Impact of a $150 Prescription Drug Cost Sharing Cap on Silver Tier Individual Exchange Plans

Prepared by
Milliman, Inc., NY

Gabriela Dieguez, FSA, MAAA
Principal and Consulting Actuary

Bruce Pyenson, FSA, MAAA
Principal and Consulting Actuary

Katherine Simon
Actuarial Analyst

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EXECUTIVE SUMMARY

Prescription drug coverage in the health exchanges has become more complex since its launch in 2014, with drug formularies offering several tiers of cost sharing levels for different medications[1]. Most formularies in the exchanges use four and five tiers, and drugs in higher tiers are commonly subject to patient coinsurance[2]. Within a metallic level, different plan designs can mean people have to pay more or less to obtain prescription drugs. This paper examines potential changes to plan designs that would make it less expensive for some people to obtain prescription drugs.

The Leukemia & Lymphoma Society (LLS), which funded this study, asked us to evaluate a policy change to Silver plans whereby plan members would pay a maximum of $150 out-of-pocket per 30 day supply of any prescription drug, regardless of whether that member reached the plan deductible. This report builds on an analysis published in March, 2015, *Pharmacy Cost Sharing Limits for Individual Exchange Benefit Plans: Actuarial Considerations*[3], projecting the impact of an out-of-pocket cap on premiums and patient cost sharing. This report extends the study period through 2018, measuring the impact of the cap under different trend scenarios. Our analysis shows that:

- Assuming no other changes to benefit design, a $150 prescription drug cost sharing cap per script for a typical Silver plan in the individual market would increase monthly premiums by about 0.7%, or less than $3 per month,

The average out-of-pocket costs per member would decrease by about 2.1%, or less than $3 per month. The table below summarizes the projected impact of a $150 cost sharing cap per script on typical Silver plan monthly premium levels for the individual market, nationwide.

Projected Monthly Premium Impact of a $150 Per-script Cost Sharing Cap

Plan Year	Average Increase in Monthly Premium
2016	$2.50 (0.7%)
2017	$2.70 (0.8%)
2018	$2.90 (0.8%)

We examined two options for offsetting the premium increases caused by the cap, including benefit design changes and annual indexing of the cap amount. We found that relatively modest changes in benefits could partially offset the premium increases caused by the introduction of the cap.

For a fixed $150 cap, the premium would be expected to increase 0.7% in 2016, or 0.8% in either 2017 or 2018. However, indexing the $150 cap at a rate similar to the prescription drug trend would largely eliminate the need for future premium increases to fund the cap beyond the initial impact, assuming no change in the utilization of drugs that exceed the cap. Many blood cancers are treated with prescription drugs for which the out-of-pocket cost could become less expensive to patients if the changes we analyzed were adopted. Others, including people with other conditions, could pay more in total out-of-pocket costs with plans containing the $150 cap if those individuals do not utilize high cost drugs. For example, a plan that increases the physician copay to offset the impact of the $150 drug cap could become more expensive to members that use physician services but do not use high cost drugs. However, our modeling indicates that only small copay increases (such as a $5 increase to a primary care physician visit copay) are needed to approximately offset the increased plan costs resulting from the cap.

This report was commissioned by The Leukemia & Lymphoma Society (LLS), an organization that exists to find cures and ensure access to treatment for blood cancer patients. LLS received funding from Pfizer and Celgene for this report. This report should not be interpreted as an endorsement of any particular legislation by Milliman or the authors. Bruce Pyenson and Gabriela Dieguez are members of the American Academy of Actuaries and meet the qualification standards to issue this report. The report reflects the authors' findings and opinions. Because extracts of this report taken in isolation can be misleading, we ask that this report be distributed only in its entirety.

