



Affordable Care Act

Non-Group Health Insurance: Many Insured Americans with High Out-of-Pocket Costs Forgo Needed Health Care

Executive Summary

Since its passage in 2010, the Affordable Care Act (ACA) has made tremendous progress in improving access to health insurance and health care for millions of Americans. Approximately 14.1 million previously uninsured Americans gained health insurance between the beginning of open enrollment in October 2013 and March 4, 2015. In fact, by that date, the share of Americans who were uninsured had dropped to 13.2 percent, compared to 20.3 percent at the end of 2013—the largest decrease in the number of uninsured since 1965.¹

Some of the greatest declines in uninsured rates were for lower- and middle-income consumers,² including those eligible for tax credits to help pay their premiums for plans in the health insurance marketplaces. Data from the Department of Health and Human Services also show that more than 11 million people selected plans through the marketplaces, and more than 85 percent of these consumers qualified for premium tax credits.³

But simply having health insurance is no guarantee that consumers can afford to pay for health care. Health insurance involves different types of costs that consumers must pay out of pocket—ranging from a health plan's deductible to copayments at a doctor's office. These

expenses add up, and research has shown that even nominal cost-sharing can deter people from getting needed care.⁴ Unfortunately—as our study shows—for many Americans with non-group coverage, deductibles and other out-of-pocket costs are prohibitively high and are associated with many of these insured consumers forgoing needed health care.

Our study examined adults who bought private health insurance in the non-group market in 2014

We analyzed data from the Urban Institute's Health Reform Monitoring Survey (HRMS) on adults who bought private, non-group health insurance (as opposed to having insurance from an employer or a public coverage program) for themselves or their families in 2014. Our study examines the following:

- » The incomes of adults who bought insurance, as well as the deductibles for those adults, grouped by three income levels: 139-249 percent of the federal poverty level, 250-399 percent of poverty, and 400 percent of poverty and higher.
- » Problems that adults experienced with being able to afford health care, grouped by these income levels: 139-249 percent of poverty and 250 percent of poverty or more, and also grouped by the amount of their deductible.

Simply having health insurance is no guarantee that consumers can afford to pay for health care.

Unfortunately—as our study shows—for many Americans with non-group coverage, deductibles and other out-of-pocket costs are prohibitively high and are associated with many of these insured consumers forgoing needed health care.

The Affordable Care Act has increased access to health insurance and financial assistance for millions of Americans. But even with the new assistance that helps consumers pay their premiums and out-of-pocket health care costs, one-quarter of consumers who buy insurance on their own still have problems being able to afford needed care.

This report analyzes the portion of adults who bought non-group health insurance and who went without needed medical care because they could not afford it or who faced high deductibles. It also includes an analysis of the potential causes of these affordability issues, as well as recommendations that health insurers and state and federal governments can take to improve the affordability of consumers' out-of-pocket health care costs.

Income Levels of People Surveyed for This Report

In this report, we present findings for adults who bought insurance in the non-group market—people who bought health plans for themselves or their families (as opposed to having insurance from an employer or public coverage program). For several measures, we analyzed adults from two income groups and divided them accordingly:

- Adults with **lower to middle incomes**, who had family incomes between 139 and 249 percent of poverty (from \$16,200 to \$29,199 for an individual in 2014, or from \$27,400 to \$49,499 for a family of three). This group is eligible for two kinds of financial help in the health insurance marketplaces: They can get tax credits to lower their monthly premiums, and they qualify for cost-sharing reduction subsidies, which lower their deductibles, copayments, or total out-of-pocket expenses in marketplace plans.
- Adults with **middle incomes**, who had family incomes between 250 and 399 percent of poverty (from \$29,200 to \$46,699 for an individual in 2014, or from \$49,500 to \$79,199 for a family of three). People in this group are eligible only for premium tax credits to lower their monthly premiums.

We excluded from our sample people who had family incomes at or below 138 percent of poverty, because that group is eligible for Medicaid in many states.

Defining High Deductibles

In this report, we define plans with “*high deductibles*” as plans with deductibles of \$1,500 or more per person.

The IRS defines high deductibles somewhat differently. For 2014, the IRS defined plans with high deductibles that could be used with health savings accounts as plans with deductibles of \$1,250 or more for an individual and \$2,500 or more for a family. In our study, \$1,500 was the number that was closest to the \$1,250 figure the IRS uses, which is why we chose that amount as the level for a high deductible.

We call plans with deductibles of \$3,000 or more per person plans with “*exceedingly high deductibles*.” However, consumers can have deductibles that are much higher: Plans that are sold to consumers in the non-group market can have deductibles that are as high as \$6,600 for an individual in 2015.

The Affordable Care Act Is Making Health Insurance and Health Care More Affordable

The Affordable Care Act (ACA) is having a measurable impact on Americans' access to health insurance, particularly those with lower to middle incomes. Research has found that the number of uninsured in this country has reached historic lows since full implementation of the ACA's coverage provisions.⁵ This is in large part due to the availability of new financial assistance to help lower- and middle-income individuals and families afford private, non-group insurance through the marketplaces, as well as to the expansion of Medicaid to low-income adults in 28 states plus the District of Columbia.⁶

And our own findings bear this out: The share of people with non-group insurance who have lower to middle incomes jumped by more than 10 percentage points from 2013 to 2014, a sign that people are seeking out and using the health care law's premium tax credits and other financial assistance. We also found that more individuals with non-group coverage had no deductible in 2014 compared to 2013 (the percentage nearly tripled), and that marketplace insurance is making out-of-pocket costs more affordable for many.

Report findings

Among adults who bought non-group insurance:

1 In 2014, the proportion of insured adults with lower to middle incomes increased (see Table 1).

In 2014, the first year that financial assistance was available in the marketplace to make insurance more affordable, more people who bought insurance on their own had lower to middle incomes.

The proportion of non-group adult enrollees who had lower to middle incomes increased from about one-quarter (**25.4** percent) in 2013 to more than one-third (**36.9** percent) in 2014.

2 More adults who bought non-group insurance had no deductible in 2014 than in 2013 (see Table 2).

The percent of adults with non-group insurance who had zero deductible nearly tripled, jumping from **3.6** percent in 2013 to **10.6** percent in 2014.

3 Adults who bought their insurance in the marketplace were less likely to have high deductibles or exceedingly high deductibles than those who bought their insurance outside the marketplace (see Table 3).

High deductibles: **42.8** percent of adults with non-group insurance in the marketplace reported having high deductibles of \$1,500 or more per person, compared to **58.3** percent of adults with non-group insurance outside the marketplace.

Exceedingly high deductibles: **22.5** percent of adults with non-group insurance in the marketplace reported having exceedingly high deductibles of \$3,000 or more per person, compared to **37.5** percent of adults with non-group insurance outside the marketplace.

However, as further discussed in the Methodology, some of the magnitude of these differences could be attributable to difficulties in how marketplace enrollees were identified in our survey data. We did more testing on questions to see if errors in survey responses could account for the change. While we could not be sure of the exact percentages of people who had no deductible in 2014, we continued to find that the increase was statistically significant, probably due to the availability of zero dollar deductible plans in the marketplace.⁷

Note: Unless otherwise noted, all of the adults referenced in our findings have incomes above 138 percent of poverty.

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One-Quarter of Health Care Consumers with Non-Group Insurance Still Have Problems Affording Care

Our data also show that many Americans with non-group insurance still have problems being able to afford needed care. Just over one-quarter of adults who were insured for a full year still reported that they went without needed medical care during that year because they could not afford it. People with lower to middle incomes were more likely to forgo medical care due to affordability issues than people with higher incomes (those with incomes at or above 250 percent of poverty).

Furthermore, we found that people with high-deductible health plans were more likely than those with lower deductibles to forgo care. These high-deductible plans are common, even among those with lower to middle incomes: Our analysis found that nearly two in five lower- to middle-income adults had deductibles of \$1,500 or more per person.

Report findings

Among adults who bought non-group insurance:

4 Just over one-quarter (25.2 percent) of adults who were insured for a full year went without needed medical care because they could not afford it (excluding dental care, see Table 4).

The two most common types of care that adults went without were:

Tests, treatments, and follow-up care: **15.3** percent went without needed tests or follow-up care

Prescription drugs: **14.2** percent went without needed medications

5 Adults with lower to middle incomes were the most likely to forgo needed medical care (excluding dental care, see Table 5).

For **lower- to middle-income** adults who were insured for a full year, **32.3** percent didn't get needed medical care because they could not afford it.

For adults with **middle or higher incomes** (at or above 250 percent of poverty), a lower number—**22.2** percent—didn't get needed medical care because they could not afford it.

6 Adults with high deductibles were more likely to forgo needed medical care (excluding dental care, see Table 6).

For adults with deductibles of \$1,500 or more per person who were insured for a full year, **29.8** percent went without needed medical care because they could not afford it.

