



ISSUE Brief

Patient Cost-Sharing Under the Affordable Care Act

TWEETS
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Cost-sharing requirements and out-of-pocket limits provide financial protection and health security to millions of individuals and families
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AHIP Issue Brief illustrates how limits on cost sharing protect consumers from medical bankruptcy
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New, more sophisticated consumer tools will enable patients to choose the health insurance plan that best meets their needs

KEY TAKEAWAYS



Maximum out-of-pocket limits included in the Affordable Care Act protect individuals and families from high medical spending, including those covered by Exchange plans in the individual market and employees and their dependents covered by small and large employers.



Cost-sharing reduction subsidies (CSR) reduce patient cost sharing (lowering deductibles, copayments, and out-of-pocket limits) in the individual Exchange market, providing enhanced financial protection for low- and middle-income families up to 250 percent of the federal poverty level (\$29,425/\$60,625 for an individual or family of four in 2015). Cost-sharing reduction plans feature lower out-of-pocket limits than required under the ACA—which helps further shield low-income patients from high out-of-pocket costs when receiving care.



Consumers enrolled through the Exchanges have a wide variety of plan choices – from platinum to bronze – that allow individuals and families to determine the combination of premium payments and out-of-pocket spending that best match their specific health care and financial needs. Lower income enrollees are further shielded from out-of-pocket spending as a result of enhanced cost-sharing reduction subsidies.



86% satisfied—A large majority of individuals covered through the exchange or expanded Medicaid are very or somewhat satisfied with their health insurance coverage. Consumers give their exchange plans high marks on choice of doctors, access to primary and specialty care, and cost-sharing features—such as co-payments for physician visits and prescription drugs.^{1,2}



Under the average bronze plan in 2015, at most an individual would be responsible for 6.7 percent of the total cost of the specialty drug Harvoni (used to treat chronic hepatitis C); the health plan would pay for 93.3 percent of the full cost.

Background

The Affordable Care Act (ACA) requires health plans to provide comprehensive benefits in the individual and small-group marketplaces (both inside and outside the new Exchanges). The essential health benefits (EHB) package requirements detail both the benefits required to be covered and how cost sharing is structured in the new marketplaces. Under the ACA, the EHB provisions require insurers to:

- Provide coverage for 10 broad categories of services as specified under the statute;³
- Limit annual cost sharing to specific amounts;⁴ and
- Meet minimum standards for actuarial value.⁵

Other ACA provisions reduce patients' out-of-pocket expenses, most notably premium subsidies and cost-sharing reductions for low- and moderate-income families purchasing coverage through the Exchanges.

In addition, large employers who make health insurance coverage available to employees under fully insured or self-insured plans must provide minimum essential coverage (MEC) to avoid a potential liability under the employer-shared responsibility requirement (i.e., an employer mandate). To qualify as MEC, employer coverage must meet both a minimum value standard and an affordability standard. Under those standards, the plan must attain a 60 percent actuarial value (i.e., the plan covers, on average, at least 60 percent of total medical costs) and the employee's premium contribution for self-only coverage in the lowest priced plan must not exceed 9.5 percent of the employee's income. Large employer plans must also include a maximum limit on out-of-pocket spending based on individual or family status.

This report summarizes the ACA's provisions that are aimed at promoting comprehensive coverage and limiting or reducing patient out-of-pocket costs. The report also details requirements in the law that mandate comprehensive coverage of prescription drugs – which is broadly similar to the scope of prescription drug coverage offered under similar employer-sponsored plans and Medicare Part D.

Essential Health Benefits and Actuarial Value Under the ACA

Essential Health Benefits

The ACA requires all health plans in the individual and small-group markets to cover essential health benefits (EHB) – a package of benefits shaped by both the statutory language of the ACA and its implementing regulations. Under the EHB requirements, consumers have access to coverage with a mandated set of 10 benefit categories – from hospitalization to physician services to prescription drugs. These benefits are similar to the scope of coverage offered under employer-sponsored plans today but more comprehensive than coverage typically offered in the pre-ACA reform individual marketplace.

