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Are Marketplace Plans Affordable? Consumer Perspectives from the Commonwealth Fund Affordable Care Act Tracking Survey, March–May 2015

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Abstract Most employers who provide health insurance to employees subsidize their premiums and provide a comprehensive benefit package. Before the Affordable Care Act, people who lacked health insurance through a job and purchased it on their own paid the full cost of their plans, which often came with skimpy benefit packages and high deductibles. Findings from the Commonwealth Fund Affordable Care Act Tracking Survey, March–May 2015, indicate that the law's tax credits have made premium costs in health plans sold through the marketplaces roughly comparable to employer plans, at least for people with low and moderate incomes. At higher incomes, the phase-out of the subsidies means that adults in marketplace plans have higher premium costs than those in employer plans. Overall, larger shares of adults in marketplace plans reported deductibles of $1,000 or more, compared with those in employer plans, though these differences were narrower among low- and moderate-income adults.

BACKGROUND

More than 150 million Americans receive health benefits from employers who substantially subsidize their cost.[1] Specifically, employers contribute an average 83 percent of premium costs and most offer plans with comprehensive benefit packages that cover an average 83 percent of employees' costs.[2] Before the Affordable Care Act, people who did not have health insurance through their jobs had to pay the full cost of their premium if they tried to buy it on their own. In addition, if they had preexisting health problems their premium cost could be higher or they could have their conditions excluded from their coverage. As a result, many people had high out-of-pocket costs: more than half of those enrolled in individual market policies

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in 2010 had plans that covered less than 60 percent of their costs.[3] Because of these factors, by 2010, nearly 50 million people were uninsured and 29 million were underinsured.[4]

The law's coverage expansions and market reforms were expressly designed to make coverage both affordable and comprehensive for people who lack job-based coverage, especially those with low and moderate incomes who made up the majority of the uninsured and underinsured.[5] Currently, about 23 million Americans have health insurance through the ACA's marketplaces or the Medicaid expansion.[6] More than eight of 10 (84%) of the nearly 10 million people enrolled in marketplace plans are paying for their premiums with the help of federal tax credits. More than half (56%) have cost-sharing subsidies that lower their deductibles and copayments.[7] All marketplace enrollees have health plans that meet the law's essential health benefit standard.

This issue brief uses the Commonwealth Fund Affordable Care Act Tracking Survey, March–May 2015, to examine the degree to which the coverage expansions have made health insurance that people buy through the marketplaces as affordable as employer plans. To do this, we compare premium costs and deductibles reported by adults enrolled in marketplace plans to those with employer plans. We also asked people if they think their plans and health care overall are affordable. Additional findings from the survey can be found in an online tool at http://www.commonwealthfund.org/aca-TrackingSurvey/index.html.

SURVEY FINDINGS

Premium Costs

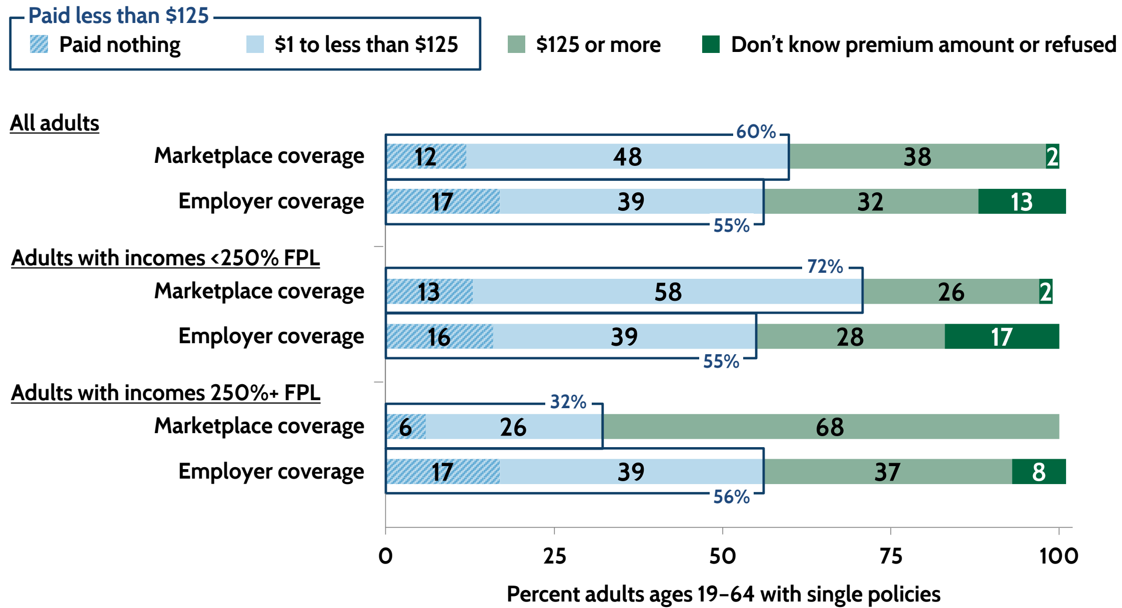
Among adults with insurance plans that only covered themselves (i.e., single policies), those with marketplace coverage reported premium costs similar to those with employer coverage. About 60 percent of adults with marketplace coverage and 55 percent with employer plans paid either nothing for their policies or less than $125 per month (Exhibit 1).

