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OCTOBER 2016

The ACA's Cost-Sharing Reduction Plans: A Key to Affordable Health Coverage for Millions of U.S. Workers

Jon Gabel, Heidi Whitmore, Matthew Green, Adrienne Call, Sam Stromberg, and Rebecca Oran

ABSTRACT

Issue: Without the cost-sharing reductions (CSRs) made available by the Affordable Care Act, health plans sold in the marketplaces may be unaffordable for many low-income people. CSRs are available to households earning between 100 percent and 250 percent of the federal poverty level that choose a silver-level marketplace plan. In 2016, about 7 million people received cost-sharing reductions that substantially lowered their deductibles, copayments, coinsurance, and out-of-pocket limits. **Goal:** To examine variations in consumer cost-sharing reductions between silver-level plans with CSRs to traditional marketplace plans and to employer-based insurance. **Methods:** Data analysis of 1,209 CSR-eligible plans sold in individual marketplaces in all 50 states and Washington, D.C. **Key findings and conclusions:** Cost-sharing amounts in silver plans with CSRs are much less than those in non-CSR base silver plans; silver plans with CSRs generally offer far better financial protection than those without. General annual deductibles range from $246 for CSR silver plans with a platinum-level actuarial value (94%) to as much as $3,063 for non-CSR silver plans. Out-of-pocket limits vary from $6,223 in base silver plans to $1,102 in silver plans with CSRs and a platinum-level actuarial level.

BACKGROUND

Cost-sharing reduction (CSR), a somewhat less well-known feature of the Affordable Care Act (ACA), allows low- and moderate-income households to use health care services at a much lower cost. In 2015, 57 percent of enrollees in plans sold in federally facilitated state marketplaces received cost-sharing reductions that substantially lowered their deductibles, copayments, coinsurance, and out-of-pocket limits.[1] People in households earning from 100 percent to 250 percent of the federal poverty level (that is, about $12,000 to $30,000 for an individual, or about $24,000 to $60,750 for a family of four) who choose a silver plan receive the cost-sharing reductions automatically. When income fluctuates, people do not have to change plans.

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Commonwealth Fund pub. 1909
Vol. 35

Without these reductions, health plans' cost-sharing requirements would be daunting for many. For example, an individual earning 150 percent of poverty ($17,820 for an individual, $36,450 for a family of four) and enrolled in a silver plan without CSRs would face an average deductible of $3,063, roughly 17 percent of income, before receiving benefits.[2] Analysts generally consider household spending of more than 10 percent of family income on health insurance premiums or deductibles to be a "catastrophic" level of spending.[3] Households met with such bills may face stark options. Only 44 percent of low-income households have three months of savings to pay for an unexpected setback, like a high medical bill. Only half of such households would qualify for standard consumer loans.[4]

Households eligible for CSRs may purchase silver-level plans with higher actuarial values—that is, the plans cover a larger portion of health care costs.[5] Most silver plans have an actuarial value of about 0.7, meaning that an average of 70 percent of costs are covered; we refer to these as base silver plans. People in households that earn 100 percent to 150 percent of poverty and choose a silver plan are enrolled in a CSR plan with an actuarial value of 0.94, which is equivalent to the actuarial value of a platinum plan. Households earning 151 percent to 200 percent of poverty are enrolled in plans with an actuarial value of 0.87 (the actuarial value of a gold plan). Households earning 201 percent to 250 percent of poverty are enrolled in plans with an actuarial value of 0.73.[6] These three variations are known as CSR 94, CSR 87, and CSR 73, respectively.

Individuals and families earning more than 250 percent of poverty do not qualify for cost-sharing subsidies. However, they are still eligible for the ACA's premium subsidies that are available for people with incomes up to 400 percent of poverty.

Previous research has looked at how out-of-pocket spending for enrollees in silver plans with CSRs varies in different states.[7] This issue brief provides a national-level overview of how cost-sharing in silver plans with CSRs compares to marketplace plans with similar actuarial values and to employer-sponsored insurance. These comparisons will focus on deductibles, out-of-pocket limits, copayments, and coinsurance.

