

The High Cost of Healthcare: Patients See Greater Cost- Shifting and Reduced Coverage in Exchange Markets 2014-2018

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I. Executive Summary

The expansion in coverage due to the Affordable Care Act (ACA) increased the number of insured Americans by 20 million.¹ Although access to health insurance has expanded significantly in recent years, and the ACA instituted important protections for patients, those who gained insurance through ACA health insurance exchanges are being offered plans that make them bear an increasing portion of their healthcare costs since the law was implemented. Access to health insurance is not sufficient if patients cannot afford to purchase coverage or utilize their benefits due to high premiums, high out-of-pocket costs, limited networks, and insufficient state and federal patient protections.

This paper outlines the key challenges facing patients in plans insurance companies offer through ACA health insurance exchange markets and details the changes in patient cost-sharing. This paper will demonstrate that:

1. Health plan networks have grown increasingly narrow, limiting patient access to in-network providers, with specialties like anesthesiologists, radiologists, and emergency physicians often out-of-network in exchange plans;
2. Non-subsidized exchange marketplace premiums have increased faster relative to other markets, such as employer-sponsored insurance and Medicare Advantage, since 2014;
3. Deductibles and maximum out-of-pocket limits (MOOPs) have grown across all payers, placing a higher financial burden on sicker patients;
4. Despite the growth in deductibles and MOOPs, cost-sharing for services after the deductible has remained relatively constant, though patients are increasingly required to pay coinsurance to access their care; and
5. Federal and state rules around network adequacy have not kept pace with the growing patient burden.

II. Introduction to the Patient Financial Burden

Patient healthcare spending is made up of various types of spending. In the case of plans insurance companies offer on the ACA exchange markets, nearly every aspect of patient out-of-pocket spending has trended towards additional costs or burdens on patients. Patient spending on healthcare generally can be split into four main areas:

- 1. Provider Networks.** Health plans do not cover all services or all providers. The number and types of providers that health plans cover in their networks varies. Narrow networks, where an insurance company strictly limits providers it considers in-network, are increasingly the only options available. In ACA exchange markets, most plans have limited to non-existent out-of-network coverage, so the entire cost of any out-of-network care falls on the patient. Importantly, patient spending on out-of-network care does not count toward a patient MOOP. Moreover, narrow networks may require patients to travel further distances to access necessary care.
- 2. Premiums.** Patients pay a premium to their health plan every month. In the ACA exchange markets, low-income enrollees are eligible for premium subsidies that limit their monthly premiums, but the vast majority of enrollees at all incomes are required to pay a monthly premium for their coverage. As insurance companies increase premiums, it can place a financial burden on patients and potentially force them to choose between healthcare or other important expenses.
- 3. Deductibles.** In most plans offered, patients are generally subject to a deductible for most services. Deductibles are a fixed amount that patients must pay, out-of-pocket, before their health plan begins paying for healthcare services. Particularly in the ACA exchange markets, deductibles can be thousands of dollars a year. Like premiums, insurance companies have been increasing deductibles dramatically in recent years.

4. Other Cost-sharing. In the vast majority of plans offered, patients are required to pay cost-sharing for specific services, even after meeting and exceeding their deductible. Insurance companies often require either a copay (fixed dollar amount) or coinsurance (a percentage of the total cost of the service) for patients when they use healthcare services. These amounts, particularly coinsurance, can quickly add up for patients who use their health insurance. While health plans offered through the ACA exchange markets are statutorily required to cap cost-sharing at a MOOP, patients are still required to pay up to \$7,150 for an individual or \$14,300 for a family in 2017.

III. Health Insurance Networks Have Become Increasingly Narrow and More Restricted, Including Fewer Providers Than Other Markets

Issue Overview

When the ACA exchange markets launched in 2014, the plans available in the market were evenly split between more restrictive networks, like health maintenance

organizations (HMOs) and exclusive provider organizations (EPOs), and less restrictive networks, like preferred provider organizations (PPOs) and point-of-service plans (POSs). Details about plan network designs can be found below in Table 1.

Since 2014, ACA exchange markets have rapidly moved away from open networks towards more restrictive networks (Chart 1). This narrow network trend can apply to specific provider types as well. Specialties like anesthesiologists, radiologists, and emergency physicians are often out-of-network in ACA exchange plans, particularly compared to employer-sponsored insurance or Medicare Advantage networks, hurting patient access to needed services and exposing them to high out-of-pocket costs.

Impact on Patients

Since 2014, patients have borne increasingly higher portions of their healthcare costs; while over the same period, plans have also become more restrictive with respect to their networks. Additionally, narrow network plans often do not provide any out-of-network coverage, requiring patients who access care out-of-network, intentionally or not, to pay the full cost of their visit. Even when some plans offer out-of-network coverage, cost-sharing is generally higher than in-network care.

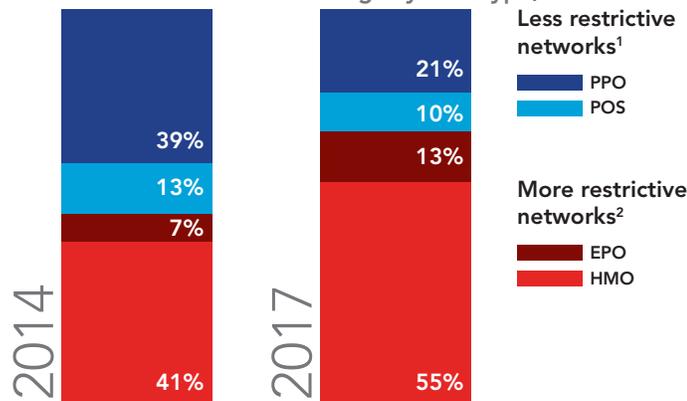
Table 1: Overview of Network Types in ACA Exchange Markets

NETWORK TYPES	OVERVIEW
HMO	Health Maintenance Organization. Patients access care by going through a single primary care physician who will then refer the patient to specialists. Provides limited to no out-of-network coverage.
EPO	Exclusive Provider Organization. Patients do not need referrals to access providers, but are only provided a limited network of physicians without out-of-network coverage.
PPO	Preferred Provider Organization. Patients can visit physicians without referrals and receive some form, though at higher cost-sharing, of out-of-network coverage.
POS	Point of Service Plan. Patients select a single primary care physician who will make referrals to other specialists. Patients are provided some measure of out-of-network coverage, though at higher out-of-pocket costs.

With enrollees in ACA exchange markets generally of low- to modest-income (84% have incomes below 400% of the federal poverty level),² having few providers serving in-network can be a real barrier to access. Patients with low income are generally unable to afford out-of-network rates and often rely on public transportation³ to access their providers. Limited or narrow networks that include fewer needed providers can substantially add to patient burden.

ACA Exchange Market Trends

Chart 1: Percent of Plan Offerings by Plan Type, 2014 – 2017



More restrictive networks (Chart 1) limit consumer choice by reducing the number of providers in-network and the ability to access out-of-network providers. Relative to other insurance markets, like traditional commercial insurance or Medicare Advantage, network inclusion of providers in ACA exchange plans is very low.

A 2015 analysis found nearly 15% of ACA exchange networks examined were “specialist-deficient” plans, lacking any in-network provider for at least 1 specialty.⁴ Other studies found that nearly 41% of silver plan physician networks in 2015 were defined as “small (10-25% of physicians in the area participate in-network) or extra small (less than 10% of physician in the area participate in-network).”⁵ Often, patients are either unaware or unable to ascertain the breadth of provider networks when enrolling in a plan, setting them up for surprises and out-of-network charges when they attempt to use their benefits.

KEY STAT: Nearly 41% of silver plan physician networks in 2015 were defined as “small or extra small.”

Illustrative Examples

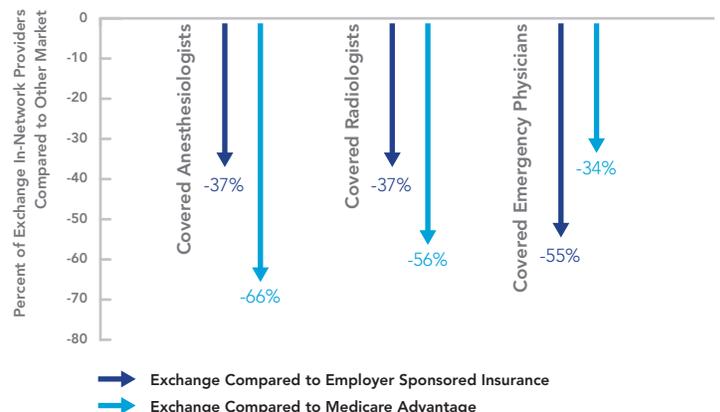
Consider the following two examples of experience with health plan provider networks.

HMO Example: In 2017, a patient in Atlanta, Georgia wants to enroll in a silver exchange plan for 2018. That patient wants to continue visiting their favorite specialist, so looks for a network which covers this specialist. There are only HMO products offered in the patient’s region, leaving her with no choice but to enroll in an HMO. That HMO does not cover her preferred specialist, leaving the patient to choose between switching providers or paying the full cost of her visit out-of-pocket.

PPO Example: In 2017, a patient in Salt Lake City, Utah enrolls in a silver exchange plan with a PPO network. That patient wants to use an out-of-network specialist. While her cost-sharing is higher to visit her preferred specialist (40% coinsurance compared to 20% in-network), she still receives some coverage from her health plan.

In 2017, exchange plans had the lowest inclusion of providers compared to employer-sponsored insurance and Medicare Advantage networks, as shown in Chart 2. This translates to less access to in-network providers, which shifts higher out-of-pocket spending to patients who are unable to access providers in-network.

