

## CCIIO Data Brief Series

### Affordability in the Marketplaces remains an issue for Moderate Income Americans

January 2021

#### I. Overview

Ten years after the enactment of the Affordable Care Act (ACA), health care coverage remains unaffordable and out of reach for many Americans. While the ACA's premium tax credit subsidies lower the cost of premiums for some lower-income individuals, the initial implementation and structure of the ACA substantially increased the cost of health insurance premiums for middle-income individuals and families who do not qualify for the ACA's premium subsidies.<sup>1</sup> These people represent a portion of the approximately 30 million Americans who remain uninsured.

Affordability remains an issue across all insurance markets in the United States. Both the employer-sponsored market and the individual market have seen a significant rise in premiums since the ACA was passed. For example, annual premiums for single coverage for employer-sponsored insurance (ESI) increased 48 percent since 2010 and worker contributions have increased 38 percent over the same time period.<sup>2</sup> Premiums in the individual market increased by a much larger margin in just the first four years after the ACA's main health insurance market reform requirements took effect. Between 2013 and 2017, average individual market premiums in states with Exchanges using HealthCare.gov more than doubled.<sup>3</sup> While premiums have declined after CMS began implementing a number of strategies to stabilize the market in 2017, premiums remain substantially higher than pre-ACA levels. In addition, across the health care sector, the underlying cost of health care continually outpaces inflation, which is unsustainable for the industry and the country.

This report provides data on the affordability of coverage available to people on the individual health insurance market - the market that was most heavily impacted by the ACA's new market reform requirements in 2014. Overall, the data in this report illustrate that affordable health coverage is not available for many consumers purchasing coverage on the individual market who do not qualify for the ACA's subsidies.

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<sup>1</sup> HHS, "Individual Market Premium Changes: 2013 – 2017", May 23, 2017.

<https://aspe.hhs.gov/system/files/pdf/256751/IndividualMarketPremiumChanges.pdf>

<sup>2</sup> Kaiser Family Foundation, "2020 Employer Health Benefits Survey." Oct 2020. <https://www.kff.org/health-costs/report/2020-employer-health-benefits-survey/> (Figure 6.4)

<sup>3</sup> HHS, "Individual Market Premium Changes: 2013 – 2017", May 23, 2017.

<https://aspe.hhs.gov/system/files/pdf/256751/IndividualMarketPremiumChanges.pdf>

## II. Measures of Affordability

There is no single definition of affordability in the context of health care. There are many factors to consider when measuring the affordability of health insurance coverage, such as family income, monthly premiums, and cost sharing requirements. As a practical matter, affordability is often measured by whether a household is able to cover their health care costs and also pay for necessities such as housing, transportation, and food.<sup>4</sup>

The tax code has provided a deduction for unreimbursed medical expenses that exceed a certain proportion of income, which recognizes a point at which medical expenses become excessive and warrant relief. This threshold began at 5.0 percent of net income in 1942, was later increased to 7.5 percent of adjusted gross income (AGI) in 1986, and the ACA then increased this threshold to 10 percent of AGI for individuals below age 65. Congress recently reduced the AGI level back to 7.5 percent starting in 2017.<sup>5</sup>

Under the ACA, an employer-sponsored health plan is deemed unaffordable to the employee for purposes of determining whether an individual offered employer-sponsored coverage may be eligible for premium tax credits if the employee's cost of the lowest cost self-only plan exceeds 9.78 percent of the employee's household income for 2020 (for 2021, this affordability test is set at 9.83% of household income). Whether or not this is the best baseline for assessing affordability remains an open question, but it is the current benchmark under the ACA.

Within this framework, this report analyzes affordability as an individual's potential premium and out-of-pocket costs, as well as regional variations in health care costs.

## III. The ACA's Impact on Individual Market Premiums

As previously noted, average individual market premiums in states with Exchanges using HealthCare.gov more than doubled between 2013 and 2017. This increase in premiums is primarily due to the implementation of the ACA's insurance reforms in 2014, including decisions on how to implement these requirements. Actuaries have identified a number of ACA requirements that contribute to substantially higher premiums, including the closure of state high risk pools, mandated premium rating requirements including compressed age rating bands, a more generous set of mandated essential health benefits, health insurance taxes, and the Exchange user fees.<sup>6</sup>

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<sup>4</sup> Weiner, Janet et al. "What is 'Affordable' Health Care?" PennLDI. November 2018.

[https://ldi.upenn.edu/sites/default/files/pdf/Penn%20LDI%20and%20USofC%20Affordability%20Issue%20Brief\\_Final.pdf](https://ldi.upenn.edu/sites/default/files/pdf/Penn%20LDI%20and%20USofC%20Affordability%20Issue%20Brief_Final.pdf)

<sup>5</sup> IRS "Medical and Dental Expenses," Publication 502, (2019). <https://www.irs.gov/publications/p502>

<sup>6</sup> See Milliman, Comprehensive Assessment of ACA Factors That Will Affect Individual Premiums in 2014, April 25, 2013.

Certain decisions on how to implement the ACA have also led to higher premiums, including decisions on Exchange implementation, the allowance of transitional policies, and the lack of Exchange verification of eligibility for special enrollment periods (SEP). Various decisions led to initial failures and ongoing glitches on Exchanges during the early years of implementation.<sup>7</sup> Research suggests these initial failures may have had long-term impacts on premiums and consumer welfare.<sup>8</sup> After insurers sent out cancellation notices for policies that did not meet the ACA's requirements in 2013, a policy decision was made to allow insurers to nonetheless continue renewing these "transitional" noncompliant policies. This decision likely kept healthier people from joining the individual market, contributing to substantial claims losses in 2014 and 2015, which contributed to substantial premium increases in 2016 and 2017.<sup>9</sup> Finally, early decisions allowed greater flexibility and lax enforcement of SEPs. This increased issuers' exposure to adverse selection by making it easier for people to time enrollment for only those months when they incurred health expenses.<sup>10</sup>

In addition to the ACA market reform requirements on insurance markets, the structure of the premium tax credit also encourages premium inflation because the amount of the subsidy is linked to the overall cost of the health plan. The ACA's subsidy structure subsidizes the full amount of premiums above a certain proportion of income on a sliding scale, which means the value of the premium tax credit subsidy effectively rises in lock step with rising premiums (see discussion below). This substantially reduces insurers' incentive to constrain premium growth because the federal government fully funds the premium increases for those who qualify for the ACA's subsidies. Research suggests this type of subsidy weakens competition, resulting in higher premiums and subsidy costs for the government.<sup>11</sup>

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<sup>7</sup> See e.g., Office of Inspector General, HealthCare.gov: Case Study of CMS Management of the Federal Marketplace February 2016), available at <https://oig.hhs.gov/oei/reports/oei-06-14-00350.pdf>; and Minnesota Office of the Legislative Auditor, Evaluation Report: Minnesota Health Insurance Exchange (MNSure) (February 2015), available at <https://www.auditor.leg.state.mn.us/ped/2015/mnsuresum.htm>.

<sup>8</sup> See Amanda Kowalski, "The Early Impact of the Affordable Care Act State-by-State," National Bureau of Economic Research Working Paper 20597 (October 2014), available at <https://www.nber.org/papers/w20597>; and Florian Scheuer and Kent Smetters, "Could a website really have doomed the health exchanges? Multiple equilibria, initial conditions and the construction of the fine," National Bureau of Economic Research Working Paper 19835 (January 2014), available at <https://www.nber.org/papers/w19835>.

<sup>9</sup> Erik Huth and Jason Karcher, "A financial post-mortem: Transitional policies and the financial implications for the 2014 individual market," Milliman, July 20, 2016, available at <https://www.milliman.com/en/insight/a-financial-post-mortem-transitional-policies-and-the-financial-implications-for-the-2014>.

<sup>10</sup> See Laura F. Garabedian, et al., "Costs Are Higher For Marketplace Members Who Enroll During Special Enrollment Periods Compared With Open Enrollment," *Health Affairs*, Vol. 39, No. 8 (August 2018), available at <https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.01155>; and Rebecca Diamond, et al., "Take-up, drop-out, and spending in ACA marketplaces," National Bureau of Economic Research Working Paper 24668 (May 2018), available at <https://www.nber.org/papers/w24668>;

<sup>11</sup> Sonia Jaffe and Mark Shepard, Price Linked Subsidies and Health Insurance Markups, HKS Working Paper No. RWP17-002 (January 24, 2017), available at [https://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=2910012](https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2910012).

#### **IV. The ACA Subsidies**

For lower-income people in need of health insurance, the ACA attempts to improve the affordability of coverage and access to care by offering premium subsidies to individuals with annual household incomes starting at 100 percent of FPL (\$12,490) up to 400 percent of FPL (\$49,960).<sup>12</sup> The subsidy amounts an individual can receive are based on income and decrease as household income increases. Under this structure, people are expected to pay a certain percent of income toward the premium of a benchmark plan (i.e. second lowest-cost silver plan), ranging from 2.07 percent of income at 100 percent of the federal poverty level (FPL) to 9.83 percent of income at 400 percent of FPL.<sup>13</sup> In addition, the ACA requires issuers to provide Cost Sharing Reductions (CSRs) to reduce out-of-pocket medical costs for enrollees who make between 100 and 250 percent FPL.<sup>14</sup> In effect, this structure establishes a sliding scale income-based affordability standard.