FINDINGS

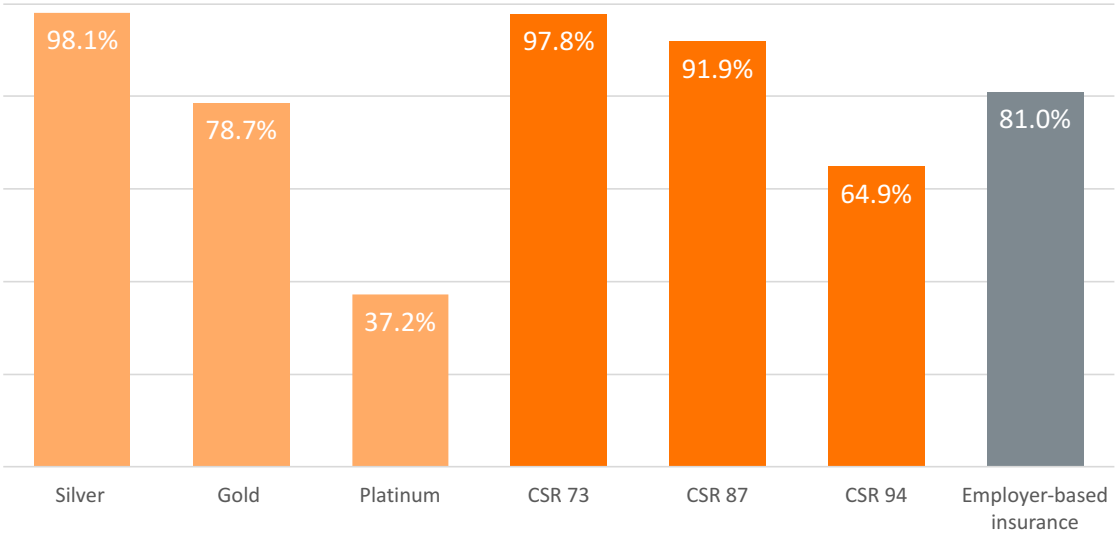
Deductibles

When plans have a deductible, beneficiaries must make out-of-pocket payments for most or all services before coverage begins. Meeting the deductible is often a consumer's most significant out-of-pocket expense. In 2016, the share of marketplace plans with a general annual deductible ranges from 98 percent of base silver plans and CSR 73 plans to 65 percent of CSR 94 plans and 37 percent of platinum plans (Exhibit 1). There is, however, considerable nuance to the use of deductibles. In an examination of the second-lowest-cost silver plans in 37 states, researchers found that 30 of 37 plans did not apply the deductible to primary care visits or generic drugs.[8] Similarly, in 24 of 37 plans, beneficiaries did not have to meet a deductible for specialists' office visits and preferred brand-name drugs. Eighty-one percent of workers with employer-based coverage faced a general deductible in 2015, the most recent year for which data are available.

In 2016, deductibles for marketplace plans range from $3,063 for base silver plans to $451 for platinum plans and $246 for CSR 94 plans (Exhibit 2). Employer-based plan deductibles fell roughly in the middle, averaging $1,318 in 2015.

Exhibit 1

Percentage of Plans with Annual Deductible, by Metal Tier, Cost-Sharing Reduction, and Employer Plans, 2016