Chart 2: In-Network Inclusion of Providers by Market, Comparing ACA Exchange Network Inclusion to Traditional Commercial and Medicare Advantage, 2017⁶



Health plans in the ACA exchange markets cover substantially fewer anesthesiologists, radiologists, and emergency physicians than other insurance markets. As exchange plans searched for ways to reduce costs and limit patient utilization, they have developed networks that deprive patients of choice for the above key specialties.

KEY STAT: ACA exchange plans at best covered 34% fewer providers than other markets.

Across all three providers examined, ACA exchange plans, on average, at best covered 34% fewer providers than other markets.

IV. ACA Exchange Market Premiums Increased while Employer-Sponsored Insurance (ESI) and Medicare Advantage Prescription Drug Plan (MA-PD) Premiums Stayed Relatively Flat

Issue Overview

For many Americans, the growing cost of healthcare is taking up a larger share of family budgets.⁷ Approximately 30% of those with health insurance report trouble affording premiums and other patient cost-sharing.⁸ Affordability is of concern for consumers in the ACA exchange markets, who have assumed the largest increases in premiums since 2014. Most individuals in the ACA exchange markets, approximately eight million people,⁹ receive some form of subsidy to help pay their premiums and are therefore protected from the premium increases. However, nearly 16% of consumers enrolled in an ACA exchange plan and all unsubsidized enrollees of off-exchange health plans—totaling approximately eight million individuals¹⁰—pay the entire cost of their health plan premium.¹¹

Impact on Patients

Extensive analysis has shown that premium increases, when incomes and other measures are held equal, lead to reductions in the number of patients enrolled in health insurance. The nonpartisan Congressional Budget Office (CBO) assumes that for every 10% increase in premiums, there is a 6% reduction in the number of individuals enrolled.¹² While there are often mitigating factors—for instance sicker

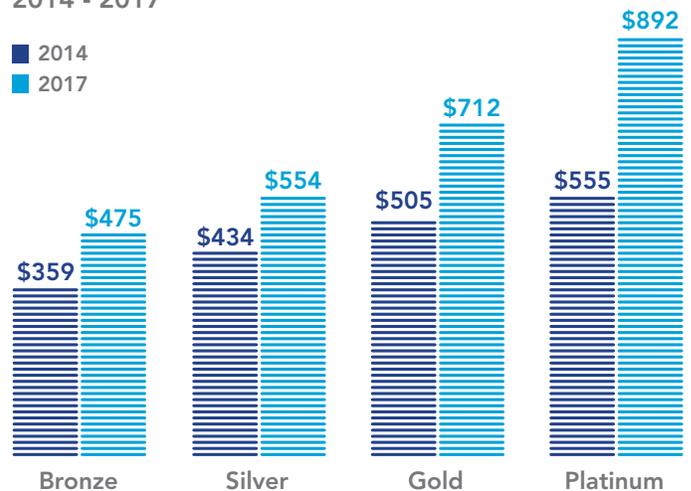
patients are less likely to drop insurance—large premiums increases have been proven to lead to patients dropping coverage.

Market Trends

Historically, health insurance premiums across all markets have steadily increased every year. However, in recent years, premiums for ESI and Medicare Advantage Prescription Drug Plans (MA-PDs) have stayed relatively stable.¹³ Average yearly premiums for single coverage ESI rose from \$6,025 to \$6,690 from 2014 to 2017, an increase of 11%.¹⁴ On average, employers subsidize 82% of an employee’s health premium. Thus, employee contributions only rose from \$1,081 a year in 2014 to \$1,213 a year in 2017.¹⁵ Beneficiary portions of the MA-PD premiums have increased just 3% from 2014 to 2017, and on average were \$36 dollars in 2017.¹⁶

Conversely, ACA exchange market premiums, particularly for the most popular type of exchange plans (silver), increased at much higher rates over the last four years (2014 – 2017). Between 2014 and 2017, unsubsidized silver exchange plan premiums increased 28% from an average of \$434 to \$554 a month, an increase of \$1,440 a year, for a non-smoking 50-year old (Chart 3).¹⁷

Chart 3: Average ACA Exchange Market Premiums, 2014 - 2017¹⁸



Illustrative Examples

Consider the following two examples of experience with monthly premiums for health plan enrollees of the same age.

Example 1: Michael is self-employed and purchases health insurance coverage on the ACA exchange. He makes too much money to qualify for subsidies, but has diabetes and needs to use his coverage regularly, so he selects a more generous gold plan. Since 2014, his gold plan has experienced similar premium increases to the rest of ACA exchange markets. In 2014, he paid \$505 a month, or \$6,060 a year, for his plan. By 2017, his gold plan premiums had risen 41%, to \$712 a month, or \$8,544 a year. This means Michael will pay \$2,484 more in 2017 than he paid in 2014 for the same healthcare coverage.

Example 2: Elizabeth receives health insurance coverage through her employer and has diabetes, so she uses her coverage every year. She has been enrolled in the same employer plan since 2014 and her employer's premium contribution has remained relatively steady, covering 82% of the total cost. Elizabeth's employee plan premium has increased by 11% since 2014, to \$101 a month, or \$1,213 a year. This means Elizabeth will pay \$132 more in 2017 than she paid in 2014. Her employer will spend approximately 11% more, or \$533, in 2017 than in 2014.

Yearly Premium Contributions	2014	2017	Total Increase
Michael <i>(ACA Exchange Gold Plan)</i>	\$6,060	\$8,544	\$2,484
Yearly Premium Contributions	2014	2017	Total Increase
Elizabeth (Employer Plan Premium Contributions)			
Elizabeth Pays <i>(Employer Coverage)</i>	\$1,081	\$1,213	\$132
Elizabeth's Employer Pays <i>(Employer Coverage)</i>	\$4,944	\$5,477	\$533

In these examples, which mirror the market trend in the individual and employer health insurance markets respectively, the patients all pay more for their premiums in 2017 compared to 2014. However, Michael's premium increased nearly \$1,800 more than Elizabeth's premium. Rapid premium increases for plans insurance companies offer on ACA exchanges create affordability challenges for enrollees like Michael, and are an example of the increased financial burden enrollees are bearing in the ACA exchange markets.

V. Deductibles and Maximum Out-of-Pocket Costs Increase Faster in Plans Offered on the ACA Exchanges, Compared to ESI and Medicare Advantage

Issue Overview

While premiums are an important part of a patient's healthcare spending in each year, deductibles and MOOPs can also shape patient total OOP costs. In the vast majority of plans, patients must spend up to their deductibles, sometimes paying thousands of dollars out-of-pocket, before their health plan starts to share in the cost of care.¹⁹ Once patients reach their deductible, they still need to continue paying cost-sharing up to the MOOP--the limit on total out-of-pocket spending an enrollee can pay for services and prescription drugs in a year before a health plan will pay 100% of all in-network covered services. As premiums have risen in recent years, so have deductibles and MOOPs in the ACA exchange market.

The ACA provided low-income individuals, those with incomes between 100% and 250% of the federal poverty level (FPL), with some assistance in affording their deductibles and MOOPs. Low-income enrollees are eligible to receive ACA cost-sharing reductions (CSRs)²⁰ and enroll in silver plans that reduce their deductibles, MOOPs, and cost-sharing for the year. However, these plans are only available to those who qualify--currently just 57% of exchange enrollees qualify and enroll.²¹ And while CSRs lower out-of-pocket costs for enrollees with low income, they do not eliminate OOP cost and still leave patients facing MOOPs and deductibles that can cost thousands of dollars out-of-pocket.

Meanwhile, middle-income enrollees face the prospect of paying the full cost of their deductibles and MOOPs.

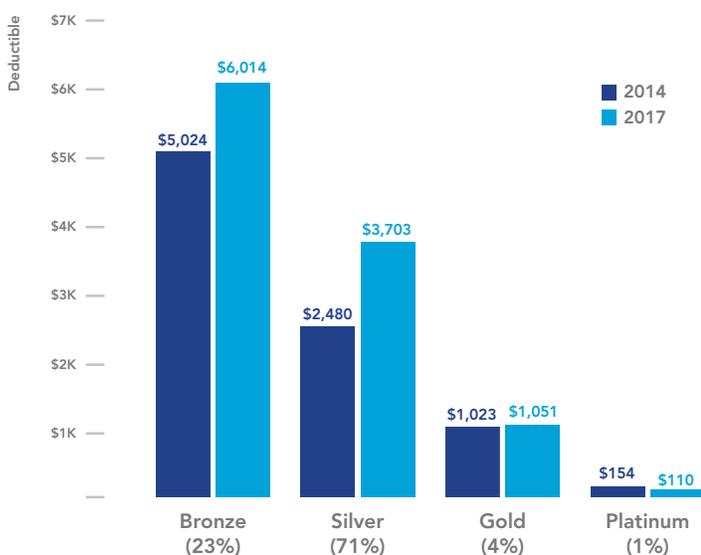
Impact on Patients

In the last year, 27% of Americans reported putting off or postponing needed care due to cost.²² Studies have shown that higher deductibles reduce utilization of healthcare services and treatments, including necessary services or prescription drugs.²³ By postponing and eliminating needed care, many Americans put themselves at risk for worse health outcomes over time.²⁴ One study done by researchers from the University of California at Berkeley and Harvard University found that employees that were switched to a high-deductible health plan (HDHP) found that the introduction of deductibles led to a 12-14% reduction in the firm’s total healthcare spending, with employees spending less on services due to the higher out-of-pocket costs.²⁵ Some of the reductions in spending came from a cut back to valuable care, such as preventive services.

