



# REALIZING HEALTH REFORM'S POTENTIAL

DECEMBER 2015

The mission of The Commonwealth Fund is to promote a high performance health care system. The Fund carries out this mandate by supporting independent research on health care issues and making grants to improve health care practice and policy. Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and not necessarily those of The Commonwealth Fund or its directors, officers, or staff.

For more information about this brief, please contact:

Jon Gabel, M.A.  
Senior Fellow  
NORC at the University of Chicago  
[Gabel-Jon@norc.org](mailto:Gabel-Jon@norc.org)

To learn more about new publications when they become available, visit the Fund's website and [register to receive email alerts](#).

Commonwealth Fund pub. 1854  
Vol. 38

## Consumer Cost-Sharing in Marketplace vs. Employer Health Insurance Plans, 2015

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

**Abstract** Using data from 49 states and Washington, D.C., we analyzed changes in cost-sharing under health plans offered to individuals and families through state and federal exchanges from 2014 to 2015. We examined eight vehicles for cost-sharing, including deductibles, copayments, coinsurance, and out-of-pocket limits, and compared findings with cost-sharing under employer-based insurance. We found cost-sharing under marketplace plans remained essentially unchanged from 2014 to 2015. Stable premiums during that period do not reflect greater costs borne by enrollees. Further, 56 percent of enrollees in marketplace plans attained cost-sharing reductions in 2015. However, for people without cost-sharing reductions, average copayments, deductibles, and out-of-pocket limits under catastrophic, bronze, and silver plans are considerably higher than under employer-based plans on average, while cost-sharing under gold plans is similar employer-based plans on average. Marketplace plans are far more likely than employer-based plans to require enrollees to meet deductibles before they receive coverage for prescription drugs.

### BACKGROUND

Cost-sharing has been at the center of health care policy debates for more than 45 years. Proponents of cost-sharing maintain that people with health insurance are subject to “moral hazard”: they overuse services because out-of-pocket expenses are low. Opponents of substantial cost-sharing maintain that it is a tax on sick people, and that it amounts to rationing by income class. Opponents of significant cost-sharing also contend that high deductibles are a blunt instrument, reducing the use of both cost-effective and cost-ineffective services.

In the 1970s and 1980s, the RAND Corp. conducted perhaps the largest study to date in health economics and health services research. One overview of that study found that when deductibles apply to physician services and prescription drugs, use of these services declines substantially.<sup>1</sup>

In December 2014, we reported that average premiums for health insurance plans for individuals and families obtained through state and federal

marketplaces had not changed from 2014 to 2015.<sup>2</sup> A common response to this finding was the question: “Did this mean that insurers increased patient cost-sharing by imposing higher deductibles and copayments?”

To answer that question, we used data from 49 states and Washington, D.C., to analyze changes in cost-sharing under marketplace plans in all metal tiers from 2014 to 2015. We also compared cost-sharing in those tiers with employer-based insurance, because employers have used high-deductible plans as a major cost-control strategy since 2004.

As of June 30, 2015, 68 percent of individuals and families that obtained health insurance through state and federal exchanges had enrolled in silver plans, while 21 percent had enrolled in bronze plans. Some 56 percent of individuals and families enrolled through these marketplaces—47.37 percent in states with their own exchange, and 59.29 percent in states that rely on the federal exchange—receive reductions in the cost-sharing they would normally have to pay.<sup>3</sup>

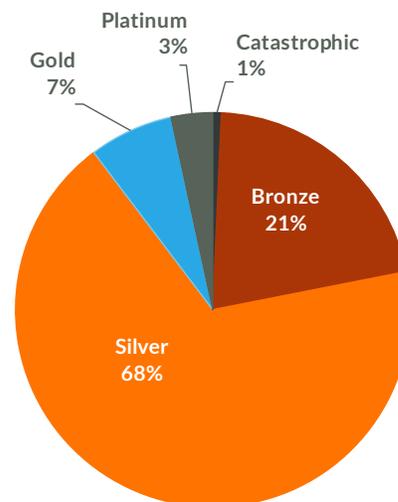
At the time of the passage of the ACA, the median “actuarial value” (i.e., the percent of costs covered on average by a health plan) for an employer-based plan was 83 percent and for an individual plan 59 percent. Restated, the typical employer plan was a gold plan and the actuarial value for a typical individual plan would not qualify to be sold on the exchange.<sup>4</sup>

