Issue Brief for August 2020 Universal Health Care Workgroup

Cost Sharing Considerations

Transitioning to a single payer system requires considering out of pocket cost sharing in the benefit design.

Cost Sharing Considerations Discussed in the June 2020 Workgroup Meeting

- Should the model include some form of cost sharing by beneficiaries?
- Should cost sharing be broad based in which most or all beneficiaries have cost sharing, potentially on a sliding scale of income?
- Should cost sharing apply to a limited group of individuals while others are exempt? What sliding scale of income is appropriate, how many income scales, and which individuals are exempt?
- Should cost sharing encourage use of cost-effective services versus more expensive services?
- Should the cost sharing be tied to evidence-based assessments/practices to demonstrate effectiveness? In other words, the member would pay less for services known to have high benefit, more for low value or avoidable care.

Deep Dive – Cost Sharing Application

A major premise of the approach to Universal Health Care is maintaining the federal funds Washington receives including Medicaid, Medicare, and subsidies through the Exchange. Workgroup recommendations for cost sharing should consider requirements for federal programs currently in place that cannot be changed or have little chance of being changed. For example, Medicaid beneficiaries could only have very limited cost sharing otherwise federal funds may be jeopardized.

In the current system cost sharing is unique to each beneficiary based on their coverage. This means both beneficiaries and health care providers navigate a variety of requirements. Under the single payer system cost sharing will need to consider how the cost sharing policy impacts both beneficiary and provider behaviors and how cost sharing policy can be efficiently operationalized by the single payer system. The cost sharing policy, excluding premiums, impacts cost and funding estimates for the models. Low or no cost sharing means higher costs that would be paid by the state via tax / fee collections.

The following provides a brief description of cost sharing for Medicaid, Medicare, exchange plans and employer sponsored insurance. This summary is intended to provide an overview of cost sharing and not a comprehensive discussion about cost sharing to provide the Workgroup information as recommendations for cost sharing under the single payer models are developed.

Cost Sharing Terms

Deductible	An amount due before insurance coverage begins to pay. Resets annually.
Coinsurance	An amount due **after** the deductible is met based on a percentage of the insured allowed amount. Coinsurance percentages may vary based on type of service (e.g. specialist visits, hospitalization, pharmacy, therapy, and in versus out-of-network providers etc…)
Copayment	An amount established by the insurance plan and due from the beneficiary to the health care provider at the time a service is rendered. Copayments may vary based on type of service (e.g. specialist visits, hospitalization, pharmacy, therapy etc…

Out of Pocket Limits	Typically, cost sharing is subject to an annual maximum. These maximums may vary for individuals versus family / household. The out of pocket limit resets annually. • Excludes services rendered not covered by the insurance plan • Non-participating / non-contracted / out of network health care providers

Cost sharing is typically not charged for preventative services. Preventative services typically include wellness visits, disease screenings and standard vaccinations. Premiums are not considered cost sharing and are not reflected in annual out of pocket limits.

Cost Sharing Today

Medicaid

Cost sharing is permissible for Medicaid (including expansion adults) and for CHIP; however, CMS has established cost sharing maximums and limitations for Medicaid beneficiaries. These protections, outlined in 42 CFR § 447.56, limit the amount of cost sharing paid by Medicaid beneficiaries. Specific to CHIP, Medicaid cost sharing limitations apply to families whose household income is at or below 150% of the Federal poverty level (FPL).

All cost sharing is limited to 5% of household income for Medicaid and CHIP beneficiaries regardless of FPL. Figure 1 illustrates the permissible cost sharing for Medicaid beneficiaries that vary based on health care service and by household income band.

