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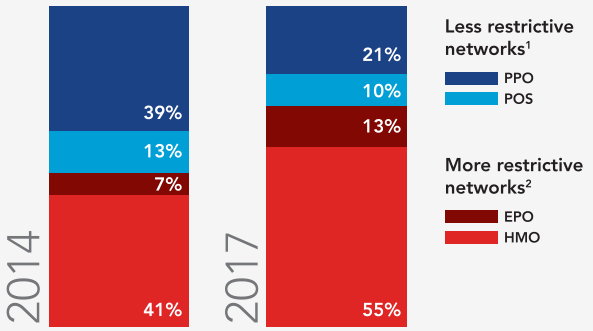
New Research Shows Higher Patient Costs and Reduced Coverage Networks in Exchange Markets 2014-2017

New research conducted by Avalere shows that health insurance plans are charging patients more for plans through increasingly higher premiums, deductibles and cost sharing, while the insurance networks these plans offer are becoming more narrow and restrictive. Patients are paying more for less coverage, doctors are being paid the same and insurance companies are making record profits.

Healthcare Networks Available on Exchange Markets Have Grown Increasingly Narrow, Restricting Patient Access to Care

These restrictive plans limit consumer choice by reducing the number of providers in-network and the ability to access out-of-network care if needed. At the same time, narrow networks can expose patients to high out-of-pocket costs and increase the risk of patients receiving surprise medical bills. Specialty providers like anesthesiologists, radiologists and emergency physicians are often not covered by these plans, exposing patients to high out-of-network costs, especially since so many plans in these markets don't cover any out-of-network care.

PERCENTAGE OF PLAN OFFERINGS BY PLAN TYPE, 2014-2017

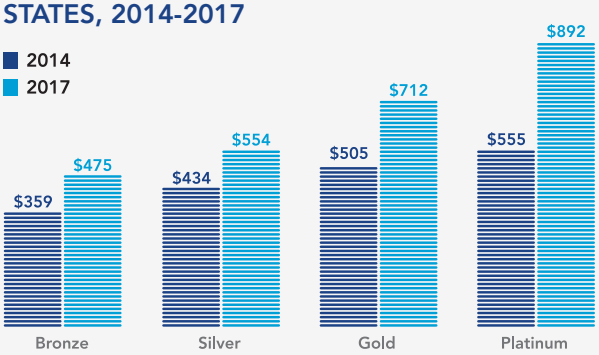


- In 2017, **68% of healthcare plans** in the exchange market offered restrictive networks, compared with 48% in 2014.
- Nearly **41%** of silver plan physician networks in 2015 were defined as **small** or **extra small**.
- Insurance plans offered in exchange markets in 2017 covered between **34% to 66% fewer providers** than plans available in other markets.
- In 2015, nearly **15% of insurance plans in exchange markets were "specialist-deficient"** lacking any in-network provider for at least one speciality, like radiologists.

Patient Costs for Insurance are Increasing Faster in Exchange Markets

30% of people with health insurance report trouble affording premiums and other patient cost-sharing. Consumers in exchange markets are faced with the largest increases in premiums since 2014. Deductibles and maximum out-of-pocket limits are also increasing, adding to higher annual out-of-pocket costs for patients with exchange plans. Some patients must pay thousands of dollars out-of-pocket before their health plan starts to share in the cost of care. This can lead to patients putting off preventative or other care, putting them at risk for worse health outcomes in the long run.

AVERAGE PLAN PREMIUMS, FFE STATES, 2014-2017



- Average health insurance plan **premiums increased 28% for exchange plans** from 2014 to 2017.
- **Almost 90% of enrollees** in exchange plans had deductibles above $1,300, the IRS definition of a high-deductible plan.
- Deductibles and maximum out-of-pocket (MOOP) limits are rising, too. The **average MOOP limit has increased by 12%** in the past four years.
- Plans are also shifting **to coinsurance vs. copays**, which can leave patients exposed to higher, unpredictable costs.