It is important to note that a larger share of adults with employer plans (13%) did not know the amount of their premium costs than did those with marketplace plans (2%).[8] This is likely because most people with employer health benefits receive and make premium contributions through their paychecks while those with marketplace plans shop for insurance and pay their premiums directly.

The similarities in premium costs reflect the fact that most people who purchased marketplace plans were eligible for premium tax credits. In the survey, 65 percent of people with marketplace coverage had incomes under 250 percent of the federal poverty level (i.e., less than $30,000 annually for a single person), and were thus eligible for the most generous premium subsidies (Appendix Table 1).[9] Seventy-two percent of these adults paid less than $125 a month toward their premiums, including 13 percent who paid nothing.[10] Fifty-five percent of adults in this income range in employer plans paid less than $125 per month, including 16 percent who paid nothing.

The experience for people with higher incomes is different. Adults with incomes between 250 percent and 400 percent of poverty (i.e., approximately $30,000 to $47,000 for a single person) receive smaller subsidies; those with income above 400 percent of poverty receive no subsidy and pay the full premium. In contrast, most people in employer plans receive premium contributions from their employers regardless of income level. This difference is evident in the findings: among adults with incomes of 250 percent of poverty or higher, 68 percent of those with marketplace coverage spent $125 a month or more on premiums compared with 37 percent of those in employer plans (Exhibit 1).

Exhibit 1. Adults with Marketplace Coverage with Incomes Under 250 Percent of Poverty Paid Monthly Premiums Comparable to Those with Employer Coverage



Note: FPL refers to federal poverty level. 250% of the poverty level is $29,175 for an individual or $59,625 for a family of four.
Bars may not sum to subtotals or to 100 percent because of rounding.
"All adults" includes adults who do not report their income and may therefore not be the average of adults below and above 250% FPL.
Source: The Commonwealth Fund Affordable Care Act Tracking Survey, March–May 2015.

Perceptions of the Affordability of Premium Costs

We asked people their personal views of the affordability of their premium costs. We limited the sample to those who paid all or part of their premium and knew the amount that they paid.

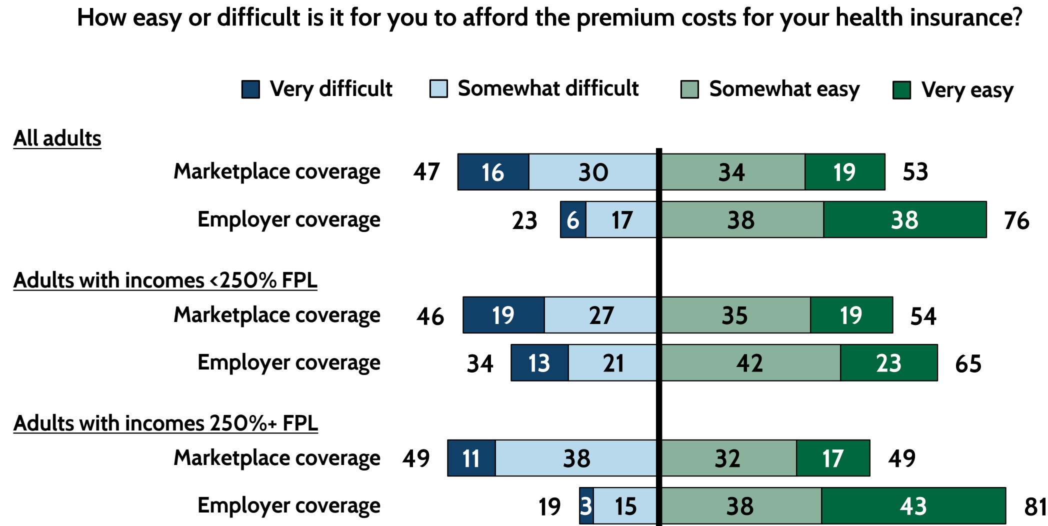
Overall, larger shares of adults in employer plans said it was very or somewhat easy to afford the premium costs for their health insurance compared to those with marketplace plans (Exhibit 2). People with higher incomes and employer coverage had the easiest time affording their premiums compared to virtually everyone else in the survey.