Figure 1 – Medicaid Cost Sharing Maximum Nominal Copayments and Limitations

	Household Income		
Service	**100% FPL**	**101-150% FPL**	**> 150% FPL**
Institutional Care (inpatient hospital, rehab, etc.)	$75.00	10% of the cost the agency pays for the entire state	20% of the cost the agency pays for the entire stay
Non-Institutional Care (physician visits, outpatient services, physical therapy visits, etc.)	$4.00	10% of the cost the agency pays	20% of the cost the agency pays
Non-Emergency use of the Emergency Room	$8.00	$8.00	No Limit 5% aggregate applies
Drugs – Preferred	$4.00	$4.00	$4.00
Drugs – Non-Preferred [1]	$8.00	$8.00	20% of the cost the agency pays
Deductible	$2.65	$2.65	$2.65
Managed Care Copayment	$4.00	$4.00	$4.00
Provider can refuse to treat beneficiaries for not making cost sharing before rendering a service	No	Yes	Yes
Services Excluded from Cost Sharing - Emergency, pregnancy-related services, family planning, and preventative services for children including immunizations.			
Populations Excluded from Cost Sharing - Children under 18, disabled, terminally ill individuals, pregnant women, individuals residing in an institution and American Indian/Alaska Native			

1 – If non-preferred drugs are medically necessary, then the preferred drug rate applies.

States can seek a waiver of cost sharing requirements from CMS; however, to date CMS has limited states ability to waive all elements outlined in Figure 1.

Medicare

Medicare includes cost sharing for beneficiaries for Part A (hospital/home health/hospice care), Part B (outpatient and health care providers) and D (pharmacy). Part C, commonly referred to as Medicare Advantage and operated by managed care plans, combine coverage for Parts A and B and may include Part D. Summary of the cost sharing applicable by each part is outlined in Figure 2.

Figure 2 – Overview of Medicare Cost Sharing

Medicare	Deductible	Coinsurance	Copayment	Comment
Part A	Yes	Yes	No	CMS updates values annually.
Part B	Yes	Yes	No	CMS updates values annually.
Part D	Yes	Yes		• Dependent on the Part D plan • Includes a catastrophic limit that reduces beneficiary cost sharing • Certain beneficiaries may qualify for financial assistance for Part D benefits.
Part C	Not typical (see note)	Possible	Possible	Deductibles applicable to Part D coverage may be included.

Exchange / Marketplace

Cost sharing in exchange plans vary based on plan category (metal). The plan category describes the cost sharing amount due by the individual before insurance pays. Figure 3 presents cost sharing, including premium considerations that is tied to cost sharing.

Figure 3 – Overview of Exchange / Marketplace Cost Sharing

Plan Type [1] (Metal)	Cost Sharing [1]	Monthly Premium	Individual Pays	Insurance Plan Pays
Platinum	Lowest	Highest	10%	90%
Gold	Higher than Platinum but lower than Silver	Lower than Platinum but higher than Silver	20%	80%
Silver	Higher than Gold but lower than Bronze	Lower than Gold but higher than Bronze	30%	70%
Bronze	Highest	Lowest	40%	60%

1 - The ACA permits coverage of "catastrophic" plans for certain eligible individuals; however, catastrophic coverage includes deductibles ($8,150 for 2020). There are no coinsurance or copayments for this coverage.

2 – Cost sharing is limited by the ACA for Exchange coverage. The 2020 out of pocket limit for an individual is $8,150 and $16,300 for a family.

Employer Sponsored Coverage including State Employees

Employer coverage includes insurance coverage provided by employers through self-funding or purchased from insurance carriers (referred to as fully insured). Employer sponsored coverage typically includes deductibles, coinsurance, and copayments. Self-funded plans are not subject state insurance department regulations allowing employers to customize the plan (e.g, benefits, cost sharing and provider network) to the needs of its employees. Fully insured plans must comply with state insurance department regulations including cost sharing requirements. Premiums and cost sharing vary by employer based on their coverage method and also include variation within employer where multiple options for coverage are provided.

Employers who provide coverage purchased through insurance companies may provide employees choices between paying higher premium in exchange for lower cost sharing and vice versa. Employer coverage offerings that includes high-deductible plans will include a health savings account for employees to make payroll contributions that can be used to offset the cost sharing included in the high-deductible plan.