Despite these subsidies, coverage and care remain unaffordable for many, particularly for those who receive minimal or no financial assistance. Moderate-income consumers who make just over 400 percent of FPL do not qualify for cost sharing or premium subsidies and shoulder the full cost of high premiums. As the data in this report show, many of these consumers find themselves priced out of the market entirely.

#### **V. The ACA's Subsidy Cliff**

Health insurance premiums are not affordable for many people without access to subsidies. There is a steep difference in how much an individual with a household income over 400 percent FPL will pay in premiums compared to an individual with a lower household income. This is often referred to as the “subsidy cliff.”<sup>15</sup> The subsidy cliff is steepest for older moderate-income consumers near retirement age.<sup>16</sup> As Figure 1 illustrates, premium prices for older, pre-Medicare moderate-income consumers far exceed the ACA-defined benchmark of no more than 9.83 percent of household income. For example, premium costs for a 60-year old earning just over 400 percent of FPL are on average 25.8 percent of their income. To put this in perspective, on average an older consumer with an annual income of \$50,000 would pay \$12,886 per year in premium costs (see Figure 1 below and Appendix IV for additional age bands).

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<sup>12</sup> Federal poverty levels from 2019, used to calculate premiums for plan year 2020.

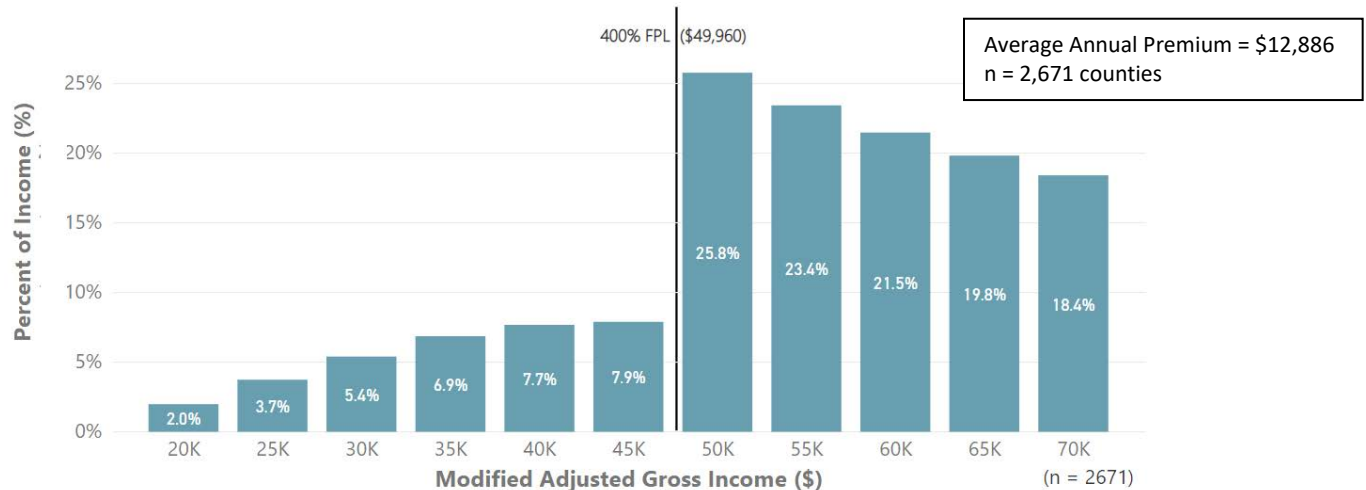
<sup>13</sup> Internal Revenue Service, Revenue Procedure 2020-36, July 21, 2020, available at: <https://www.irs.gov/pub/irs-drop/rp-20-36.pdf>

<sup>14</sup> ACA § 1402; Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2021; Notice Requirement for Non-Federal Governmental Plans. 85 Fed. Reg. 29,164, 29,229-29,230. (May 14, 2020).

<sup>15</sup> Fehr, Rachel et al. “How Affordable are 2019 ACA Premiums for Middle-Income People?” Kaiser Family Foundation. March 5, 2019. <https://www.kff.org/health-reform/issue-brief/how-affordable-are-2019-aca-premiums-for-middle-income-people/>

<sup>16</sup> Federal Register/ Vol. 78, No. 39, 45 CFR Parts 144, 147, 150, 154 and 156 <https://www.govinfo.gov/content/pkg/FR-2013-02-27/pdf/2013-04335.pdf>

**Figure 1 - Lowest-Cost Silver Plan Average Premium as Percentage of Income for 60-Year Olds<sup>17</sup>**



This does not mean that younger consumers are impervious to the high cost of premiums and the subsidy cliff. For a 30-year old living in one of the top fifth highest cost counties in the U.S., the percent of household income spent on premiums increases from 8.4 percent to 14.8 percent when their income rises from just under 400 percent to just above 400 percent FPL (See Appendix II).

## VI. Health Coverage Affordability: Regional Variation

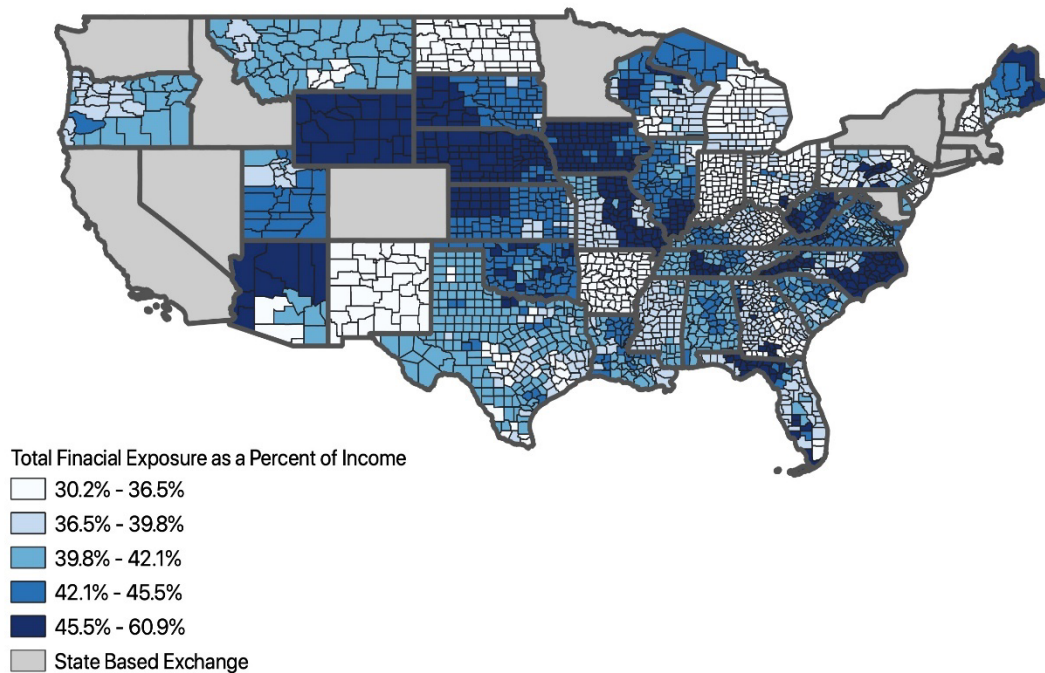
When assessing affordability of a health plan, an individual’s maximum financial exposure under the plan, including premiums, deductibles, co-payments, and co-insurance should be taken into account. While only a small portion of people may reach this maximum level of financial exposure—the full premium and the maximum out-of-pocket limit—it represents the financial risk a high-cost health incident or chronic condition could impose on any individual.

When factoring in all these components, a 60-year-old individual earning \$50,000 (too much to qualify for premium subsidies) with high health needs who reaches their maximum financial exposure may be required to pay between 30.2 percent and 60.9 percent of their total income for health insurance coverage and services, depending on where they live in the U.S. To be clear, healthier 60-year-olds with a moderate income may not pay this maximum amount each year, but this is the range of financial exposure. The map below (Figure 2) illustrates how the financial exposure for this population varies across the country, with consumers living in rural areas hit

<sup>17</sup> Calculated by determining the premiums that 60-year-olds at varying levels of household income would pay for an average of the lowest cost silver plan across all counties using the healthcare.gov platform excluding Alaska and Hawaii. Total of 2,671 counties were included. Calculation includes advanced premium tax credits for income levels under 400% of FPL. The data used is from 2020.

hardest. In addition, these older consumers are more vulnerable to reaching this maximum amount as they tend to have more complex medical needs.<sup>18</sup>

**Figure 2: Maximum Financial Exposure as a Percent of Income for a 60-year-old earning \$50,000 Compared at the County Level<sup>19</sup>**



While Marketplace plans are costly for unsubsidized consumers, the financial burden is especially high for 60-year-old consumers living in areas of the country where premiums combined with out-of-pocket costs are most expensive. The disparity is stark. Figures 3 and 4 depict the range of financial exposure by income level for a 60 year old living in the highest cost quintile of counties (Figure 3) and lowest cost quintile of counties (Figure 4). 60-year-old consumers living in counties with the highest cost have a maximum financial exposure that is close to 1.5 times higher than those living in the least expensive counties (see Appendices II and III for additional age bands). Specifically, the consumers in the most expensive counties could potentially spend, on average, 51.4 percent of their total income for health insurance coverage