BACKGROUND

Plans sold in the health exchanges must meet many rules; benefit designs must provide essential health benefits and must meet "actuarial value" requirements. To promote competition and to make the products sold by different companies easier for the consumer to compare, only four "metallic" plans are permitted: Platinum, Gold, Silver and Bronze. Plans falling into a metallic level must meet well-defined actuarial value tests. The actuarial value of a health plan approximates the percent of essential health benefit costs that the plan will cover. The four plans and their actuarial values are:

Figure 1 – Actuarial Value Ranges for Metallic Plans Sold in the Exchanges

Metallic Level	Actuarial Value Range
Bronze	58%-62%
Silver	68%-72%
Gold	78%-82%
Platinum	88%-92%

This report focuses on Silver plans, the most commonly purchased among the plans in the exchanges. In 2016, 71% of members enrolled in plans sold through the Federally Facilitated Marketplace (FFM) were enrolled in Silver plans.[4] Silver plans cover about 70% of costs while beneficiaries are responsible for about 30% in the form of patient cost-sharing, unless they qualify for cost sharing reduction (CSR).[1]

In most states, a variety of plan designs can meet metallic level requirements. Some patient advocates, who believe that affordable access to prescription drugs has important public health implications, have pointed out that people can pay more or less to obtain prescription drugs depending on which design they choose, even within a metallic level. This paper examines potential changes to the benefit designs that would make it less expensive for some people to obtain prescription drugs.

Prescription drug tiers in insurance benefits are used to vary the patient cost-sharing level by covered drug. In commercial health plans, drug benefits have historically been structured around three or four tiers with increasing patient cost sharing:

- Generics
- Preferred brands
- Non-preferred brands
- Specialty (In three tier structures, specialty may be within preferred or non-preferred brand tiers)

The use of four or more tiers has become more common in recent years. The highest priced drugs are often placed on the highest tiers where patients may be required to pay a percentage of the cost of the drug (coinsurance) rather than a flat copayment[5]. The prevalence of coinsurance for drugs placed on specialty tiers in Exchange plans increased in 2015, and plans used higher coinsurance amounts. Among non-CSR Silver exchange plans, the portion with patient coinsurance greater than 30% for specialty medications increased from 27% to 33% between 2015 and 2016.[6][7]

High prescription cost sharing has been shown to be associated with patients' reduced adherence to the prescribed treatment regimen. There is some evidence that reduced adherence leads to poorer health outcomes.[8] [9] [10] [11] In response, some states have limited cost-sharing for prescription drugs in commercial plans. Examples include:

[1] CSR plans are available to members enrolling through the exchanges who qualify for financial assistance with cost sharing, and the actuarial value is more generous for these types of plans than for those available through the Silver non-CSR plans.

- Per prescription out-of-pocket caps for specialty drug spending – Laws in Delaware, Maryland, and Louisiana set a limit on member cost sharing per 30 day supply of a specialty drug. These limits apply after the plan's deductible has been met.[12] [13] [14] [15]
- Per prescription out-of-pocket caps for all drug spending – A law in California sets limits on the member cost sharing per 30 day supply of any prescription medication. These limits apply after the plan's deductible has been met. The law also sets limits on pharmacy deductibles.[16]
- Limitations on use of a specialty tier – In 2010, New York enacted a law prohibiting drug cost sharing that exceeds the amount required for a non-preferred tier, preventing health plans from creating a specialty drug cost sharing tier.[17] [18]

Other states, including Connecticut, Massachusetts and Virginia, have proposed legislation that would limit member cost sharing for prescription drugs with caps as low as $100 per 30 day supply. While some of these efforts impact only cost sharing limits for specialty drugs, the benefit changes we model in this report apply to all prescription drugs, including generics, brands, and specialty drugs.

We previously examined the impact of several plan design changes on out-of-pocket costs for different types of patients in a report published March 5, 2015.[19] This report builds on that work, and focuses on the impact on member premium of a theoretical $150 per-script pre-deductible cost sharing cap for members enrolled in individual healthcare exchange Silver plans. The amount of the cap is consistent with the out-of-pocket laws enacted in Delaware[20], Louisiana[21], and Maryland[22], although the limit in these states applies post-deductible.

Patient advocates have argued that high deductibles may cause patients to forgo necessary care due to the high upfront expenses[23] [24]. As modeled here, the $150 pre-deductible cap is designed to reduce the high cost sharing prescription drug users often have to pay, especially those who must meet a high deductible before a health plan covers their out-of-pocket expenses.

In this report we examine possible steps to limit increases in premiums that may be triggered by the adoption of a $150 cap. For the purposes of this paper, we considered benefit design changes allowing plans to limit the premium increase to 0.5% or less, which we labeled as a minimal increase, as potential solutions, and we consider that such solutions would approximately offset what would otherwise be an increase in premium. We recognize others may choose a higher or lower threshold for "minimal," and that, in some circumstances an increase of 0.5% may be significant to a plan or to some of its members.

