



# Addressing the Increasing Burden of Health Insurance Cost Sharing

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American College of Physicians  
A Position Paper  
2016



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A Position Paper of the  
American College of Physicians

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How to cite this paper:

American College of Physicians. **Addressing the Increasing Burden of Health Insurance Cost Sharing.** Philadelphia: American College of Physicians; 2016: Position Paper. (Available from American College of Physicians, 190 N. Independence Mall West, Philadelphia, PA 19106.)

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## Executive Summary

Health insurance provides financial security against health care costs and lessens the risk of incurring medical debt. However, there is growing concern about the affordability of health insurance. During the 2000s, total health care expenditures grew substantially. Per capita health spending was \$4,703 in 2000 and rose to \$7,538 in 2008 (1). The cost of health insurance also has exploded: the average annual premium for family coverage in 2015 was \$17,545, a 27% increase from 2010 and a 61% increase from 2005 (2). Facing pressure from the rising cost of health insurance premiums, employers are shifting a larger portion of the burden to their employees, mostly in the form of deductibles. In 2005, the average annual deductible for single coverage was \$584 for all plans; in 2015, it was \$1,318 (2). While employees have shouldered more of the health insurance cost burden, median family income has risen at a much slower rate (3). Many health insurance options available through health insurance marketplaces have higher cost sharing than private employer-sponsored insurance (ESI).

Evidence shows that cost sharing, particularly deductibles, may cause patients to forgo or delay care, including medically necessary services. The effects are particularly pronounced among those with low incomes and the very sick. In the private insurance market, cost sharing typically is used as a blunt instrument, without regard for an individual's income or health status. Christopher Robinson from the University of Arizona James E. Rogers College of Law states, "Because cost-sharing exposure is in effect the absence of insurance for those expenses, cost-sharing can undermine the primary function of insurance" (4). A different cost-sharing approach is needed to ensure that vulnerable people can afford medically necessary care in the face of rising health coverage costs and stagnant wages. This paper offers recommendations on ways cost sharing can be made more equitable in the private market by reducing overall health care spending, designing insurance plans that allow access to high-value services, enhancing financial subsidies for marketplace-based insurance plans, improving outreach and health insurance literacy and education, and advocating for updated research on the effects of patient cost sharing.

## Recommendations

1. To help contain health insurance premiums and cost sharing, the health care system must accelerate its efforts to reduce overall health care spending in ways that do not rely principally on shifting the cost burden onto insured persons who cannot afford to pay more for their medical care. Among the ways that health care spending may be curbed without imposing excessive costs on insured persons include:
  - a. Reforming the way health care is paid for and delivered and encouraging value-oriented rather than volume-based care;
  - b. Promoting team-based care that emphasizes prevention as well as cooperation and coordination among physicians, hospitals, and other health care professionals;
  - c. Enhancing the transparency of price and quality data so that patients, employers, and payers are better informed about the actual costs and quality of health care services;
  - d. Allocating resources with a focus on medical efficacy, clinical effectiveness, and need, with consideration of cost based on best available medical evidence to ensure that limited health care resources are directed to cost-effective services.

2. To encourage use of high-value health care, employer-sponsored health plans should:
  - a. Consider implementing value-based insurance design strategies that reduce or eliminate out-of-pocket contributions for services proven to offer the greatest comparative benefit, with higher cost-sharing for services with less comparative benefit. Such strategies should be based on rigorous comparative effectiveness research by independent and trusted entities that do not have a financial interest in the results of the research. The goal should be to ensure that high-value cost-sharing strategies encourage enrollees to seek items and services proven to be of exceptional quality and effectiveness and not just on the basis of low cost;
  - b. Consider implementing income-adjusted cost-sharing approaches that reduce or directly subsidize the expected out-of-pocket contribution of lower-income workers to avoid creating a barrier to their obtaining needed care.
3. Cost-sharing provisions under the Patient Protection and Affordable Care Act should be improved by:
  - a. Expanding eligibility for qualified health plan premium tax credits and cost-sharing subsidies for families unable to afford employer-sponsored insurance (elimination of the “family glitch”);
  - b. Enhancing the affordability of marketplace-based qualified health plans by expanding cost-sharing assistance eligibility, increasing premium tax credits and cost-sharing subsidies, and eliminating the premium cap indexing policy.
4. Stakeholders must work together to enhance health insurance literacy and promote better, more accessible, and objective information about cost-sharing requirements and health insurance plan design.
  - a. Federal and state governments, navigators and other assisters, community and health professional organizations, health insurers, and other stakeholders must educate enrollees about the availability of premium tax credits, cost-sharing subsidies, and free or low-cost preventive care and why it is important. Efforts must be made to educate enrollees about value-based cost sharing.
5. A large-scale demonstration should be implemented to test the short- and long-term effects of cost sharing in different populations.