Deductibles

People with incomes between 100 percent and 250 percent of poverty who are enrolled in silver-level marketplace plans are eligible for cost-sharing reduction subsides that lower their deductibles, copayments, and out-of-pocket limits. (See box.) People with incomes from 100 percent to 150 percent of poverty receive the largest subsidies. In 2015, 56 percent of marketplace enrollees had cost-sharing subsidies. In Alabama and Mississippi, the share ranged above 70 percent.[11]

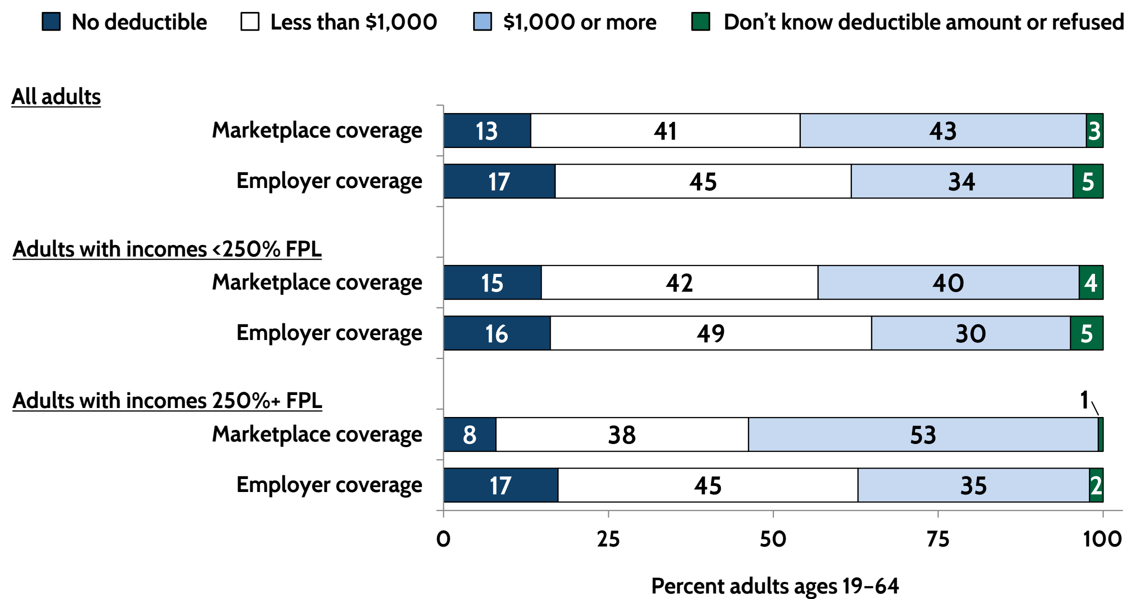
Overall, larger shares of adults with marketplace plans had per-person deductibles of $1,000 or more compared with adults in employer plans (43% vs. 34%) (Exhibit 3). There were differences by income: among adults with higher incomes (i.e., those at 250 percent of poverty or higher), more than half (53%) of those with marketplace coverage had a deductible of $1,000 or more compared with just over one-third (35%) of those with employer coverage. Adults with low and moderate incomes in marketplace plans reported deductibles that were more similar to those in employer plans. Forty percent of adults enrolled in marketplace plans with incomes under 250 percent of poverty had deductibles of $1,000 or higher compared with 30 percent of those enrolled in employer plans, and the difference was not statistically significant.

Exhibit 2. Adults with Employer Coverage Are More Likely Than Those with Marketplace Plans to Say It Is Easy to Afford Premiums



Note: FPL refers to federal poverty level. 250% of the poverty level is $29,175 for an individual or $59,625 for a family of four.
Bars may not sum to 100 percent because of "don't know" responses or refusal to respond; segments may not sum to subtotals because of rounding.
"All adults" includes adults who do not report their income and may therefore not be the average of adults below and above 250% FPL.
Source: The Commonwealth Fund Affordable Care Act Tracking Survey, March–May 2015.

Exhibit 3. Larger Shares of Adults with Marketplace Coverage Have Plans with High Deductibles Compared to Those with Employer Plans



Note: FPL refers to federal poverty level. 250% of the poverty level is $29,175 for an individual or $59,625 for a family of four.
Bars may not sum to 100 percent because of rounding; all deductibles are per-person deductibles.
"All adults" includes adults who do not report their income and may therefore not be the average of adults below and above 250% FPL.
Source: The Commonwealth Fund Affordable Care Act Tracking Survey, March–May 2015.

THE AFFORDABLE CARE ACT'S COST-SHARING REDUCTION SUBSIDIES

Under the reforms of the Affordable Care Act, health plans sold through the marketplaces, as well as in the individual and small-group markets outside the marketplaces, must meet an essential benefit standard. Plans are sold at four different "metal levels," which indicate the degree of cost protection. Bronze plans cover 60 percent on average of medical costs for those enrolled in the plan (this is also known as the "actuarial value" of the plan), silver plans cover 70 percent, gold plans cover 80 percent, and platinum plans cover 90 percent. People with incomes between 100 percent and 250 percent of poverty who purchase silver-level plans through the marketplaces are eligible for cost-sharing reduction subsidies that increase the actuarial value—that is, the cost protection—of their plans through lower deductibles and copayments. People with incomes between 100 percent and 149 percent of poverty are eligible for cost-sharing subsidies that increase the actuarial value of their plans to 94 percent; for those with incomes between 150 percent and 199 percent of poverty, it increases to 87 percent; and for those with incomes between 200 percent and 249 percent of poverty, it increases to 73 percent. In effect, people with the lowest incomes who buy silver plans have platinum-level cost protection.