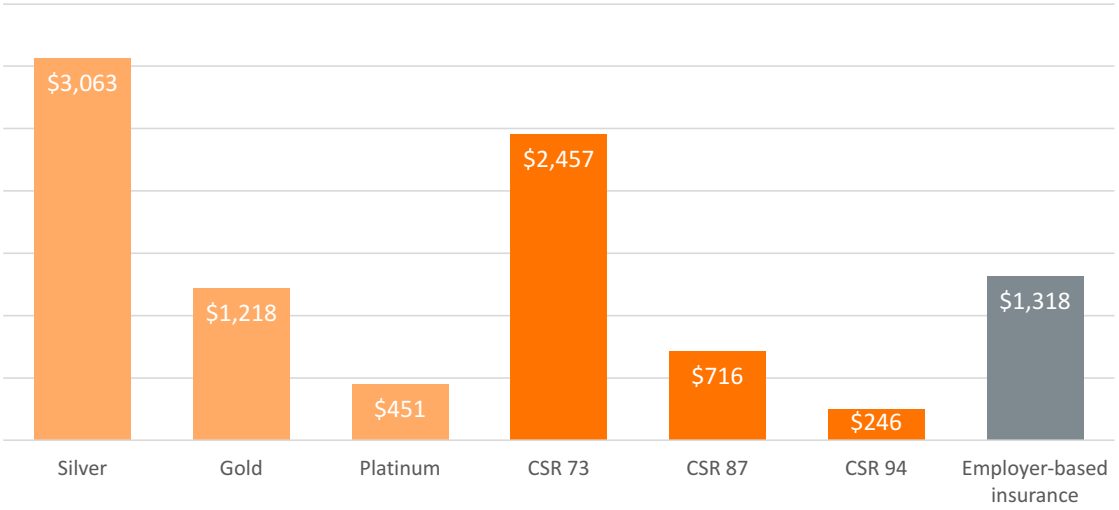


Notes: Base silver plans have an actuarial value of about 0.7, meaning an average of 70 percent of costs are covered; CSR 73, CSR 87, and CSR 94 silver plans have actuarial values of 0.73, 0.87, and 0.94, respectively. The most recent employer-based insurance survey data are from 2015.

Sources: Qualified Health Plan Landscape Files for federally facilitated marketplaces, Nov. 2015; state insurance websites and state marketplace websites for state-based marketplaces, Nov. 2015; and Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2015 Annual Survey* (Kaiser/HRET, Sept. 2015).

Exhibit 2

Average Annual Deductible, by Metal Tier, Cost-Sharing Reduction, and Employer Plans, 2016



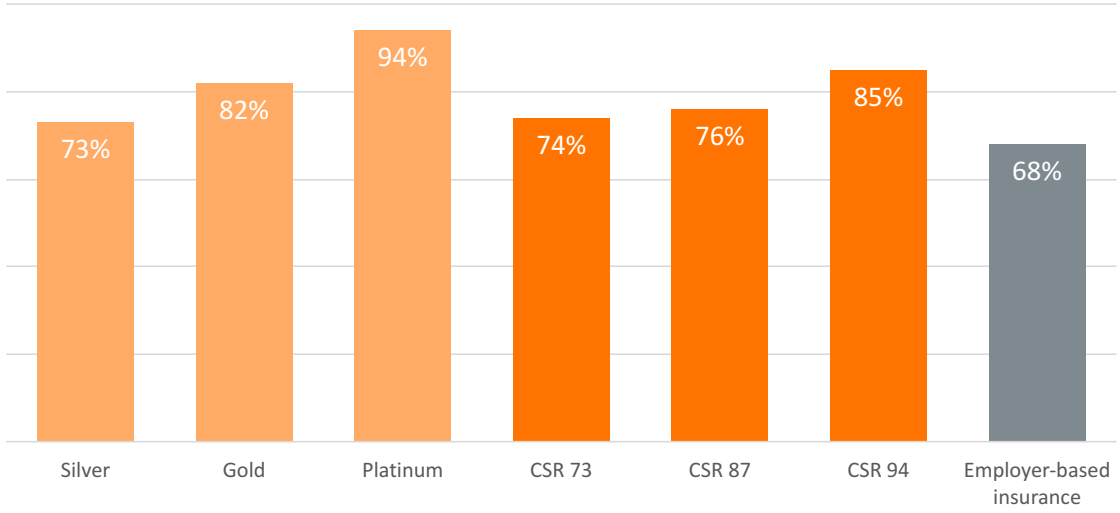
Notes: For plans with deductibles. Base silver plans have an actuarial value of about 0.7, meaning an average of 70 percent of costs are covered; CSR 73, CSR 87, and CSR 94 silver plans have actuarial values of 0.73, 0.87, and 0.94, respectively. The most recent employer-based insurance survey data are from 2015.