## Background

### Underinsurance

Thanks in part to the Patient Protection and Affordable Care Act (ACA), the number of uninsured Americans has declined sharply. According to the U.S. Census Bureau, the number of uninsured individuals dropped by 8.8 million from 2013 to 2014 (5). Despite these impressive gains, 33 million people were uninsured for the entire calendar year. Compared with their uninsured counterparts, insured Americans are more likely to have regular access to care, to receive preventive and screening services on a timely basis, to obtain appropriate care for chronic illness, and to be hospitalized and receive more services for trauma (6). A survey of adults who gained coverage in 2014 found that these newly insured individuals were more likely to access regular care, less likely to delay needed care, and more likely to use preventive services than the uninsured population (7).

Concerns about underinsurance have been raised as deductibles, coinsurance, and copayments have become more prevalent in health insurance plans. The Commonwealth Fund defines a person as underinsured if his or her out-of-pocket costs, excluding premiums, over the 12-month coverage period exceed or are equal to 10% of annual household income, the total deductible amount exceeds 5% of annual household income, or if nonpremium out-of-pocket costs equal or exceed 5% for someone with an annual income less than 200% of the federal poverty level (FPL) (8).

Thirty-one million adults, or 23% of insured adults aged 18 to 64 who were insured all year, were underinsured in 2014, according to the Commonwealth Fund survey. Although this number is unchanged from 2010 and 2012, it is nearly double the number of underinsured in 2003, the first year underinsurance was reported in the survey. Underinsurance affects enrollees in both private market coverage and public insurance programs. In 2014, 20% of ESI, 37% of individual market, 22% of Medicaid, and 42% of under-65 (that is, disabled) Medicare enrollees were underinsured. Underinsurance is more likely to occur with plans offered by small firms (up to 100 employees) than large ones. African Americans are more likely than Hispanic or white individuals to be underinsured (9). A study by Link and McKinlay (9) found that the underinsured population generally is older and sicker, and has a lower health-related quality of life. The authors concluded that underinsurance may be an “even more insidious problem” than uninsurance.

Many households may not have the financial means to meet cost-sharing requirements. Among all nonelderly, nonpoor households, 63% have liquid financial assets greater than a midrange deductible (that is, \$1,200 for an individual, \$2,400 for a family) and only 51% have sufficient assets to cover a high-deductible plan (10).

### High-Deductible Health Plans

High-deductible health plans (HDHPs), also called consumer-directed health plans, typically have lower premiums than traditional plans but also have higher deductibles. They often are tied to tax-advantaged health savings accounts. High-deductible plans intend to make enrollees more cost conscious and discourage use of unnecessary services.

The availability of HDHPs has exploded in the past decade. According to the Commonwealth Fund, the number of privately insured adults aged 18 to 64 with zero-deductible plans dropped from 40% in 2003 to 25% in 2014 (8). Those with plans requiring deductibles in the \$1,000 to \$2,999 range increased from 7% in 2003 to 27% in 2014. The percentage of private plan-insured adults facing deductibles of \$3,000 or more was 11% in 2014.

## The ACA and Cost Sharing

The ACA established several provisions that seek to expand insurance access and protect insured individuals from financially catastrophic health care costs. The law created a new category called qualified health plans (QHPs), which are sold through a regulated marketplace operated by the federal government, the state, or a hybrid arrangement. Qualified health plans must adhere to a range of benefits and cost-sharing requirements. These plans are organized into tiers—bronze, silver, gold, platinum, and catastrophic—based on their actuarial value, a figure that indicates health plan generosity. Generally, bronze-level plans have relatively low premiums but higher cost sharing, whereas platinum plans have high premiums and low cost sharing. Catastrophic plans are available to lower-income people up to age 30 and generally provide limited benefits with high deductibles.