Households earning 100 percent to 250 percent of the federal poverty level that purchase silver plans are eligible for cost-sharing reductions. For example, households earning 100 percent to 200 percent of the federal poverty level with silver plans are eligible for deductibles, copayments, coinsurance, and out-of-pocket limits equivalent to the cost-sharing available to households that enroll in platinum or gold plans. Households earning 200 percent to 250 percent of the federal poverty level with silver plans face slightly higher cost-sharing—equivalent to plans with an actuarial value of 73 percent.<sup>5</sup> Individuals and families earning more than 250 percent of the federal poverty level do not qualify for subsidies that reduce their cost-sharing.

For background purposes Exhibit 1 shows enrollment by metal tier on June 30, 2015. Silver plans account for 68 percent of enrollment and bronze plans account for 21 percent. Data in this issue brief are for people with individual marketplace coverage who do not qualify for cost-sharing reduction subsidies (i.e., they earn more than 250 percent of the federal poverty level).

Exhibit 1

Percentage of Marketplace Enrollment by Metal Tier, June 2015



Source: U.S. Department of Health and Human Services, June 30, 2015 Effectuated Enrollment Snapshot, <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-09-08.html>.

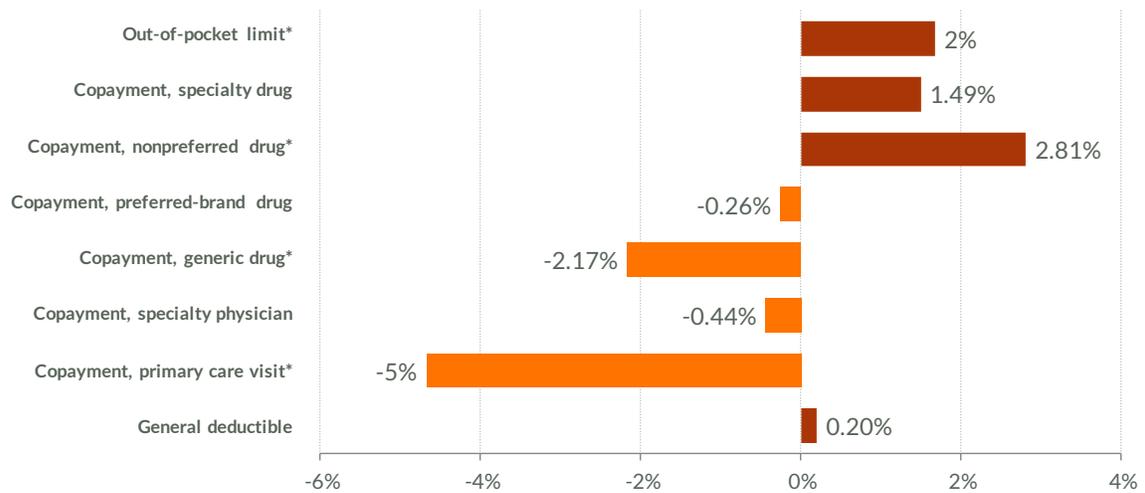
## FINDINGS

### Trends in Cost-Sharing

Of eight types of cost-sharing under marketplace plans we examined, only two increased significantly from 2014 to 2015 (Exhibit 2). Out-of-pocket limits rose by nearly 2 percent, while copayments for nonpreferred drugs rose by nearly 3 percent.<sup>6</sup> Deductibles remained statistically unchanged.

Exhibit 2

Average Change in Cost-Sharing Under Marketplace Plans, 2014–2015



\* Significant at  $p < .05$ .

Sources: Qualified health plan landscape files for federally facilitated marketplace, Nov. 2014; state insurance websites and marketplace websites.