Market Trends

As seen in Chart 4, in 2014, combined deductibles for silver plans—the most popular plans offered—averaged \$2,480 a year. By 2017, average silver plan deductibles had risen to \$3,703, an increase of 49% over a period of only four years. Likewise, for the second most popular metal level—bronze plans—average deductibles rose 20% from \$5,024 in 2014 to \$6,014 in 2017.²⁶

Chart 4: Average Combined Deductibles by Metal Levels, 2014 and 2017²⁷



In 2016, 42% of enrollees faced deductibles between \$2,500 and \$7,150.^{28 29} Astoundingly, almost 90% of enrollees in ACA exchange plans, including those that receive CSR subsidies, had deductibles above \$1,300, which is above the Internal Revenue Service (IRS) definition of a high-deductible health plan.³⁰ Average plan deductibles for individuals with employer-sponsored insurance have not risen as much as those in exchange plans.³¹ Additionally, ESI deductibles tend to be a lower dollar amount than deductibles in the ACA exchanges. According to the Employer Health Benefits Annual Survey, average deductibles for employer plans increased 23%, from \$1,217 in 2014 to \$1,505 in 2017.³²

Along with deductibles, average MOOP amounts increased for exchange enrollees, though much less dramatically. The average silver plan MOOP increased 12% over the last four years, from \$5,844 in 2014 to \$6,528 in 2017.³³ Between 2016 and 2017, MOOPs increased 6%, outpacing the statutory limit (\$7,150 for an individual and \$14,300 for a family in 2017)³⁴ growth of 4% annually.³⁵ Most years MOOPs rise parallel to the increase in MOOP limit dictated by the ACA.

Illustrative Examples

Consider the following two examples of experience with out-of-pocket costs for health plan enrollees of the same age.

Example 1: Janet has been enrolled in her silver exchange plan since 2014. She makes too much money to be eligible for ACA cost-sharing reduction (CSR) subsidies. In 2014, she hit her deductible and paid \$2,500 out-of-pocket in addition to her premiums. By 2017, her deductible had risen to \$3,700 a year, growing nearly 48%. Janet still has the same yearly healthcare expenses, but the growth in deductibles has increased her out-of-pocket spending by \$1,200 in just over four plan years.

Example 2: Juan has received health insurance through his employer since 2014. His employer plan deductible was \$1,200 in 2014. His healthcare needs lead him to spend up to the deductible every year. By 2017, his deductible had risen to \$1,500 a year, an increase of approximately 23%, or \$300.

Yearly Deductibles	2014	2017	Total Increase
Janet <i>(ACA Exchange Silver Plan)</i>	\$2,500	\$3,700	\$1,200
Juan <i>(Employer Coverage)</i>	\$1,200	\$1,500	\$300

While both examples demonstrate how deductibles and cost-sharing have risen across the healthcare industry, there are substantial differences between the ACA exchange market and traditional employer-sponsored insurance. Deductibles and the required out-of-pocket cost-sharing for exchange enrollees are not only substantially higher for someone like Janet, but they are also growing at a faster rate than in other markets, greatly contributing to higher patient financial burdens.

VI. Cost-sharing for Specific Services Has Remained Relatively Stable, Despite Increases in Deductibles

Issue Overview

In recent years, while deductibles and premiums have increased dramatically, the amount of cost-sharing consumers are required to pay after the deductible has remained relatively constant, with more plans shifting cost-sharing from copays to coinsurance. Patients are paying more to reach their deductibles, but then not seeing an associated reduction in cost-sharing for those services after the deductible.

Impact on Patients

The literature strongly suggests that insurance company use of high cost-sharing, both copayments and coinsurance, leads to reductions in needed care. Some healthcare complications tend to be relatively inelastic, like acute events or emergency non-elective surgeries, and the patient will use the healthcare service regardless of cost. However, for other services, including prescription drugs, preventive care, primary care and specialist visits, and ambulatory care, increased cost-sharing reduces utilization.³⁶ One study found that newly imposing 25% coinsurance to health plan enrollees led to a 21.4%³⁷ reduction in patients using physician services.

While high copayments and coinsurance both hurt patient access to care and lead to high out-of-pocket costs, coinsurance often creates the biggest burden for patients. With coinsurance, patients pay a percentage of the total cost of the service, which for high cost services or prescription drugs can require patients to pay nearly all their MOOP in a given month. Additionally, unlike standardized copayments, coinsurance amounts are unpredictable and harder for a family to budget.

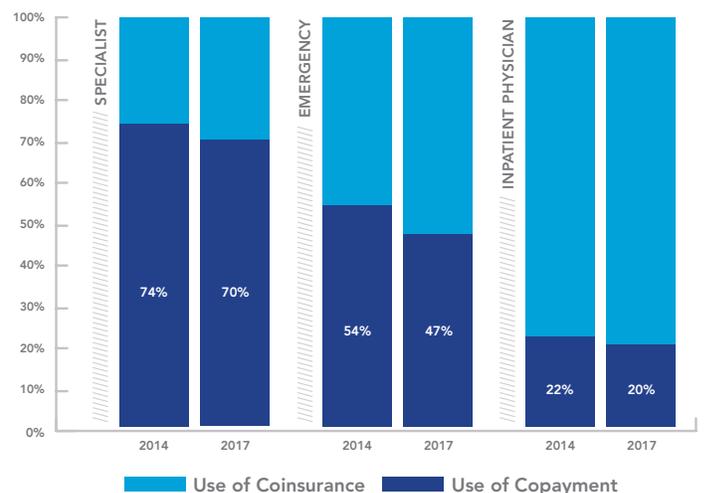
Market Trends

Table 2: Average Cost-Sharing for Silver ACA Exchange Plans for Selected Services, 2014 - 2017

Average Silver Plan	Specialist Visit Cost-Sharing	Emergency Physician Cost-Sharing	Inpatient Physician Cost-Sharing
Copay			
2014	\$54	\$289	\$97
2017	\$54	\$292	\$699
Coinsurance			
2014	22%	24%	24%
2017	25%	25%	24%

Cost-sharing amounts for specialists, emergency room, and inpatient physicians has remained relatively constant in the ACA exchange market (Table 2). However, despite the relative stability of the cost-sharing amounts in ACA exchange plans, the types of cost-sharing (coinsurance compared to a copay) have shifted towards greater use of coinsurance and potentially higher, more unpredictable patient burden.

Chart 5: Percentage of Plans that Cover Benefits Using Coinsurance vs. Copay, 2014 – 2017³⁸



For all three of the physician services shown in Chart 5, the use of coinsurance has risen from 2014 to 2017. As coinsurance rises, patients are more exposed to the cost of services and required to pay more out-of-pocket. Patients generally do not visit specialists, the emergency department, or have inpatient visits electively. The services included in Chart 5 are examples of healthcare utilization that patients need. The additional costs to patients from coinsurance fit with a general trend along with premiums and deductibles: that of more costs being passed along to patients.

VII. Federal and State Rules Around Network Adequacy Have Not Kept Pace with the Growing Patient Burden

Federal Network Adequacy Standards Have Improved Since 2014, But Gaps Remain

To help ensure that plans offered by health insurance companies in the ACA exchange markets serve the needs of enrollees, the ACA established a national standard for network adequacy.³⁹ Exchange plans must maintain “a network that is sufficient in number and types of providers” so that “all services will be accessible without unreasonable delay,” and are required to disclose their provider directories to the exchange for online publication.⁴⁰ However, network standards set forth by federal regulation and guidance serve as the minimum requirements, giving states significant latitude to enforce additional state-specific network rules, so long as they do not conflict with federal law. To date, the federal standards have not stemmed the increasing prevalence of insurance companies offering plans with narrow provider networks, nor do they enforce a standard for all provider types.

Federal network adequacy standards have become more stringent from 2014 through 2018, but remain inadequate. Health plans with limited networks of providers plans were common in ACA exchange markets in 2014 and continue to grow in prominence through 2018, from 48% of plans in 2014⁴¹ to 73% of plans in the exchange market offering restrictive networks in 2018.⁴²

2014: In 2014, CMS relied on states’ reviews of network adequacy standards and accreditation to assess adequate networks for qualified health plans (QHPs).⁴³ Network adequacy was based on “reasonable access” and ensuring that QHP exchange issuers maintained networks that were sufficient in number and types of providers to ensure all services be accessible without unreasonable delay.⁴⁴

2015: In 2015, CMS assumed from states the responsibility of ensuring plans maintained adequate networks. Instead of using accreditation to determine network adequacy, CMS instead required plans to submit provider lists to assess “reasonable access.” CMS focused most closely on hospital systems, mental health providers, oncology providers, and primary care providers in reviewing “reasonable access.”⁴⁵

2017: For the 2017 plan year, CMS provided more details to plans, including the proposed time and distance standards used to assess “reasonable access.” Additionally, CMS expanded the types of specialties in which they focused their network adequacy review to: dental providers (if applicable), endocrinology, infectious disease, outpatient dialysis, and rheumatology, in addition to hospital systems, oncology, mental health and primary care.⁴⁶

Timeline of Federal ACA Exchange Network Requirements

2014	2015	2017	2018
Federal network standards based on broad “reasonable access”	CMS requires plan to submit provider lists and focuses on access for hospitals, mental health, oncology, and primary care providers	CMS reveals how it determines reasonable access and increased providers of focus to include dental, endocrinology, infectious disease, dialysis, and rheumatology. CMS withdraws more stringent proposals for time and distance standards	CMS launches a pilot in 4 states to provide enrollees a measure of “network breadth”

2018: In 2018, HHS will codify a pilot for federally-facilitated exchanges but only in four states.⁴⁷ The pilot currently allows consumers to use Healthcare.gov to compare the breadth of provider networks used by plans operating in a selected county. The Healthcare.gov tool also indicates whether a plan is part of an integrated delivery system.⁴⁸ This tool could be helpful in driving consumers toward plans with more provider choice, but currently there are no plans to expand the tool beyond four states. For all other network adequacy requirements, CMS maintained the same standards as 2017.

