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MAY 2016

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Commonwealth Fund pub. 1875
Vol. 11

Changes in Consumer Cost-Sharing for Health Plans Sold in the ACA's Insurance Marketplaces, 2015 to 2016

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Abstract This brief examines changes in consumer health plan cost-sharing—deductibles, copayments, coinsurance, and out-of-pocket limits—for coverage offered in the Affordable Care Act's marketplaces between 2015 and 2016. Three of seven measures studied rose moderately in 2016, an increase attributable in part to a shift in the mix of plans offered in the marketplaces, from plans with higher actuarial value (platinum and gold plans) to those that have less generous coverage (bronze and silver plans). Nearly 60 percent of enrollees in marketplace plans receive cost-sharing reductions as part of income-based assistance. For enrollees without cost-sharing reductions, average copayments, deductibles, and out-of-pocket limits remain considerably higher under bronze and silver plans than under employer-based plans; cost-sharing is similar in gold plans and employer plans. Marketplace plans are more likely than employer-based plans to impose a deductible for prescription drugs but no less likely to do so for primary care visits.

BACKGROUND

Cost-sharing has been at the center of health care policy debates for the past five decades. Proponents argue that health insurance plans' deductibles, copayments, coinsurance, and out-of-pocket limits prevent overuse of services and provides an incentive to seek lower-cost care. Opponents assert that substantial cost-sharing constitutes rationing by income and that high deductibles reduce the use of both cost-effective and cost-ineffective services.

In the 1970s and 1980s, a study by the RAND Corporation showed that when deductibles were imposed for physician services and prescription drugs, their use declined substantially, but the reductions were similar for effective and ineffective services and drugs.¹ More recent data are generally consistent with these findings.²

We have reported that cost-sharing for individual and family plans obtained through the state and federal marketplaces established under the

Affordable Care Act remained largely unchanged from 2014 to 2015, as did premiums.³ However, premiums increased, by an average of 6 percent, from 2015 to 2016.⁴ To determine whether cost-sharing under marketplace plans also increased over the last year, we analyzed data from 49 states and Washington, D.C., in all plan tiers—platinum, gold, silver, and bronze.⁵ We also analyzed cost-sharing for employer-based plans, since employers have turned to high-deductible plans as a major cost-control strategy since 2004.⁶

Data in this issue brief are for all marketplace plans. But we excluded silver-level plans with cost-sharing reductions that are available for people with lower incomes.⁷ Because enrollment data for purchased plans are not available, our data are for plans that are *offered* rather than purchased. For 2015 plans, data were collected from August to November of 2014. For the 2016 plan year, data are from August through November of 2015.

For an explanation of the sampling and weighting methods that we used, see [About This Study](#).

ENROLLMENT IN THE METAL TIERS

On September 30, 2015, silver plans accounted for 68 percent of enrollment, bronze plans 20 percent, gold plans 7 percent, platinum plans 4 percent, and catastrophic plans 1 percent. Some 57 percent of individuals and families had plans with cost-sharing reductions, 47 percent in states with their own marketplace and 59 percent in states that rely on the federal marketplace.⁸ Estimates for 2016 federal marketplace enrollment are similar.⁹

At the time of the passage of the Affordable Care Act, the median “actuarial value” of health insurance—the proportion of enrollees’ health care costs it covers—was 83 percent for an employer-based plan and 59 percent for an individual plan.^{10,11} Thus, the typical employer plan was a gold plan, and the typical individual plan would not qualify to be sold in today’s marketplaces.¹² Low-income individuals and families that purchase silver plans are eligible for cost-sharing reductions, such as reduced deductibles, copayments, coinsurance, and out-of-pocket limits, making the silver plan closer in value to a platinum or gold plan.^{13,14}

FINDINGS

Trends in Cost-Sharing

Of the seven types of cost-sharing in the plans that we examined, one—copayments for generic drugs—decreased in 2016, by 3 percent (Exhibit 1). Three types of cost-sharing increased significantly: out-of-pocket limits increased by 7 percent, general annual deductibles by 10 percent, and copayments for nonpreferred drugs by 14 percent.¹⁵ However, these overall figures may not reflect a given plan’s year-to-year changes in cost-sharing, since changes in the available mix of plans—an increase in bronze and silver plans and a decline in gold and platinum plans—could also contribute to increases in average deductibles and out-of-pocket payments. (Our 2015 analysis and figures are available [here](#).)