Sources: Qualified Health Plan Landscape Files for federally facilitated marketplaces, Nov. 2015; state insurance websites and state marketplace websites for state-based marketplaces, Nov. 2015; and Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2015 Annual Survey* (Kaiser/HRET, Sept. 2015).

In some health plans, beneficiaries are required to meet a medical deductible before primary care office visits are covered but many plans (sometimes referred to as "deductible exclusion" plans) do not apply a deductible to primary care office visits. The percentage of plans where beneficiaries do not need to meet a deductible before primary care coverage kicks in ranges from 73 percent for base silver plans to 74 percent of CSR 73 plans to 85 percent of CSR 94 plans (Exhibit 3). In employer-based plans, the deductible applies to primary care office visits for approximately 68 percent of those insured. Approximately one-fourth of Americans with employer-based insurance are enrolled in a high-deductible health plans with a savings option, such as health savings accounts (HSAs). This accounts for the high percentage of people in employer-based plans who do not have deductible exclusions for primary care.[9,10]

Exhibit 3

Percentage of Plans with Primary Care Coverage Without Having to Meet Deductible, by Metal Tier, Cost-Sharing Reduction, and Employer Plans, 2016



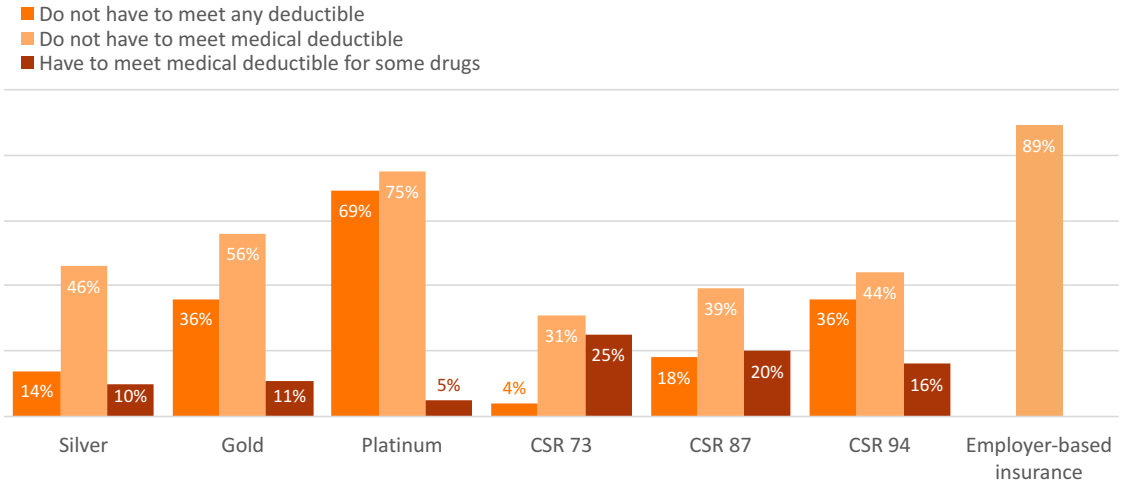
Notes: For plans with deductibles. Base silver plans have an actuarial value of about 0.7, meaning an average of 70 percent of costs are covered; CSR 73, CSR 87, and CSR 94 silver plans have actuarial values of 0.73, 0.87, and 0.94, respectively. The most recent employer-based insurance survey data are from 2015.

Sources: Qualified Health Plan Landscape Files for federally facilitated marketplaces, Nov. 2015; state insurance websites and state marketplace websites for state-based marketplaces, Nov. 2015; and authors' calculations based on Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2015 Annual Survey* (Kaiser/HRET, Sept. 2015).

