In 2016, about 60 percent of all enrollees who received coverage in the Exchanges, or 6.4 million people, benefited from reduced cost-sharing (e.g., deductibles, co-payments) due to cost-sharing reductions (CSRs).

While CSRs provide real value and extra savings to consumers, health plans receive no net financial gain because CSR funding is only for covered healthcare treatments and services (e.g., physician visits, drugs) provided to eligible enrollees.

If CSR funding is eliminated, consumers at all income levels would face substantially higher total monthly premiums and likely have fewer coverage choices due to plans leaving the market, and hardworking taxpayers will pay billions of dollars in extra costs.
Cost-Sharing Reductions Are Essential for Consumer Affordability, Choice, & Stability

Executive Summary

Currently, there are two primary mechanisms in the individual health insurance exchanges that work to improve affordability for consumers:

1. advance premium tax credits (APTC) to reduce monthly premiums; and
2. cost-sharing reductions that reduce out-of-pocket expenses for lower- and moderate-income individuals and families.

CSRs make health care more affordable for millions of individuals and families by reducing patient cost-sharing—that is, deductibles, co-payments, and/or annual maximum out-of-pocket (MOOP) limits. In 2016, about 60 percent of all enrollees with exchange coverage, or 6.4 million people, benefited from a reduction in their overall cost-sharing due to CSRs. These benefits go directly to consumers – a recent Kaiser Family Foundation analysis found that CSRs reduced the average deductible for enrollees in the lowest income bracket by $3,354. While CSRs provide real value and savings to consumers, health plans receive no net financial gain. They simply act as an administrator of CSR payments to providers for covered treatments and services received by eligible enrollees. Consequently, program funding is based on the actual cost-sharing reductions paid to providers for the health care they provided to eligible individuals.

The authority for government funding of the program is currently under legal dispute between the U.S. House of Representatives and the U.S. Department of Health and Human Services (HHS). This dispute is creating significant market uncertainty about the availability of CSR funding for consumers in 2017, 2018, and beyond.

State filing deadlines for the 2018 plan year generally require health plans to make decisions about products, rates, and market participation in the second quarter of 2017. The current deadline to file products on the federally-facilitated marketplace (FFM) for 2018 is June 21, 2017. As a result, health plans need to understand all applicable rules and have certainty regarding the regulatory and financial market stability of the individual market in 2018 before making these decisions.

If CSR funding remains unpredictable or is discontinued, health plans will have to make difficult decisions about market participation in 2018. They will have to choose between not participating in some or all segments of the individual market—e.g., exchanges—or increasing premiums for all enrollees to cover the cost of providing CSRs to consumers—an estimated $10 billion in 2018.

If health plans decide to not offer coverage through the exchanges in 2018, consumers would have fewer coverage options, including the possibility of no plans eligible for APTCs or CSRs in some counties. Rising premiums would result in significantly higher costs for all enrollees, including lower- and moderate-income consumers, and would result in increased federal spending on APTCs, imposing billions of dollars in extra costs on taxpayers.

“...if insurers do not have clear assurances that they will be paid for CSRs in 2018, they will have to make a decision on pricing and participation without adequate information.”

— S&P Global Ratings
April 7, 2017
Cost-Sharing Reductions Are Essential for Consumer Affordability, Choice, & Stability

If funding for CSRs remains uncertain and results in health plans exiting the market or increasing premiums to cover the cost of the program, the individual market may deteriorate beyond repair. As a result, health plans and many other stakeholders—including hospitals, physicians’ groups, employer and business groups, insurance commissioners and others—have recommended that Congress and the Administration commit to uninterrupted CSR funding.

What is Cost Sharing and How Do CSRs Work?

Cost sharing is the out-of-pocket spending that consumers routinely incur when they access health care services. This often includes an annual deductible, as well as fixed copayments or coinsurance for covered health care services. When consumers reach their annual MOOP limit, no cost-sharing is required, as health plans pay 100 percent of the cost of covered treatments and services. Before choosing a health plan, consumers are encouraged to evaluate their potential total annual costs for health care, including premiums and out-of-pocket costs.