Deductibles

Actuaries often regard the presence and size of deductibles as the most important determinants of the share of health care expenses borne by enrollees. In 2016, the proportion of marketplace plans with a general annual deductible ranges from 40 percent of platinum plans to nearly 100 percent of bronze plans to (Exhibit 2); 81 percent of employer-based plans had general deductibles in 2015, the most recent year for which data are available.

Exhibit 1. Average Change in Cost-Sharing Under Marketplace Plans, by Metal Tier, 2015–2016

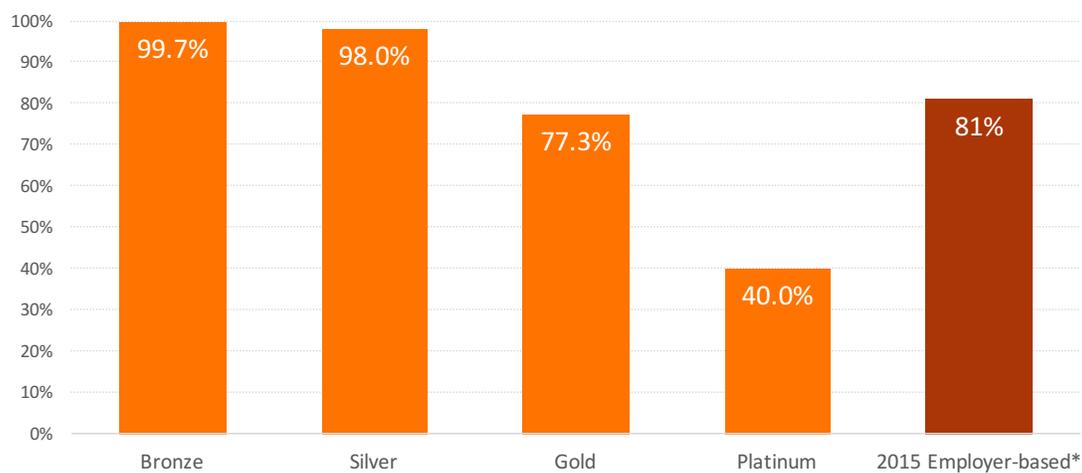
	Marketplace plans				
	Bronze	Silver	Gold	Platinum	All plans
Out-of-pocket limit	2.7%*	6.4%*	8.1%	16.2%	7.1%*
General annual deductible	10.4%*	5.0%	5.0%	-15.7%	10.3%*
Copayment, primary care provider visit	10.2%	1.9%	-3.4%	-0.6%	0.4%
Copayment, specialty visit	26.1%*	1.7%	0.2%	8.4%	4.9%
Copayment, generic drugs	-3.7%	-2.3%	-6.9%	1.5%	-3.2%
Copayment, preferred-brand drugs	-1.9%	1.4%	9.4%	0.7%	4.7%
Copayment, non-preferred-brand drugs	16.0%*	11.6%*	7.8%	27.9%	13.6%*

Note: * Significant at $p < 0.05$.

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.

Exhibit 2

Percentage of Plans with General Annual Deductible, Marketplace and Employer-Based Plans, 2016



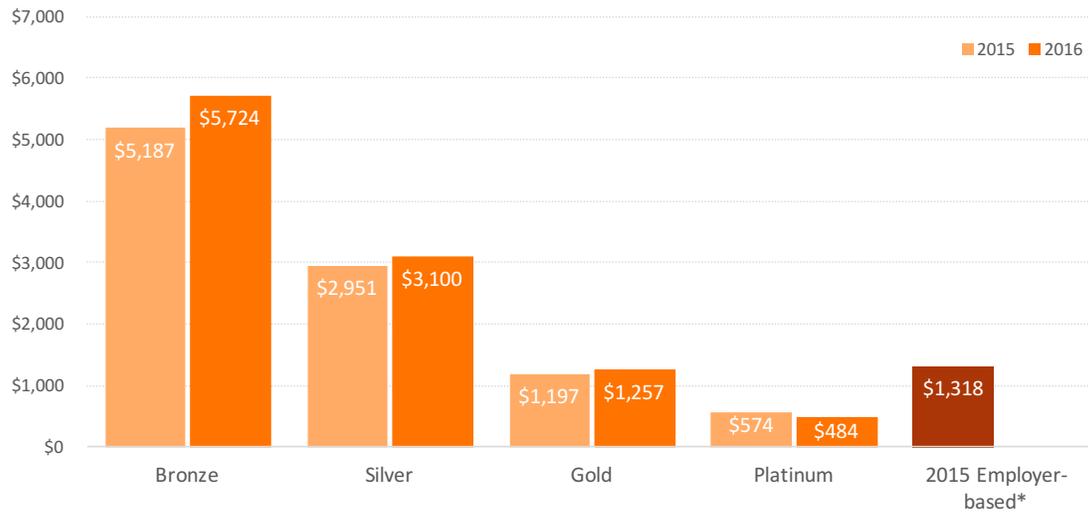
* Most recent employer survey data are from 2015.