For adults with deductibles under \$1,500 per person, only **19.6** percent went without needed medical care because they could not afford it.

7 In 2014, half (50.6 percent) of adults had high deductibles of \$1,500 or more, and 30 percent had exceedingly high deductibles of \$3,000 or more (see Table 7).

Of adults with **lower to middle incomes**, **39.3** percent had high deductibles of \$1,500 or more per person, and **22** percent had exceedingly high deductibles of \$3,000 or more per person.

And for **middle-income** adults, **53.2** percent had high deductibles of \$1,500 or more per person, and **29.9** percent had exceedingly high deductibles of \$3,000 or more per person.

Note: Unless otherwise noted, all of the adults referenced in our findings have incomes above 138 percent of poverty.

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Introduction

Consumers who buy health insurance in the non-group market saw many welcome changes in 2014, including several consumer protections. Many of these protections apply to insurance bought both inside and outside the health insurance marketplaces established by the Affordable Care Act (see sidebar).

But even with these changes, insured consumers may still have problems being able to afford care or understand their health plan's benefits. They may face high deductibles before their plans begin to pay for any care beyond preventive services. And after meeting their deductibles, they may still have to pay steep copayments and co-insurance until they reach their annual limit on out-of-pocket expenses. In addition, many consumers continue to struggle to understand the benefits and costs associated with their insurance.

We undertook this study to examine the portion of adults with non-group insurance who had high deductibles, difficulty affording care, and trouble understanding how to use their health insurance in 2014—the first year the marketplaces were fully operational. Using survey data collected in September 2013, September 2014, and December 2014 through the Urban Institute's quarterly Health Reform Monitoring Survey, we examined coverage,

deductibles, reported problems with affording health care, and the ability to understand health insurance among adults with non-group coverage. We compared data across adults of various income levels, and, for some measures, between adults with marketplace coverage and adults with non-group coverage outside the marketplace.

Insurance Improvements for Consumers Who Buy Non-Group Coverage

Consumer protections that apply to insurance sold both inside and outside the marketplaces:

- Insurance companies can no longer deny coverage to people with pre-existing conditions or charge them higher premiums.
- Health plans must cover a more comprehensive scope of health care services and cover certain preventive services with no cost-sharing.
- There are annual limits on the most an individual or family has to pay out of pocket for covered benefits that are provided through their plan's network.
- Health plans are classified as platinum, gold, silver, or bronze based on their level of cost-sharing, which helps consumers understand how generous a plan's coverage is.

Benefits that apply only to plans sold in the marketplaces:

- Consumers with lower and middle incomes may qualify for tax credits to help pay for premiums.
- Consumers with lower to middle incomes may also qualify for cost-sharing reduction subsidies that lower their out-of-pocket costs for covered services.
- Marketplace websites provide new tools to help consumers compare plans and learn about insurance.

Abridged Methodology

We contracted with the Urban Institute to analyze data from the Health Reform Monitoring Survey (HRMS) collected in September 2013, September 2014, and December 2014 regarding people who bought non-group individual or family health insurance. This quarterly survey is designed to provide timely information about implementation issues in the Affordable Care Act and about changes in insurance. The questions in the HRMS are often based on questions used in federal government surveys. More information about the survey is available online at <http://hrms.urban.org/about.html>.

We asked the Urban Institute to analyze data on non-elderly adults with non-group insurance (that is, insurance people bought for themselves or their families, rather than insurance people get through their employers or a public coverage program), including data on their deductibles and access to care. We limited our analysis to respondents with incomes above 138 percent of poverty for two reasons: First, this is the primary population that the Affordable Care Act is designed to help afford non-group insurance. And second, we wanted to be sure respondents were not confusing non-group insurance with Medicaid (which is available to consumers with incomes up to 138 percent of poverty in states that have expanded Medicaid under the Affordable Care Act).

We also limited our analysis of adults not getting needed care to adults who did not get needed medical care—excluding dental care. This is because health plans typically do not cover dental care for adults, and the primary focus of our analysis is assessing the problems consumers have being able to afford *covered care* due to cost-sharing. Adults' inability to afford dental care may be due to their not having any dental coverage rather than to problems with affording the cost-sharing associated with their health plan.

The Urban Institute tested all reported data for significance and reviewed this report for accuracy. For the full methodology, including key assumptions and limitations, see page 24.

I. The Affordable Care Act Is Making Health Insurance and Health Care More Affordable

Section findings

Since the full implementation of the Affordable Care Act's coverage provisions, there have been landmark improvements in people's access to affordable health insurance and health care. As we noted earlier, surveys have found that the number of uninsured in this country has dipped to an historic low since the ACA was fully implemented.

Our findings also show notable improvements related to the affordability of health coverage and care for those buying insurance on their own in 2014. A greater portion of adults with non-group insurance had lower to middle incomes, and more people with non-group insurance had no deductible whatsoever in 2014. This is an encouraging sign that the affordability of both coverage and care is improving for some consumers.

People with marketplace insurance also were less likely to have high deductibles than people buying insurance on their own outside the marketplace in 2014. This underscores the enhanced value that marketplace coverage is providing to consumers, particularly those who qualify for financial assistance to help with cost-sharing in marketplace plans.

Among adults who bought non-group insurance:

1 In 2014, the proportion of insured adults with lower to middle incomes increased (see Table 1).

In 2014, the first year that financial assistance was available in the marketplace to make insurance more affordable, more people who bought insurance on their own had lower to middle incomes.

The proportion of non-group adult enrollees who had lower to middle incomes increased from about one-quarter (25.4 percent) in 2013 to more than one-third (36.9 percent) in 2014.

2 More adults who bought non-group insurance had no deductible in 2014 than in 2013 (see Table 2).

The percent of adults with non-group insurance who had zero deductible nearly tripled, jumping from 3.6 percent in 2013 to 10.6 percent in 2014.

3 Adults who bought their insurance in the marketplace were less likely to have high deductibles or exceedingly high deductibles than those who bought their insurance outside the marketplace (see Table 3).

High deductibles: 42.8 percent of adults with non-group insurance in the marketplace reported having high deductibles of \$1,500 or more per person, compared to 58.3 percent of adults with non-group insurance outside the marketplace.

Exceedingly high deductibles: 22.5 percent of adults with non-group insurance in the marketplace reported having exceedingly high deductibles of \$3,000 or more per person, compared to 37.5 percent of adults with non-group insurance outside the marketplace.

However, as further discussed in the Methodology, some of the magnitude of these differences could be attributable to difficulties in how marketplace enrollees were identified in our survey data. We did more testing on questions to see if errors in survey responses could account for the change. While we could not be sure of the exact percentages of people who had no deductible in 2014, we continued to find that the increase was statistically significant, probably due to the availability of zero dollar deductible plans in the marketplace.⁷

Note: Unless otherwise noted, all of the adults referenced in our findings have incomes above 138 percent of poverty.

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Financial assistance is helping lower- to middle-income adults afford insurance

The share of adults buying coverage on their own who had lower to middle incomes rose by more than 10 percentage points from 2013 to 2014. That's an important finding because people in this income group are the least likely to be able to afford the full cost of private insurance on their own. And that's precisely why the Affordable Care Act provides generous premium tax credits to this population.

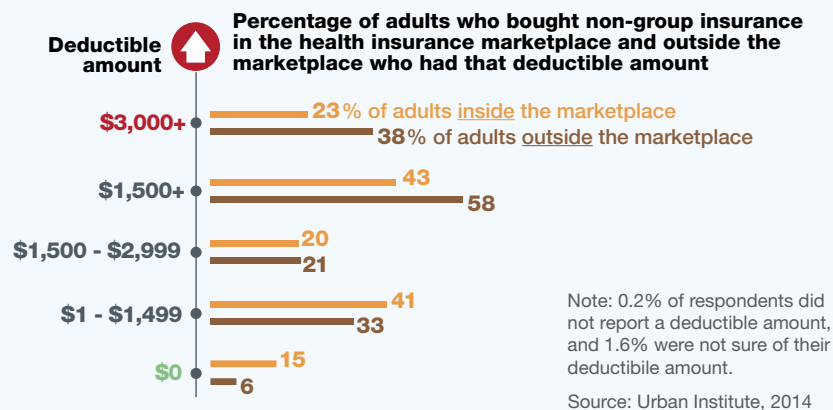
This finding is an encouraging sign that the ACA's financial assistance is truly helping more lower- to middle-income Americans afford insurance on their own.