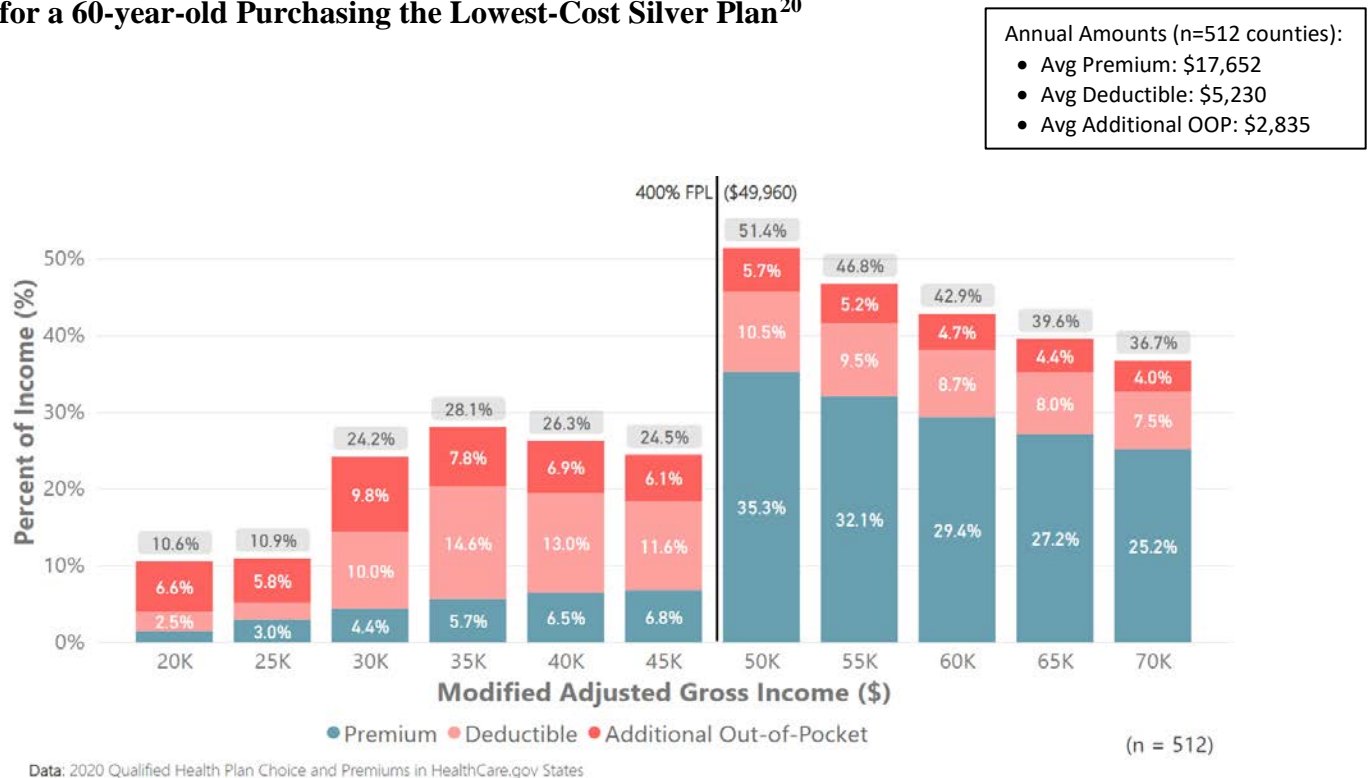
<sup>18</sup> Sawyer, Bradley & Gary Claxton. "How do health expenditures vary across the population?" Peterson-Kaiser Family Foundation. Jan. 16, 2019. <https://www.healthsystemtracker.org/chart-collection/health-expenditures-vary-across-population/#item-start>

<sup>19</sup> Maximum Financial exposure was calculated as the sum of the premium for the lowest cost silver plan in each county plus the maximum out-of-pocket limit associated with that specific plan. Given that this map shows the financial exposure of 60-year-olds making over 400% of FPL, advance premium tax credits (APTC) are not included in the calculation. Additionally, only states using the healthcare.gov platform (excluding Hawaii and Alaska) were included in this map for a total of 2,671 counties. The data used is from 2020.

and services if they reach their maximum financial exposure. In comparison, the consumers in counties with lower costs could potentially spend, on average, 34.6 percent of their income.

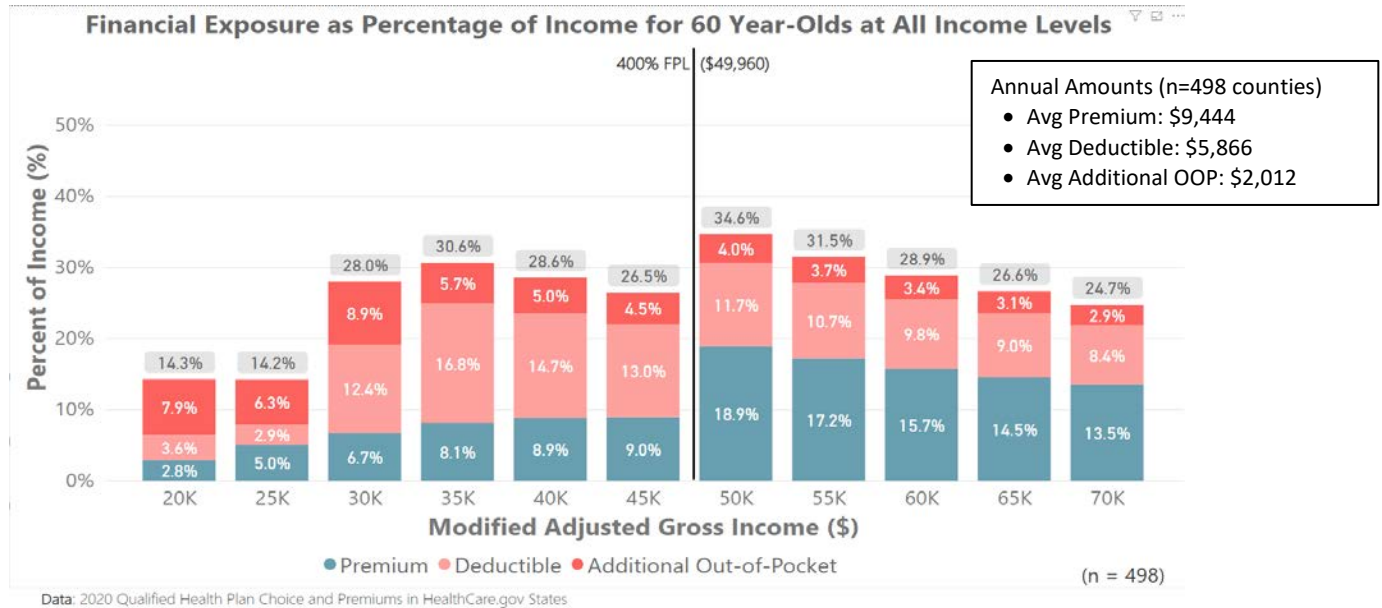
Figures 3 and 4 further illustrate that even for those older moderate-income consumers who receive some premium subsidy, if their annual income is too much to qualify for the CSR subsidy (i.e., household incomes higher than \$31,225), their total financial exposure is high – often exceeding 25 percent of income in both the higher and lower cost counties.

**Figure 3: Maximum Financial Exposure for Highest-Cost Counties as a Percent of Income for a 60-year-old Purchasing the Lowest-Cost Silver Plan<sup>20</sup>**



<sup>20</sup> Figure 3 displays the premiums, deductibles and additional out of pocket costs that 60-year-olds at varying levels of income would pay for an average of the lowest cost silver plan across all counties using the healthcare.gov platform, excluding Alaska and Hawaii. Calculations include advanced premium tax credits for income levels under 400% of FPL and cost sharing reductions for income levels under 250% of FPL. Figure 3 only considers the top twenty percent of counties (n=512) using healthcare.gov platform where financial exposure for 60-year-olds with incomes more than 400% of FPL is greatest. The data used is from 2020.

**Figure 4: Maximum Financial Exposure for Lowest-Cost Counties as a Percent of Income for a 60-year-old Purchasing the Lowest-Cost Silver Plan<sup>21</sup>**



As noted, not all people reach the maximum out of pocket limit. In fact, most people, especially those who are healthier and younger, do not. For older enrollees in the individual market aged 55 to 64 who are considered healthy, approximately 1 in 10 would reach their deductible (on average \$4,500). For those aged 55 to 64 who have one or more conditions that would characterize them as “unhealthy”, approximately 4 in 10 would hit their deductible and an additional 1 in 10 would hit their maximum out-of-pocket limit (\$8,150 for plan year 2020).<sup>22</sup>

While the figures in this report focus on the financial exposure of older non-subsidized adults, younger consumers are also at risk for a substantial level of financial exposure by income. However, as shown in Appendix 1, for younger consumers 30, 40 and 50 years of age, the potential for substantial financial exposure is relatively steady across incomes due to the fact that premiums account for a lower share of the maximum financial exposure.