If a fixed $150 cap is applied to years beyond 2016, premium increases would likely accelerate. This is because prescription drug spending is expected to increase, which will cause more scripts and higher prices to be absorbed by the payer. One way to ameliorate this acceleration is to increase or index the cap with an inflation metric such as the annual trend for prescription drug spending. We analyzed years 2016 through 2018 assuming a $150 cap with and without indexing. Given uncertainty in future pharmacy trends, we estimated the impact of the $150 cap in 2017 and 2018 under two different prescription drug spending trend scenarios: 1) prescription drug and medical spending increase at the same rate and 2) prescription drug spending increases at a higher rate than medical spending. We modeled medical spending trends at an annual rate of 4%, and prescription drug spending trends at an annual rate of either 4% or 8%. Although the trends chosen are illustrative, the 4% annual increase is consistent with the 2014 increase in private health insurance spending reported by CMS[25], which includes both medical and pharmacy.

FINDINGS

The purpose of this study was to model the impact of a $150 per prescription cost sharing limit on Silver plans and determine its impact on member out-of-pocket spending (for both medical and pharmaceutical services) and premiums. The $150 cap on member cost sharing would apply to any 30 day supply script, including generic drugs, and would take effect regardless of whether or not a member has met their deductible. Member spending on prescription drugs up to the cap would accumulate towards the deductible and out-of-pocket maximum.

In a report published March 5, 2015, we examined the impact of a $150 per prescription cost sharing cap on member out-of-pocket costs for several different types of patients[26]. This report does not address the specific decreases in out-of-pocket spending for different types of members and focuses instead on the average impact of the cap on member premium and on cost sharing across plan members.

Premiums and Total Cost Impact to Silver Plan Members

Premiums are based primarily on plan spending on benefits, which rises if member cost sharing decreases. Therefore, we expect premiums to increase by about the same amount as the average reduction in member cost sharing.[2] However, to the extent that the reduced members cost sharing is accompanied by a higher use of the benefits, the average premium increase may exceed the average reduction in member cost sharing.

Premiums also include non-benefit items such as administrative costs, profit, and taxes, so the increase in premium should be slightly higher than the average reduction in member cost sharing. Therefore, the plan member, *on average*, is expected to see very little change in their total expected annual healthcare spending (premiums plus out-of-pocket costs) upon implementation of the cap. Figure 2 shows the estimated change in monthly premium as a result of the $150 per-prescription cost sharing cap across all three years, holding all other benefits constant, and assuming the plan passes the extra cost to the member.

Figure 2 – Per Member Per Month (PMPM) Impact of a $150 Cap on Typical Silver Plan Premiums, 2016-2018

Per Member Per Month Estimated Premium[iii] [iv] Typical Silver Plan				
	No Cap	With $150 Per-Script Cap	Difference	
			PMPM	Percent
2016	$334.80	$337.30	$2.50	0.7%
2017	$348.60	$351.30	$2.70	0.8%
2018	$362.80	$365.70	$2.90	0.8%

The increase in premium remains small across all three years, ranging from $2.50 per month or $30 per year in 2016 to a maximum of $2.90 per month or approximately $35 per year in 2018. Older members and those living in high cost areas, who typically pay higher premiums, may see higher increases and vice versa.

While the impact of this cap on a Silver plan appears to be relatively small, it would likely increase for plans with higher deductibles and less favorable prescription drug cost sharing for the member, such as Bronze plans. Likewise, the premium impact would decrease for a plan with more generous cost sharing, such as Gold or Platinum plans. We did not quantify that impact in this analysis.

[2] Premiums are expected to rise slightly more than the reduction in member cost sharing due to retention loadings applied by insurance companies to the plan's claim costs. These include loadings for administrative expenses, risk, and profit, among others.

[iii] Medical and prescription drug costs trended at 4% annually.

[iv] Assuming plan applies 15% load for retention and that all loadings are included in this retention.