Under the approach adopted by the U.S. Department of Health and Human Services (HHS) for the first three years of coverage under the ACA, states selected from among several federally designated “benchmark” plan options that form the foundation of the EHB package.⁶ HHS determined that these plans were the most likely options to preserve state flexibility but still fulfill the ACA’s EHB requirement. In early 2015, HHS extended this approach for an additional year. States have selected among health plans sold in 2014 as the new benchmark for determining the scope of EHB for 2017.⁷

With the EHB package now a part of all new individual and small group coverage, all consumers regardless of health status have access to a minimum benefit package that is more comprehensive than typical coverage in the pre-ACA marketplace – particularly as compared with the pre-ACA individual market.⁸ As a result, individuals and families now have coverage for these and other benefits that they might not have had before the passage of the ACA.

Actuarial Value

Closely related to the EHB standards, the ACA also requires health plans in the individual and small-group markets to meet one of four actuarial value (AV) levels.

These are often referred to as “metallic levels”:

1. Bronze (60 percent AV),
2. Silver (70 percent AV),
3. Gold (80 percent AV), and
4. Platinum (90 percent AV).

A fifth type of plan – catastrophic coverage – is available in the individual market and only to those under 30 or those who qualify for a financial hardship exemption.

AV generally describes a health plan’s benefit levels and cost-sharing structures for standard population. A silver plan (70 percent AV) would, on average, pay 70 percent of the health care costs of its enrollees, with enrollees paying the remaining 30 percent in the form of copayments, coinsurance, and deductibles. Importantly, a plan’s AV does not describe what proportion of a specific individual’s health care costs will be covered by the health plan. It is a general measure of the health plan’s generosity – as AV increases, a greater share of health care costs will be paid for by the health plan for all of its enrollees.

At a minimum, health plans subject to the EHB requirements must generally have an AV of 60 percent. The choices of four different metal levels provides consumers with options to meet their specific health care and financial needs. Individuals expecting to have high levels of health care spending may select a gold or platinum plan, while an individual looking for more affordable premiums can select a silver or bronze plan – with out-of-pocket cost protections. It is important to note that many plans in the pre-reform individual market had actuarial values that were lower than 60 percent. A Health Affairs study found that more than half of individuals (51 percent) enrolled in the pre-reform individual market were covered under plans with an actuarial value below 60 percent.¹⁰

The ability to choose from a wide range of plan options is important to consumers. Of the more than 11 million individuals who selected a plan during the Open Enrollment period for 2015, 67 percent chose a silver plan (which must include cost-sharing reduction subsidies for lower-income enrollees), 22 percent chose a bronze plan, 7 percent chose a gold plan, and 3 percent chose a platinum plan.¹¹

Prescription Drug Coverage Under the ACA

Prescription drugs are required to be covered in the individual and small-group markets under the EHB package. The vast majority of large group and self-insured health plans include coverage for prescription drugs. Under the EHB requirements, the breadth of prescription drug coverage is largely based on the state's benchmark plan – which, in turn, is based on popular private sector group options available in the marketplace. Specifically, plans are required to cover drugs in all categories and classes – with the specific number of drugs largely determined by the state's benchmark plan or at least one drug in each United States Pharmacopeia (USP) category and class – whichever is greater.¹² Health plans must also have robust procedures, such as standards for expedited reviews, in place for consumers to gain access to non-formulary drugs when it is clinically appropriate. Enrollees also now have the option for secondary reviews by independent entities. Additionally, drugs covered under the exemption process count toward the annual limitation of out-of-pocket spending.

