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Key Facts You Need to Know About: Cost-Sharing Reductions

In January 2014, new health insurance Marketplaces (also called exchanges) began to provide a way for people to buy affordable health coverage on their own. This collection of key facts explains the cost-sharing reductions that are available to low income individuals and families, to help them afford health care under their Marketplace plans.

What are cost-sharing reductions?

In January 2014, when health coverage became available in the new Marketplaces (also known as exchanges), some people receiving premium tax credits to help pay their premiums also were eligible to receive cost-sharing reductions to help them pay their cost-sharing charges. (For more information about the premium tax credit, see the Center on Budget and Policy Priorities' (CBPP) *Key Facts You Need to Know About Premium Tax Credits.*) These subsidies reduce the deductibles, copayments, and other out-of-pocket charges that people eligible for cost-sharing reductions pay when they use benefits covered by their health plan.

Who is eligible for cost-sharing reductions?

Individuals and families with incomes between the federal poverty line ($23,550 for a family of four in 2013) and 250 percent of the poverty line ($58,875 for a family of four in 2013) are eligible for cost-sharing reductions (or CSRs) if they are eligible for a premium tax credit and purchase a silver plan through the health insurance Marketplace in their state. People with lower incomes receive the most assistance.

How are the cost-sharing reductions provided?

People eligible for cost-sharing reductions who enroll in a silver plan will automatically receive a version of the plan with reduced cost-sharing charges, such as lower deductibles, out-of-pocket maximums or copayments. Unlike the premium subsidies, cost-sharing reductions are not provided as a tax credit and they do not have to be "reconciled" when people file their taxes for the year the cost-sharing reductions were received.

What is a silver plan?

A silver plan is one type of plan available through both the Marketplaces and each state's individual market outside the Marketplace. Plans offered in the individual market inside and outside the Marketplace generally must fit within one of four metal tiers: bronze, silver, gold, and platinum. These tiers are defined by what's known as actuarial value.

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What is actuarial value?

In general, actuarial value percentages represent how much of a typical population's medical spending a health insurance plan would cover. The actuarial value is 60 percent for bronze plans, 70 percent for silver plans, 80 percent for gold plans, and 90 percent for platinum plans. The higher the actuarial value, the more the plan covers of a typical population's costs (and thus the typical population would pay less out-of-pocket). A lower actuarial value means the plan covers less of the costs (and the population pays more). The actuarial value calculation focuses mainly on cost-sharing charges. This means that a bronze plan generally would have higher overall enrollee cost-sharing than a gold plan would. For more information about actuarial value and the metal tiers, see CBPP's *Key Facts You Need to Know About Cost-Sharing Charges*.

Will the cost-sharing reductions lower the out-of-pocket charges under a plan by a specific amount?

No, the cost-sharing reductions increase the actuarial value of a standard silver plan, which results in lower out-of-pocket charges. (Actuarial value is discussed further below.) Specific cost-sharing charges will vary from silver plan to silver plan with the same actuarial value; in most states, insurers have significant flexibility to set these charges.

Table 1 (based on standardized plans established in New York) shows an example of how various cost-sharing charges in a standard silver plan could be reduced to meet each of the cost-sharing reduction levels. For example, a person with annual income of $22,000 enrolled in a silver plan would be subject to a $250 deductible under the standard silver plan.

Table 1

How Does the Cost-Sharing Reduction Level Affect Cost-Sharing Charges?

	Standard Silver – No CSR	CSR Plan for 201-250% FPL ($22,981-$28,725)	CSR Plan for 151-200% FPL ($17,236-$22,980)	CSR Plan for up to 150% FPL (up to $17,235)
Actuarial Value	70% AV	73% AV	87% AV	94% AV
Deductible (individual)	$2,000	$1,750	$250	$0
Maximum OOP Limit (individual)	$5,500	$4,000	$2,000	$1,000
Inpatient hospital (After deductible)	$1,500/ admission	$1,500/ admission	$250/ admission	$100/ admission
Physician visit (After deductible)	$30	$30	$15	$10

(The deductible is the amount that the person must pay each year before the plan starts to pay for most covered services. CBPP's *Key Facts You Need to Know About Cost-Sharing Charges* provides an explanation of the different types of cost-sharing charges.)