<sup>21</sup> Figure 4 uses the same methodology as Figure 3 but only includes the bottom twenty percent of counties (n=498) where financial risk exposure is lowest. The data used in Figure 4 is from 2020.

<sup>22</sup> Derived by estimating claims expense for four population segments: healthy under 55, healthy over 55, unhealthy under 55, and unhealthy over 55. Modeled out-of-pocket costs (deductible, co-pay, coinsurance) for all segments using a typical lowest cost silver plan with a \$4500 deductible, 10% coinsurance, and \$8000 maximum out-of-pocket limit. The presence of one of the HHS-HCC model conditions, or Hierarchical Condition Categories was used to mark those in the population data set considered “unhealthy.” HCCs include diagnoses/conditions like Cancer, Diabetes, HIV/AIDS, Pregnancy, Severe burns, and other such conditions with large, somewhat predictable costs. Source: Wakely ACA Database (WACA). WACA is an aggregated database based on de-identified CMS Enrollee-level External Data Gathering Environment (EDGE) Server input and output files (including enrollment, claims, and pharmacy data) from the 2017 benefit year submitted through April 2018, along with supplemental risk adjustment transfer and issuer-reported financial information, representing approximately 4 million lives from the individual ACA market. For further details please see <https://www.wakely.com/services/product/wakely-aca-database-waca>.



## VII. CMS Progress

The data presented here indicates that moderate-income consumers who have household incomes just over 400 percent of the FPL and who do not qualify for the ACA's subsidies continue to struggle with health insurance costs as the cost of an individual market plan continues to increase. As outlined earlier, the implementation of the ACA's main health insurance market reform requirements are responsible for a portion of the rise in insurance costs. The fact that the underlying cost of health care continues to rise faster than inflation is also a substantial factor. Both of these factors pose a large barrier to affordability. However, in recent years CMS has taken substantial steps to mitigate the costly impact of the ACA on health insurance markets and address other longstanding issues in our health care system that are driving up costs.

While many of the ACA's cost drivers are built into the statute, there are opportunities to make coverage more affordable under the ACA. To reverse rising premiums and fewer choices on the individual insurance market, CMS has implemented regulations and policies to improve risk pools and increase competition among health insurers. New regulations have improved risk pools by encouraging individuals to maintain continuous coverage and providing states with new tools to stabilize their markets and deliver a more predictable regulatory framework.<sup>23</sup> CMS also implemented an outreach plan to bring insurers back into the individual market to increase competition to lower premiums. To promote competition on quality, CMS required Exchanges across the country to publicly display quality information for the 2020 plan year.<sup>24</sup> In addition, CMS approved 15 state reinsurance waivers, all of which drove insurance premiums down—in most cases by double digit percentages.<sup>25</sup>

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<sup>23</sup> Patient Protection and Affordability Care Act; Market Stabilization, 82 Fed. Reg. 18346 (April 18, 2017), <https://www.federalregister.gov/documents/2017/04/18/2017-07712/patient-protection-and-affordable-care-act-market-stabilization>; Patient Protection and Affordable Care Act; Notice of Benefit and Payment Parameters for 2019, 83 Fed. Reg. 16930 (April 17, 2018), <https://www.federalregister.gov/documents/2018/04/17/2018-07355/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2019>; and Patient Protection and Affordable Care Act; Notice of Benefit and Payment Parameters for 2021; Notice Requirement for Non-Federal Governmental Plans, 85 Fed. Reg. 29164 (May 14, 2020), <https://www.federalregister.gov/documents/2020/05/14/2020-10045/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2021>,

<sup>24</sup> Quality Rating Bulletin. Centers for Medicare and Medicaid Services. <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/QualityRatingInformationBulletinforPlanYear2020.pdf>. Published August 15, 2019.

<sup>25</sup> State Relief and Empowerment Waivers: State-based Reinsurance Programs. Centers for Medicare and Medicaid Services. <https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/1332-Data-Brief-June2020.pdf>. Published June 2020.

As a result of these agency actions, more issuers are coming back to the market, increasing competition and bringing down premiums.<sup>26</sup> In 2021, average premiums for a benchmark plan sold on HealthCare.gov declined for the third straight year.<sup>27</sup>

As part of its comprehensive approach, CMS has also advanced a number of policies to address the rising cost of health care. These policies focus on empowering patients with better information to improve their decision-making to drive greater competition within the market. For instance, CMS finalized price transparency rule that requires hospitals to post a list of their standard charges<sup>28</sup> and requires most health insurance issuers and self-insured employer health plans to disclose their negotiated in-network rates and out-of-network payments on a public website, and provide cost-sharing liability information to participants.<sup>29</sup> CMS also finalized the Interoperability and Patient Access rule, which requires most health plans doing business in Medicare, Medicaid, and the Federal Marketplaces to share health claims data and other important information with their beneficiaries and enrollees.<sup>30</sup>

In addition, in an effort aimed at reducing regulatory barriers to care coordination and improving the coordination of patient care across care settings, CMS issued a final rule modifying implementation of the Stark Law<sup>31</sup> which presents significant opportunities for new value-based care arrangements that reduce burden on providers and protect patients from unnecessary services that drive up costs. All these measures will help lower the overall cost of health care and lead to lower premiums and lower out-of-pocket spending for consumers.

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<sup>26</sup> Increasing Competition on the Exchanges to Improve Consumer Choice and Affordability. Centers for Medicare and Medicaid Services. <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Issuer-Participation-in-the-Marketplace.pdf>. Published October 30, 2020.

<sup>27</sup> Plan Year 2021 Qualified Health Plan Choice and Premiums in HealthCare.gov States. <https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2021QHPPremiumsChoiceReport.pdf>. Published November 23, 2020.

<sup>28</sup> Medicare and Medicaid Programs: CY 2020 Hospital Outpatient PPS Policy Changes and Payment Rates and Ambulatory Surgical Center Payment System Policy Changes and Payment Rates. Price Transparency Requirements for Hospitals to Make Standard Charges Public, 84 Fed. Reg. 65524 (Nov. 27, 2019), <https://www.govinfo.gov/content/pkg/FR-2019-11-27/pdf/2019-24931.pdf>.

<sup>29</sup> Transparency in Coverage, 85 Fed. Reg. 72158 (Nov. 12, 2020), <https://www.federalregister.gov/documents/2020/11/12/2020-24591/transparency-in-coverage>

<sup>30</sup> CMS, Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Interoperability and Patient Access for Medicare Advantage Organization and Medicaid Managed Care Plans, State Medicaid Agencies, CHIP Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the Federally-Facilitated Exchanges, and Health Care Providers, 85 Fed. Reg. 25510 (May 1, 2020), <https://www.govinfo.gov/content/pkg/FR-2020-05-01/pdf/2020-05050.pdf>.

<sup>31</sup> CMS, Medicare Program; Modernizing and Clarifying the Physician Self-Referral Regulations, 85 Fed. Reg. 77492 (Dec. 2, 2020), available at: <https://www.federalregister.gov/documents/2020/12/02/2020-26140/medicare-program-modernizing-and-clarifying-the-physician-self-referral-regulations>

## **VIII. Conclusion**

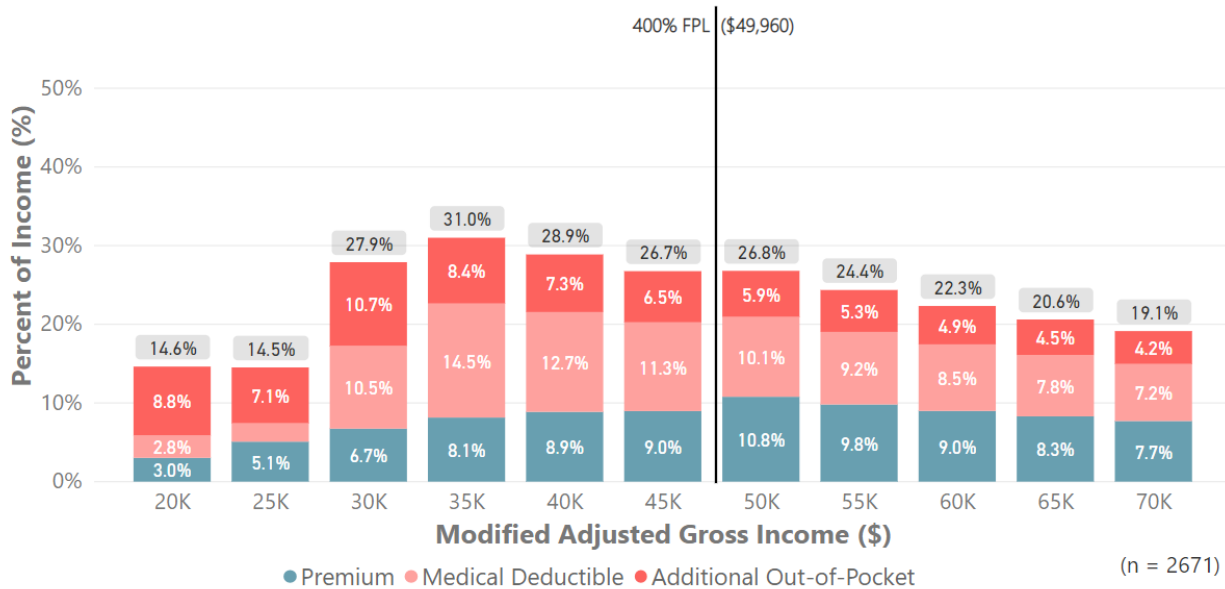
The data in this report shows that health coverage is not affordable for many middle-income Americans who do not qualify for premium subsidies. Affordability is a particular challenge for older Americans near retirement age and people living in rural areas.