Beginning in 2017, health plans must also establish a pharmacy and therapeutics (P&T) committee comprised of physicians, pharmacists, and other health care professionals to develop their prescription drug formularies.¹³ Already in use by many health plans, these committees are tasked with examining clinical evidence on the safety and efficacy of approved drugs for certain treatments and ensuring that the formulary provides broad prescription drug coverage for all conditions. Together, these requirements ensure that all enrollees have access to the treatments they need.

Limits on Patient Cost Sharing Under the ACA

An important feature of health plan design is not only covered benefits, but limits on patient cost-sharing. As described above, the ACA contains a number of requirements related to cost sharing that provide consumers with options to meet individual circumstances and protect them from medical bankruptcy.

Annual Limits on Cost-Sharing

The ACA limits the total amount of spending on medical care (including prescription drugs) that an individual or family spends on health care during the year (excluding insurance premiums). All health plans in the individual and group markets (including large group and self-insured plans) have maximum out-of-pocket limits.

Once an individual or family reaches that amount of health care spending in a given year, they are no longer responsible for any cost sharing for medical care from “in-network” providers: The health plan pays 100 percent of the cost of any EHB above that threshold. For 2016, the limit for individual coverage will be \$6,850, while the limit for family coverage is \$13,700. Starting in 2016, HHS along with the Department of Labor and the Treasury Department recently clarified that out-of-pocket spending for someone enrolled in family coverage cannot exceed the maximum limit on cost sharing set for individual coverage – further limiting families' exposure to high health care costs.¹⁴ These maximum limits will increase each year by the growth in overall health insurance premiums.

Many organizations – including every major patient organization, consumer group, and AHIP – recognize the importance of the financial protection and health security provided to individuals and families by out-of-pocket limits.¹⁵ This feature of the ACA is particularly important for patients with high-cost, chronic conditions. Patient organizations and leading policy experts – including the American Cancer Society Cancer Action Network, the American Heart Association, Georgetown University's Health Policy Institute, and the Center on Budget and Policy Priorities – have also acknowledged that the ACA's out-of-pocket limits provide “an important new protection for consumers facing high-cost health problems.”¹⁶

While the statute sets the ceiling on maximum out-of-pocket costs, many plans have set their out-of-pocket limits well below the required level, which reflects the

benefits of a competitive market. An analysis of 2015 health plans by HealthPocket found that the nationwide average maximum out-of-pocket limit for individuals in silver plans was \$5,775 while the average limit for platinum plans was \$1,971.¹⁷ Bronze plans typically feature out-of-pocket limits that are closer to the statutory maximum because, at lower out-of-pocket limits, they would otherwise fail to meet the 60 percent actuarial value standard under the ACA.

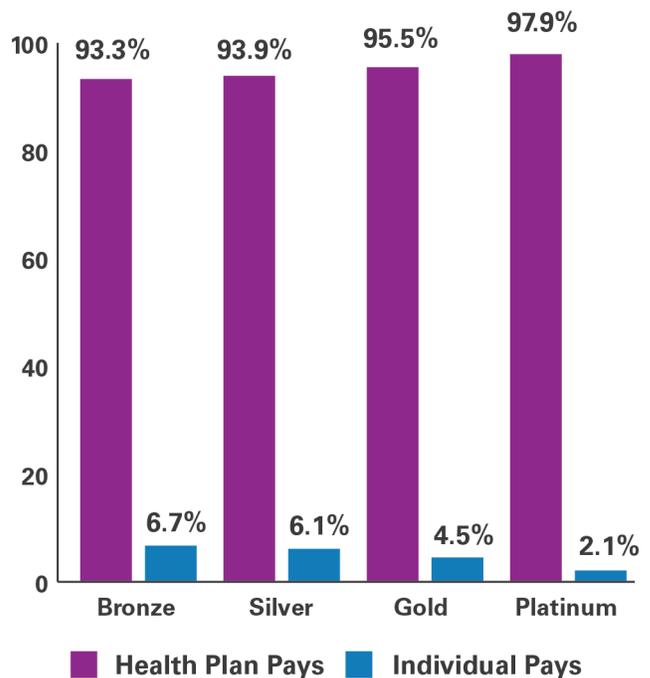
Annual limits on cost sharing went into effect in 2014 for all non-grandfathered health plans. Prior to the application of these limits, about 12 percent of individuals covered under employer-sponsored plans did not have such limits on cost sharing.¹⁸ Moreover, prior to the ACA, out-of-pocket spending for prescription drugs generally did not count toward the annual limit on cost sharing. Specifically, for most employer-sponsored plans with an out-of-pocket maximum (84 percent of workers covered under PPOs and 71 percent enrolled in HMOs), out-of-pocket spending for prescription drugs did not count toward the plan's annual limit on cost sharing.¹⁹