We are hopeful that the increased proportion of non-group enrollees with lower and middle incomes is a sign that the disparity in access to coverage is closing. The Census Bureau's Current Population Survey shows that before the Affordable Care Act, people with incomes below 250 percent of poverty were less likely to have private insurance (that is, insurance either through a job or through buying non-group coverage) than people at higher income levels, and they were more likely to be uninsured.⁸

More adults have zero deductible, meaning they face one less potential barrier to care

The percent of adults with non-group insurance that had zero deductible significantly increased from 2013 to 2014, rising from 3.6 percent in 2013 to 10.6 percent in 2014. Deductibles, which require people to pay the full cost of care on their own up to a certain amount, can pose significant barriers to getting necessary care for people who can't afford to pay the full cost of care on their own.

Adults faced higher deductibles outside the marketplace



Research has shown that even nominal cost-sharing can deter people from getting needed care.⁹ Given this, it is welcome news that more people buying insurance on their own do not have to worry that their deductible could make it difficult for them to be able to afford the care they need.

The increased availability of plans with no deductible may be due in part to the new cost-sharing reduction subsidies that reduce out-of-pocket costs (like deductibles) for lower- to middle-income people with marketplace insurance. We know from other data that a number of marketplace plans available to people with family incomes below 150 percent of poverty had no deductibles after cost-sharing reduction subsidies were applied.¹⁰

Marketplace coverage provides better value to consumers in many ways: Financial assistance that lowers premiums and cost-sharing and new tools to help consumers make informed choices about which plan to buy.

Marketplaces are making the greatest strides in improving affordability

We also found that the health insurance marketplaces are making the biggest strides in improving the affordability of cost-sharing.

People buying insurance inside the marketplace were significantly less likely to have high deductibles (deductibles of \$1,500 or more per person) or exceedingly high deductibles (deductibles of \$3,000 or more per person) than those buying insurance outside the marketplace.

This makes sense: Marketplace coverage provides better value to consumers in many ways. Financial assistance to lower premiums and cost-sharing is available only to those with marketplace insurance. Marketplaces also include new tools consumers can use to compare coverage based on plans' out-of-pocket costs, which can help them make informed choices about which plan to buy.

II. One-Quarter of Health Care Consumers with Non-Group Insurance Still Have Problems Affording Care

Even with the historic gains made by the Affordable Care Act, many Americans with non-group insurance still have problems being able to afford needed care. Just over one-quarter of adults who were insured for a full year still went without needed medical care (excluding dental care) during that year because they could not afford it. People with lower to middle incomes were more likely to forgo medical care due to affordability issues than people with incomes above 250 percent of poverty.

Furthermore, we found that people with high-deductible health plans were more likely than those with lower deductibles to forgo care. These high-deductible plans are common, including among those with lower to middle incomes: Our analysis found that nearly two in five lower- to middle-income adults had high deductibles of \$1,500 or more per person.

Section findings

Among adults who bought non-group insurance:

4 Just over one-quarter (25.2 percent) of adults who were insured for a full year went without needed medical care because they could not afford it (excluding dental care, see Table 4).

The two most common types of care that adults went without were:

Tests, treatments, and follow-up care: 15.3 percent went without needed tests or follow-up care

Prescription drugs: 14.2 percent went without needed medications

5 Adults with lower to middle incomes were the most likely to forgo needed medical care (excluding dental care, see Table 5).

For lower- to middle-income adults who were insured for a full year, 32.3 percent didn't get needed medical care because they could not afford it.

For adults with middle or higher incomes (at or above 250 percent of poverty), a lower number—22.2 percent—didn't get needed medical care because they could not afford it.

6 Adults with high deductibles were more likely to forgo needed medical care (excluding dental care, see Table 6).

For adults with deductibles of \$1,500 or more per person who were insured for a full year, 29.8 percent went without needed medical care because they could not afford it.

For adults with deductibles under \$1,500 per person, only 19.6 percent went without needed medical care because they could not afford it.

7 In 2014, half (50.6 percent) of adults had high deductibles of \$1,500 or more, and 30 percent had exceedingly high deductibles of \$3,000 or more (see Table 7).

Of adults with lower to middle incomes, 39.3 percent had high deductibles of \$1,500 or more per person, and 22 percent had exceedingly high deductibles of \$3,000 or more per person.

And for middle-income adults, 53.2 percent had high deductibles of \$1,500 or more per person, and 29.9 percent had exceedingly high deductibles of \$3,000 or more per person.

Note: Unless otherwise noted, all of the adults referenced in our findings have incomes above 138 percent of poverty.

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Even adults who were insured for a full year had to go without needed medical care because they could not afford their out-of-pocket costs for care

Overall, 25.2 percent of adults who were insured for a full year didn't get needed care (excluding dental care) during the year because they could not afford it. Medical tests, treatments, and follow-up care were the most common types of care that adults had to forgo, followed by prescription drugs. For adults who were insured for a full year, 15.3 percent did not get needed medical tests, treatment, or follow-up care because they could not afford it, and 14.1 percent did not get needed medication because they could not afford it.

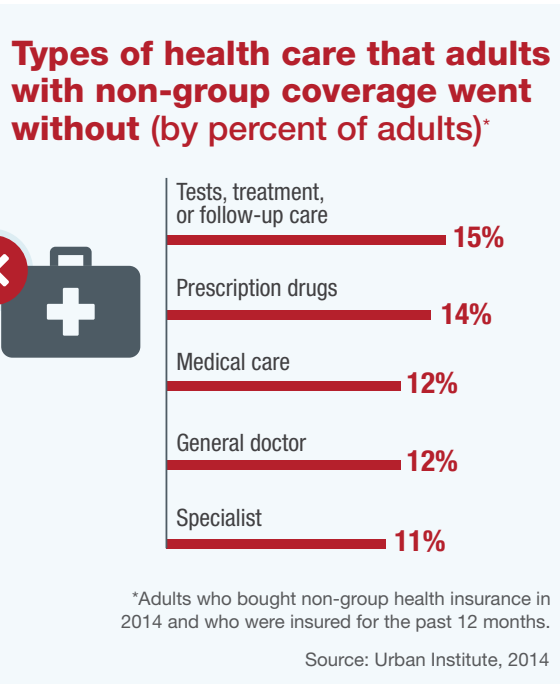
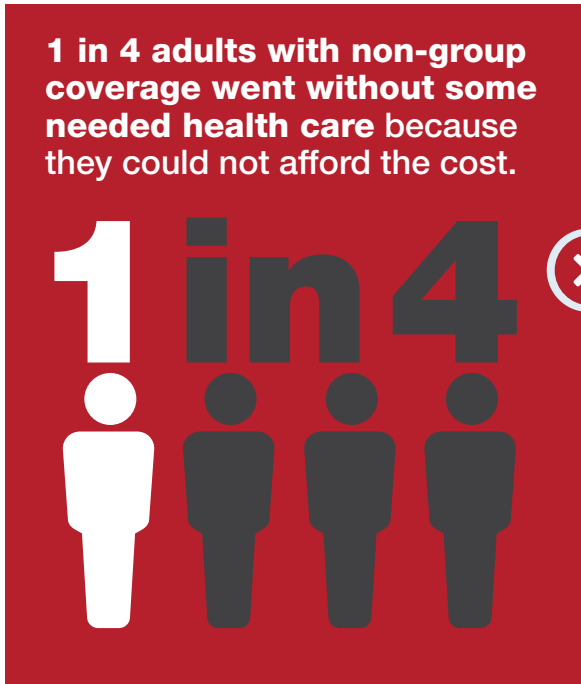
It is critically important that consumers be able to afford all of these types of care. Not getting recommended follow-up care to treat an illness or not taking needed medications can result in people facing avoidable, more serious health problems and more expensive health care costs down the road. For people with chronic conditions, consistently taking necessary medications and getting recommended tests can be vital to managing their condition.

Other research has found that insurers are designing many marketplace plans in ways that could impede access to these types of care. For example, silver marketplace plans often require that people meet a large deductible before the plan covers any care except for preventive care. Furthermore, nearly half of silver plans have a single deductible that applies to both medical and drug costs.¹¹

These types of benefit designs can make being able to afford necessary prescription drugs and follow-up care more difficult for people who cannot afford to pay all or most of the cost of such care on their own.

A more consumer-friendly benefit design would have two smaller deductibles, including a small deductible for drugs and a separate deductible for other health care. Consumer-friendly plans could also be similar to many employer-based plans, which are more likely to cover some services, such as doctor visits, even before enrollees pay the full deductible.¹²

Silver marketplace plans, a popular choice with consumers, often require that people meet a large deductible before the plan covers any care except for preventive care. A more consumer-friendly benefit design would cover some services even before enrollees pay the full deductible.



Adults with lower to middle incomes have the most trouble affording some medical costs

Lower- to middle-income adults who were insured for the full year were significantly more likely than those with higher incomes to forgo needed care because they could not afford it: Nearly one-third (32.3 percent) of lower- to middle-income adults didn't get needed medical care (excluding dental care) because they could not afford it.