Sources: Qualified Health Plan Landscape Files for federally facilitated marketplace, Nov. 2015; state insurance websites and state marketplace websites for state-based marketplaces, Nov. 2015; Henry J. Kaiser Family Foundation, *Employer Health Benefits: 2015 Annual Survey*, Sept. 2015.

Among 2016 marketplace plans with deductibles, the average deductible ranges from \$484 for platinum plans to \$5,724 for bronze plans (Exhibit 3). Employer-based plans had an average deductible of \$1,318 in 2015. From 2015 to 2016, general deductibles increased by 10 percent for bronze plans and by 5 percent for silver and gold plans, whereas platinum plans had a 16 percent decrease in deductibles.

Exhibit 3

Average General Annual Deductible, in Plans with Deductibles, Marketplace and Employer-Based Plans, 2015–2016



* Most recent employer survey data are from 2015.

Sources: Qualified Health Plan Landscape Files for federally facilitated marketplace, Nov. 2015; state insurance websites and state marketplace websites for state-based marketplaces, Nov. 2015; Henry J. Kaiser Family Foundation, *Employer Health Benefits: 2015 Annual Survey*, Sept. 2015.

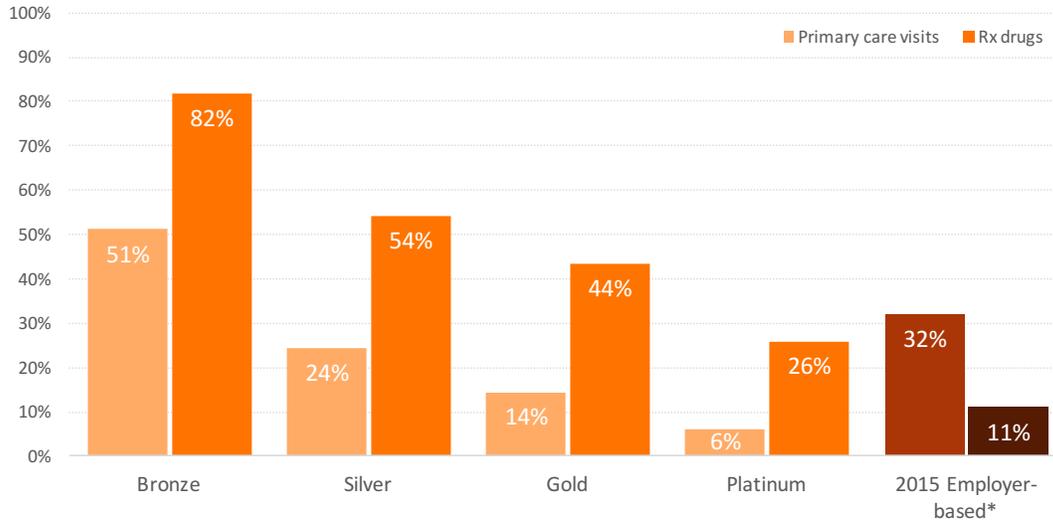
The plan mix also changed from 2015 to 2016, with the share of platinum and gold plans declining slightly and the share of silver and bronze plans increasing slightly. Thus, the annual deductible changes within plan tiers, with the exception of bronze plans, are smaller than the overall deductible change of 10 percent, reflecting the market shift toward plans with higher deductibles.

