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The ACA@15
Tracking Prior and Emerging Results since its Inception

Health Care Cost Trends

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The ACA@15

Tracking Prior and Emerging Results since its Inception

The Affordable Care Act (ACA) will turn 15 years old on March 23, 2025. When the ACA had its 10th anniversary in 2020, the Society of Actuaries Research Institute (SOA) released "Fifty States, Fifty Stories: A Decade of Healthcare Reform Under the ACA."[1] The ACA, at that point, had just passed through a period of growing pains that included a wave of insurer financial losses in the Individual markets, followed by issuer exits, lower than expected individual market enrollment, increasing prices, and regulatory turmoil. However, as the market approached the end of its first decade, there were signs of increasing market stability as data matured, competition returned, and more states used 1332 waivers to implement reinsurance programs.

Then, in an abrupt plot twist, the ACA's 10th anniversary aligned almost perfectly with the beginning of the global COVID-19 pandemic. The pandemic fundamentally altered the course of the U.S. healthcare system and led to an array of financial relief policies, many of which involved healthcare coverage options and costs[2], intended to limit its disruption. Five years later, it is interesting to reflect on how the ACA's reforms responded to a number of new market forces and policy reforms over this time period, the years that followed, and how it is positioned to perform into the future.

[1] Fifty States, Fifty Stories: A Decade of Health Care Reform Under the Affordable Care Act

[2] Major Congressional actions that were attributed to the COVID pandemic include the Coronavirus Aid, Relief and Economic Security (CARES) Act, the Families First Coronavirus Response Act (FFCRA) and the American Rescue Plan Act (ARPA). The FFCRA's Medicaid coverage and financing provisions and ARPA's enhanced individual market premium tax credits have had the largest impacts on the markets reshaped by the ACA. Enhanced Premium Tax Credits (PTCs) are scheduled to expire at the end of 2025, which would return market regulations largely to a pre-COVID state.

Executive Summary

This report builds on the original headline market indicators from the previous ACA@10 research to evaluate the full history of the ACA's effectiveness relative to its stated goals. The three goals of focus for this report, along with their assessment criteria, are as follows:

- **Reduce the Uninsured Rate.** Decrease the proportion of the population in each year that did not (or could not) have enrolled in comprehensive health insurance coverage (the uninsured), and changes in the total number of people who have comprehensive coverage, especially individual and Medicaid.

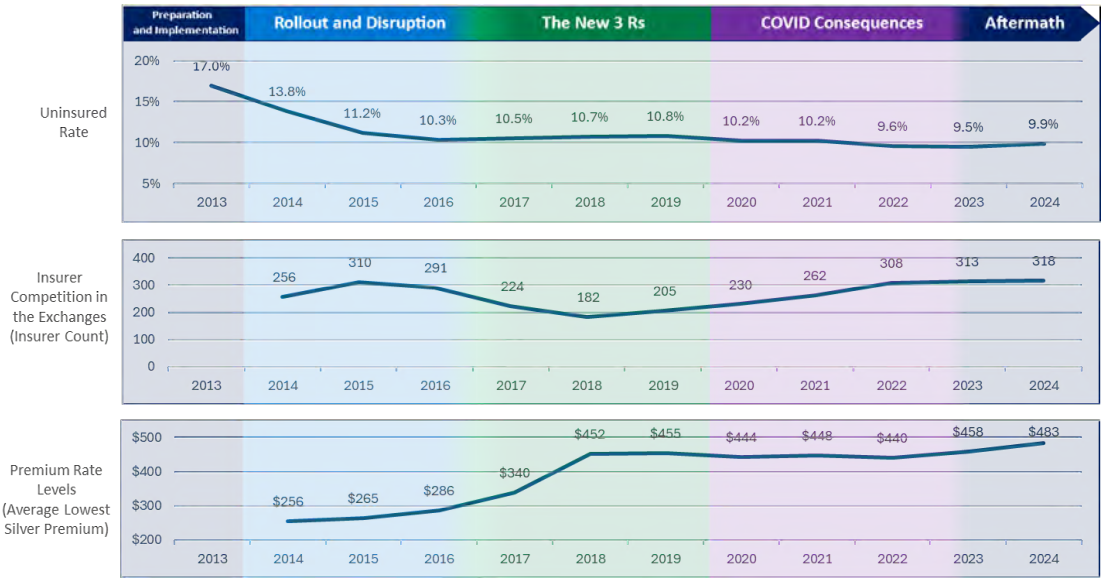
- **Increase Insurer Competition.** Increase the number of insurance companies offering comprehensive, ACA-compliant coverage in the individual exchange markets to encourage competition that will hold prices down and provide adequate consumer choices.

- **Affordable Coverage.** Provide premium stability in the form of low or moderate premium changes in the individual market.

The research into these measures creates a time series of data that provides insights into the factors driving these market indicators and examines the successes and shortfalls of the ACA from an actuarial perspective. Figure 1 illustrates this time series, visualizing the key measurable outcomes most associated with the three goals outlined above across key drivers that have shaped these 15 years.

Figure 1

SELECT NATIONWIDE METRICS ASSOCIATED WITH ACA'S STATED GOALS

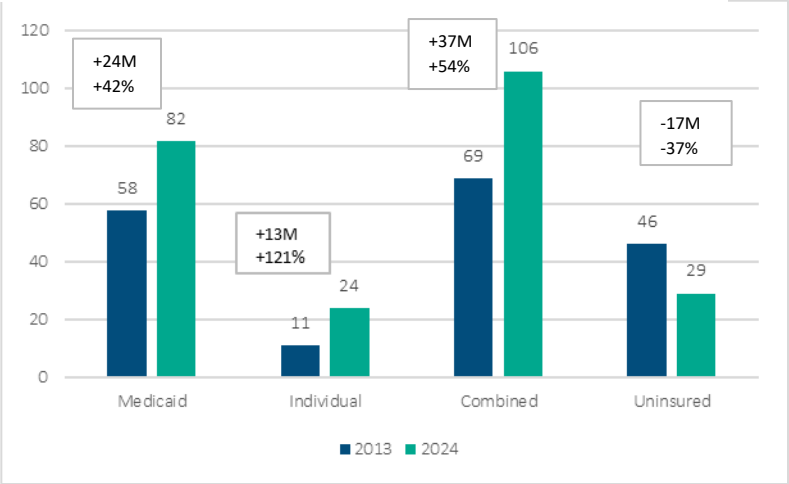


Sources: https://hixcompare.org
https://www.healthcare.gov/health-and-dental-plan-datasets-for-researchers-and-issuers
American Community Survey Public Use Microdata Sample from https://data.census.gov/app/mdat/

This report divides the 15-year history of the ACA into five distinct eras, each marked by significant changes in market dynamics brought about as a result of policy changes and / or economic forces. Through this lens, insights can be gained into the extent to which the ACA has achieved its goals of improving healthcare access and affordability for Americans in the face of shifting market conditions. In Figure 1 and Figure 2, the uninsured rate for the under 65 population has continued its downward trajectory since the ACA's ten-year anniversary, decreasing from the initial high of 17% in 2013 to 10.2% by 2020, and further to 9.9% in 2024. This reduction was initially driven by increased Medicaid enrollment mainly during the "Rollout and Disruption Period" due to the ACA's expansion of the program. However, recent years have also seen substantial growth in both the individual and Medicaid markets, spurred by policies enacted in the wake of the COVID-19 pandemic. In particular, the American Rescue Plan Act of 2021 (ARPA), passed by Congress as a way to address economic disruption caused by the pandemic, extended eligibility for, and enhanced the

Figure 2

COMBINED COVERAGE AND EFFECT ON THE UNINSURED



Sources: Medicaid and CHIP monthly enrollment data
American Community Survey Public Use Microdata Sample
CMS Medical Loss Ratio Data

level of, premium subsidies available in the individual market. In the most recent years of 2023 and 2024, the resumption of Medicaid income verifications and resulting disenrollments also likely moved some of those individuals into the exchanges. Insurer competition has continued to rise in the last five years. Insurer exchange participation reached its lowest point in 2018, having declined by a third since the implementation of the ACA, largely due to the significant underwriting losses and regulatory uncertainty of the Rollout and Disruption era. However, substantial rate increases in 2017 and 2018, to address both the financial losses and the loss of federal funding for the program's cost-sharing reductions, led to a recovery in individual market margins nationwide by the end of 2018. As the improved financial results became known, insurer competition began to climb in 2019, ultimately reaching a new high in 2024.

Given the rise in insurer competition, as well as the emerging financial stability that preceded it, it is perhaps unsurprising that individual market premiums leveled off and even began to decrease at the start of the COVID Consequences era. In fact, from 2019 to 2024, nationwide average premium rate increases trailed general inflation by 21%, improving the relative affordability of coverage for individuals purchasing coverage without the help of premium tax credits. This premium rate stability is in no small part due to the continued steady rollout of Section 1332 State Innovation Waivers, now offered by 17 states primarily in the form of state-based reinsurance programs. In 2024, these waivers reduced gross premiums in those states by approximately 15%.

The body of this report is structured around a number of key observations, shown to the right, each related to the ACA's goals of access and affordability. These observations are based on an objective review of available data to gain insight into the evolution of the ACA over its first 15 years.

KEY OBSERVATIONS

Observation #1: The ACA's access chassis has continued to drive Increased coverage through both the Medicaid program and the individual market, resulting in a significantly reduced uninsured rate. Recent coverage growth is primarily attributable to policies associated with the COVID-19 Pandemic.

Observation #2: Medicaid expansion has a multi-year effect on enrollment. Since 2013, Medicaid enrollment, on average, grew 56% in expansion states versus 6% in non-expansion states, with expansion states accounting for 90% of total Medicaid growth.

Observation #3: Medicaid expansion has had a multi-year negative impact on the individual market enrollment since 2013, with growth of 50% in Medicaid expansion states as compared to 250% in non-expansion states.

Observation #4: From 2013-2023, the uninsured population fell 48% in expansion states versus only 30% in non-expansion states.

Observation #5: Since 2018, states that have implemented a 1332 waiver have seen favorable multi-year growth in non-subsidized enrollment relative to states without a 1332 waiver, providing strong evidence and policy rationale that reinsurance waivers have increased coverage and likely reduced the uninsured.

Observation #6: Insurer participation is highest when the regulatory environment is favorable and following periods of favorable financial results.

Observation #7: Exiting insurers generally exhibit poor financial performance across multiple measurable metrics including operating margin, administrative costs, and market share.

Observation #8: Entering insurers may face financial and operational headwinds, but hurdles to success are surmountable and may be easing with time.

Observation #9: After two years of corrective rate action in 2017 and 2018, average ACA premium rates have remained remarkably stable for the past six years, with average annual premium rate increases that trail consumer price inflation.

Observation #10: State 1332 waivers reduce premiums for unsubsidized consumers in both the short and medium terms.

Observation #11: Silver Loading significantly improved affordability of bronze and gold coverage for subsidized individuals, an effect which has persisted amidst other changes to subsidies in the years since.

Observation #12: Faced with substitute product offerings, declining enrollment, and increasing morbidity, the fully insured Small Group Market has not flourished under the ACA and faces higher prices and decreasing relevance.

Section 1 A Short History of the ACA

1.1 OVERALL ACA POLICY GOALS

The ACA was signed into law on March 23, 2010.[4] Consisting of ten different titles, its intent was to address a wide variety of deficiencies in the healthcare coverage and delivery systems in the United States and make improvements in many aspects of the health ecosystem (see sidebar). Many of the lesser-known provisions of the law continue to shape the healthcare delivery landscape even today.

Arguably, the sections most directly associated with the law in the public eye are those Titles (I-III) that relate to the goal of improving *access and affordability* of comprehensive healthcare coverage for all Americans. Specifically, the goal of achieving near universal coverage (described as "95% of Americans having coverage"[5] was pursued most notably by addressing the impediments to a robust individual market and filling in existing gaps in Medicaid eligibility for lower income Americans.

THE ACA: A BIG LAW WITH BIG GOALS, PART 1

With ten separate titles, the ACA touched almost every area of American healthcare. Its aims were broad and intended to address not only access and affordability (key focuses of this paper), but many other areas including[3]:

- ***Quality of care***, including the establishment of the Patient-Centered Outcomes Research Institute (PCORI), Accountable Care Organizations (ACOs), and the promotion of evidence-based medical practices
- Reinforcing existing ***public programs*** through initiatives such as Medicaid expansion, extended CHIP funding, and improving Medicare's financial sustainability
- ***Improving public health*** by increasing funding for public health programs and initiatives and mandating coverage for preventive services without cost-sharing

Some of the law's most popular provisions, such as the prohibition on lifetime benefit maximums and the ability to keep dependents on their parents' policies until age 26, were implemented immediately upon signing. However, the most significant changes to the individual, Medicaid and employer-group markets became effective January 1, 2014. That date officially marked the expansion of Medicaid eligibility in many states, as well as a major overhaul of the individual market, including new federal funding for premium subsidies and fundamental changes in the rules around issuance and renewal, covered benefits, plan offerings, and premium rating. Important policy features relating to access and affordability in the employer-sponsored markets also took effect.

1.1.1 MEDICAID EXPANSION

Individual market reforms were intended to ensure access to affordable healthcare coverage for households with incomes above the federal poverty level, but the ACA relied on Medicaid eligibility expansion to address access to affordable care among the lowest income households. State-sponsored coverage for most low-income children and certain adults (e.g., aged, blind, disabled adults and pregnant women) was already available in patchwork form through CHIP and Medicaid. Medicaid expansion was intended to close gaps in coverage, particularly for non-disabled adults with household incomes below a set threshold.

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[3] Patient Protection and Affordable Care Act Detailed Summary | senate.gov, accessed January 15, 2025

[4] Technically, the Patient Protection and Affordable Care Act was signed on March 23, 2010. A companion bill containing significant modifications to the law, the Health Care and Education Reconciliation Act of 2010, was signed on March 30 of the same year. Together, these two pieces of legislation make up the ACA.

[5] Why We Can't Wait | whitehouse.gov, accessed July 15, 2024

While the Supreme Court removed the law's requirement for states to implement this expansion in a landmark 2012 ruling, the ACA provided a mix of temporary and permanent financial incentives for states to extend Medicaid coverage to all individuals with household incomes up to approximately 133% of the federal poverty guidelines (FPL, which varies by household size and location), regardless of disability or parental status. Due to a 5% safe harbor for additional income, this resulted in an effective Medicaid income limit of 138% FPL in states which elected to expand coverage. Some of the important modifications made to Medicaid are summarized in Table1:

Table 1
ACA ELIGIBILITY CHANGES TO MEDICAID THAT EXPANDED ACCESS

Medicaid Program Feature	Pre-ACA	Post-ACA
Eligibility for children	▪ Medicaid funding up to 133% FPL,[6] frequently higher ▪ Increased federal match through CHIP for higher household income	▪ Increased CHIP funding for 2014 through 2019 (enhanced funding was reduced in 2020 and gone by 2021)
Eligibility for aged, blind, and disabled adults	▪ Typically, 75% FPL or higher	▪ Individuals with higher income eligible under Medicaid expansion with increased federal match
Eligibility for working parents	▪ Significant variation by state, from 11% - 215% (median 38%)	▪ Eligibility up to 133% FPL with increased federal match
Eligibility for jobless parents	▪ Significant variation by state, from 17% - 215% (median 64%)	▪ Eligibility up to 133% FPL, with increased federal share
Eligibility for childless non-disabled adults	▪ Limited	▪ Eligibility up to 133% FPL, with increased federal share

Due to these important changes, millions of individuals became immediately eligible for Medicaid coverage in 2014 for the 27 states that had adopted expansion through the end of the year. Over the course of the next 10 years, millions more would join those ranks as 14 additional states expanded Medicaid. In later sections, a deeper analysis of the impacts of Medicaid expansion on overall coverage, the individual market, and the uninsured populations is presented.

1.1.2 INDIVIDUAL MARKET REFORMS

The provisions of the ACA related to individual (and to a lesser extent, the small group) market reforms were designed to improve affordability and accessibility, while at the same time providing important consumer protections and taking steps to promote stability in the individual insurance markets of each of the states and the District of Columbia.

Prior to January 1, 2014, when the major reforms took effect, the individual insurance market was markedly different in terms of enrollee composition and benefit design, as well as underwriting, rating, and issuance practices. In many states, premiums were relatively affordable. While individual markets varied

*The parts of the ACA most visible to the public eye are those that relate to the goal of **improving access and affordability** of comprehensive coverage.*

[6] Medicaid eligibility is determined based on federal poverty guidelines, which vary based on household size. Primary guidelines cover the 48 contiguous states and the District of Columbia, with separate guidelines for Hawaii and Alaska. The applicable guideline for a household is typically referred to as the Federal Poverty Level (FPL). Income is typically measured using modified adjusted gross income, and households are typically permitted to exceed stated income limits by up to 5% of the applicable FPL.

greatly by state,[7] [8] a general description of the nationwide practices is summarized below in Table 2, while a more detailed summary of provisions can be found in Appendix B.

Table 2
KEY ACA REFORMS TO INDIVIDUAL MARKETS

Individual Market Features	Pre-ACA	Post-ACA
Enrollee Composition	Generally higher income	Lower income, with some higher income enrollment
Issuance	Focused on risk selection with the ability to decline issuance to any applicant	Guaranteed issue
Issuer Risk Management	Rating and issuance used an individual's medical history to decline issuance or issue at a higher premium rate	Medical underwriting disallowed and replaced with risk adjustment
Single Risk Pools	No requirement for a single risk pool resulted in closed block rating practices, effectively creating a multi-tiered rating system largely driven by health status	Single risk pool is required for each state and each market (small group and individual, or a merged market). Claims experience for the entire pool must be used to set rates for the entire market.
Premium Subsidies / Cost Sharing	No state or federal premium subsidies existed, generally disadvantaging those with lower income	Federal subsidies (i.e., premium tax credits) and cost-sharing subsidies for those below 250% of federal poverty level. Ten states also offer additional premium and / or cost-sharing subsidies that supplement federal subsidies.
Covered Benefits and Member Cost Sharing	No uniform benchmark of covered benefits nor a minimum level of coverage	All benefit plans sold in the individual market covered 10 essential health benefits and maximum levels of member cost-sharing (i.e., bronze plans and caps on cost-sharing) were instituted.
Rating and Pricing	No uniform age rating; gender rating allowed	Single age curve used across risk pool; no gender rating; minimum medical loss ratio requirement

With these reforms, the ACA largely remade and standardized the most important aspects of the individual markets across all states (with some notable state variations), providing access to comprehensive coverage regardless of health status or conditions. It also provided substantial financial assistance to lower-income households that previously may not have been able to afford coverage. With expanded subsidies under the American Rescue Plan/Inflation Reduction Act, coverage has grown even more dramatically since 2021.

1.1.3 GROUP MARKET REFORMS

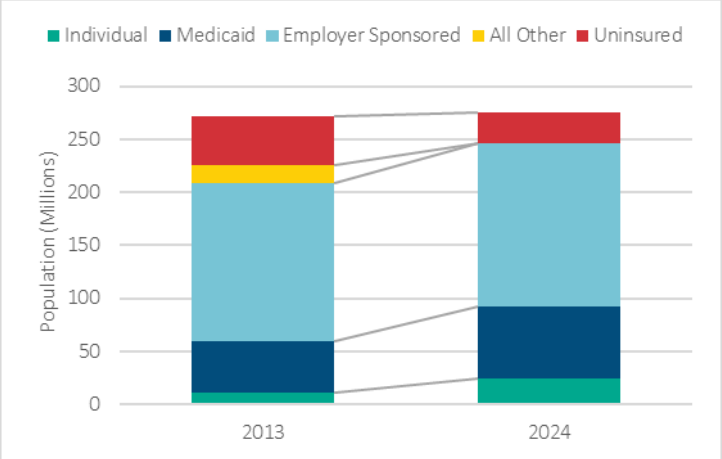
Employer coverage has been the backbone of America's healthcare landscape for those not eligible for federal programs, such as Medicare and Medicaid, beginning during and in the years after World War II as employers increased fringe benefits to compensate for wage controls in place due to the war effort. Coverage through employers constituted the overwhelming majority of health coverage in the private market in 2013 and still does to this day (see Figure 3). The primary push of the ACA with regards to

[7] For example, states such as Maine and New York had guaranteed issue prior to the ACA and did not allow medical underwriting.
[8] State Characteristics | Actuary.org, accessed February 3, 2025

employer coverage was to ensure that employees retained access to comprehensive, affordable benefits through their place of employment featuring key consumer protections introduced by the act.[9]

Figure 3

UNDER 65 INSURANCE MARKET COMPOSITION



Sources: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products
https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr
American Community Survey Public Use Microdata Sample
Medicaid and CHIP beneficiary enrollment data from https://data.medicaid.gov/

Employers and employees have long considered health insurance coverage a key element of the employee compensation package, and coverage already comprised many of the key individual market reforms prior to the adoption of the ACA, including guaranteed issue coverage and limitations on when coverage for pre-existing conditions could be limited or denied. Moreover, employers typically subsidized a substantial portion of coverage for their employees, so that coverage through employers was broadly available and broadly used.

Employer coverage was able to take advantage of the reduced variability in costs associated with larger groups, which created a natural risk pool to absorb the costs of members (including workers, their spouses, and dependents) who had higher claims. These mechanisms work best for larger employers; as a result, many states drew distinctions around employer size to limit the variation smaller employers might face.