Advance premium tax credits are available to QHP enrollees with incomes of 100% to 400% FPL. Cost-sharing assistance is provided to silver-level plan enrollees with incomes ranging from 100% to 250% FPL. In June 2015, 5.6 million (56%) of the 9.9 million individuals with effectuated marketplace-based health insurance coverage (that is, active enrollment and paid premiums) received a cost-sharing reduction (11). Cost-sharing subsidies effectually increase the plan's actuarial value; for example, a silver-level enrollee with an income of 100% FPL would receive subsidies increasing the plan's actuarial value to platinum level. Those with incomes in the 150% to 200% FPL range would see their silver-level plan's actuarial value boosted to 87%, and enrollees in the 200% to 250% range would see a modest increase in plan generosity from 70% to 73%. An enrollee in an unsubsidized silver-level plan might have an average copayment of \$28 for a physician's visit, whereas an individual enrolled in a silver plan with cost-sharing subsidies that raise the actuarial value to 94% would pay \$14 for the service (12).

Cost sharing is among the top concerns for shoppers of marketplace-based plans. Among those with ACA-compliant individual market plans who considered more than one plan, the top three factors they considered extremely or very important were monthly premium costs (34%, extremely important; 46%, very important), deductibles and copays (28% and 44%, respectively), and choice of doctors and hospitals (24% and 39%, respectively) (13). Even within a metal tier, health plan cost sharing may vary widely; for example, one silver plan with an actuarial value of 70% may have a \$4,500 deductible with a \$10 copayment for physician visits, whereas another may have no deductible but require a \$50 copayment for physician visits and 50% coinsurance for inpatient care (14). Other cost-sharing protections include annual individual and family out-of-pocket spending limits for care received by an in-network provider (in 2015, the out-of-pocket limits were \$6,600 for individual and \$13,200 for family coverage) and prohibitions on annual and lifetime dollar limits on health care benefits. Most plans waive cost sharing for preventive services rated "A" or "B" by the U.S. Preventive Services Task Force, care covered under the Women's Preventive Services Guidelines supported by the Health Resources and Services Administration, immunizations recommended by the Advisory Committee on Immunization Practices, and children's preventive services included in the Bright Futures Guidelines.

Bronze and silver plans often combine the medical and prescription drug deductible, whereas higher-tier plans separate the two categories. The average combined medical and prescription deductible for a bronze plan is \$5,328. The average medical deductible is \$3,453 in a silver and \$418 in a platinum plan with separate medical and drug deductibles (14).

Recent evidence shows that premium tax credits and cost-sharing assistance have made individual marketplace-based QHP plans roughly comparable in generosity to ESI, at least among lower-income marketplace enrollees receiving subsidies. A 2015 survey comparing participants in ESI plans with those in marketplace-based QHPs found that a larger proportion of marketplace enrollees had high-deductible plans, with higher-income participants most likely to have an annual deductible of at least \$1,000. Further, adults with ESI were more likely than those with marketplace plans to express confidence that they could afford needed care if they became seriously ill (15). This gap was especially pronounced among



individuals who reported being in fair or poor health or having at least one chronic condition: only 57% of marketplace plan enrollees in this group were somewhat or very confident they could afford necessary care, versus 78% of the ESI enrollees. Participants in high-deductible plans expressed less confidence than those with low deductibles that they could afford a serious illness. Survey data show that QHP enrollees generally are pleased with their premiums, copayments, choice of doctors, and other plan characteristics, although deductibles receive the lowest satisfactory rating (16).

The ACA also defines health insurance affordability in two ways. The act requires individuals to have minimum essential coverage (such as a QHP, comprehensive ESI, or Medicaid or Medicare) or pay a fine (often called the "individual mandate"). An exemption may be applied for those whose insurance is deemed unaffordable, that is, exceeds 8% of annual household income. Employer-sponsored insurance is considered unaffordable if the employee's share exceeds 9.5% of household income, in which case the employee may be eligible for premium tax credits to purchase a QHP through the marketplace.

### **How Does Cost Sharing Affect Consumer Behavior?**

Although cost sharing may be an effective tool to curb unnecessary health care use, it also may cause some enrollees, especially those with lower incomes, to forgo necessary services. Generally, higher cost sharing may not have negative consequences for healthy enrollees but is associated with adverse health outcomes among vulnerable populations, including individuals with a low income, poor health, or chronic illness, or those who are elderly (17). The RAND Health Insurance Experiment, a randomized, controlled study conducted from 1971 to 1986, concluded that moderate cost sharing reduces health care use, generally without negative effects on health or quality; however, it reduces the use of highly effective as well as less-effective services (18). Further, the poorest and sickest patients enrolled in plans without cost sharing had better health outcomes for 4 of 30 conditions measured (hypertension, vision, dental, serious symptoms) than those with plans subject to cost sharing.