Many plans sold through the marketplaces and provided by employers exclude certain services from the deductible. That is, enrollees do not have to first meet their deductible before their coverage kicks in.¹⁶ The proportion of marketplace plans in the analysis that require that people first meet their deductible before coverage for primary care office visits begins ranges from 6 percent for platinum plans to 51 percent for bronze plans to (Exhibit 4). The corresponding proportion of 2015 employer-based plans was 32 percent.¹⁷ In all tiers, the proportion of marketplace plans requiring a deductible for primary care office visits decreased from 2015 to 2016 (Exhibit 5). The decreases were largest for bronze plans and gold plans.

The proportion of plans requiring enrollees to meet their deductible prior to prescription drug coverage ranges from 26 percent for platinum plans to 82 percent for bronze plans (Exhibit 4), as compared with 11 percent for employer-based plans.¹⁸ These percentages increased from 2015 to

Exhibit 4

Percentage of Plans Where the Beneficiary Must Meet a Deductible Before Primary Care Office Visits or Prescription Drugs Are Covered, Marketplace and Employer-Based Plans, 2016

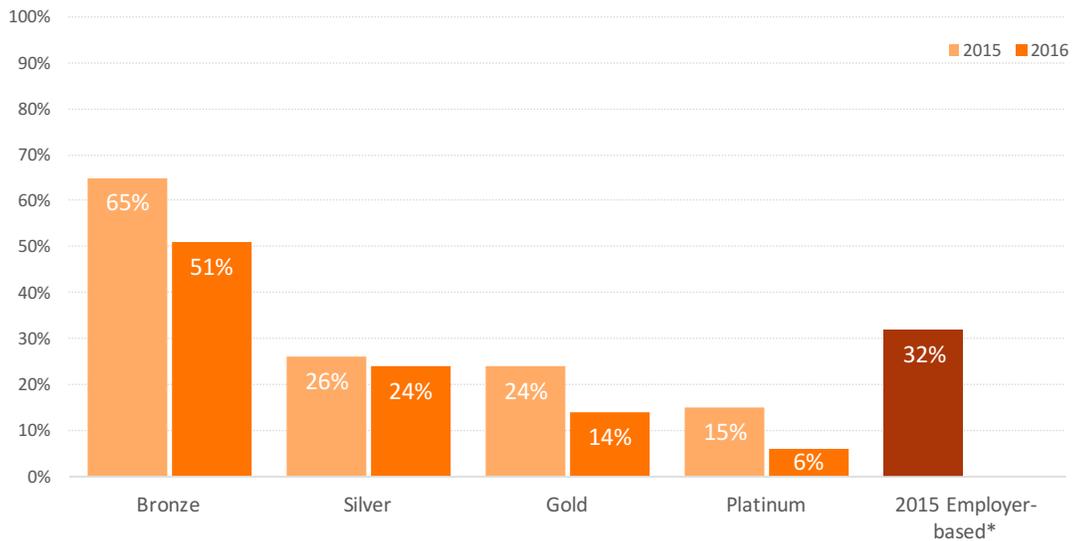


* Authors' calculations from Henry J. Kaiser Family Foundation, *Employer Health Benefits: 2015 Annual Survey*, Sept. 2015. Most recent employer survey data are from 2015.

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

Exhibit 5

Percentage of Plans Where the Beneficiary Must Meet a Deductible Before Primary Care Office Visits Are Covered, Marketplace and Employer-Based Plans, 2015–2016



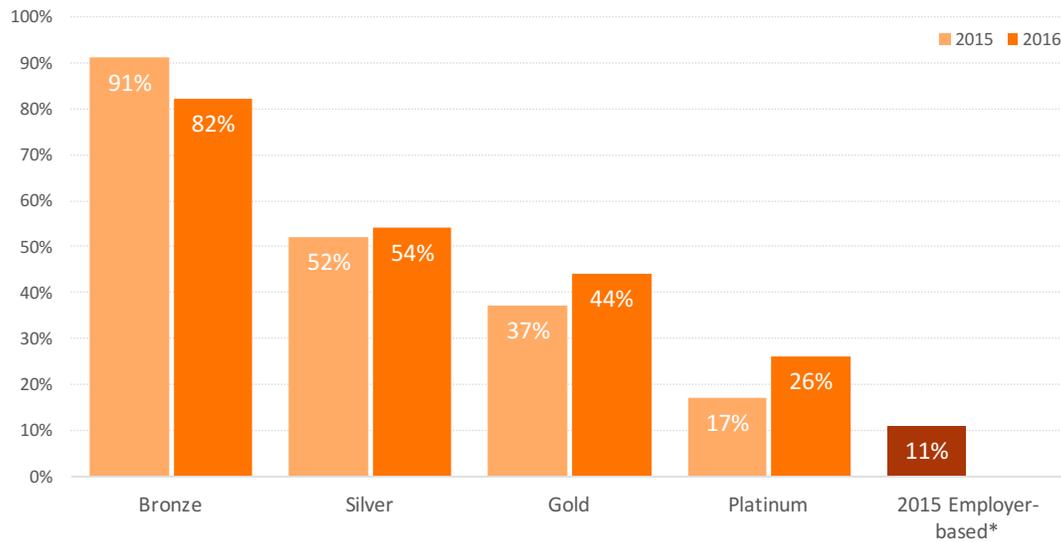
* Authors' calculations from Henry J. Kaiser Family Foundation, *Employer Health Benefits: 2015 Annual Survey*, Sept. 2015. Most recent employer survey data are from 2015.

