Plan Choice and Affordability in the Individual and Small Group Markets:

Policy and Performance in the Past and Present

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Abstract

The individual and small group health insurance markets have experienced considerable changes since the passage of the Affordable Care Act, affecting access, choice, and affordability for enrollees in these markets. We review the changes that have altered these markets over the past decade. Then, using 2018 HIX Compare data on all 50 states, we examine how health plan access, choice, and affordability vary between the individual Exchange, off-Exchange and small group markets. We find relatively similar outcomes between the on-Exchange, off-Exchange, and small group markets with respect to deductibles and maximum out-of-pocket spending limits. However, the small group market maintains greater plan choice and lower premiums – outcomes that appear to be associated with higher insurer participation. We conclude by considering strategies to increase insurer participation as a way to improve access, choice, and affordability in the individual market.

Introduction

In 2016, approximately 32 million persons in the United States were covered by the individual and small employer group markets for health insurance.[1] Historically, individuals and small employers seeking coverage frequently encountered significant challenges, including ineligibility or coverage limitations due to pre-existing medical conditions and higher premiums due to increased administrative costs for underwriting.[2,3]

Improving access, choice, and affordability in the individual and small employer markets were key policy goals of the Patient Protection and Affordable Care Act (ACA) in 2010. Federal policymakers designing the ACA transformed both markets through the introduction of actuarial value-based plan standardization, essential health benefits requirements, modified community rating, the creation of Exchanges, and the availability of subsidies for certain individuals or small employers (SHOP) to achieve these policy goals.[4] The ACA introduced a new regulatory environment that treated the individual and small group markets similarly under the assumption that similar regulations would best address the issues common to both markets and thereby produce similar outcomes.

In this paper, we investigate whether the similar regulations applied to the individual on-Exchange market, off-Exchange market, and small group market under the ACA have led to similar outcomes in those markets as of 2018. We find that contrary to policymakers' expectations, there are more differences in outcomes between these markets than there are similarities, especially between the two individual market segments and the small group market.

Our investigation of these markets requires an understanding of their history. We begin by briefly summarizing how these markets performed on the dimensions of access, choice, and affordability prior to the ACA. Then, we examine the current landscape on these same dimensions, highlighting similarities and differences between past and present and between market segments. We conclude with a discussion of explanations for the observed differences and briefly highlight some policy options that could improve outcomes in the two individual market segments, which we find to have poorer outcomes than those in the small group market.

Individual and Small Group Market Regulation over Time

Historically, many small employers and individuals faced barriers in purchasing health insurance. Businesses operating in certain industries were "red-lined" and ineligible to purchase

coverage. Other small employers were denied coverage on the basis of having an employee with high expected future claims due to a pre-existing condition. In most states, if an insurer was willing to underwrite a policy, information was required on every employee's medical history and pre-existing condition exclusions could be imposed.[5] Medical underwriting also was prevalent in the individual market. Insurers could use information on a person's age, sex, occupation, residence, and medical history to set premiums and impose coverage exclusions for pre-existing medical conditions.[6]

During the early to mid-1990s, several states and the federal government passed legislation to address some of these insurer practices in small group markets. Guaranteed issue (GI) and guaranteed renewability (GR) provisions were prominent as were new limits on pre-existing condition provisions. Passage of the Health Insurance Portability and Accountability Act (HIPAA) in 1996 incrementally expanded or reinforced many state regulations pertaining to GI, GR, and pre-existing conditions.[7,8] Although HIPAA included protections guaranteeing individuals access to a plan without pre-existing condition exclusions, it did not regulate the premiums that could be charged to such individuals; coverage was often unaffordable. Over time, 35 states created high-risk pools, often subsidized with state

taxpayer dollars, through which individuals who were medically eligible could purchase insurance.[9]

Individual and Small Group Market Performance Prior to the ACA

Access: A 2009 report by America's Health Insurance Plans reported that 12.7% of applicants were denied individual coverage due to medical underwriting in 2008.[10] Among applicants aged 60-64, one-third could not purchase coverage. For the 87% of applicants offered coverage in 2008, 6% were subject to pre-existing conditions exclusions. For small employers with 2 to 50 workers, the HIPAA created protections for guaranteed issue, though some employers were still faced with high premiums and self-employed individuals did not enjoy the same protections.

Insurer Choice, Plan Types, and Coverage Generosity: Based on 2010 data from the National Association of Insurance Commissioners' Supplemental Health Care Exhibit Report,[11] states had, on average, 23 insurers with at least 50 covered lives in the individual market and 18 insurers in the small employer market. Insurer participation was highly variable across states; the number of individual market insurers in a state ranged from 2 to 52, whereas that range was 5 to 42 in the small group market (Appendix Exhibit 1).

Individual policies in force prior to the ACA's passage were typically preferred provider organization (PPO) or point-

of-service (POS) plans. In the 2009 AHIP survey, insurers reported that 83% of single policies and 73% of family policies in force were one of these two plan types.[12] Among small firms offering coverage, about 80% offered a PPO or POS plan, while approximately 20% offered a health maintenance organization (HMO).[13]

There were also differences in plan generosity. Examining individual market plans in five states in 2010 and employer plans using the KFF/HRET survey, one study concluded that the average actuarial value of individual plans was 60%, 20 percentage points lower than for small group policies.[13] They also found no individual market plans with actuarial values of 90% or greater.