Advanced pharmaceutical research and development has led to the introduction of new specialty drugs that offer the potential for breakthrough treatments. To better understand how limits on cost sharing protect consumers, it is helpful to use real-world examples of the varying out-of-pocket costs for each metal level plan offered through the Exchanges. While specialty drugs may represent an important therapeutic advance for patients, they also carry enormous price tags that strain our health care system.

Harvoni is one highly publicized specialty drug used to treat chronic hepatitis C (CHC). Approved by the Food and Drug Administration (FDA) in October 2014, Harvoni has been shown to effectively cure CHC in up to 99 percent of patients. However, Harvoni comes with a significant list price: \$94,500 for a 12-week course of treatment. A recent study by the Institute of Clinical and Economic Review showed that the total cost of these combination regimens to effectively treat CHC

(including additional drugs and treatments) may reach \$190,000.²⁰ Depending on the metallic level plan, an individual taking Harvoni would exceed their yearly limit on out-of-pocket spending in a matter of days or weeks. At that point, the plan pays 100 percent of that individual's medical costs, including the cost of all covered drugs and other covered medical services. The chart below shows the proportion of the cost of Harvoni – not including any costs attributable to physician or other medical services or additional drugs – that would be paid for by the health plan and the individual at each metal level, given the average maximum out-of-pocket limits reported by HealthPocket (Figure 1).

Figure 1: Payment Distribution of Harvoni by Metal Level



Under the average Bronze plan, an individual would be responsible for 6.7 percent (\$6,373) of the total cost of Harvoni. The health plan would pay for 93.3 percent – or \$88,127 – of the full cost. Many times health plans (or a pharmacy benefits manager on their behalf) can negotiate with prescription drug manufacturers to receive substantial discounts on drugs through volume purchasing. Even if a health plan negotiated a 50 percent discount on Harvoni, it would still pay the vast majority of the cost for the drug.

Table 1: Average Annual Cost Per Patient by Cost Category

Cost Category	Total	Plan	Out-of-Pocket	%OOP
>\$100,000	\$159,693	\$156,911	\$2,782	1.7%
\$50,000 - \$99,999	\$69,018	\$67,245	\$1,773	2.6%
\$10,000 - \$49,999	\$19,351	\$18,186	\$1,165	6.0%
\$5,000 - \$9,999	\$7,051	\$5,107	\$944	13.4%
\$1,000 - \$4,999	\$2,400	\$1,926	\$474	19.8%
<\$1,000	\$256	\$166	\$89	34.9%
Overall	\$1,370	\$1,185	\$185	13.5%

While this example focuses on just one high-cost prescription drug, health plans pay for a significant proportion of the costs for all enrollees' prescriptions. Analysis by Express Scripts found that for those individuals with the highest overall prescription drug spending (greater than \$100,000 in 2014), health plans paid for over 98 percent of the enrollee's total costs (Table 1).²¹

Cost-Sharing Subsidies

In addition to subsidies that make premiums more affordable, the ACA provides extra assistance to reduce cost sharing and out-of-pocket costs for persons with incomes between 100 and 250 percent of the federal poverty level (FPL) – \$11,770 to \$29,425 for an

individual in 2015. Qualifying individuals who enroll in a silver plan receive cost-sharing reductions (CSR).²² These CSR plans are based off of the standard silver plans with a 70 percent actuarial value (AV), but issuers lower maximum out-of-pocket limits, copayments, coinsurance, and deductibles in the silver plan variations to increase their AV. In 2015, approximately 5.6 million individuals were enrolled in a CSR plan.²³ Based on income, individuals are assigned to one of three silver plan variations – with the amount of cost sharing required falling as income decreases (Table 2).

