

Cost-Sharing Reductions: What Are They and Why Do They Need to Be Funded?

What are cost-sharing reductions (CSRs)?

Under the Affordable Care Act (ACA), individual market plan enrollees with household incomes between 100 percent and 250 percent of the federal poverty level (FPL)¹ are eligible for cost-sharing reductions to decrease their out-of-pocket spending requirements (i.e., lower deductibles and copayments). These reductions are in addition to the premium subsidies (refundable tax credits) that the ACA provides for individuals with household incomes between 100 percent and 400 percent of FPL.

Cost-sharing reductions are provided through health plans with enhanced actuarial values. Enrollees must purchase silver tier plans, which have a target actuarial value (AV) of about 70 percent. This means that on average, 70 percent of medical spending incurred by enrollees is covered by the plan. But rather than having a 70 percent AV, eligible enrollees have enhanced silver plans that reduce the out-of-pocket costs, resulting in higher AVs—73 percent for enrollees with incomes between 200 and 250 percent of FPL, 87 percent for enrollees with incomes between 150 and 200 percent of FPL, and 94 percent for enrollees with incomes below 150 percent of FPL. These cost-sharing subsidies currently are provided to eligible enrollees at no additional premium.

How many people receive CSRs?

As of the end of the 2017 open enrollment period (Nov. 1, 2016, to Jan. 31, 2017), approximately 7 million enrollees—or 58 percent of individual marketplace enrollees—qualified for cost-sharing reductions.²

Why are CSRs important?

Higher cost-sharing is often cited as a means to offer incentives for individuals to seek out cost-effective care and avoid unnecessary care. Research suggests that higher cost-sharing can reduce not only unnecessary care, but also necessary care, especially among those with low incomes and the chronically ill. For example, the RAND Health Insurance Experiment found that although the reduction in services resulting from higher cost-sharing did not lead to poorer health outcomes

¹ The 2017 federal poverty level for the 48 contiguous states and the District of Columbia is \$12,060 for an individual and \$24,600 for a family of four. Federal poverty levels are set higher for Alaska and Hawaii. (“[Poverty Guidelines](#)”; Office of the Assistant Secretary for Planning and Evaluation; January 2017.)

² “[Health Insurance Marketplaces 2017 Open Enrollment Period—Final Enrollment Report: November 1, 2016–January 31, 2017](#)”; Centers for Medicare & Medicaid Services; March 15, 2017.



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for the average person, lower-income individuals in poor health were more likely to suffer poorer health outcomes.³ By lowering out-of-pocket costs, the cost-sharing subsidies reduce financial barriers to care for lower-income individuals.

How are CSRs funded?

The federal government has been making payments directly to insurers to offset the cost of lowering cost-sharing requirements. For 2017, the Congressional Budget Office (CBO) estimates CSR payments will be approximately \$7 billion.⁴ Although the ACA stipulates the federal government to reimburse insurers for these reductions, a U.S. district court ruling in a challenge brought by the House of Representatives found that a congressional appropriation is required to make such reimbursements.⁵ The case is now on hold because both parties asked for a continuance to allow time for a resolution.⁶ As a result, the administration makes payment decisions on a month-to-month basis.

What happens if CSR payments are eliminated? How would it affect the stability of the market?

There are a number of potential adverse consequences of eliminating CSR reimbursements. The ACA requires insurers to provide CSRs even if reimbursements are eliminated, and premiums for 2017 were based on the assumption that CSR reimbursements would be paid. If these reimbursements were to be terminated during 2017, premiums would be too low to cover the cost of care, potentially leading to insurer losses. In addition, the contracts signed by insurers for the 2017 plan year allows them to terminate the contract should CSR funding not be made available.

Beyond 2017, health plan actuaries need to know whether the reimbursements will be funded in order to assess premium requirements and ensure premiums are sufficient to cover the cost of care. Decisions not to pay the reimbursements or even uncertainty about the reimbursements could result in 2018 premium increases averaging nearly 20 percent for silver plans, over and above premium increases due to medical inflation and other factors.⁷ This is because even if funding is not provided, the benefits are still required to be provided and insurers would need to include the cost of those additional benefits in the premiums. Although those who receive premium subsidies would be insulated from the full increase in premiums, unsubsidized enrollees would face the full increase, potentially reducing their enrollment, increasing the uninsured population, and deteriorating the risk pool.

³ See *Free for All? Lessons from the RAND Health Insurance Experiment*; Joseph P. Newhouse and the Health Insurance Experiment Group; 1993. More recently, Amitabh Chandra et al. found evidence that the savings associated with raising cost-sharing for physician visits and prescription drugs is offset modestly by increased hospital utilization. The offsets are more substantial, however, for the chronically ill. See “Patient Cost-Sharing and Hospitalization Offsets in the Elderly”; *American Economic Review*; 2010.

⁴ “Federal Subsidies Under the Affordable Care Act for Health Insurance Coverage Related to the Expansion of Medicaid and Nongroup Health Insurance: Tables from CBO’s January 2017 Baseline”; CBO; 2017.

⁵ *U.S. House of Reps. v. Burwell*; D.D.C.; May 12, 2016.

⁶ *U.S. House of Reps. v. Price*; *Joint Motion to Continue Abeyance*; May 22, 2017.

⁷ “Estimates: Average ACA Marketplace Premiums for Silver Plans Would Need to Increase by 19% to Compensate for Lack of Funding for Cost-Sharing Subsidies; Estimated Increases Range from 9% in North Dakota to 27% in Mississippi”; Kaiser Family Foundation; April 6, 2017.

The continued uncertainty or prospect of higher premium increases could cause more insurers to withdraw from the market, potentially leaving more areas of the country with a single or even no participating insurers. Final rates for 2018 must be filed with CMS by mid-August and insurers have until mid-September to withdraw from the market.

Why should CSRs be made permanent and automatic?

Until recently, CSR reimbursements have been made automatically. However, reimbursements have become more uncertain, raising questions each month regarding whether the administration will make the payments, thereby making it more difficult for health plan actuaries to set premiums for 2018. Permanently funding the CSR reimbursements through congressional action is needed to avoid premium increases and potential further market withdrawals.

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