This population has income that would qualify it for financial assistance to reduce cost-sharing in marketplace insurance. For some, that extra help reduces their deductibles. But for others in this income group, the extra help reduces only the maximum annual out-of-pocket limit that they would face in a year.

As our findings show, even with cost-sharing assistance, some lower- to middle-income consumers still found their out-of-pocket costs for covered care to be unaffordable during the previous 12 months.

But middle- and higher-income adults also struggle to afford medical costs

Among adults with incomes at or above 250 percent of poverty (who do not qualify for financial assistance with cost-sharing), more than one-fifth (22.2 percent) didn't get some needed care because they could not afford it.

While lower- to middle-income adults have the most difficulty with out-of-pocket costs, this finding clearly shows that many consumers with incomes at or above 250 percent of poverty also struggle to afford their cost-sharing for medical care that is covered by their plan.

High deductibles are associated with barriers to health care

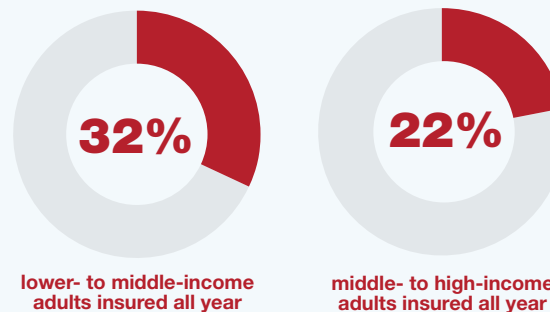
Our analysis found that adults who had deductibles of \$1,500 or more per person were more likely than those with lower deductibles to forgo needed care (excluding dental care) because they could not afford it.

Previous research has also found that high deductibles can create barriers that prevent consumers from getting needed care, particularly for consumers with lower incomes. Most notably, a recent Commonwealth Fund report found that people with deductibles that exceeded 5 percent of their income were more likely to delay or forgo needed care due to cost than those with lower deductibles relative to their income.¹⁴

A recent Commonwealth Fund report found that people with deductibles that exceeded 5 percent of their income were more likely to delay or forgo needed care due to cost than those with lower deductibles relative to their income.

Insured adults with lower to middle incomes frequently went without needed care

Percentage of adults at these income levels who went without some care



Source: Urban Institute, 2014

Table 8. Combined Cost of Deductibles and Premiums for a Single Individual with Non-Group Health Insurance, 2014

INCOME	DEDUCTIBLE AMOUNT	DEDUCTIBLE AS A PERCENT OF INCOME	PREMIUM CONTRIBUTION AS A PERCENT OF INCOME	PREMIUM CONTRIBUTION AMOUNT	COMBINED ANNUAL COST AS A PERCENT OF INCOME	COMBINED ANNUAL AMOUNT
\$29,200	\$1,500	5.14%	8.05%	\$2,351	13.19%	\$3,851
MIDDLE INCOME (250% of poverty)	\$3,000	10.27%	8.05%	\$2,351	18.32%	\$5,351

Source: Families USA's estimate of the premium contribution for an adult with income at 250 percent of poverty is based on the percent of income the federal government expected consumers with this income to spend on premiums for a second least-expensive silver plan in 2014.

This means that **lower- and middle-income adults are particularly likely to forgo needed care when faced with deductibles that exceed \$1,500 or, even more problematic, \$3,000.** For these consumers, high and exceedingly high deductibles take up a relatively larger portion of their income compared to consumers with higher incomes (see Table 8 and the graphic on page 15).

Proponents of high deductibles argue that because high-deductible plans require consumers to pay more of their medical costs up front, these plans give consumers an incentive to use health care more wisely. However, our findings and previous research tell a different and more troubling story: High deductibles are associated with consumers having difficulty getting the care they need.

A significant number of adults have high deductibles that could be unaffordable

We also found that a substantial number of adults with lower to middle incomes still faced high deductibles (deductibles of \$1,500 or more) that could be unaffordable and could prevent them from getting

needed care. Among adults with lower to middle incomes, nearly two in five (39.3 percent) had deductibles that were \$1,500 per person or higher. And more than one in five (22 percent) had deductibles that were \$3,000 per person or higher.

Among middle-income adults, more than half (53.2 percent) had deductibles of at least \$1,500 per person, and nearly one in three (29.9 percent) had exceedingly high deductibles of \$3,000 or more per person.

As discussed in the previous section, our own findings and previous research suggest that deductibles of this magnitude can create problems obtaining needed care, particularly for lower- and middle-income consumers. Recent research has also found that less than half of people with private insurance who have incomes between 100 and 250 percent of poverty have financial assets that are adequate to cover a deductible of even \$1,200 for an individual.¹⁵

It is important to note that not everyone needs enough health care that they would end up paying all of a

The Combined Cost of Premiums and Deductibles Can Eat Up a Substantial Portion of People's Income

Covering the cost of a high deductible in addition to premiums can be a substantial financial burden for lower- to middle-income consumers. These graphics illustrate the scope of problems deductibles pose for consumers.

To calculate premiums for these adults, we used the percent of income the federal government expects consumers to spend on premiums for a second least-expensive silver plan.

1 How high deductibles and premiums can add up for a middle-income individual

Middle-income individual with marketplace coverage

Annual income
middle-income adult
(250% of poverty)

\$29,200

Deductible: **\$1,500** (5.14% of income)



Annual premium contribution after premium tax credits: **\$2,351** (8.05% of income)

Individual's combined cost of deductible + annual premium: **\$3,851**
(13.19% of income)

Deductible: **\$3,000** (10.27% of income)

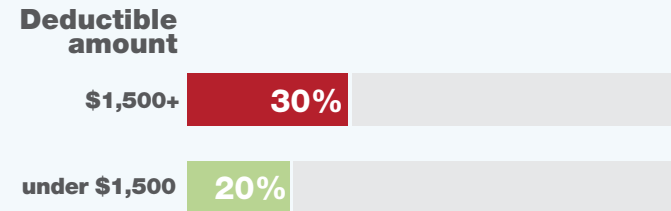
Annual premium contribution after premium tax credits: **\$2,351** (8.05% of income)

Individual's combined cost of deductible + annual premium: **\$5,351**
(18.32% of income)

Source: Families USA, 2014

2 Insured adults with higher deductibles are more likely to go without needed care

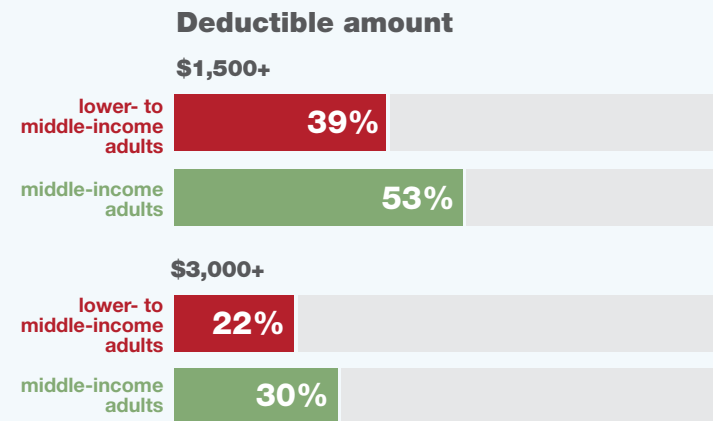
Percentage of adults at these deductible levels who went without some care



Source: Urban Institute HRMS, September and December 2014

3 Significant portions of lower- and middle-income adults face high deductibles

Percentage of adults at these income levels who had high deductibles



Source: Urban Institute HRMS, September and December 2014

\$1,500 or \$3,000 deductible. But lower- and middle-income adults who do have high health care costs would spend a substantial portion of their income on meeting their deductible—in addition to paying their premium—before their plan would help pay for needed care (see Table 8). For example:

- » For a single adult making \$29,200 (250 percent of poverty), a deductible of \$1,500 plus what he or she is expected to pay in premiums for a silver plan, after premium tax credits, constitutes more than 13 percent of his or her income.
- » With a \$3,000 deductible, that same adult would have to pay more than 18 percent of his or her income toward premiums for a silver plan and the deductible.

The bottom line: Our findings show that too many lower- and middle-income consumers face deductibles that are likely unaffordable relative to their income and that could create barriers to them getting the care they need.

Too Many Adults Continue to Go Without Dental Care

Access to dental coverage and care is one of the most persistent problems for many adults. The Affordable Care Act made dental care a required benefit for children’s insurance, but it did not extend this requirement to insurance for adults. Therefore, many adults who buy non-group insurance may still have no dental coverage. In 2008, nearly 70 percent of people who bought health insurance on their own did not have dental coverage.¹³

Without dental coverage, many adults struggle to get the dental care they need.