Despite the improving requirements, CMS has routinely pulled back on more prescriptive requirements for network adequacy, giving insurance plans more flexibility. The 2017 proposed time and distance standards were not finalized and instead CMS simply reiterated their previous network adequacy standards.⁴⁹ Additionally, CMS allows health plans to submit justifications for failing to meet the network adequacy standards without any detailed information on how CMS determines the validity of the health plans' verification.

While CMS details which providers they review to ensure sufficient access, the limited list of specialties leaves out

a vast array of specialists and providers. Specialists like radiologists and anesthesiologists, providers that are routinely not included in-network, are excluded from the reviews.

As such, while CMS has improved its requirements around network adequacy since 2014, it does not ensure access to all needed specialties and has generally been less prescriptive with its requirements than originally proposed. Though the federal standards serve as the minimum and states could require much more stringent network adequacy rules, many states fail to provide sufficient network adequacy patient protections.

State Network Adequacy Standards Vary Widely

As shown in Table 3, network adequacy standards vary widely by state. Many states have enacted network adequacy regulations since the implementation of the ACA, while at least 17 states had enacted laws prior to the ACA.⁵⁰ As outlined in Table 3, there are substantial differences between states' network adequacy protections, providing patients differing levels of protections. Some states have gone above the federal requirements, but many have simply aligned their states to the federal requirements, which as noted previously have proved inadequate for the ACA exchange market.

Table 3: Network Adequacy Regulations in Key Selected States

State	Summary of Selected Network Adequacy Protections
<p>Conform with the Federal Standard Example: Georgia</p>	<p>Georgia has enacted a statute and promulgated regulations that align with the federal standards.</p>
<p>Go Beyond the Federal Standard Example: Pennsylvania</p>	<p>Pennsylvania's standards align with the federal standards and implement a set of time and distance standards for health plans in each county in their service areas, ensuring at least 90% of enrollees in the county can access covered services within 20 miles or 30 minutes travel for a list of provider types, including primary care, hospitals, and anesthesiology.</p>
<p>Go Beyond the Federal Standard Example: Washington,</p>	<p>Washington has extensive network adequacy requirements that align with federal standards and exceed them. Washington requires issuers to demonstrate a comprehensive range of primary, specialty, institutional, and ancillary services are readily available without reasonable delay to all enrollees. Health plans are required to include all categories of providers in their networks.</p>
<p>Less Prescriptive or Nonexistent Standards Example: North Carolina,</p>	<p>North Carolina requires health plans to develop a methodology for determining the size and adequacy of a provider network. Health plans are required to establish performance targets for member accessibility to primary and specialty care physician and hospital based services.</p>
<p>Less Prescriptive or Nonexistent Standards Example: Ohio</p>	<p>Ohio has not enacted a statute nor promulgated network adequacy regulations.</p>

Even among states with greater network adequacy protections than the federal standard, the standard of protection for patients varies dramatically. With the federal standard lacking, states have a higher obligation to ensure enrollees in their ACA exchanges can access needed care and providers.

Federal Requirements for Out-of-Network Coverage Are Limited

While the ACA provides some level of out-of-network protections for patients, it contains only two main requirements for coverage of out-of-network care. Those requirements include:

1. Out-of-network emergency services at in-network rates; and
2. Out-of-network services received at in-network settings (i.e. care from an out-of-network physician at an in-network hospital) at in-network rates.

As noted previously, insurance companies are increasingly offering products with limited or non-existent out-of-network coverage, which greatly increases the risks of patients bearing high costs for visiting patient preferred providers.

Under the ACA, health plans are required to cover out-of-network emergency services at in-network rates for consumers. As such, a consumer who utilizes out-of-network emergency services while enrolled in an ACA exchange plan will pay their health plan's normal in-network cost-sharing. The health plan is required to reimburse the emergency provider the greater of:

1. The median amount the plan pays in-network providers for the emergency service;
2. The amount for the emergency service calculated using the same method the plan generally uses to determine payments for out-of-network services (such as the usual, customary, and reasonable amount); and
3. The amount that would be paid under Medicare for the emergency service.⁵¹

While this requirement ensures health plans pay emergency providers some amount for utilization of provider services, that amount is not always sufficient to compensate the

provider's costs. As such, providers are forced to choose between losing money or balance billing the patient, which leads to additional charges for the consumer above and beyond the in-network cost-sharing paid under the health plan. Some states—New York being the most prominent example⁵²—have implemented some form of arbitration or similar process to insulate patients from balance billing while ensuring providers are compensated. However, the federal requirements leave most patients and providers without adequate protections.

Aside from the federal rules around out-of-network emergency services, CMS finalized for 2018 a new requirement for ACA exchange health plans. QHPs in ACA exchanges must now include the cost-sharing paid by an enrollee for an essential health benefit (EHB) provided by an out-of-network provider at an in-network setting, towards the patient's MOOP.⁵³ While this requirement allows patients to reach a MOOP limit faster, it does not insulate them from future balance billing nor does it ensure the provider is sufficiently reimbursed for their services by the health plan.

As such, despite some protections, cost-sharing for out-of-network services in the exchanges continues to threaten a large financial burden on to enrollees. As prevalence of narrow exchange networks continues to increase, in-network providers of certain services could become sparser and enrollees more vulnerable to surprise costs.

Comparing Federal ACA Exchange Policies to Medicare Advantage Policies:

Federal policy for the ACA's exchanges differs from federal policy for Medicare Advantage plans, which caps cost-sharing or coinsurance services both in- and out-of-network to 50% of the total MA plan financial liability.⁵⁴ There are also additional protections for MA enrollees who are medically stabilized in an out-of-network facility who believe their health would be compromised if they were transferred to an in-network facility.⁵⁵

While federal protections for patients utilizing out-of-network services has improved since 2014, they are still woefully inadequate to protecting patients from high cost-sharing and balance billing. Limited oversight, coupled with the increasing trend towards narrower networks contribute to additional patient burdens under ACA exchange coverage.

VII. Next Steps and Opportunities for Action

This paper demonstrates in detail how patients in the ACA exchange market are burdened with an increasingly larger share of their healthcare costs in recent years. Patients are paying more in premiums and cost-sharing, and facing ever more narrow and restrictive networks. While access to insurance coverage has dramatically increased, access to insurance is but one piece to ensuring patients can afford the healthcare services they need.

In many states across the country, legislatures have passed laws that ensure stringent and sufficient network adequacy requirements, actively work to slow the growth of premiums, limit cost-sharing and deductibles, and protect patients from out-of-network charges. However, these laws are not applied in every state nor do they address all aspects of patient burden. At this rate, the increasing patient burden is unsustainable. As clearly outlined in this paper, federal and state protections have not kept pace with this increased burden, emphasizing the need for future action to ensure that a growing patient financial burden does lead to widespread barriers to care.