But not everyone who is eligible for the subsidies is enrolled in a silver-level plan. We asked people with marketplace plans the metal level of their plan. Among those with incomes between 100 percent and 250 percent of poverty, 39 percent said they had a silver-level plan, which meant they received the cost-sharing reduction subsidies. But 24 percent of people at this income level said they were enrolled in bronze-level plans and thus did not receive subsidies. A quarter of adults in this income range did not know the metal level of their plan. Recent estimates by the consulting company Avalere Health suggest that about one-quarter of those eligible for the subsidies in marketplace plans did not receive them because they did not enroll in silver-level plans.[12]

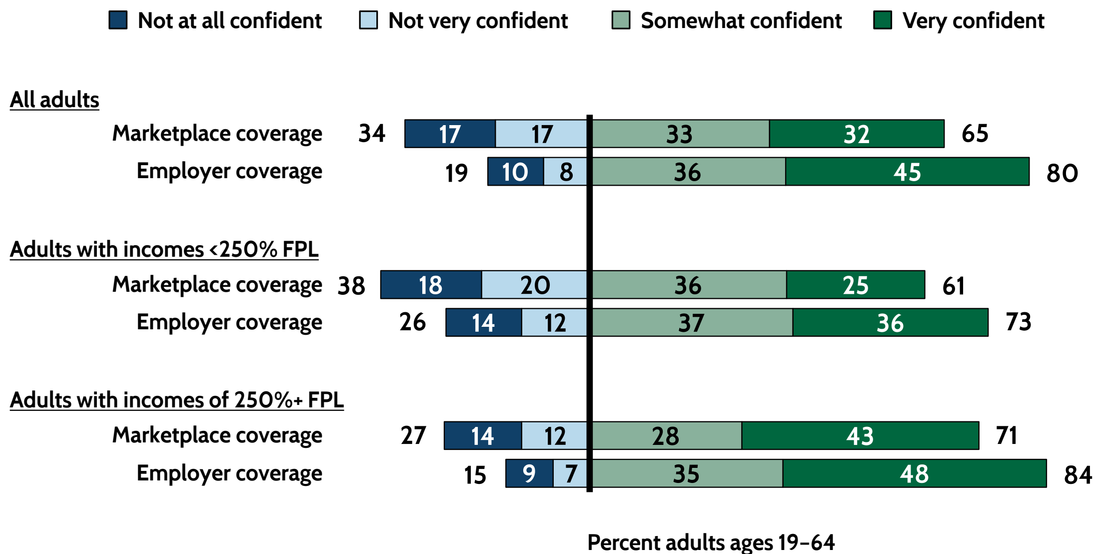
Some people who select bronze-level plans may do so because these plans have lower premiums, although higher deductibles, than silver-level plans. In a companion issue brief, 41 percent of adults who newly enrolled in marketplace plans or changed plans recently said the premium amount was the most important factor in choosing a plan, while 25 percent said the deductible and other copayment amounts were the most important.

In the survey, the cost-sharing subsidies had less of an effect on deductible size than premium tax credits had on people's premium cost. There are a few possible reasons for this. First, the largest cost-sharing reduction subsidies are available for people with incomes between 100 percent and 150 percent of poverty and phase out as incomes rise to 250 percent of poverty.[13] (See box.) Compared with the premium tax credits, which are available to people with incomes up to 400 percent of poverty, fewer people benefit from the cost-sharing subsidies. In addition, reducing the deductible amount is one of several ways that insurers can increase the cost protection of health plans. They also may reduce copayments, coinsurance, or out-of-pocket limits, none of which was asked about in the survey. Finally, about one of four adults in the survey with incomes in the range that make them eligible for cost-sharing subsidies enrolled in bronze-level plans. People in bronze plans are not eligible for cost-sharing subsidies and thus may have higher deductibles.

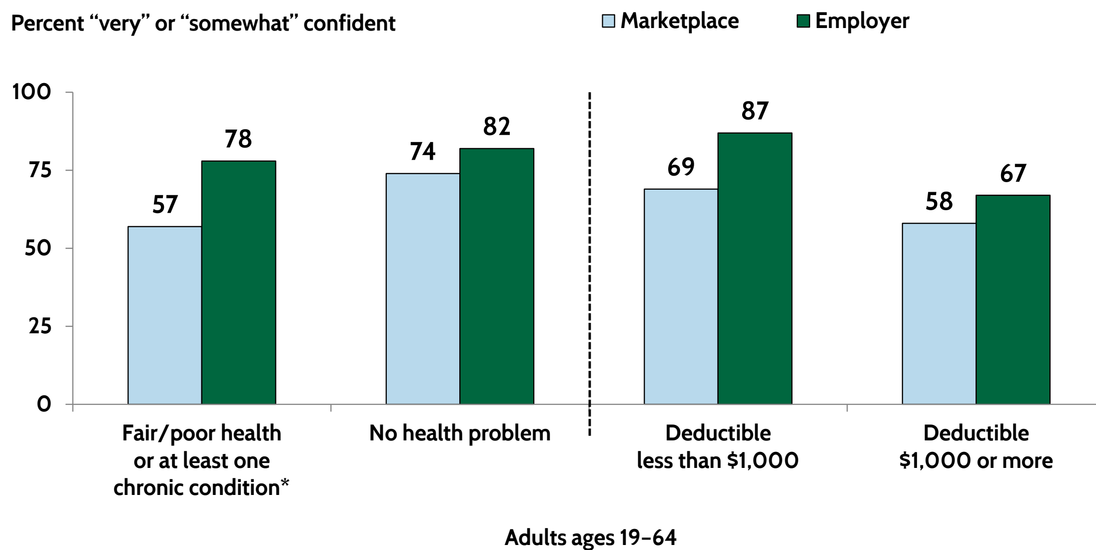
Confidence in Ability to Afford Health Care in the Future