Still, the offer rates for small employer health coverage have long lagged far behind large employer coverage, and assisting this market was one of the original pushes under the ACA. As a result, the ACA created a small group single risk pool subject to most of the same protections as in the individual market, while large group coverage was subject to a smaller core set of reforms, as shown in Table 3. However,

THE ACA: A BIG LAW WITH BIG GOALS, PART 2

The 2,400 pages of the ACA touched almost every area of healthcare. With 10 separate titles, its aim was broad and intended to address not only access and affordability (key focuses of this paper), but many other areas including[10]:

- Strengthening the ***healthcare workforce***, including investment in training programs and combating shortages of nursing and public health professionals in areas with provider shortages.
- Increasing healthcare ***transparency and program integrity*** in part by enhancing measures to prevent fraud and abuse
- *Supporting* ***innovative medical care delivery methods*** *designed to lower the costs of healthcare generally*[11]

[9] Consumer-friendly aspects of the ACA affecting the large group space included dependents staying on parents' policies to age 26, prohibitions on annual and lifetime policy maximums, and the concept of "minimum value."
[10] Patient Protection and Affordable Care Act Detailed Summary | senate.gov, accessed January 15, 2025
[11] Affordable Care Act (ACA) - Glossary | HealthCare.gov, accessed January 15, 2025

coverage in force on March 23, 2010 (commonly referred to as grandfathered coverage) was exempted from many of these reforms, both in the group and individual markets.

Table 3
KEY ACA REFORMS TO EMPLOYER GROUP MARKETS

Reform	Small Group	Large Group	Grandfathered Plans
Issuance	✓	✓	✓
Ban on annual and lifetime limits	✓	✓	✓
Dependents on parent coverage until age 26	✓	✓	✓
Minimum medical loss ratio requirement*	✓	✓	✓
Maximum limit on annual cost-sharing	✓	✓	
Zero cost-sharing for preventive services	✓	✓	
Essential health benefits*	✓		
Single risk pools / single age curve*	✓		
Risk adjustment*	✓		

* Does not apply to employer coverage that is self-funded

Notably, the group market is not eligible for the individual market's premium and cost-sharing subsidies, as employers already subsidized most employer-sponsored coverage, with an implicit federal subsidy in the form of tax deductibility of health insurance premiums for both employers and employees. Rather, large employers, who typically offered coverage before the passage of the ACA, were now required to offer coverage that meets minimum premium affordability and benefit generosity standards or pay a penalty when employees enroll in affordable coverage through the individual market. Large employers have generally complied with this requirement, and large group coverage is a linchpin in the U.S. health coverage landscape. In contrast, small group insurance has stagnated, and the law's provisions have not generally served to induce small employers to offer coverage more frequently.

One important difference between individual and group markets is the ability of employers to self-insure coverage for their employees. Under the terms of the Employee Retirement and Income Security Act of 1974, self-insured coverage is not subject to most state health benefits regulations. This streamlines compliance, particularly for large multi-state employers. Small employers who self-insure are not part of the small group market reforms of the ACA but are subject to most of the rules affecting larger employers.

1.2 A FRAMEWORK FOR EVALUATING THE FIRST 15 YEARS OF THE ACA

To evaluate the ACA over its 15-year history, it is useful to first divide this span into five distinct eras, each of which coincides with notable shifts in policy implementation, market conditions, or economic forces.

ERAS OF THE ACA – 2010 THROUGH 2024

1. Preparation and Implementation (2010–2013)

The years leading up to the full implementation of the ACA's market and rating rules – States were preparing for coverage expansions through Medicaid and the insurance exchanges, and insurers were preparing to comply with new market rules, a process which accelerated in mid-2012 once the ACA's core provisions were upheld by the Supreme Court.

2. Rollout and Disruption (2014–2016)

The early years of the ACA's exchanges – The individual market saw significant growth but also growing pains, including large shifts in insurer market share in many markets, technical challenges, evolving regulation, and financial losses for many issuers, exacerbated by regulatory and statutory setbacks, most notably the transitional "if you like your health plan, you can keep it" policy and insufficient funding for the risk corridors program.

Technical issues delayed the Small Business Health Options Program (SHOP) until 2015, and the market never caught up. Medicaid expansion saw a smoother rollout—where it was adopted.

3. The New 3 Rs – Repeal & Replace, Retrenchment, and CSR Defunding (2017–2019)

The first three years of the ACA's steady state – The individual market was reshaped and reshaped again by political and regulatory developments, but by the eve of the COVID-19 pandemic, there were signs of increased stability as it settled into a more compact market driven by premium tax credits and more targeted efforts to reduce member premiums. The small group market's slow slide continued, and Medicaid held to a relatively steady state as new states began to seriously consider expanding Medicaid.

4. COVID Consequences (2020–2022)

The public health emergency (PHE) years – The COVID pandemic and the associated regulatory response influenced nearly all aspects of the healthcare system including, but not limited to, deferred or foregone healthcare services, economic disruption influencing healthcare coverage options, and direct healthcare costs. The individual market experienced dramatic enrollment growth in response to legislative and regulatory responses to the pandemic and resulting economic disruption. Not so in the small group fully insured market: its slow enrollment fade continued but growth in self-funded options offset almost all of the loss in small group insurance coverage. Medicaid grew significantly due to COVID response efforts (and some additional states adopting expansion).

5. Aftermath (2023–2024)

The years following the heart of the PHE – Medicaid enrollment gains during the PHE were pared back due to the resumption of coverage redeterminations but total enrollment remained substantially above January 2020 levels. At the same time, the individual market grew even further amidst a very generous premium tax credit schedule and continued state efforts to optimize their individual markets. Signs of stability began to appear yet again. It remains to be seen whether the ACA will sustain this stability as remaining PHE era policies are scheduled to sunset, and how new policies and market forces will influence new eras into the future.

Analysis and discussion is framed around a set of outcome metrics that shed light on the successes and shortfalls of the ACA in achieving its stated policy goals related to its foundational purpose: achieving near universal access to affordable, high-quality coverage[12].Through a review of key measures over time, a deeper understanding can be gained of how market reforms and Medicaid expansion have performed in pursuit of this goal. The gains and losses for these measures over time illustrate a story of both access and affordability over the ACA's first 15 years and the key themes necessary to understand the six distinct eras of America's health coverage during that period. Table 4 outlines these goals along with corresponding outcome metrics for each and the analysis that was used to assess whether those outcomes indicate a successful achievement of that goal.

Table 4

CORE ACA POLICY GOALS, METRICS, AND ASSESSMENT CRITERIA

ACA Goal	Outcome Metrics	Analysis Focus
Reduce the Uninsured Rate	▪ Uninsured rate—percentage of the population who does not have comprehensive health insurance coverage ▪ Total enrollment in Medicaid and the individual market	▪ Assessment of overall changes in Medicaid and individual coverage and reductions in uninsured ▪ Changes in individual market enrollment composition ▪ Effects of Medicaid expansion on the individual market and uninsured populations ▪ Effects of 1332 waivers on individual market enrollment

[12] https://obamawhitehouse.archives.gov/the-press-office/remarks-president-and-vice-president-signing-health-insurance-reform-bill

Increase Insurer Competition	▪ Change in the number of insurers participating in the exchanges	▪ Overall insurer participation in individual market and by insurer type ▪ Financial assessment of exiting and entering insurers
Affordable Coverage	▪ Individual market premium rate levels ▪ Changes in individual market premium rates over time	▪ Assessment of rate increases over time relative to CPI ▪ Impact of 1332 waivers on Premium rates and rate changes

Having established the key policy goals of the ACA that will serve as this paper's focus and with an analysis framework put forth, the remainder of this paper delves deeper into the quantitative and qualitative measures for the reader to evaluate the effectiveness of the ACA at achieving its stated goals.

Section 2 Policy Goal - Reduce the Uninsured Rate

The most obvious—and easiest to evaluate—policy goal of the ACA is its push towards universal access to coverage and near-universal enrollment in coverage. Through an exploration of both program enrollment data and national uninsurance statistics, several interesting and meaningful statements regarding the law's access-focused provisions can be made.

Observation #1: The ACA's access chassis has continued to drive increased coverage through both the Medicaid program and the individual market, resulting in a significantly reduced uninsured rate. Recent coverage growth is primarily attributable to policies associated with the COVID-19 pandemic.

2.1 OVERVIEW OF INCREASES IN COVERAGE AND DECREASES IN UNINSURED

The ACA was designed to reduce the uninsured rate through a multi-pronged set of programs and policies, including Medicaid expansion, expanded access to affordable comprehensive individual insurance coverage (mainly through guaranteed issue benefit requirements and both subsidized premiums and enrollee cost-sharing), and coverage mandates (see sidebar).

Enrollment levels are the most basic measure of access to coverage, and Figure 4 shows that from the beginning of the ACA to the present, the number of Americans covered by one or both of Medicaid[14] and individual health insurance has increased significantly (up 37 million individuals or 54%), while the uninsured population has declined by 18 million individuals, or 40%.

THE LOST PRONG?

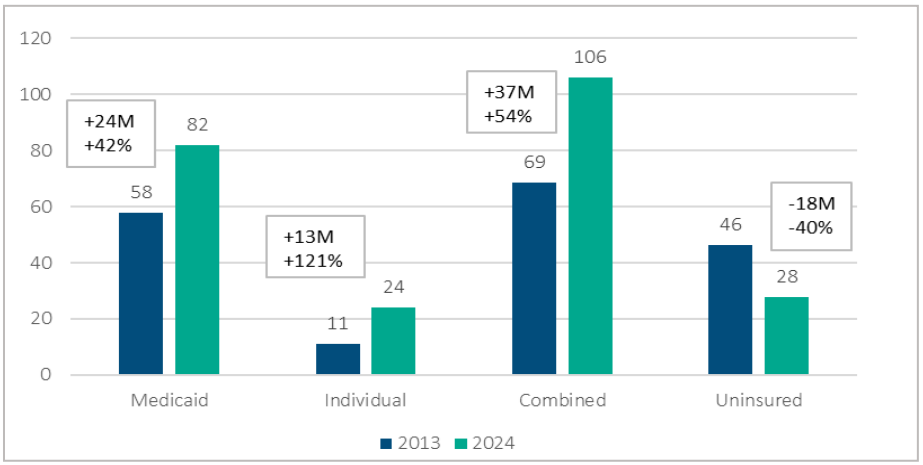
The ACA was crafted with two coverage mandates intended to support increased access and enrollment in comprehensive coverage—an employer mandate designed to ensure large employers retained their role in the coverage landscape and an individual mandate to require individuals to obtain comprehensive coverage. The latter was challenged in a case that reached the Supreme Court, which upheld the individual mandate as constitutional. However, in 2017, Congress set the mandate penalty to zero, where it has remained, making the provision moot. [13]

[13] The Individual Mandate for Health Insurance Coverage: In Brief

[14] Medicaid enrollment figures include enrollment in the Children's Health Insurance Plan (CHIP) program and in Basic Health Plan (BHP) offerings which, to date, have been administered by state Medicaid agencies.

Figure 4

COMBINED COVERAGE AND EFFECT ON THE UNINSURED



Sources: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products
https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr
American Community Survey Public Use Microdata Sample
Medicaid and CHIP monthly beneficiary enrollment data from https://data.medicaid.gov

Medicaid enrollment increases constituted 24 million of the 37 million, or about 65%, of the combined growth. As a result of the increases in enrollment in comprehensive coverage and the decreases in the uninsured, the composition of coverage versus the uninsured changed materially between 2013 and 2024 (see Figure 4 above).

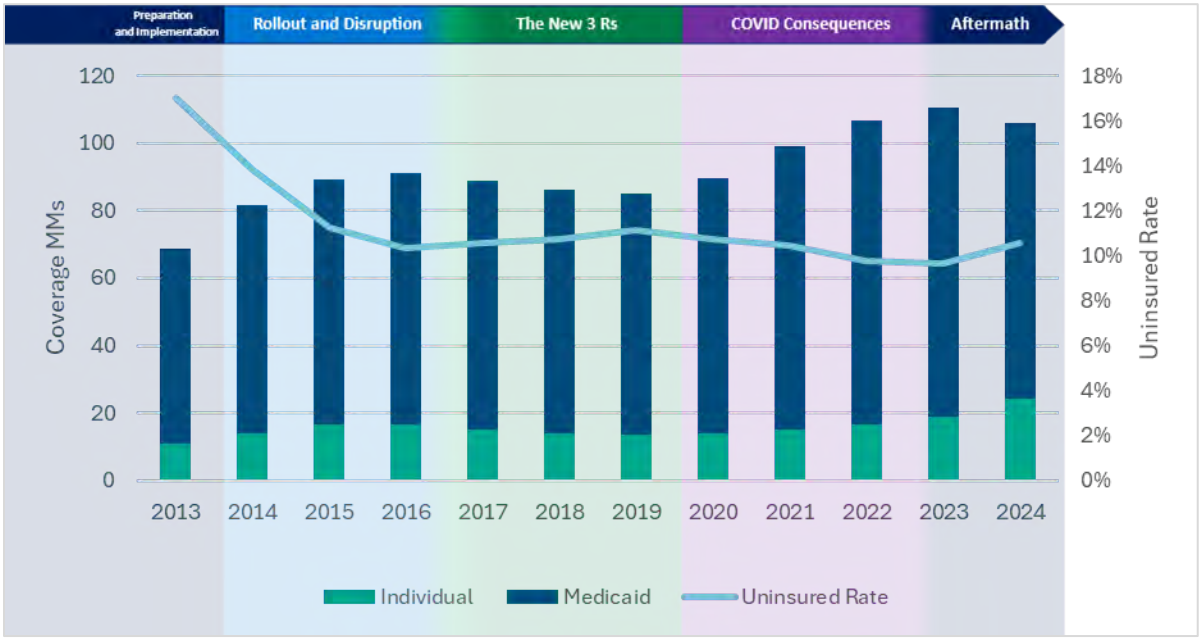
The road to current levels of coverage and uninsurance was not direct. Each of the eras had its own pattern of change, reflecting the distinct influences that shaped American's coverage choices.

DATA NOTE:
Figure 4 demonstrates that the data used to measure coverage and the uninsured do not always move in unison. Our data sources and analysis suggest that, while 37 million individuals gained coverage in these two markets since 2013, there was only an 18 million drop in the uninsured without major enrollment shifts in other types of coverage. Public Health Emergency response provisions give us a notable example that may be contributing to this: a surprisingly large number of individuals were reportedly unaware they had Medicaid coverage.[15]

[15] Why Medicaid's 'Undercount' Problem Counts - KFF Health News notes roughly a third of Medicaid beneficiaries (as many as 26 million individuals in 2022) may not have been aware they had Medicaid coverage during the pandemic, though only about three million of those individuals indicated they thought they were uninsured. This limits the degree to which survey-driven uninsurance overestimates may be able to explain the excess coverage growth noted in Figure .

Figure 5

TIME SERIES OF COVERAGE AND UNINSURED RATE



Sources: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products
https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr
American Community Survey Public Use Microdata Sample
Medicaid and CHIP monthly enrollment data from https://data.medicaid.gov

2.1.1 WHAT HAPPENED DURING THE ERAS OF THE ACA IMPLEMENTATION?

"ROLLOUT AND DISRUPTION" ERA 2014-2016

Guaranteed issue and premium rating protections created coverage opportunities for many of the previously uninsured who could not find coverage in an underwritten market. Financial support significantly improved the affordability of coverage for many low- and moderate-income individuals who could not previously afford coverage. Temporary reinsurance and risk corridor provisions supplemented the ACA's permanent risk-adjustment program, encouraging high participation from insurers and supporting relatively low prices (see Figure 1). In conjunction with publicity from insurers and the Obama Administration, the individual market as a whole saw significant increases in enrollment in 2014 and 2015.

ROLLOUT AND DISRUPTION:

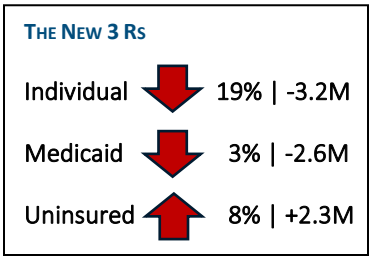
Individual	53% | +5.8M
Medicaid	29% | +16.6M
Uninsured	39% | -17.9M

Some of the initial signs of strain also began to show—the transitional policy permitting individuals and small groups to keep their pre-ACA coverage in force removed a number of generally healthier lives from both individual and small group single risk pools. Congress refused to appropriate additional funds for the risk corridor program, and the program ultimately paid less than 20% of 2014 claims—and none at all for 2015 and 2016—sharply limiting the financial protection provided. The gradual phase out of transitional reinsurance added a few percentage points to premium trends, heightening concern about prices in the evolving individual market. Congress also opted not to provide funding for individual market cost-sharing subsidies and even sued the administration over its continued reimbursement of issuers for these expenditures.

Beyond individual market growth, Medicaid saw 27 states opt to expand eligibility in 2024. Three additional states expanded in 2015 and two more in 2016, driving coverage gains in Medicaid as well.

"THE NEW 3 RS" ERA 2017-2019

In contrast to the initial surge in enrollment of the Rollout and Disruption era, the New 3 Rs era was a period of retrenchment as Medicaid and individual enrollment dipped modestly between 2017 and 2018 (and even into 2019).



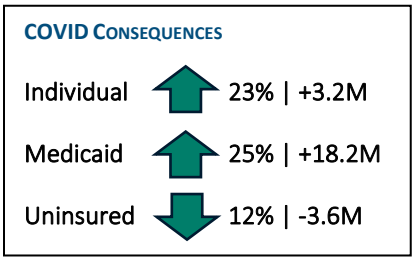
In the individual market, unsubsidized consumers faced unusually high gross premium rate increases for 2017 and 2018 coverage (see Figure 16) as insurers sought to improve underwriting margins following lackluster financial performances of the prior era.[16] Premium increases were amplified by the expiration of the temporary risk protections and the loss of direct federal funding for consumer cost-sharing subsidies. Meanwhile, a change in administration at the federal level raised serious questions about the future of the ACA, embodied by a concerted, but ultimately unsuccessful, effort by Congress and the administration to repeal and replace the law. While the ACA survived the existential legislative threat, reduced spending on outreach coupled with active promotion of alternative coverages added to these other dynamics, as evidenced by the decline in individual market enrollment.

At the same time, the new administration placed significant emphasis on program integrity and fiscal responsibility in Medicaid. In conjunction with a lack of new state expansions and a healthy economy, Medicaid enrollment levels dropped slightly over this period, and the uninsured rate stayed relatively stagnant.[17]

By 2019, the individual market began to show signs of stability, with improved profitability and higher underwriting margins. This was further aided by the introduction of the first two waves of individual market state reinsurance waivers in 2018 and 2019, which were designed to reduce the rate of premium growth and stem enrollment losses. Medicaid enrollment flattened out, and the uninsured rate appeared ready to return to the decreases of the Rollout and Disruption years.

THE "COVID CONSEQUENCES" ERA 2020-2022

The sudden emergence of a novel coronavirus shattered this nascent status quo, creating profound disruption to economies and healthcare delivery systems. As federal, state, and local governments implemented a range of social distancing and quarantine measures, employment levels and incomes dropped. To help address the health and economic consequences of the pandemic, an unprecedented range of economic supports were enacted. The Families First Coronavirus Response Act included provisions to increase the federal share of



[16] Underwriting performance is analyzed in more detail in Section 2 of this report.
[17] https://www.kff.org/medicaid/issue-brief/recent-medicaid-chip-enrollment-declines-and-barriers-to-maintaining-coverage/#:~:text=24-,Some%20of%20this%20decline%20may%20reflect%20people%20moving%20to%20other,administration%20and%20some%20state%20officials

Medicaid funding, designed to help states handle increased levels of resident dependence on the low-income program. In exchange, states were required to implement several beneficiary protections, including a continuous coverage requirement, which prohibited the state from terminating enrollment unless requested by the beneficiary. This began a steady upward trajectory in Medicaid enrollment, as new enrollees joined but existing enrollees remained eligible regardless of income or changes in other eligibility criteria.

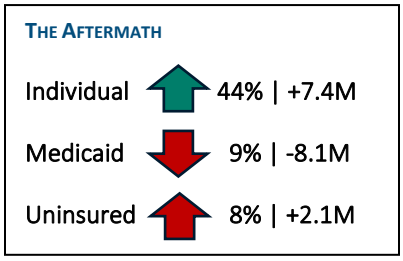
The immediate responses had a relatively limited effect on the individual market, but the uninsured rate dropped even further, a testament to the effectiveness of Congress' immediate response in maintaining access to coverage for Americans.

As the public health emergency continued, enrollment in Medicaid and individual markets skyrocketed to new heights as a result of continued economic disruption and federal policy responses to the COVID-19 pandemic. The new Congress and administration made the individual market a priority. The American Rescue Plan Act of 2021 (ARPA) expanded eligibility for premium tax credits and increased the generosity of existing credits. This was coupled with expanded enrollment opportunities through the heart of 2021, and increased outreach and consumer engagement funding helped the individual market return to enrollment levels not seen since the end of the rollout and disruption era.