To meet these lower cost-sharing requirements, health plans first lower the out-of-pocket maximum. In 2015, CSR plans for individuals between 100 and 200 percent of FPL cannot have an out-of-pocket maximum greater than

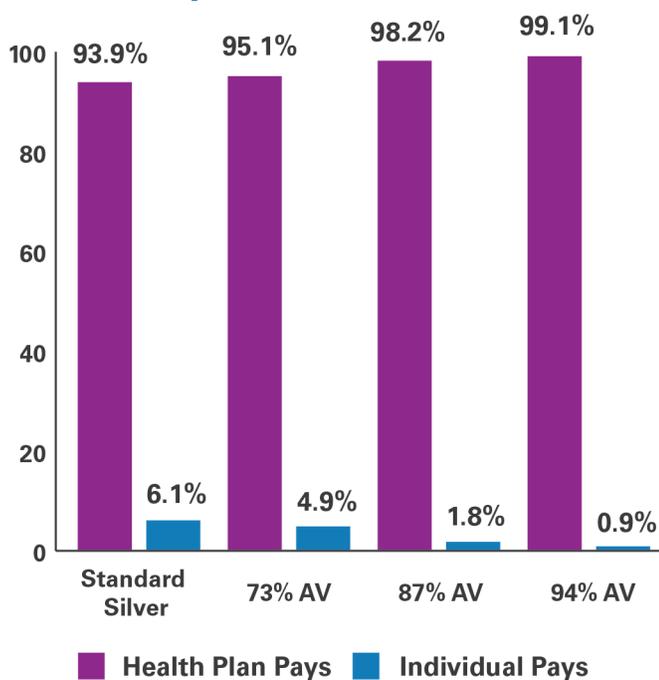
Table 2: Average Annual Cost Per Patient by Cost Category

Income Range (Individual, 2015)	AV	Out-of-Pocket Maximum (Statutory Maximum, 2015)	Out-of-Pocket Maximum (FFM Average, 2015)
>\$29,540 - \$29,425	70% (standard silver plan)	\$6,000	\$5,775
\$23,540 - \$29,425	73%	\$5,200	\$4,626
\$17,505 - \$23,540	87%	\$2,250	\$1,685
\$11,770 - \$17,655	94%	\$2,250	\$886

\$2,250. Similarly, those with incomes between 200 to 250 percent of FPL may have an out-of-pocket maximum of no more than a \$5,200. In practice, however, individuals and families enrolled in silver plan variations, on average, face much lower caps on out-of-pocket spending than are required by the law. An analysis of data from the Robert Wood Johnson Foundation (RWJF) shows that the average out-of-pocket maximum for the 73 percent silver plan variant was \$4,626, while the average for the 94 percent variant was \$886.²⁴ Many of the 94 percent CSR variant plans had out-of-pocket maximums of \$500 or less.

These cost-sharing reductions can substantially reduce out-of-pocket spending for lower-income patients, thereby promoting access to coverage and care. Using the data set from RWJF on the cost-sharing features of silver plan variations and the example of treatment for CHC discussed above, the chart below illustrates the maximum financial responsibility for individuals enrolled who are prescribed Harvoni. An individual enrolled in the 94 percent CSR plan variation would be responsible for only 0.9 percent (\$886) of the cost of Harvoni while the plan pays the remaining 99.1 percent (\$93,614) (Figure 2).