A 2007 survey found that 29% of people with HDHPs delayed or skipped care because of cost, compared with 16% of individuals with low-deductible plans (19). A 2013 review of health care use by employees who were switched from a preferred provider organization to a high-deductible plan found that they visited their physicians and used prescription drugs significantly less often, visited the emergency department slightly more often, and during the first year, underwent recommended cancer screening less frequently, even though it was not subject to cost sharing (20). Another study found that participants in HDHPs were more likely than those in lower-deductible or tiered-copayment prescription drug plans to discontinue use of lipid-lowering and antihypertensive medications (21). However, individuals insured by high-deductible plans switched to generic drugs at a higher rate for 1 of 5 classes, although the total usage rate was lower for HDHP enrollees than for those insured by other plans. A 2011 study found that among families in which a member had a chronic condition, those insured by HDHPs were more likely than those with traditional, low-deductible health plans to report a health care-related financial burden, such as difficulty paying bills or setting up a payment plan with a physician or hospital (22). A systematic review of studies evaluating the effects of cost sharing on medication adherence in patients with or at risk for cardiovascular disease concluded that although cost sharing's overall effect is unclear, it may reduce adherence among people of lower socioeconomic status (23).

Health system savings from cost sharing may be tempered by elevated costs elsewhere. When a Medicare supplemental plan increased cost sharing for physician visits and prescription drugs, use of those services dropped and hospitalization rates increased, especially among the sickest enrollees; hospitalization costs are absorbed by the Medicare program rather than the supplemental insurer (24).

Emerging evidence indicates that cost savings from HDHPs may be the result of lower usage rather than informed consumers shopping for the best price. An

October 2015 study evaluated a large self-insured firm that shifted its employees from a zero-deductible health care plan to an HDHP with a fully funded health savings account (25). After the change, health care spending dropped by up to 13.8% as enrollees reduced their use of potentially valuable services, such as preventive screening, and potentially unnecessary services, such as imaging. Ninety percent of the spending reduction occurred when the enrollees were required to pay a deductible, and sicker workers were most likely to forgo care while subject to paying the deductible. The researchers found no evidence that after 2 years of HDHP coverage, the employees learned to shop for the lowest prices, despite having had access to online tools showing prices for doctor visits, tests, and other services (26).

M. Gregg Bloche (27) has raised concerns about the potential for consumer-directed health plans to induce a “reverse Robin Hood effect” in which low-income HDHP enrollees, who are less able than wealthier ones to contribute to their health savings accounts, quickly exhaust their pretax contributions and are forced to pay posttax income on out-of-pocket expenses. Further, low-income individuals who are unable or unwilling to pay their deductibles on outpatient diagnostic care, resulting in hospitalization or other therapeutic interventions, are less likely to reap the benefits of fully insured (or nearly fully insured) postdiagnostic treatment than wealthier enrollees who meet the deductible and therefore receive full coverage.

## Recommendations

- 1. To help contain health insurance premiums and cost sharing, the health care system must accelerate its efforts to reduce overall health care spending in ways that do not rely principally on shifting the cost burden onto insured persons who cannot afford to pay more for their medical care. Among the ways that health care spending may be curbed without imposing excessive costs on insured persons include:**
  - a. Reforming the way health care is paid for and delivered and encouraging value-oriented rather than volume-based care;**
  - b. Promoting team-based care that emphasizes prevention as well as cooperation and coordination among physicians, hospitals, and other health care professionals;**
  - c. Enhancing the transparency of price and quality data so that patients, employers, and payers are better informed about the actual costs and quality of health care services;**
  - d. Allocating resources with a focus on medical efficacy, clinical effectiveness, and need, with consideration of cost based on best available medical evidence to ensure that limited health care resources are directed to cost-effective services.**

Growth levels of U.S. health care spending have fluctuated in the past 15 years, hitting a high of 8.6% before steadily dropping (28). In 2008, health care spending rose at historically low levels, probably as a result of the economic downturn and an unstable recovery, and cost-sharing burdens shifted, resulting in lower health care use and reduced Medicare and Medicaid payment levels (29). The Centers for Medicare & Medicaid Services (CMS) Office of the Actuary projects that health care spending will resume its upward trajectory during the next few years, to an average growth rate of 5.8% from 2014 to 2024 (30). This growth may be attributed, in part, to expanded ACA coverage, an aging population, and improved economic performance. Cost-sharing increases are expected to moderate dramatic spending growth.