In addition to the ongoing continuous coverage requirement, the ARPA also included additional funding for states that chose to expand Medicaid. As the public health emergency saw repeated extensions even as new vaccines and therapies emerged and the economy returned to form, Medicaid eclipsed 80 and then 90 million enrollees. Combined, this drove the uninsurance rate to historically low levels.[18]

THE AFTERMATH 2023-2024

As the public health crisis showed signs of ebbing, Congress phased out the enhanced federal match starting in April of 2023, allowing states to resume eligibility redeterminations.[19] While Medicaid enrollment has fallen significantly, coverage levels remain above pre-COVID levels, driven at least in part by additional expansions, which bring the number of non-expansion states down to 10.



In contrast, the enhanced subsidies introduced by the ARPA were extended through 2025 by the Inflation Reduction Act of 2022, and the individual market has responded with explosive growth not seen since the initial rollout and disruption days. Individual enrollment continues to climb as many who were determined to no longer be eligible for Medicaid qualified for subsidized individual marketplace coverage. These changes have roughly offset each other while the number of uninsured increased somewhat but has remained relatively stable amidst the significant shifts in coverage.

[18] While the uninsured rate declined, the data used to measure this does not exactly coincide with the increase in Medicaid enrollment. See sidebar "Data Note" on page 18.
[19] https://www.kff.org/medicaid/issue-brief/fiscal-implications-for-medicaid-of-enhanced-federal-funding-and-continuous-enrollment/#:~:text=The%20Consolidated%20Appropriations%20Act%2C%202023,from%20October%20to%20December%202023, accessed January 17, 2025

2.2 EFFECTS OF MEDICAID EXPANSION ON COVERAGE AND UNINSURED RATE

The ACA was written to require all states to expand coverage to 138% FPL or lose all federal funding for Medicaid. However, the Supreme Court eliminated the penalty component in the landmark 2012 case *NFIB v. Sebellius*, making expansion of Medicaid optional for states. Prior to the adoption of the ACA, only nine states and the District of Columbia provided Medicaid coverage to parents at or above the 138% FPL threshold applied to the expansion population. Even in these states, expansion extended coverage to low-income childless adults who were otherwise generally ineligible for Medicaid.

As noted previously, Medicaid enrollment has grown significantly as states have expanded, even taking into account the losses of coverage attributable to the end of the public health emergency. Moreover, this change in enrollment is in reasonable alignment with federal reporting on enrollment amongst this new adult population—as of June 2024, the number of nondisabled adults newly eligible for Medicaid by virtue of expansion sits at over 15 million beneficiaries—individuals who are enrolled in Medicaid through the expansion authority who would not otherwise have been eligible for Medicaid. This population represents the majority of Medicaid's growth of 24 million enrollees since the passage of the ACA. A full list of the states that have expanded by year can be found in Table C-2. in Appendix C.

Based on this overall enrollment pattern, Medicaid expansion had obvious and substantial effects on enrollment in the Medicaid program itself. Prior to expansion, most individuals in low-income households who weren't eligible for Medicaid nor had access to employer-sponsored coverage typically had individual market coverage or else were uninsured. As a result, one would expect expansion to influence both populations as well. What can the data reveal about the interplay between these markets?

Observation #2: Medicaid expansion has a multi-year effect on enrollment. Since 2013, Medicaid enrollment, on average, grew 56% in expansion states versus 6% in non-expansion states, with expansion states accounting for 90% of total Medicaid growth.

Expansion Impact on Medicaid Enrollment

Increases in Medicaid enrollment due to expansion were expected to be driven by two forces:

1. Nondisabled adults made newly eligible as result of the increased income limit of 138% of FPL, and

2. Increases in enrollment amongst those already eligible under the previous criteria but who had not enrolled. The increase in enrollment for this population (the "welcome mat" effect) was expected as a result of greater publicity around the Medicaid program as a whole, as well as additional state and federal outreach.[20] Table 5 below summarizes the history of state expansions of Medicaid in terms of the number of states that expanded each year, the remaining states that had not yet expanded, and the enrollment in each population.[21]

Over the 11 years that Medicaid expansion has been available, total enrollment across all states has grown by 22 million enrollees, or almost 38%. However, total enrollment across all expansion states grew by 31 million enrollees as the number of expansion states grew over time. Likewise, non-expansion states shrank from 24 in 2014 down to just ten as of 2024, accompanied by a predictable decline in total Medicaid enrollment attributable to states that have not expanded. Said differently, more Medicaid enrollees were

[20] Also known as the "woodwork" effect; Premium Subsidies, the Mandate, and Medicaid Expansion: Coverage Effects of the Affordable Care Act | NBER, accessed February 8, 2024

[21] A list of state expansion decisions by year can be found in **Table C-1.** in Appendix C.

covered in states that had expanded by 2024 than in 2014, simply because states moved from one status to another.

To isolate the impact of expansion independent of this changing mix of states, Table 5 recalculates annual growth rates using a consistent mix of states from each year to the next.

Table 5
MEDICAID ENROLLMENT CHANGES BY EXPANSION STATUS 2013-2024

Expansion States	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	Change
# Expansion States		27	30	32	32	32	34	37	39	39	41	41	
Enrollment (millions)													
Start of Year		32.9	45.0	50.5	51.7	52.1	52.4	52.8	61.0	65.8	72.4	68.4	
Growth		8.4	4.2	1.2	0.4	-1.0	-0.4	6.3	4.8	4.3	-4.0	-4.7	19.5
(a) % Growth Rate		**26%**	**9%**	**2%**	**1%**	**-2%**	**-1%**	**12%**	**8%**	**7%**	**-6%**	**-7%**	**56%**
Non-Expansion States													
# Non-Expansion States		24	21	19	19	19	17	14	12	12	10	10	
Enrollment (millions)													
Start of Year		24.8	22.5	22.2	22.6	21.4	19.6	18.5	19.2	20.9	20.2	17.2	
Growth		1.4	0.9	0.5	-1.2	-0.6	-0.2	2.6	1.7	1.7	-3.0	-1.5	2.2
(b) % Growth Rate		**6%**	**4%**	**2%**	**-5%**	**-3%**	**-1%**	**14%**	**9%**	**8%**	**-15%**	**-9%**	**6%**
Net Effect of Expansion													
Expansion Lift = (a)-(b)		**20%**	**5%**	**0%**	**6%**	**1%**	**0%**	**-2%**	**-1%**	**-2%**	**10%**	**2%**	**50%**

Sources: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products
https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr
Medicaid and CHIP monthly eligibility and enrollment reporting on https://data.medicaid.gov

Table 5 clearly illustrates that Medicaid expansion does increase Medicaid enrollment significantly, independent of any increase in the number of states that adopted expansion. Specifically,

- Independent of mix, Medicaid expansion states experienced a 56% increase in enrollment since 2013, while non-expansion states increased just 6%. By way of reference, enrollment growth in non-expansion states tracked closely with total population growth in the United States, which was also about 6% over the same time period.[22]
- Medicaid expansion (including both the direct and indirect / "welcome mat" impacts described above) accounts for about 20 million of the total 22 million member increase in Medicaid enrollment over the past 11 years, or about 90% of the overall growth.

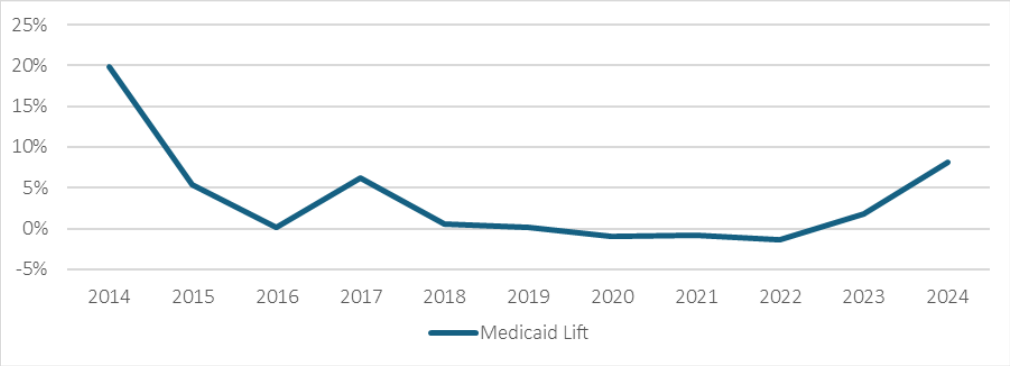
By comparing the enrollment growth in expansion states to non-expansion states, one can get a sense of the effect of Medicaid expansion on enrollment. This effect, or "lift," is calculated by subtracting the enrollment growth rate in non-expansion states from that in expansion states. While imperfect, this

[22] From 316 million to 337 million or 6.6%. Population figures from https://www2.census.gov/programs-surveys/popest/tables/2020-2023/state/totals/NST-EST2023-POP.xlsx. 2024 estimated by authors based on historical trend.

method treats non-expansion states as a benchmark[23] by which the isolated annual relative effect of Medicaid expansion on enrollment growth can be calculated. The "Expansion Lift" calculated in this manner can be seen below in Figure 6.

Figure 6

ENROLLMENT LIFT OF MEDICAID EXPANSION



Source: Monthly Medicaid and CHIP enrollment and eligibility data from https://data.medicaid.gov

Figure 6 clearly shows Medicaid expansion's anticipated large first year effect on enrollment—driving enrollment growth by about 20%—along with the somewhat more surprising finding that this expansion continues to have declining but still positive effects through the fourth year after expansion. Following this initial growth period, expansion's effects are negligible (i.e., no meaningful difference in annual growth rate compared to non-expansion states) over the next five years. The "Aftermath" years of 2023 and 2024, once again show a favorable effect of expansion on enrollment relative to non-expansion states. The reappearance of enrollment favorability in expansion states in those years is likely attributable to differences in redetermination practices between expansion and non-expansion states that are specific to differences in the populations covered (see sidebar).

THE EFFECT OF REDETERMINATIONS: EXPANSION VERSUS NON-EXPANSION STATES

It is certainly possible that this difference is a feature of expansion itself. The pandemic may have had a "welcome mat" effect, inducing more individuals to enroll in coverage who were already eligible (and remained eligible in the wake of the public health emergency). One would expect this to show up as a reduction in the uninsured rate—and federal reporting shows such a reduction during the pandemic, though the effect is significantly smaller compared to the overall enrollment gains in the Medicaid program.

However other policy priorities could have the same effect. For example, the remaining non-expansion states tend to lean heavier into program integrity. One manifestation of this might be more aggressive pursuit of active re-enrollment evaluations even as federal regulators were encouraging states to look for automated methods of validating continued eligibility (referred to as ex parte renewals). Federal data on ex parte renewals shows that non-expansion states had some of the lowest rates of ex parte renewals observed across the country.[24]

[23] In addition to the relatively simple analysis performed here, we also evaluated an alternative calculation that isolates the effects of Medicaid expansion by program year, looking at each Medicaid program by year since expansion. As part of this, we created an appropriately weighted benchmark to compare cohort effects on a consistent basis. This more complex method is more accurate than the calendar year approach used above but is much more cumbersome to explain given the sheer number of expansion states and program years. Moreover, the results of the calendar year calculation did not differ materially in terms of estimated Medicaid expansion lift by program year. An example of this calculation approach can be found in Section 2.3's analysis of 1332 waivers, which is more amenable to this analysis due to the smaller number of states involved. We note this methodological distinction here to address potential concerns that the results in this section are distorted by states expanding Medicaid in the middle of this 11-year window.

[24] Data for ex parte renewals can be found at https://data.medicaid.gov/dataset/ebcfc16f-8291-4c61-82a4-055846d72f3a/data

Observation #3: Medicaid expansion has had a multi-year negative impact on the individual market enrollment since 2013, with growth of 50% in Medicaid expansion states as compared to 250% in non-expansion states.

Expansion Impact on Individual Enrollment

As described above, Medicaid expansion draws enrollment from individuals who may have otherwise enrolled in the individual market, primarily those in households between 100% and 138% of the federal poverty level. As a result, expansion would be expected to have materially dampened the size of the individual market in states that chose to expand. Moreover, the ACA's simultaneous evaluation of exchange enrollees for Medicaid coverage and the requirement of failure to qualify for Medicaid as a prerequisite for receipt of premium tax credits is likely to concentrate this effect in the first year or two of expansion.

Applying the same methodology used to estimate the expansion impact on Medicaid enrollment, Table 6 isolates[25] the impact of Medicaid expansion on the individual market by program year.

Table 6

INDIVIDUAL ENROLLMENT CHANGES BY EXPANSION STATUS 2013-2024

Expansion States	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	Change
# Expansion States		27	30	32	32	32	34	37	39	39	41	41	
Enrollment (millions)													
Start of Year		5.5	7.2	9.0	8.8	8.5	8.2	8.1	8.6	8.9	9.9	10.3	
Growth		0.8	1.4	-0.1	-0.4	-0.7	-0.5	0.1	0.3	0.3	0.5	1.9	3.6
(a) % Growth Rate		**15%**	**20%**	**-2%**	**-4%**	**-9%**	**-6%**	**1%**	**3%**	**3%**	**5%**	**18%**	**50%**
Non-Expansion States													
# Non-Expansion States		24	21	19	19	19	17	14	12	12	10	10	
Enrollment (millions)													
Start of Year		5.4	6.9	7.8	7.9	6.9	5.9	5.4	5.4	6.3	6.8	8.7	
Growth		2.3	1.3	0.1	-1.0	-0.5	-0.1	0.3	0.9	1.2	1.9	3.1	9.6
(b) % Growth Rate		**42.6%**	**19%**	**1%**	**-13%**	**-7%**	**-2%**	**6%**	**17.4%**	**19%**	**28%**	**36%**	**253%**
Net													
Expansion Lift = (a)-(b)		**-27%**	**1%**	**-2%**	**9%**	**-1%**	**-5%**	**-5%**	**-14.2%**	**-16%**	**-24%**	**-18%**	**-204%**

Sources: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products
https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr

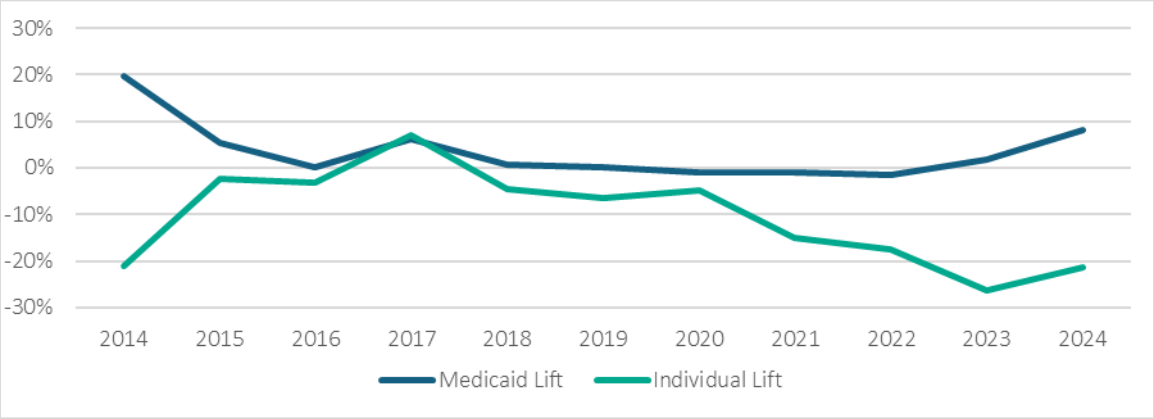
In program year 1, the relative impact of Medicaid expansion on individual market enrollment growth was materially negative, as expected. Based on Table 6, the individual markets in expansion states could be as much as 25-30% larger in the first year of expansion if the state had simply chosen not to expand. There is also a noticeable negative impact on the individual market enrollment in later years, beginning in earnest as markets stabilized. The effect amplified significantly during the COVID Consequences era as the various COVID response efforts emphasized retention of Medicaid coverage which was available to more individuals who otherwise would have been eligible for subsidized coverage in the individual market. More surprisingly, this effect held on into the ensuing Aftermath.

[25] For simplicity, there are no adjustments made for possible confounding state-specific factors including, but not limited to, the switch to a state-based exchange, etc.

Figure 7 builds on Figure 6, adding Medicaid expansion's lift on individual market coverage to the previously shown lift on Medicaid enrollment.

Figure 7

ENROLLMENT IMPACT OF MEDICAID EXPANSION ON INDIVIDUAL ENROLLMENT

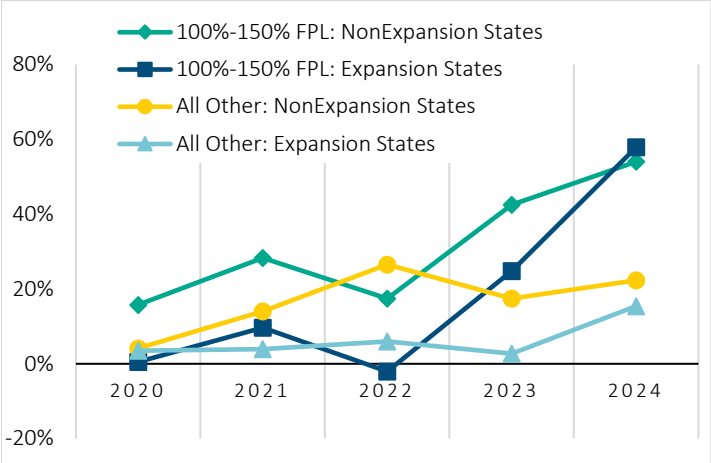


Sources: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products
https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr
Monthly Medicaid and CHIP enrollment and eligibility data from https://data.medicaid.gov

The continuation of this effect into 2024[26] suggests that the enhanced ARPA premium subsidies have a significantly greater effect at the lowest income levels. Figure 8 shows open enrollment trends separately for expansion and non-expansion states, as well as for individuals between 100% and 150% who are eligible for zero premium silver plans as compared to all other metal tiers.

Figure 8

INDIVIDUAL MARKET ENROLLMENT GROWTH BY FPL



Source: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products

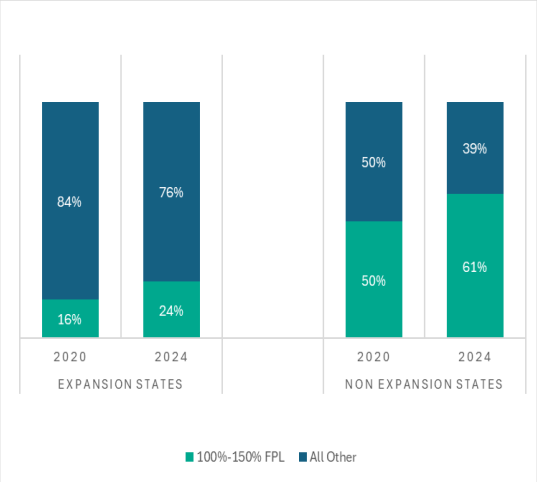
During the COVID Consequences years, expansion state growth lagged non-expansion state growth across the board - the result of the continued coverage requirement and broader eligibility standards. As the market entered the Aftermath era, enrollment growth amongst the zero silver premium cohorts grew dramatically across both expansion and non-expansion states. Enrollment growth was significantly higher in total in non-expansion states for each income-based cohort.

[26] It is worth noting the negative effect of expansion on individual market enrollment beyond the early years of a state's expansion is not caused by the outsized impact of Texas and Florida in the non-expansion state benchmark.

Figure 9 takes an alternate view, looking at how the distribution of individual market enrollment in both expansion and non-expansion states has shifted dramatically toward low-income individuals at or below 150% of the federal poverty level. While the pre-ACA individual market was largely focused on healthier individuals paying the full cost of coverage, individual market enrollment has been highly subsidy-driven, attaining the basic shape shown in 2020 by 2016. However, the significant enhancement to premium subsidies saw both expansion and non-expansion markets shift about 10% higher weight on the 100%-150% FPL category, reaching over 60% of marketplace enrollments in non-expansion states by 2024.[27] This aligns with the idea that ARPA's enhanced tax credits have a significantly greater effect at the lowest income levels, a reasonable inference given that individuals with household incomes up to 150% FPL (including all those between 100% and 138% FPL in non-expansion states) are eligible for zero premium benchmark coverage under the expanded ARPA subsidies, as opposed to a small but nonzero premium in the absence of enhanced subsidies.

Figure 9

INDIVIDUAL MARKET COMPOSITION BY FPL



Source: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products

Observation #4: From 2013-2023, the uninsured population fell 48% in expansion states versus only 30% in non-expansion states.

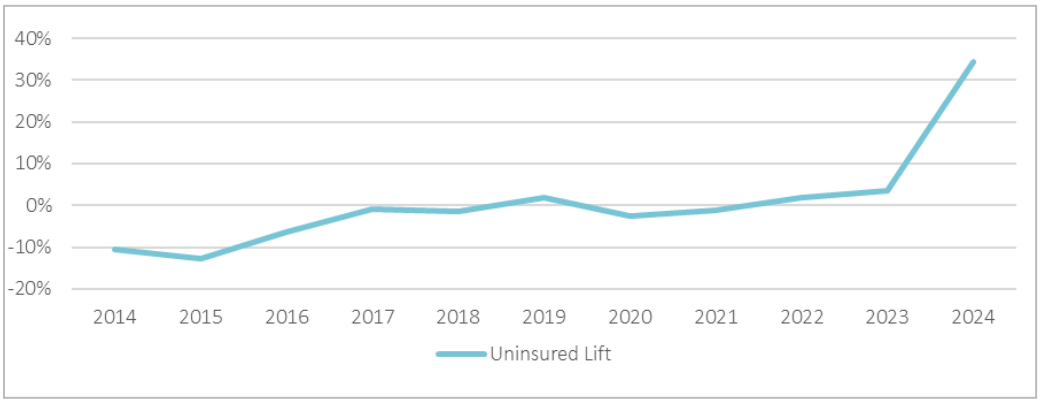
Expansion Impact on Uninsured

The previous report demonstrated a strong link between the expansion and a reduction in the uninsured rate.[28] This is a core expectation of expansion, which was anticipated to draw from both the uninsured population and individuals who otherwise would enroll in the individual market. Figure 10 returns to a time series analysis to demonstrate the impact of Medicaid expansion on the uninsured rate.