CSRs are provided only through “silver” level qualified health plans (QHPs) purchased through a health insurance marketplace operated by a state or the federal government. Eligibility for CSRs is limited to individuals and families with incomes between 100 percent and 250 percent of the Federal Poverty Level (FPL). Special cost-sharing reduction rules apply to American Indians and Alaska Natives. CSRs are provided automatically to eligible individuals who select silver QHPs.

The exchange plans that include reduced cost-sharing for eligible enrollees are often called CSR plan variants, and are variations of a standard silver Exchange plan with a 70 percent actuarial value (AV). All health plans that participate in the

<table>
<thead>
<tr>
<th>Household Income Tier, by Federal Poverty Level</th>
<th>Household Income Range Individual</th>
<th>Household Income Range Family of Four</th>
<th>Eligible for Cost Sharing Reductions?</th>
</tr>
</thead>
<tbody>
<tr>
<td>100 – 150%</td>
<td>$11,880-$17,820</td>
<td>$24,300-$36,450</td>
<td>Yes</td>
</tr>
<tr>
<td>150 – 200%</td>
<td>$17,821-$23,760</td>
<td>$36,451-$48,600</td>
<td>Yes</td>
</tr>
<tr>
<td>200 – 250%</td>
<td>$23,761-$29,700</td>
<td>$48,601-$60,750</td>
<td>Yes</td>
</tr>
<tr>
<td>+250%</td>
<td>$29,700</td>
<td>$60,750</td>
<td>No</td>
</tr>
</tbody>
</table>

Source: 2016 Federal Poverty Level (FPL) Guidelines

Know the Numbers

- 6.4 million People who have cost-sharing reduction plans
- <$29,700 Income level below which a single person qualifies
- <$60,750 Income level below which a family of four qualifies
Cost-Sharing Reductions Are Essential for Consumer Affordability, Choice, & Stability

Exchanges are required to offer at least one silver level plan and all its CSR plan variants. There are different CSR plan variants for each level of income eligibility and for American Indians and Alaska Natives. The CSR plan variants have higher AV levels as specified in the law and are displayed on HealthCare.gov to eligible consumers as “extra savings” plans.

CSR plans have lower MOOP limits, copayments, coinsurance, and annual deductibles compared to a standard silver Exchange plan. Table 2 outlines the AV levels and 2017 MOOP limits for individuals and families in CSR plan variants versus a standard silver Exchange plan. The amounts listed above are the MOOP limits specified by HHS and updated annually, but consumers in CSR plans often face lower out-of-pocket caps than required by law.⁸

Deductibles and copayments are also considerably lower for individuals and families in CSR plans, which helps lower consumers’ out-of-pocket costs at the point of service when they need care. A recent Kaiser Family Foundation analysis of 2017 Exchange plans found that cost-sharing subsidies lower deductibles by as much as $3,354 for individuals with incomes below 150 percent FPL.⁹

What CSRs Mean to Consumers

For the 6.4 million low- and moderate-income enrollees in CSR plans, CSRs substantially reduce annual deductibles, point of service copayments, and other cost-sharing elements, thereby promoting access to care. Without CSRs, many of these individuals may be able to afford their monthly premiums due to APTCs, but care would be largely inaccessible due to unaffordable cost-sharing.

To highlight the consumer benefit of CSRs and the estimated financial impact to the health plan and the federal government, consider the hypothetical example below in Table 3. In the example, an individual visits the emergency room (ER) to treat a broken ankle that results in a total hospital bill of $4,000. In this scenario, the consumer has not sought any health care services prior to the incident during the current plan year and will therefore be subject to the full annual deductible for this trip to the ER. After the deductible has been met for the year, the health plan coverage kicks in to provide coverage for covered treatments and services for the remainder of the plan year.