Potential Benefit Reductions to Offset Increased Plan Costs

Although our simulations show that premiums are expected to increase by between 0.7% and 0.8% for all three years as a result of the cap, we tested some potential changes an insurer could make to plan designs to partially offset the potential increases. We consider benefit design changes to have minimal premium impact if the new plan's rates are not expected to increase by more than 0.5% of the original premium. Figure 3 illustrates the required increase in copay for primary care physician (PCP) visits and generic drugs to approximately offset the impact of the $150 prescription drug cost sharing cap and limit premium increases to less than 0.5%. We note that other benefit changes are possible to achieve the same savings.

Figure 3 –Benefit Design Changes to Offset Premium Increases Due to Out-of-Pocket Cap

	Premium Neutral Changes Needed
2016	+$5 Primary Care Physician Visit Copay +$1 Generic Prescription Drug Copay
2017	+$5 Primary Care Physician Visit Copay +$1.50 Generic Prescription Drug Copay
2018	+$5 Primary Care Physician Visit Copay +$2 Generic Prescription Drug Copay

Even as medical and prescription drug costs increase over time, only small copay increases in other benefits are necessary to approximately offset premium increases resulting from the $150 cap.

Alternative Trend Scenario

To address the uncertainty of future prescription drug costs, we estimated the impact of the $150 per-prescription cap if prescription drug costs increase at a higher rate than medical trends. For illustrative purposes, we examined a scenario where prescription drugs increased at a rate double that of medical trends. In this case, we set medical costs to increase at 4% annually and prescription drugs to increase at 8% annually. Figure 4 shows the impact on premiums of the $150 per-prescription cap on an average member under this scenario, as well as the benefit changes necessary to maintain the premium increases to 0.5% or less.

Figure 4 – Impact on Premiums for Typical Silver Plan of $150 per Script Cap, Prescription Drugs Trended at 8%

Per Member Per Month Estimated Premium					
Prescription Drug Costs at 8% Annual Trend, Medical Costs at 4% Annual Trend					
	No Cap	**With $150 Per-Prescription Cap**	**Difference**		**Changes Needed to Maintain Premium Increases to 0.5% or less**
2017	$351.20	$354.00	$2.80	0.8%	+$5 PCP Copay +$1.50 Generic Copay
2018	$368.20	$371.30	$3.10	0.8%	+$5 PCP Copay +$2.50 Generic Copay

If prescription drug costs increase at double the assumed 4% annual medical trend rate, the impact of the $150 cap on premiums is small. In 2017, premiums would be estimated to increase only 10 cents more per month than in the lower trend scenario, and in 2018 the additional premium would only be 20 cents more per month than the in original scenario.

We performed additional sensitivity testing to determine the impact of the cap if specialty or brand drug costs were to increase at very high rates. We tested scenarios with annual trend rates of 12.5% for brand drugs and 15% for

specialty drugs, and found that the impact of the cap was not materially different from the scenarios modeled in this paper. For instance, while using an 8% annual drug trend resulted in a 0.8% premium increase for the $150 cap in 2018, trends of 12.5% and 15% for brand and specialty drugs, respectively, resulted in a 0.9% premium increase.

Cap Indexing

If prescription drug costs increase in future years, a $150 cap would have an increasing dollar impact on both the plan paid and the member cost sharing amounts, and thus a greater impact on premiums. To keep the impact of the cap consistent across years, the amount of the cap would need to increase at a rate similar to the increase in prescription drug costs. To test the impact of an annual increase in the cap, we trended the $150 cap forward to 2017 and 2018 at a rate of 4% per year for all benefits, rounding to the nearest dollar. The 4% annual increase is consistent with the 2014 increase in private health insurance spending reported by CMS[27], and is also consistent with the annual indexing of the maximum out-of-pocket value for plans sold on the exchanges.

We modeled a $156 per-prescription cap in 2017 and a $162 per-prescription cap in 2018. Figure 5 shows the resulting premium increases for an average member of a typical Silver plan in 2017 and 2018 when the cap is indexed annually. As shown, the premium impact of the cap remains steady at 0.7% in both years as the dollar amount of the cap increases at a rate similar to medical inflation. Therefore, no further changes in benefit design would be necessary beyond 2016 to offset the expected premium increases.