Most marketplace plans require enrollees to meet some form of deductible before prescription drug coverage begins, but the format can vary across plans (Exhibit 4). Plans may choose to exclude all drugs from deductibles, exclude drugs from the medical deductible but require a separate drug deductible, or exclude some or no drugs from the medical deductible. Fourteen percent of silver plans exclude all drugs from deductibles, as do 69 percent of platinum plans. Only 4 percent of CSR 73 plans exclude all drugs from deductibles. A higher proportion of plans across the board exempt drugs from the medical deductible, often requiring enrollees to meet a separate, smaller drug deductible. Approximately 89 percent of covered workers in employer-based plans receive drug coverage without meeting a medical deductible.[11]

Exhibit 4

Percentage of Plans with Coverage for Prescription Drugs Without Having to Meet a Medical or Drug Deductible, by Metal Tier, Cost-Sharing Reduction, and Employer Plans, 2016



Notes: Base silver plans have an actuarial value of about 0.7, meaning an average of 70 percent of costs are covered; CSR 73, CSR 87, and CSR 94 silver plans have actuarial values of 0.73, 0.87, and 0.94, respectively. The most recent employer-based insurance survey data are from 2015. The employer survey asks only whether prescription drugs are subject to the medical deductible; this value is an authors' calculation.

Sources: Qualified Health Plan Landscape Files for federally facilitated marketplaces, Nov. 2015; state insurance websites and state marketplace websites for state-based marketplaces, Nov. 2015; and authors' calculations based on Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2015 Annual Survey* (Kaiser/HRET, Sept. 2015).

Copayments and Coinsurance for Office Visits

Regardless of the cost of an office visit, many health plans may require enrollees to pay a copayment—a fixed amount such as $20. Alternatively, enrollees may be required to pay coinsurance, a percentage of the total cost. For those with employer-based insurance, this is often 20 percent.[12] Coinsurance provides enrollees with greater incentives to monitor costs, since they pay more out of pocket for a more expensive office visit than for a less costly one.

However, copayments are more often used as the cost-sharing method for primary care and specialty office visits. The average copayment for primary and specialty care visits decreases as the plan's actuarial value increases. Copayments for primary care visits range from $31 in base silver plans to $10 for CSR 94 plans (Exhibit 5). For specialty care visits, copayments range from $58 for base silver plans to $21 for CSR 94 plans. Primary care visit copayments for employer-based plans averaged $24 in 2015, and copayments for specialty care visits were $37. Thus, on average, CSR 94 plans have the lowest cost-sharing requirements, base silver plans have the highest level, and employer-based plans are in the middle.

Exhibit 5. Copayments and Coinsurance for Primary Care and Specialty Care Visits by Metal Tier, Cost-Sharing Reduction, and Employer Plans, 2016

	Marketplace plan tier						Employer-based plans
Cost-sharing type	Silver	Gold	Platinum	CSR 73	CSR 87	CSR 94	
Primary care							
Copayment	76.5%	85.6%	95.0%	77.9%	77.3%	70.9%	68%
Coinsurance	10.6%	7.5%	4.6%	11.3%	10.5%	9.6%	23%
Average copayment	$30.95	$22.50	$16.96	$27.72	$15.29	$10.12	$24
Specialty care							
Copayment	74.3%	84.9%	94.0%	76.4%	75.9%	72.7%	68%
Coinsurance	15.3%	11.2%	5.6%	14.7%	13.8%	12.8%	24%
Average copayment	$58.28	$44.95	$33.92	$52.02	$33.48	$21.08	$37

Notes: Base silver plans have an actuarial value of about 0.7, meaning an average of 70 percent of costs are covered; CSR 73, CSR 87, and CSR 94 silver plans have actuarial values of 0.73, 0.87, and 0.94, respectively. The most recent employer-based insurance survey data are from 2015.

Sources: Qualified Health Plan Landscape Files for federally facilitated marketplaces, Nov. 2015; state insurance websites and state marketplace websites for state-based marketplaces, Nov. 2015; and Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2015 Annual Survey* (Kaiser/HRET, Sept. 2015).

