US health exchanges will impose high out-of-pocket costs, limit choices

Kate Randall
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The Obama administration on Wednesday unveiled premiums and plan choices for the health insurance markets in 36 states where the federal government is running the exchanges set up under the 2010 Affordable Care Act. State governments will administer exchanges in the remaining states.

President Obama spoke Thursday at a Maryland community college to promote his health care overhaul, claiming that many plans on the exchanges "will cost much less than they do now" because insurance companies will be competing for business.

In reality, many uninsured people who begin to shop for health care coverage on the exchanges will be in for a rude shock. The preponderance of "affordable" coverage will consist of cut-rate plans that leave the insured responsible for a considerable proportion of the costs.

Premiums will vary widely from state to state and many plans with lower premiums will significantly limit the choice of doctors and hospitals. With few exceptions, individuals and families that do not receive insurance through an employer or a government program such as Medicare or Medicaid will be required to obtain insurance or pay a fine.

Consumers shopping on the exchanges will be presented with a confusing selection of plans to choose from. All of the coverage is offered by private insurance companies that have tailored policies to suit their profit interests. They are banking on a substantial number of young, healthy people signing up for coverage to offset costs associated with requirements that sicker individuals or those with pre-existing conditions not be charged higher premiums or turned away. If adequate numbers of young and relatively healthy people do not sign up, premiums are sure to rise.

According to figures provided by the Department of Health and Human Services (HHS), premiums for a mid-range "silver" plan will average $328 a month nationally, before any tax credit subsidies are applied. But silver plan costs will vary greatly, ranging from a low of $172 in Minnesota to a high of $516 in Wyoming. The same plan will cost $373 in California, $328 in Florida, and $305 in Texas.

HHS officials point out that subsidies will bring these costs down, and that a 27-year-old making $25,000 a year will see premiums for the silver plan drop to $145 a month in nearly every state. Monthly premium costs will be reduced if this same young adult purchases the lowest-tier "bronze" plan—dropping to $74 in Dallas-Fort Worth, Texas; $102 in Orlando, Florida; and $119 in Pittsburgh, Pennsylvania.

But the bronze plans come with the highest out-of-pocket costs through annual deductibles and cost-sharing. The bronze plans are required to cover only 60 percent of costs, compared to 70 percent for the mid-range silver plans and 90 percent for the highest priced "platinum" plans.

While the Obama administration has made much of the ACA's cap on annual out-of-pocket expenses, they are actually set quite high—$6,350 for individuals, $12,700 for families. For the hypothetical 27-year-old earning $25,000 annually, the maximum out-of-pocket costs would be more than a quarter of his or her income. Similarly, a family of four making $50,000 a year could be hit with $12,700 in out-of-pocket costs.

An analysis by private consulting firm Avalere Health of exchanges in six states—Colorado, Connecticut, Indiana, Rhode Island, Vermont and Washington—found that the average deductible on the mid-level silver plans ranged from $1,500 to $5,000. With the average deductible of an employer-sponsored

plan currently running at $1,135, those workers dropped from coverage by their employers and forced onto the exchanges will see an immediate increase in costs from the deductible alone.

In addition, almost 90 percent of the least expensive bronze plans rely on coinsurance instead of co-pays for at least some prescription drugs. This means the insured pays a percentage of the drug cost instead of a flat fee, which could significantly drive up costs for those needing expensive prescription medications for cancer or other serious conditions. By contrast, less than a third of employer-sponsored plans presently include coinsurance.

While touting some of the lower premiums on the exchanges, White House officials rarely mention that many private insurers are seeking to cut costs by significantly limiting the choice of doctors and hospitals available on their plans. The choice of providers is not only smaller, they will be paid less than what they have been paid by commercial insurers.

Insurer Cigna will participate in exchanges in Arizona, Colorado, Florida, Tennessee and Texas. Cigna spokesman Joseph Mondy told the *New York Times* that the insurer's "networks will be narrower than the networks typically offered to large groups of employees in the commercial market."

The Health Research Institute of PricewaterhouseCoopers finds in a recent study that "insurers passed over major medical centers" in their selection of providers in California, Illinois, Indiana, Kentucky and other states. The study notes: "The use of narrow networks may also lead to higher out-of-pocket expenses, especially if a patient has a complex medical problem that's being treated at a hospital that has been excluded from their health plan."

Blue Cross Blue Shield of California will include only 30,000 doctors on its exchange network, compared to 57,000 in its broadest commercial network. Only 235 of 302 hospitals will be included, with all five medical centers of the University of California excluded.

An HHS report estimates that about 95 percent of people shopping for coverage on the exchanges will have at least two insurers to choose from, but some states will have only one. In New Hampshire, Anthem Blue Cross and Blue Shield, a unit of WellPoint, is the only commercial carrier offering health plans.

Anthem is excluding 10 of the state's 26 hospitals from its plans, which means that some people will be forced to drive an hour or more to reach a doctor. Also, as many physicians' practices are owned by hospitals, patients may find that their doctors are not in their networks, forcing them to either find another physician or pay out of pocket to remain with their doctor.

While the ACA prohibits discriminating against patients with pre-existing conditions, insurers are seeking to discourage their enrollment by limiting the hospitals and doctors available in their networks.