Insurers Are Increasing Profit Margins While Doctor Salaries Remain Consistent

Several top insurance companies saw profit margins in Q1 for 2018 that were the highest in a decade. Aetna Inc., recorded a profit margin of 1.2 billion, its largest since 2004, and Centene Corp. reported its most profitable quarter since 2008 at 1.8 billion. Four of the largest insurers had profit margins that were between 5% and 8%.

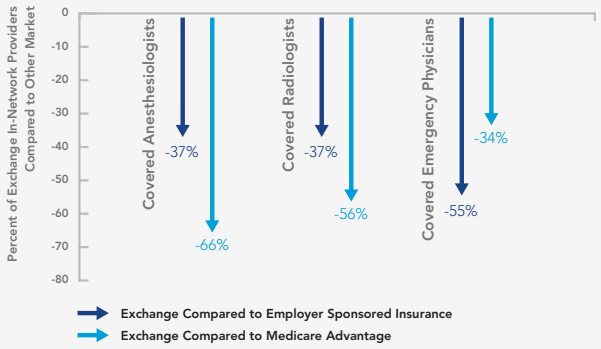
Meanwhile, emergency medicine physicians on average throughout the U.S. earned around 3% more in 2018 than in 2017, just slightly more than the rate of inflation at 2.54%. Doctors practicing in dense, metropolitan areas have seen their salaries decline or barely keep up with inflation.

Despite rising costs for patients and no major increases in physician salaries, health insurance CEOs are some of the highest paid individuals of all U.S. corporations. **All six of the largest insurance companies paid their CEOs over $17 million** in total compensation in 2017, with several making upwards of $25 million. As this research shows, **insurers are making record profits while raising patient premiums, often by double-digits each year, and limiting patient access to doctors and hospitals.**

Federal and State Network Adequacy Rules Are Insufficient

The ACA established a national standard for network adequacy. Exchange plans are supposed to maintain "a network that is sufficient in number and types of providers" so that "all services will be accessible without unreasonable delay." And all plans are required to disclose their provider directories to the exchange for online publication. But these standards have clearly not stemmed the increasing prevalence of insurance companies offering plans with narrow provider networks. And, they don't enforce a standard for all provider types. States have latitude to go beyond these standards, and state standards vary widely. Even states that go beyond federal standards vary in their standards for protecting patients.

IN-NETWORK INCLUSION OF PROVIDERS BY MARKET, COMPARING ACA EXCHANGE NETWORK INCLUSION TO TRADITIONAL COMMERCIAL AND MEDICARE ADVANTAGE, 2017



- In 2018 **73% of plans offered narrow networks** in exchange markets. **Exchange plans covered between 34% and 66% fewer specialty providers** than plans available in other markets.
- CMS has routinely pulled back on network adequacy requirements, giving insurance plans more flexibility. Insurance plans can submit justifications for failing to meet adequacy standards without detailed information.
- **Specialties like radiologists and anesthesiologists are routinely excluded from reviews** – meaning no one is checking to see if these services are provided adequately to patients, exposing them to potentially high out-of-network bills.

What Does This Mean? Patients Are Increasingly Vulnerable to Surprise Bills.

The ACA provides some level of out-of-network protections for patients. However, as health plans are increasingly offering limited or non-existent out-of-network coverage, patients are at higher risk of bearing greater costs and receiving balance bills for services their insurers aren't covering.

Some states, including New York and Connecticut, have implemented laws to protect patients from balance billing while ensuring providers are compensated. But federal requirements alone leave most patients and providers exposed.

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End the Surprise Insurance Gap is powered by Physicians for Fair Coverage, a national non-profit, non-partisan multi-specialty alliance of physician practices advocating for state and national legislation that takes patients out of the middle, boosts transparency, and effectively ends surprise billing while ensuring access to quality healthcare.

RESEARCH CONDUCTED BY AVALERE, A LEADING HEALTHCARE RESEARCH FIRM LOCATED IN WASHINGTON, DC