- 1 March 3, 2016, U.S. Department of Health and Human Services ASPE. Health Insurance Coverage and the Affordable Care Act, 2010 – 2016, <https://aspe.hhs.gov/system/files/pdf/187551/ACA2010-2016.pdf>.
- 2 June 12, 2017, CMS, 2017 Effectuated Enrollment Snapshot, <https://downloads.cms.gov/files/effectuated-enrollment-snapshot-report-06-12-17.pdf>.
- 3 April 7, 2016, Pew Research Center, *Who relies on public transit in the U.S.*, <http://www.pewresearch.org/fact-tank/2016/04/07/who-relies-on-public-transit-in-the-u-s/>.
- 4 April 2017, Dorner SC, Jacobs DB, Sommers BD. Adequacy of Outpatient Specialty Care Access in Marketplace Plans Under the Affordable Care Act. *JAMA*. 2015;314(16):1749–1750. doi:10.1001/jama.2015.9375
- 5 June 2015, Robert Wood Johnson Foundation and Penn LDI, *The Skinny on Narrow Networks in Health Insurance Marketplace Plans*, https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2015/rwjf421027.
- 6 Avalere analysis of Strenuous network data for the 2017 plan year. To conduct the analysis, Avalere determined the number of each specialty type in-network by market for 7 regions: Atlanta, GA, Philadelphia, PA, Columbus, OH, Fairfax, VA, Seattle, WA, Nashville, TN, and Salt Lake City, UT. The geographic areas of these cities are defined by the ACA Rating Region division that covers each of the cities.
- 7 August 2016, *Beyond the Numbers Vol. 5 No 13*, Bureau of Labor Statistics, <https://www.bls.gov/opub/btn/volume-5/household-health-care-spending-in-2014.htm>.
- 8 March 2017, Kaiser Family Foundation Data Note: Americans' Challenges with Health Care Costs, <https://www.kff.org/health-costs/poll-finding/data-note-americans-challenges-with-health-care-costs/>.
- 9 September 2017, Congressional Budget Office. Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2017 to 2027, <https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53091-fshic.pdf>.
- 10 September 2017, Congressional Budget Office, Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2017 to 2027. <https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53091-fshic.pdf>.
- 11 October 2016, HHS ASPE, *Health Plan Choice and Premiums in the 2017 Health Insurance Market*, <https://aspe.hhs.gov/system/files/pdf/212721/2017MarketplaceLandscapeBrief.pdf>.
- 12 August 2005, Congressional Budget Office. The Price Sensitivity of Demand for Nongroup Health Insurance, <https://www.cbo.gov/sites/default/files/109th-congress-2005-2006/reports/08-24-healthinsurance.pdf>.
- 13 Comparisons between premiums for individuals across different markets do not include adjustments for actuarial value, utilization, or age-distribution.
- 14 September 2017, Employer Health Benefits Annual Survey, <https://www.kff.org/report-section/ehbs-2017-section-1-cost-of-health-insurance/#figure11>.
- 15 September 2014, Kaiser Family Foundation. 2014 Employer Health Benefits Survey. <https://www.kff.org/report-section/ehbs-2014-summary-of-findings/>.
- 16 June 2017, Kaiser Family Foundation, Medicare Advantage 2017 Spotlight: Enrollment Market Update, <https://www.kff.org/medicare/issue-brief/medicare-advantage-2017-spotlight-enrollment-market-update/>.
- 17 December 2016, Avalere Planscape®, a proprietary analysis of exchange plan features. Average premiums are calculated using benchmark silver plan premiums in federally-facilitated exchanges (FFE).
- 18 Avalere analysis of Healthcare.gov HHS Individual Market Landscape Files. 2014 – 2017. Accessed November 2017. <https://www.cms.gov/ccio/resources/data-resources/marketplace-puf.html>
- 19 July 2016, Centers for Medicare and Medicaid Services (CMS) Data Brief: 2016 Median Marketplace Deductible \$850, with Seven Health Services Covered Before the Deductible on Average, <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-07-12.html>.
- 20 As of October 2017, the Department of Health and Human Services (HHS) officially ceased making CSR payments to health plans. Under the ACA, health plans are still required to offer CSR variations to enrollees, as such patient cost-sharing will not increase due to this decision, but health plans have responded by increasing the price of silver plans (and in some states, all metal levels) to compensate for the loss of federal CSR payments.
- 21 February 2017, Kaiser Family Foundation, Total Marketplace Enrollment and Financial Assistance, <https://www.kff.org/health-reform/state-indicator/total-marketplace-enrollment-and-financial-assistance/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.
- 22 December 2016, Kaiser Family Foundation Health Tracking Poll, <https://www.kff.org/health-costs/poll-finding/data-note-americans-challenges-with-health-care-costs/>.
- 23 December 1984, *The Effect of Coinsurance on the Health of Adults: Results from the Rand Health Insurance Experiment*. <https://www.rand.org/content/dam/rand/pubs/reports/2006/R3055.pdf>.
- 24 December 2013, *Medication Utilization and Adherence in a Health Savings Account-Eligible Plan*, *The American Journal of Managed Care*, <http://www.ajmc.com/journals/issue/2013/2013-1-vol19-n12/medication-utilization-and-adherence-in-a-health-savings-accounteligible-plan>.
- 25 November 2015. *What Does a Deductible Do? The Impact of Cost-Sharing on Health Care Prices, Quantities, and Spending Dynamics*, the National Bureau of Economic Researchers Working Paper No. 21632, <http://www.nber.org/papers/w21632>.
- 26 This includes plans operating in the FFE and California and New York exchanges.
- 27 Avalere analysis of Healthcare.gov HHS Individual Market Landscape Files. 2014 – 2017. Accessed November 2017.
- 28 July 2016, Centers for Medicare and Medicaid Services (CMS) Data Brief: 2016 Median Marketplace Deductible \$850, with Seven Health Services Covered Before the Deductible on Average, <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-07-12.html>.

- plans-with-more-restrictive-networks-comprise-73-of-exchange-market.
- 29 December 2016, Avalere PlanScape®, a proprietary analysis of exchange plan features. Avalere analyzed data from the FFE Individual Landscape File released October 2016 and the California and New York state exchange websites. In the FFE landscape file, plans note either a “combined” maximum out-of-pocket (MOOP) limit, which includes one MOOP for all medical and drug spending, or separate medical MOOP and drug MOOP limits. The information shared here examines only plans with a combined MOOP limit, which is the vast majority of exchange plans.
- 30 February 2016, Health Affairs Health Policy Brief: High Deductible Health Plans, <http://www.healthaffairs.org/doi/10.1377/hpb20160204.950878/full/>
- 31 Comparisons of plan deductibles for individuals across different markets do not include adjustments for actuarial value, utilization, or age-distribution.
- 32 September 2017, Employer Health Benefits Annual Survey, Figure 7.9, <https://www.kff.org/report-section/ehbs-2017-section-1-cost-of-health-insurance/#figure11>.
- 33 December 201., Avalere Planscape®.
- 34 HHS Healthcare.gov. Out-of-pocket maximum/limit. <https://www.healthcare.gov/glossary/out-of-pocket-maximum-limit/>.
- 35 December 2016., Avalere Planscape®.
- 36 Kill A., Houlberg K. How does copayment for health care services affect demand, health and redistribution? A systematic review of the empirical evidence from 1990 to 2011. *Eur J Health Econ.* 2014 Nov;15(8):813-28. doi: 10.1007/s10198-013-0526-8. Epub 2013 Aug 29. <https://link.springer.com/article/10.1007%2Fs10198-013-0526-8>.
- 37 Scitovsky A., Synder N. Effect of Coinsurance on Use of Physician Services. June 1972. <https://www.ssa.gov/policy/docs/ssb/v35n6/v35n6p3.pdf>.
- 38 Avalere analysis of Healthcare.gov HHS Individual Market Landscape Files. 2014 – 2017. Accessed November 2017.
- 39 Pub. L. 111-148, 124 Stat. 782 (2010) § 1311(c)(1)(B) (codified at 42 U.S.C. § 18031(c)(1)(B)).
- 40 45 C.F.R. § 156.230. In addition, the health law requires marketplace plans to include within their networks a sufficient number and geographic distribution of “essential community providers” that serve predominantly low-income, medically underserved individuals. Pub. L. 111-148, 124 Stat. 782 (2010) § 1311(c)(1)(C) (codified at 42 U.S.C. § 18031(c)(1)(C)); 45 C.F.R. § 156.235. For analysis of how some states have implemented the essential community providers requirement, see S. Rosenbaum, N. Lopez, D. Mehta et al., *Realizing Health Reform’s Potential: How Are State Insurance Marketplaces Shaping Health Plan Design?* (New York: The Commonwealth Fund, Dec. 2013); S. McCarty and M. Farris, *ACA Implications for State Network Adequacy Standards* (Princeton, N.J.: State Health Reform Assistance Network, Aug. 2013).
- 41 Avalere. Fewer PPOs Offered on Exchanges in 2016. November 5, 2016. <http://avalere.com/expertise/managed-care/insights/fewer-ppos-offered-on-exchanges-in-2016>.
- 42 Avalere. Plans with More Restrictive Networks Comprise 73% of Exchange Market. November 30, 2017. <http://avalere.com/expertise/managed-care/insights/>
- 43 March 2013, *Summary of the CMS Annual Notice to Issuers Participating in Federally-Facilitated and State Partnership Exchanges*, Avalere Health
- 44 Ibid
- 45 March 2014, CMS, 2015 Letter to Issuers in the Federally-facilitated Marketplace (FFM). <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-final-issuer-letter-3-14-2014.pdf>.
- 46 February 2016, CMS, 2017 Letter to Issuers in the Federally-facilitated Marketplaces, <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2017-Letter-to-Issuers-2-29-16.pdf>.
- 47 June 2017, Network Breadth Pilot updated CMS Bulletin on network breadth information for QHPs on HealthCare.gov, <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/NA-Pilot-Guidance.pdf>
- 48 According to HHS, a plan would be considered part of an integrated network if the majority of its covered services were provided through physicians employed by the insurance carrier or through a single contracted medical group.
- 49 Centers for Medicare & Medicaid Services. 2017 Letter to Issuers in the Federally-facilitated Marketplaces. February 29, 2016. <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2017-Letter-to-Issuers-2-29-16.pdf>.
- 50 November 2015, *Insurance Carriers and Access to HealthCare Providers/ Network Adequacy*, National Conference of State Legislatures.
- 51 Department of Health and Human Services. Final Rules for Grandfathered Plans, Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, Dependent Coverage, Appeals, and Patient Protections Under the Affordable Care Act. November 18, 2015. <https://www.gpo.gov/fdsys/pkg/FR-2015-11-18/pdf/2015-29294.pdf>.
- 52 New York Department of Financial Services. Protection from Surprise Bills and Emergency Services. <http://www.dfs.ny.gov/consumer/hprotection.htm>.
- 53 Centers for Medicare & Medicaid Services. 2018 Letter to Issuers in the Federally-facilitated Marketplaces. December 16, 2016. <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2018-Letter-to-Issuers-in-the-Federally-facilitated-Marketplaces.pdf>.
- 54 January 2017, CMS, Medicare Advantage Network Adequacy Criteria Guidance. https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/MA_Network_Adequacy_Criteria_Guidance_Document_1-10-17.pdf
- 55 January 2017, CMS, Medicare Advantage Network Adequacy Criteria Guidance. https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/MA_Network_Adequacy_Criteria_Guidance_Document_1-10-17.pdf

High Out-of-Pocket Costs and Poor Access May Prevent Georgia Patients from Accessing Needed Care



About James in Atlanta, Georgia

James lives in Atlanta, Georgia. Since 2014, James has been enrolled in on-exchange coverage. In 2016, he got a job at a small business that pays enough to make him ineligible for subsidies (\$50,000). However, his employer doesn't offer health insurance. In 2017, James selects a new on-exchange plan.

James has a variety of unexpected health complications in 2017. During the year, James's healthcare spending will reach his deductible – meaning he will need to pay the entire deductible amount out-of-pocket. His limited network means James will have to use out-of-network services, which don't count towards his deductible and require him to pay even more money out-of-pocket.

What Barriers to Access Exist for James?

In Atlanta, James is faced with high premiums (since he no longer qualifies for subsidies), substantial deductibles and out-of-pocket costs, and access to in-network physicians. These factors create financial or structural barriers to accessing care.