We asked people about their confidence in their ability to afford care if they were to become seriously ill. Majorities of people with marketplace plans (65%) and employer plans (80%) were very or somewhat confident they could afford needed care if they became sick, but larger shares of those with employer plans expressed confidence (Exhibit 4).

Confidence varied by the health status of respondents and the design of their health plans. Adults with health problems in marketplace plans were less confident than those with health problems in employer plans that they could afford care in the future (Exhibit 5).[14] People with higher



Note: FPL refers to federal poverty level. 250% of the poverty level is $29,175 for an individual or $59,625 for a family of four.
Bars may not sum to 100 percent because of "don't know" responses or refusal to respond; segments may not sum to subtotals because of rounding.
"All adults" includes adults who do not report their income and may therefore not be the average of adults below and above 250% FPL.
Source: The Commonwealth Fund Affordable Care Act Tracking Survey, March–May 2015.

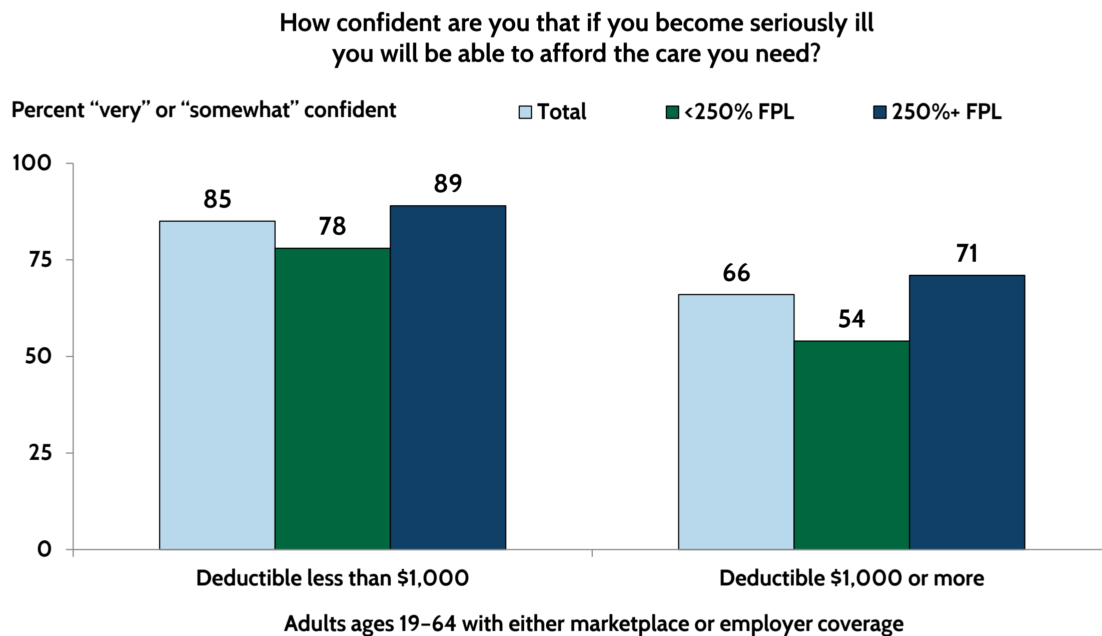


Notes: * Respondent reported having at least one of the following chronic conditions: hypertension or high blood pressure; heart disease; diabetes; asthma, emphysema or lung disease; high cholesterol; or depression or anxiety. All deductibles are per-person deductibles.
Source: The Commonwealth Fund Affordable Care Act Tracking Survey, March–May 2015.

deductibles in both employer and marketplace plans were less confident they could afford needed care in the future than were those with lower deductibles.[15]

Adults with low and moderate incomes with high deductibles were the least confident. Among people enrolled in high-deductible plans ($1,000 or more) either through an employer or the marketplace, only half (54%) of those with incomes under 250 percent of poverty were confident they could afford care if they became ill compared with 78 percent of those in that income range with a deductible of less than $1,000 (Exhibit 6).[16]

Exhibit 6. Adults with High-Deductible Health Plans with Incomes Under 250 Percent of Poverty Are Least Confident They Can Afford Care



Note: All deductibles are per-person deductibles.
Source: The Commonwealth Fund Affordable Care Act Tracking Survey, March–May 2015.

