WHAT IS COST SHARING IN HEALTH INSURANCE?

An Overview of Common Terms

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CALIFORNIA HEALTH BENEFITS REVIEW PROGRAM

ABOUT THIS RESOURCE

Health insurance has complex terms that can quickly be confusing. This resource has been prepared by the California Health Benefits Review Program (CHBRP) as a tool for our stakeholders to help clarify and explain the common cost-sharing terms often addressed in health policy legislation. CHBRP responds to requests from the California State Legislature to provide independent analysis of the medical, financial, and public health impacts of proposed health insurance benefit mandates and repeals.

WHAT IS COST SHARING?

In health insurance, the cost of covered benefits is shared between the payer (e.g., health plan/insurer or employer) and the enrollee (the insured or "covered" individual). An enrollee is responsible for paying the portion of the insurance premium for which they are responsible and the cost-sharing components required under the health insurance plan or policy, as well as any expenses for noncovered services or treatments; noncovered services or treatments are generally paid in full by the enrollee. Cost sharing is the portion that enrollees are responsible for paying out-of-pocket directly to the provider for a covered health care service or treatment. Common cost-sharing mechanisms include copayments, coinsurance, and deductibles.[1]

COMMON COST-SHARING MECHANISMS AND HOW THEY INTERACT

Step 1: Deductibles

Deductibles are a fixed dollar amount (lump sum for one or more health care services) an enrollee is required to pay out-of-pocket within a given time period (e.g., a year) before the health plan or insurer begins to pay, in part or in whole, for covered health care services. A plan[2] can have more than one deductible. Examples of plan designs with multiple deductibles include: a general deductible that applies to a specified set of covered medical benefits and another deductible that applies to prescription drugs; or a deductible that applies to covered health care services provided by in-network health care practitioners and another deductible that applies to covered health care services provided by out-of-network health care practitioners. For family coverage, plans may have a deductible that applies to each family member, with a maximum deductible amount a family would pay in a given year. For example, each enrollee in a family may have a deductible of $500 per year, but the family deductible is capped at $1,000 per year. It is important to note that not all plans have deductibles, but for those plans that do, often not all covered benefits are subject to the deductible. For example, most plans are required to cover the full cost of specified preventives services, regardless of whether an enrollee has met their deductible.[3]

Step 2: Copayments and Coinsurance

Copayments and coinsurance apply after the deductible has been met (if a plan has a deductible).

Copayments: A copayment is a form of cost sharing in which an enrollee pays a predetermined, flat dollar amount out-of-pocket at the time of receiving a health care service, such as a $20 copayment for a physician office visit, or when paying for a prescription, such as a $5 copayment for a generic prescription drug. As with deductibles, a plan may not require any copayments or may only require copayments for certain benefits.

Coinsurance: Coinsurance is the percentage of covered health care costs for which an enrollee is responsible, such as 20% of a hospital stay. Similar to deductibles and copayments, coinsurance percentages can vary across covered benefits and a plan may not require any coinsurance or may only require coinsurance for some covered benefits.

[1] Cost sharing is separate from premium payments; cost sharing does not include premium payments.

[2] California has two health insurance regulators that oversee health insurance plans and policies. For brevity, this factsheet refers only to health insurance plans.