Our primary analysis excluded reports of forgoing needed dental care (see the Methodology on page 24). However, the Urban Institute’s Health Reform Monitoring Survey does ask people whether they went without needed dental care because they could not afford it.

We examined reports of adults not getting needed dental care, and the findings were striking:

Dental care was the most common type of health care service adults went without due to affordability issues. Nearly one in four (24 percent of) adults who were insured for a full year reported not getting needed dental care during the year due to affordability issues. While those with lower to middle incomes were most likely to have trouble affording this care, even among adults with incomes at or above 250 percent of poverty, it was still the most common type of care that they had to forgo because they could not afford it (see Table 5).

This finding underscores the need to address the dental coverage gap in this country. Moving forward, it is critical that Congress requires all marketplace plans to include adult dental coverage. Without policies that expand access to affordable dental coverage to all adults, many adults will continue to be unable to afford the dental care they need.



Do high-deductible plans help consumers make better (“high-value”) decisions about their health insurance?

Proponents of high-deductible plans assert that making consumers spend more to cover their medical care will induce them to seek high-value care. But this is not possible for the many consumers who do not have the tools or the basic understanding of how their health insurance works in order to make informed decisions about what care to get at what price.

Health insurance is complex. Not only is it difficult for any consumer to understand the complexities of his or her insurance and the resulting health care costs, but consumers who struggle with literacy or whose primary language is not English face even greater barriers. About 25 million Americans have limited English proficiency.^a

Without an understanding of what they will have to pay out of pocket, consumers may buy plans that have low monthly premiums but that also have high deductibles that are difficult to afford and that don't meet their needs. And once enrolled, consumers who are uncertain about their out-of-pocket costs can experience problems with paying medical bills or may need to forgo care.

The Affordable Care Act provides new tools, such as a short “summary of benefits and coverage,” that are designed to help consumers understand what care is covered by their plan and how much they may need to pay for care. However, it is still a big leap to assume that consumers are able to determine their costs.

In our study, about a quarter of survey respondents for quarters three and four of 2014 lacked the confidence that they could determine:

- whether a service was covered
- which drugs were covered or what they would cost
- the maximum they could be charged out of pocket for covered services in their health plan

And about a third of respondents were not confident that they could figure out what costs counted toward their deductible.

These findings are consistent with previous research on health insurance literacy.^{b,c}

a. U.S. Census Bureau, *2009-2013 5-Year American Community Survey*, available online at http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_13_5YR_DP02&prodType=table.

b. Kathryn Paez and Coretta Mallery, *A Little Knowledge Is a Risky Thing: Wide Gaps in What People Think They Know about Health Insurance and What They Actually Know* (Washington: American Institutes for Research, October 2014), available online at http://www.air.org/sites/default/files/Health%20Insurance%20Literacy%20brief_Oct%202014_amended.pdf.

c. Mira Norton, Liz Hamel, and Mollyann Brodie, *Assessing Americans' Familiarity with Health Insurance Terms and Concepts* (Washington: Kaiser Family Foundation, November 2014), available online at <http://kff.org/health-reform/poll-finding/assessing-americans-familiarity-with-health-insurance-terms-and-concepts/>.

III. Why are people still struggling with out-of-pocket costs?

The Affordable Care Act provides critical financial assistance to lower- and middle-income individuals and families to help them afford both coverage and care in the marketplace. However, our findings show that a substantial portion of people with non-group coverage, including some who may be eligible for this financial assistance, continued to have trouble being able to afford care.

There are multiple factors that are likely contributing to affordability problems in the non-group market. We discuss the three most salient factors.

In the federally facilitated marketplaces, more than three out of four people who received premium tax credits bought silver plans in 2014.

1. Premium tax credits are tied to silver plans, which often have cost-sharing that is too high for many consumers to be able to afford

Premium tax credits are designed for lower- and middle-income consumers to help them pay their monthly premiums. These tax credits are benchmarked to silver level plans: The formula for calculating the amount of tax credits is intended to assure that people who buy a typical silver plan will not have to pay more than an affordable percentage of their income on premiums.

Although consumers are allowed to use these tax credits to cover the cost of more generous (and more expensive) gold or platinum plans, most lower- to middle-income consumers cannot afford to buy these more expensive plans. This is likely one reason why silver plans are the most popular type of plan. For example, in the federally facilitated marketplaces, more than three out of four people who received premium tax credits bought silver plans in 2014.¹⁶

Because these tax credits are designed to help a population with lower and middle incomes, it is equally important to keep these consumers' cost-sharing amounts (deductibles and other out-of-pocket costs)

Because these tax credits are designed to help a population with lower and middle incomes, it is equally important to keep these consumers' cost-sharing amounts (deductibles and other out-of-pocket costs) low.

low. Consumers with low to middle incomes can get help with reducing their cost-sharing in a silver plan through cost-sharing reductions. This help reduces cost-sharing a great deal for people with incomes below 200 percent of poverty (about \$23,500 for an individual), and it reduces cost-sharing somewhat for people with incomes up to 250 percent of poverty (about \$29,200 for an individual).

But these reductions are not available to middle-income consumers. And if middle-income consumers cannot get help that reduces those high cost-sharing amounts in silver plans, these consumers can still face unaffordable deductibles and other out-of-pocket costs: The estimated average deductible of silver plans in 2014 was between \$2,267 and \$3,030.¹⁷

2. Only a portion of the lower-income consumers who are eligible for subsidies to reduce cost-sharing in silver plans receive substantial help to also reduce their deductibles

People with incomes between 100 and 250 percent of poverty qualify not just for premium tax credits, but also for cost-sharing reduction subsidies that lower the out-of-pocket costs associated with silver plans. Of this group:

» **People with incomes below 200 percent of poverty** qualify for assistance that greatly reduces their out-of-pocket maximum in silver plans, as well as the specific amounts they must pay in upfront cost-sharing for care, like deductibles, copayments, and co-insurance.

» **People with incomes between 200 and 250 percent of poverty** are eligible only for more limited assistance, which significantly reduces their out-of-pocket maximum but provides only **minor assistance** with the amounts of upfront cost-sharing.

Avalere, a public policy research firm that has conducted extensive analyses of marketplace plan offerings, has estimated that **the average deductible of silver plans offered in the marketplace to people with incomes between 200 and 250 percent of poverty, after accounting for cost-sharing reductions, was \$2,342 in 2014.**¹⁸ This shows that even some consumers who receive help with cost-sharing may still find their out-of-pocket costs for care to be unaffordable.

3. Insurers are choosing to design silver plans with upfront cost-sharing that is too high for lower- and middle-income consumers to afford

As we noted earlier, many insurers are offering silver plans that have high deductibles. In addition, many of these plans don't help pay for even basic primary care and medications before the consumer pays the full cost of his or her deductible.¹⁹ This can make high-deductible plans particularly problematic for lower- and middle-income consumers.

Due to federal requirements that govern the way silver plans are designed, these plans must have higher cost-sharing for more extensive or complex medical care. However, **insurers do have the flexibility to design silver plans that charge low cost-sharing**

Only a portion of the lower-income consumers who are eligible for subsidies to reduce cost-sharing in silver plans receive substantial help to also reduce their deductibles.

for basic outpatient care like primary care visits, some prescription drugs, blood work, diagnostic testing, and secondary preventive services (services that help manage chronic conditions like diabetes or asthma).

The main ways insurers can do this is by exempting these types of services from the deductible (meaning that the health plan helps pay for these services even before the deductible is fully paid) and by charging low copayments for this type of care. Insurers also can design silver plans with low or no deductible.

Unfortunately, **not enough insurers are taking advantage of that flexibility**. This means that many lower- and middle-income consumers with silver plans may still struggle to get the basic care they need because they are not able to afford to pay the full cost of a doctor visit or medication out of pocket.

Designing Silver Health Plans that Are More Affordable for Lower- and Moderate-Income Consumers

In the health insurance marketplaces, low- and moderate-income consumers who use premium tax credits tend to buy silver plans. But recent analyses show that these types of plans typically have high deductibles. Our original research shows that it doesn't have to be this way—insurers can choose to create silver plans with upfront cost-sharing amounts that are lower than those in high-deductible plans.

Our brief, *Designing Silver Health Plans with Affordable Out-of-Pocket Costs for Lower- and Moderate-Income Consumers* (<http://familiesusa.org/silver-plan-design>), features:

- original research identifying existing silver plan designs that make the upfront cost for care more affordable
- policy and advocacy strategies to help advocates and policy makers effectively promote similar plan designs in other marketplaces across the country

IV. Policy Recommendations

To address the issues we outlined above, we've included five recommendations that health insurers, marketplaces, and state and federal policy makers can take up to reduce the burden of out-of-pocket costs for lower- and middle-income consumers with non-group coverage.