Affordability: We examine affordability by looking at premiums, deductibles, and maximum out-of-pocket (OOP) spending limits. It is problematic to focus on changes over time in premiums since benefit designs and risk pools pre-ACA are very different from today. What is evident is that premiums in the individual and small group markets have had higher administrative loading fees relative to the large employer group market, given medical underwriting and lack of economies of scale for spreading fixed costs of insurance contracting.[14,15]

In the individual market in 2009, almost 50% of PPO and POS plans in force had individual deductibles of over $2,500 ($3,255 in 2018 dollars). Over 30% of family policies had deductibles over $6,000 ($7,811 in 2018 dollars). Based on the 2009 Medical Expenditure Panel Survey - Insurance Component, 73.5% of small employers offering insurance offered a plan that required an annual deductible. And, conditional on a deductible requirement, the average deductible for single coverage was $1,283 ($1,670 in 2018 dollars).[16,17]

In 2009, among individual plans in force, approximately 2.8% of PPO/POS and 16.4% of HMO/EPO plans had no OOP maximum limit. As reported in the 2009 AHIP survey, the average OOP maximum limit for PPO/POS plans was $5,858 (2018 dollars) for single policies and $12,077 (2018 dollars) for family policies. Some evidence also suggests that a significant proportion of small employers offered plans that did not explicitly limit enrollees' financial exposure.[18] However, when such a limit was specified, it tended to be lower relative to the individual market.

In summary, prior to the ACA, access to insurance coverage was better in the small group market compared to the individual market. There were more insurers operating in individual markets across states as compared to small group markets though

individual market insurers were less regulated and faced more favorable conditions since they could deny coverage based on health status in most states. Small group markets had greater diversity in plan types and offered plans with higher actuarial values. Both segments faced higher loading fees as compared to the large group market. Deductibles were higher, on average, in the individual market and maximum OOP spending limits were also high in this market. Next, we detail our approach for examining the small group and two individual markets to understand whether the introduction of a common regulatory framework under the ACA has led to convergence in market outcomes.

Data and Methods

To investigate the current landscape of the individual and small group markets, we use the 2018 HIX Compare data from the Robert Wood Johnson Foundation.[19] These data provide comprehensive information on benefits and premiums across geographic rating areas (GRAs) for all ACA-compliant plans offered in the on-Exchange, off-Exchange and small group markets. For our analysis, we excluded cost-sharing reduction plans as well as the small number of plans offered solely in the Small Business Health Options Program. We used a two-step process to construct our insurance market outcomes. First, using

information on all plans offered in each GRA, we constructed the following measures:

1) Number of plan types offered (HMO, EPO, POS, PPO);
2) Availability of a platinum-level plan;
3) Annual premium for the lowest-priced individual silver plan;
4) Annual, individual total deductible for the lowest-priced silver plan;
5) Annual, individual maximum out-of-pocket (OOP) spending limit for the lowest-priced silver plan;
6) Number of insurers.

Second, we aggregated each outcome from the GRA- to the state-level by constructing weighted averages based on the number of 2016 billable member months in each GRA for the individual and small group markets using data from CMS.[20] We defined plan types and platinum plans as broadly available if at least 70% of a state's population could access them.

The study is subject to several limitations. First, to construct an "apples-to-apples" comparison of premiums and cost-sharing across states and markets, we use the lowest-priced silver plan offered by GRA, the most affordable option for the most popular metal level. However, there are multiple other plans offered in each market that we do not consider. Second,

our premium measure represents the amount prior to the deduction of premium tax credits. Third, our weights reflect the most recent year in which data are available, 2016, rather than the year that we study, 2018. Fourth, our weights are at the individual market level and do not distinguish between on- and off-Exchange markets. Assuming that these enrollment quantities are correlated, we apply the individual market weights to both the on- and off-Exchange markets.

Results

Research suggests that consumers place significant value on having a choice of health plans.[21] Here, we consider two dimensions of choice: the plan types available to consumers and the availability of a platinum-level plan. Plan type can influence enrollees' access to hospitals and physicians. Typically, PPOs and POS plan types have broader provider networks and permit enrollees more direct access to specialty physicians than do HMOs or EPOs.

To illustrate the stark differences across markets, we group more restrictive HMOs and EPOs and less restrictive PPO and POS plans, and graph the availability of these plan types in the on-Exchange, off-Exchange, and small group markets (**Exhibit 1**). For the small group market, 39 states provide consumers with broad access to both a HMO/EPO and a PPO/POS plan in local

markets. Plan type diversity is narrower in the individual market. In only 20 states are both the more and less restrictive plan types offered in the off-Exchange and only 16 states offer such variety on their Exchanges.

When we look at states where only an HMO or EPO is offered, we find that in the on-Exchange markets, 23 states only offer consumers these more restrictive plans; that is the case for 19 states in the off-Exchange markets. This compares to only three states' small group markets. Although these markets operate with similar regulations, a consumer in the same state buying insurance in different markets ends up with very different sets of plan types from which to choose.

Coverage generosity represents another important plan attribute.[22] Since 2014, platinum-level plans with a 90% actuarial value are the most generous coverage level available in these markets. As **Exhibit 2** shows, the availability of platinum-level plans across markets within states varies widely. As with plan type, the small group market has much greater access to platinum plans. Forty-six states have platinum plans available in the small group market. In 29 states, platinum plans are available only in that market. Platinum plans were available to Exchange enrollees in only 14 states and off-

Exchange enrollees in 18 states. Again, similar regulations do not produce similar plan offerings in the three markets.

Exhibit 3 illustrates that plan availability is not the only dimension on which plans differ across these three markets. Exhibit 3 presents overall means and means of each quintile for annual premiums for a 50-year-old as well as deductibles and individual maximum OOP spending limits for the lowest-priced silver plan. The differences we see across markets are in premiums. Average premiums across states are 38% higher in the on-Exchange market than in the small group market. We see similar differences between the two markets throughout the distribution. On-Exchange plans are also higher than off-Exchange individual silver plan premiums but by a much lower 7%.