Although much work remains to make insurance more affordable for all Americans, over the past several years, CMS has made significant strides to improve the affordability of individual health insurance coverage for people who don't have access to employer coverage and don't qualify for premium subsidies. These actions include efforts to increase competition and consumer choice, reduce premium costs and the underlying cost of care throughout the United States. CMS continues to focus on providing systemic solutions to address the longstanding problems in the health care system and create more opportunities for all Americans to be able to access affordable care.

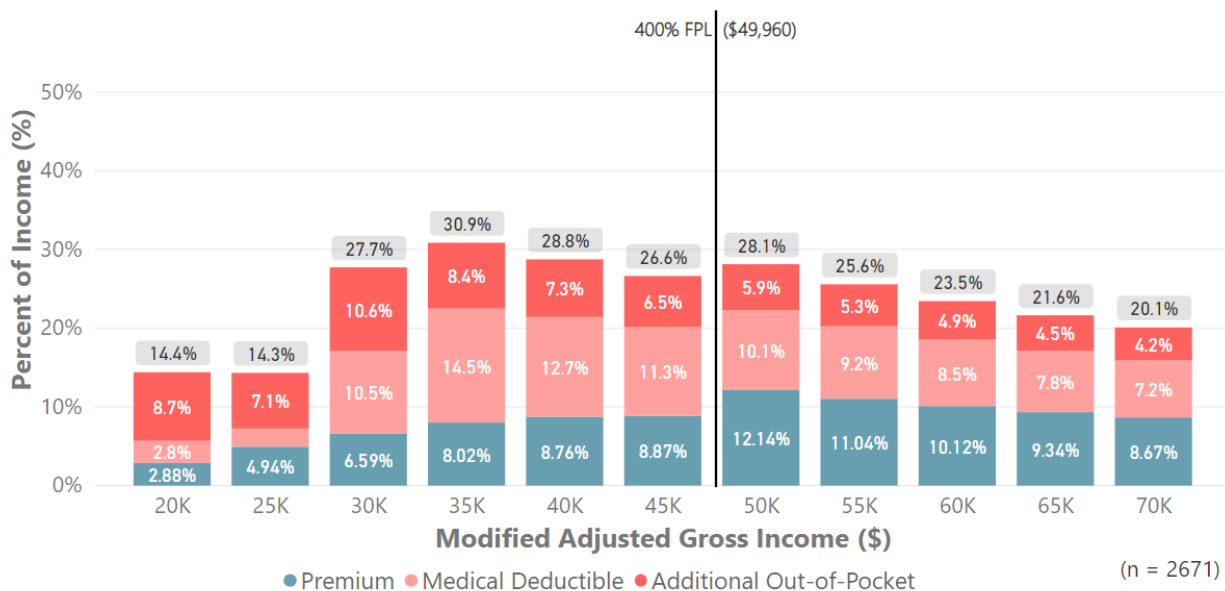
## Appendix I: Average Financial Exposure as Percentage of Income by Age at All Income Levels\*

\*All appendices contain data for all counties in states that use the healthcare.gov platform except Hawaii and Alaska.

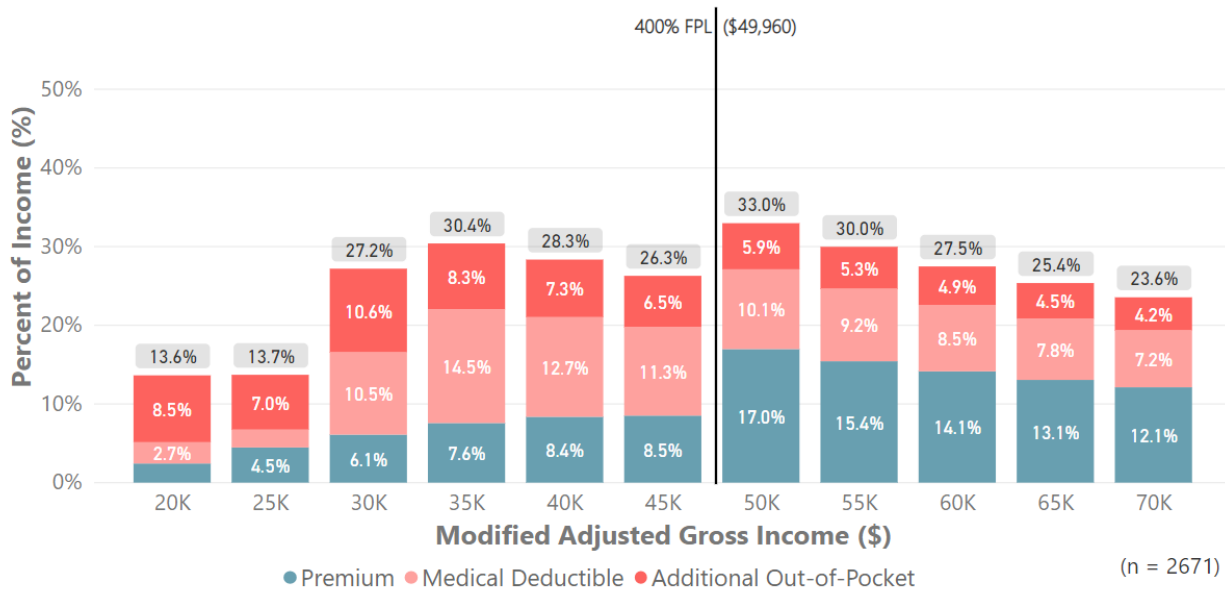
### Financial Exposure as Percentage of Income for 30 Year-Olds at All Income Levels



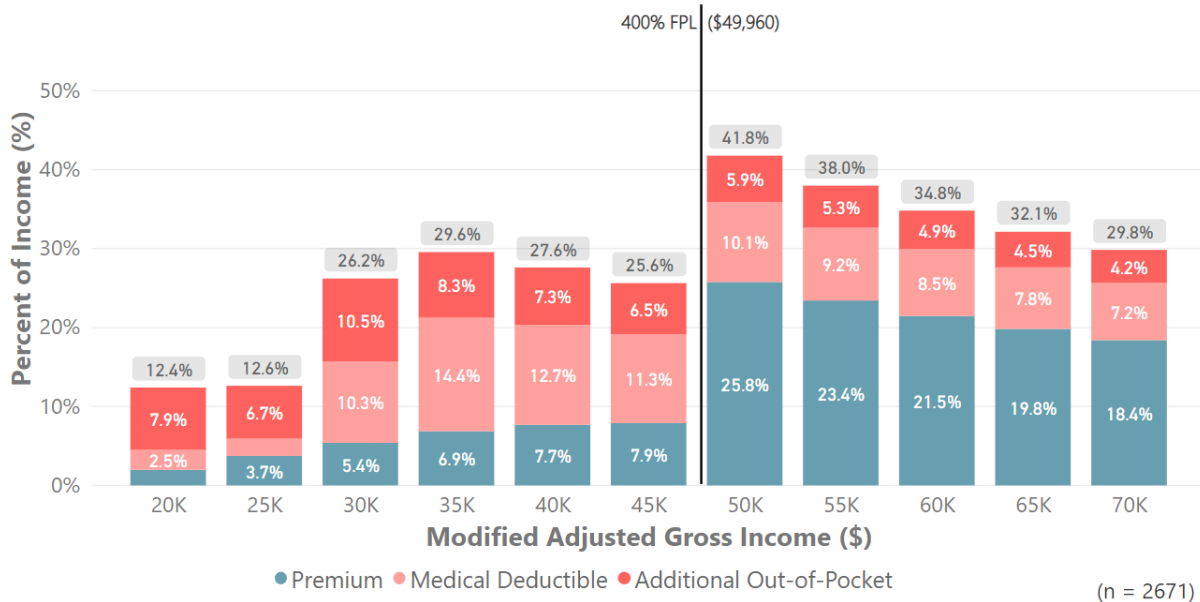
### Financial Exposure as Percentage of Income for 40 Year-Olds at All Income Levels