Health Insurers, Marketplaces, and State and Federal Policy Makers Should Improve Health Plan Offerings in the Non-Group Market

Moving forward, more health plans in the marketplaces need to have affordable cost-sharing for, at minimum, primary care, basic outpatient services, and prescription drugs. This is particularly important for plans at the silver level, given their popularity and the fact that premium tax credits are tied to the cost of silver plans. Increasing the number of plans with affordable cost-sharing for basic care is critical to ensuring that all individuals can afford the care they need to maintain their health and well-being regardless of their deductible.

There are multiple actions that health insurers, marketplaces, and state and federal policy makers can take to achieve this goal:

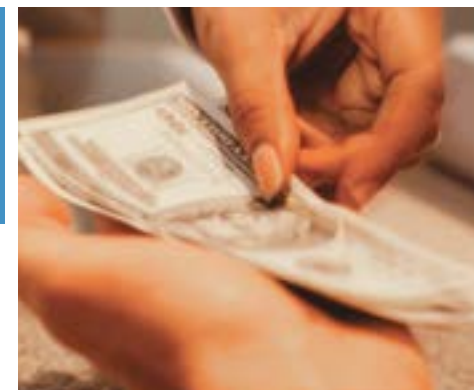
Health insurers should offer more plans at the silver level that have low or no cost-sharing for primary

care, other outpatient services, and prescription drugs. Insurers have the flexibility to design silver plans with low or no medical deductibles. They can also offer silver plans that help pay for many outpatient services before the deductible is fully paid, including primary care, mental health visits, prescription drugs, blood work, diagnostic testing, and secondary preventive services. It is critical that more insurers take advantage of this flexibility.

Policymakers at the state and federal levels should require health insurers to sell silver plans with lower cost-sharing for primary care, other outpatient services, and prescription drugs.

For example, a state could require all insurers in the state to sell at least one plan at the silver level (both inside and outside the marketplace) that exempts primary care, mental health visits, prescription drugs, and secondary preventive services from its deductible. A state-based marketplace could establish such a requirement for all insurers that sell qualified health plans in the marketplace. Or the federal government could require this of all insurers that sell qualified health plans, across all states.

More state-based marketplaces should design standardized plan offerings (plan designs that



Moving forward, more health plans in the marketplaces need to have affordable cost-sharing for, at minimum, primary care, basic outpatient services, and prescription drugs.

participating insurers are required to sell) that have lower cost-sharing for primary care, other outpatient services, and prescription drugs. Six state-based marketplaces already have standardized plan offerings, and the District of Columbia will have standardized plan offerings in the 2016 plan year.²¹ Many of these states have designed standardized plans at the silver level that exempt numerous outpatient services from the deductible. These standardized plans can serve as models for other state-based marketplaces.²²

Federal and State Lawmakers Must Strengthen the Financial Assistance for Marketplace Insurance

Even with existing financial assistance, lower- and middle-income consumers can still face unaffordable out-of-pocket costs relative to their income. Looking forward, state governments and the federal government must find ways to provide more generous financial assistance to reduce the out-of-pocket costs in marketplace insurance.

At the federal level, Congress should:

Provide cost-sharing reduction subsidies to middle-income consumers and increase the generosity of this help. Congress should expand eligibility for cost-

sharing reduction subsidies to middle-income consumers with incomes above 250 percent of poverty. It should also increase the generosity of these subsidies so that they reduce consumers' upfront out-of-pocket costs more than they currently do. This will help ensure that cost-sharing is more affordable relative to consumers' income.

At the state level, lawmakers can also strengthen financial assistance:

States can also enhance financial assistance. Some states have reduced the cost-sharing for lower- to middle-income consumers with marketplace coverage by adding state funding to the funding that is available from the federal government. For example, Minnesota has established a Basic Health Program, an option available under the Affordable Care Act, using federal funds to design a plan for residents with incomes up to 200 percent of poverty that has lower cost-sharing.



See our blogs, *Tackling Affordability Barriers in the Affordable Care Act* (<http://familiesusa.org/blog/2014/09/trending-tackling-affordability-barriers-affordable-care-act>) and *Promoting Plans with Affordable Upfront Out-of-Pocket Costs* (<http://familiesusa.org/product/designing-silver-health-plans-affordable-out-pocket-costs-lower-and-moderate-income>) for more information about state strategies and standardized health plans.

Conclusion

The Affordable Care Act has made landmark achievements in expanding access to affordable coverage, and it provides substantial help with out-of-pocket costs for many lower-income consumers. However, as our findings show, many lower- and middle-income consumers who buy insurance on their own continue to face high out-of-pocket costs and have problems affording care.

Moving forward, we must build upon the foundation created by the health care law. Health insurers, marketplaces, and state and federal policymakers must take additional steps to improve the affordability of cost-sharing to ensure that all consumers can afford the care they need.

Methodology

We contracted with the Urban Institute to analyze data through the Health Reform Monitoring Survey (HRMS) concerning the population enrolled in non-group coverage in 2013 and 2014. The HRMS is a nationally-representative, quarterly survey of the nonelderly population that explores the value of cutting-edge, Internet-based survey methods to monitor the Affordable Care Act (ACA) before data from federal government surveys are available.

This analysis examines data collected from adults aged 18-64 in the September 2013, September 2014, and December 2014 waves of the HRMS who reported that they purchased coverage directly from an insurance company, including through an exchange or marketplace such as Healthcare.gov. We excluded people with incomes at or below 138 percent of poverty from the analysis to ensure that respondents were not confusing Medicaid with private insurance, and we excluded people who reported that they had coverage through an employer or the military, as well as people who had multiple coverage types if Medicare or Medicaid was the main source of their coverage.

Source of Coverage

One limitation of the HRMS survey is that respondents may have difficulty accurately reporting whether they have public or private coverage and whether they use the marketplace to purchase coverage. The survey asks two main questions to discern this information.

First, respondents are asked about the type of coverage they have.

- » One of the alternatives is: “Insurance purchased directly from an insurance company (by you or another family member). This would include coverage purchased through an exchange or marketplace, such as Healthcare.gov [or the state-specific marketplace name].”

- » Another option is: “Medicaid, Medical Assistance (MA), the Children’s Health Insurance Program (CHIP) or any kind of state or government-sponsored assistance plan based on income or a disability. [IF THE RESPONDENT IS IN A STATE WITH STATE-SPECIFIC PROGRAM NAMES INSERT: You may know this type of coverage as [state-specific program name(s)].]”
- » Respondents can select more than one coverage type, and those reporting other, non-specified coverage are asked in a follow-up question to provide a verbatim response describing what type of health insurance they have.

Second, respondents are asked:

- » “As you may know, new state and federal health insurance marketplaces can be used to shop for health insurance and compare prices and benefits. These marketplaces can also be used to enroll in Medicaid, Medical Assistance or the Children’s Health Insurance Program (CHIP). You may know the marketplace as Healthcare.gov [IF THE RESPONDENT IS IN A STATE WITH STATE-SPECIFIC NAMES, INSERT [or (INSERT PROGRAM NAME)]. You may have seen a website or materials with the following marketplace logo[s]. [INSERT HEALTHCARE.GOV LOGO AND RELEVANT STATE MARKETPLACE LOGO, IF ANY] Is your current coverage a health insurance plan through the marketplace?”

By eliminating from our sample the group of adults with family income at or below 138 percent of poverty who reported having a plan through the marketplace, we minimized the chances that people with Medicaid would be among our sample. Still, there may be inaccuracies in responses. For example, for people who reported income inaccurately or who lived in states with higher Medicaid income guidelines, there may still have been some confusion between the two programs. In addition, because premium

and cost-sharing subsidies are provided through the public sector, some respondents might interpret marketplace coverage as “Medicaid, Medical Assistance (MA), the Children’s Health Insurance Program (CHIP) or any kind of state or government-sponsored assistance plan based on income or a disability” instead of private non-group coverage.

Income Groups

We compared the incomes of people enrolling in plans between 2013 and 2014 and the size of their deductibles. For some measures, we looked closely at two income groups: “lower- to middle-income adults” with family income between 139 and 249 percent of poverty, and “middle-income adults” with family income between 250 and 399 percent of poverty.

Beginning in 2014, lower- to middle-income adults who purchase coverage through an exchange or marketplace such as Healthcare.gov are eligible for tax credits that lower their monthly premiums and for cost-sharing reductions. Middle-income adults are not eligible for cost-sharing reductions, but they are eligible for premium tax credits if they buy plans through exchanges or marketplaces.