Four types of cost-sharing actually fell from 2014 to 2015, two of which were statistically significant. Copayments for generic drugs declined by about 2 percent, and copayments for primary care visits fell by nearly 5 percent. We conclude that stable prices for nonemployer health insurance plans obtained through the state and federal exchanges do not reflect greater cost-sharing by enrollees.

### Deductibles

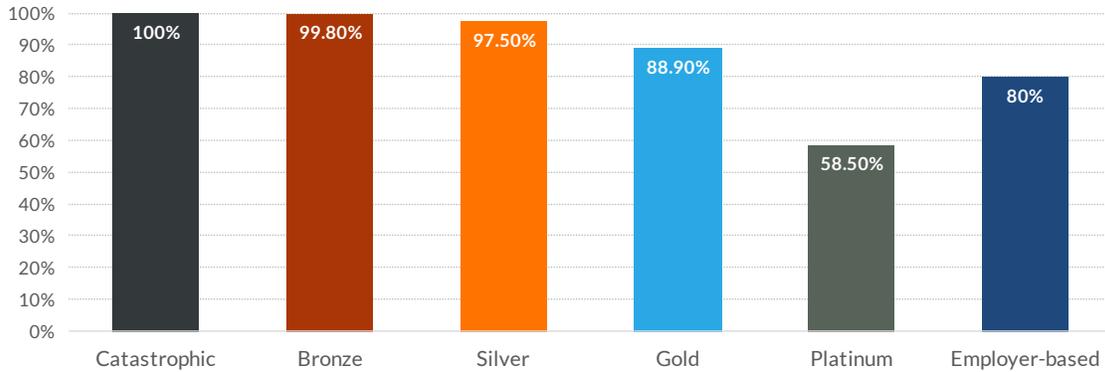
Actuaries often regard the presence and size of deductibles as the most important determinant of the share of health care expenses borne by enrollees versus their insurance plan. In 2015, the share of plans with general deductibles varied from 100 percent for catastrophic plans, to 97.5 percent for silver plans, to 58.5 percent for platinum plans (Exhibit 3). Under employer-based coverage, 80 percent of insured workers and their dependents face a general deductible.<sup>7</sup>

Among marketplace plans with deductibles, catastrophic plans averaged \$6,577, silver plans \$2,951, and platinum plans \$574. For employer-based coverage, the average deductible in 2014 was \$1,217—the equivalent of a gold plan obtained through a marketplace (Exhibit 4).

Although deductibles remained unchanged, on average, from 2014 to 2015, they dropped for gold and platinum plans by 7 and 14 percent, respectively, but rose slightly for plans under the

**Exhibit 3**

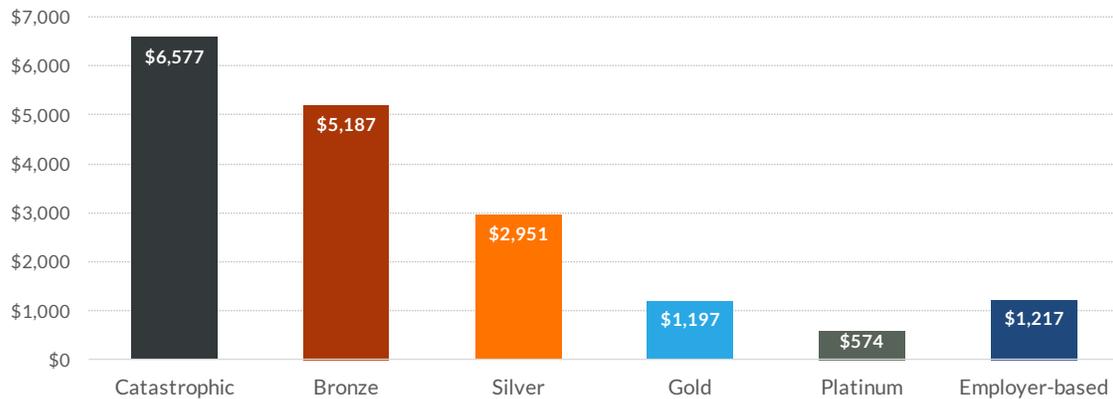
## Percentage of Plans with General Deductible for Marketplace and Employer-Based Plans



Sources: Qualified health plan landscape files for federally facilitated marketplace, Nov. 2014; state insurance websites and marketplace websites.