### Table 2: Actuarial Values and 2017 Maximum Out-of-Pocket Limits for Individuals and Families Eligible for CSR Plans

<table>
<thead>
<tr>
<th>Household Income Tier, by Federal Poverty Level</th>
<th>Actuarial Values for CSR Plan Recipients</th>
<th>Maximum Out-of-Pocket Individual</th>
<th>Maximum Out-of-Pocket Family of Four</th>
</tr>
</thead>
<tbody>
<tr>
<td>High CSR 100 – 150%</td>
<td>94%</td>
<td>$2,350</td>
<td>$4,700</td>
</tr>
<tr>
<td>Med CSR 150 – 200%</td>
<td>87%</td>
<td>$2,350</td>
<td>$4,700</td>
</tr>
<tr>
<td>Low CSR 200 – 250%</td>
<td>73%</td>
<td>$5,700</td>
<td>$11,400</td>
</tr>
<tr>
<td>Standard Silver +250%</td>
<td>70%</td>
<td>$7,150</td>
<td>$14,300</td>
</tr>
</tbody>
</table>

Reducing out-of-pocket costs through CSR plans removes barriers to getting needed care for lower- and moderate-income individuals and families. The hypothetical example in Table 3 outlines those differences in out-of-pocket costs (Consumer Portion) for care, and the amount that is covered by the health plan and the federal government.

The impact of CSRs is further magnified for individuals who have significant health care expenses in a given year. Expenses totaling $100,000 or more may be common for individuals who are diagnosed with chronic or acute diseases that require extensive treatment and/or high-cost drugs. In these scenarios, individuals and families usually reach their annual MOOP limit early in the year. That limit is considerably lower for individuals and families with coverage through a CSR plan. In the hypothetical example in Table 4, a consumer diagnosed with a chronic or acute disease receives in-network care totaling $100,000.

### Table 3: Hypothetical Example of an ER Visit Totaling $4,000

<table>
<thead>
<tr>
<th>CSR / % FPL</th>
<th>Total Cost</th>
<th>Typical Deductible</th>
<th>Typical ER Copay</th>
<th>Consumer Portion</th>
<th>Government Portion</th>
<th>Health Plan Portion</th>
</tr>
</thead>
<tbody>
<tr>
<td>High CSR 100%-150% FPL</td>
<td>$4,000</td>
<td>$250</td>
<td>$100</td>
<td>$350</td>
<td>$3,550</td>
<td>$100</td>
</tr>
<tr>
<td>Med CSR 150%-200% FPL</td>
<td>$4,000</td>
<td>$700</td>
<td>$150</td>
<td>$850</td>
<td>$3,050</td>
<td>$100</td>
</tr>
<tr>
<td>Low CSR 200%-250% FPL</td>
<td>$4,000</td>
<td>$3,000</td>
<td>$300</td>
<td>$3,300</td>
<td>$600</td>
<td>$100</td>
</tr>
<tr>
<td>Standard Silver +250% FPL</td>
<td>$4,000</td>
<td>$3,500</td>
<td>$400</td>
<td>$3,900</td>
<td>$0</td>
<td>$100</td>
</tr>
</tbody>
</table>

### Table 4: Hypothetical Example of an ER Visit Totaling $100,000

<table>
<thead>
<tr>
<th>CSR / % FPL</th>
<th>Total Cost</th>
<th>Maximum Out-of-Pocket - Individual</th>
<th>Consumer Portion</th>
<th>Government Portion</th>
<th>Health Plan Portion</th>
</tr>
</thead>
<tbody>
<tr>
<td>High CSR 100%-150% FPL</td>
<td>$100,000</td>
<td>$2,350</td>
<td>$2,350</td>
<td>$4,800</td>
<td>$92,850</td>
</tr>
<tr>
<td>Med CSR 150%-200% FPL</td>
<td>$100,000</td>
<td>$2,350</td>
<td>$2,350</td>
<td>$4,800</td>
<td>$92,850</td>
</tr>
<tr>
<td>Low CSR 200%-250% FPL</td>
<td>$100,000</td>
<td>$5,700</td>
<td>$5,700</td>
<td>$1,450</td>
<td>$92,850</td>
</tr>
<tr>
<td>Standard Silver +250% FPL</td>
<td>$100,000</td>
<td>$7,150</td>
<td>$7,150</td>
<td>$0</td>
<td>$92,850</td>
</tr>
</tbody>
</table>
How Are CSRs Paid?