Out-of-Pocket Limits

Out-of-pocket limits serve to protect enrollees from catastrophic medical expenses by capping the dollar amount they have to pay themselves in any one year. These limits can serve as a critical form of protection for individuals who use a high volume of health care services in a plan year. In 2016, the out-of-pocket legal limit for marketplace plans was $6,850 for single coverage and $13,700 for family coverage.[13]

Consumers in lower actuarial value plans (bronze and silver) face higher potential out-of-pocket costs than those in gold or platinum plans. Annual out-of-pocket limits in 2016 range from $6,224 for base silver plans to $1,102 for CSR 94 plans (Exhibit 6). The silver plans with CSRs have more generous out-of-pocket limits than base silver plans, and two of the CSR levels are more generous than the other standard metal levels as well, providing far more financial protection for covered services.

Exhibit 6. Average Out-of-Pocket Limits, by Metal Tier and Cost-Sharing Reduction, 2016

Marketplace plan tier					
Silver	Gold	Platinum	CSR 73	CSR 87	CSR 94
$6,223.57	$4,984.55	$2,694.14	$4,913.04	$2,046.89	$1,102.49

Note: Base silver plans have an actuarial value of about 0.7, meaning an average of 70 percent of costs are covered; CSR 73, CSR 87, and CSR 94 silver plans have actuarial values of 0.73, 0.87, and 0.94, respectively.

Sources: Qualified Health Plan Landscape Files for federally facilitated marketplaces, Nov. 2015; and state insurance websites and state marketplace websites for state-based marketplaces, Nov. 2015.

Copayments and Coinsurance for Prescription Drugs

As a patient moves from less expensive generic and preferred-brand drugs to more expensive non-preferred and specialty drugs, the use of copayments declines and use of coinsurance increases. For example, 82 percent of CSR 73 plans require copayments for generic drugs and 8 percent require coinsurance (Exhibit 7). In contrast, 19 percent require copayments and 61 percent require coinsurance for specialty drugs. As the metal tiers increase, going from bronze to platinum, a greater proportion of plans use copayments rather than coinsurance for prescription drugs. The percentage of plans requiring copayments for generic drugs range from 81 percent of base silver plans to 94 percent of platinum plans.

Exhibit 7. Plans Using Copayments and Coinsurance for Generic, Preferred, Nonpreferred, and Specialty Drugs, by Metal Tier, Cost-Sharing Reduction, and Employer Plans, 2016

	Marketplace plan tier						Employer-based plans
Cost-sharing type	Silver	Gold	Platinum	CSR 73	CSR 87	CSR 94	
Generic drugs							
Copayment	81.4%	85.6%	94.1%	82.0%	80.7%	74.8%	84%
Coinsurance	8.2%	4.7%	2.2%	8.2%	7.5%	7.4%	11%
Preferred brands							
Copayment	76.9%	84.3%	92.1%	78.2%	78.1%	74.1%	75%
Coinsurance	17.2%	12.2%	6.5%	16.9%	16.0%	15.9%	24%
Nonpreferred brands							
Copayment	51.0%	59.3%	68.8%	54.3%	54.3%	50.3%	70%
Coinsurance	34.1%	29.5%	29.8%	31.2%	30.0%	29.7%	26%
Specialty drugs							
Copayment	16.1%	18.8%	28.4%	18.6%	19.1%	19.1%	–
Coinsurance	61.1%	63.0%	60.3%	61.2%	59.5%	58.3%	–

Notes: Base silver plans have an actuarial value of about 0.7, meaning an average of 70 percent of costs are covered; CSR 73, CSR 87, and CSR 94 silver plans have actuarial values of 0.73, 0.87, and 0.94, respectively. The most recent employer-based insurance survey data are from 2015; the survey did not ask about specialty drugs separately in 2015.

Sources: Qualified Health Plan Landscape Files for federally facilitated marketplaces, Nov. 2015; state insurance websites and state marketplace websites for state-based marketplaces, Nov. 2015; and Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2015 Annual Survey* (Kaiser/HRET, Sept. 2015).

Copayment amounts fall with rising actuarial values. For the base silver plan, a generic drug copayment is $13 compared to $6 for CSR 94 plans (Exhibit 8). For preferred drugs, the base silver plan copayment is $48 while the average CSR 94 copayment is $25. Copayments increase with the price of medications, with base silver plan copayments ranging from $13 for generic drugs to $253 for specialty drugs.