[27] Note that there has been activity at the federal level to investigate the possibility of fraudulent income reporting for many ACA enrollees at the 100-150% income level, https://waysandmeans.house.gov/2024/07/02/ways-means-ec-and-judiciary-chairs-demand-watchdogs-review-after-report-exposes-widespread-fraud-in-obamacare-plans/, accessed February 17, 2025

[28] See Fifty States, Fifty Stories: A Decade of Health Care Reform Under the ACA | SOA, Figure 6, page 11.

Figure 10
MEDICAID EXPANSION IMPACT ON UNINSURED



Sources: https://www.census.gov/programs-surveys/acs
National Health Interview Survey Early Release Data

Three observations follow from Figure 10:

- Expansion states show material reductions in the uninsured rate compared to non-expansion states (e.g., in 2014, expansions states saw ~10% greater reduction in uninsured than non-expansion states, etc.).

- It also suggests that Medicaid expansion has a relatively long period of impact, through roughly the first four years, on the uninsured rate—an influence that gives support to the presence of a welcome mat effect for Medicaid expansion, where increased publicity and coverage leads others to discover their eligibility and sign up over time.

- Expansion states also had small but favorable impacts on uninsured during the COVID pandemic of 2020 and 2021, followed by unfavorable impacts during the unwinding of Medicaid enrollment and heading into 2024. This latter outcome, in particular, is somewhat surprising, but provides further evidence that the massive expansion of exchange coverage in non-expansion states noted in Figure 8—individual market growth net of the change in Medicaid enrollment in non-expansion states—is significantly lower than the net effect in expansion states.

Medicaid Expansion Impact Summary
Taken altogether, Medicaid expansion is a significant benefit for Medicaid enrollment, over and above normal enrollment increases (as measured by the non-expansion state benchmark) over the course of the first four years from implementation. It also has a multi-year effect, largely a mirror reflection of its effect on Medicaid, for the uninsured and individual populations, which decrease when Medicaid increases and vice versa.

Moreover, in non-expansion states, the enhanced subsidies of the ARPA are increasing enrollments amongst the under 150% FPL crowd, possibly making up for some of the coverage gains that could have occurred if these states have expanded, and which may be moderating effects on the uninsured rate to some degree.

2.3 EFFECTS OF SECTION 1332 WAIVERS ON INDIVIDUAL MARKETPLACE ENROLLMENT

The ACA's reforms extend beyond the core policies of Medicaid expansion and expanded access and affordability in the individual market. Somewhat akin to waiver flexibilities in Medicaid, the ACA provides

states with an avenue to pursue innovative state-specific reforms that improve their markets without violating the core principles, protections, and goals of the law. In exchange for complying with specific guardrails, states are able to leverage federal funding that might otherwise have been lost as a result of these state-specific reforms. These innovation waivers, known as section 1332 waivers, have primarily been used for reinsurance programs in the individual markets. However, recently both Colorado and Nevada had waivers approved for public option programs in conjunction with reinsurance programs.

KEY NUMBERS THAT STRUCTURE 1332 WAIVERS

Four Waivable Provisions

Standards for Exchanges and QHPs
including Exchange requirements, plan certification criteria, and the single risk pool definition

Essential Health Benefits
including EHB definition and development, standard benefit levels, cost-sharing rules, and maximum out-of-pocket rules

Subsidies
including premium tax credits and cost-sharing reductions

Coverage Mandates
including individual and employer coverage mandate requirements

Four Guardrails

Affordability
Coverage must be at least as affordable as without the waiver

Benefit Generosity
Coverage must remain as comprehensive as without the waiver

Coverage Levels
Must maintain or increase the number of insured residents

Deficit Neutrality
Cannot increase federal deficit

One Big Carrot, with One Big Caveat

Pass-through Funding
States can recoup net federal savings from reduced premium subsidy outlays but without increasing the deficit. Usage of funds should be to support health coverage programs central to the waiver, such as paying for reinsurance claims under a reinsurance waiver. States typically need additional funds to cover all the costs of a waiver.

2.3.1 OVERVIEW OF SECTION 1332 WAIVERS

Section 1332 waivers were included in the original law but were not permitted prior to benefit year 2017. As of this writing, 27 states have submitted applications for waivers with all but one (Hawaii) being a waiver applicable to the individual market.[29] Eighteen of the 26 individual market waivers have been approved, all of which include a reinsurance program. The remaining eight waivers have been withdrawn.

The two structural elements of 1332 waivers (see sidebar) have led most waivers to focus on reducing gross premiums (specifically the benchmark silver plan, which reduces federal premium subsidy outlays) in order to generate and receive pass-through funding. Pass-through funding, being defined as savings in the federal government's net subsidy obligation, is only generated on subsidy-eligible individuals. Therefore, a good rule of thumb for figuring pass-through funding is the product of the state's subsidized enrollment and the anticipated reduction in premiums per member per month attributable to the waiver. This leaves the state responsible for the costs of the waiver for unsubsidized individuals. As such, it can be valuable to think of a waiver as a way a state can improve access and affordability for unsubsidized individuals.

On average, waivers have provided material rate relief to unsubsidized enrollees in individual markets that have adopted them, ranging from as low as 5% to as high as 30%, averaging 15%. Table C-1 in Appendix C summarizes the premium impacts of the approved waivers by year.

Observation #5: Since 2018, states that have implemented a 1332 waiver have seen favorable multi-year growth in non-subsidized enrollment relative to states without a 1332 waiver, providing strong

[29] Authors' review of CMS site: Section 1332: State Innovation Waivers | CMS

evidence and policy rationale that reinsurance waivers have increased coverage and likely reduced the number of uninsured.

2.3.2 ANALYSIS OF 1332 WAIVERS IMPACTS ON INDIVIDUAL ENROLLMENT

As part of their applications, states that have submitted waivers have routinely cited expected enrollment increases as a result of the waiver.[30] These enrollment increases stem largely from the reductions in gross premiums for households that are not subsidized. There is a smaller impact on subsidized enrollment that depends on the size of the reinsurance program, the gross cost of insurance, and the person's income. A simple example of subsidy dynamics on three different income levels, with and without a reinsurance program, can be seen in Table C-2 in Appendix C. Based on the waiver dynamics illustrated in Table C-2, states that implement reinsurance programs under a 1332 waiver should expect to see little impact from the waiver on highly subsidized enrollment and more impact on lightly subsidized or completely unsubsidized enrollment.

2.3.3 OVERVIEW OF SUBSIDIZED AND UNSUBSIDIZED ENROLLMENT COMPOSITION

The story of the ACA is often told in terms of premium tax credits, but unsubsidized enrollment was the status quo ante in 2013, and unsubsidized enrollment saw steep and largely unrelenting declines during the Rollout and Disruption and New 3 Rs eras. This is almost certainly due to the large increases in gross premiums, which are directly absorbed in their entirety by the unsubsidized consumer. While the rate of decline has slowed, it has remained stubbornly negative in most years. At the same time, subsidized enrollment has grown steadily and, particularly in recent years, dramatically – which appears to be due to enhanced subsidies. Section 4 focuses on these affordability dynamics in the individual market in more detail.

However, even prior to the introduction of enhanced subsidies starting in 2021, the individual market had already transformed from a higher income market of consumers paying gross premiums entirely out-of-pocket to a lower income, premium tax credit-driven market where a majority of consumers are paying much lower income-driven net premiums, which insulates them from a significant portion of premium growth. This shift is illustrated in Table 7 and Figure 11.

Table 7
ENROLLMENT IN THE INDIVIDUAL MARKET BY SUBSIDY STATUS 2014-2024

	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Subsidized Enrollment		5.0	7.6	8.4	8.2	8.6	8.5	8.9	10.3	12.2	14.8	19.7
Subsidized Change			52%	11%	-2%	4%	-1%	5%	16%	18%	22%	33%
Unsubsidized* Enrollment	10.9	9.1	9.2	8.3	7.1	5.5	5.0	5.0	4.9	4.5	4.2	4.3
Unsubsidized Change		-17%	2%	-10%	-15%	-22%	-10%	1%	-4%	-7%	-6%	2%

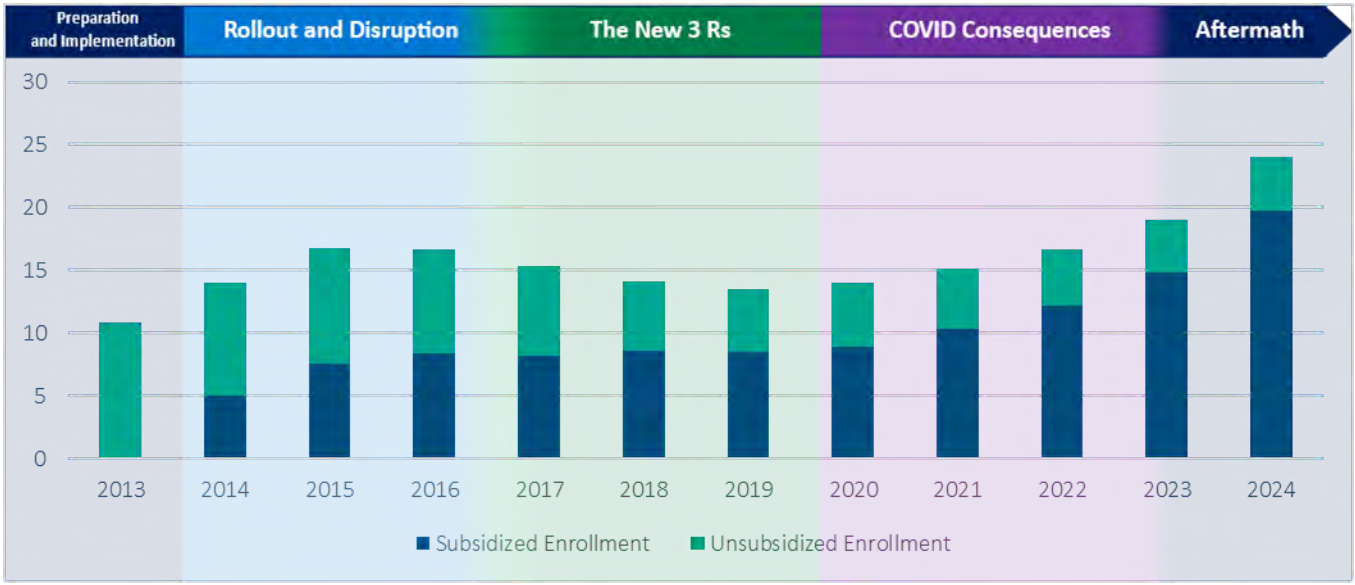
*Both on- and off-exchange

Sources: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products
Effectuated enrollment reports published by the Centers for Consumer Information and Insurance Oversight
Medical Loss Ratio data

[30] Authors' review of 1332 waiver applications: Section 1332: State Innovation Waivers | CMS

Figure 11

ENROLLMENT IN THE INDIVIDUAL MARKET BY SUBSIDY STATUS 2014-2024



Source: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products

Starting in 2021, subsidy eligibility changed significantly as a part of the ARPA enhancements. Subsidies were not only made richer for those already eligible, but eligibility was extended to those with household incomes over 400% FPL. These subsidies could be relatively small, but any level of subsidy insulates members who receive them from the greater part of future premium increases. The ARPA subsidies certainly contributed to an increase in subsidized enrollment, and resulting moderation in premium growth may be part of the smaller declines in the unsubsidized market observed in the last few years.

The general decrease in unsubsidized enrollment across the country and across virtually all years of the ACA, in conjunction with the subsidy dynamics shown above, illustrates clear challenges for the unsubsidized population, but also the clear benefit that a 1332 waiver can have for this population. To what extent can a 1332 waiver influence this enrollment trend by providing some price relief to the unsubsidized, given that most of the benefit accrues to this population?

Table 8 summarizes the initial waiver year unsubsidized enrollment change by state and waiver year. Since waivers all have a different starting year, a reference change in unsubsidized enrollment was calculated that reflects the change in unsubsidized enrollment for all other states that did not have a waiver in the preceding year. For example, the reference change for the first three waiver states (Alaska, Minnesota, and Oregon), compares 2018 unsubsidized enrollment to 2017 unsubsidized enrollment in the other 48 individual markets.

Table 8

1332 REINSURANCE WAIVER IMPACT IN FIRST YEAR OF IMPLEMENTATION

State	First Year of Waiver	Total Program Years	Unsubsidized Enrollment Prior to 1st Year of Waiver	1st Year Enrollment Change	Reference Change[a]	Enrollment Change Relative to Reference Change
Alaska	2018	7	5,173	-1.9%	-20.0%	18%
Minnesota	2018	7	93,291	-6.9%	-20.0%	13%
Oregon	2018	7	115,642	-19.0%	-20.0%	1%
Maine	2019	6	15,426	-1.9%	-9.5%	8%
Maryland	2019	6	84,038	-5.9%	-9.5%	4%
New Jersey	2019	6	136,132	4.6%	-9.5%	14%
Wisconsin	2019	6	67,634	-9.3%	-9.5%	0%
Colorado	2020	5	86,975	20.8%	0.0%	21%
Delaware	2020	5	5,706	27.7%	0.0%	28%
Montana	2020	5	15,821	7.0%	0.0%	7%
North Dakota	2020	5	26,366	-2.3%	0.0%	-2%
Rhode Island	2020	5	17,609	1.0%	0.0%	1%
New Hampshire	2021	4	18,972	26.6%	-5.1%	32%
Pennsylvania	2021	4	157,855	-5.8%	-5.1%	-1%
Georgia	2022	3	80,192	4.9%	-7.5%	12%
Idaho	2023	2	19,811	-6.9%	-7.9%	1%
Virginia	2023	2	54,990	25.1%	-7.9%	33%
All Waivers			1,001,631	-0.1%	-9.2%	**9.1%**

[a] Reference Change is the change in unsubsidized enrollment in states without a waiver in the current or preceding year.

Source: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products

Table 8 shows a wide range of first year enrollment changes for the different waiver states. Eight states actually saw decreases in unsubsidized enrollment, even with the waiver benefit. However, a large portion of these declines can reasonably be attributed to market-wide forces that also affected non-waiver states. While the first two waves of waivers saw reductions in unsubsidized coverage, these effects were much smaller than the prevailing reductions in unsubsidized enrollment in 2018 and 2019 illustrated in

Table 7. Overall, of the 17 states that have implemented reinsurance programs under a 1332 waiver program, 15 have shown favorable unsubsidized enrollment gains relative to the non-waiver benchmark states, while the two waivers that did not show benefits showed only nominal negative effects.

Applying this same construct to later program years 2-7 of waivers, the favorable effects continue beyond program year 1, as summarized in Table 9 and Figure 12:

Table 9

UNSUBSIDIZED ENROLLMENT GROWTH IN WAIVER STATES, PROGRAM YEARS 1-7

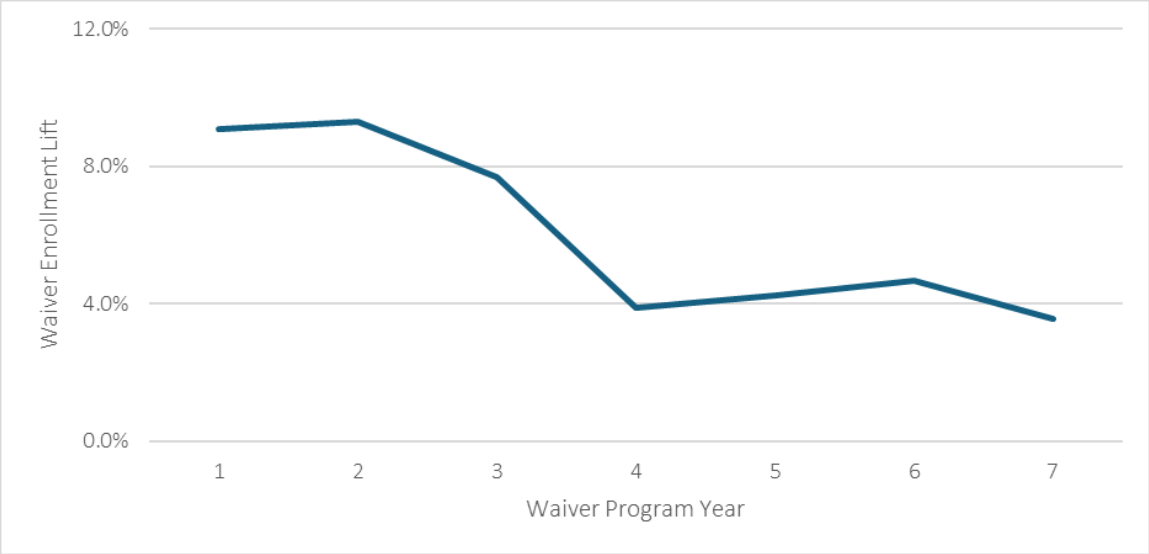
	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7

Sources: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products
https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr

1332 State Annualized Growth	-0.1%	4.6%	3.0%	-1.7%	-1.7%	1.5%	3.3%
Weighted Benchmark	-9.2%	-4.7%	-4.7%	-5.5%	-6.0%	-3.2%	-0.3%
Waiver Lift	9.1%	9.3%	7.7%	3.9%	4.2%	4.7%	3.6%

Figure 12

UNSUBSIDIZED ENROLLMENT GROWTH IN WAIVER STATES, PROGRAM YEARS 1-7



Sources: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products
https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr

While a waiver's large initial coattails fade by year 4, the effect of a 1332 waiver on the enrollment of unsubsidized individuals extends all the way through the 7th year of a program.[31]

Waivers have demonstrated a significant benefit to unsubsidized enrollees (see subsection 4.1 for additional analysis of the affordability impacts of waivers)—the very individuals who are least able to absorb the premium rate increases that many waivers have been designed to limit. However, states who seek to implement a waiver should take note of the following considerations:

- **Except** in very limited situations (such as a fully subsidized market, where no consumers would benefit directly from the waiver), reinsurance waivers will have a net cost to the state. In other words, with reinsurance, there is "no free lunch." States must provide for their portion of the cost—essentially paying for the premium reductions unsubsidized individuals receive - through general revenues, assessments, or some other means. This has a significant effect on state costs for any given program – a waiver in the District of Columbia (which is mostly unsubsidized) would cost DC more per enrollee than a waiver seeking the same level of per enrollee impact in a highly subsidized state such as Mississippi because DC will not benefit from pass-through funding.

[31] Note that for the 7th year of program, the only states available to measure were the first three states that offered waivers in 2018, namely Alaska, Minnesota, and Oregon.

Finally, waivers can affect subsidized consumers unfavorably in a couple different ways.

- Enrollees choosing the benchmark plan would see no change in their net premium. However, those choosing lower premium plans will see a smaller decrease in gross premiums from reinsurance, coupled with a larger decrease in subsidies, leaving them with a net cost increase. See subsection 4.2 of this report for more discussion of this dynamic, or Table C-3 in Appendix C for an illustrative example.
- Members whose PTCs are smaller than the reduction in benchmark premium will lose that premium assistance and will become unsubsidized members. This likely explains some of the lift observed in Figure 12, though this effect is primarily limited to the initial year of a waiver, assuming that the overall premium reduction associated with the waiver remains at similar levels in later years. These individuals still see a reduction in their net premium, but at a smaller level than other unsubsidized consumers would see for the same plan.

Section 3 Policy Goal: Increase Insurer Competition

Access to coverage first requires availability of coverage, and a central tenet of the American economic system is that competition creates optimal outcomes for both consumers and markets. As noted earlier, the ACA also sought to enhance direct competition between insurers through the establishment of exchanges and reasonably similar benefit packages (i.e., essential health benefits and the use of metal levels).

The question for insurers is whether the individual market, either generally or in any particular state, is an attractive market to participate in. Attractiveness for various insurers could mean different things but would almost certainly include the ability to attain meaningful market share, at a reasonable administrative cost, and obtain a population that can be managed profitably. With 11 years of financial data to draw from, past financial performance may provide some insights into the various factors that have driven success and the types of insurers who have obtained success.

In this section, the publicly available financial data from Medical Loss Ratio reports are summarized to deepen the understanding of insurer participation and profitability since implementation of ACA marketplaces in 2014, covering both success stories and cautionary tales.

Observation #6: Insurer participation is highest when the regulatory environment is favorable and following periods of favorable financial results.