Deductibles and OOP maximums are much more similar across markets than are premiums and plan types. Deductibles are within 2-8% of each other across markets, but the pattern is not the same at each point in the distribution. The only more substantial differences are at the top of the distribution where we see that in the top two quintiles off-Exchange plans are 20% higher than small group deductibles. For OOP maximums, the amounts are quite similar across markets. This is most likely due to federal regulations establishing an explicit limit.[23]

Exhibits 1, 2, and 3 illustrate that despite operating under the same rules, the on-Exchange, off-Exchange, and small group market outcomes are not as similar as one might expect. Although our research design is unable to identify a causal effect of any particular market characteristics, we highlight one market attribute strongly associated with several of the differences in outcomes across markets: the number of insurers operating in each state's markets. As detailed in Appendix Exhibit 1, the average number of insurers operating in a state in 2018 in the on-Exchange market is approximately 3.9; in the off-Exchange market the average is 4.8; and in the small group market it is 7.0.

Exhibit 4 illustrates the association between the number of insurers and the numbers of plan types available (HMO, EPO, POS, and PPO). For markets with five or fewer insurers, a greater number of insurers is associated with an increase in the number of plan types offered, but this association does not vary by the type of market. Instead, in states with five or fewer insurers, the effect on number of plan types overall occurs because there are so many more states with small numbers of insurers in the individual market segments than the small group market. When there are six or more insurers in a state, the number of insurers has a greater effect on plan type diversity in the

small group market and there are more small groups with 6 or more insurers.

Appendix Exhibits 2-5 document the relationship between the number of insurers and our other outcomes – platinum plan availability, premiums, deductibles, and maximum OOP limits. As seen in Appendix Exhibit 2, the likelihood of having a platinum plan is associated with the number of insurers in the state for both types of individual markets. Even more dramatic, however, is the across-the-board platinum advantage of the small group market. Small group markets have a substantially higher likelihood of having a platinum plan available no matter how many insurers are in the market. Appendix Exhibit 3 shows that states with larger numbers of insurers tend to have lower premiums, as has been found in other work.[24-25] Finally, Appendix Exhibits 4 and 5 show average deductibles and OOP maximum spending limits by number of insurers.

Discussion

The ACA introduced insurance market regulations imposing similar "rules" being applied to the individual and small employer group markets. In some cases, this has led to convergence of plan characteristics across markets and in some it has not. Deductibles and maximum OOP limits are for the most part similar across the on-Exchange, off-Exchange, and small group market in

2018. These benefit designs are more similar today than prior to ACA implementation based on the pre-ACA statistics above. These two aspects of benefit design that converged across markets are also the two that ACA regulations likely affected most directly. The greater plan standardization imposed on both markets by the ACA may have contributed to the narrowing of the difference in deductibles across markets within states. Direct ACA limits on maximum OOP spending capped the upper tail of the distribution of potential values and most likely created an anchoring effect.

Access to insurance also converged across markets after the ACA due to direct regulation – in this case the ban on coverage denials or exclusions of benefits due to pre-existing conditions. With state reforms in the 1990s, access improved prior to the ACA for those small employers with employees who had pre-existing conditions, but not without altering the composition of the risk pool and generating affordability concerns. In the individual market, access to insurance for those with pre-existing conditions was often limited to HIPAA-compliant policies which had specific eligibility criteria or state-based high-risk pools. After implementation of the ACA coverage protections in 2014, the 13% of applicants that were denied coverage in the individual market in 2008 due to medical underwriting were now guaranteed that insurers could not deny them coverage.

In contrast, the number of plan types offered and platinum plan availability as well as premiums vary substantially across the markets within states in 2018. Data sources available from the pre-ACA period do not permit a precise comparison of these plan characteristics pre- and post-ACA, but the observed differences in these three plan characteristics across markets are large enough to conclude that we see no evidence of convergence on these dimensions. In each dimension, small groups are better off. They have more plan choice and, on average, lower premiums. While off-Exchange markets look somewhat better than the on-Exchange markets, the differences are small relative to differences between the two individual market segments and the small group markets.

So what can policymakers learn from the better functioning of the small group market that might be applied to the individual market? As noted above, ours is not a research design that supports causal inference. However, we find a strong positive association between the number of insurers in a market and the number of plan types offered as well as the availability of a platinum plan. We also find a negative association between the number of insurers in a market and premiums – an inference reached by others.[24-25] As such, we suggest the examination of policy options for increasing insurers in the individual market.

Policymakers may pursue various strategies to increase insurer participation. For example, seven states within the past three years have pursued 1332 waivers to allow federal pass-through funding for individual market reinsurance programs. By doing so, states have sought to lessen insurers' risk due to high-cost claimants as well as to mitigate premium volatility, creating more favorable conditions for entry or retention of insurers.[26]

Another strategy is to merge a state's individual and small group markets. Only Massachusetts and Vermont to date have merged their markets.[27] Proponents of merged individual and small group markets suggest that a merged market would enlarge the risk pool and would be more attractive to insurers considering entry. They also note that a merged market could reduce insurers' regulatory compliance costs. Opponents of a merged market strategy argue that there would be significant disruption to both markets with clear winners and losers based on the relative market sizes and health risk composition of the enrollee populations in a state.[28]

Third, policymakers may promote competition among insurers through participation requirements or incentives. For example, Nevada at one point required that insurers offer an on-Exchange plan if they wanted to participate in their Medicaid managed

care program. More recently, Nevada gave "bonus points" in the contest to win a place in their Medicaid managed care program to insurers who participated in the Exchange.[29] New York also banned from Medicaid managed care participation insurers that exited the on-Exchange market.[30] The Urban Institute reports these requirements and incentives in its investigation of how states facing the prospect of "bare counties" with no insurer managed eventually to get all counties covered for 2018, but such approaches could also be used to increase the number of insurers in counties that are not "bare."