**Exhibit 4**

## Average General Deductible for Marketplace and Employer-Based Plans (for plans with deductibles)



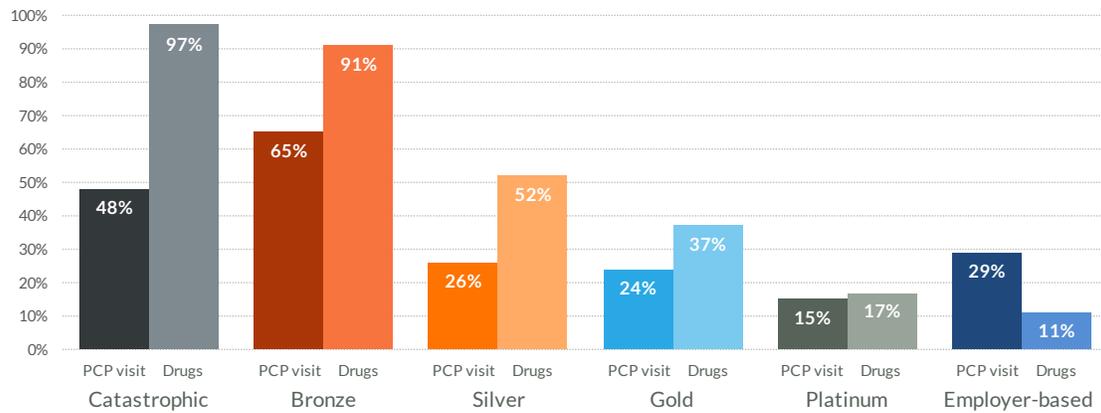
Sources: Qualified health plan landscape files for federally facilitated marketplace, Nov. 2014; state insurance websites and marketplace websites.

lower-cost tiers: 4 percent for catastrophic plans, and 2 percent for bronze and silver plans. Insurers seem to have viewed purchasers of lower-cost plans as seeking low premiums, and purchasers of higher-cost plans as seeking low cost-sharing.

The share of enrollees who must meet a deductible before their plan pays for primary care office visits ranges from 48 percent for catastrophic plans, to 26 percent for silver plans, to 15 percent for platinum plans. Under employer-based coverage, some 29 percent of employees and dependents must meet a deductible before their plan pays for primary care visits<sup>8</sup> (Exhibit 5).

**Exhibit 5**

Percentage of Plans Where the Beneficiary Must Meet a Deductible for Primary Care Reimbursement and for Prescription Drug Reimbursement



Sources: Qualified health plan landscape files for federally facilitated marketplace, Nov. 2014; state insurance websites and marketplace websites.

The share of plans requiring enrollees to meet a deductible before prescription drug coverage begins ranges from 97 percent for catastrophic plans, to 52 percent for silver plans, to 17 percent for platinum plans. For employer-based plans, this figure is 11 percent<sup>9</sup> (Exhibit 5).

Of course, these figures vary from state to state. The states with the highest share of plans under which enrollees must meet a deductible before insurers pay for primary care visits include Maryland (100 percent of plans) Vermont (80 percent), Minnesota (63 percent), and Utah (61 percent). States with the lowest share of plans under which enrollees must meet a deductible before insurers pay for primary care visits are New Mexico (17 percent), Oklahoma and Kansas (22 percent), and Arkansas (26 percent).

For prescription drugs, states with the highest share of plans under which enrollees must meet a deductible are Maryland and Montana (100 percent), Arkansas (90 percent), and North Dakota and New Hampshire (88 percent). States with the lowest share of plans under which enrollees must meet a deductible are Hawaii (14 percent), Nevada (39 percent), and Rhode Island and West Virginia (40 percent).

### Copayments and Coinsurance for Office Visits

Copayments require patients to pay a fixed fee such as \$25 per visit regardless of the costs incurred related to that visit. Coinsurance obligates patients to pay a share of the cost—commonly 20 percent under employer-based coverage.