### Financial Exposure as Percentage of Income for 50 Year-Olds at All Income Levels

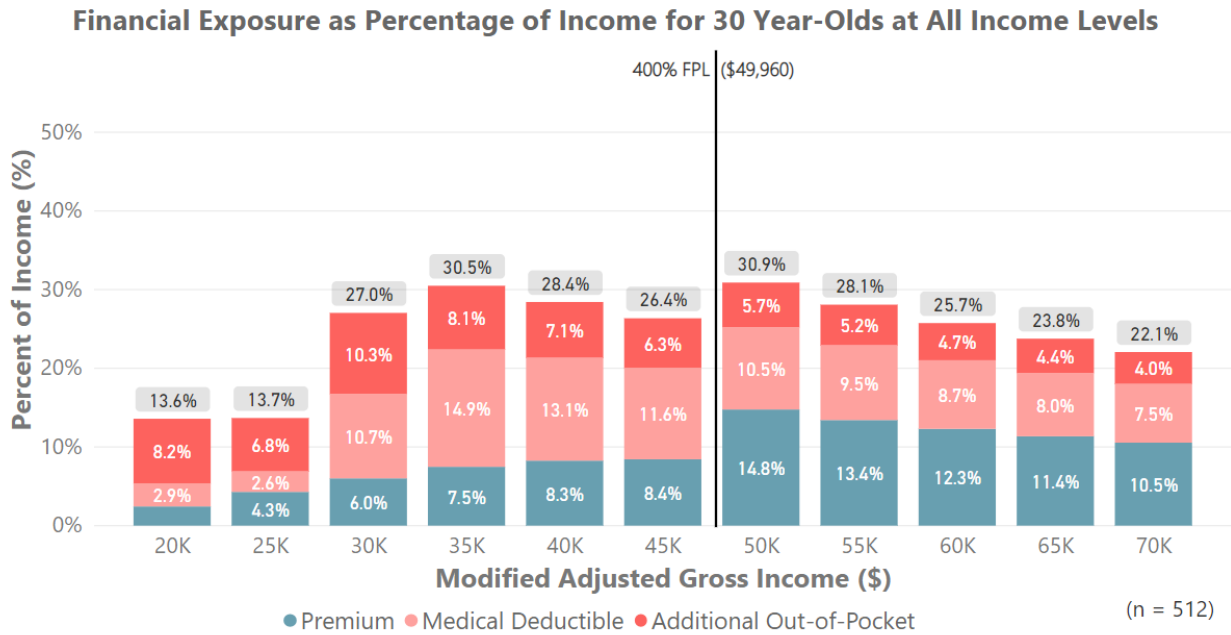


### Financial Exposure as Percentage of Income for 60 Year-Olds at All Income Levels

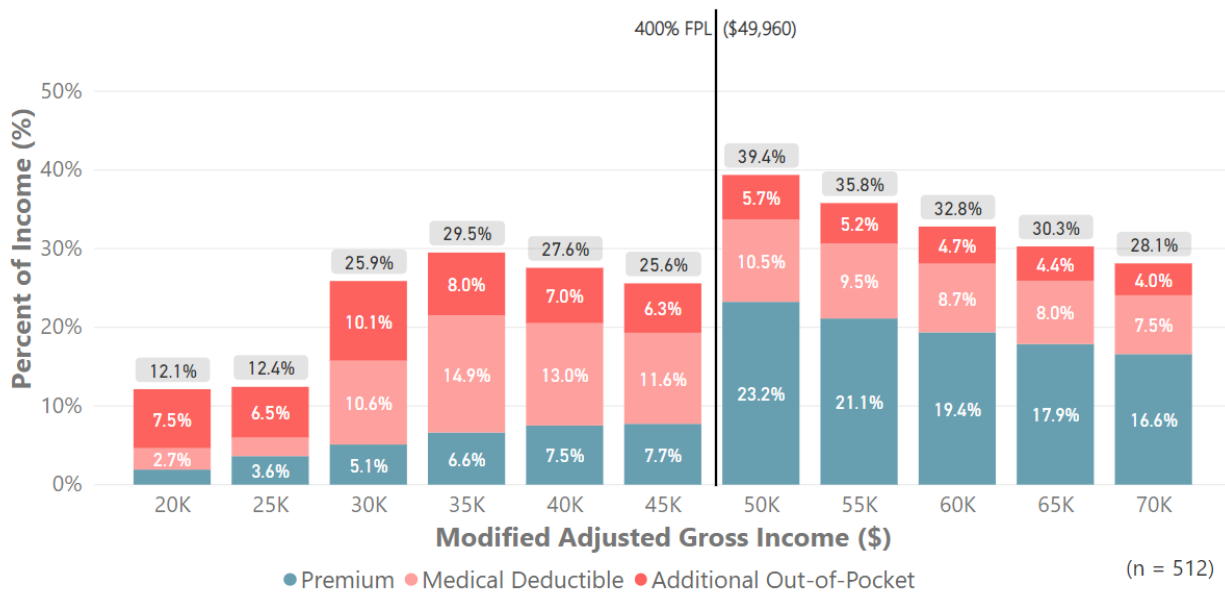


Data: 2020 Qualified Health Plan Choice and Premiums in HealthCare.gov States

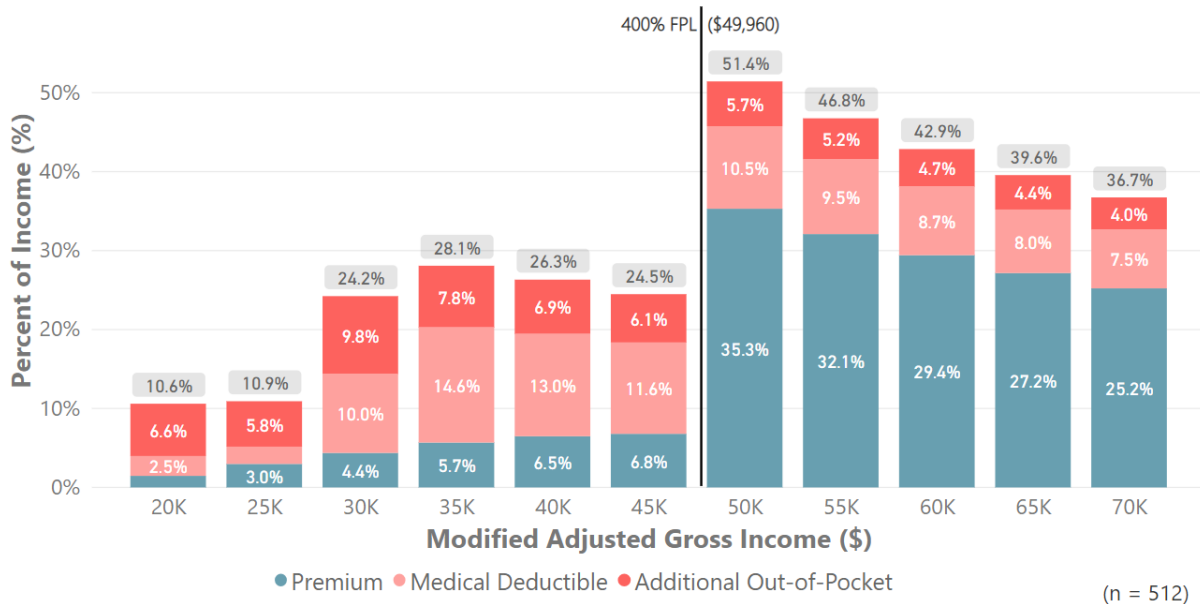
## Appendix II: Maximum Financial Exposure for Highest-Cost Counties as a Percent of Income by Age at All Income Levels Purchasing the Lowest-Cost Silver Plan



