



NEWS RELEASE

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NEW COMMONWEALTH FUND REPORT: CONSUMER COST-SHARING IN AFFORDABLE CARE ACT MARKETPLACE PLANS INCREASED MODESTLY FROM 2015 TO 2016

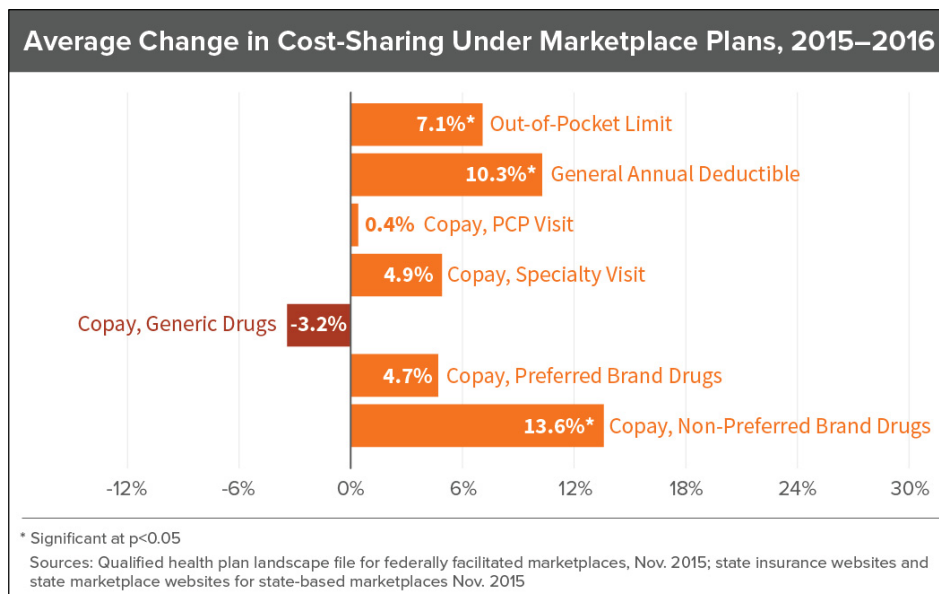
Comparison of Marketplace and Employer Plans Finds Fewer Consumer Protections in Employer-Sponsored Plans

New York, NY, May 12, 2016—Out-of-pocket costs such as copayments and deductibles rose moderately in Affordable Care Act (ACA) marketplace plans between 2015 and 2016, for the more than 40 percent of enrollees who are not receiving cost-sharing subsidies, according to a new Commonwealth Fund study. While the law reduces cost-sharing for low-income people enrolled in silver plans, people with annual incomes over about \$30,000 have plans without these subsidies.

The study found that cost-sharing in gold-level marketplace plans was on average about the same as in employer plans. However, employer plans have fewer mechanisms in place to protect consumers from rising out-of-pocket costs.

In *Changes in Cost-Sharing for Health Plans Sold in the ACA’s Insurance Marketplaces, 2015 to 2016*, Jon Gabel and colleagues at *NORC* at the University of Chicago examined deductibles, copayments, coinsurance, and out-of-pocket limits (i.e., the annual cap on what enrollees would have to spend on their health care) in plans offered in ACA marketplaces across 49 states and Washington, D.C. They compared these findings with cost-sharing in employer-based plans in 2015.

The authors found that cost-sharing increased overall in the marketplaces in 2016 for out-of-pocket limits, annual deductibles, and brand-name drugs not included in a plan’s list of preferred prescriptions.



However, copayments for primary care office visits remained constant, copayments for generic drugs declined by more than 3 percent, and there was little change in the percentage of plans that require enrollees to meet a deductible before it begins paying for drugs and office visits.

“Affordability of health care is a top concern for consumers,” said Sara Collins, Vice President for Health Care Coverage and Access at The Commonwealth Fund. “More than 40 percent of people buying plans in the Affordable Care Act marketplaces don’t qualify for plans with reduced cost-sharing, so it is important that we track people’s cost-sharing obligations and the effect they have on their ability to get the care they need.”

