Cost Sharing in Medicaid

Many states have adopted monthly contributions and modest copays for their Medicaid expansion population. Most of these states charge Medicaid copays at or below the federal maximums, but a few states have waivers to charge higher copays for non-emergency use of the emergency department (ED).

Opportunities

Proponents expect that enrollee cost sharing will offset some state costs and will increase enrollees’ responsibility for their health coverage, reduce unnecessary utilization, and familiarize enrollees with private insurance models.

Challenges

Lower-income individuals are especially sensitive to cost sharing. Research shows that cost sharing can decrease enrollment, decrease access to essential health care, and increase the use of more expensive forms of care such as the ED. Experience also shows that states may face increased administrative burden when implementing enrollee cost sharing. It is also not clear to what extent cost sharing affects total health care spending.

Lessons from the States

Healthy Indiana Plan

In the Healthy Indiana Plan (HIP), enrollees below 100% FPL have the option to make monthly contributions, but enrollees above 100% FPL are required to do so. Enrollees who make contributions are placed in HIP Plus, a plan that provides enhanced benefits such as dental and vision. Enrollees below 100% FPL who do not make contributions are placed in the HIP Basic plan.

Enrollees pay contributions equal to 2% of their household income (enrollees under 5% FPL pay $1.00/month). Enrollees below 100% FPL who do not make contributions are responsible for copays. Enrollees above 100% FPL have no other copays besides for non-emergency use of the ED.

About 65% of HIP enrollees make monthly contributions, 81% of whom have incomes below 100% FPL. According to an HIP evaluation, 39% of enrollees below 100% FPL and 46% of enrollees above 100% FPL
who made contributions reported that they sometimes, usually, or always worried about being able to afford contributions. A survey of enrollees who were either placed in the Basic plan or were disenrolled from HIP Plus due to not making an initial contribution cited unaffordability as the reason (42% of those below 100% FPL and 44% of those above 100% FPL).

An HIP evaluation found that more than 46,000 individuals were found eligible for HIP but were not enrolled because they didn’t make an initial contribution. In a survey of these individuals, 44% of respondents said they couldn’t afford the monthly payment or were confused about the payment process.

**Best Practices for Implementing Cost Sharing in Medicaid**

- Target copays for services that may be overused.
- Give new enrollees a “grace period” to access care before implementing cost sharing.
- Keep the cost sharing program simple.
- Ensure frequent and objective evaluation is part of the cost sharing program.

Read more in our issue brief, “Cost Sharing, Payment Enforcement, and Healthy Behavior Programs in Medicaid: Lessons from Pioneering States.”