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

2016 (Exhibit 6) for silver, gold, and platinum plans, with the largest increase in platinum plans. The proportion of bronze plans requiring a deductible for prescription drugs decreased by 10 percent.

Exhibit 6

Percentage of Plans Where the Beneficiary Must Meet a Deductible Before Prescription Drugs Are Covered, Marketplace and Employer-Based Plans, 2015–2016



* Authors' calculations from Henry J. Kaiser Family Foundation, *Employer Health Benefits: 2015 Annual Survey*, Sept. 2015. Most recent employer survey data are from 2015.

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

Copayments and Coinsurance for Office Visits

Copayments require enrollees to pay a fixed fee (for instance, \$25 for an office visit), regardless of the costs incurred during that visit. Coinsurance obligates enrollees to pay a percentage of the cost for an office visit, commonly around 20 percent under employer-based coverage.¹⁹ With coinsurance, enrollees assume greater financial risk for the cost of care and therefore have a greater incentive to monitor that cost. With employer-based plans, declining enrollment in HMOs and a growing reliance on high deductibles, with options for tax-preferred savings to pay out-of-pocket medical expenses, have led to larger numbers of employees who are covered by plans requiring coinsurance rather than copayments for office visits.²⁰

Under marketplace plans, copayments are the major vehicle for sharing the costs of office visits. The ratio of plans requiring copayments to plans requiring coinsurance for primary care visits is 4 to 1; for specialty care visits, the ratio is 3 to 1. The average copayment for primary care visits ranges from \$17 under platinum plans to \$43 with bronze coverage (Exhibit 7); the average copayment across plans is similar to the average for 2015 employer-based plans (\$29 and \$24, respectively).

Exhibit 7. Percentage of Plans Using Copayments or Coinsurance for Primary Care and Specialty Care Visits, and Average Copayment and Coinsurance, Marketplace and Employer-Based Plans, 2016

Cost-sharing type	Marketplace plans					Employer-based plans, 2015
	Bronze	Silver	Gold	Platinum	All plans	
Primary care						
Copayment	39.3%	76.7%	85.0%	95.0%	67.5%	68%
Coinsurance	25.5%	10.4%	8.0%	5.0%	14.3%	23%
Average copayment	\$43.04	\$30.97	\$22.38	\$17.13	\$28.68	\$24
Specialty care						
Copayment	29.0%	74.4%	85.0%	93.9%	63.4%	68%
Coinsurance	32.5%	14.8%	11.1%	6.1%	19.3%	24%
Average copayment	\$83.81	\$58.66	\$45.31	\$33.87	\$54.08	\$37

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; Henry J. Kaiser Family Foundation, *Employer Health Benefits: 2015 Annual Survey*, Sept. 2015.

Out-of-Pocket Limits

Out-of-pocket limits protect enrollees from catastrophic bills. From 2015 to 2016, the average out-of-pocket limit for all marketplace plans increased by 7 percent (Exhibit 8). The increase ranged from 3 percent for bronze plans to 16 percent for platinum plans. The average out-of-pocket limit for all marketplace plans was \$5,819 in 2016. Out-of-pocket limits are capped at \$6,850 for individual coverage (and \$13,700 for family coverage) in 2016, representing a 4 percent increase from 2015.