Although cost sharing may temper overall health care spending, it likely does so by discouraging the use of services that benefit patient health as well as those not supported by evidence. If patients delay or forgo screening and other diagnostic services because of cost, it may lead to more severe health problems in the future, including chronic disease that is costly to manage. Although outside the scope of this paper, the health care sector, including public and private health

insurers, must explore and implement policies that bend the cost curve while reducing the financial burden of obtaining and keeping coverage. Over the years, ACP has supported policies encouraging the use of high-value care, leading to lower costs and positive health outcomes. The College has strongly supported the patient-centered medical home and other team-based care arrangements that emphasize collaboration and close cooperation among health professionals that deliver efficient, high-value care at a lower cost (31). To make it easier for consumers to shop for high-quality, low-cost care, the College has offered recommendations on price transparency (32). The College has worked to educate its members about the importance of delivering high-value, cost-conscious care (33) and has provided policy recommendations on effective and efficient use of health care resources (34).

**2. To encourage use of high-value health care, employer-sponsored health plans should:**

- a. Consider implementing value-based insurance design strategies that reduce or eliminate out-of-pocket contributions for services proven to offer the greatest comparative benefit, with higher cost-sharing for services with less comparative benefit. Such strategies should be based on rigorous comparative effectiveness research by independent and trusted entities that do not have a financial interest in the results of the research. The goal should be to ensure that high-value cost-sharing strategies encourage enrollees to seek items and services proven to be of exceptional quality and effectiveness and not just on the basis of low cost;**
- b. Consider implementing income-adjusted cost-sharing approaches that reduce or directly subsidize the expected out-of-pocket contribution of lower-income workers to avoid creating a barrier to their obtaining needed care.**

The literature indicates that cost sharing may dissuade health insurance enrollees, especially those who are sick or have a low income, from seeking both unnecessary and necessary care. Forgoing necessary care may delay diagnosis of serious health problems, leading to higher health care costs from chronic disease management (35). To encourage individuals to seek medically necessary services and items of proven effectiveness, value-based insurance design (VBID) strategies should be expanded. Doing so may reduce overall health care costs, which may lead to lower premiums and out-of-pocket requirements while encouraging the use of services that contribute to desired health outcomes. The VBID approach is associated with better medication adherence (36, 37) and may lead to reduced costs (38). The ACA promotes the concept of VBID by requiring most plans to cover evidence-based preventive services, including those rated “A” or “B” by the U.S. Preventive Services Task Force, without cost sharing. The Medicare Payment Advisory Commission has considered VBID as a way to reform the Medicare benefit structure, and a survey of large firms found that most intended to make it a part of employee benefits (39). The CMS has announced that it will test VBID strategies in its Medicare Advantage Plans (40).

As employers shift more of the cost of health insurance on employees and more individuals are enrolled in health plans with high deductibles, efforts must be made to ensure that necessary care is received and enrollees are protected from financial ruin. This is particularly important because most enrollees do not have the financial resources to cover out-of-pocket costs from a serious medical event. By integrating VBID strategies into existing HDHPs, ESI and other offerings may be able to better protect those with chronic illness or low incomes from excessive medical costs while preventing enrollees from forgoing or delaying care.

Although VBID for prescription drugs is relatively well studied, further evidence is needed to support wider implementation. Evidence is lacking regarding the health effects and cost of such programs, and more experience is necessary to effectively target value-based plans to populations in which it will have the most influence (41). More research also is needed to determine how to

structure VBID to achieve cost savings in addition to improving quality of care (42). Other approaches should be tested, including an exemption from the deductible for services used to manage chronic conditions (43). A proposal by the Center for Value-Based Insurance Design recommends that HDHPs be allowed to exempt secondary prevention services (that is, “the prevention of complications from, or progression of, chronic disease”) from deductibles (44).