Exhibit 8. Average Copayments for Generic, Preferred, Nonpreferred, and Specialty Drugs, by Metal Tier, Cost-Sharing Reduction, and Employer Plans, 2016

	Marketplace plan tier						Employer-based plans
Drug type	Silver	Gold	Platinum	CSR 73	CSR 87	CSR 94	
Generic drugs	$12.69	$10.20	$7.96	$11.51	$7.98	$6.11	$11
Preferred brands	$47.91	$40.24	$27.02	$45.57	$34.26	$25.46	$31
Nonpreferred brands	$92.37	$77.56	$60.79	$88.01	$69.77	$54.20	$54
Specialty drugs	$253.16	$203.01	$202.60	$261.08	$242.73	$226.53	–

Notes: Base silver plans have an actuarial value of about 0.7, meaning an average of 70 percent of costs are covered; CSR 73, CSR 87, and CSR 94 silver plans have actuarial values of 0.73, 0.87, and 0.94, respectively. The most recent employer-based insurance survey data are from 2015; the survey did not ask about specialty drugs separately in 2015.

Sources: Qualified Health Plan Landscape Files for federally facilitated marketplaces, Nov. 2015; state insurance websites and state marketplace websites for state-based marketplaces, Nov. 2015; and Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2015 Annual Survey* (Kaiser/HRET, Sept. 2015).

BEHIND THE NUMBERS

Silver plans with cost-sharing reductions, or CSRs, are not outlier marketplace plans; they are, in fact, mainstream plans constituting 57 percent of marketplace enrollment. Without these plans, low- and modest-income families in silver plans could incur catastrophic out-of-pocket costs. Individuals earning $18,000 annually or less (at or below 150 percent of poverty) who experience a serious injury or illness could incur, on average, out-of-pocket expenses of $6,224—that is, 35 percent of annual income—before they hit their out-of-pocket limit. Without the option of a CSR plan, low-income people who seek greater financial protection would have to pay a higher premium for a gold plan, which could also pose serious financial hardship.

Many people eligible for silver plans with CSRs are not enrolled in them. One survey found that in 2015, one-third of individuals eligible for CSR coverage selected a bronze plan instead and therefore received no cost-sharing reductions.[14] Improving technology on marketplace websites may help to increase enrollment. Marketplace website upgrades can help call attention to CSRs when enrollees are shopping for and purchasing plans.

Cost-sharing requirements differ widely among plans—particularly between base silver plans and the CSR 87 and CSR 94 plans. People with CSR coverage rate their satisfaction with their coverage higher than those without cost-sharing reduction plans. They also report fewer problems accessing care and paying medical bills. And the enrollment rate for persons with incomes between 100 percent and 250 percent of poverty is substantially higher than for individuals between 250 percent and 400 percent of poverty or those above 400 percent.[15] By expanding CSR plans to people earning more than 250 percent of the poverty level, people with moderate incomes would see greater financial protection and satisfaction with their coverage, while marketplace enrollment would likely increase.

Notes

[1] Centers for Medicare and Medicaid Services, "March 31, 2016 Effectuated Enrollment Snapshot" (CMS, June 30, 2016).

[2] Essential preventive benefits require no patient cost-sharing and are the exception.

[3] C. Schoen, M. M. Doty, S. R. Collins, and A. L. Holmgren, "Insured But Not Protected: How Many Adults Are Underinsured?" *Health Affairs* Web Exclusive, published online June 14, 2005.

[4] Corporation for Enterprise Development, "Financial Assets and Income" (CFED, Jan. 2016).

[5] Actuarial value is a measure of plan generosity. It is the percentage of the medical bill paid by the insurer for a large standardized population.

[6] Silver plans have an actuarial value of 0.7, meaning that the plan will cover about 70 percent of the medical costs of a large standardized population. Gold plans have an actuarial value of about 0.8, while platinum plans have an actuarial value of 0.9.

