household income	5% household income	5% household income
Source: Medicaid and Chip Learning Collaborative, "Overview of Medicaid Cost Sharing and Premium Requirements," <i>Medicaid.gov</i> , last modified November 25, 2014, <a href="https://www.medicaid.gov/state-resource-center/mac-learning-collaboratives/learning-collaborative-state-toolbox/downloads/cost-sharing-premium-requirements.pdf">https://www.medicaid.gov/state-resource-center/mac-learning-collaboratives/learning-collaborative-state-toolbox/downloads/cost-sharing-premium-requirements.pdf</a> .			

<sup>22</sup> Medicaid and Chip Learning Collaborative, "Overview of Medicaid Cost Sharing and Premium Requirements."

<sup>23</sup> Medicaid and Chip Learning Collaborative, "Overview of Medicaid Cost Sharing and Premium Requirements."

<sup>24</sup> Medicaid and Chip Learning Collaborative, "Overview of Medicaid Cost Sharing and Premium Requirements."

## Conclusion

The rules and regulations of Medicaid and cost-sharing are defined by the federal government and are based off of the FPL. States may obtain Section 1115 waivers to better shape their state health plans in a way that produces desirable health outcomes. Many states are still experimenting and adjusting to the ACA and its implications for cost-sharing as well as utilization of services. In the VLRS report “Medicaid Cost-Sharing Programs, Copayments and Utilization Levels,” the relationship between cost-sharing programs and service utilization levels will be explored.

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This report was completed on May 13, 2016, by Daniel Brown, Cole Angley and Brenna Rosen under the supervision of Professors Jack Gierzynski, Robert Bartlett and Eileen Burgin in response to a request from Representative Anne Donahue.

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Disclaimer: This report has been compiled by undergraduate students at the University of Vermont under the supervision of Professor Anthony Jack Gierzynski, Professor Robert Bartlett and Professor Eileen Burgin. The material contained in the report does not reflect the official policy of the University of Vermont.