3.1 OVERALL INSURER PARTICIPATION, RATE INCREASES, AND OPERATING GAIN

The goal of increasing the number of insurers participating in the individual market (and the small group market) through the exchanges has a two-fold purpose. The first is that competition is thought to hold prices down.[32,33] A second reason is to provide more choices for consumers as each qualified health plan may have various value propositions or appeal to different consumers.[34] Examples of this are outlined below, with each choice coming with different premiums levels:

- Individual market plans offered by Medicaid Managed Care Organizations may appeal to lower income individuals who have had or could have Medicaid coverage. Name recognition or the ability to stay with a particular issuer (and their in-network doctor) as their income and eligibility changes may appeal to these consumers.

- Issuers such as the Blue Cross and Blue Shield plans, Kaiser Permanente, United Healthcare, and others may attract consumers for a variety of reasons, including having previous coverage through an employer plan, a broader network of providers, or a visible brand name.

- Regional issuers may appeal to consumers for similar reasons: local brand presence and familiarity or a regional plan could be aligned with a prominent and trusted health system.

The variety of consumer-facing value propositions may make it more likely that consumers will enroll, stay enrolled, or re-enroll in the future as they identify in some meaningful manner with the provider of an

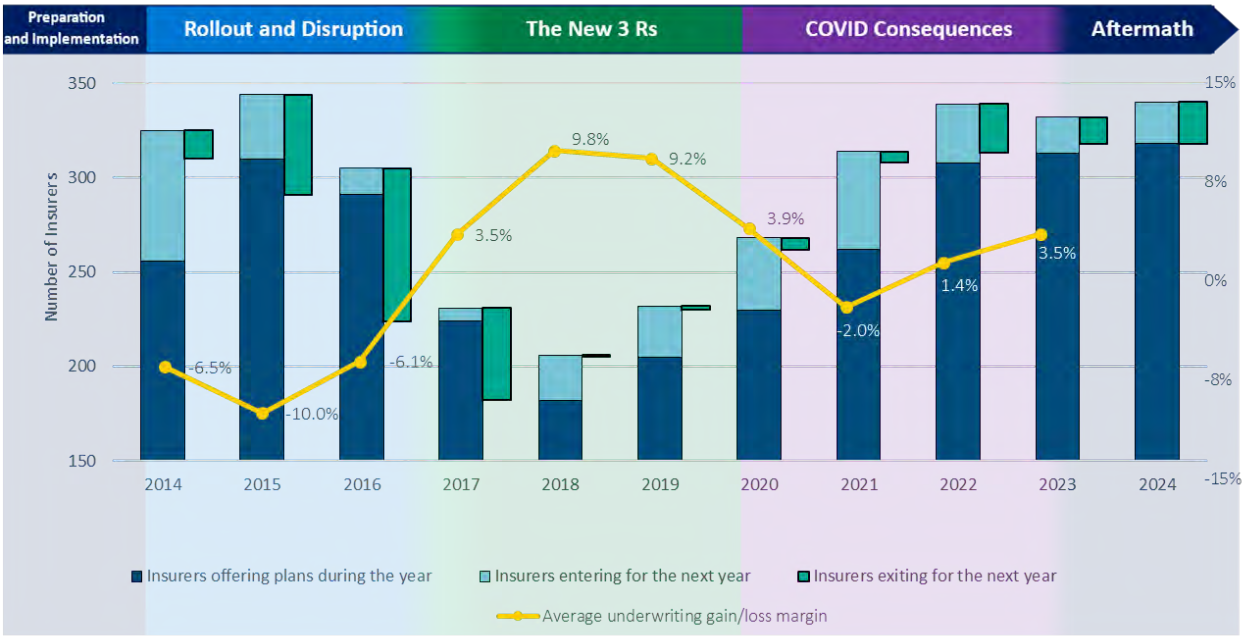
[32] ACA Marketplace Premiums Grew More Rapidly In Areas With Monopoly Insurers Than In Areas With More Competition | Health Affairs, accessed January 8, 2025
[33] https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2653907, accessed January 8, 2025
[34] Obama remarks to State of Maryland in 2013. Accessed July 13, 2024. President Obama Speaks on the Affordable Care Act | The White House

important part of a household's financial security. However, the importance of competition leading to the consumer benefits of lower prices and more consumer choices is balanced with insurer's expectations and requirements for reasonable financial performance in these markets.

The previous report[35] compiled data on total insurers, yearly exits and yearly entries of issuer-states[36] overlaid with composite, market-wide underwriting gain. In these summaries, underwriting gain refers to the profit an insurer earns from its core business operations, specifically from the premiums collected minus the claims paid and other non-benefit expenses. Figure 13 below updates and extends this data through 2024, while Figure 14 combines that same underwriting gain figure with composite market-wide changes in on-exchange silver premium rates.

Figure 13

ANALYSIS OF INSURER EXITS, ENTRANCES, AND UNDERWRITING GAIN



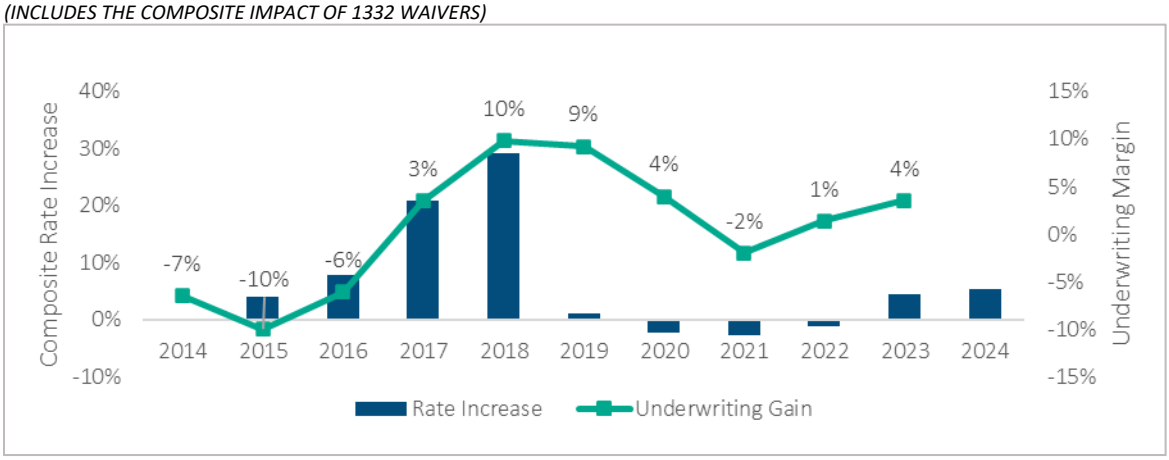
Sources: https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr ;
https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs
https://hixcompare.org
https://www.healthcare.gov/health-and-dental-plan-datasets-for-researchers-and-issuers

[35] Fifty States, Fifty Stories: A Decade of Health Care Reform Under the Affordable Care Act
[36] A single count is one issuer in one state, with its own unique HIOS ID, hence the terminology "issuer-state."

Figure 14

ANALYSIS OF UNDERWRITING GAIN AND COMPOSITE RATE INCREASES

(INCLUDES THE COMPOSITE IMPACT OF 1332 WAIVERS)



Sources: https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr ; https://hixcompare.org ; https://www.healthcare.gov/health-and-dental-plan-datasets-for-researchers-and-issuers ; https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programshttps://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs

With additional years of data, a clear relationship, lagged two years, exists between a stabilized and more profitable market and the number of insurers that participate in the individual market. For example, during the Rollout and Disruption years, underwriting gains were below zero and, as a result, issuer exits reduced total participation by a third by 2018. However, with the benefit of two years of significant rate increases in 2017 and 2018, margins improved and reached a peak of 9.8%. Two years after margins turned positive in 2017, 2019 began to see an increase in issuer participation. After 2019, several years of rate decreases brought margins back to lower levels near zero and overall issuer participation has subsequently leveled off.

This pattern is indicative of the underwriting cycle. Insurer decisions to enter or exit the individual market may not be made with financial data from the immediately preceding year as this is not known with full clarity. However, issuers can make decisions to enter or exit based on known financial results from the year prior to the immediately preceding year. For example, financial results for 2018 would be known in about the middle of 2019 for decision-making related to market participation in 2020.

3.2 INSURER PARTICIPATION BY INSURER TYPE

While overall participation declined through the "New 3 Rs" years, the different categories of insurers all had different responses to the broad market underwriting losses during the Roll Out and Disruption years that led to it. Insurers were classified, where possible, into distinct categories based on either their approach to the market or consumer value proposition, their brand, or their capabilities. The top insurers in each of the categories are:

- **National:** Aetna, Cigna, Coventry, Humana, United Healthcare
- **Medicaid:** Molina, Centene, CareSource
- **Blue:** Blue plans, affiliates including HCSC, Anthem & Highmark
- **Insurtech:** Bright, Friday, Oscar
- **Regional:** Harvard Pilgram, Medica
- **Provider:** Kaiser and 22 Others

- **CO-OP:** All 23 CO-OP plans[37]

Using these groupings, the total participation by insurer type is shown below in Table 10. Note that participation is calculated at the state level, meaning that a single insurer will be counted for each state in which it offers individual market coverage.

Table 10
INSURER EXCHANGE PARTICIPATION BY INSURER TYPE

CY	National	Medicaid	Blue	Insurtech	Regional	Provider	CO-OP	Other	Total
2014	44	30	59	2	30	28	23	40	256
2015	59	36	57	4	33	29	24	68	310
2016	63	37	59	6	35	29	11	51	291
2017	25	39	59	6	32	29	7	27	224
2018	8	40	49	9	31	26	5	14	182
2019	10	46	53	14	34	27	5	16	205
2020	13	49	55	24	37	30	5	17	230
2021	18	49	64	33	42	33	5	18	262
2022	37	61	65	43	46	33	5	18	308
2023	48	67	69	25	50	33	5	16	313
2024	55	70	70	20	53	33	5	12	318

Source: https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr

By 2018, overall insurer participation had bottomed out. However, there are noticeable differences in the number of exits between the plan types. For example, the nationwide footprint of Medicaid and Insurtech insurers actually increased from 2017 to 2018, while every other segment declined. Of note the National insurers dropped fully 87%, from 63 issuer-states in 2016 down to just eight in 2018. However, by 2022, all issuers saw increasing participation, except Insurtechs.[38] The next section explores the potential financial drivers of these actions.

3.2.1 FINANCIAL RESULTS BY INSURER TYPE

To gain deeper insight into this, one can look at financial results by these issuer types through 2023 in Table 11 below. Using the same issuer-state groupings introduced in the previous section, underwriting gain or loss is summarized and shown as a percentage of premium, that each insurer type experienced.

[37] For a detailed summary of Consumer Oriented and Operated Plans, see https://www.healthinsurance.org/obamacare/co-op-health-plans-put-patients-interests-first/#failures.

[38] The "Other" category declined primarily due to exits of pre-ACA insurers who entered the ACA but ultimately exited as they found limited success.

Table 11
INSURER UNDERWRITING GAIN/(LOSS)[39] BY INSURER TYPE

CY	National	Medicaid	Blue Plans	Insurtech	Regional	Provider Sponsored	CO-OPs	All Other	Total
2014	-7.9%	-1.4%	-5.9%	-41.1%	-5.9%	3.9%	-43.4%	-15.6%	-6.5%
2015	-10.7%	-2.2%	-5.1%	-36.3%	-10.6%	-10.6%	-44.3%	-20.5%	-10.0%
2016	-1.9%	-1.9%	-4.4%	-39.9%	-12.2%	-13.7%	-26.8%	-7.9%	-6.1%
2017	6.1%	3.3%	8.0%	-25.1%	-3.1%	-6.3%	-4.2%	-8.9%	3.5%
2018	11.0%	10.1%	12.9%	-4.4%	10.9%	2.8%	17.8%	0.4%	9.8%
2019	7.6%	5.9%	12.4%	-7.9%	10.4%	5.9%	21.1%	5.0%	9.2%
2020	-5.9%	-0.6%	8.5%	-7.5%	3.2%	2.3%	12.2%	-0.1%	3.9%
2021	-5.1%	-4.8%	2.1%	-12.0%	-4.2%	-4.5%	9.3%	4.1%	-2.0%
2022	-8.1%	-0.1%	6.3%	-4.5%	3.9%	-4.5%	13.7%	-3.5%	1.4%
2023	-0.6%	4.8%	6.0%	2.6%	3.6%	-3.3%	9.1%	0.5%	3.5%

Source: https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr

Based on both tables, it becomes somewhat clearer how financial results influenced each insurer type in its participation decisions.

Nationals – These issuers began their exits one year earlier (in 2017) than the other insurer types. At that time, decision makers would have had 2015 financial results that showed an average 10.7% underwriting loss, slightly worse than the overall market. After exiting what were likely the least profitable geographic areas or states, underwriting results improved in 2017 to a 6.1% gain.

Medicaid – Financial results for Medicaid plans in the earliest years were the most favorable, relative to the total market. These plans experienced an average underwriting loss of ~2% from 2014-2016, while the total market averaged a loss of closer to 8%. Thus, it is understandable that Medicaid plan decision makers might have seen more upside to remaining in the market as the path to profitability was clearer.

Blues – Financial results for Blue plans in the early years, like the market, were unfavorable. However, most Blue plans stayed in the ACA individual market. Of the 10 exits in 2017, five were a Blues-conglomerate, and the other five were separate single-state Blue plans. Blue plans have since increased their participation and have not, in aggregate, experienced an underwriting loss.

Insurtechs – The experience of Oscar, Bright Health, and Friday health plans in the early years was (along with the CO-OPs) the most unfavorable of all of the insurer types. Two of the three (Bright Health and Friday) are no longer offering coverage, while the third has, as of date of this report, produced a positive operating gain in 2023, the first time in its existence.

CO-OPs – These had the most unfavorable results of all of the insurer types, with the first three years of the individual market reforms averaging a ~38% operating loss. They were unable to stay sufficiently capitalized

[39] Does not include belated payments under the risk corridor program.

and many CO-OPs exited after only 1-2 years of being in business.[40] Today, there are three remaining (operating in five states), though these all have shown solid financial outcomes in the years since.

3.2.2 FINANCIAL RESULTS FROM EXITING INSURERS

Observation #7: Exiting insurers generally exhibit poor financial performance across multiple measurable metrics, including operating margin, administrative costs, and market share.

Building on the patterns of market exits and entrances by insurer type observed in the previous section, it is also insightful to examine the financial characteristics of insurers who chose to exit the individual market, irrespective of type. While there may be a variety of reasons that an insurer ultimately chooses to exit the market, a common theme among almost all those who exited is poor financial performance. By analyzing the financial characteristics of these exiting insurers, patterns can be identified that suggest what influenced the decisions to withdraw and understand the broader implications for the market.

As seen in Table 12, there are indicators that insurers may leave for multiple reasons, but all are fundamentally connected to their financial performance.

Table 12
FINANCIAL CHARACTERISTICS OF EXITING INSURERS

Last Year of Participation (Year-1)	2014	2015	2016	2017	2018	2019	2020	2021	2022
Year of Exit	2015	2016	2017	2018	2019	2020	2021	2022	2023
# of Exits	15	53	81	49	1	2	6	6	26
1 Year Operating Gain									
Insurers Who Exited the Market	-11.5%	-34.3%	-5.8%	2.3%	1.9%	10.1%	7.1%	-0.2%	-7.5%
Insurers Who did not Exit the Market	-9.1%	-4.3%	4.2%	10.1%	8.9%	4.6%	-1.3%	2.5%	4.3%
Difference	-2.4%	-29.9%	-9.9%	-7.8%	-7.1%	5.5%	8.4%	-2.8%	-11.7%
2 Year Operating Gain									
Insurers Who Exited the Market	NA	-8.3%	-24.7%	-16.8%	-6.9%	-4.3%	2.5%	17.2%	1.1%
Insurers Who did not Exit the Market		-6.9%	-7.3%	-6.0%	4.0%	10.0%	9.2%	3.9%	-2.0%
Difference		-1.3%	-17.3%	-10.8%	-10.9%	-14.3%	-6.7%	13.3%	3.1%
Administrative Costs - % Premium									
Insurers Who Exited the Market	18.5%	18.6%	13.9%	12.8%	11.2%	12.3%	8.9%	11.1%	12.8%
Insurers Who did not Exit the Market	10.1%	8.8%	7.5%	6.4%	7.2%	8.3%	8.4%	8.5%	8.3%
Difference	8.4%	9.8%	6.4%	6.4%	4.0%	4.0%	0.4%	2.6%	4.4%
Risk-Adjustment Receipt / (Payment) - % of Premium									
Insurers Who Exited the Market	-2.4%	-3.7%	-2.6%	0.6%	7.3%	4.8%	-0.4%	-1.9%	-26.0%
Insurers Who did not Exit the Market	-0.2%	0.5%	0.6%	0.2%	0.4%	0.5%	0.6%	2.2%	2.7%
Difference	-2.2%	-4.2%	-3.3%	0.4%	6.9%	4.4%	-1.0%	-4.1%	-28.7%
Risk Adjustment - % Payers									

Source: https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr

[40] CO-OPs faced several struggles in this regard, including the loss of risk corridor funding, less favorable than expected results from risk adjustment, and the rescission of most of the funding originally appropriated by Congress to help these new insurance businesses stand up.

Insurers Who Exited the Market	47%	45%	41%	37%	0%	50%	17%	33%	69%
Insurers Who did not Exit the Market	56%	66%	63%	56%	53%	54%	56%	58%	60%
Difference	9.7%	20.4%	22.5%	18.8%	52.9%	4.3%	39.7%	25.1%	-9.0%
Market Share									
Insurers Who Exited the Market	9.8%	6.0%	5.0%	8.7%	8.5%	6.3%	7.7%	6.7%	9.5%
Insurers Who did not Exit the Market	13.5%	14.7%	16.3%	21.1%	22.7%	22.3%	20.7%	18.1%	16.5%
Difference	-3.7%	-8.7%	-11.3%	-12.3%	-14.2%	-16.0%	-13.0%	-11.5%	-6.9%
Market Share - % of Insurers < 5%									
Insurers Who Exited the Market	67%	68%	77%	57%	0%	50%	83%	83%	38%
Insurers Who did not Exit the Market	46%	47%	38%	31%	28%	35%	37%	39%	45%
Difference	-20.6%	-20.5%	-38.9%	-25.7%	28.2%	-15.0%	-46.3%	-44.7%	6.2%

In Table 12, several patterns can be found among the financial characteristics of insurers who decided to exit the market, specifically:

- **Operating gains:** The operating gain from the year immediately preceding the decision to exit is unfavorable compared to the market average in all years with the exception of 2020 and 2021. While this data is not entirely known to the leadership of market participants at the time of decision-making, what is known may be indicative of existing financial challenges.

  However, the operating gain from two years prior is known at the time a decision needs to be made about remaining in the market. As seen in the analysis of the market as a whole (see Figure 13) and in the analysis of the insurer types, this historical financial underperformance is likely a significant driver behind the decision to exit the market as it is fully known prior to an insurer's decision regarding market participation.

- **Administrative costs[41]:** Exiting insurers were found to have higher reported administrative costs compared to those that remained in the market. Early in the market reform years (2014-2015), the medical loss ratio (MLR) constraints established by the ACA that limits the administrative costs that can be priced into premiums may have contributed to less administratively-efficient insurers leaving the market. The transition from an underwritten market to a guaranteed issue / risk-adjustment market required insurers to develop new capabilities, eliminate previous systems and processes, and stand up new ones. This changeover likely added to their administrative burden and, in certain cases, the effort may not have been entirely successful, leading to a market exit.

- **Risk-adjustment program payers:** Risk-adjustment program status (payer or receiver) also showed some signs of a consistent pattern amongst insurers exiting. While payer status typically means a population is healthier and has less paid claims, the relationship between risk adjustment and paid claims is not one-to-one. Moreover, being in a payer position under the risk-adjustment program could be unfavorable, as Hierarchical Condition Categories (HCCs) are known to overpredict costs

[41] Excludes profit, state and federal taxes. Reported expenses are from the NAIC Medical Loss Ratio reports taken from Part 1, Line 10_5.

for higher risk individuals.[42] Generally, historical financial results also bear this out, with risk-adjustment payers facing a medical loss ratio headwind of 5-8%.[43]

Table 13
LOSS RATIO BY ISSUER RISK-ADJUSTMENT STATUS

	2018	2019	2020	2021	2022	2023
Risk-Adjustment Payer	84%	85%	89%	94%	87%	89%
Risk-Adjustment Receiver	76%	78%	83%	89%	89%	83%

Source: https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr

Furthermore, despite industry studies, accurately predicting risk-adjustment outcomes for purposes of pricing and other financial analysis remains challenging, contributing to financial instability. The challenge of predicting risk adjustment is particularly pronounced for smaller insurers, creating further financial uncertainty for insurers with low market share.[44]

- **Market share:** Perhaps the clearest pattern emerges when examining the market share of insurers who exited the market. In all years, the average market share of insurers who exited the market was below that of the insurers who remained, with the majority of exiting insurers having a market share below 5%. Smaller insurers are likely to lack the economies of scale, as well as the provider negotiating power that are afforded to larger insurers, making it harder for small insurers to compete on price.

Taken together, not only do these characteristics provide insight into the reasons behind insurers' decisions to exit the individual market, but they also identify three of the key elements necessary to achieve financial success in a single risk pool world: administrative efficiency, success in risk adjustment (both through accurate risk score capture and accounting for risk adjustment in premium development), and sufficient market influence to negotiate favorable provider reimbursement rates.