[7] S. R. Collins, M. Z. Gunja, and S. Beutel, *How Will the Affordable Care Act's Cost-Sharing Reductions Affect Consumers' Out-of-Pocket Costs in 2016?* (The Commonwealth Fund, March 2016).

[8] M. Z. Gunja, S. R. Collins, and S. Beutel, *How Deductible Exclusions in Marketplace Plans Improve Access to Many Health Care Services* (The Commonwealth Fund, March 2016).

[9] Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2015 Annual Survey* (Kaiser/HRET, Sept. 2015).

[10] In 2016, health savings accounts (HSAs) are required to have a deductible of $1,300 for individuals and $2,600 for a family. Plans are not permitted to exclude office visits or prescription drugs from the deductible requirement. See "Health Savings Accounts" (U.S. Department of the Treasury).

[11] The 2015 Kaiser Employer Health Benefits survey used in this estimate does not break out how deductibles are applied across different drug tiers, so the figure for medical deductibles represents the percentage of workers that must meet the annual deductible before drug coverage begins.

[12] Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2015 Annual Survey* (Kaiser/HRET, Sept. 2015).

[13] "Out-of-Pocket Maximum Limits on Health Plans," ObamaCare Facts.

[14] S. R. Collins, M. Z. Gunja, P. W. Rasmussen, M. M. Doty, and S. Beutel, *Are Marketplace Plans Affordable? Consumer Perspectives from the Commonwealth Affordable Care Act Tracking Survey* (The Commonwealth Fund, Sept. 2015).

[15] M. Buettgens, G. M. Kenney, and C. Pan, *Variation in Marketplace Enrollment Rates in 2015 by State and Income* (Urban Institute, Oct. 2015).

How This Study Was Conducted

We analyzed data on 1,209 CSR-eligible plans sold in individual marketplaces in all 50 states and Washington, D.C. Data on plans in states that rely on the federal exchange are from Qualified Health Plan Landscape Files maintained by the Centers for Medicare and Medicaid Services. Data from states with their own exchanges are from marketplace websites maintained by state departments of insurance. We collected data on CSR-eligible plans in up to six rating areas, up to two within each sampling stratum (urban, suburban, and rural), depending on how many rating areas were present within each state.

In states that rely on the federal exchange, all plans with CSR variants in the sampled rating areas were collected. In SBM states, NORC collected data on two silver plans with CSRs per state, selecting the plans at random from the rating area in our sample with the largest population (i.e., the largest urban area). National figures were generated by weighting by rating area populations.

About the Authors

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Adrienne Hooper Call, M.P.P., M.S.W., is a principal research analyst in the Health Care Department at NORC at the University of Chicago. She acts as project manager and lead for projects involved in public data dissemination, health insurance analysis, public health research, policy recommendation and analysis, and program evaluation. Currently, Ms. Call conducts research on a number of projects, including the Monitoring Trends on the Individual and Small-Group Marketplaces, General Social Survey Data Explorer Dissemination Tool, and Reducing Health Disparities through Quality Improvement. Ms. Call received her Master of Public Policy and Master of Social Work dual degree from the University of Michigan.

Sam Stromberg is a principal research analyst in the Health Care Department at NORC at the University of Chicago. He has worked on a series of projects focusing on the individual and small group health insurance markets, before and after the implementation of marketplaces, across plan years 2007–2015. Other project work has included analysis of Medicare Part D beneficiary records, Medicaid enrollment, and survey data. Mr. Stromberg holds a B.A. from Pomona College.

Rebecca Oran is a research analyst in the Health Care Department at NORC at the University of Chicago. While at NORC, her projects have focused on state and federal health insurance marketplace exchanges and the implementation of state demonstration programs for Medicare–Medicaid enrollees. Her current projects include an assessment of trends in the Individual and Small Group Marketplaces on a real time basis, tracking Managed Care Quality in Medicaid and CHIP, and the Financial Alignment Initiative Operation Support Contract. Ms. Oran holds a bachelor's degree from Kenyon College.

Editorial support was provided by Deborah Lorber.

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