Coinsurance requires patients to assume greater financial risk for the cost of care, but provides greater incentive for them to monitor that cost. Under employer-based coverage, growing reliance on high-deductible health plans with options for tax-preferred savings to pay out-of-pocket medical expenses, and declining HMO enrollment, have spurred a slight increase in the use of coinsurance.<sup>10</sup>

Copayments are the major vehicle for cost-sharing for primary care and specialist office visits under marketplace plans. Enrollees in these plans contribute copayments nearly four times as often

as they pay coinsurance when visiting primary care clinicians, and three times as often when visiting specialists. The average copayment for primary care visits ranges from \$39 under bronze plans to about \$17 under platinum plans. The average copayment for such visits under all marketplace plans—28.64—is more than the average under employer-based plans (\$24) (Exhibit 6).

### Exhibit 6. Share of Plans Using Copayments and Coinsurance for Primary Care and Specialty Care, and Average Copayment and Coinsurance by Plan Tier, 2015

	Catastrophic	Bronze	Silver	Gold	Platinum	All marketplace plans	Employer-based
<b>Primary care visit</b>							
Use copayment	52.3%	38.7%	75.1%	82.5%	94.5%	66.4%	73%
Use coinsurance	0.4%	34.9%	15.3%	12.6%	3.3%	18.6%	18%
Average copayment	\$34.83	\$39.05	\$30.39	\$23.16	\$17.24	\$28.64	\$24
<b>Specialist care visit</b>							
Use copayment	1.1%	31.9%	71.8%	81.2%	95.0%	60.0%	72%
Use coinsurance	1.6%	39.7%	18.3%	14.9%	3.4%	21.6%	71%
Average copayment	\$63.69	\$66.47	\$57.66	\$45.23	\$31.24	\$52.15	\$36

Sources: Qualified health plan landscape file for federally facilitated marketplaces, Nov. 2014; state insurance websites and state marketplace websites for state-based marketplaces, Nov. 2014; Kaiser Family Foundation, *Employer Health Benefits: 2014 Annual Survey* (Menlo Park, Calif.: Henry J. Kaiser Family Foundation, Sept. 2014).

Copayments for visits to specialty clinicians are higher, averaging \$52, and range from \$66 for bronze plans to \$31 per visit for platinum plans. The average copayment for these visits is substantially higher than the \$36 average under employer-based coverage (Exhibit 6).

### Out-of-Pocket Limits

Out-of-pocket limits protect consumers from incurring catastrophic bills. From 2014 to 2015, out-of-pocket limits for marketplace plans declined by 1.7 percent (Exhibit 7). For households earning 250 percent or more of the federal poverty level, the Department of Health and Human Services raised out-of-pocket limits about 3.2 percent during that period.<sup>11</sup> Platinum plans saw the largest increase—4.3 percent—while catastrophic plans had the sharpest decline: –3.6 percent. In contrast, out-of-pocket limits increased on average in employer plans by 4.6 percent.

The out-of-pocket limit for all marketplace plans averaged \$5,519 in 2015, and ranged from \$6,581 for catastrophic plans to \$5,866 for silver plans to \$2,347 for platinum plans. Under employer-based coverage, the out-of-pocket limit averaged \$3,409 (Exhibit 8).

Catastrophic plans have different cost-sharing provisions from those of other metal tiers. Under most catastrophic plans, the deductible and the out-of-pocket limit are the same dollar figure. When enrollees exceed this threshold amount, they do not pay for additional services.

**Exhibit 7. Average Out-of-Pocket Limit by Plan Tier and Percentage Change, 2014–2015**

Category	Catastrophic	Bronze	Silver	Gold	Platinum	All plans	Employer-based
2014	\$6351.25	\$6272.15	\$5869.40	\$4538.16	\$2452.00	\$5428.68	\$3260*
2015	\$6580.92	\$6375.80	\$5865.84	\$4634.20	\$2346.52	\$5519.10	\$3409
Percent change	-3.6%	-1.7%	0.1%	-2.1%	4.3%	-1.7%	4.6%

\* Authors estimate from Kaiser Family Foundation, *Employer Health Benefits: 2014 Annual Survey* (Menlo Park, Calif.: Henry J. Kaiser Family Foundation, Sept. 2014).