Ratings of Health Insurance

Overall, a majority of people with marketplace coverage said their insurance was good, very good, or excellent (70%) (Exhibit 7). Large shares of adults with employer coverage gave their health plans high ratings (86%).

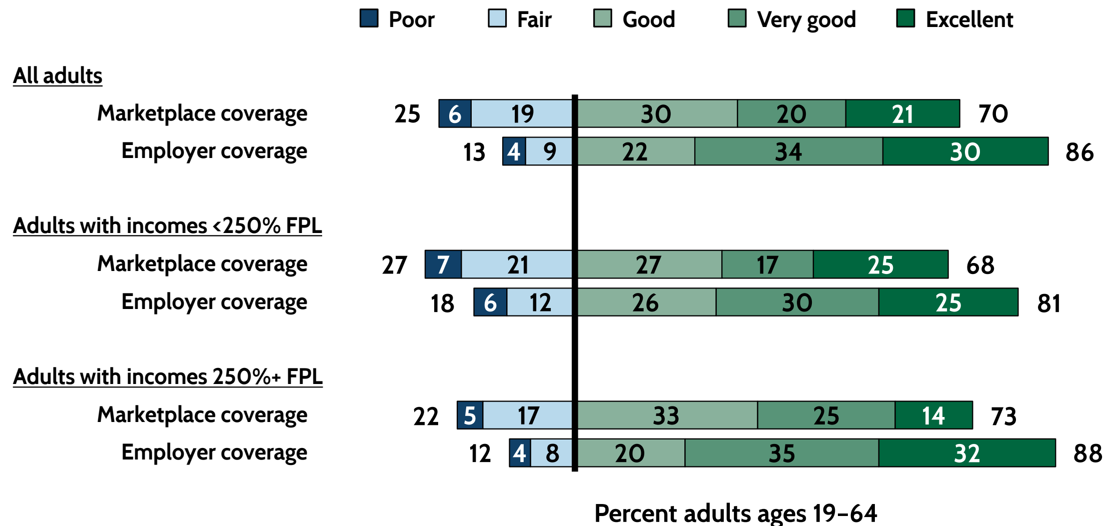
CONCLUSION

The survey findings indicate that the Affordable Care Act's subsidized coverage options have been effective in making individual market coverage comparable to employer-based health benefits in terms of affordability for people with low or moderate incomes. But at higher incomes, given the phase-out of the premium tax credits, people with marketplace coverage spend more on premiums compared to those with employer health benefits.

On average, larger shares of people with marketplace plans have high deductibles than those in employer plans, with the differences widest among enrollees with higher incomes. Among those

Exhibit 7. Seven of 10 Adults with Marketplace Plans Rate Their Coverage as Excellent, Very Good, or Good

Now thinking about (your current health insurance coverage/ all the health insurance you have combined), how would you rate it?



Note: FPL refers to federal poverty level. 250% of the poverty level is $29,175 for an individual or $59,625 for a family of four.
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Source: The Commonwealth Fund Affordable Care Act Tracking Survey, March–May 2015.

with lower incomes, the cost-sharing reduction subsidies appear to have had the effect of narrowing the difference in deductibles between those in marketplace plans and employer plans. Still, a large share of people with low and moderate incomes in marketplace plans have deductibles of more than $1,000. This is the result in part of the phase-out of subsidies at relatively low incomes, because many people in this income range selected lower-premium bronze-level plans and thus did not receive the subsidies, and because insurers also increase cost protection by lowering copayments, coinsurance, and out-of-pocket limits which are not explored in the survey. We know from the results reported in our companion issue brief that premium cost factors more heavily than do deductible size and copayments when people are choosing health plans.

Consistent with recent research by The Commonwealth Fund, the growing use and size of deductibles in both employer and marketplace plans as a means to lower premiums threatens to undermine the gains Americans have made in coverage since 2014.[17] The House of Representatives has sued the Obama Administration over its funding of the cost-sharing subsidies, which, if the plaintiffs were to prevail, could lead to even higher deductibles and greater out-of-pocket cost exposure for people with low and moderate incomes enrolled in marketplace plans.[18] Adults in high-deductible health plans are less confident in their ability to pay for their care if they were to become seriously ill compared to those with lower deductibles. People with the lowest incomes in these plans are the most at risk of spending large amounts of their income on medical care. Their lack of confidence about the future suggests they are aware of their financial vulnerabilities. In an economy that is still struggling to deliver significant wage gains to working families, ever higher cost-sharing in health plans will further degrade their financial security.