### Financial Exposure as Percentage of Income for 50 Year-Olds at All Income Levels

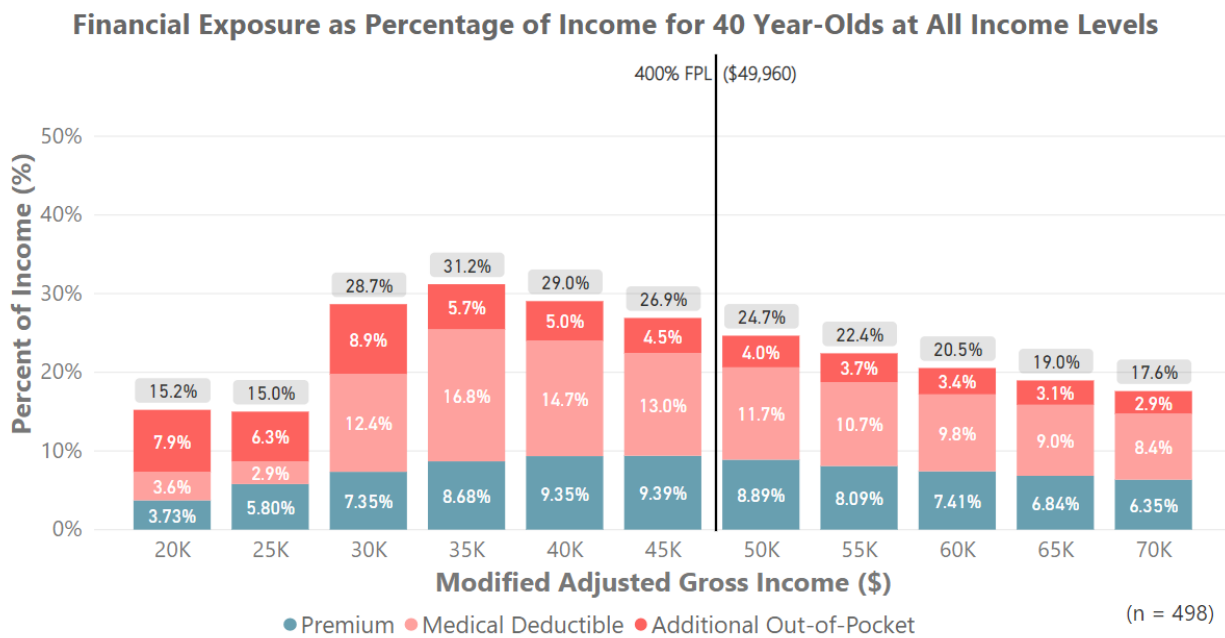
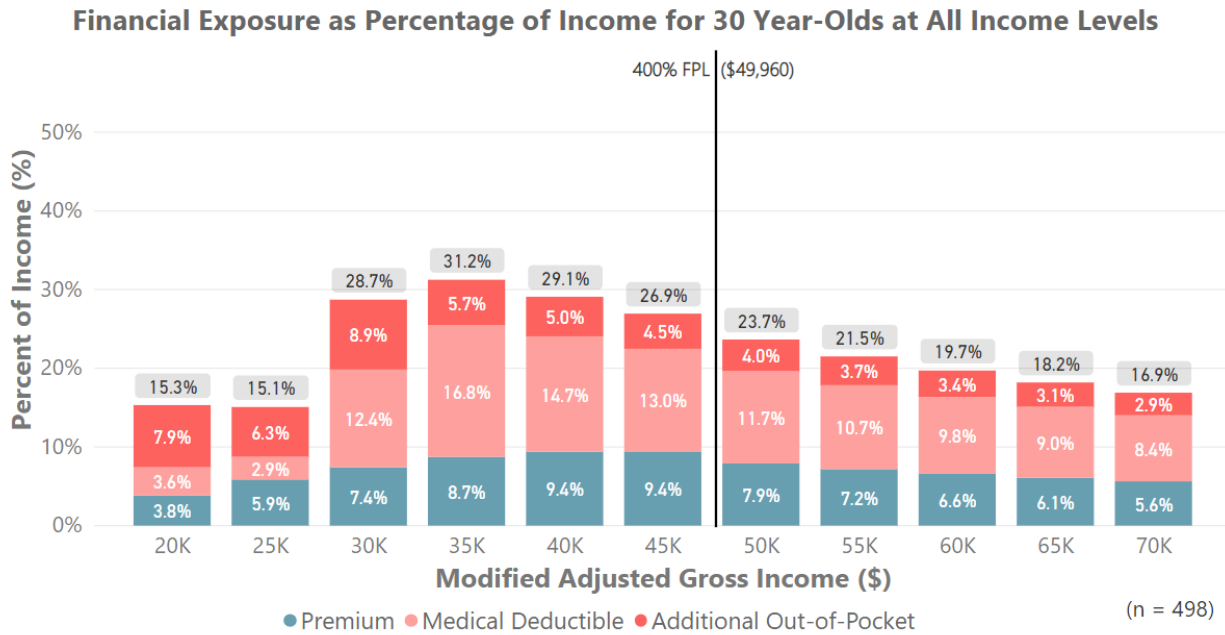


### Financial Exposure as Percentage of Income for 60 Year-Olds at All Income Levels



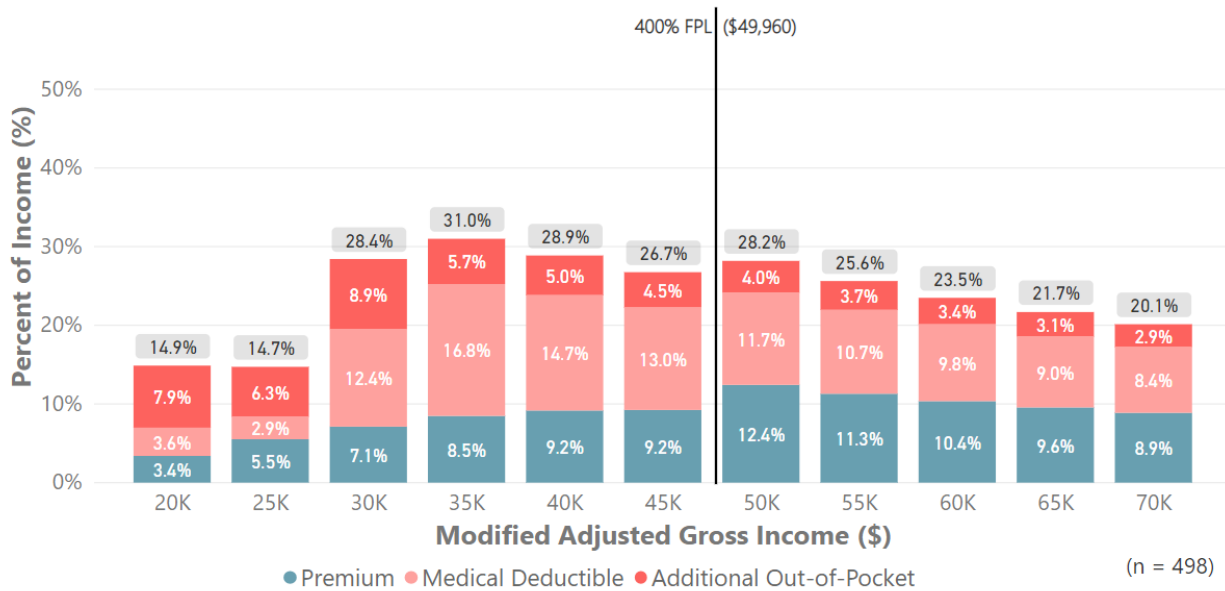
Data: 2020 Qualified Health Plan Choice and Premiums in HealthCare.gov States

### Appendix III: Maximum Financial Exposure for Lowest-Cost Counties as a Percent of Income by Age at All Income Levels Purchasing the Lowest-Cost Silver Plan