James Will Need to Spend Up to 15% of His Income on Premiums

\$5,335

Average Bronze Premiums

Percent of Income:
11%

\$5,663

Average Silver Premiums

Percent of Income:
11%

\$7,529

Average Gold Premiums

Percent of Income:
15%

James Faces High Up Front Costs to Use His Coverage, Even After Paying Substantial Premiums

\$6,225

Average Bronze Deductible

\$4,214

Average Silver Deductible

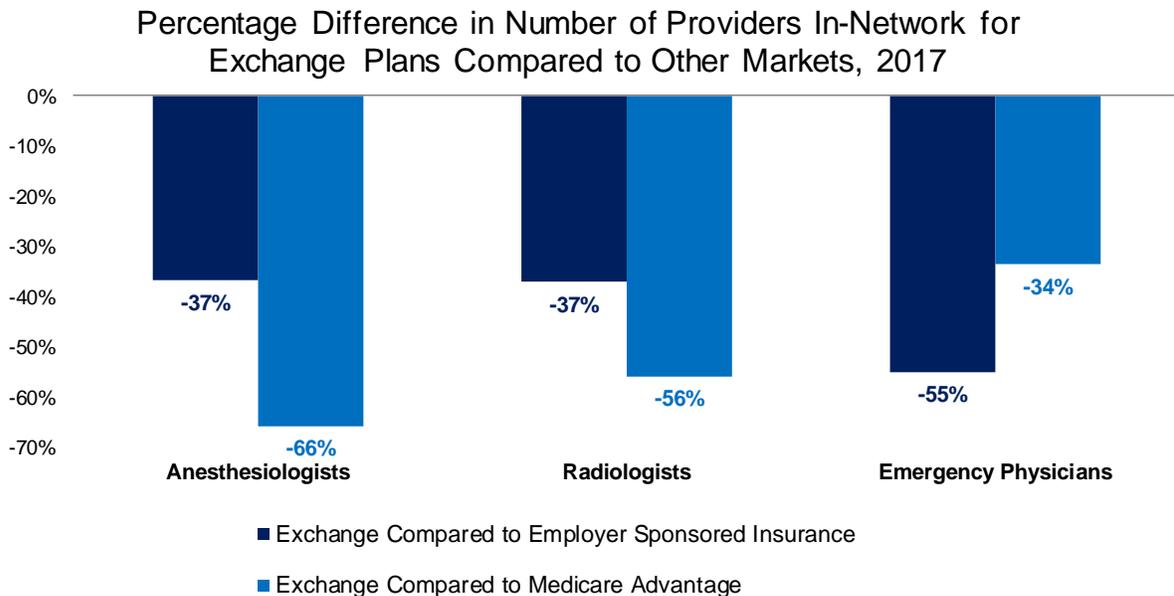
\$1,380

Average Gold Deductible

James Will Have Limited to No Out-of-Network Coverage, with 100% of Plans Offered Being HMOs



James May Find It Hard to Access to Needed Providers, With Fewer Included In-Network Compared to Commercial Coverage or Medicare



Conclusion: Patients like James in Georgia need additional protections to ensure he gets the care he needs. Georgia has the opportunity to promote regulations and legislation that ensure James has access to needed providers and affordable coverage in the coming years.

High Out-of-Pocket Costs and Poor Access May Prevent Ohio Patients from Accessing Needed Care



About James in Columbus, Ohio

James lives in Columbus, Ohio. Since 2014, James has been enrolled in on-exchange coverage. In 2016, he got a job at a small business that pays enough to make him ineligible for subsidies (\$50,000). However, his employer doesn't offer health insurance. In 2017, James selects a new on-exchange plan.

James has a variety of unexpected health complications in 2017. During the year, James's healthcare spending will reach his deductible – meaning he will need to pay the entire deductible amount out-of-pocket. His limited network means James will have to use out-of-network services, which don't count towards his deductible and require him to pay even more money out-of-pocket.

What Barriers to Access Exist for James?

In Columbus, James is faced with high premiums (since he no longer qualifies for subsidies), substantial deductibles and out-of-pocket costs, and access to in-network physicians. These factors create financial or structural barriers to accessing care.

James Will Need to Spend Up to 14% of His Income on Premiums

\$5,162

Average Bronze Premiums

Percent of Income:
10%

\$6,094

Average Silver Premiums

Percent of Income:
12%

\$6,829

Average Gold Premiums

Percent of Income:
14%

James Faces High Up Front Costs to Use His Coverage, Even After Paying Substantial Premiums

\$6,288

Average Bronze Deductible

\$3,566

Average Silver Deductible

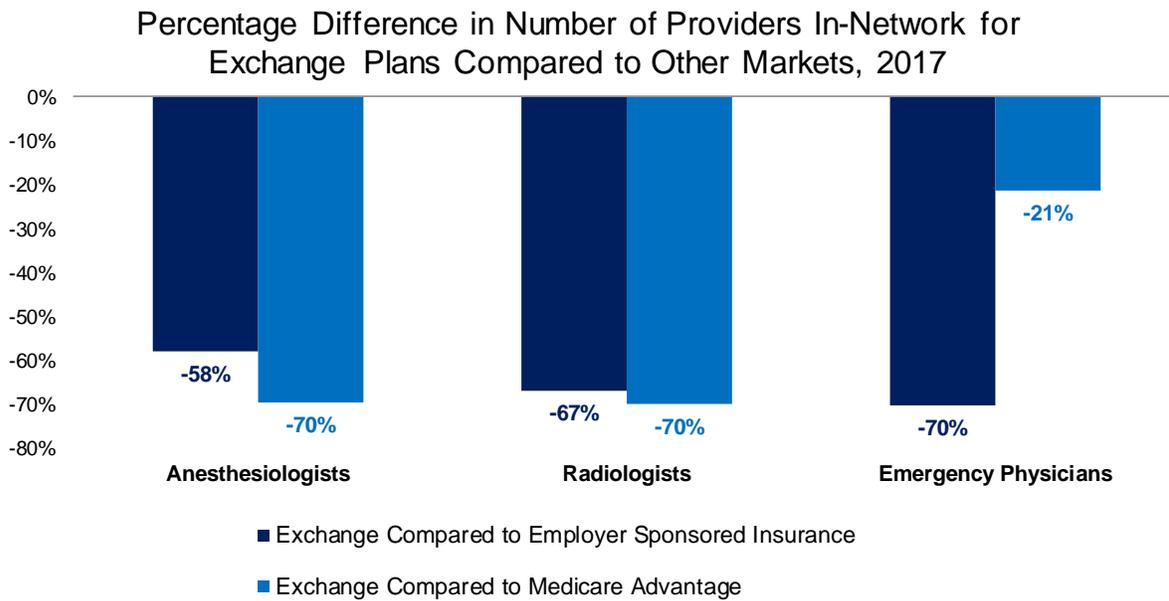
\$1,254

Average Gold Deductible

James Will Have Limited to No Out-of-Network Coverage, with 74% of Plans Offered Being HMOs



James May Find It Hard to Access to Needed Providers, With Fewer Included In-Network Compared to Commercial Coverage or Medicare



Conclusion: Patients like James in Ohio need additional protections to ensure he gets the care he needs. Ohio has the opportunity to promote regulations and legislation that ensure James has access to needed providers and affordable coverage in the coming years.

High Out-of-Pocket Costs and Poor Access May Prevent Pennsylvania Patients from Accessing Needed Care



About Jenn in Philadelphia, Pennsylvania

Jenn lives in Philadelphia, Pennsylvania. Since 2014, Jenn has been enrolled in on-exchange coverage. In 2016, she got a job at a small business that pays enough to make her ineligible for subsidies (\$50,000). However, her employer doesn't offer health insurance. In 2017, Jenn selects a new on-exchange plan.

Jenn has a variety of unexpected health complications in 2017. During the year, Jenn's healthcare spending will reach her deductible – meaning she will need to pay the entire deductible amount out-of-pocket. Her limited network means Jenn will have to use out-of-network services, which don't count towards her deductible and require her to pay even more money out-of-pocket.

What Barriers to Access Exist for Jenn?

In Philadelphia, Jenn is faced with high premiums (since she no longer qualifies for subsidies), substantial deductibles and out-of-pocket costs, and access to in-network physicians. These factors create financial or structural barriers to accessing care.