Another approach that may protect lower-income workers from high cost sharing is for ESI plans to adjust cost sharing based on income rather than an arbitrary, one-size-fits-all structure (45). For example, an employee who earns 250% FPL would have an annual deductible of \$500, whereas a higher-income worker would be subject to a deductible of \$1,000; alternatively, employees with higher incomes might have an annual out-of-pocket spending cap of 6%, whereas their lower-income coworkers would have a 3% cap. Medicaid has adopted this concept by mandating nominal cost sharing for its poor enrollees and by income adjusting maximum allowable copayments for institutional care and other services (46). Cost-sharing subsidies that enhance the generosity of coverage for lower-income marketplace-based QHPs were established in the ACA. Some large employers, such as Pitney Bowes, have offered health coverage with income-adjusted deductibles, out-of-pocket maximums, and company contributions (47). Under the Pitney Bowes plan, an hourly employee may have a deductible of \$1500 with an out-of-pocket maximum of \$3000 whereas a salaried director has a deductible of \$2500 and a \$5000 out-of-pocket maximum.

Proponents of income-adjusted cost sharing argue that fixed cost-sharing requirements are regressive because low-income workers will pay a larger proportion of their income toward medical care (4, 45). An income-adjusted cost-sharing approach may also minimize overuse of health services among higher-income workers, who direct a smaller portion of their income to health coverage costs and thus have less “skin in the game.” Several legislative changes may need to be made to enable income-adjusted cost sharing, including changing the ACA’s annual out-of-pocket spending cap to allow higher caps for higher earners (that is, change the out-of-pocket maximum from a fixed \$6,600 per individual and \$13,200 per family to 6% of household income) and clarifying existing health insurance nondiscrimination laws to allow income-scaled cost sharing (4).

### **3. Cost-sharing provisions under the Patient Protection and Affordable Care Act should be improved by:**

- a. Expanding eligibility for qualified health plan premium tax credits and cost-sharing subsidies for families unable to afford employer-sponsored insurance (elimination of the “family glitch”);**
- b. Enhancing the affordability of marketplace-based qualified health plans by expanding cost-sharing assistance eligibility, increasing premium tax credits and cost-sharing subsidies, and eliminating the premium cap indexing policy.**

The U.S. Department of Health and Human Services (HHS) Office of the Assistant Secretary for Planning and Evaluation estimates that as of September 2015, 17.6 million uninsured people had gained insurance as a result of the ACA (48). Evidence shows that QHP enrollment is highest among those who receive more generous premium tax credits and cost-sharing subsidies. Because low-income enrollees are particularly cost conscious, it is important to maintain adequate premium and cost-sharing assistance so that necessary care is financially accessible to them. Enrollment is lower among people with incomes in the 251% to 400% FPL range, possibly because subsidy levels drop as income increases. According to enrollment data released in March 2015, 80% of consumers who selected QHPs in federally facilitated marketplace states in 2015 had incomes in the 100% to 250% FPL range, thus were eligible for premium tax credits and cost-sharing subsidies. Yet after the 2014 enrollment season, 58% of uninsured adults surveyed said they visited the marketplace but did not enroll in coverage because costs were too high or they could not afford coverage (49). Higher-income individuals—those in the 250% to 400% FPL range—may receive

insufficient, limited premium subsidies and no cost-sharing assistance. The subsidies in this income range would cap premiums at 8.1% to 9.56%, above the ACA's affordability standard exempting from the individual mandate those who would have to pay more than 8% of their income for coverage (50). More relevant to this paper is that the affordability standards do not consider cost sharing. Even if an enrollee's premium is well under the 8% threshold, the deductibles, copayments, coinsurance, and other financial responsibilities may push the total cost of coverage well beyond the law's definition of affordable.

Even with the QHP out-of-pocket cap, the financial burden posed by cost sharing may be substantial, especially for those ineligible for cost-sharing subsidies. The Government Accountability Office estimates that the 2014 out-of-pocket maximum of \$6,350 for a person at 251% FPL (\$28,725) would consume 22% of annual income (51). The cost-sharing burden might be even higher if an enrollee seeks care from an out-of-network physician or other health care professional, because the out-of-pocket maximum may not apply to out-of-network cost sharing. This is a concern because many QHPs have narrow network plans that limit enrollees' choice of physician, potentially forcing them to go out of network and exempting them from the out-of-pocket cap (51).