Sources: Qualified health plan landscape file for federally facilitated marketplaces, Nov. 2014; state insurance websites and state marketplace websites for state-based marketplaces, Nov. 2014; Kaiser Family Foundation, *Employer Health Benefits: 2014 Annual Survey* (Menlo Park, Calif.: Henry J. Kaiser Family Foundation, Sept. 2014).

**Exhibit 8**

Average Out-of-Pocket Limit and Percentage Change, 2014–2015



\* Authors' calculation.

Sources: Qualified health plan landscape files for federally facilitated marketplace, Nov. 2014; state insurance websites and marketplace websites.

**Copayments and Coinsurance for Prescription Drugs**

Copayments are the dominant form of cost-sharing for generic drugs, used by 69 percent of plans (Exhibit 9). For more expensive drugs, the use of copayments declines and the use of coinsurance increases. Some 62 percent of plans require copayments for preferred-brand drugs, 44 percent require them for nonpreferred drugs, and 14 percent require them for specialty drugs.<sup>12</sup> Comparable figures for employer-based plans are 85 percent for generics, 77 percent for preferred drugs, 73 percent for nonpreferred drugs, and 39 percent for specialty drugs.

Higher-tier marketplace plans require copayments more often than coinsurance. Some 53 percent of bronze plans, 78 percent of silver plans, 83 percent of gold plans, and 95 percent of platinum plans require copayments for generic drugs, while the share of higher-tier plans using coinsurance declines. The average copayment increases for more expensive drugs, rising from \$13 for generics, to \$44 for preferred-brand drugs, to \$79 for nonpreferred drugs, to \$142 for specialty drugs (Exhibit 10).

### Exhibit 9. Share of Plans Using Copayments and Coinsurance for Generic, Preferred, Nonpreferred, and Specialty Drugs, 2015

Category	Catastrophic	Bronze	Silver	Gold	Platinum	All plans	Employer-based (2014)
Copayments, generic drugs	0.2%	53.0%	78.1%	82.5%	94.6%	68.5%	85%
Coinsurance, generic drugs	1.78%	25.3%	9.3%	5.5%	2.4%	12.1%	11%
Copayments, preferred-brand drugs	–	36.4%	74.0%	82.1%	96.5%	62.4%	77%
Coinsurance, preferred-brand drugs	1.8%	36.4%	18.9%	14.7%	3.1%	20.8%	72%
Copayments, nonpreferred drugs	–	27.0%	46.9%	61.4%	79.9%	44.2%	73%
Coinsurance, nonpreferred drugs	1.45%	46.5%	41.7%	34.6%	19.5%	37.6%	25%
Copayments, specialty drugs	–	3.8%	17.2%	20.3%	29.2%	14.0%	39%
Coinsurance, specialty drugs	2.8%	68.9%	70.1%	74.2%	68.2%	66.8%	49%

Sources: Qualified health plan landscape file for federally facilitated marketplaces, Nov. 2014; state insurance websites and state marketplace websites for state-based marketplaces, Nov. 2014; Kaiser Family Foundation, *Employer Health Benefits: 2014 Annual Survey* (Menlo Park, Calif.: Henry J. Kaiser Family Foundation, Sept. 2014).

### Exhibit 10. Average Copayment for Generic, Preferred, Nonpreferred, and Specialty Drugs, 2015

Category	Catastrophic	Bronze	Silver	Gold	Platinum	All plans	Employer-based (2014)
Average copayment, generic drugs	\$13.95	\$19.03	\$12.98	\$11.00	\$7.43	\$13.22	\$11
Average copayment, preferred-brand drugs	–	\$60.59	\$47.55	\$37.07	\$25.42	\$44.11	\$31
Average copayment, nonpreferred drugs	–	\$102.34	\$83.72	\$72.61	\$46.96	\$78.66	\$53
Average copayment, specialty drugs	–	\$149.72	\$163.09	\$126.99	\$107.25	\$141.72	\$83

Sources: Qualified health plan landscape file for federally facilitated marketplaces, Nov. 2014; state insurance websites and state marketplace websites for state-based marketplaces, Nov. 2014; Kaiser Family Foundation, *Employer Health Benefits: 2014 Annual Survey* (Menlo Park, Calif.: Henry J. Kaiser Family Foundation, Sept. 2014).