Figure 2: Payment Distribution of Harvoni by CSR Plan Variation



Again, these simplified examples assume that Harvoni is the only health care spending for an individual during the year. Since the cost of Harvoni alone would exceed the cap on out-of-pocket spending, any other health care services provided by in network providers to the individual during the year – such as physician office visits, other prescription drugs, or other medical procedures – would be fully paid for by the health plan.

New Tools for Consumers

Consumers will also have new decision-support tools to understand their coverage options – including the ability to estimate their own out-of-pocket spending under various qualified health plans. Starting in 2016, drug formularies and provider directories must be made publicly available in “machine readable” formats. These will be used by third parties to create intuitive and interactive tools for consumers that confirm whether a specific prescription drug is covered under the plan and how much they can expect to pay (including the amount of the copayment or other cost sharing). The tools would also be used to determine whether or not specific providers are included in a health plan’s network. Health plans must update these data sources monthly to ensure that consumers have up-to-date information on newly approved drugs and changes in provider participation.

HHS has also developed a new Out-of-Pocket Cost Comparison Tool for consumers in the federally facilitated marketplace. Consumers describe how they expect to use health care services and can compare how their out-of-pocket costs would change under different plan designs. HHS believes this comparison tool “should help [consumers] evaluate the tradeoff between a bronze plan with a lower premium versus a silver plan with a slightly higher premium but cost sharing that may be significantly reduced.”²⁵

More sophisticated consumer tools and transparency of drug formularies and provider directories will empower consumers to examine their coverage options and choose the plan that best meets their specific needs.

Consumer Satisfaction with Marketplace Plans

Millions of Americans have signed up for health insurance coverage in the new marketplaces – 9.9 million people were enrolled in plans as of June 30, 2015.²⁶ Moreover, the evidence shows that the combination of new insurance Exchanges and expanded Medicaid coverage have significantly reduced the number of uninsured. A recent study by the HHS Assistant Secretary for Planning and Evaluation found that 16.4 million people gained health insurance coverage since the ACA coverage provisions went into effect.²⁷

In addition, survey research finds that consumers that have signed up are broadly satisfied with their new coverage options. Market research by JD Power found that consumer satisfaction with Exchange plans increased significantly from 2014 to 2015 with overall satisfaction levels comparable or exceeding satisfaction levels for employer-sponsored coverage.²⁸ Similarly, a Commonwealth Fund survey found that 81 percent of individuals enrolling in an Exchange plan for 2015 were somewhat or very satisfied with their coverage.²⁹ Consumers are also pleased with the selection of health care providers participating in their plan – 89 percent of those surveyed said they were satisfied with the choice of doctors offered under their coverage, and 60 percent were able to get an appointment with a primary care physician within two weeks.³⁰ The new marketplace coverage options are also improving access to care. Consumers enrolled in Exchange plans report that they are gaining access to needed medical care that was previously unaffordable.³¹ Finally, the Kaiser Family Foundation also found high levels of consumer satisfaction with large majorities of those in marketplace plans (74 percent) rating their coverage as excellent or good. On specific elements of plan design, large majorities also report high satisfaction levels with plan copays for physician visits (73 percent), cost sharing for prescription drugs (70 percent), and deductible amounts (60 percent).³²

Conclusion

With millions of Americans gaining access to coverage and care, it is important to understand the consumer experience and the impact of affordability on access to medical care, including prescription drugs. The evidence shows that consumers with all sources of coverage – through individual exchange markets, small employers, and large employers – have greater financial protection and health security delivered through health plans due to maximum out-of-pocket limits. And while the ACA set caps on out-of-pocket spending, the competitive market for health coverage has resulted in maximum out-of-pocket limits that are lower than statutorily required. Millions of lower- and moderate-income consumers are benefitting from even greater protection against out-of-pocket costs due to the cost-sharing reductions available through the new Exchange marketplaces. But while maximum out-of-pocket limits, CSR, and different coverage options reduce consumer cost sharing with escalating prescription drug prices, premiums ultimately reflect the underlying cost of care. The skyrocketing prices of prescription drugs and other health care services will continue to push the cost of coverage upward.