Finally, a small number of states are reviving the idea of a public option, a plan run by the government that would compete with private plans and provide certainty that every county would have a plan available.[31] If the political climate does not allow for a serious reconsideration of a federal public option, states could pursue their own.[32]

Conclusion

Our analysis of ACA-compliant plans in the individual on-Exchange, off-Exchange, and small group plans reveals that, despite being subject to the same regulatory structure certain outcomes – plan type diversity, availability of platinum plans, and premiums – are quite different across markets. Small group markets have on average more plan types, more platinum

availability, and lower premiums than both of the two individual market segments. We suggest that a possible explanation for these differences is the greater insurance competition in the small group market and we discuss policy options that could increase competition in the on-Exchange and off-Exchange markets.

Looking to the future, it is important for federal and state policymakers as well as other key stakeholders to evaluate the impact of additional regulatory changes on the individual and small group markets, including recent provisions to allow for the sale of short-term duration and association health plans that may trigger additional concerns about access, plan choice, and affordability in these markets.

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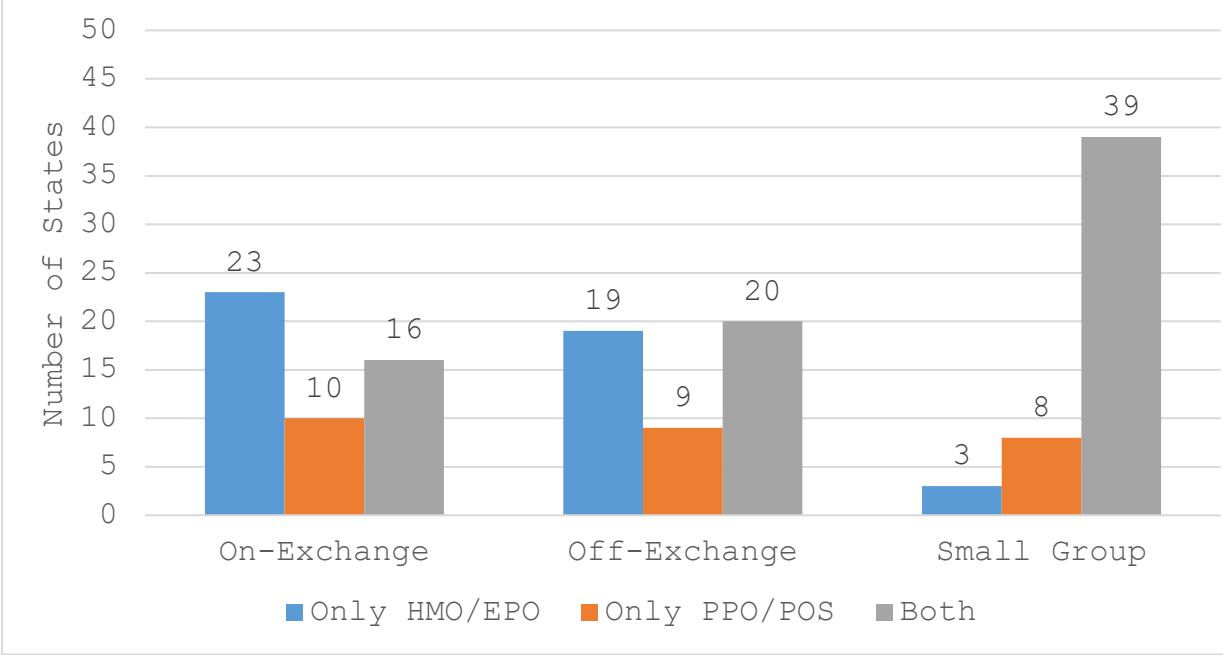
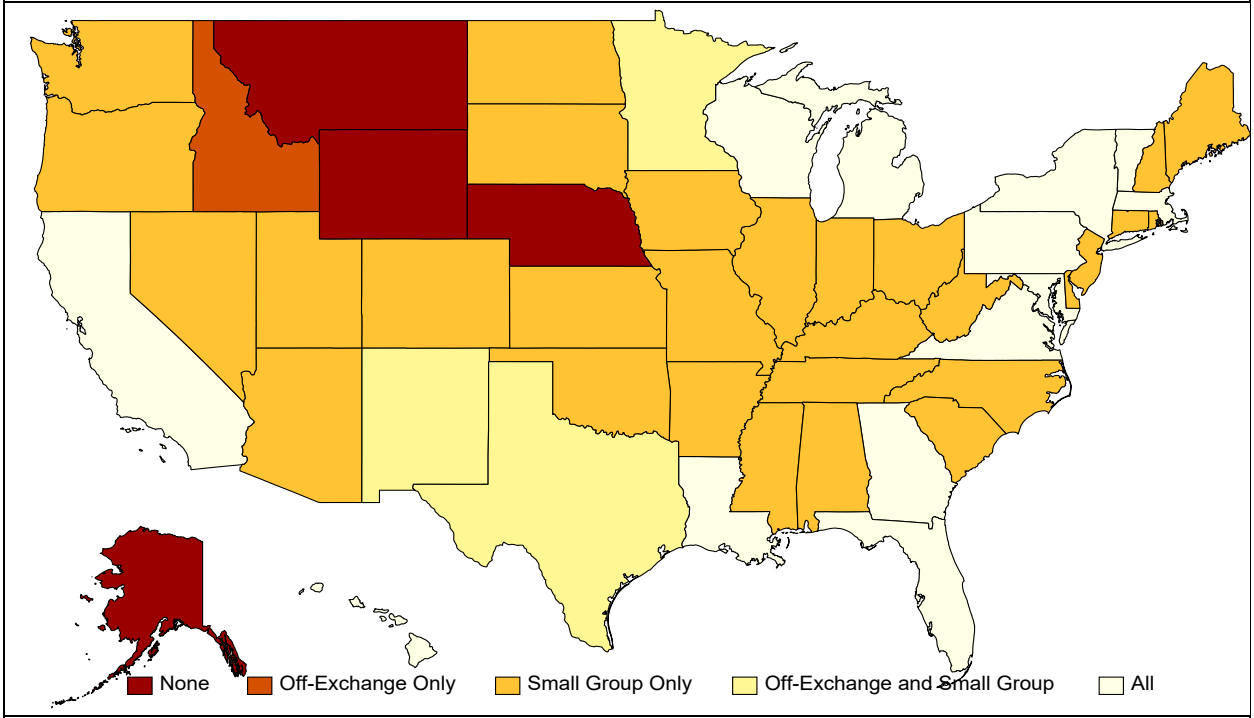
Exhibit 1: Plan Type Availability by Market Segment in 2018