Exhibit 8. Average Out-of-Pocket Limit and Percentage Change in Marketplace Plans, by Metal Tier, 2015 to 2016

Year	Marketplace plans				
	Bronze	Silver	Gold	Platinum	All plans
2015	\$6375.80	\$5865.84	\$4634.20	\$2346.52	\$5433.92
2016	\$6545.68	\$6240.21	\$5008.59	\$2727.06	\$5819.45
Change	2.7%	6.4%	8.1%	16.2%	7.1%

Sources: Qualified health plan landscape file for federally facilitated marketplaces, Nov. 2015; state insurance websites and state marketplace websites for state-based marketplaces, Nov. 2015.

Copayments and Coinsurance for Prescription Drugs

Copayments are the predominant form of cost-sharing for generic drugs; for more expensive drugs, the use of copayments declines and the use of coinsurance increases. The proportions of plans that require copayments for drugs are 68 percent for generic drugs, 62 percent for preferred drug brands, 41 percent for nonpreferred brands, and 16 percent for specialty drugs (Exhibit 9).²¹ The figures for employer-based plans in 2015 are 84 percent for generic drugs, 75 percent for preferred drug brands, 70 percent for nonpreferred brands, and 50 percent for fourth tier or specialty drugs.

The higher the plan tier, the greater the proportion of plans within the tier that require copayments rather than coinsurance for prescription drugs. Those proportions range from 35 percent for bronze plans to 94 percent for platinum plans (Exhibit 9). The average copayment increases with the price of the drugs, ranging from \$12 for generic drugs to \$252 for specialty drugs (Exhibit 10). The copayment generally falls as the actuarial value of the plan increases. For example, the average copayment for generic drugs is \$18 for bronze plans, \$13 for silver plans, \$10 for gold plans, and \$8 for platinum plans. Copayments are considerably lower under employer-based plans than under marketplace plans for all formulary tiers other than generic drugs.

Exhibit 9. Percentage of Plans Using Copayments and Coinsurance for Generic Drugs, Preferred Brands, Nonpreferred Brands, and Specialty Drugs, Marketplace and Employer-Based Plans, 2016

Cost-sharing type	Marketplace plans					Employer-based plans, 2015
	Bronze	Silver	Gold	Platinum	All plans	
Generic drugs						
Copayment	34.9%	81.7%	84.9%	94.0%	68.4%	84%
Coinsurance	31.7%	7.7%	5.0%	2.3%	14.3%	11%
Preferred brands						
Copayment	21.8%	77.2%	83.8%	91.9%	62.3%	75%
Coinsurance	41.5%	16.8%	12.8%	7.0%	23.1%	24%
Nonpreferred brands						
Copayment	11.9%	49.5%	58.6%	67.4%	41.4%	70%
Coinsurance	47.3%	34.8%	29.8%	31.4%	36.7%	26%
Specialty drugs						
Copayment	7.4%	17.1%	20.1%	31.0%	15.8%	*
Coinsurance	49.8%	65.2%	67.2%	65.9%	60.4%	*

* The Kaiser Family Foundation employer 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; Henry J. Kaiser Family Foundation, *Employer Health Benefits: 2015 Annual Survey*, Sept. 2015.

Exhibit 10. Average Copayment for Generic Drugs, Preferred Brands, Nonpreferred Brands, and Specialty Drugs, Marketplace and Employer-Based Plans, 2016

Cost-sharing type	Marketplace plans					Employer-based plans, 2015
	Bronze	Silver	Gold	Platinum	All plans	
Generic drugs	\$18.32	\$12.68	\$10.24	\$7.54	\$12.23	\$11
Preferred brands	\$59.42	\$48.22	\$40.57	\$25.59	\$44.72	\$31
Nonpreferred brands	\$118.73	\$93.46	\$78.24	\$60.06	\$87.07	\$54
Specialty drugs	\$265.87	\$269.99	\$203.01	\$202.60	\$252.38	*

* The Kaiser Family Foundation employer 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; Henry J. Kaiser Family Foundation, *Employer Health Benefits: 2015 Annual Survey*, Sept. 2015.