Affording Needed Health Care

We also examined responses to questions about the ability to afford care in the 2014 waves of the HRMS. The HRMS asks respondents whether there was any time over the past 12 months that they did not get one of the following needed medical services because they couldn’t afford it: prescription drugs, medical care, an appointment with a general doctor, an appointment with a specialist, medical tests, treatment or follow-up care, dental care, mental health care or counseling, treatment of counseling for alcohol or drug abuse, medical equipment or supplies, and family planning or contraceptive prescriptions (for females only).

Dental Care

In its questions regarding whether adults did not get needed care in the past 12 months because they could not afford it, the HRMS asks whether people went without dental care because they could not afford it. We chose to exclude from our main analysis reports of not obtaining needed dental care and looked only at the proportion of adults who had problems affording other health care services besides dental care.

We did this because the primary goal of our analysis was to assess whether plans’ cost-sharing was unaffordable and made it difficult for consumers to obtain necessary care. To do this, we needed to look at how often people went without *covered services* due to affordability issues.

However, adult dental care is not a required benefit that health plans must cover, so many health insurance plans simply don’t cover it. This means that determining how many adults found their plan’s cost-sharing to be unaffordable and did not get covered care as a result can be muddied by looking at individuals who did not get needed care, including dental care.

By excluding reports of not getting needed dental care, our analysis more accurately captured how many adults find cost-sharing for *covered services* to be unaffordable.

Health Insurance Literacy

Finally, we examined responses to questions in the 2014 waves of the HRMS that asked insured respondents to rate their confidence in figuring out which drugs and services were covered by their plan; what they would have to pay for a drug, visit, or service; which costs counted toward the plan’s deductible; and the maximum they would need to pay out of pocket for services covered by the health plan in a given year.

Endnotes

1 Office of the Assistant Secretary for Planning and Evaluation, *Health Insurance Coverage and the Affordable Care Act* (Washington: Office of the Assistant Secretary for Planning and Evaluation, March 16, 2015), available online at http://aspe.hhs.gov/health/reports/2015/uninsured_change/ib_uninsured_change.pdf; Sarah Kliff, “Under Obamacare, America’s Uninsured Rate Has Fallen 35 Percent,” *Vox*, March 16, 2015, available online at <http://www.vox.com/2015/3/16/8225253/obamacare-uninsured-medicare>.

2 These are families with incomes between 139 and 400 percent of poverty. Office of the Assistant Secretary for Planning and Evaluation, op. cit.

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6 Katherine Grace Carman and Christine Eibner, op. cit.; Sara Collins, Petra W. Rasmussen, and Michelle M. Doty, op. cit.; Sharon Long et al., op. cit.

7 For example, using a more restrictive definition of marketplace enrollment, we find that only 7 percent of marketplace enrollees had a zero dollar deductible in 2014. This definition excludes respondents who reported having only public coverage when asked what type of health insurance coverage they had, but who reported having a health insurance plan through the marketplace in a follow-up question. See the Methodology for additional details.

8 Jessica Smith and Carla Medalia, *Health Insurance Coverage in the United States: 2013* (Washington: U.S. Census Bureau, September 2014), available online at <http://www.census.gov/content/dam/Census/library/publications/2014/demo/p60-250.pdf>.

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14 Sara R. Collins, Petra W. Rasmussen, Michelle M. Doty, and Sophie Beutel, *Too High a Price: Out-of-Pocket Health Care Costs in the United States: Findings from the Commonwealth Fund Health Care Affordability Tracking Survey, September-October 2014* (Washington: The Commonwealth Fund, November 2014).

15 Gary Claxton, Matthew Rae, and Nirmita Panchal, *Consumer Assets and Patient Cost Sharing* (Washington: Kaiser Family Foundation, February 2015), available online at <http://kff.org/health-costs/issue-brief/consumer-assets-and-patient-cost-sharing/>.

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17 Estimates of the average deductible of silver plans in 2014 have varied depending on the data sources and methodology used to calculate them. Breakaway Policy Strategies' analysis of a sample of 1,208 unique silver plans sold through health insurance marketplaces in 2014 found the average individual deductible for silver plans that had a combined deductible (where medical and drug expenses count toward the same deductible) was \$2,267. This analysis found that the median individual medical deductible for silver plans with a separate drug deductible was \$2,500. Avalere conducted multiple analyses of silver plan offerings in 2014. Its December 2013 analysis of 207 silver marketplace plans found that the average individual medical deductible was \$2,567. It did not specify whether this analysis

included both combined deductibles and medical-only deductibles. A subsequent analysis by Avalere used the HHS Landscape file to analyze all silver marketplace plans across 34 states. It found that the average individual medical deductible for silver plans was \$3,030. This subsequent analysis defined medical deductibles to include both combined deductibles and separate medical deductibles. Robert Wood Johnson Foundation and Breakaway Policy Strategies, *Eight Million and Counting: A Deeper Look at Premiums, Cost Sharing, and Benefit Design in the New Health Insurance Marketplaces*, op. cit.; Mathew Eyles, *Analysis: Consumer Deductibles Vary Significantly across Exchange Plans* (Washington: Avalere, December 11, 2013), available online at <http://avalere.com/expertise/managed-care/insights/analysis-consumer-deductibles-vary-significantly-across-exchange-plans>; Kelly Brantley, Hillary Bray, and Caroline Pearson, *Analysis of Benefit Design in Silver Plan Variations* (Washington: Avalere, June 2014), available online at <http://avalere.com/expertise/managed-care/insights/avalere-analysis-cost-sharing-reductions-unevenly-applied-across-services-i>.

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20 For more information, see Lydia Mitts, *Designing Silver Health Plans with Affordable Out-of-Pocket Costs for Lower- and Moderate-Income Consumers* (Washington: Families USA, May 2014), available online at <http://familiesusa.org/product/designing-silver-health-plans-affordable-out-pocket-costs-lower-and-moderate-income>.

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22 For more information see, Lydia Mitts, *Designing Silver Health Plans with Affordable Out-of-Pocket Costs for Lower- and Moderate-Income Consumers*, op. cit.

Appendix

Table 1. Income of Adults with Non-Group Health Insurance, 2013 and 2014

INCOME AS A PERCENT OF POVERTY	PERCENT OF NON-GROUP INSURANCE ENROLLEES IN 2013 [^]	PERCENT OF NON-GROUP INSURANCE ENROLLEES IN 2014
LOWER- TO MIDDLE-INCOME (139-249%)	25.4%	36.9%***
MIDDLE-INCOME (250-399%)	29.1%	25.9%
HIGH-INCOME (at or above 400%)	45.6%	37.2%***

Source: Urban Institute analysis of Health Reform Monitoring Survey data collected in September 2013 and September and December 2014.

Notes: We excluded people with incomes at or below 138 percent of poverty to eliminate possible confusion with Medicaid coverage. In many states, people with incomes up to 138 percent of poverty are eligible for Medicaid.

As more lower- to middle-income adults were able to afford marketplace insurance, they made up a bigger portion of non-group market enrollees. This does not mean that fewer middle- or higher-income adults bought coverage on their own in 2014 than previously: We do not provide data on the overall number of people with non-group insurance or the overall number of people with insurance. Analysis by HHS found that between the start of 2014 and the first two months of 2015, the number of uninsured dropped significantly among people with incomes between 139 and 400 percent of poverty. The number of people with incomes above 400 percent of poverty who were uninsured did not significantly change. Both before and after implementation of the ACA, the vast majority of people with incomes above 400 percent of poverty (about 98 percent) had health insurance.

*/**/*** Estimate differs significantly from those in the reference group, denoted by ^, at the 0.10/0.05/0.01 level, using two-tailed tests.

Table 2. Percent of Adults with Non-Group Health Insurance that Had No Deductible, 2013 and 2014

	2013 [^]	2014
No deductible	3.6%	10.6%***

Source: Urban Institute analysis of Health Reform Monitoring Survey data collected in September 2013 and September and December 2014.

Note: There were no significant differences between 2013 and 2014 in the percentage of people that had deductibles up to \$1,500, \$1,500-3,000, or above \$3,000.

*/**/*** Estimate differs significantly from those in the reference group, denoted by ^, at the 0.10/0.05/0.01 level, using two-tailed tests.

Table 3. Annual Deductible Per Person for Adults with Non-Group Health Insurance, by Marketplace Status, 2014

AMOUNT OF DEDUCTIBLE	INSURED IN THE MARKETPLACE [^]	INSURED OUTSIDE THE MARKETPLACE
No deductible	15.2%	6.0% ^{***}
Up to \$1,500	40.8%	33.1% ^{**}
\$1,500-2,999	20.3%	20.8%
\$1,500 or more	42.8%	58.3% ^{***}
\$3,000 or more	22.5%	37.5% ^{***}
Not reported	0.1%	0.3%
Not sure of amount	1.0%	2.3%

Source: Urban Institute analysis of Health Reform Monitoring Survey data collected in September and December 2014.