Does a person eligible for a cost-sharing reduction have to keep track of her spending on health care services, so she can get reimbursed by the health plan or the federal government?

No. The cost-sharing charges for the silver plan are automatically reduced. For example, consider the situation of Jane, a single woman buying her own health insurance. If Jane is not eligible for CSRs and enrolls in the standard silver plan shown in Table 1, she would have a $2,000 annual deductible and a $30 copayment for each physician visit after that deductible. She could be charged no more than $5,500 in out-of-pocket charges (deductibles, copayments, and coinsurance) for in-network covered benefits for the year. However, if Jane has income equal to 200 percent of the federal poverty line, she would face lower cost-sharing charges, as shown in the column of Table 1 for the plan with an 87 percent actuarial value. For example, she would have a $250 deductible instead of the $2,000 deductible under the standard silver plan. She would pay $15 for each doctor visit (after meeting the deductible) instead of $30.

Will people who have the same income spend the same amount of money out-of-pocket if they qualify for a cost-sharing reduction?

No. How much anyone spends out-of-pocket depends on what health care they use and the details of the specific health insurance plan they select. As Figure 1 shows, two people in the same

Figure 1

Two People, One Silver Plan

Silver Plan: 87 percent AV, $250 deductible, $2,000 out-of-pocket maximum, $250 copayment for hospital admission, $15 copayment for physician office visit

Example: John		Example: Jane	
	Health Care: 3 non-preventive physician visits Total Cost $300 John's share of the cost: **$265 ($250 deductible + $15 copayment)**		Health Care: Hospitalized, 3 physician visits, 20 physical therapy visits Total Cost $7,300 Jane's share of the cost: **$845 ($250 deductible + $250 hospital copayment + $15 for each of 23 office visits)**

silver plan with the same cost-sharing reduction will pay different amounts because they use different medical services.

Are there any requirements for how insurers must design their cost-sharing reduction plans?

Yes. Insurers offering coverage in the Marketplaces must offer variations of each standard silver plan that corresponds to the different cost-sharing reduction levels. A standard silver plan has an actuarial value of 70 percent. Insurers will provide several variants of each silver plan: one with a 73 percent actuarial value for people with incomes between 200 percent and 250 percent of the poverty line, one with a 87 percent actuarial value for those with incomes between 150 percent and 200 percent of the poverty line, and one with a 94 percent actuarial value for those with incomes between 100 percent and 150 percent of the poverty line. Each silver plan variation will cover the same benefits and include the same health care providers in its network as the standard silver plan on which it is based.

Federal rules also specify *how* cost-sharing charges under a standard silver plan should be adjusted to increase their actuarial values. First, the out-of-pocket maximum is reduced. This is the maximum amount that an enrollee would pay out of pocket each year for in-network items and services covered by the plan.

The 2014 out-of-pocket maximum amounts for the income levels of people receiving cost-sharing reductions appear in Table 2. For example, a person with income at 140 percent of the poverty line will receive a silver plan with an out-of-pocket limit no greater than $2,250. The enrollee would not have to spend more than the maximum annual out-of-pocket limit on deductibles, copayments, and coinsurance for in-network, covered items and services during the course of the year.

After the insurer reduces the maximum out-of-pocket limit for a plan to an amount no greater than the amount in the Table 2 below, further adjustments may be needed so that the plan reaches the actuarial value target for the specific cost-sharing reduction level. In general, insurers can make these reductions in the deductible

Table 2

How Do Cost-Sharing Reductions Affect Maximum Out-of-Pocket Limits?

Income		**Maximum Annual Out-of-Pocket Limit**		**Actuarial Value of Plan**
% of Federal Poverty Line (FPL)	Dollar Amount (for individuals in 2013)	Individual	Family	
100-150% FPL	$11,490 -$17,235	$2,250	$4,500	94%
150-200% FPL	$17,235 - $22,980	$2,250	$4,500	87%
200-250% FPL	$22,980 - $28,725	$5,200	$10,400	73%

and/or the copayments or coinsurance for each silver plan variation. However, some states have set specific standards for the cost-sharing charges insurers may establish under the cost-sharing reduction plans.

Under the health reform law, weren't people between 250 and 400 percent of the poverty line supposed to be eligible for help with cost-sharing charges as well?