BEHIND THE NUMBERS

For the more than 40 percent of marketplace enrollees who are not receiving cost-sharing reductions, cost-sharing rose moderately from 2015 to 2016. The changes were substantial in some cost-sharing categories and minimal in others. For example, out-of-pocket limits increased by 7 percent, copayments for nonpreferred drug brands rose sharply, and deductibles increased substantially for bronze plans. In contrast, copayments for primary care office visits were flat, copayments for generic drugs declined, and there was little change in the percentage of plans requiring a deductible for drugs and office visits. Hence, increases in cost-sharing, although substantial in some instances, were not of the magnitude depicted in the media.²² Moreover, a portion of the overall increase in cost-sharing is a consequence of the increasing number of marketplace plans offered (rather than purchased) that are bronze or silver plans—the tiers with the lowest actuarial values.

Marketplace plans are considerably more likely than 2015 employer-based plans to impose a deductible for prescription-drug coverage (for example, 54 percent of silver plans vs. 11 percent of employer-based plans). However, the proportion of silver plans requiring a deductible for primary care office visits is similar to the proportion of employer-based plans. The increasing number of employers offering high-deductible plans with features such as health savings accounts or health reimbursement arrangements, which exempt fewer services on average, from deductibles,²³ contributes to this equivalency.

Some supporters of the Affordable Care Act view cost-sharing requirements for persons who are not eligible for cost-sharing reductions as a major area in need of reform.²⁴ A single person earning \$30,000 a year (272 percent of the federal poverty level) and enrolled in a silver plan has an average deductible of approximately \$3,000, or 10 percent of pretax income. Individuals spending more than 10 percent of their incomes on medical care or insurance are usually considered to be underinsured.²⁵

As with premiums, future trends in cost-sharing will be linked to trends in medical care expenses. With rising expenses, insurers will need to increase deductibles, copayments, out-of-pocket limits, and other fixed-amount forms of cost-sharing to maintain a constant actuarial value (e.g., 0.7 for a silver plan). Coinsurance, in contrast, automatically stays in tandem with rising medical care expenses.

Future increases in cost-sharing under marketplace plans are likely to be smaller than cost-sharing increases in employer-based insurance, since the former, unlike the latter, are pegged to constant actuarial values. Over the past 15 years, there has been a shift in employer-based coverage from high-actuarial-value HMO and point-of-service plans to lower-value plans with high deductibles. From 2014 to 2015, the average deductible in employer-based coverage (including plans with and those without deductibles) increased by approximately 9 percent. Since 2005, the average deductible for this same group of plans grew from approximately \$266 to \$1,068, an average annual increase of 15 percent per year.²⁶

What is clear from the RAND experiment and other research is that increased cost-sharing will reduce the use of both appropriate and inappropriate services.

NOTES

- ¹ J. P. Newhouse and the Insurance Experiment Group, *Free for All? Lessons from the RAND Health Insurance Experiment* (Harvard University Press, 1993).
- ² S. R. Collins, P. W. Rasmussen, S. Beutel, and M. M. Doty, *The Problem of Underinsurance and How Rising Deductibles Will Make It Worse—Findings from the Commonwealth Fund Biennial Health Insurance Survey* (The Commonwealth Fund, May 2015); and A. Chandra, J. Gruber, and R. McKnight, “The Impact of Patient Cost-Sharing in Low-Income Populations: Evidence from Massachusetts,” *Journal of Health Economics*, Jan. 2014 33:57–66.
- ³ J. Gabel, H. Whitmore, S. Stromberg et al., “[Analysis Finds No Nationwide Increase in Health Insurance Marketplace Premiums](#),” *The Commonwealth Fund Blog*, Dec. 22, 2014.
- ⁴ J. Gabel, H. Whitmore, A. Call et al., “[Modest Changes in 2016 Health Insurance Marketplace Premiums and Insurer Participation](#),” *The Commonwealth Fund Blog*, Jan. 28, 2016.
- ⁵ New York is not included because data were unavailable.
- ⁶ K. Davis, *Will Consumer-Directed Health Care Improve System Performance?* (The Commonwealth Fund, Aug. 2004).
- ⁷ For an explanation of the cost-sharing reduction payments, see S. R. Collins, M. 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 Centers for Medicare and Medicaid Services, “[September 30, 2015 Effectuated Enrollment Snapshot](#)” (CMS, Dec. 22, 2015).
- ⁹ Centers for Medicare and Medicaid Services, “[December 31, 2015 Effectuated Enrollment Snapshot](#)” (CMS, March 11, 2016).
- ¹⁰ Actuarial value is the percentage of the bill paid by the insurer for a large population. For example, a plan with an actuarial value of 0.7 pays for, on average, 70 percent of the total health care expenditures incurred by the covered population.
- ¹¹ 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, published online May 23, 2012.