As one would expect, the average copayment usually drops as the actuarial value of the tiers increases. For example, the average copayment for generic drugs is \$19 for bronze plans, \$13 for silver plans, \$11 for gold plans, and \$7 for platinum plans. Copayments under employer-based plans are considerably lower than under marketplace plans for all formulary tiers except generics.

## OVERALL FINDINGS AND DISCUSSION

Our analysis shows that stable premiums from 2014 to 2015 do not reflect more cost-sharing. Overall, cost-sharing is greater under catastrophic, bronze, and silver plans than under employer-based coverage, while cost-sharing under the typical gold plan is roughly equivalent to that under employer-based coverage.

Silver plans—which account for 68 percent of marketplace enrollment—have daunting deductibles and out-of-pocket limits: \$2,951 and \$5,866, respectively. However, the majority of enrollees in silver plans qualify for and are enrolled in coverage with reduced cost-sharing.

For prescription drugs, marketplace plans lack the financial protection provided by employer-based plans. Some 91 percent of bronze plans, 52 percent of silver plans, and 37 percent of gold plans require enrollees to meet a deductible before receiving coverage for prescription drugs, compared with only 11 percent of enrollees with employer-based coverage. Out-of-pocket limits are also notably higher under marketplace plans than under employer-based plans. However, a majority of enrollees in marketplace plans—56 percent—obtain reduced cost-sharing.

States with their own health insurance exchanges—which account for 27.5 percent of all enrollees in marketplace plans—usually have lower shares of enrollees with reduced cost-sharing than states that rely on the federal exchange. Most of the former have expanded Medicaid, while most of the latter have not. States with their own exchanges also tend to have higher per capita income than states that rely on the federal exchange. The result is that a much greater share of insured residents in the federal marketplace states who earn 100 percent to 138 percent of the federal poverty level are enrolled in marketplace plans rather than Medicaid.

Low-income households—those earning 100 percent to 250 percent of the federal poverty level—rate their coverage more highly than moderate-income households: those earning more than 250 percent of the federal poverty level. Some 70 percent of low-income households rate their coverage as “excellent,” very good,” or “good,” while 20 percent rate it “poor” or “fair.” Comparable figures for moderate-income households are 64 and 27 percent, respectively.<sup>13</sup> Reduced cost-sharing for low-income households may be a major factor in this disparity.

### ABOUT THIS STUDY

We analyzed data on 2,964 plans offered in 2014 and 4,153 offered in 2015 in 49 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.

Within each state, we downloaded data from all carriers and plans within three “rating areas,” which all insurers must use to set their rates: one urban, one suburban, and one rural. Weights reflect the probability that we would have selected the rating area from among the sample, as well as the population of the rating area. We designated statistical significance when  $p < .05$ .