SOURCE: Authors' analysis of 2018 HIX Compare data and 2016 Center for Consumer Information and Oversight enrollment data.
NOTES: The unit of observation is the state-market. A state-market has a given plan type if at least 70% of its enrollees, weighted by billable member months, have access to the given plan type. NC and TN did not have any plan type broadly available to at least 70% of enrollees in their on- and off-Exchange markets. DC and VT merged their on- and off-Exchange markets. Data for WY are missing for the off-Exchange and small group markets.

Exhibit 2: Platinum Plan Availability in 2018



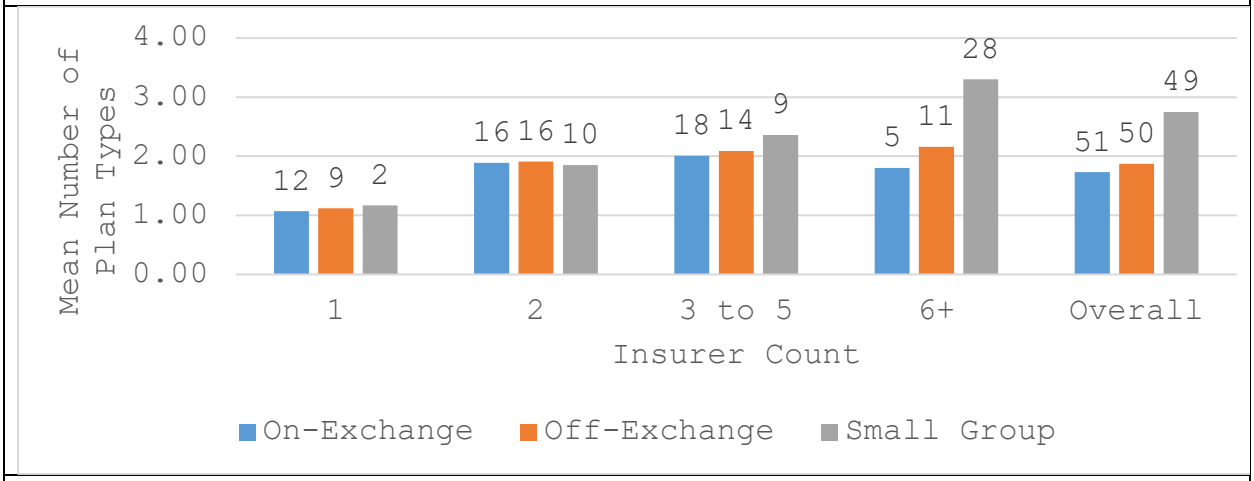
SOURCE: Authors' analysis of 2018 HIX Compare data and 2016 Center for Consumer Information and Oversight enrollment data.
NOTES: The unit of observation is the state-market. A state-market has a platinum plan available if at least 70% of its enrollees, weighted by billable member months, have access to a platinum plan. Approximately, 44.6% of enrollees have a platinum plan in on-Exchange; 48.5% in off-Exchange; 97.4% in small group.

Exhibit 3: Quintiles of State-Level Annual Premiums, Deductibles, and Individual Out-of-Pocket Maxima for Lowest-Priced Silver Plans

Annual Lowest-Priced Silver Plan Attributes ($)	On-Exchange	Off-Exchange	Small Group
Premium for Single 50-Year-Old Adult			
Mean	7,714	7,188	5,586
Quintile Means			
1	5,422	5,233	4,419
2	6,642	6,003	4,962
3	7,655	6,813	5,431
4	8,413	7,925	5,919
5	10,668	9,966	7,377
Deductible			
Mean	4,660	4,545	4,164
Quintile Means			
1	2,377	2,563	2,428
2	3,417	3,417	3,580
3	4,700	4,481	4,318
4	6,037	5,621	4,992
5	6,995	6,641	5,817
Individual Single Maximum Out-of-Pocket Limit			
Mean	7,073	6,975	6,640
Quintile Means			
1	6,392	5,937	5,433
2	7,061	7,000	6,409
3	7,282	7,247	6,855
4	7,349	7,345	7,268
5	7,350	7,350	7,350

SOURCE: Authors' analysis of 2018 HIX Compare data and 2016 Center for Consumer Information and Oversight enrollment data.
NOTES: The unit of observation is the state-market. Deductibles and out-of-pocket maxima are for the lowest-priced, non-cost-sharing reduction silver plan. A state-market's annual premium, deductible, and individual out-of-pocket limits are the billable member month-weighted average of those plan attributes across a state's rating areas. HI does not have silver plans in its small group market. WY has no observations in its off-Exchange and small group markets.