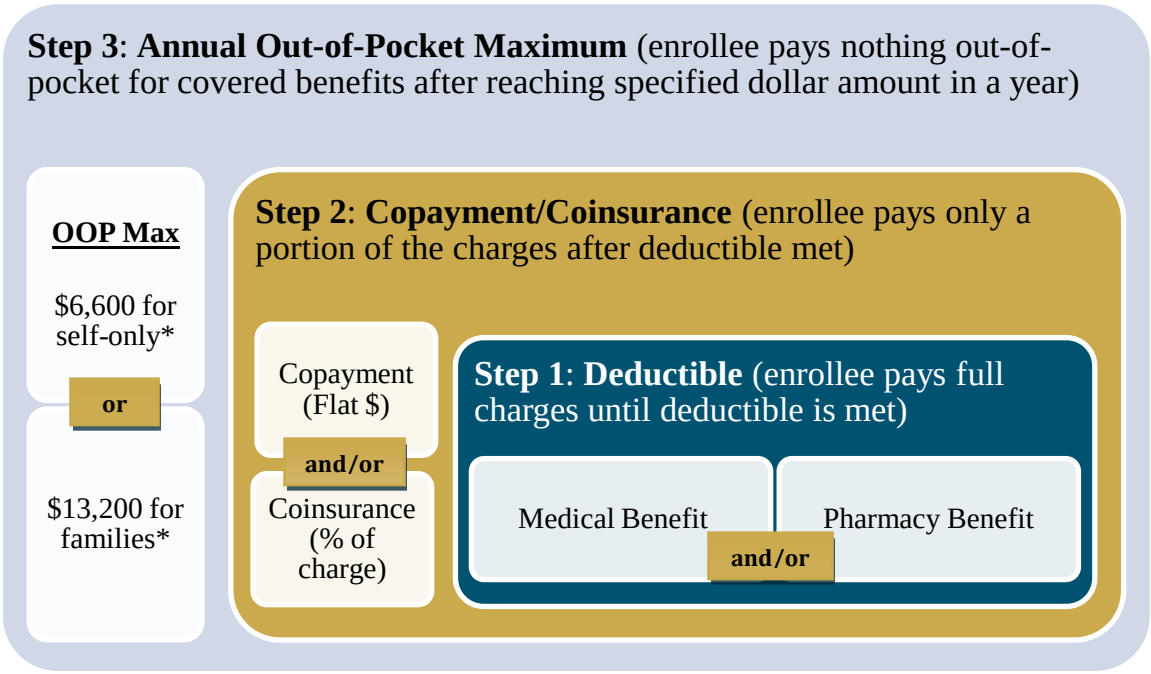
[3] For further information on coverage for preventive services see CHBRP's resource *Federal Preventive Services Benefit Mandate and California Benefit Mandates*, available here: www.chbrp.org/other_publications/index.php.

Step 3: Annual Out-Of-Pocket Maximums

Annual out-of-pocket maximums are limits on an enrollee's cost-sharing (copayments, coinsurance, and deductibles) obligations in a 1-year period.[4] The Affordable Care Act (ACA) established an annual out-of-pocket maximum for all nongrandfathered plans.[5,6] In 2015, the annual out-of-pocket maximum allowed under the ACA is $6,600 for self-only coverage and $13,200 for family coverage.[7] Nongrandfathered plans and policies may have lower annual out-of-pocket maximums, for example platinum plans[8] sold in Covered California, California's health insurance marketplace, have an annual out-of-pocket maximum in 2015 of $4,000 for self-only coverage and $8,000 for family coverage.[9] Grandfathered plans and policies are not subject to this requirement and so could have higher annual out-of-pocket maximums.

Figure 1 below demonstrates the general interaction of the cost-sharing mechanisms discussed above. There are numerous cost-sharing combinations, and this example will not apply to all situations; health plans use many different combinations of cost-sharing mechanisms to help assure medically necessary treatment and control costs.

Figure 1. Overview of the Interaction of Cost-Sharing Mechanisms Used in Health Insurance



Source: California Health Benefits Review Program, 2014.
Note: * The annual out-of-pocket amounts in this figure are the maximum amounts allowed in 2015 for nongrandfathered plans; some nongrandfathered plans may have lower annual out-of-pocket maximums.
Key: OOP Max=annual out-of-pocket maximum.

[4] Health care services that are not covered by the health plan would not be included in the annual out-of-pocket maximum; enrollees are generally responsible for the full charges associated with noncovered services.
[5] Affordable Care Act (ACA) Section 1302(c).
[6] A grandfathered health plan is defined as: "A group health plan that was created — or an individual health insurance policy that was purchased — on or before March 23, 2010. Grandfathered plans are exempted from many changes required under the ACA. Plans or policies may lose their 'grandfathered' status if they make certain significant changes that reduce benefits or increase costs to consumers" (www.healthcare.gov/glossary/grandfathered-health-plan/).
[7] Information on the annual out-of-pockets maximum allowed in 2015 is available at: www.healthcare.gov/glossary/out-of-pocket-maximum-limit/.
[8] Section 1302(d) of the ACA requires coverage within specified levels of coverage, or "precious metal" levels: bronze; silver; gold; and platinum. These precious metal levels correspond to an actuarial value for the plan or policy based on the cost-sharing features, not the benefits covered. The actuarial levels are as follows: 60% actuarial value for bronze-level plans; 70% actuarial value for silver-level plans; 80% actuarial value for gold-level plans; and 90% actuarial value for platinum-level plans.
[9] Information on Covered California's standard benefit designs for 2015 is available at: www.coveredca.com/individuals-and-families/getting-covered/health-plans/.