Plan Mix Matters

According to the report, some of the overall increase in cost-sharing in 2016 may be due to the mix of plans offered. Bronze and silver plans require more cost-sharing from consumers than gold and platinum. Therefore, an increase in the number of bronze and silver plans offered contributed to an overall rise in cost-sharing among all plans in the marketplaces.

In 2016, nearly all bronze plans (99.7 percent) had an annual deductible, while less than half (40 percent) of platinum plans did. Among 2016 marketplace plans with deductibles, bronze plan deductibles averaged \$5,724, silver plans averaged \$3,100, gold plans averaged \$1,257, and platinum plan deductibles averaged \$484. Thus, some of the overall deductible increase of 10.3 percent in 2016 reflects the shift toward less-expensive plans with higher potential out-of-pocket costs.

Comparing Marketplace and Employer-Based Plan Cost-Sharing

The study found that marketplace plans are considerably more likely to require that people meet their deductible before their coverage for prescription drugs kicks in than are employer-based plans (54 percent for silver plans versus 11 percent for employer-based plans in 2015). Moreover, copayments for prescription drugs other than for generics are on average higher in marketplace plans than in employer-based ones.

However, employer-based plans are more likely to require beneficiaries to meet a deductible for primary care visits than marketplace plans. For example, 28 percent of silver plans require the patient to meet a deductible before coverage for primary care compared with 35 percent for employer-based plans. The average copayment for primary care visits under marketplace plans was \$29, comparable to the average copayment of \$24 under employer-based plans. While most marketplace plans require a copayment for primary care, a larger number of employer-based plans are using coinsurance. Coinsurance requires patients to assume greater financial risk for the cost of care, often obligating patients to pay 20 percent of the cost.

Moving Forward

The authors note that as medical care expenses continue to rise, consumers are likely to be more protected from rising out-of-pocket costs in the ACA marketplaces than in employer-based insurance. That’s because marketplace plans must maintain a constant actuarial value (for example, 70 percent of medical costs for silver plans), while employer-based plans do not have such requirements, other than a minimum standard. Over the past 15 years, there has been an increase in lower-valued, high-deductible plans offered by employers, and this trend is expected to continue.

“It is certainly promising that cost-sharing only increased moderately in marketplace plans this year. However, health care costs will likely continue to rise in the next few years, and many consumers will feel the impact of those increases,” said Commonwealth Fund President David Blumenthal, M.D. “The

financial protections the Affordable Care Act provides for those buying plans on the marketplaces will help assure people can continue to afford the health care they need. But more work is needed to lower growth in medical costs overall.”

When the embargo lifts, the study will be available at

<http://www.commonwealthfund.org/publications/issue-briefs/2016/may/cost-sharing-increases>.

Methods

For this study, the authors analyzed data on 4,153 plans in 2015 and 3,700 in 2016 that were offered in individual marketplaces in 49 states and Washington, D.C. Data on plans in states that rely on the federal marketplace are from Qualified Health Plan Landscape Files maintained by the Centers for Medicare and Medicaid Services. Data on states with their own exchanges are from marketplace websites maintained by state departments of insurance.

For PY (program year) 2014–2015, the authors downloaded data from all carriers and plans within three “rating areas,” which all insurers must use to set their rates: one urban, one suburban, and one rural. For PY 2016, they collected data on up to six rating areas, up to two within each sampling stratum (urban, suburban, and rural), depending on how many rating areas were present within each state. After a series of rating areas had been sampled, NORC conducted a second stage of sampling in 2016 for state-based marketplaces; for each carrier offering plans in a given rating area, one plan was sampled from each of the four plan tiers (if the carrier offers at least one plan in each tier). In states that rely on the federal marketplace, all plans within the sampled rating areas were collected. Weights reflect the probability that they would have selected the rating area from among the sample, as well as the population of the rating area, with an additional sampling weight in PY 2016 reflecting the probability of sampling a plan in a given tier in a given rating area. Statistical significance is designated at $p < 0.05$.

The Commonwealth Fund is a private, nonprofit foundation supporting independent research on health policy reform and a high performance health system.