Exhibit 4: Mean Number of Plan Types Available by Market and Insurer Count



SOURCE: Authors' analysis of 2018 HIX Compare data and 2016 Center for Consumer Information and Oversight enrollment data.
NOTES: The unit of observation is the state-market. The value displayed at the top each bar is the number of states in the market with the specified number of insurers. Plan types are HMO, PPO, EPO, and POS. A state-market has a plan type if at least 70% of its enrollees, weighted by billable member months, have access to the plan type. A state-market insurer count is its billable member month weighted average of insurer counts across the state's rating areas.

Appendix Exhibits

Appendix Exhibit 1: Insurer Counts by Market and State, 2010 and 2018

	Insurer Count in 2010		Insurer Count in 2018		
State	**Individual**	**Small Group**	**On-Exchange**	**Off-Exchange**	**Small Group**
AK	10	7	1	1	2
AL	21	8	2	3	2
AR	24	16	4	5	7
AZ	30	28	2	4	11
CA	19	12	12	10	16
CO	36	17	7	9	13
CT	18	16	2	3	7
DC	9	14	3	3	5
DE	14	11	1	1	3
FL	52	22	6	8	6
GA	36	30	4	5	11
HI	3	6	2	2	1
IA	23	23	1	1	12
ID	10	10	4	5	7
IL	37	37	4	4	7
IN	32	31	2	3	11
KS	26	22	3	3	4
KY	15	11	2	2	2
LA	27	15	3	3	6
MA	17	20	8	7	3
MD	19	16	4	4	4
ME	8	7	2	2	6
MI	42	32	8	10	14
MN	23	11	3	4	8
MO	33	30	3	5	7
MS	24	13	1	2	2

MT	16	8	3	3	3
NC	28	22	2	2	1
ND	10	7	2	2	1
NE	25	18	1	1	3
NH	11	8	3	3	5
NJ	15	15	4	6	8
NM	19	10	4	5	2
NV	20	23	2	6	7
NY	33	28	12	13	16
OH	40	42	8	9	16
OK	30	21	1	2	2
OR	23	10	5	7	9
PA	39	36	9	14	17
RI	3	7	2	2	4
SC	33	20	1	1	6
SD	17	10	2	2	3
TN	30	25	3	3	5
TX	50	38	8	11	12
UT	18	13	2	6	7
VA	29	32	7	7	12
VT	2	5	2	2	2
WA	20	15	7	8	12
WI	37	36	11	14	15
WV	17	20	2	3	3
WY	19	8	1	n/a	n/a
Average	23.37	18.47	3.88	4.82	6.96

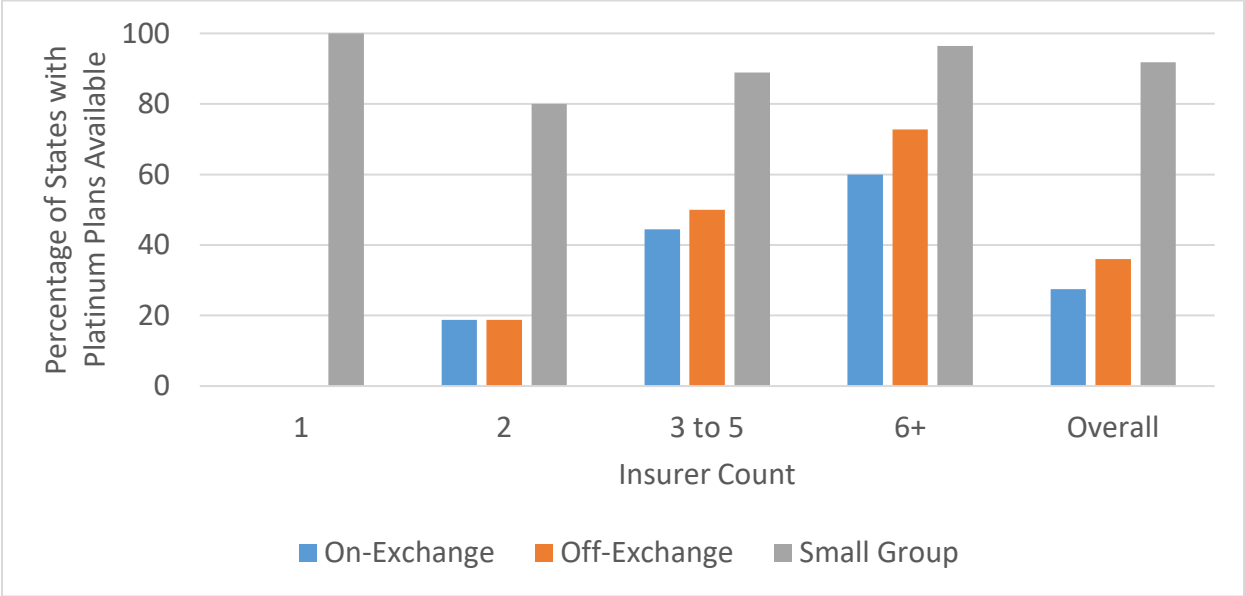
SOURCE: Authors' analysis of 2018 HIX Compare data, 2016 Center for Consumer Information and Oversight enrollment data, and 2010 NAIC report entitled, "Supplemental Health Care Exhibit Report." Accessed: https://www.naic.org/prod_serv/HCS-ZB_2010.pdf

NOTES

For 2010 NAIC data, the number of insurers in a state is restricted to those insurers who reported at least 50 covered lives during the filing year.

For 2018 HIX Compare data, the number of insurers is its billable member month weighted average across the state's rating areas, rounded to the nearest integer.