Figure 5 – Monthly Increase in Premium for Typical Silver Plan with 4% Annual Indexing of Cap

Plan Year	Monthly Increase in Premium
2017	$2.60 (0.7%)
2018	$2.70 (0.7%)

METHODOLOGY AND SOURCES

Development of Typical Silver Plan

Utilizing datasets available through the federal healthcare exchange website, we created a benefit structure designed to represent a "typical" Silver plan sold on the federally-facilitated exchange markets (FFM). Silver plans enroll the majority of exchange members since premium subsidies are based on the second lowest Silver plan in each market. Our typical plan design represents a national average of benefits for Silver individual plans available through the federal-run exchange in the 2016 plan year. To construct the typical plan, we selected plans with a combined deductible as these types of plans were most prevalent in 2016. The resulting typical Silver plan was determined to be AV compliant for 2016.

To model a realistic Silver plan design for 2017 and 2018, we increased the plan deductible and maximum out-of-pocket values for anticipated trends. The federally mandated out-of-pocket maximum for health plans sold on the exchange have increased at about 4% per year for plans sold in 2014, 2015 and 2016; therefore, we assumed the average deductible and out-of-pocket maximum for our typical Silver plan would increase at an annual rate of 4%. An overview of the benefit design for the Silver plan for all three years is shown in Figure 6.

Figure 6 – "Typical" Silver Plan Design, 2016-2018

Typical Individual Silver Plan Design			
	2016	**2017**	**2018**
Deductible*	$2,750	$2,850	$2,950
Out-of-Pocket Maximum	$5,500	$5,700	$5,950
Primary Care Visit	$30	$30	$30
Specialist Visit	30%	30%	30%
Inpatient Hospital	30%	30%	30%
Generic Drugs	$15	$15	$15
Preferred Brand Drugs	$45	$45	$45
Non-preferred Brand Drugs	30%	30%	30%
Specialty Drugs	35%	35%	35%

* All copays are paid prior to meeting the deductible, and all coinsurances are paid after the member has met the deductible.

We did not examine any cost-sharing-reduction (CSR) plans in this analysis, because the actuarial value is more generous for these types of plans than for those available through the Silver non-CSR plans. Roughly 59% of members enrolled in marketplace plans on the HealthCare.gov platform were eligible for CSR in 2016[28].

In our analysis, we modeled the member cost sharing and plan cost using Milliman's 2016 Claim Simulation Model. This model simulates the payment of claims by the member and health plan under the specified plan's cost sharing features, using a large sample of medical and pharmacy claims-level data underlying Milliman's 2014 Health Cost Guidelines[v] (HCG), trended forward to the applicable year. The simulation was run on a sample of claims from 200,000 commercial members on the Individual marketplace, chosen to be nationally representative. The member

[v] The *HCGs* are a cooperative effort of Milliman health actuaries and represent a combination of their experience, research, and judgment. An extensive amount of data is used in developing the *HCGs* and that data is updated annually.

and plan cost sharing was calculated claim by claim. All cost sharing was then aggregated to derive the average per member per month cost for the sample population.

To estimate the premium level for our typical Silver plan, we added a retention charge of 15% to the plan claim cost. This retention charge is assumed to account for all non-claim charges, including administrative expenses, taxes and fees, and a provision for profit. This retention is illustrative and does not reflect the impact of some additional pricing adjustments that plans may make, such as risk transfer payments from HHS. In the exchanges, different carriers' costs and strategic goals can produce different premiums for any given benefit design. Our models produced premium estimates in the range of actual observed premiums.

We evaluated out of pocket (OOP) spending for each member in the context of their household health care spending, because a plan's OOP maximum depends on the number of people covered under the plan. For example, a household may consist of one member who would be subject to the individual OOP maximum ($5,500). However, if that same member were part of a family contract, that member's spending would be accumulated with other family spending for the OOP maximum calculation (although each member's annual spending is capped at the individual plan's limit). The ACA sets limits for how high the OOP maximums can be. Under these limits, the family OOP maximum is twice that of the individual.

LIMITATIONS

The average values presented in this report are estimates based on historical data. Actual results for specific plans and for specific members will differ for a number of reasons. Differences between our estimates and actual amounts depend on the extent to which future experience conforms to the assumptions made in our projections. Random or non-random fluctuations could cause actual results to be different from those presented here.

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