To address the premium and cost-sharing affordability issue, Blumberg and Holahan (51) of the Urban Institute propose tying the premium tax credit level to the second least-expensive gold-tier plan (that is, 80% actuarial value) rather than the second least-expensive silver-tier (70% actuarial value) plan. This change would enhance coverage, particularly for those with incomes in the 250% to 400% FPL range. Because the gold-tier plans have a higher actuarial value, the cost sharing would be reduced regardless of whether the enrollee is eligible for a cost-sharing subsidy. The proposal also would reduce the percentage-of-income premium caps to make the premium tax credits more generous across the board. Under the revised schedule, enrollees in the 138% to 150% FPL range would have premiums capped at 1.0% to 2.0% rather than 3.02% to 4.02% of annual income. An enrollee whose income is 400% FPL would pay no more than 8.5% of it toward premiums. The proposal would expand cost-sharing subsidies up to 300% FPL, granting those in the 250% to 300% FPL income range an enhanced actuarial value of 85%. Finally, the authors proposed discontinuing the premium subsidy cap index, which increases the cost-sharing burden as health care costs rise. The Urban Institute's proposal to establish a new, more generous subsidy schedule would protect higher-income individuals from exorbitant premiums and cost sharing while providing slightly better coverage to those in the lower range of the schedule. Doing so might encourage higher enrollment and a lower uninsured rate, especially among those who indicate that current health insurance costs are too high to justify signing up.

Another potential solution to rising ESI out-of-pocket costs is to make it easier for moderate-income workers and their families to qualify for subsidized QHP coverage, which might be achieved by fixing the so-called family glitch. The ACA states that if a worker's ESI costs exceed 9.5% of annual household income, he or she may qualify for a premium tax credit and other subsidies. However, this cut-off applies only to the individual employee's coverage and does not consider the cost of a family plan, essentially disqualifying many workers and their families from enrolling in more affordable coverage. The family glitch affects an estimated 2 million to 4 million dependents (including half a million children), so revising the regulation would help a substantial number of families locked into expensive ESI (52).

#### **4. Stakeholders must work together to enhance health insurance literacy and promote better, more accessible, and objective information about cost-sharing requirements and health insurance plan design.**

- a. Federal and state governments, navigators and other assisters, community and health professional organizations, health insurers, and other stakeholders must educate enrollees about the availability of premium tax credits, cost-sharing subsidies, and free or low-cost preventive care and why it is important. Efforts must be made to educate enrollees about value-based cost sharing.**

As more individuals enroll in health plans with high deductibles, stakeholders must emphasize the availability of free preventive care and other necessary services that may be exempt from deductibles. Although proponents of HDHPs argue that they promote cost consciousness, this goal can be achieved only if the patient has ample health and health insurance literacy and has access to understandable health care cost and quality information to make informed decisions. The literature shows that even when preventive services are exempt from cost sharing, patients may forgo such services because they are unaware that such services are free (53). A survey of uninsured individuals and public or private insurance enrollees found that although most respondents could identify terms such as premiums and appeal, fewer understood the terms step therapy (37%) or medically necessary (60%) (54). Twenty-three percent could name the characteristics of a preferred provider organization. Only 21% could accurately calculate out-of-pocket costs involving a deductible, a copayment, and coinsurance. To educate enrollees, health plans must provide understandable, multilingual, accessible information explaining health insurance terms, which services are and are not subject to a deductible, the problems that may arise if the enrollee forgoes or delays necessary care, and the importance of evidence-based preventive services. In addition, physicians and their health care teams may have a role in ensuring adherence to necessary care by following up with patients to remind them of prescription regimens and other health management activities. Patient navigators also may be recruited to guide the patient toward better medical adherence (55).

Individuals who remain uninsured because of cost concerns should receive targeted support from navigators, brokers, and other assisters to guide them toward affordable comprehensive coverage and to indicate the availability of financial assistance. Enrollment in health insurance marketplaces met government projections in 2014 and 2015. However, thousands remain uninsured and many are unaware of or misinformed about the necessity of health coverage and what financial resources may be available. An Urban Institute survey conducted after the 2014 enrollment period reported that many adults who remained uninsured did so because they believed QHP coverage was unaffordable even with financial subsidies. Part of the reason for this lack of engagement may be inadequate knowledge about the availability of subsidies: 72% of the uninsured who did not visit a marketplace heard “little or nothing” about subsidies (49). Sixty-eight percent of uninsured adults had not visited a marketplace. The Commonwealth Fund found that marketplace visitors who did not obtain coverage were more likely than those who did select a plan to report difficulties in comparing different insurance plans with regard to potential out-of-pocket costs, premiums, covered benefits, and available physicians and other health care professionals (15).