Jenn Will Need to Spend Up to 18% of Her Income on Premiums

\$5,558

Average Bronze Premiums

Percent of Income:
11%

\$6,964

Average Silver Premiums

Percent of Income:
14%

\$9,058

Average Gold Premiums

Percent of Income:
18%

Jenn Faces High Up Front Costs to Use Her Coverage, Even After Paying Substantial Premiums

\$6,383

Average Bronze Deductible

\$1,667

Average Silver Deductible

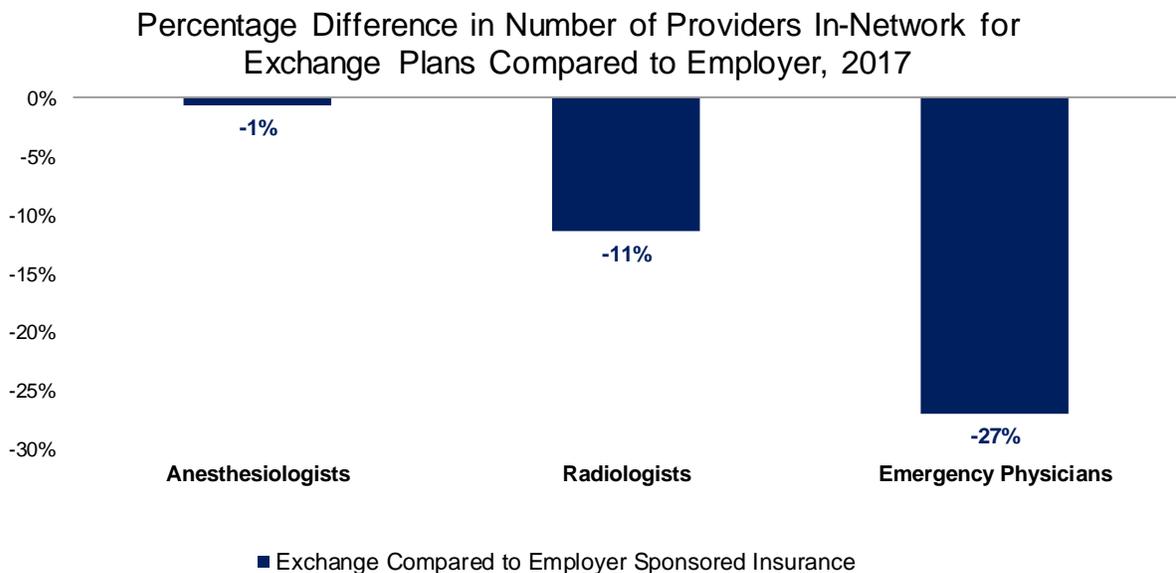
\$0

Average Gold Deductible

Jenn Will Have Limited to No Out-of-Network Coverage, with 54% of Plans Offered Being HMOs or EPOs



Jenn May Find It Hard to Access to Needed Providers, With Fewer Included In-Network Compared to Employer Coverage



Conclusion: Patients like Jenn in Pennsylvania need additional protections to ensure she gets the care she needs. Pennsylvania has the opportunity to promote regulations and legislation that ensure Jenn has access to needed providers and affordable coverage in the coming years.

High Out-of-Pocket Costs and Poor Access May Prevent Tennessee Patients from Accessing Needed Care



About Jenn in Nashville, Tennessee

Jenn lives in Nashville, Tennessee. Since 2014, Jenn has been enrolled in on-exchange coverage. In 2016, she got a job at a small business that pays enough to make her ineligible for subsidies (\$50,000). However, her employer doesn't offer health insurance. In 2017, Jenn selects a new on-exchange plan.

Jenn has a variety of unexpected health complications in 2017. During the year, Jenn's healthcare spending will reach her deductible – meaning she will need to pay the entire deductible amount out-of-pocket. Her limited network means Jenn will have to use out-of-network services, which don't count towards her deductible and require her to pay even more money out-of-pocket.

What Barriers to Access Exist for Jenn?

In Nashville, Jenn is faced with high premiums (since she no longer qualifies for subsidies), substantial deductibles and out-of-pocket costs, and access to in-network physicians. These factors create financial or structural barriers to accessing care.

Jenn Will Need to Spend Up to 20% of Her Income on Premiums

\$5,769

Average Bronze Premiums

Percent of Income:
12%

\$7,541

Average Silver Premiums

Percent of Income:
15%

\$9,871

Average Gold Premiums

Percent of Income:
20%

Jenn Faces High Up Front Costs to Use Her Coverage, Even After Paying Substantial Premiums

\$5,713

Average Bronze Deductible

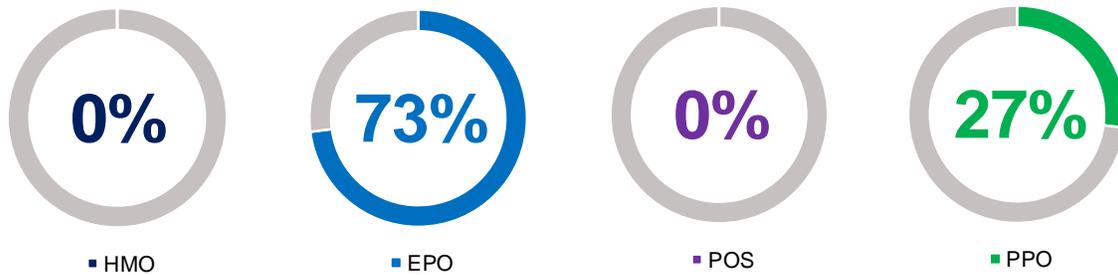
\$3,410

Average Silver Deductible

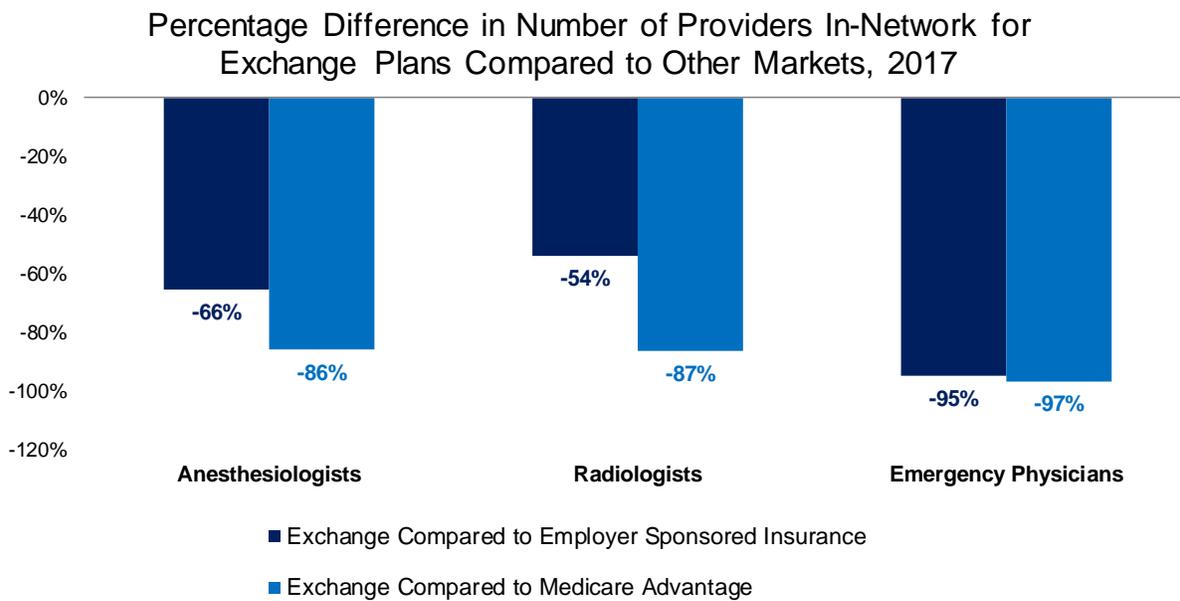
\$1,625

Average Gold Deductible

Jenn Will Have Limited to No Out-of-Network Coverage, with 73% of Plans Being EPOs



Jenn May Find It Hard to Access to Needed Providers, With Fewer Included In-Network Compared to Employer Coverage or Medicare Advantage



Conclusion: Patients like Jenn in Tennessee need additional protections to ensure she gets the care she needs. Tennessee has the opportunity to promote regulations and legislation that ensure Jenn has access to needed providers and affordable coverage in the coming years.

High Out-of-Pocket Costs and Poor Access May Prevent Utah Patients from Accessing Needed Care



About James in Salt Lake City, Utah

James lives in Salt Lake City, Utah. Since 2014, James has been enrolled in on-exchange coverage. In 2016, he got a job at a small business that pays enough to make him ineligible for subsidies (\$50,000). However, his employer doesn't offer health insurance. In 2017, James selects a new on-exchange plan.

James has a variety of unexpected health complications in 2017. During the year, James's healthcare spending will reach his deductible – meaning he will need to pay the entire deductible amount out-of-pocket. His limited network means James will have to use out-of-network services, which don't count towards his deductible and require him to pay even more money out-of-pocket.

What Barriers to Access Exist for James?

In Salt Lake City, James is faced with high premiums (since he no longer qualifies for subsidies), substantial deductibles and out-of-pocket costs, and access to in-network physicians. These factors create financial or structural barriers to accessing care.

James Will Need to Spend Up to 18% of His Income on Premiums

\$4,547

Average Bronze Premiums

Percent of Income:
9%

\$5,870

Average Silver Premiums

Percent of Income:
12%

\$8,763

Average Gold Premiums

Percent of Income:
18%

James Faces High Up Front Costs to Use His Coverage, Even After Paying Substantial Premiums

\$6,359

Average Bronze Deductible

\$3,395

Average Silver Deductible

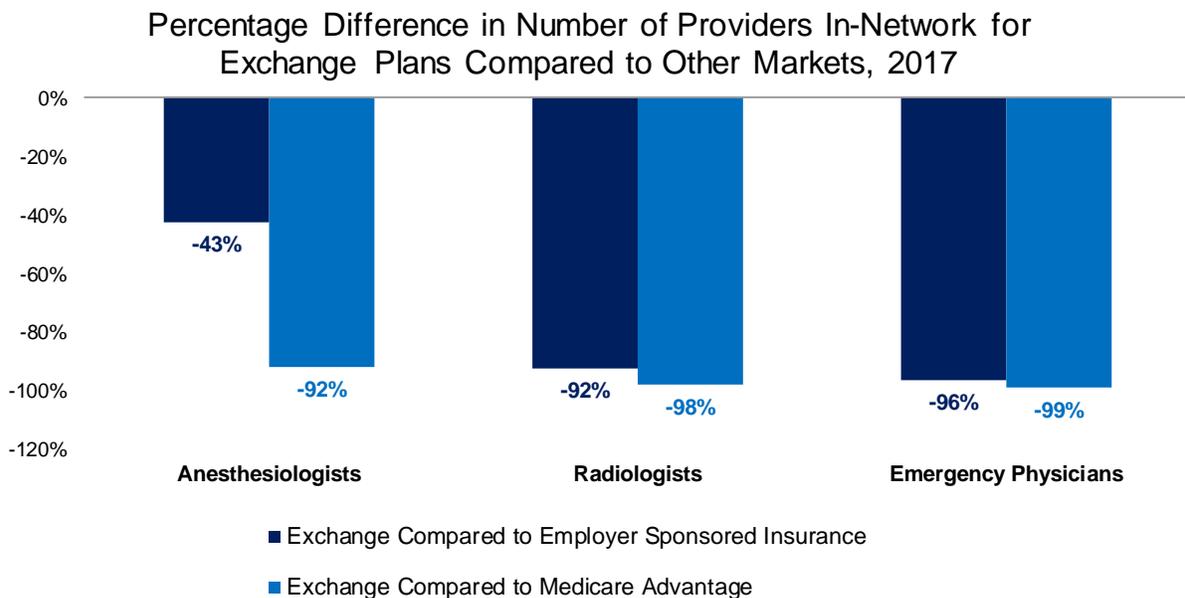
\$1,319

Average Gold Deductible

James Will Have Limited to No Out-of-Network Coverage, with 81% of Plans Offered Being HMOs