Notes: Definition of marketplace enrollees includes all insured respondents who reported being enrolled through the marketplace, excluding those reporting coverage through an employer or the military; those with incomes at or below 100 percent of poverty in states that had not expanded Medicaid as of December 2014; and those with incomes at or below 138 percent of poverty in states that had expanded Medicaid as of December 2014. However, we excluded all people with incomes at or below 138 percent of poverty from this analysis. We also exclude those who reported multiple coverage types if they reported that Medicaid or Medicare was their main source of coverage.

^{**}/^{***} Estimate differs significantly from those in the reference group, denoted by [^], at the 0.10/0.05/0.01 level, using two-tailed tests.

Table 4. Percent of Adults with Non-Group Health Insurance Who Were Insured for the Past 12 Months and Who Had to Forgo Care Because They Could Not Afford It, by Type of Care, 2014

	PERCENT OF ADULTS
Any service (excluding dental)	25.2%
Tests, treatment, or follow-up care	15.3%
Prescription drugs	14.2%
Medical care	12.0%
General doctor	11.8%
Specialist	11.3%
Mental health care or counseling	5.6%
Contraceptive prescriptions (among women only)	5.0%
Medical equipment or supplies	4.4%
Treatment for alcohol or drugs	2.5%
Dental care [†]	24.0%

Source: Urban Institute analysis of Health Reform Monitoring Survey data collected in September and December 2014.

Notes: Excludes people with family income at or below 138 percent of the federal poverty level. Data are limited to people who had to forgo care at some time *in the past 12 months*.

[†]We looked at reports of adults not getting needed dental care separately from our main analysis of adults not getting needed health care because they could not afford it. This is because health plans are not required to (and typically don't) cover dental care for adults. Therefore, problems affording dental care may be due to adults not having dental coverage rather than to them having problems affording cost-sharing for that care.

Table 5. Percent of Adults with Non-Group Health Insurance Who Were Insured for the Past 12 Months and Who Had to Forgo Care Because They Could Not Afford It, by Income Level and Type of Care, 2014

	INCOME AS A PERCENT OF POVERTY	
	LOWER TO MIDDLE INCOME (139-249%) [^]	MIDDLE TO HIGH INCOME (AT OR ABOVE 250%)
Any service (excluding dental)	32.3%	22.2%**
Tests, treatment, or follow-up care	18.7%	13.8%
Prescription drugs	18.3%	12.5%
Medical care	14.9%	10.8%
General doctor	13.7%	11.0%
Specialist	13.4%	10.5%
Contraceptive prescriptions (among women only)	5.8%	4.5%
Mental health care or counseling	5.8%	5.5%
Medical equipment or supplies	5.4%	3.9%
Treatment for alcohol or drugs	1.3%	3.1%
Dental care [†]	30.3%	21.3%**

Source: Urban Institute analysis of Health Reform Monitoring Survey data collected in September and December 2014.

Notes: Excludes people with family income at or below 138 percent of the federal poverty level. Data are limited to people who had to forgo care at some time *in the past 12 months*.

[†]We looked at reports of adults not getting needed dental care separately from our main analysis of adults not getting needed health care because they could not afford it. This is because health plans are not required to (and typically don't) cover dental care for adults. Therefore, problems affording dental care may be due to adults not having dental coverage rather than to them having problems affording cost-sharing for that care.

*/**/**** Estimate differs significantly from those in the reference group, denoted by ^, at the 0.10/0.05/0.01 level, using two-tailed tests.

Table 6. Percent of Adults with Non-Group Health Insurance Who Were Insured for the Past 12 Months and Who Had to Forgo Medical Care Because They Could Not Afford It, by Deductible Amount and Type of Care, 2014

	DEDUCTIBLE AMOUNT (PER PERSON)			
	LESS THAN \$1,500 [^]	\$1,500 OR MORE	LESS THAN \$3,000 [^]	\$3,000 OR MORE
Any service (excluding dental)	19.6%	29.8%***	21.3%	33.2%***
Prescription drugs	11.9%	15.8%	12.3%	17.7%**
Tests, treatment, or follow-up care	11.5%	18.3%**	12.7%	20.5%***
General doctor	10.3%	13.1%	9.5%	16.7%*
Specialist	9.5%	12.7%*	9.5%	14.9%**
Medical care	9.4%	14.0%**	10.0%	15.9%**
Contraceptive prescriptions (among women only)	5.1%	4.7%	5.4%	3.9%
Mental health care or counseling	4.8%	6.0%	5.1%	6.3%
Medical equipment or supplies	4.2%	4.3%	3.9%	5.0%
Treatment for alcohol or drugs	3.8%	1.3%	2.8%	1.5%
Dental care [†]	24.7%	23.7%	24.9%	22.6%

Source: Urban Institute analysis of Health Reform Monitoring Survey data collected in September and December 2014.

Notes: Excludes people with family income at or below 138 percent of the federal poverty level. Data are limited to people who had to forgo care at some time *in the past 12 months*.

[†]We looked at reports of adults not getting needed dental care separately from our main analysis of adults not getting needed health care because they could not afford it. This is because health plans are not required to (and typically don't) cover dental care for adults. Therefore, problems affording dental care may be due to adults not having dental coverage rather than to them having problems affording cost-sharing for that care.

*/**/*** Estimate differs significantly from those in the reference group, denoted by ^, at the 0.10/0.05/0.01 level, using two-tailed tests.

Table 7. Annual Deductible for Adults with Non-Group Health Insurance, by Income Group, 2014

AMOUNT OF DEDUCTIBLE	INCOME GROUP (PERCENT OF POVERTY)			ALL
	LOWER- TO MIDDLE-INCOME (139-249%) [^]	MIDDLE-INCOME (250-399%)	HIGH-INCOME (AT OR ABOVE 400%)	
No deductible	12.1%	10.1%	9.6%	10.6%
\$1-1,499	45.7%	34.9%**	29.6%***	36.9%
\$1,500-2,999	17.3%	23.3%*	21.9%*	20.6%
\$1,500 or more	39.3%	53.2%***	59.9%***	50.6%
\$3,000 or more	22.0%	29.9%**	38.0%***	30.0%
Not reported	0.4%	0.2%	0.0%	0.2%
Not sure of amount	2.4%	1.6%	0.9%	1.6%

Source: Urban Institute analysis of Health Reform Monitoring Survey data collected in September and December 2014.

Note: Excludes people with family income at or below 138 percent of the federal poverty level.

*/**/*** Estimate differs significantly from those in the reference group, denoted by [^], at the 0.10/0.05/0.01 level, using two-tailed tests.

Table 8. Combined Cost of Deductibles and Premiums for a Single Individual with Non-Group Health Insurance, 2014

INCOME	DEDUCTIBLE AMOUNT	DEDUCTIBLE AS A PERCENT OF INCOME	PREMIUM CONTRIBUTION AS A PERCENT OF INCOME	ANNUAL PREMIUM CONTRIBUTION AMOUNT	COMBINED ANNUAL COST AS A PERCENT OF INCOME	COMBINED ANNUAL AMOUNT
\$29,200	\$1,500	5.14%	8.05%	\$2,351	13.19%	\$3,851
MIDDLE-INCOME (250% of poverty)	\$3,000	10.27%	8.05%	\$2,351	18.32%	\$5,351

Source: Families USA's estimate of the premium contribution for an adult with income at 250 percent of poverty is based on the percent of income the federal government expected consumers with this income to spend on premiums for a second least-expensive silver plan in 2014.

A selected list of relevant publications to date:

Standardized Health Plans: Promoting Plans with Affordable Upfront Out-of-Pocket Costs (December 2014)

Basic Health Programs: Nine Requirements for State Programs (November 2014)

Designing Silver Health Plans with Affordable Out-of-Pocket Costs for Lower- and Moderate-Income Consumers (May 2014)

For a more current list, visit:

www.familiesusa.org/publications

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This publication was written by:

Lydia Mitts, Senior Health Policy Analyst, Families USA

Cheryl Fish-Parcham, Private Insurance Program Director, Families USA

The following Families USA staff contributed to the preparation of this material (listed alphabetically):

Ron Pollack, Executive Director

Evan Potler, Art Director

Carla Uriona, Director of Content Strategy

Ingrid VanTuinen, Director of Editorial

Alex Walker, Senior Web Editor

The following Urban Institute staff assisted with this publication:

Fredric Blavin, Senior Research Associate

Michael Karpman, Research Associate

Stephen Zuckerman, Co-Director and Senior Fellow

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FAMILIESUSA 
THE VOICE FOR HEALTH CARE CONSUMERS

1201 New York Avenue NW, Suite 1100

Washington, DC 20005

202-628-3030

info@familiesusa.org

www.FamiliesUSA.org

facebook / FamiliesUSA

twitter / @FamiliesUSA