- ¹² A plan with an actuarial value of 0.59 can be sold as either a catastrophic plan or a bronze plan (if the state allows plans to round up the actuarial value for the tier).
- ¹³ Cost-sharing reductions are available to enrollees in a silver plan who have incomes at 100 percent to 250 percent of the federal poverty level and choose a silver plan. Premium subsidies are available to enrollees with incomes at 100 percent to 400 percent of the federal poverty level and are calibrated to each region's benchmark plan premium. For more details, see J. Gabel, H. Whitmore, S. Stromberg et al., "[Analysis Finds No Nationwide Increase in Health Insurance Marketplace Premiums](#)," *The Commonwealth Fund Blog*, Dec. 22, 2014.
- ¹⁴ Silver plans have an actuarial value of 0.7, gold plans have an actuarial value of about 0.8, and platinum plans have an actuarial value of 0.9.
- ¹⁵ Carriers may or may not label their tiers of prescription drugs when presenting cost-sharing information. In our analysis, we call the least-expensive tier "generic," followed by "preferred," "nonpreferred," and "specialty." Almost all plans have four tiers for prescription drugs; less than 5 percent of plans have only three tiers (generic, preferred, and nonpreferred), and 1 percent have five or more tiers.
- ¹⁶ See for example, M. 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).
- ¹⁷ Authors' calculations from Kaiser Family Foundation, [Employer Health Benefits: 2015 Annual Survey](#) (Henry J. Kaiser Family Foundation, Sept. 2015).
- ¹⁸ Ibid.
- ¹⁹ Ibid.
- ²⁰ Kaiser Family Foundation, [Employer Health Benefits: 2015 Annual Survey](#) (Henry J. Kaiser Family Foundation, Sept. 2015).
- ²¹ 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. These drugs are typically higher-cost medications that have recently come on the market. Specialty drugs, which are structurally complex and often require special handling or delivery, are typically priced much higher than traditional drugs.
- ²² E. Planin, "[Obamacare Enrollees Are Reeling from Higher Deductibles](#)," *The Fiscal Times*, Nov. 16, 2015.
- ²³ Kaiser Family Foundation, [Employer Health Benefits: 2015 Annual Survey](#) (Henry J. Kaiser Family Foundation, Sept. 2015).
- ²⁴ T. S. Jost and H. Pollack, "[Key Proposals to Strengthen the Affordable Care Act](#)," *The Century Fund Blog*, Nov. 23, 2015; and L. J. Blumberg and J. Holahan, [After King v. Burwell: Next Steps for the Affordable Care Act](#) (Urban Institute, Aug. 2015).
- ²⁵ S. R. Collins, P. W. Rasmussen, S. Beutel, and M. M. Doty, [The Problem of Underinsurance and How Rising Deductibles Will Make It Worse—Findings from the Commonwealth Fund Biennial Health Insurance Survey](#) (The Commonwealth Fund, May 2015).
- ²⁶ Authors' calculations from Kaiser Family Foundation, [Employer Health Benefits: 2015 Annual Survey](#) (Henry J. Kaiser Family Foundation, Sept. 2015).

ABOUT THIS STUDY

We analyzed data on 4,153 plans in 2015 and 3,700 in 2016 that were offered in individual marketplaces 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 on states with their own exchanges are from marketplace websites maintained by state departments of insurance.

For PY (program year) 2014–2015, 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. For PY 2016, we collected data on 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. After a series of rating areas had been sampled, NORC conducted a second stage of sampling in 2016 for state-based marketplaces; for each carrier offering plans in a given rating area, one plan was sampled from each of the four plan tiers (if the carrier offers at least one plan in each tier). In states that rely on the federal exchange, all plans within the sampled rating areas were collected. 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, with an additional sampling weight in PY 2016 reflecting the probability of sampling a plan in a given tier in a given rating area. We designated statistical significance at $p < 0.05$.

ABOUT THE AUTHORS

Jon R. Gabel, M.A., is a senior fellow in the Health Care Department 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 140 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.

Matthew Green is a senior research analyst in the Health Care Department 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.

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Editorial support was provided by Victoria Alexander.



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