HOW THIS SURVEY WAS CONDUCTED

The Commonwealth Fund Affordable Care Act Tracking Survey, March–May 2015, was conducted by SSRS from March 9, 2015, to May 3, 2015. The survey consisted of 16-minute telephone interviews in English or Spanish and was conducted among a random, nationally representative sample of 4,881 adults, ages 19 to 64, living in the United States. Overall, 2,203 interviews were conducted on landline telephones and 2,678 interviews on cellular phones, including 1,729 with respondents who lived in households with no landline telephone access. To view the survey questionnaire, please click here.

This survey is the third in a series of Commonwealth Fund surveys to track the implementation and effects of the Affordable Care Act. The first was conducted by SSRS from July 15 to September 8, 2013, by telephone among a random, nationally representative U.S. sample of 6,132 adults ages 19 to 64. The survey had an overall margin of sampling error of +/– 1.8 percent at the 95 percent confidence level.

The second survey in the series was conducted by SSRS from April 9 to June 2, 2014, by telephone among a random, nationally representative U.S. sample of 4,425 adults ages 19 to 64. The survey had an overall margin of sampling error of +/– 2.1 percent at the 95 percent confidence level. The sample for the April–June 2014 survey was designed to increase the likelihood of surveying respondents who were most likely eligible for new coverage options under the ACA. As such, respondents in the July–September 2013 survey who said they were uninsured or had individual coverage were asked if they could be recontacted for the April–June 2014 survey. SSRS also recontacted households reached through their omnibus survey of adults who were uninsured or had individual coverage prior to the first open enrollment period for 2014 marketplace coverage.

The March–May 2015 sample also was designed to increase the likelihood of surveying respondents who had gained coverage under the ACA. SSRS also recontacted households reached through their omnibus survey of adults between November 5, 2014, and February 1, 2015, who were uninsured, had individual coverage, had a marketplace plan, or had public insurance. These households were then recontacted for the March–May 2015 survey. All waves of the survey oversampled adults with incomes under 250 percent of poverty to further increase the likelihood of surveying respondents eligible for the coverage options as well as allow separate analyses of responses of low-income households. The measure used to designate insurance type was modified in 2015 using new follow-up questions that were asked of those adults who reported having more than one type of coverage.

The data are weighted to correct for the stratified sample design, the use of recontacted respondents from the omnibus survey, the overlapping landline and cellular phone sample frames, and disproportionate nonresponse that might bias results. The data are weighted to the U.S. 19-to-64 adult population by age, gender, race/ethnicity, education, household size, geographic division, and population density using the U.S. Census Bureau's 2013 American Community Survey and weighted by household telephone use using the U.S. Centers for Disease Control and Prevention's 2014 National Health Interview Survey.

The resulting weighted sample is representative of the approximately 187.8 million U.S. adults ages 19 to 64. Data for income, and subsequently for federal poverty level, were imputed for cases with missing data, utilizing a standard regression imputation procedure. The survey has an overall margin of sampling error of +/– 2.1 percentage points at the 95 percent confidence level. The landline portion of the main-sample survey achieved a 16.9 percent response rate and the cellular phone main-sample component achieved a 13.3 percent response rate. The overall response rate, including the recontacted sample, was 12.8 percent.

Notes

1. Analysis of 2014 Current Population Survey by Sherry Glied and Claudia Solis-Roman of New York University for The Commonwealth Fund.

2. J. R. Gabel, R. Lore, R. D. 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; and Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999–2015, http://kff.org/report-section/ehbs-2015-section-six-worker-and-employer-contributions-for-premiums/.

3. Gabel, Lore, McDevitt et al., "More Than Half of Individual Health Plans," 2012.

4. 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* (New York: The Commonwealth Fund, May 2015).

5. S. R. Collins, R. Robertson, T. Garber, and M. M. Doty, *Insuring the Future: Current Trends in Health Coverage and the Effects of Implementing the Affordable Care Act* (New York: The Commonwealth Fund, April 2013).

6. As of June 30, 2015, about 9.9 million Americans had paid for health insurance coverage purchased through the marketplaces (https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-09-08.html). As of June 2015, nearly 13.1 million additional individuals had enrolled in Medicaid and CHIP since October 2013, the start of the first marketplace open enrollment period (http://www.medicaid.gov/medicaid-chip-program-information/program-information/downloads/june-2015-enrollment-report.pdf).

7. Centers for Medicare and Medicaid Services, June 30, 2015, "Effectuated Enrollment Snapshot," https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-09-08.html.

8. Included in this response are some people who refused to answer the question.

9. Premium costs for people with incomes between 100%–249% of poverty are capped at 2.01% to 8.1% of income. Contributions increase to 9.56% at 300%–400% of poverty.

10. A small number of adults in marketplace plans had incomes under 100 percent of poverty. People in this income range might plausibly be enrolled in marketplace plans if they were legal residents in the five-year waiting period for Medicaid, in which case they would be eligible for subsidies under the ACA, or if they were living in a state that had not expanded eligibility for Medicaid and were able to buy a private plan. It is also possible that some people's income estimates in the survey were inconsistent with the income on which their eligibility was based, or had changed since they enrolled. Results were not sensitive to removal of this group from the sample.