Evidence shows that navigators, in-person assisters, insurance brokers, and other similar entities provide crucial information, raise awareness about the law, and help marketplace shoppers apply for coverage. Seventy-eight percent of individuals who received personal assistance during the health care decision-making process obtained coverage (56). Assisters can guide shoppers to plans that meet their affordability and usage needs, explain health insurance terms, and aid in the application process. Some states have approved policies to hinder the work of navigators and assisters (for example, by requiring fingerprinting) or have done little to support or fund their work. Because assister programs play an important role in helping people find affordable coverage, state and federal governments must continue to support them, particularly among populations in which enrollment has lagged, such as Latinos (57).

Some state-based health insurance exchanges are implementing tools for health plan shopping that match consumers with plans that fit their level of health care use, income, and other factors. Kentucky’s health insurance marketplace, kynect, offers a pricing tool that helps consumers find a plan based on medical conditions, current health providers, frequency of physician visits, prescription drug use, and future medical needs. The District of Columbia HealthLink marketplace offers a similar tool. Pricing tools may help direct sicker individuals to more comprehensive plans with cost sharing that reflects their needs. In addition, tools that replicate real-life scenarios, including face-to-face counseling,

to illustrate plan selection and cost sharing also may help shoppers and enrollees better understand concepts (58).

Once insured, enrollees may be confronted by unexpectedly high medical bills. Some states are taking action to ensure that patients are aware of their cost-sharing responsibilities and to minimize the potential for surprise out-of-pocket charges. For example, a patient may receive inpatient care by an in-network surgeon in an in-network hospital. However, the surgical team may include an out-of-network anesthesiologist, exposing the patient to a balance billing charge despite having received care in an in-network hospital. In Texas, 45% of United HealthCare, 56% of Humana, and 21% of Blue Cross Blue Shield in-network hospitals have no in-network emergency room physicians (58). New York recently passed legislation to protect patients from surprise bills that establishes strict disclosure and transparency requirements and a reimbursement process for out-of-network providers (with an option to appeal to an independent dispute resolution board if they disagree with the amount), and ensures enrollees are committed only to in-network costs (59, 60). Further research is needed to find a solution that protects patients while establishing predictable reimbursement schedules for physicians and other health care professionals.

#### **5. A large-scale demonstration should be implemented to test the short- and long-term effects of cost sharing in different populations.**

The RAND Health Insurance Experiment is widely cited as the “gold standard” for understanding the effects of cost sharing (61). The study, funded by the U.S. Department of Health, Education, and Welfare (the precursor to HHS), included a sample of 5800 participants younger than 64 years with varying demographics and locations in the United States. Participants were randomly assigned to different health insurance plans with various levels of coinsurance, ranging from zero to 95%. As mentioned earlier, the chief takeaway from the experiment was that cost sharing caused enrollees to forgo both unnecessary and necessary care.

Although the RAND experiment continues to be cited and considered relevant, it is more than 40 years old. A new, large-scale project is needed that reflects today’s health insurance landscape, wide array of innovative services and technologic advancements, cost-sharing complexities, and rising levels of chronic disease (17). The HHS should fund such a study to evaluate modern health insurance options so that evidence-based policy decisions can be made that lead to lower costs, better patient health outcomes, and more plan satisfaction.

## **Conclusion**

Despite some moderation, health care spending remains substantial, and ESI plans and other coverage programs have responded by shifting more financial responsibility to the health plan enrollee. The shift may accelerate as employers attempt to avoid the so-called Cadillac tax, which seeks to raise revenue from generous health insurance plans. Underinsurance is emerging as a serious problem that may be more difficult to tackle than uninsurance. Evidence shows that when cost sharing is imposed, consumers may respond by reducing their use of both necessary and unnecessary care. Although proponents of HDHPs claim that deductibles encourage judicious use of insurance and push consumers to shop for lower-cost, high-quality care, it is unclear whether this is true. An alternative approach is needed to reduce spending through systemic reform of the health care sector, protect low-income workers from overly burdensome out-of-pocket costs, enhance subsidies for marketplace-based QHPs, increase health care insurance literacy, and direct shoppers to the right type of plan so that patients are shielded from financial ruin and insurance can function as intended.

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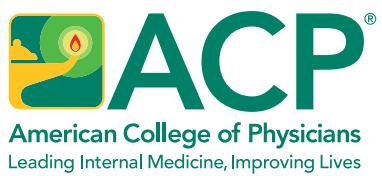
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