Health plans administer cost-sharing reductions and automatically provide them to eligible consumers to reduce out-of-pocket costs. The federal government makes estimated monthly CSR payments to health plans so that plans can pay providers directly for the portion of patients’ bills covered by CSRs. After the end of the plan year, health plans and the federal government reconcile these estimated advance CSR payments with the actual value of cost-sharing reductions paid by the health plan toward the health care bills received for CSR enrollees during the year. As a result, health plans operate as a “pass through” of CSRs to consumers, making no profit while only covering the actual amounts of cost-sharing reductions paid out for covered health care services. These CSR payments are already included and counted in the current Congressional Budget Office (CBO) budget baseline.

Current Litigation Surrounding CSRs: House v. Price

In July 2014, the House of Representatives brought a lawsuit against the Department of Health and Human Services under the Obama Administration (House v. Burwell), alleging that the payment of CSR amounts to health plans without a congressionally-approved funding appropriation is illegal. The Obama Administration contended that the permanent appropriation for APTCs also provided an appropriation of CSR payments to health plans. Both parties shared a common legal perspective that health plans that remain on the exchanges will continue to be required to lower enrollees’ cost sharing, even if the health plans stop receiving payments from the federal government to cover these costs.

A U.S. district court sided with the House of Representatives and held that the payment of CSR amounts to health plans lacked an appropriation and was therefore illegal. The district court, however, allowed such payments to continue pending an appeal of its decision to a U.S. Court of Appeals. The parties were in the middle of briefing the case to that court, when the election occurred, resulting in a change in administration and a potential change in the litigating position of the Executive Branch.

Because of this change, the court agreed, after the election, to temporarily suspend the case (hold it in abeyance) to allow the House and the Trump Administration to explore resolution of the matter. (As a result of the confirmation of a new HHS Secretary (Thomas Price, M.D.), the case is now known as House v. Price.) The parties are obligated to give the court periodic status reports, with the next report due on May 22, 2017 and future reports every 90 days after that date. This legal limbo adds to uncertainty regarding the continued availability of CSR funding and creates substantial uncertainty for health plans that are making decisions about products, premiums, and participation in the market for 2018.

Know the Numbers

- CSR funding that goes towards health plan profits: $0
- Likely budget offset needed for a direct appropriation to fund CSRs: $0
- Estimated total CSR payments paid by health plans to providers for services rendered in 2016: $7 billion
Cost-Sharing Reductions Are Essential for Consumer Affordability, Choice, & Stability

Estimated Impact of Discontinuing CSR Funding

If the parties involved in the pending litigation abruptly end or discontinue the payments of CSRs for consumers to health plans during the 2017 plan year or in the future, significant disruption will occur in the individual health insurance market. Several recent analyses have quantified the premium impact of discontinuing CSR funding:

- Researchers at the University of California Los Angeles found that without CSRs, premiums for silver plans in the state of California – the most popular plan type – will go up by more than 16 percent because of this change alone.\(^{11}\)

- A Kaiser Family Foundation analysis found average premiums for a silver benchmark plan in the exchanges “would need to increase by an estimated 19 percent for health insurers to compensate for lost funding if they do not receive federal payment for ACA cost-sharing subsidies.”\(^{12}\)

- The Kaiser analysis further segmented the impact based on a state’s decision to expand Medicaid and found an average premium increase for expansion states of 15 percent, and 21 percent for non-expansion states.