## NOTES

- <sup>1</sup> J. P. Newhouse and the Insurance Experiment Group, *Free for All? Lessons from the RAND Health Insurance Experiment* (Cambridge, Mass.: Harvard University Press, 1993).
- <sup>2</sup> J. Gabel, H. Whitmore, S. Stromberg, M. Green, D. Weinstein, R. Oran, “[Analysis Finds No Nationwide Increase in Health Insurance Marketplace Premiums](#),” *The Commonwealth Fund Blog*, Dec. 22, 2014.
- <sup>3</sup> Centers for Medicare and Medicaid Services, “June 30, 2015 Effectuated Enrollment Snapshot” (Washington, D.C.: CMS, Sept. 8, 2015), <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-09-08.html>.
- <sup>4</sup> J. Gabel, R. Lore, R. McDevitt et al., “[More Than Half of Individual Health Plans Offer Coverage That Falls Short of What Can Be Sold Through Exchanges as of 2014](#),” *Health Affairs* Web First, May 23, 2012.
- <sup>5</sup> 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 standard population. Gold plans have an actuarial value of about 0.8, while platinum plans have an actuarial value of 0.9.
- <sup>6</sup> The U.S. Department of Health and Human Services raised out-of-pocket limits about 3.2 percent from 2014 to 2015. To achieve the actuarial targets for each metal tier, many insurers also raised the out-of-pocket limit.
- <sup>7</sup> Kaiser Family Foundation, *Employer Health Benefits: 2014 Annual Survey* (Menlo Park, Calif., Henry J. Kaiser Family Foundation, 2014), <http://files.kff.org/attachment/2014-employer-health-benefits-survey-full-report>.
- <sup>8</sup> Authors’ calculation from Kaiser Family Foundation, *Employer Health Benefits, 2014 Annual Survey*.
- <sup>9</sup> Kaiser Family Foundation, *Employer Health Benefits: 2014 Annual Survey* (Menlo Park, Calif., Henry J. Kaiser Family Foundation, 2014), <http://files.kff.org/attachment/2014-employer-health-benefits-survey-full-report>.
- <sup>10</sup> Kaiser Family Foundation, *Employer Health Benefits: 2014 Annual Survey* (Menlo Park, Calif., Henry J. Kaiser Family Foundation, 2014), <http://files.kff.org/attachment/2014-employer-health-benefits-survey-full-report>.
- <sup>11</sup> Out-of-pocket limits increased by \$250 for single coverage (from \$6,350 to \$6,600) and \$500 for family coverage (from \$12,700 to \$13,200) from 2014 to 2015.
- <sup>12</sup> Preferred drugs are drugs for which generic equivalents are not available. They have been on the market for a while, are widely accepted, and are on the plan’s formulary. The insurer has typically negotiated discounts with the supplier. Nonpreferred drugs are not on the formulary and the plan has not negotiated discounts. Nonpreferred drugs are typically higher-cost medications that have recently come on the market. Specialty drugs are structurally complex and typically priced much higher than traditional drugs, and often require special handling or delivery.
- <sup>13</sup> P. W. Rasmussen, S. R. Collins, M. M. Doty, and S. Beutel, [Are Americans Finding Affordable Coverage in the Health Insurance Marketplaces?](#) (New York: The Commonwealth Fund, Sept. 2014).

## ABOUT THE AUTHORS

**Jon R. Gabel, M.A.**, is a senior fellow at NORC at the University of Chicago. Previously, he served as vice president of the Center for Studying Health System Change and vice president of health system studies at the Health Research and Educational Trust, director of the Center for Survey Research for KPMG Peat Marwick LLP, and director of research for the American Association of Health Plans and the Health Insurance Association of America. Mr. Gabel is the author of more than 100 published articles and serves on the editorial boards of a number of scholarly journals. He holds degrees in economics from the College of William and Mary and Arizona State University.

**Heidi Whitmore, M.P.P.**, is a health policy analyst at NORC at the University of Chicago's Health Policy and Evaluation department. Previously, she served as deputy director of health system studies at the Health Research and Educational Trust, where she was responsible for studies and surveys that track changes in health benefits and the health care delivery system. Ms. Whitmore holds degrees in political science from Carleton College and a master's degree in public policy from Georgetown University.

**Matthew Green** is a research analyst at NORC at the University of Chicago. While at NORC, he has worked on numerous projects related to the private health insurance market, focusing mainly on trends in premiums and plan offerings for the individual and small group markets since the passage of the Affordable Care Act. Mr. Green is a current M.P.P. student at the University of Chicago Harris School of Public Policy, and he holds a bachelor's degree from the University of Chicago.

**Sam Stromberg** is a senior research analyst in the health care research department at NORC. 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 assistant 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 Sandra Hackman.*



The  
COMMONWEALTH  
FUND

[www.commonwealthfund.org](http://www.commonwealthfund.org)