James May Find It Hard to Access to Needed Providers, With Fewer Included In-Network Compared to Commercial Coverage or Medicare



Conclusion: Patients like James in Utah need additional protections to ensure he gets the care he needs. Utah has the opportunity to promote regulations and legislation that ensure James has access to needed providers and affordable coverage in the coming years.

High Out-of-Pocket Costs and Poor Access May Prevent Virginia Patients from Accessing Needed Care



About Jenn in Fairfax, Virginia

Jenn lives in Fairfax, Virginia. Since 2014, Jenn has been enrolled in on-exchange coverage. In 2016, she got a job at a small business that pays enough to make her ineligible for subsidies (\$50,000). However, her employer doesn't offer health insurance. In 2017, Jenn selects a new on-exchange plan.

Jenn has a variety of unexpected health complications in 2017. During the year, Jenn's healthcare spending will reach her deductible – meaning she will need to pay the entire deductible amount out-of-pocket. Her limited network means Jenn will have to use out-of-network services, which don't count towards her deductible and require her to pay even more money out-of-pocket.

What Barriers to Access Exist for Jenn?

In Fairfax, Jenn is faced with high premiums (since she no longer qualifies for subsidies), substantial deductibles and out-of-pocket costs, and access to in-network physicians. These factors create financial or structural barriers to accessing care.

Jenn Will Need to Spend Up to 16% of Her Income on Premiums

\$4,884

Average Bronze Premiums

Percent of Income:
10%

\$6,065

Average Silver Premiums

Percent of Income:
12%

\$7,919

Average Gold Premiums

Percent of Income:
16%

Jenn Faces High Up Front Costs to Use Her Coverage, Even After Paying Substantial Premiums

\$6,029

Average Bronze Deductible

\$3,653

Average Silver Deductible

\$1,204

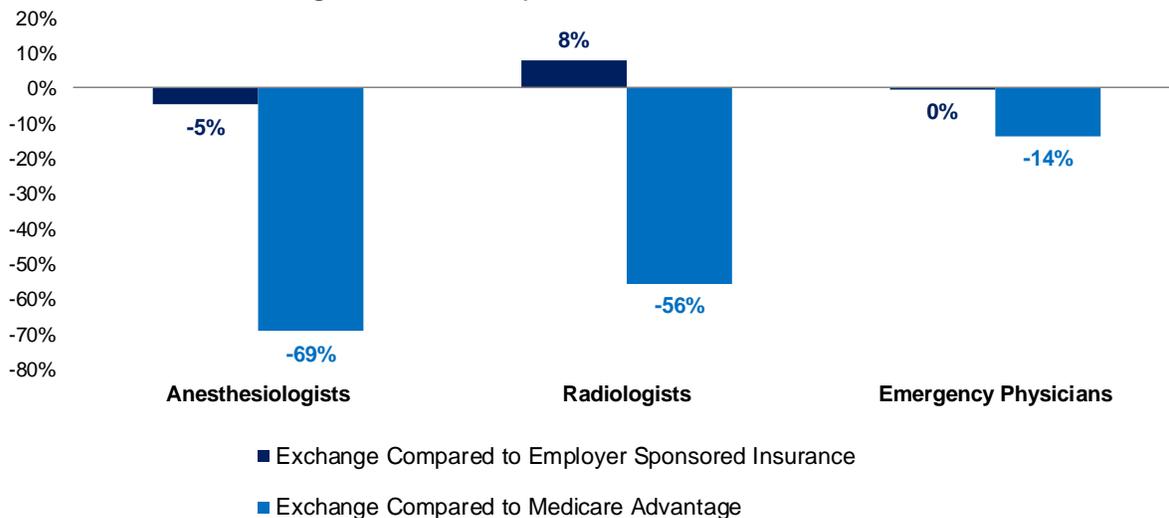
Average Gold Deductible

Jenn Will Have Limited to No Out-of-Network Coverage, with 76% of Plans Offered Being HMOs or EPOs



Jenn May Find It Hard to Access to Needed Providers, With Fewer Included In-Network Compared to Medicare Advantage

Percentage Difference in Number of Providers In-Network for Exchange Plans Compared to Other Markets, 2017



Conclusion: Patients like Jenn in Virginia need additional protections to ensure she gets the care she needs. Virginia has the opportunity to promote regulations and legislation that ensure Jenn has access to needed providers and affordable coverage in the coming years.

High Out-of-Pocket Costs and Poor Access May Prevent Washington Patients from Accessing Needed Care



About Jenn in Seattle, Washington

Jenn lives in Seattle, Washington. Since 2014, Jenn has been enrolled in on-exchange coverage. In 2016, she got a job at a small business that pays enough to make her ineligible for subsidies (\$50,000). However, her employer doesn't offer health insurance. In 2017, Jenn selects a new on-exchange plan.

Jenn has a variety of unexpected health complications in 2017. During the year, Jenn's healthcare spending will reach her deductible – meaning she will need to pay the entire deductible amount out-of-pocket. Her limited network means Jenn will have to use out-of-network services, which don't count towards her deductible and require her to pay even more money out-of-pocket.

What Barriers to Access Exist for Jenn?

In Seattle, Jenn is faced with high premiums (since she no longer qualifies for subsidies), substantial deductibles and out-of-pocket costs, and access to in-network physicians. These factors create financial or structural barriers to accessing care.

Jenn Will Need to Spend Up to 15% of Her Income on Premiums

\$5,341

Average Bronze Premiums

Percent of Income:
11%

\$6,539

Average Silver Premiums

Percent of Income:
13%

\$7,497

Average Gold Premiums

Percent of Income:
15%

Jenn Faces High Up Front Costs to Use Her Coverage, Even After Paying Substantial Premiums

\$6,500

Average Bronze Deductible

\$4,854

Average Silver Deductible

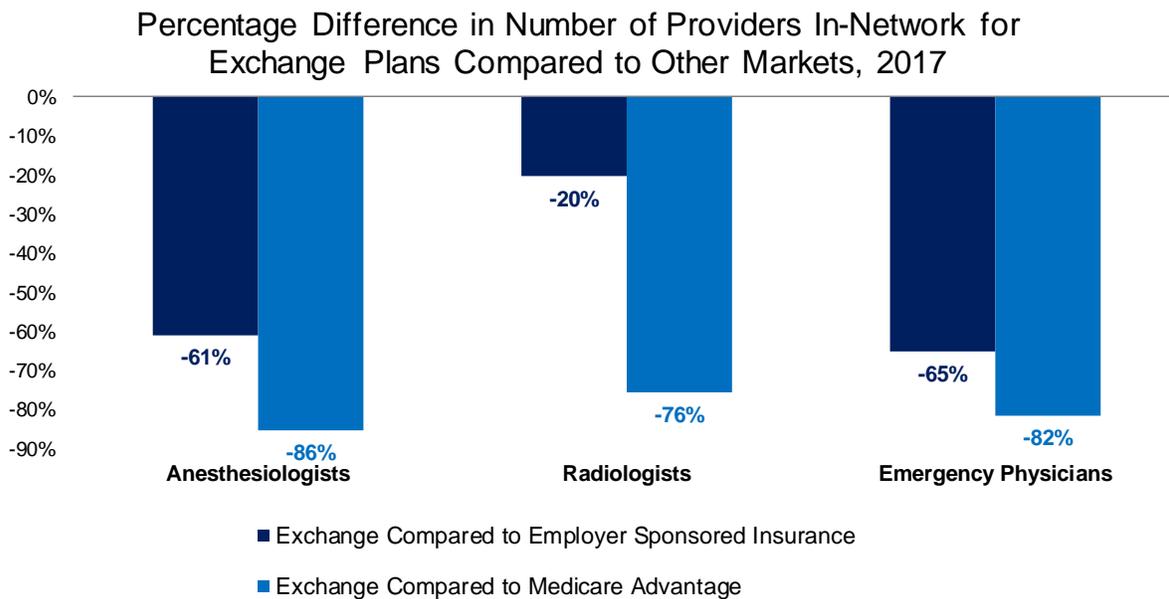
\$1,883

Average Gold Deductible

Jenn Will Have Limited to No Out-of-Network Coverage, with 95% of Plans Being HMOs



Jenn May Find It Hard to Access to Needed Providers, With Fewer Included In-Network Compared to Employer Coverage or Medicare Advantage



Conclusion: Patients like Jenn in Washington need additional protections to ensure she gets the care she needs. Washington has the opportunity to promote regulations and legislation that ensure Jenn has access to needed providers and affordable coverage in the coming years.