Appendix Exhibit 2: Percentage of States Where Platinum Plans Are Available by Market and Insurer Count



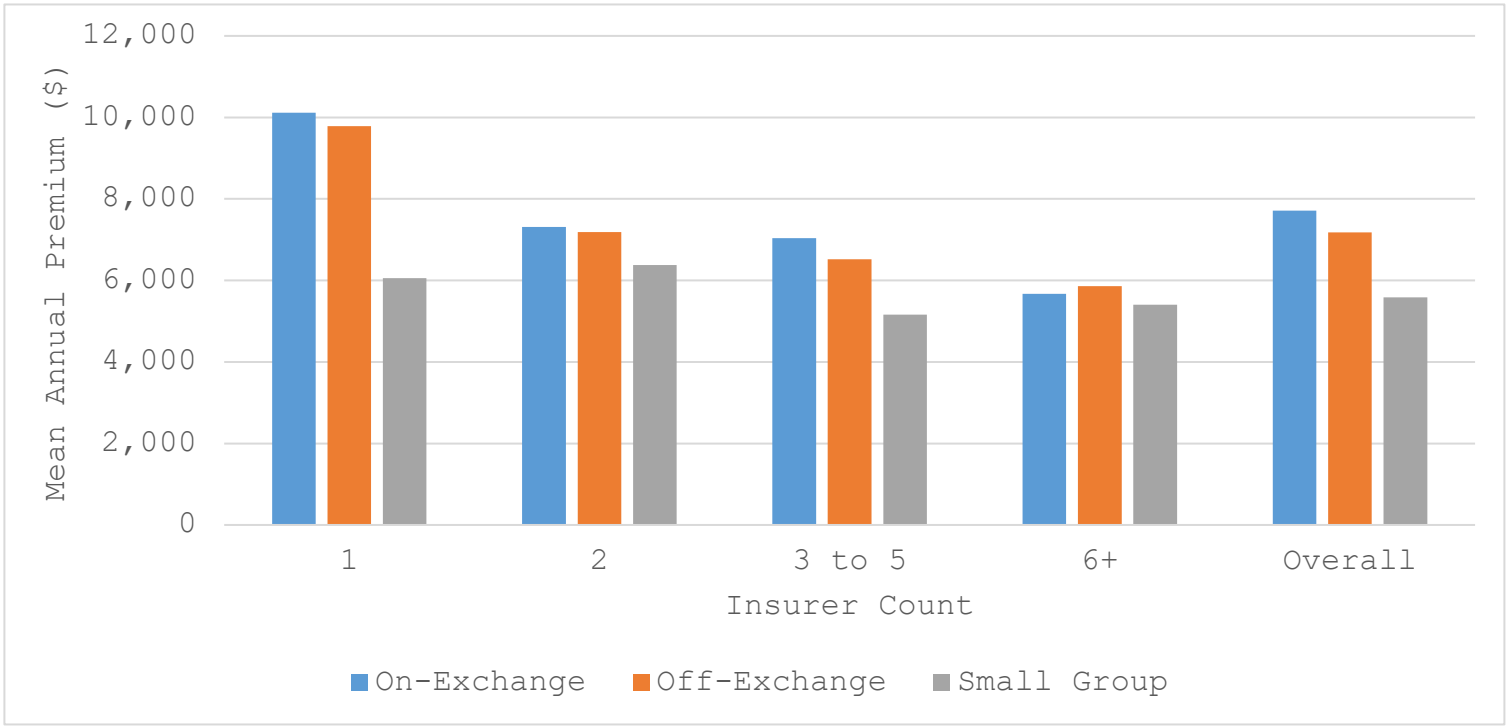
SOURCE: Authors' analysis of 2018 HIX Compare data and 2016 Center for Consumer Information and Oversight enrollment data.

NOTES:

The unit of observation is the state-market.
A state-market has a platinum plan available if at least 70% of its enrollees, weighted by billable member months, have access to a platinum plan.

A state-market insurer count is its billable member month weighted average of issuer counts across the state's rating areas.

Appendix Exhibit 3: Mean Annual Premiums for the Lowest-Priced Silver Plan by Market and Insurer Count