11. CMS, "Effectuated Enrollment Snapshot," 2015.

12. E. Carpenter, "More Than 2 Million Exchange Enrollees Forgo Cost-Sharing Assistance," Avalere, Aug. 19, 2015, http://avalere.com/expertise/managed-care/insights/more-than-2-million-exchange-enrollees-forgo-cost-sharing-assistance.

13. In an analysis of 2015 marketplace plans in states with federal marketplaces, the Kaiser Family Foundation found that the average deductible for silver-level plans was $2,559. Average deductibles declined to $2,078 for people with incomes between 200%–249% of poverty who enrolled in silver plans; $737 for those with incomes between 150%–199% of poverty, and $229 for those with incomes between 100%–149% of poverty. See http://kff.org/health-costs/issue-brief/cost-sharing-subsidies-in-federal-marketplace-plans/.

14. Hypertension or high blood pressure; heart disease; diabetes; asthma, emphysema or lung disease; high cholesterol; or depression or anxiety.

15. Among adults enrolled in marketplace plans, the difference in confidence in ability to afford health care between those with high and low deductibles was not statistically significant.

16. Because of sample size limitations, we grouped adults in employer and marketplace plans for this analysis.

17. Collins, Rasmussen, Beutel, and Doty, *Problem of Underinsurance,* 2015.

18. S. Rosenbaum, "The House of Representatives Sues Secretary Burwell, Round One," *The Commonwealth Fund Blog,* Sept. 24, 2015.

Appendix Table 1. Demographics of Adults Enrolled in Employer-Sponsored Insurance, the Marketplace, or Medicaid, and Uninsured Adults

	Total adults (19–64)	Enrolled in employer-sponsored insurance	Enrolled in a private health plan through the marketplace	Enrolled in Medicaid for less than two years	Uninsured adults
Unweighted n	4,881	2,316	458	344	702
Age					
19–34	32	28	31	46	47
35–49	32	32	31	32	31
50–64	34	37	36	22	21
Race/Ethnicity					
Non-Hispanic White	62	70	51	50	42
Black	13	11	15	15	18
Latino	17	11	26	31	33
Asian/Pacific Islander	4	4	6	1	3
Other/Mixed	3	2	2	2	3
Poverty Status					
Below 138% poverty	30	12	27	63	55
138%–249% poverty	19	17	37	23	23
250%–399% poverty	14	19	14	6	9
400% poverty or more	27	43	17	1	5
Undesignated	10	10	5	7	8
Health Status					
Fair/Poor health status, or any chronic condition or disability^	53	47	52	61	54
No health problem	47	53	48	39	46
Political Affiliation					
Democrat	31	32	37	29	24
Republican	18	22	14	9	11
Independent	24	23	24	32	26
Something else	18	16	17	19	22
State Medicaid Expansion Decision*					
Expanded Medicaid	58	60	54	73	43
Did not expand Medicaid	41	39	45	27	57
Marketplace Type**					
State-based marketpalce	36	36	35	39	30
Federally facilitated marketplace	64	63	64	61	70
Adult Work Status					
Full time	51	69	48	18	39
Part time	14	11	21	27	14
Not working	35	20	31	55	46
Employer Size^^					
1–24 employees	27	15	54	35	52
25–99 employees	12	9	13	28	19
100–499 employees	14	16	10	13	12
500 or more employees	44	57	20	21	14

* The following states expanded their Medicaid program and began enrolling individuals in March 2015 or earlier: AR, AZ, CA, CO, CT, DE, HI, IA, IN, IL, KY, MA, MD, MI, MN, ND, NH, NJ, NM, NV, NY, OH, OR, PA, RI, VT, WA, WV, and the District of Columbia. All other states were considered to have not expanded.
** The following states have state-based marketplaces: CA, CO, CT, HI, ID, KY, MA, MD, MN, NM, NV, NY, OR, RI, VT, WA, and the District of Columbia. All other states were considered to have federally facilitated marketplaces.
^ At least one of the following chronic conditions: hypertension or high blood pressure; heart disease; diabetes; asthma, emphysema, or lung disease; or high cholesterol.
^^ Base: Full- and part-time employed adults ages 19–64.
Source: The Commonwealth Fund Affordable Care Act Tracking Survey, March–May 2015.

About the Authors

Sara R. Collins, Ph.D., is vice president for Health Care Coverage and Access at The Commonwealth Fund. An economist, Dr. Collins joined the Fund in 2002 and has led the Fund's national program on health insurance since 2005. Since joining the Fund, she has led several national surveys on health insurance and authored numerous reports, issue briefs, and journal articles on health insurance coverage and policy. She has provided invited testimony before several Congressional committees and subcommittees. Prior to joining the Fund, Dr. Collins was associate director/senior research associate at the New York Academy of Medicine. Earlier in her career, she was an associate editor at *U.S. News & World Report,* a senior economist at Health Economics Research, and a senior health policy analyst in the New York City Office of the Public Advocate. Dr. Collins holds a Ph.D. in economics from George Washington University.

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