3.2.3 FINANCIAL RESULTS FROM INSURERS' FIRST YEARS IN THE ACA

Observation #8: Entering insurers may face financial and operational headwinds, but hurdles to success are surmountable and may be easing with time.

As insurers exit the ACA market, which will inevitably happen, it is important that new insurers enter to provide consumers with a choice of plans and robust competition to hold prices down. The experience of these new entrants into the individual market by year, with a focus on similar characteristics reviewed for market exits, can provide insights into the challenges new insurers might face. Moreover, a review of the financial performance of new entrants provides a unique view of the financial health of the market as a whole.

[42] The HHS-HCC Risk Adjustment Model for Individual and Small Group Markets under the Affordable Care Act - PMC (see tables of predictive ratios starting with Exhibit 7)
[43] Authors' analysis of Medical Loss ratio data for years 2018-2022
[44] Sizing up ACA risk adjustment volatility: How the interplay between risk adjustment and issuer size influences profitability under the ACA, accessed January 15, 2024

Table 14

FINANCIAL CHARACTERISTICS OF NEW MARKET ENTRANTS

Year of Entrance	2015	2016	2017	2018	2019	2020	2021	2022	2023
# of Entrants	69	34	14	7	24	27	38	52	31
1 Year Operating Gain									
Insurers Who Entered the Market	-24.4%	-9.9%	-4.1%	15.7%	9.8%	-9.9%	-9.1%	-11.7%	0.2%
Insurers Who did not Enter the Market	-9.1%	-4.3%	4.2%	10.1%	8.9%	4.6%	-1.3%	2.5%	4.3%
Difference	-15.3%	-5.5%	-8.3%	5.6%	0.9%	-14.5%	-7.8%	-14.2%	-4.1%
Administrative Costs - % Premium									
Insurers Who Entered the Market	18.5%	15.9%	14.0%	13.3%	12.7%	16.0%	15.9%	14.8%	13.2%
Insurers Who did not Enter the Market	10.1%	8.8%	7.5%	6.4%	7.2%	8.3%	8.4%	8.5%	8.3%
Difference	8.4%	7.1%	6.5%	6.9%	5.6%	7.7%	7.4%	6.3%	4.8%
Risk Adjustment - % of Premium									
Insurers Who Entered the Market	5.8%	-6.2%	-17.3%	1.5%	-9.1%	-18.1%	-13.8%	-31.2%	-17.5%
Insurers Who did not Enter the Market	-0.2%	0.5%	0.6%	0.2%	0.4%	0.5%	0.6%	2.2%	2.7%
Difference	5.9%	-6.7%	-17.9%	1.3%	-9.5%	-18.5%	-14.5%	-33.4%	-20.2%
Market Share									
Insurers Who Entered the Market	2.9%	5.9%	9.1%	8.4%	5.4%	2.7%	3.7%	2.9%	5.8%
Insurers Who did not Enter the Market	13.4%	14.7%	16.3%	21.1%	22.7%	22.3%	20.7%	18.1%	16.5%
Difference	-10.5%	-8.8%	-7.1%	-12.7%	-17.3%	-19.6%	-17.0%	-15.3%	-10.6%
Market Share - # of Insurers < 5%									
Insurers Who Entered the Market	83%	79%	57%	57%	75%	89%	79%	88%	55%
Insurers Who did not Enter the Market	46%	47%	38%	31%	28%	35%	37%	39%	45%
Difference	36.6%	31.9%	19.5%	25.7%	46.8%	53.9%	41.9%	49.8%	10.2%

Source: https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr

Similar to the previous section, several patterns can be found among the market entrants:

- **Operating gains:** In the early years of the ACA, new market entrants had significantly worse financial performance compared to established insurers. This difference is likely due to myriad factors, including a lack of historical claims data to inform premium development, administrative start-up costs, immature risk coding operations to support risk adjustment, and aggressive pricing strategies to support garnering meaningful market share.

- **Administrative costs:** Indicative of the start-up costs necessary to enter the market, new entrants consistently have higher administrative costs than insurers already in the market.

- **Risk-adjustment program:** Market entrants are more likely to be risk-adjustment payers in their first year. This may be due to immature risk coding operations relative to those of the established insurers.

- **Market share:** It is no surprise that new insurers in the individual market would have significantly less market share than previously participating insurers. Market leading share develops over time as the benefits of sustained market presence accumulate and the strategic advantages of an insurer's brand can be leveraged.

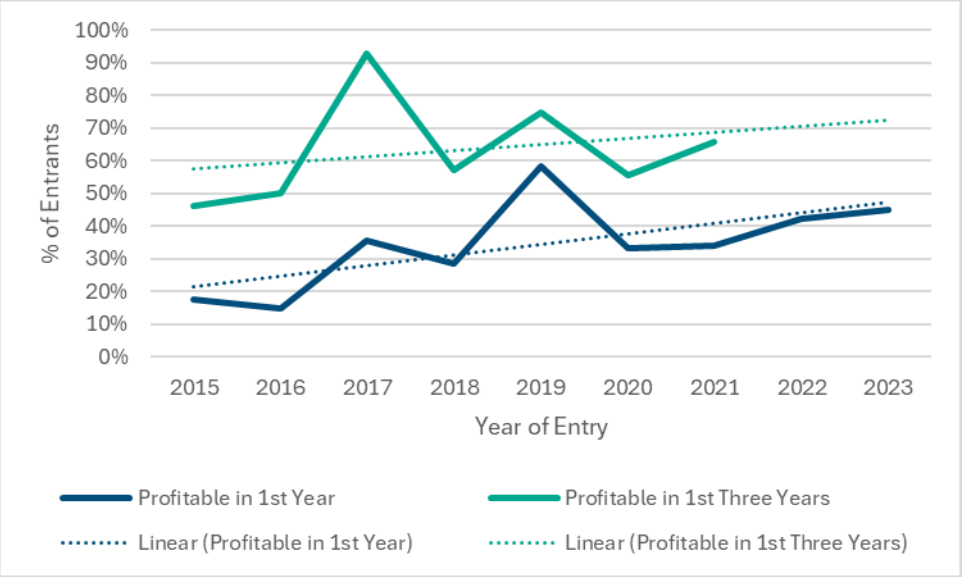
While first year new entrants' financial performance is unfavorable to incumbents, many (certainly not all) new insurers improve performance over time and find a path towards profitability. Understanding these

challenges faced by new market entrants in the individual market provides valuable context for evaluating their financial trajectories.

In Figure 15, the number of years that were needed for new entrants to achieve profitability after entering the individual market is shown. Further data supporting Figure 15 can be found in Table C-4 in Appendix C.

Figure 15

YEARS TO PROFITABIITY FOR NEW ACA MARKET ENTRANTS



Source: https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr

Over time, the proportion of market entrants who have seen financial success in their first year, as well as the proportion to see success within the first three years, has generally increased. This could be a sign of ACA markets that are structurally profitable (stable regulatory environment coupled with rationale pricing by participants). It could also be the accumulation of experience and improved execution on the part of industry participants as they navigate a maturing market. With increased odds of success, more issuers may enter the market or stay in the market, providing the type of consumer choice and competition envisioned by the ACA.

Section 4 Policy Goal: Affordable Coverage

With a greater understanding of the ACA's effects on enrollment and competition, the focus now turns to the issue of affordability. The ACA includes several measures designed to improve the affordability of coverage to consumers, with the greatest emphasis placed on the affordability of comprehensive coverage in the individual market.

Premium tax credits represent one of the law's key affordability provisions, but many consumers are not eligible to receive them. This creates a sharp distinction in the experience of affordability based on whether a consumer is purchasing individual market coverage on their own or using a premium tax credit to pay a lower net cost. This section delves into key market affordability themes that emerge from the law in its first 15 years, first through the lens of those who do not receive PTCs, and then through the lens of those who do.

THE ACA: A BIG LAW WITH BIG GOALS, PART 3: AFFORDABILITY PROVISIONS BEYOND THE INDIVIDUAL MARKET

While the ACA's focus on affordability primarily targets individual market coverage, other provisions of the law are targeted at improving affordability in other markets, including:

- Closing the Medicare Part D "donut hole"
- The Small Business Health Care Tax Credit
- Capping employee premium contributions for large employer coverage as part of the employer mandate
- Minimum medical loss ratio requirements for insurance coverage in the commercial market, Medicare Advantage and Part D, and managed Medicaid plans

4.1 THE COST OF UNSUBSIDIZED COVERAGE

Unlike individuals who receive PTCs, unsubsidized individuals are directly exposed to rate changes in their plan of choice, directly taking the full brunt of increases and the relief of rate decreases. One cannot fully understand ACA market affordability without considering gross premium trends and the ACA policy provisions—such as Section 1332 State Innovation Waivers—that states have employed to reduce them. Below, we consider affordability of gross premiums in aggregate and by metal tier.[45]

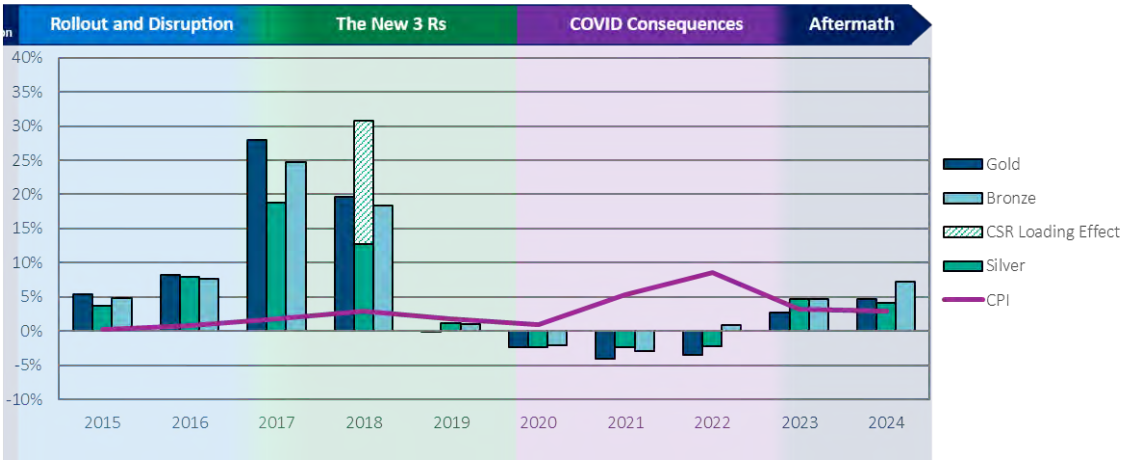
Observation #9: After two years of corrective rate action in 2017 and 2018, average ACA premium rates have remained remarkably stable for the past six years, with average annual premium rate increases that trail consumer price inflation.

Figure 16 summarizes rate changes for the lowest cost plan by metal tier (excluding platinum[46]) from 2015 through 2024. We have included consumer price inflation as a point of comparison and lagged market-average underwriting gains for context.[47]

[45] State and federal rate reviewers do, in fact, review gross premiums, with relatively little attention paid to net premium growth for reasons discussed later in subsection 4.2.
[46] Platinum plans are richer plans (generally around 90% AV), which are offered in only select states, not broadly across the country. For this reason, these plans are excluded from this analysis.
[47] We report financial results with a two year offset to account for the delay between financial performance and prospective rate-setting based on that performance.

Figure 16

CHANGE IN LOWEST-COST ON-EXCHANGE RATE BY METAL IN THE INDIVIDUAL MARKET



Sources: https://hixcompare.org
https://www.healthcare.gov/health-and-dental-plan-datasets-for-researchers-and-issuers
Inflation data is per the U.S. Bureau of Labor Statistics

Note: The 2018 CSR loading estimate on silver plans above is based on silver load estimates from CMS' final administrative order related to adjusting the Basic Health Plan funding formula for the lack of CSR appropriations, weighted by state ACA enrollment. Data underlying this graph can be found in Table C-5 in Appendix C.

The rate increases in 2017 and 2018 illustrate the national market's delayed response to inadequate initial rate levels, as described in the ACA@10, a reflection of the negative underwriting gains from two years prior (from Figure 14). These increases were further compounded by the scheduled phase-out of federal reinsurance (2014-2016), the loss of funding for risk corridors, and an unanticipated transitional "grandmothering" policy that allowed people to retain non-ACA-compliant coverage if still enrolled at the end of 2013 (subject to state permission).

This trend reversed itself by 2019 as losses turned to gains and many issuers incurred large MLR rebates[48] leading, in some cases, to rate decreases during the COVID Consequences era. To date, the Aftermath era has seen relatively modest premium rate increases as underwriting gain has stabilized and ARPA's enhanced PTCs have remained in force.

In addition to the broader underwriting story shown in Figure 16, two clear shifts affecting gross silver premiums are apparent. The 2017 termination of federal funding for CSR reimbursements on 2018 premiums caused a roughly 18% increase in silver premiums as issuers sought to recoup the foregone funding. Insurers also took steps to constrain silver premium growth amidst the broader rate correction, driven perhaps by advantages to offering the second-lowest-cost (benchmark) silver plan, a concentration of enrollment in silver plans in many markets, and a risk-adjustment design that rewards and potentially overcompensates issuers for subsidized CSR plan enrollees, particularly those in the most generous 87%

[48] Commercial health insurance: Detailed 2020 financial results and emerging 2021 trends, page 8, accessed February 18, 2025

and 94% AV plan variations.[49, 50] Moreover, Figure 16 suggests that a more concise view of rate increase information can tell the bulk of the story.

To that end, Table 15 summarizes rate increase information by metal tier for 2014 through 2018, 2019 through 2024, and in total, and compares composite gross premium increases to the Consumer Price Index for all Urban Consumers (CPI-U). Overall, gross premiums in the individual market rose 80%, roughly in line with bronze and silver premium growth over this period. Issuers were most cautious with gold premiums through 2018, raising premiums 74% relative to 67% for bronze. However, this appears to have been somewhat of an overcorrection, as gold premiums actually fell in the second half of this window, while bronze plans saw the highest growth during the COVID Consequences and Aftermath eras.

Taking a broader economic view, gross premium rate increases over this 11-year period have outpaced general price inflation by 48 percentage points. However, the story is markedly different by half—early premium growth is highly driven by the high-rate increases associated with insurer retrenchment and CSR loading and exceeded general inflation by almost 70%. However, later rate increases across gold, silver, and bronze metal levels separately and in total have been significantly *lower* than general inflation—by 21 percentage points. Taking a broader economic view, gross premium rate increases since the start of the single risk pool have outpaced general price inflation by 48 percentage points, or about 4% per year.

Table 15
GROSS PREMIUM TRENDS VS. TREND IN CPI-U, 2014-2024

Quantity	2014 -2018	2019 -2024	All Years
Composite Gross Premium	**75%**	**4%**	**80%**
Bronze Premiums	67%	9%	81%
Silver Premiums	77%	3%	82%
Excluding CSR Load	*50%*	*3%*	*54%*
Gold Premiums	74%	-3%	69%
CPI - All Items	**6%**	**25%**	**32%**
Difference	**69%**	**-21%**	**48%**

Sources: https://hixcompare.org
https://www.healthcare.gov/health-and-dental-plan-datasets-for-researchers-and-issuers
bls.gov

Gross premiums aren't always the result of an evolving steady state market. Section 1332 State Innovation Waivers provide states an additional opportunity to influence gross premiums facing unsubsidized individuals.

4.1.1 EFFECTS OF 1332 WAIVERS ON COVERAGE FOR UNSUBSIDIZED INDIVIDUALS

Observation #10: State 1332 waivers reduce premiums for unsubsidized consumers in both the short and the medium term.

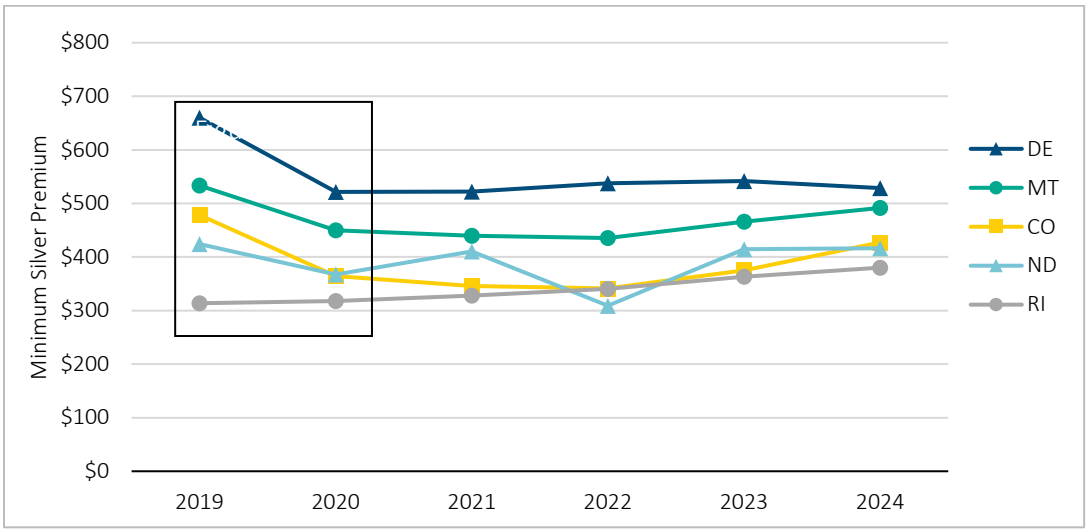
As discussed in subsection 2.3, state waivers under section 1332 of the ACA are intended to allow states to modify certain rules of the ACA and, for waivers that reduce premiums, to recapture some or all of the reduced federal expenditure on premium tax credits, which are then used to fund the state's reform

[49] This was demonstrated convincingly in CMS October 2026 risk-adjustment technical paper in Appendix A that noted that risk adjustment reasonably predicted plan paid amounts in the absence of CSR reimbursements—assuming that premiums were not increased on silver plans to account for the lack of funding.
[50] The 2016 SOA annual meeting session "Learning from the first two years of the ACA" is one of the first public indications that CSR enrollees were profitable after accounting for risk adjustment, per slides 35 and 36 of https://media01.commpartners.com/SOA/Vegas_2016/Session02/V90%20Handout.pdf.

efforts. As a result, waivers are most often viewed through the lens of their effect on consumer premiums. Waivers have been introduced by states at a relatively steady rate over the years, and it is most useful to evaluate affordability by state cohort based on the year of introduction. As an example, in 2020, five different states implemented section 1332 waivers (all reinsurance programs) and the impacts on gross silver premium rates (the rates paid by unsubsidized consumers) are shown in Figure 17.

Figure 17

CHANGE IN LOWEST-COST ON-EXCHANGE SILVER RATE IN 2020 WAIVER STATES



Sources: https://hixcompare.org; https://www.healthcare.gov/health-and-dental-plan-datasets-for-researchers-and-issuers

Focusing on the initial year of effect, silver premiums fell in four of the five states in this cohort. However, this year-over-year view in and of itself does not tell a complete story—as noted in the previous discussion, premium rates fell more generally over this period. To better understand the affordability effects of 1332 waivers, it is important to compare these premium changes to the broader national landscape of rate changes in states that did not implement 1332 waivers, as shown in Table 16.

Table 16

IMPLEMENTATION EFFECTS OF 1332 WAIVERS IN THEIR FIRST YEAR COMPARED TO RATE CHANGES IN STATES WITHOUT WAIVERS[51]

Implementation Year	Implementation States	Non-Implementation States
2018	4%	36%
2019	-8%	2%
2020	-18%	-2%
2021	-6%	-2%
2022	-12%	-2%
2023	-18%	5%

Sources: https://hixcompare.org; https://www.healthcare.gov/health-and-dental-plan-datasets-for-researchers-and-issuers

[51] A detailed list of states that implemented reinsurance waivers and their impacts on gross premium rates by year can be found in Appendix Table C-1.

Table 16 illustrates a clear relative premium differential between states implementing 1332 waivers and states without waivers—even when a direct year-over-year premium analysis may not reveal savings. These savings are directly experienced by consumers who do not receive premium subsidies.

Gross price analysis, while useful, ignores a key dynamic in the ACA—premium tax credits. For subsidized consumers, premium tax credits ultimately determine the net premium paid out-of-pocket for most individuals who purchase coverage in the individual market.

4.2 THE AFFORDABILITY OF SUBSIDIZED COVERAGE

Growth in net (after subsidy) premiums is driven by the relationship of gross premium growth and income growth, rather than the growth in premium on its own. The story of net premiums reflects both the continued growth of federal poverty level guidelines (FPL) over time, the leveraging effects associated with CSR loading, and the significant increase in PTCs created by the American Rescue Plan Act of 2021.

4.2.1 CHANGES IN FPL AND NET PREMIUMS FOR INDIVIDUALS RECEIVING PREMIUM TAX CREDITS

The ACA's premium tax credit structure is designed to limit the premiums a household is required to pay for health insurance relative to that household's income. It targets a specific net premium on a pair of sliding scales for the second-lowest cost silver plan (the benchmark plan). The primary factor used to determine this target is household income as a percentage of the applicable federal poverty guidelines.[52] Prior to the ARPA enhanced PTCs, which began in 2021, net premiums were also influenced to a lesser degree by the difference between premium growth and income growth.[53] Table 17 shows change in these factors from a 2014 baseline through 2024.