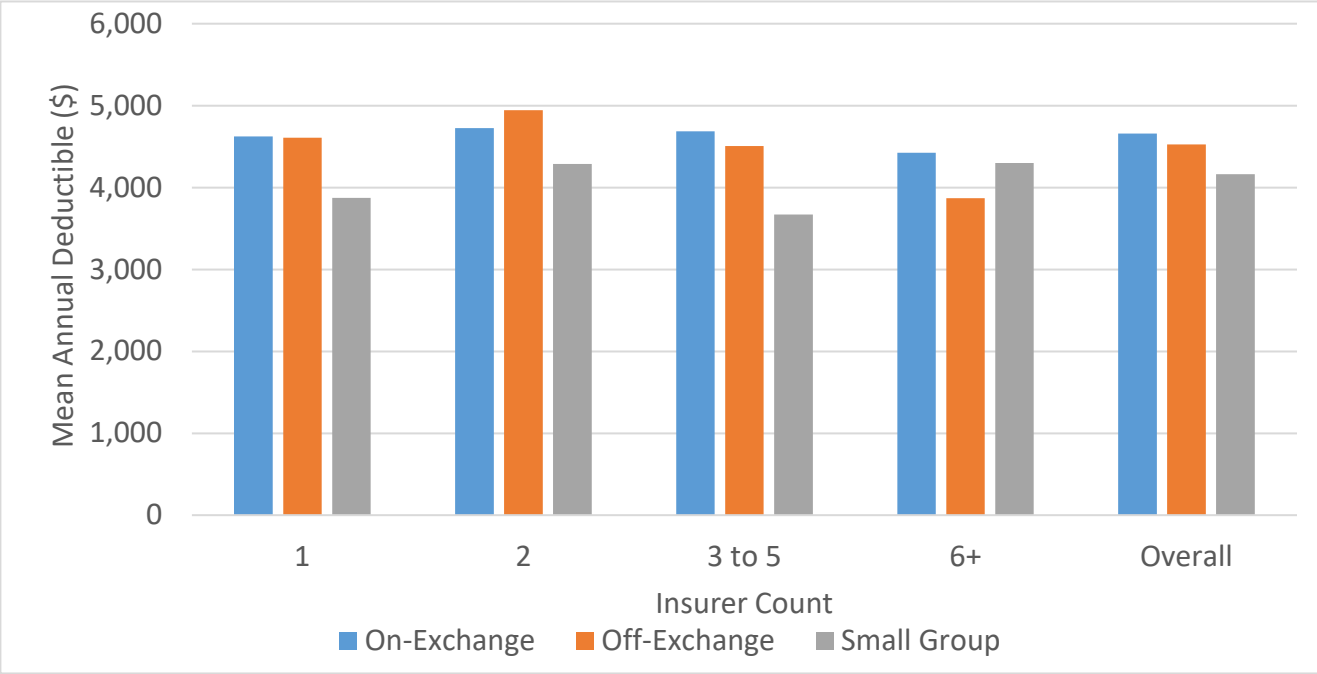


SOURCE: Authors' analysis of 2018 HIX Compare data and 2016 Center for Consumer Information and Oversight enrollment data.

NOTES:

The unit of observation is the state-market.
A state-market insurer count is its billable member month weighted average of insurer counts across the state's rating areas.
A state-market's premium is the billable member month-weighted average of premiums across rating areas for the lowest-priced silver plan.

Appendix Exhibit 4: Mean Annual Deductibles for the Lowest-Priced Silver Plan by Market and Insurer Count

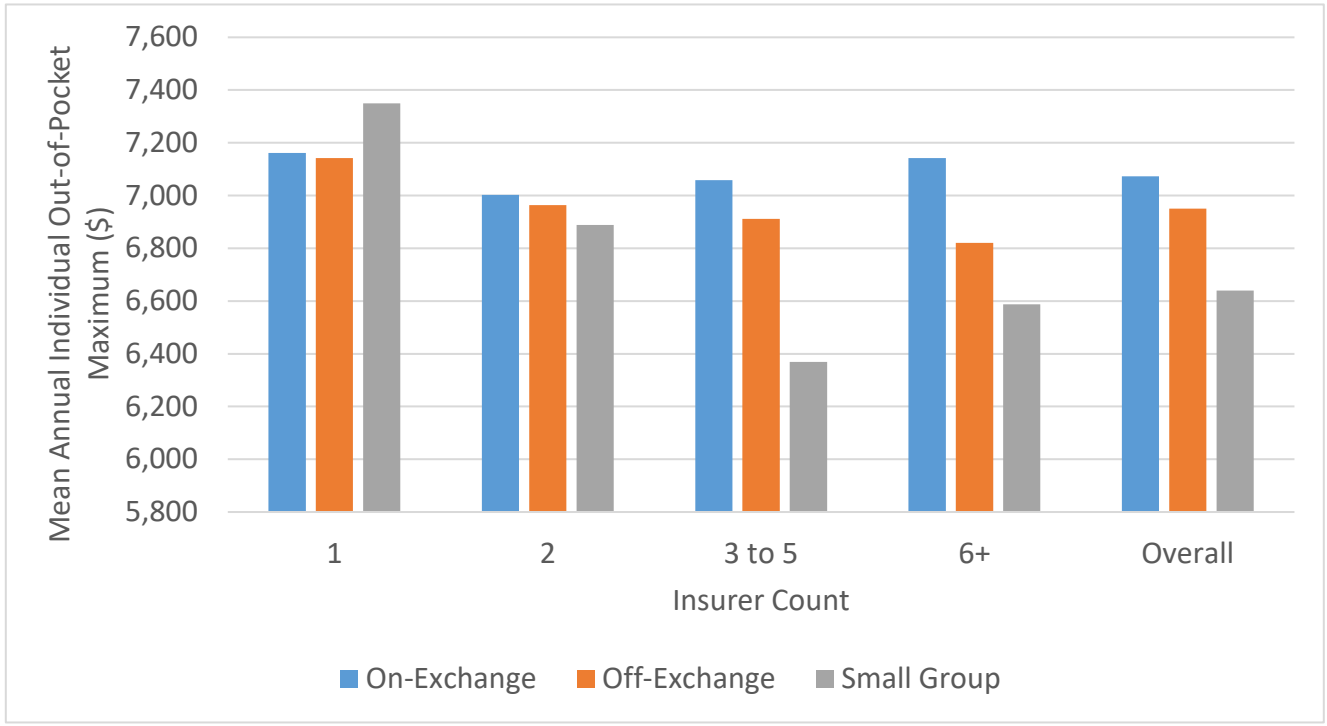


SOURCE: Authors' analysis of 2018 HIX Compare data and 2016 Center for Consumer Information and Oversight enrollment data.

NOTES:

The unit of observation is the state-market.
A state-market insurer count is its billable member month weighted average of issuer counts across its state's rating areas.
A state-market's annual deductible is the billable member month-weighted average of annual deductibles across rating areas for the lowest-priced silver plan.

Appendix Exhibit 5: Mean Annual Individual Out-of-Pocket Maxima for the Lowest-Priced Silver Plan by Market and Insurer Count



SOURCE: Authors' analysis of 2018 HIX Compare data and 2016 Center for Consumer Information and Oversight enrollment data.

NOTES:

The unit of observation is the state-market.
A state-market insurer count is its billable member month weighted average of insurer counts across its state's rating areas.

A state-market's out-of-pocket maximum is the billable member month-weighted average of out-of-pocket maxima across rating areas for the lowest-priced silver plan.