Yes, the law calls for people with incomes from 250 to 400 percent of the federal poverty line to also have their maximum out-of-pocket limits reduced, specifically an annual out-of-pocket limit equal to two-thirds of the regular maximum. However, the law also specified that people in this income range continue to be enrolled in a silver plan with an actuarial value of 70 percent. To both reduce the out-of-pocket limit for a standard silver plan and maintain its actuarial value of 70 percent would require an increase in the plan's upfront cost-sharing charges like the deductible. This would have had the result, however, of requiring people with incomes between 200 percent and 400 percent of the poverty line to pay higher deductibles, coinsurance and co-payments when they receive health care services than people with higher incomes would be required to pay under the standard silver plan. For this reason, the Administration did not implement the reduced maximum out-of-pocket limits for people in this income range. Even though people with incomes in this range may be eligible for a premium tax credit, if they purchase a silver plan, they would *not* be enrolled in a variation of the silver plan with cost-sharing reductions.

How are insurers paid for providing the cost-sharing reductions?

The federal government reimburses each health insurer for the estimated costs of reducing the cost sharing that would otherwise be charged under their standard silver plans for all the plan enrollees eligible for cost-sharing reductions. The payments are provided over the course of the year. Later, the federal government will compare the upfront payments to the costs the insurer actually incurred to provide cost-sharing reductions to eligible people, and make adjustments needed to account for any under- or overpayments.

How will someone eligible for cost-sharing reductions select a plan?

The Marketplace or exchange web site is likely to be the easiest place to compare various plans. Once a person has applied and received a determination that they are eligible for both premium credits and cost-sharing reductions, the web site will display the silver plan variations corresponding to the individual's cost-sharing reduction level. In other words, the plans that the individual sees will have the cost-sharing reductions built in. Most people are expected to have multiple silver plan options to choose from in each state. This means that people eligible for cost-sharing reductions will also have multiple plan options. Each of the standard silver plans may have differences in benefits, visit limits, provider networks, and drug formularies. One insurer may offer different silver plan options, each with its own set of cost-sharing reduction variations that may differ substantially in terms of the specific deductibles and co-payments charged to enrollees.

Does it matter which silver plan someone getting the cost-sharing reductions selects?

Yes. Silver plans are going to be different in various ways, as noted above, in addition to the cost-sharing charges. For example, one silver plan may include the doctor or hospital a person now sees in its network, while another may not. It will be important for people, including those receiving cost-sharing reductions, to be aware of such differences as they decide which plan to choose.

Would it ever make sense for someone eligible for cost-sharing reductions to buy a bronze plan instead of a silver plan?

If a person with income below 250 percent of the poverty line enrolls in a bronze plan instead of a silver plan, he would not be eligible for cost-sharing reductions. He would have to pay whatever out-of-pocket charges are required under the bronze plan. In most cases, it will make the most sense for people at the lower end of the income scale to pick a silver plan and receive cost-sharing reductions. But the choice will depend on an individual's situation and preferences. Consider the example in Figure 2.

John has income equal to 200 percent of the federal poverty line and is eligible for a premium credit of $3,552 per year to help him purchase coverage. He is also eligible for a cost-sharing reduction if he enrolls in a silver plan. With the premium credit, he could get a silver plan by paying $121 per month of his own money, with the credit taking care of the remaining cost of getting the health insurance. With the cost-sharing reduction, he is able to get a plan with a deductible of $250. The plan also caps his out of pocket costs for in-network, covered benefits at $2,000 for the year.

If John picks a bronze plan, he would pay nothing toward the premium because his premium credit covers the entire cost. But the cost-sharing

Figure 2

Comparing Different Plan Tiers

John
Age: **24**
Premium Credit: **$3,552**
Income: **$22,980**

	Example 1: Silver Plan	Example 2: Bronze Plan
	Total Premium: **$5,000** John's Premium Contribution: **$121/month** Plan AV with CSR: **87%**	Total Premium: **$3,000** John's Premium Contribution: **$0 / month** Plan AV without CSR: **60%**
	Sample Silver-CSR Plan (enrollee pays)	**Sample Bronze Plan (enrollee pays)**
Deductible	$250	$3,000
OOP Maximum	$2,000	$6,350
Inpatient Hospital	$250 per admission	50% of the charge
Physician Visit	$15	$35

charges he could face should he need health care services would be significantly greater in the bronze plan than in the silver plan with a cost-sharing reduction. He would face a $3,000 annual deductible in the bronze plan, and up to $6,350 in out-of-pocket costs if he ends up having very high medical expenses.