Looking ahead to the next Open Enrollment period, new consumer-oriented tools (such as the out-of-pocket cost estimator and new provider and drug search tools) hold promise in enabling patients to make more informed decisions about their coverage and care and select the plan that best meets their health care and financial needs.

Recommendations

As implementation of the ACA moves forward, we offer the following policy recommendations to further protect consumers from rising health care costs and help keep coverage affordable:

- HHS should refrain from placing additional constraints on benefit design – including prescription drug coverage requirements. The benchmark approach adequately balances the need for comprehensive coverage with affordability and stability. The flexibility that currently exists has allowed health plans to design a range of coverage options and promotes market competition.
- HHS should ensure that standards around actuarial value are consistent and predictable from year to year to assure consumers have access to a wide array of quality coverage options and minimize the potential for disruptions in coverage.
- HHS should extend the existing state benchmark process for determining the essential health benefits (EHB) through 2019. This process has allowed state flexibility in selecting a benchmark plan that meets the health needs of their population.
- Pharmaceutical companies should be required to provide greater transparency on prescription drug research, development, and pricing. This would help health plans, physicians, and patients evaluate available treatments and select the most appropriate option. The timely availability and accessibility of clinical data from drug trials about efficacy, complications, and safety are critical to that decision-making process.
- Policymakers should address ongoing concerns around affordability and out-of-pocket spending through the existing framework of premium and cost-sharing reduction subsidies. For example, one proposal would enhance the ACA cost-sharing reductions for low-income consumers – by extending eligibility for cost-sharing reductions to individuals and families up to 300 percent of FPL (up from 250 percent currently) and significantly increasing actuarial value for cost-sharing reduction plans for those with incomes between 200 percent and 300 percent of FPL (up from 73 percent to 85 percent).³³ By building on and strengthening the existing ACA affordability programs, this approach would more effectively promote access to care and reduce out-of-pocket spending than artificial price caps on services that do not directly target lower-income populations.

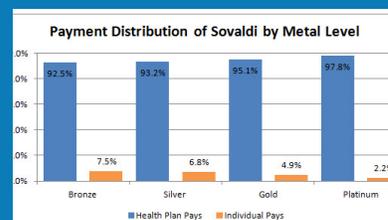
Endnotes

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- 2 The Commonwealth Fund. Large Majority of Affordable Care Act Coverage Enrollee Are Satisfied with Their Insurance, People Using Plans Are Getting Care They Could Not Have Afforded Before, 2015. <http://www.commonwealthfund.org/publications/press-releases/2015/jun/aca-tracking-survey-release>
- 3 The ACA's essential health benefit package requires plans to cover at least the following general categories and the items and services covered within the categories—(1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance abuse disorder services, including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care.
- 4 The ACA includes an annual limit on patient cost-sharing for plans in the individual and group market (including the large group market). For 2015, these limits are \$6,660 for self-only coverage and \$12,700 for family coverage.
- 5 The ACA requires plans in the individual and small-group market to meet actuarial value requirements and offer coverage within metal level tiers—bronze plan (60% AV), silver plan (70% AV), gold plan (80% AV), and platinum plan (90% AV). Most individuals are required to have coverage that at least meets the minimum value standards for bronze level coverage (60% AV).
- 6 States could choose from either (1) the largest plan by enrollment in any of the three largest small group insurance products in the state's small group market, (2) any of the largest three state employee health benefit plans by enrollment, (3) any of the largest three national FEHB plan options by enrollment, or (4) the largest insured commercial non-Medicaid HMO operating in the state.
- 7 <https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html>
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- 22 Special CSR variant plans – in many cases with even lower cost sharing than standard CSR variants – are available to American Indians and Alaskan Natives.
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