Table 17

GROWTH IN FACTORS AFFECTING NET PREMIUMS IN THE INDIVIDUAL MARKET

	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	Total
FPL	1.6%	0.9%	0.9%	1.5%	0.7%	2.9%	2.2%	0.9%	5.5%	7.3%	27%
Premium Net of Income Factor	0.6%	-0.3%	1.7%	-1.3%	3.1%	-0.8%	-2.9%†	N/A	N/A	N/A	0%
Change in Net Premium for Benchmark Coverage	2.2%	0.6%	2.7%	0.2%	3.8%	2.1%	-0.8%	0.9%	5.5%	7.3%	27%

† The ARPA's enhancements to the premium tax credit schedule are not indexed, effectively removing the effect of the premium net of income factor. This factor will return if enhanced premium tax credits expire as scheduled for 2026. Based on final guidance published by HHS in December 2024, this factor will reduce net premiums for PTC-eligible individuals by 3.75%.

[52] Under prevailing IRS and HHS guidance, the FPL used in a given year is the one known at the start of open enrollment. Since FPL for a year is published in February, while open enrollment begins in November, there is a disconnect between the FPL year published by HHS and the FPL year used for purposes of subsidies. For example, 2025 coverage uses the 2024 FPL levels to determine household incomes, since 2025 FPLs were not released until February of 2025, while the annual open enrollment period began in November 2024.

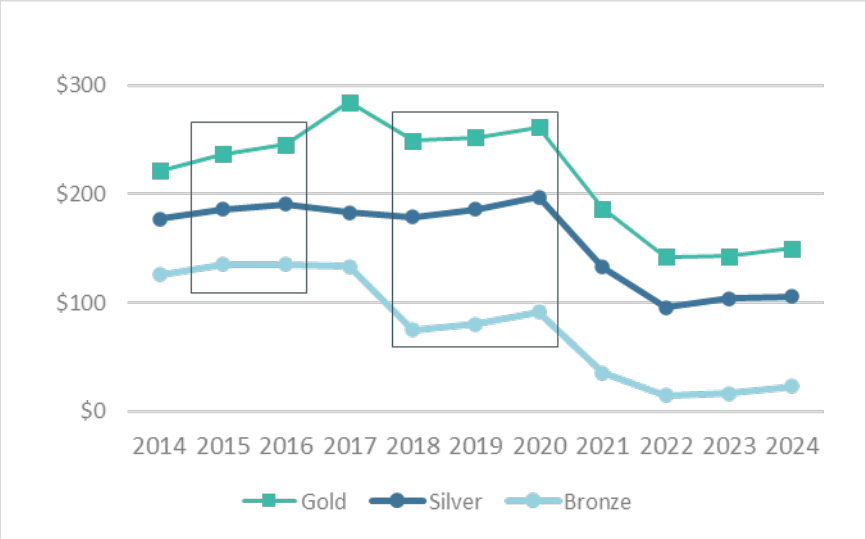
[53] HHS and the IRS have historically leveraged the national health expenditure (NHE) projections published by the CMS Office of the Actuary available at the time of value publication for the year preceding the year under consideration relative to the value in 2013 (the year preceding 2014). For example, 2019 values were determined in early 2018 using the projected national health expenditures for 2016-2025 published by CMS in the second half of 2017. Premium growth is determined by comparing per capita employer-sponsored coverage expenditures in 2018 over 2013—an increase of 25.17%. Income growth is determined by comparing per capita income for the same periods, an increase of 20.59%. As such, the premium net of income growth factor was roughly 1.0308 (= 1.2517/1.2059), an increase of 3.1% over the value calculated using this methodology for 2018 coverage in the preceding year. For 2020 and 2021, the premium growth component was calculated using a blend of employer-sponsored coverage costs and individual health insurance costs. Since the baseline reflects 2013 costs, this revised methodology produced a higher estimate of premium growth due to the significant increase in the generosity of individual coverage from 2013 to 2014.

Sources: https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines ; https://www.cms.gov/marketplace/resources/regulations-guidance#Affordable_Care_Act ; National Health Expenditure Projections published by CMS at https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/projected, which the authors have collected over the years.

For example, an individual receiving subsidies with constant household income in 2015 and 2016 as a percentage of FPL would see a net premium increase for benchmark coverage of 0.6%—as long as the benchmark plan's premium remains above this indexed amount. The "subsidy shield" dynamic insulates subsidized consumers from gross premium increases. This dynamic is an important benefit of federally subsidized coverage under the ACA and a key reason for the growth in subsidized coverage. However, the subsidy shield only operates at full strength for the benchmark plan. Consumers electing to purchase other coverage can face a range of different net premium outcomes. To better understand net premium dynamics, Figure 18 presents average lowest cost gold, silver, and bronze premiums in urban counties for an individual with income at 250% of the FPL.

Figure 18

MINIMUM PREMIUM RATES BY METAL-URBAN COUNTIES: 250% OF FPL



Sources: https://hixcompare.org ; https://www.healthcare.gov/health-and-dental-plan-datasets-for-researchers-and-issuers

The two highlighted time segments are indicative of relatively stable years (i.e., no silver loading and no ARPA, both of which are discussed below). Figure 16 indicates that bronze, silver, and gold premiums increased at about the same rate from 2015 to 2016. Since gold premiums are higher than silver, the cost of gold coverage increased by more dollars than silver coverage. Because PTCs are tied to silver coverage, the net cost of gold coverage will increase *at a faster rate* than silver coverage, evidenced by the steeper slope of the gold premium line from 2015 to 2016 in Figure 19.

Similarly, bronze premiums increase by a smaller dollar amount, and the fixed nature of the subsidy causes net bronze premiums to increase *at a slower rate*—essentially staying steady in this example despite the small positive trend in the cost of silver coverage. The subsidy shield leverages premiums, creating the small but present increase in spread between the three metal levels.

Figure 16 also tells us that gold and silver premiums decreased at about the same rate from 2019 to 2020. Because benchmark silver premiums and gold premiums are decreasing at the same rate, the *dollar* reduction in the cost of gold coverage is greater than that of silver coverage, giving extra power to the subsidy, and Figure 18 shows the gold and silver premium lines moving more closely together. Similarly, the bronze and silver premiums in Figure 18 move closer together, as the PTC, which is based on the cost of silver coverage, decreases by more *dollars* than bronze premiums between 2019 and 2020.

However, Figure 18 has more—and clearer—stories to tell. The loss of federal funding for CSR reimbursements was initially a cause for significant concern due to the increases in gross premiums. However, analysis from HHS[54] and from the Congressional Budget Office[55] both suggested that this action had the potential to improve affordability of net premiums.

1332 WAIVERS AND SUBSIDIZED COVERAGE

While 1332 waivers are an effective tool to reduce gross premiums, their influence on net premiums is more complicated. It is tempting to conclude that net premiums are unchanged for subsidized individuals, but this is only true in a strict sense for benchmark coverage. Most 1332 waivers are understood to cause similar percentage reductions in rates. Since the first year of a 1332 waiver frequently results in a premium reduction, the second scenario often applies and so individuals using a PTC to purchase the lowest cost coverage, but who still have a net premium greater than zero, will generally be unable to avoid net premium increases under a 1332 waiver. This dynamic can complicate analysis of waiver compliance with the affordability guardrail discussed in subsection 2.3.

4.2.2 THE INFLUENCE OF CSR LOADING ON NET PREMIUMS

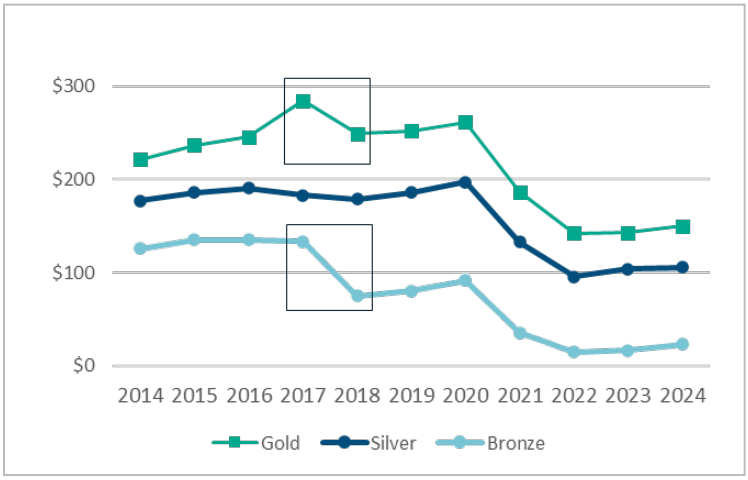
While the ACA has largely survived a number of legal perils over the year, reimbursements for cost-sharing reductions (CSRs) provided by issuers to eligible members marked a significant legal setback. The 2016 *House v Burwell* district court ruling went against the federal government and, following a change in administration, HHS ceased providing payments in October 2017 to issuers for benefits that issuers were still required by law to provide to low income exchange enrollees purchasing silver coverage and American Indian / Alaska Natives purchasing any metal level of coverage.[56] Approaches for recapturing the lost subsidy reimbursements were initially varied, but over the following years the market has largely coalesced around "silver loading," where the premium load associated with CSRs was applied solely to the on-exchange silver plans, which were required to offer these CSRs.[57] This increase in silver premiums notably applies to benchmark coverage—directly increasing PTC amounts for subsidized consumers by the amount of benchmark premium increase.

[54] https://aspe.hhs.gov/sites/default/files/migrated_legacy_files//130481/ASPE_IB_CSRs.pdf
[55] https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53009-costsharingreductions.pdf
[56] The number of American Indian / Alaska Native cost-sharing reductions is very small in most states, typically at or below 1% of individual market enrollment, only exceeding 10% of the market in Oklahoma. Most discussions of CSR issues ignore the unique considerations associated with CSRs for this population, as will be the case in the remainder of this paper. However, the risk profile of these members is significantly different, a factor which drove notable changes to the ACA risk adjuster for these members starting with benefit year 2025.
[57] Most states have an effective rate review program, and federal regulators have formally granted states flexibility to permit or require plan-level variations in rates attributable to CSR loading, as discussed and finalized in the 2026 HHS Notice of Benefit and Payment Parameters. While most states either permit or require silver loading, many states give issuers some flexibility in how costs are reflected, while other states require costs to be spread across all plans or even prohibit use of a CSR load.

Observation #11: Silver loading significantly improved affordability of bronze and gold coverage for subsidized individuals, an effect which has persisted amidst other changes to subsidies in the years since.

Figure 19

MINIMUM PREMIUM RATES BY METAL-URBAN COUNTIES: 250% OF FPL



Sources: https://hixcompare.org ; https://www.healthcare.gov/health-and-dental-plan-datasets-for-researchers-and-issuers

Figure 19 revisits the same set of net premiums as Figure 18, but instead, highlights net premium changes in 2018.

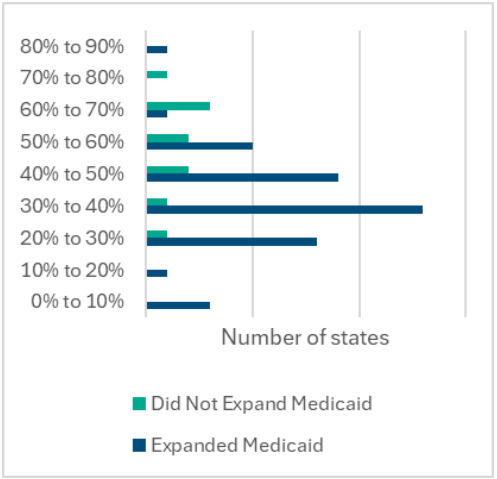
Recall from Figure 16 that gross premiums for silver coverage increased over 30% in 2018. Yet Figure 20 shows flat net silver premiums, more in line with the 0.2% increase noted in

Table 17 - demonstrating the subsidy shield. Meanwhile, back in Figure 16, gross premiums for gold coverage increased about 20%, while gross bronze premiums rose somewhat less than that. Despite these high gross premium increases for gold and bronze, net premiums decreased about 15% for gold coverage and about 45% for bronze coverage due to the leverage of the subsidy shield.

This one-time excess increase to silver premiums sharply shifted the relative value of gold and bronze coverage to silver plans, which can be observed by the sharp downward movement in 2018 in Figure 19.

Figure 20

EXCHANGE CSR ENROLLMENT DISTRIBUTIONS BY MEDICAID EXPANSION STATUS, H1 2024



Source: Effectuated enrollment data from https://www.cms.gov/marketplace/resources/forms-reports-other

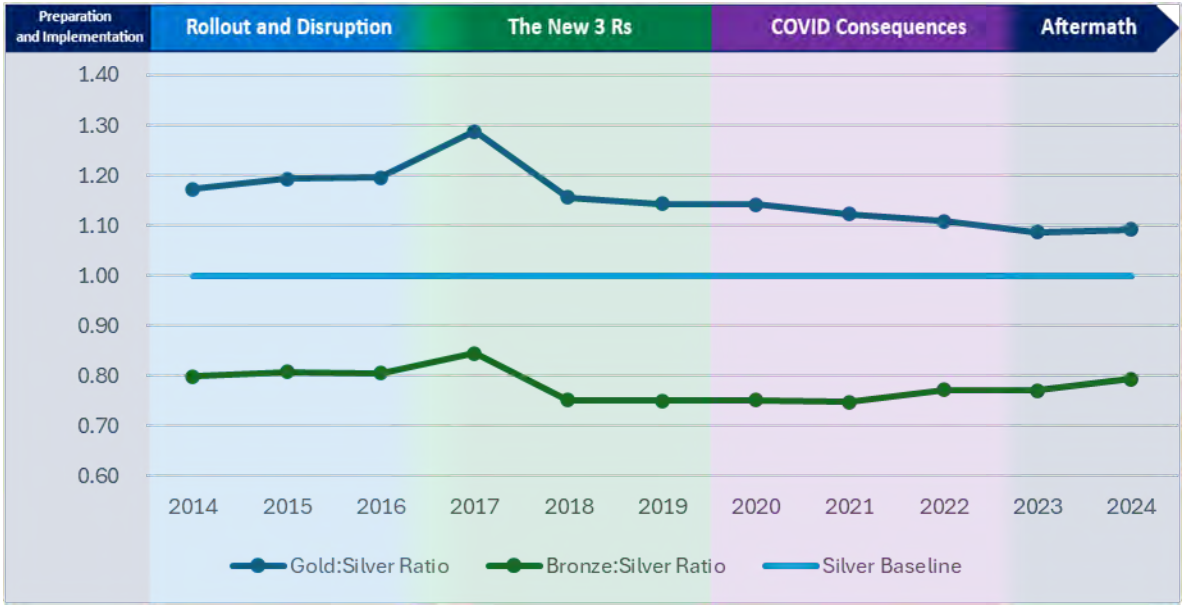
The amount of this shift in any given region is dependent on how much enrollment is present in CSR plans, particularly the most generous 87% and 94% CSR variants for individuals between 100% and 200% of FPL. Figure 20 shows the distribution of CSR enrollment as a percentage of total exchange enrollment in the first half of 2024 for states that expanded Medicaid and those that did not. CSR enrollment penetration clearly

skews higher in non-expansion states than in expansion states, with one notable exception,[58] - the higher CSR penetration drive to higher gross silver premiums and increased PTCs. The cost of gold and bronze coverage is typically unaffected (again, in states that use the on-exchange silver-loading method), so that these increased PTCs provide increased affordability for other metal tiers.

This dependence suggests a straightforward way to evaluate the change in affordability of net premiums over time. Figure 21 presents the ratio of average lowest-cost gold and bronze rates to lowest-cost silver rates.

Figure 21

RATIO OF MINIMIUM GOLD AND BRONZE GROSS PREMIUMS TO MINIMUM SILVER PREMIUMS



Sources: https://hixcompare.org ; https://www.healthcare.gov/health-and-dental-plan-datasets-for-researchers-and-issuers

Here, increases in the gold (blue line) and bronze (green line) represent increases in gross prices realtive to silver.

- These ratios were steady during the Rollout and Disruption era, suggesting little change in average affordability of subsidized gold and bronze coverage.
- 2017 saw significant increases in the relative cost of subsidized gold and bronze coverage before CSR loading reversed that dynamic.[59]
- While these relationships remained relatively steady through 2020, premiums for both gold and bronze coverage have slowly moved towards silver. This results in increased affordability of gold coverage and reduced affordability of bronze coverage as the pandemic evolved and the

[58] Massachusetts, which operates its own market and has a robust system of cost-sharing subsidies that extend well above the federal limit, reports over 80% of individuals enrolled through the Connector in CSR plans. These additional state subsidies beyond the federal CSR requirement are paid for by the state, and do not result in increased premiums.

[59] One takeaway from Figure is that, in the absence of silver loading, affordability of subsidized gold and bronze coverage would have decreased on average.

Aftermath began, though bronze coverage (for now) is still more affordable by this measure than it was at any time prior to CSR loading.

The narrative around Figure 21 mirrors the net premium changes in Figure 18, with one notable exception: the sharp shift in affordability associated with ARPA's enhanced PTCs in 2021 and 2022.

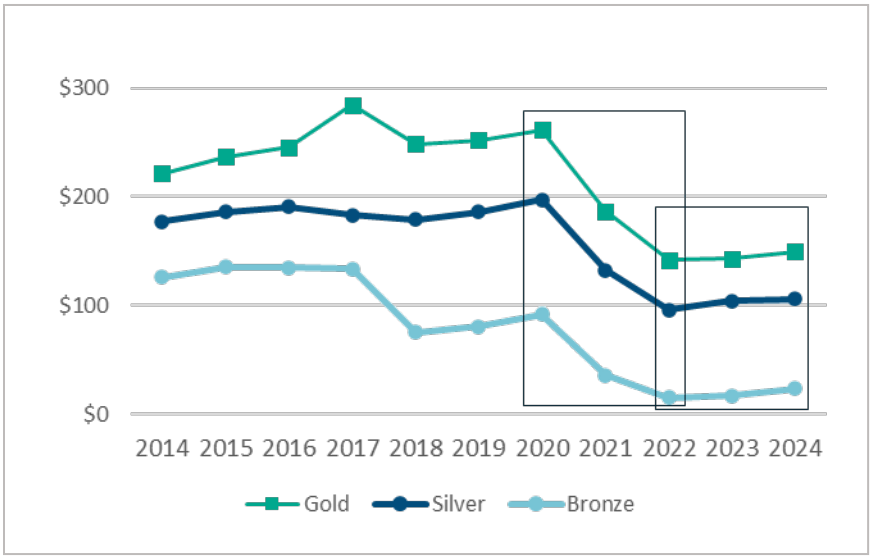
4.2.3 ARPA'S ENHANCED PREMIUM TAX CREDITS SUGGEST FREE, IS INDEED, THE RIGHT PRICE

As noted in Section 2, individual market enrollment has risen significantly over the last four years—an effect generally presumed to be the direct result of improved affordability of coverage through reduction of the required contribution for benchmark coverage (i.e., increases in subsidies). However, the experience of this increase in PTCs is complicated by both legislative timing and some of the relative affordability dynamics outlined in Figure 21.

Figure 22 returns to the time series of average minimum net premiums by metal tier for urban counties for an individual with income at 250% of FPL.

Figure 22

MINIMUM PREMIUM RATES BY METAL-URBAN COUNTIES: 250% OF FPL



Sources: https://hixcompare.org https://www.healthcare.gov/health-and-dental-plan-datasets-for-researchers-and-issuers

The final four years of this figure provide a view into the challenges of rapid policy reactions and the continued role that relative affordability plays over time.

ARPA was passed in March of 2021, and its enhanced PTC provisions applied in that same year. However, gross premiums for 2021 were developed in the summer of 2020, and could not reflect the coming increase in subsidies and its effects on the individual market's overall composition until 2022. Figure 16 shows consistent gross premium decreases across all three metal tiers in 2021 and 2022. As expected from our earlier discussion, Figure 23 shows net premiums tighten, with gold falling by about $120, more than silver's $100 fall which, in turn, was greater than bronze's $80 drop.

However, the drop in the cost of bronze coverage relative to silver that came about as a result of silver loading has moved bronze plans to near zero, on average (and for many consumers, they are actually zero), which mitigates some of the compression in the silver-to-bronze ratio observed in Figure 21 (in other

words, you can't go lower than zero). As FPL has grown in the two years since, net premiums can be seen growing modestly from 2022's nadir (right-hand box).

Taken together, it becomes clear that the key reforms of the ACA—premium subsidies, Medicaid expansion—and some of its more boutique elements—such as 1332 waivers—have generally improved affordability in the individual market. However, affordability concerns are not confined to the individual market. Employers frequently raise concerns about coverage affordability when evaluating annual employee compensation changes. Here the story is less clear. [60]

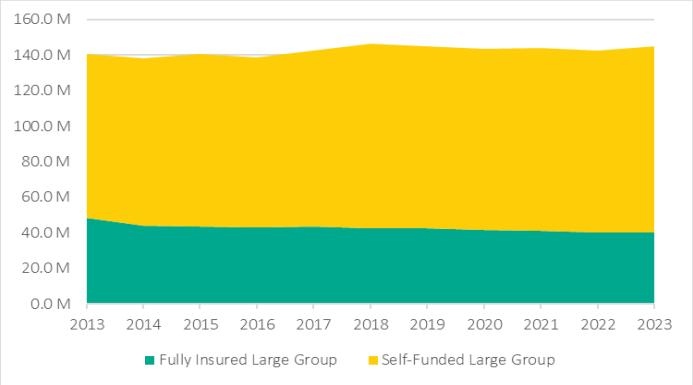
4.3 COMPOSITION AND AFFORDABILITY IN THE GROUP MARKET

Observation #12: Faced with substitute product offerings, declining enrollment, and increasing morbidity, the fully insured Small Group Market has not flourished under the ACA and faces higher prices and decreasing relevance.