If John does not expect to use much health care, he may choose to buy the bronze plan and forgo the cost-sharing reduction. If he does that, he would be taking a risk that he may have to pay high out of pocket charges if he gets sick, but he may decide the risk is worth taking because he would pay nothing in premiums (because of the premium tax credit) in order to purchase the bronze plan.

Might someone eligible for a cost-sharing reduction be better off getting a gold or platinum plan instead of a silver plan?

In general, a person with income at 200 percent of the poverty line or less would be better off enrolling in a silver plan and taking advantage of the cost-sharing reduction. For example, if John (who has income equal to 200 percent of the poverty line) used his premium tax credit to purchase a gold plan, he would pay more for his share of the premium — a total of roughly $200 per month if the gold plan costs $6,000 per year — than he would pay for the silver plan with a cost-sharing reduction. Moreover, under the cost-sharing reduction variation of the standard silver plan John is eligible to receive, the cost-sharing charges would also be lower compared to a gold plan. The gold plan has an actuarial value of 80 percent (with, say, a $600 deductible and $25 physician-visit copayments), while the cost-sharing reduction John can get would make an 87 percent actuarial value plan available to him (with a $250 deductible and $15 physician copayments in our example). So, in this case, John would clearly be better off from a pure cost perspective buying a silver plan and taking advantage of the cost-sharing reduction because it would mean paying less toward the premium *and* paying less out-of-pocket when he uses health care services.

If John's income were at 225 percent of the poverty line, the decision may not be as clear. He would be eligible for a 73 percent actuarial value version of the silver plan, but the difference between cost-sharing charges under that plan and the 70 percent standard silver plan are not likely to be dramatic. If John wants more generous coverage and can manage to pay a higher premium, he might decide to choose an 80 percent gold plan.

Does someone have to take the premium tax credit in advance in order to receive the cost-sharing reduction?

No. To get the cost-sharing reductions, a person only needs to be eligible for the premium tax credit. The person can still get the cost-sharing reductions if they choose to wait until they file their taxes to receive the premium tax credits.

What happens if someone receiving a cost-sharing reduction experiences a change (such as a change in income) during the course of the year?

A change in circumstances during the year may result in a change in eligibility for cost-sharing reductions. A person could no longer be eligible and move to a standard silver plan without a cost-sharing reduction, or a person could become eligible for a lesser or more generous cost-sharing reduction level. Unlike with the premium credits,

no reconciliation or repayment of cost-sharing reduction amounts occurs in these situations; nor can the person generally receive a refund of any prior cost-sharing charges he or she paid that he or she wouldn't have had to pay if enrolled in a cost-sharing reduction plan with a higher actuarial value. But in some cases, the person can get credit for cost-sharing charges already paid that year.

Consider an example: John anticipates an annual income of $22,980 for 2014, enrolls in a silver plan, and automatically is placed in a cost-sharing reduction plan (a silver plan variation) with an 87 percent actuarial value. During January and February, John spends a total of $250 out of pocket, the amount of the deductible in the 87 percent plan. Then, he loses his job and gets a new one with lower pay. His new total expected income for the year is $16,000. He informs the exchange and gets a redetermination of his eligibility, resulting in John being enrolled in a different cost-sharing reduction variation of the silver plan he is in. This new variation has an actuarial value of 94 percent. The deductible under this cost-sharing reduction plan is $0. John is able to get credit for the $250 he already paid out of pocket toward the out-of-pocket limit in the cost-sharing reduction version he newly enrolls in, but he would not receive a refund of the amounts he paid toward his deductible.

John would receive "credit" for his prior out-of-pocket costs only if he remains enrolled in the same silver plan offered by the same health insurer when his cost-sharing reduction level changes. He can enroll in a different silver plan, but if he does that, any out-of-pocket amounts he already spent during the year would not count toward the out-of-pocket maximum.