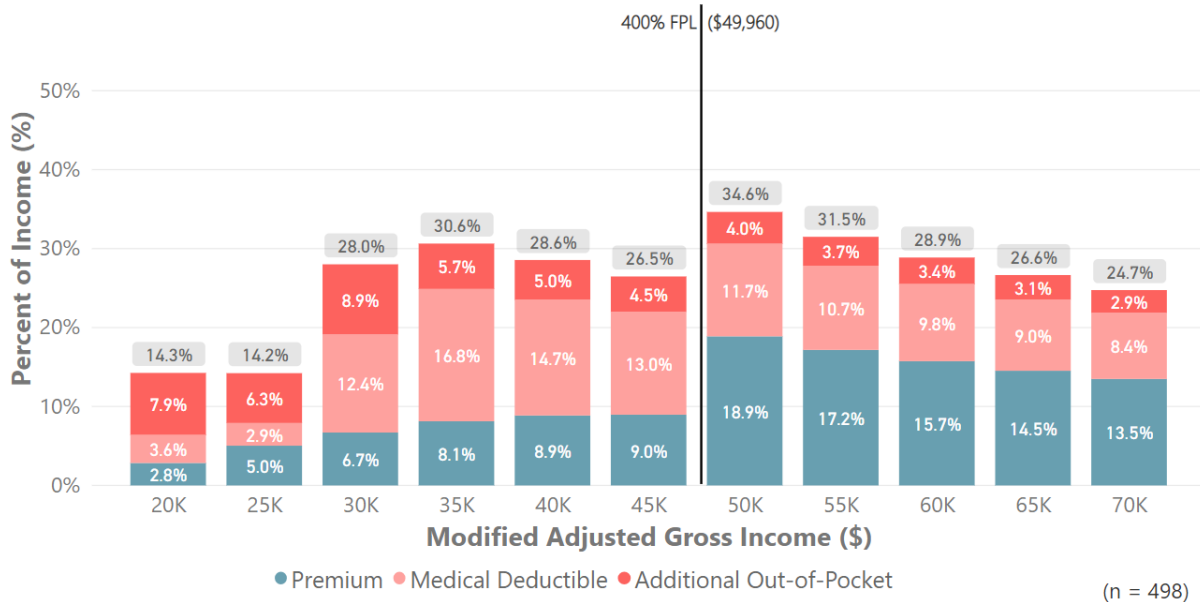




### Financial Exposure as Percentage of Income for 50 Year-Olds at All Income Levels



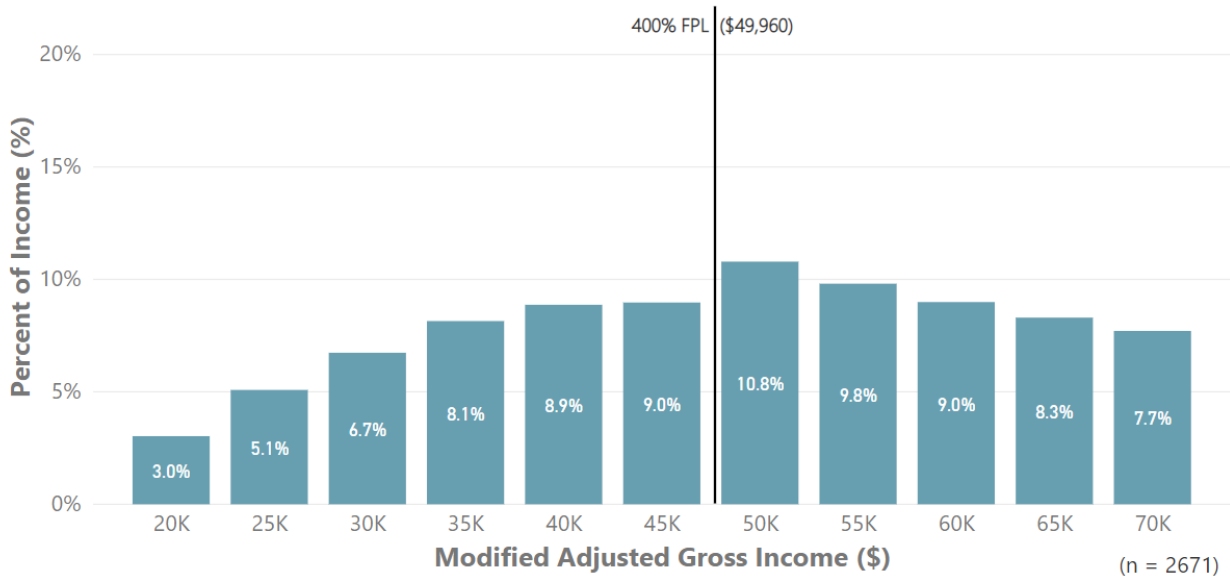
### Financial Exposure as Percentage of Income for 60 Year-Olds at All Income Levels



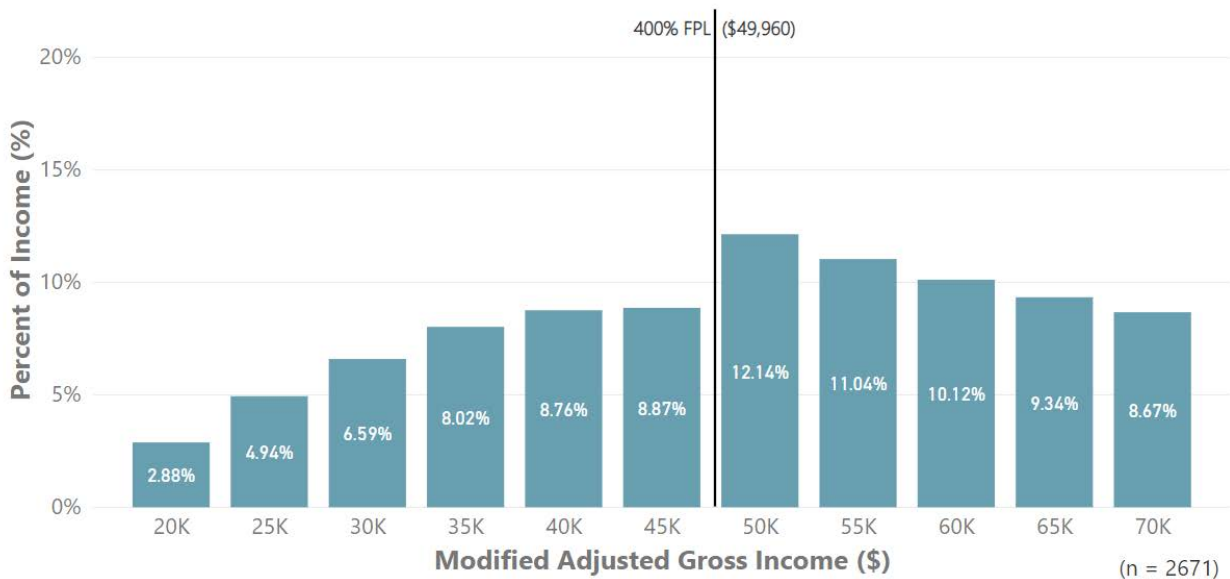
Data: 2020 Qualified Health Plan Choice and Premiums in HealthCare.gov States

### Appendix IV: Lowest-Cost Silver Plan Average Premium as Percentage of Income by Age (30, 40, 50, & 60 year-olds)

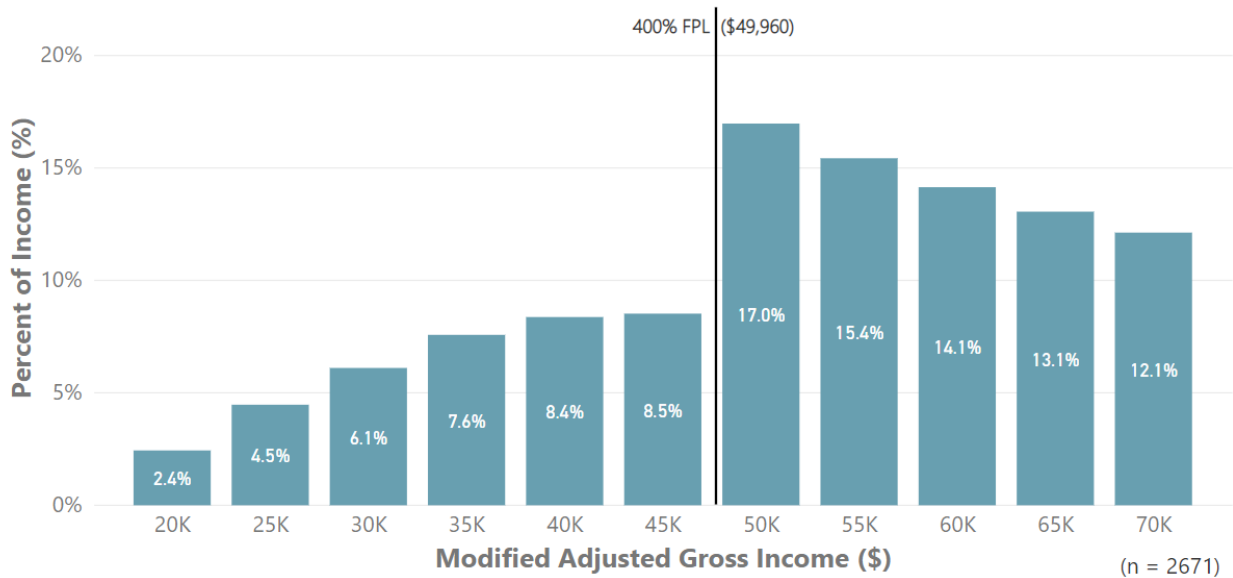
Lowest-Cost Silver Plan Average Premium as Percentage of Income for 30 Year-Olds



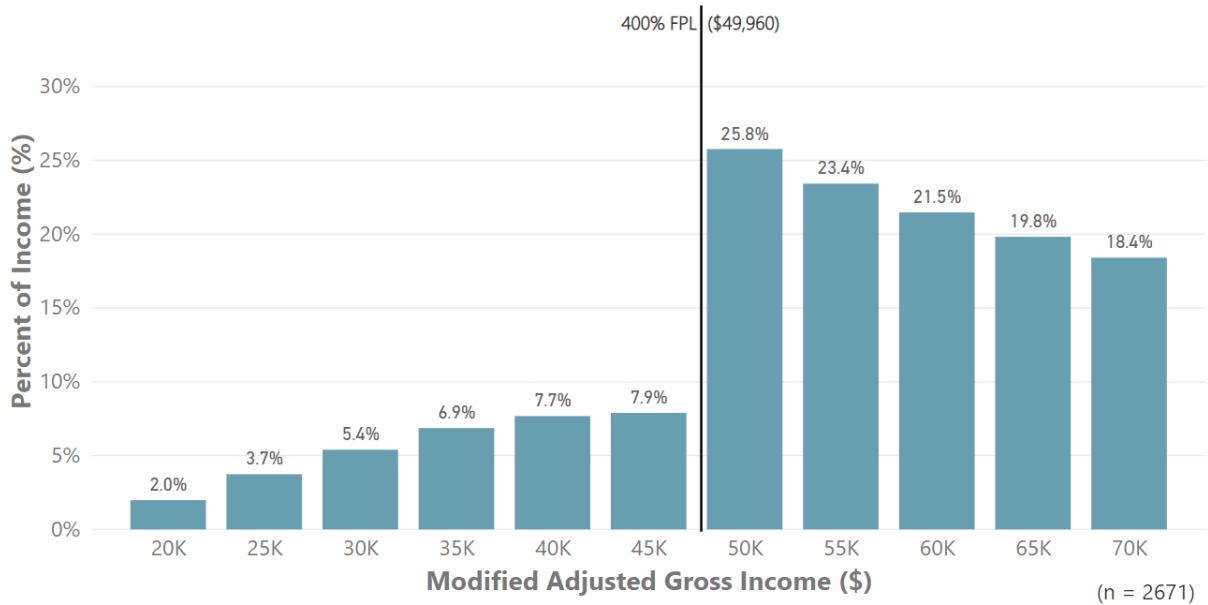
Lowest-Cost Silver Plan Average Premium as Percentage of Income for 40 Year-Olds



### Lowest-Cost Silver Plan Average Premium as Percentage of Income for 50 Year-Olds



### Lowest-Cost Silver Plan Average Premium as Percentage of Income for 60-Year Olds



Data: 2020 Qualified Health Plan Choice and Premiums in HealthCare.gov States