Using HHS data, Kaiser found that cost-sharing subsidies are generally higher in non-expansion states because those states have a greater number of enrollees with incomes between 100 percent and 150 percent of FPL, who receive the largest cost-sharing reductions. For states that use the Federally Facilitated Marketplaces (FFM), the range of premium increases is 18 percent, with premiums in North Dakota increasing 9 percent and premiums in Mississippi increasing 27 percent.\(^{13}\)

The impact of discontinuing funding for CSRs extends beyond consumers to the federal government and taxpayers. Net federal budgetary outlays will increase (as would the federal budget deficit). This would occur because APTCs are tied to premium costs, and APTCs are provided to an even larger number of individuals (those with incomes up to 400 percent of FPL) than CSRs. Without CSR funding, as noted above, premiums will rise substantially for all individuals (including those who receive no APTC), as plans will need to compensate for the lack of CSR funding. The increase in premiums will result in higher federal spending for APTCs. An analysis from the Kaiser Family Foundation finds the government could pay out as much as $12.3 billion in higher tax credits for premiums next year. Factoring in a $10 billion savings from withholding CSRs, this results in a net $2.3 billion increase in 2018 federal spending caused by discontinuing CSRs.\(^{10}\)

Recommendation: Commit to Funding the CSR Program Through Direct Spending

Consumers who rely on the individual health insurance market deserve stability and to be held harmless as policymakers debate and define any potential new roadmap to health care reform. A strong commitment to promoting a stable individual market in 2017, 2018, and beyond would be to directly appropriate funding for the CSR program. Additionally, since CSRs are already counted and included in the current CBO budget baseline, a direct appropriation should not require a corresponding budget offset.

Health plans and numerous other stakeholders have recognized the importance of uninterrupted CSR funding and issued letters to Congress and the Administration. On March 12, a diverse group of organizations representing hospitals (American Hospital Association and Federation of American
Cost-Sharing Reductions Are Essential for Consumer Affordability, Choice, & Stability

Hospitals), physicians (American Medical Association and American Academy of Family Physicians), the employer and business community (American Benefits Council and U.S. Chamber of Commerce) and health plans (America’s Health Insurance Plans and Blue Cross Blue Shield Association) sent a letter urging continued CSR funding. The National Association of Insurance Commissioners (NAIC), the Bipartisan Policy Center, and other organizations have issued similar letters and statements.

Consumers, health plans, and states need certainty. The deadline for issuers to file products in the FFM is currently June 21; however, more than half of states have earlier deadlines in April and May. For the sake of consumers, it is critical that the regulatory and financial requirements of the 2018 individual market are known before health plans finalize these decisions. If CSR funding remains unpredictable, health plans will effectively have to choose between not participating in the exchanges (or the entire individual market), or increasing premiums for all enrollees to cover the cost of the CSR program—an estimated $10 billion in 2018. As a result, many consumers may have fewer coverage choices and some may have no health plans available through which to access premium credits and/or CSRs for which they would otherwise be eligible.

Related Topic
Cost-Sharing Reductions Are Essential for Consumer Affordability, Choice, & Stability

3 House v. Price (filed as House v. Burwell)
5 “Cost sharing” does not include premiums, balance billing amounts for non-network providers, or the cost of non-covered services.
6 Cost sharing is subject to a maximum limit for consumers and families each year – including deductibles, copayments, and coinsurance. For 2017, the maximum out-of-pocket (MOOP) for individuals is $7,150 and the MOOP for families is $14,300.
7 AV generally describes a health plan’s benefit levels and cost-sharing structures for a standard population. A silver level plan with an AV of 70 percent would, on average, pay 70 percent of the health care costs across the entire group of enrollees, with enrollees collectively paying the remaining 30 percent of total expenses in the form of co-payments, coinsurance, and deductibles.
9 Ibid.
10 Ibid.
12 Ibid.
13 Ibid.
14 Ibid.