Patient Out-of-Pocket Costs

The Affordable Care Act (ACA) introduced key reforms to provide health care consumers with greater access to affordable, high-quality health care. While the ACA requires certain preventative services to be provided at no cost and makes some reforms to patient cost sharing, consumers are often still facing high out-of-pocket costs for services and prescription drugs. High out-of-pocket costs negatively impact adherence, ultimately resulting in avoidable health care expenses and poorer health outcomes. The out-of-pocket cost for services and prescription drugs should not be so large as to prohibit access to care, especially for those patients with severe and chronic conditions.

The Affordable Care Act and Out-of-Pocket Costs

Cost sharing refers to what patients spend “out of pocket” for their health care at the time of service. Plan design features like deductibles, co-payments, and coinsurance are considered elements of cost sharing. As employers, insurers, and policymakers look to control health care spending, cost sharing has increased and patients are routinely paying more out-of-pocket for their health care and prescription drugs.

The Affordable Care Act (ACA) includes provisions requiring plans to cover certain services with no out-of-pocket costs for patients. Most private insurance plans are now required to provide coverage and eliminate patient cost sharing for specific evidence-based preventive health services, including certain immunizations, mammograms, and smoking cessation screening. The ACA also improved Medicare coverage for preventive services by adding a new annual wellness visit benefit and eliminating cost-sharing requirements for many Medicare-covered preventive services.

The ACA also took steps to reduce out-of-pocket costs for patients. Most private plans, including plans sold on health insurance marketplaces (also known as exchanges) are subject to an annual out-of-pocket maximum established by the ACA for covered, in-network, essential health benefits. This limit is indexed annually and in 2016 is set at $6,850 for an individual and $13,700 for a family. Annual and lifetime limits on coverage for essential health benefits were also eliminated in most private plans.

For individuals and families at or below 250 percent of the Federal Poverty Level (FPL), the ACA also provides financial assistance for cost sharing for those enrolled in silver-level “cost-sharing reduction (CSR)” plans purchased on the health insurance marketplaces. This is intended to protect patients from high out-of-pocket costs, like deductibles, co-pays, and coinsurance, for essential health services and benefits.

Even with the ACA, Out-of-Pocket Costs Are Still a Barrier

While the ACA provided broader access to coverage and some patient protections, consumers are still exposed to significant cost sharing. Plans are increasingly subjecting both medical and prescription drug benefits to a deductible. Since 2006, the percentage of covered workers in employer-sponsored health plans with a general annual deductible has increased from 55 percent to 80 percent, with an average general annual deductible of $1,217 in 2014. Although it is uncommon for employer-sponsored plans to subject items and services such as primary care visits and prescription drugs to a substantial deductible, this plan design feature is common in many marketplace plans. In 2015, the average combined medical and prescription drug deductible in a silver plan was $2,658, while the average in bronze plans was $5,249. When a deductible applies to a service or to a prescription drug, the patient typically must pay the full cost of the service or drug before any cost sharing (such as a co-pay or coinsurance) applies. Deductibles shift costs away from insurers and often represent high up-front costs for patients.

While the ACA established a maximum annual limit on out-of-pocket spending, spending for individual services and drugs is not limited. This means that even after a deductible is paid, consumers can still be faced with substantial out-of-pocket expenses in the form of co-pays and coinsurance. Prescription drugs may be placed on what is commonly referred to as a “specialty tier”; patients are required to pay a percentage of the cost (coinsurance) of drugs on this tier rather than a flat copayment. Out-of-pocket costs for patients can commonly reach 40 percent or more of the cost of the medication. Although the ACA does provide financial assistance for certain individuals enrolled in silver CSR plans, an analysis of CSR silver plans in 2014 illustrated that while these plans typically reduce deductibles and out-of-pocket caps,
cost sharing for other treatments and services, like specialty drugs, remains high. Most medicines placed on specialty tiers are those that treat a small number of severely ill patients with debilitating diseases, and there are typically no generic alternatives for these products. The use of coinsurance on specialty tiers makes out-of-pocket costs unpredictable for the sickest patients and could reduce access to these critical products.

Even with the annual out-of-pocket maximum established under the ACA, it is important to consider that some services and treatments are excluded from this maximum. Out-of-network providers, services, drugs that are not covered and nonessential health benefit services do not need to count toward the annual out-of-pocket maximum. A patient whose condition requires the use of a noncovered drug or an out-of-network provider could potentially face unlimited out-of-pocket expenses.

In light of the substantial out-of-pocket costs faced by some patients, states are taking action to protect their residents from excessive cost sharing. Vermont has an annual limit on prescription drug expenditures, while Delaware, Maryland, and Louisiana limit out-of-pocket expenses per thirty-day supply of a prescription drug to $150. Covered California, California’s health insurance marketplace, limited out-of-pocket costs for prescription medicines to $250 in most plans. While patients in these states may still be subject to deductibles that are in the thousands of dollars, these laws provide some protection for patients who need access to life-saving therapies. In the absence of federal reform, states should pursue legislative or regulatory changes to protect patients from inappropriate out-of-pocket expenditures.

**Pfizer’s Position**

While the ACA has done much to enhance access to care, the effort must be sustained by providing coverage with appropriate patient cost sharing. Research has indicated that prescription abandonment rates increase with patient cost-sharing amounts over $100. Cost-sharing requirements should not be so large as to inappropriately restrict or interfere with the proper use of medications, which can lead to negative health outcomes and additional costs to the health care system.

Insurance is intended to make health care costs more predictable for patients and provide coverage for appropriate medically necessary care. Disproportionate cost sharing for pharmaceuticals is a significant diversion from these basic principles and requires patients with certain conditions to pay much more out of pocket for necessary drugs than they do for other treatments and services. Excessive cost sharing required by prescription drug benefit designs, including specialty tiers and high deductibles, should be prohibited in Medicare and commercial health plans.

**Impact on Patients and Health Care Professionals**

The inability to afford health care treatments is one of the greatest barriers to patient adherence. Higher cost sharing is associated with lower rates of drug treatment, poor adherence among existing users, and more frequent discontinuation of therapy. Patients and their physicians need access to affordable treatment options that will best improve a patient’s overall health and outcomes. As such, it is critical for treatment activity to be driven by the physician-patient relationship and not by costs.

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1 The Patient Protection and Affordable Care Act (PPACA, P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA, P.L. 111-152), is collectively referred to in this paper as the Affordable Care Act of 2010 (ACA).
4 Avalere Health PlanScape™ a proprietary analysis of exchange plan features. Data as of December 2014.
5 Avalere Health PlanScape™ a proprietary analysis of exchange plan features. Data as of December 2014.
6 Avalere Health PlanScape™ a proprietary analysis of exchange plan features. Data as of December 2014.