As noted in subsection 1.1, large employers face explicit affordability tests as part of the employer mandate. Health benefits are viewed as a core part of the employee compensation package, and the employer mandate requires issuers to offer coverage to most employees. Large group coverage is able to be much more flexible than Medicaid or individual market coverage, and perhaps the most important coverage choice facing large employers is the decision to self-fund coverage or purchase insurance. Self-funding frees employers from complying with a wide array of state laws affecting health benefits. However, it does expose the employer to more financial risk. Figure 23 shows the relative stability of large employer coverage during the eras of the ACA.

Figure 23

LARGE EMPLOYER COVERAGE BY FUNDING STATUS, 2013-2023



Sources: Federal MLR data; American Community Survey Public Use Microdata Sample; AHRQ Medical Expenditure Panel Survey – Insurance Component data

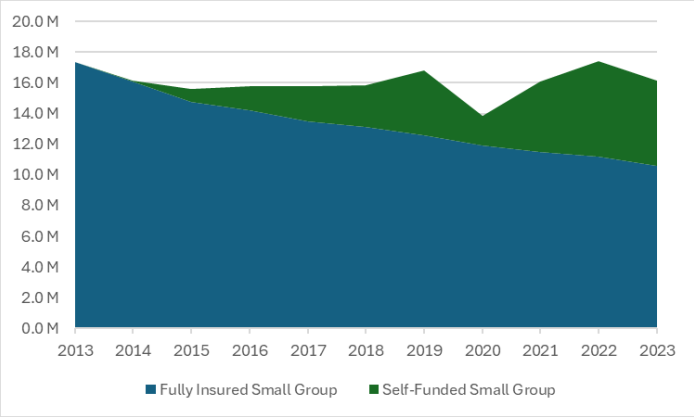
While there has been a modest reduction in fully insured coverage over time, the overall level of large employer-sponsored coverage has remained steady, with some small fluctuations during the COVID consequences era, but consistent with the structure of the ACA, and remains the backbone of private health coverage in the U.S.

[60] As discussed in the sidebar at the beginning of this section, the ACA took a number of other steps to address affordability beyond private health coverage. We note that Medicaid, the market of focus in this paper not addressed in this section, is designed to limit member premium and cost sharing by design and so does not possess the same degree of affordability dynamic as individual or group coverage.

This leaves the small group market which, as shown in Table 3, was subject to meaningful reforms under the ACA. With the individual market typically the center of attention, this market is frequently overlooked in evaluations of the law. Figure 24 uses the same data sources as Figure 23, but focuses instead on small groups with 50 or fewer employees. While the overall volume of small group coverage has remained relatively constant over time, the steady decline of the fully insured market is apparent, as is the growth of self-funded coverages, which now make up over 25% of small employer coverage. Unlike the large group market, self-funded small group coverage provides a very clear value proposition to healthy groups, as they can gain the advantage of underwritten premiums, leaving less healthy groups to the guaranteed issue ACA single risk pool—creating the potential for the classic death spiral where enrollment decreases until only the highest cost groups are left in a high morbidity / high premium market.

Figure 24

SMALL EMPLOYER COVERAGE BY FUNDING STATUS, 2013-2023



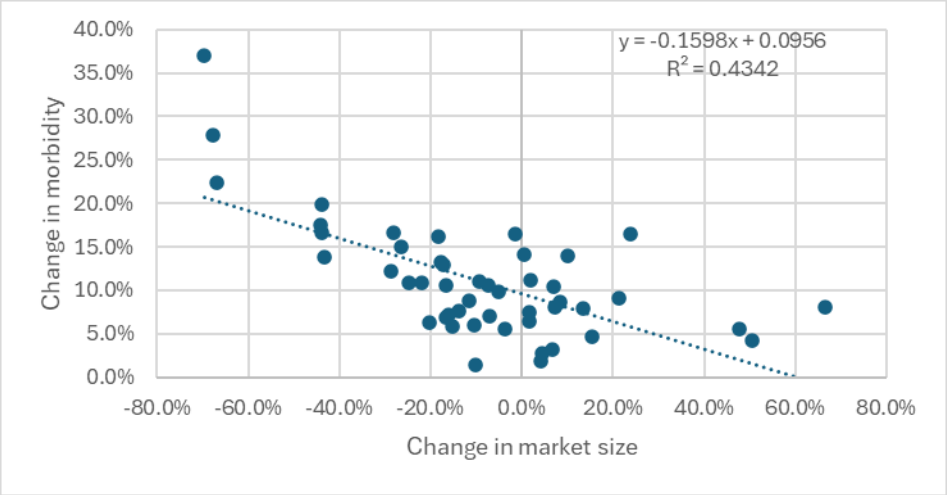
Sources: Medical Expenditure Panel Survey data and NAIC Medical Loss Ratio Reports
https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr

ACA risk adjustment provides a longitudinal data set with which to evaluate premiums, enrollment, and health status in the small group market. Starting with benefit year 2018—a convenient cut point that bypasses early ACA growing pains and allows for most pre-ACA policies to have transitioned into the ACA-compliant market—Table C-5 shows the relationship between the change in the small group market size from 2018 to 2023 and change in normalized morbidity for all 50 states and DC.

At a high-level, more enrollment in a particular market is generally thought to have favorable influence on the overall morbidity of that pool and vice versa. This intuitive view is largely supported in Figure 25—while morbidity increased in ALL states during this period, the variations in the change in market size are moderately correlated with an increase in morbidity.

Figure 25

CHANGE IN SMALL GROUP SINGLE RISK POOL SIZE RELATIVE TO CHAIN-ADJUSTED RISK SCORE, 2018-2023



Sources: https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr ; Federal risk-adjustment program data.

To illustrate the increasing rate at which this reduction in coverage in the fully insured small group market is approaching a critical state, Table 18 shows the number of states where the fully insured small group market has fallen below 4% of total under 65 employer-sponsored coverage in the state.

Table 18

STATES WITH SMALL GROUP FULLY INSURED ENROLLMENT BELOW 4% OF THE UNDER 65 POPULATION ENROLLED IN EMPLOYER SPONSORED COVERAGE POPULATION

	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
State count	0	0	0	0	0	1	4	6	9	9
State List						SC	GA IN KY SC	GA IN KY NE OH SC	AK GA IN KY MO NE OH SC WV	AK GA IN KY MO NE OH SC WV

Sources: https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr ; American Community Survey Public Use Microdata Sample

Table 18's 4% criterion represents an arbitrary threshold of reduced prevalence of small employer coverage in a state. The combined data in Figure 24, Figure 25, and Table 18 suggest that, if it has not yet, the small group fully insured market will likely soon face a reckoning, even as individual coverage, Medicaid, and large employer coverages remain relatively healthy in the ACA world. This reckoning may come in the form of a crisis of relevance and practicality:

- Relevance: The small group market has at least two defined forces contributing to the decline in enrollment, one of which we saw above: the availability of an affordable substitute product (level-funded plans).

  Account-based plans represent another alternative. While qualified small employer health reimbursement arrangements (QSEHRAs) have been available since 2017, Individual Coverage

Health Reimbursement Accounts (ICHRAs) have seen increased attention in recent years. Both ICHRAs and QSEHRAs allow small employers to provide funds to their employees through a dedicated account to purchase coverage on the individual market or pay for medical services. Robust data on the overall prevalence of ICHRAs and QSEHRAs is not available, but there is increasing evidence that stakeholders in the industry are taking notice of this opportunity and making investments.[61]

These products provide small employers viable alternatives to the traditional fully insured insurance plan. Moreover, they present a challenge to the value proposition of such plans, especially as prices rise. Combined, the relevance of the small group fully insured market may be declining.

- Practicality: As the forces driving the decline in enrollment become increasingly apparent, the relationship between enrollment decline and increases in morbidity in the small group ACA market leaves insurers little choice. Prices in the small group market will have to increase beyond current levels to cover rising costs of a less healthy pool. Issuers may be able to absorb some of this cost increase through lower profits or, as we saw in Section 3, issuers may exit as financial performance fails to meet expectations.

  For each small employer, there is a point—which certainly varies—at which the price that must be paid will simply be impractical. Employers may choose to move to a cheaper level funded plan (if that option is available to them based on the health of group members) or a cheaper account-based offering (which may not be available either).

  The last alternative is to leave their employees without a job-based coverage offering—which is permitted as long as the employer falls under the 50 full-time equivalent employee requirement that triggers the employer mandate. Individuals who lose access to this source of coverage will then face a choice—move to the individual market, opt to be uninsured, or seek another employment opportunity with better coverage options.

This dynamic will have a greater impact on less healthy groups, i.e., those who have the greatest health needs. For any single small employer, it is entirely possible that one of these alternatives may be available and meet the needs of all of their employees. However, there is less certainty, even for these groups. As such, the small group market is a significant example of an area where the ACA has fallen short of one of its original goals of access to *affordable* coverage.

[61] https://www.fiercehealthcare.com/payers/ichra-having-moment-vcs-are-taking-notice-and-looking-invest-emerging-space, accessed March 5, 2025

Section 5 Lessons Learned and Looking to the Future

To this point, this report has added the latest five available years of data and experience for the ACA and examined some themes and key observations about the law's performance across its entire lifespan. It is equally important to also look forward and find opportunities to apply those lessons. With the ACA, as with all management frameworks, the only certainty is that there will be uncertainty. What has been learned thus far may make navigating the future a bit easier.

5.1 EMBRACE CHANGE – OR AT LEAST LEARN TO MANAGE IT

If this sounds familiar, it is because this lesson learned is borrowed verbatim from the previous report, the ACA@10. Why? As the history of the ACA over the last 15 years—including and especially the last five years—have illustrated, change did occur—just as the authors of that paper said it would—and more change appears to be on the way. As of this report, the fate of enhanced subsidies in the individual market (scheduled to end in 2025 absent congressional action) is being debated. The outcome of this could have profound impacts on enrollment, the uninsured rate, and even gross premiums in the individual exchanges.

Simultaneously, Individual Coverage Health Reimbursement Accounts, or ICHRAs, appear to be gaining traction as an alternative to group coverage. Data on ICHRAs is currently difficult to obtain, so verifying their actual penetration and impact is difficult, if not impossible. However, if this popularity is real and increasing, it raises the possibility of a material number of individuals and families migrating from group markets into the individual market. This structural change could bring new opportunities for issuers and consumers but, as noted below, there are always trade-offs, market shifts, and policy changes.

Finally, it may go without saying that the levers of federal power—administration changes as well as congressional shifts—are changed relatively frequently and each party has decidedly different ideas than the one it is replacing. These different political ideas often translate into regulatory and legislative changes that can affect the ACA markets and Medicaid. These effects can either improve ACA and Medicaid markets or disrupt them. Either way, managing these changes going forward, both financially and from a policy perspective, will be just as important as it has been over the first 15 years of the ACA's existence.

5.2 EFFECTIVE PUBLIC POLICIES CAN HELP ACHIEVE GOALS – BUT THERE ARE ALWAYS TRADEOFFS

Like all statutes, the ACA provides a frame on which regulators hang the regulations that shape the practical experience of the law. But regulators have policy priorities and preferred points of view that shape how they interpret and implement the law. The experience of the ACA has been informed by direct policy changes such as enhanced subsidies, but also by policies which are only tangentially related to the goals of the law, such as the public health emergency response. These policies have had clear effects on enrollment in comprehensive coverage and prices paid by consumers on the exchange. But those benefits were not without costs either—federal spending increased dramatically during this time as well.[62] Even 1332 waivers had tradeoffs despite a requirement to be deficit neutral, providing cheaper coverage for higher income households ineligible for premium subsidies (and increasing enrollment in this population), but potentially at the cost of reduced affordability of coverage for subsidized individuals seeking coverage at minimum up-

[62] "The COVID-19 pandemic brought significant challenges to the nation's public health and economy. Since March 2020, Congress has provided over $4.65 trillion in federal funds through the Coronavirus Aid, Relief, and Economic Security (CARES) Act and other laws to help the nation respond to and recover from the pandemic." Federal Response to COVID-19 | U.S. GAO, accessed January 16, 2025

front cost. New policies can further improve upon the goals of the ACA, but successful implementation of these policies will depend on awareness and management of the inevitable consequences.

5.3 STABLE MARKETS ARE GOOD FOR EVERYBODY

If the Rollout and Disruption era—and to a lesser extent the New 3 Rs era—taught us anything, it is that market participants (insurers and enrollees) prefer stability. Clarity and consistency in policies in conjunction with stable and reasonably predictable pricing provide an environment that allow competition to produce favorable outcomes for consumers and insurers.

5.4 BLOCKING AND TACKLING STILL MATTER

Even in stable markets, insurers need to master the fundamentals to see continued success. Best pricing practices, efficient claims management, quality initiatives, and effective marketing all contribute to a sound financial foundation that gives insurers a base from which to innovate. Value propositions need to translate into lower costs, competitive pricing, and profitability—a difficult proposition as the hundreds of market exits will likely testify to. Market entries will need to excel in at least one of these dimensions—and be competent at the other—to find success. And even then, success may take time and patience.

Section 6 Acknowledgments

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Appendix A Data and Methods

A.1 DATA SOURCES

The data in this report was generally compiled through publicly available sources. Table A-1 includes a list of the information and data sources used in this analysis. Table A-2 shows which data sources from Table A-1 were used in the development of each figure and table in this report.

Table A-1
DATA SOURCES

Source	Data	Link[63]
A	CMS and Office of the Assistant Secretary for Planning and Evaluation (ASPE) ACA Open Enrollment Reports / Public Use Files (PUF)	https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products (accessed September 26, 2024) https://aspe.hhs.gov/reports/health-insurance-marketplace-summary-enrollment-report-initial-annual-open-enrollment-period-1 and https://aspe.hhs.gov/reports/addendum-health-insurance-marketplace-summary-enrollment-report (accessed February 15, 2025)
B	CMS Effectuated Enrollment Summaries	https://www.cms.gov/marketplace/resources/forms-reports-other#Health_Insurance_Marketplaces (accessed January 30, 2025) https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products (accessed September 26, 2024)
C	CMS Risk-Adjustment Reports	https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs (accessed January 18, 2025)
D	Exchange Benefits and Premium Rate Data	https://hixcompare.org (accessed November 5, 2024) HIX Compare database sponsored by the Robert Woods Johnson Foundation, providing plan design and premium rate data for 2014 (states on the federal exchange platform only) and 2015–2024 (all states) Milliman internal database of plan design and premium rates for 2014 state-based exchanges
E	Healthcare.gov premium database for states participating in federal marketplace	https://www.healthcare.gov/health-and-dental-plan-datasets-for-researchers-and-issuers (accessed January 27, 2025)
F	Medicaid enrollment, budget, and expenditure data provided on Medicaid.gov and other HHS websites	https://www.medicaid.gov/index.html (accessed January 15, 2025) https://aspe.hhs.gov/profiles-affordable-care-act-coverage-expansion-enrollment-medicaid-chip-and-health-insurance-marketplace-10-1-2013-3-31-2014 (accessed October 8, 2024) https://www.cms.gov/data-research/research/statistical-resources-dually-eligible-beneficiaries/mmco-statistical-analytic-reports (accessed January 28, 2025)

[63] Retrieval dates listed. Links may become outdated.

G	U.S. Census Bureau data	https://www.census.gov/programs-surveys/acs (accessed November 14, 2024) https://www.bls.gov/cpi/
H	CMS Medical Loss Ratio PUF	https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr (accessed December 16, 2024)
I	National Association of Insurance Commissioners (NAIC) annual financial statements	https://www.naic.org/insdata_home.htm (accessed November 1, 2024)
J	National Health Expenditure Data[64]	https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data (accessed December 18, 2024)
K	Medical Expenditure Panel Survey through the Agency for Healthcare Research and Quality	https://www.ahrq.gov/data/meps.html (accessed November 1, 2024)
L	National Health Interview Survey Early Release Data	https://www.cdc.gov/nchs/nhis/early-release/index.html (accessed February 28, 2025)

[64] CMS does not maintain copies of historical reports on its website. Milliman maintains an internal repository of most years' reports starting with the 1960-2003 historical estimates and the 1960-2013 projections, both of which were released in 2005.

Table A-2

DATA SOURCES USED FOR EACH FIGURE / TABLE

	Data Sources											
Figure / Table	A	B	C	D	E	F	G	H	I	J	K	L
Figure 1				x	x		x					x
Figure 2						x	x	x				x
Table 1												
Table 2												
Figure 3						x	x	x				x
Table 3												
Table 4												
Figure 4						x	x	x				
Figure 5						x	x	x				x
Table 5	x	x				x		x				
Figure 6						x	x					x
Table 6	x	x				x	x	x				
Figure 7	x	x				x	x	x				x
Figure 8	x					x						
Figure 9	x					x						
Figure 10						x	x					x
Table 7	x	x	x					x				
Figure 11	x	x	x					x				
Table 8					x							
Table 9		x	x		x			x				
Figure 12		x	x		x			x				
Figure 13			x	x	x			x				
Figure 14				x	x			x				
Table 10								x				
Table 11								x				
Table 12								x				
Table 13								x				
Table 14								x				
Figure 15								x				
Figure 16				x	x		x					
Table 15				x	x		x					
Figure 17				x	x							
Table 16				x	x							
Table 17										x		
Figure 18				x	x							
Figure 19				x	x							
Figure 20		x										
Figure 21				x	x							
Figure 22				x	x							
Figure 23							x	x			x	
Figure 24							x	x			x	
Figure 25			x					x				
Table 18							x	x				
Table C-1												
Table C-2					x							
Table C-3												
Table C-4								x				
Table C-5				x	x		x	x				

A.2 METHODS AND ASSUMPTIONS

Estimates provided throughout this report are described in detail here.

A.2.1 PREMIUM RATE CALCULATION

- Premiums for 2013 are based on insurer MLR filings.
- Individual market rate increases from 2013 to 2014 utilize Avik Roy's county-level reported premium increases published by Forbes, weighted together using demographics in the 2013 ACS for direct enrollment.
- Premiums by ACA rating region in each year from 2014-2024 were obtained from the HIX Compare database sponsored by the Robert Wood Johnson Foundation (except for state-based exchange states in 2014).
- Premiums by ACA rating region for state-based exchange states in 2014 were obtained from Milliman's internal database of plan design and premium rates for 2014 state-based exchanges.
- Statewide average premiums were calculated by weighting together premiums by county using "direct" enrollment by county from the ACS census data. When a county spanned multiple ACA rating areas, the enrollment within that county was assumed to be distributed evenly across those areas.
- Except where noted, premiums and Advanced Premium Tax Credits (APTCs) were estimated using the second lowest silver plan for an age 40 individual with an income equivalent to 250% federal poverty level.
- The estimated rate impact of CSRs is determined using data provided by federal regulators as part of the 2018 administrative order directing them to adjust BHP funding to reflect the loss of CSR funding. High-level estimates for BHP states, Medicaid expansion states, and non-expansion states used marketplace enrollment for each class of state.

A.2.2 INSURER PARTICIPATION AND SERVICE AREAS

- Insurer participation is calculated by counting unique parent companies in each state, derived from the HIX Compare database sponsored by the Robert Wood Johnson Foundation (insurance companies are identified as "insurer" in the database). Insurers are counted once for each state exchange they participate in (for example, if an insurer participates in three state exchanges and has plans under two legal entities in each state, the count for that insurer would be three).
- Service area information is publicly available from healthcare.gov at the plan and county level for states on the federally facilitated exchange platform.
- Service area information is publicly available from the HIX Compare database at the county and issuer ID level (but not the plan level) for state-based exchange states. Therefore, an insurer's entire service area is assumed to apply to all plans the insurer offers within each ACA rating region.
- Insurers offering ACA-compliant business were identified by matching issuer IDs from insurer MLR filings to the issuer IDs reported in the CMS risk-adjustment reports.

A.2.3 POPULATION ESTIMATES

- Uninsured counts were retrieved from the American Community Survey (ACS) census data. The 2024 uninsured count was estimated using 2023 ACS data, adjusting for changes in the uninsured rate in

2024 in the National Health Interview Survey Early Release Estimates for 2023 through the third quarter of 2024 published by the CDC.[65]

- The distribution of individual market enrollment by ACA rating region was estimated from county-level ACS census data for the "direct" population. When a county spanned multiple ACA rating areas, the enrollment within that county was assumed to be distributed evenly across those areas.
- Total individual market enrollment was retrieved from enrollment reported in CMS MLR filings.
- On-exchange enrollment was obtained from the individual market effectuated enrollment reports released by CMS. On-exchange enrollment for the second half of 2024 was estimated using first half enrollment and historical patterns of growth in the second half of the year.
- Off-exchange enrollment was estimated based on differences between individual market billable risk-adjustment member months reported in risk-adjustment reports and exchange enrollment reported in CMS effectuated enrollment reports.
- The split of subsidy-eligible and non-subsidy-eligible individual market enrollment was estimated from the CMS effectuated enrollment reports.
- Medicaid enrollment was retrieved from CMS eligibility reports and includes all beneficiaries receiving comprehensive coverage (including dual and non-dual eligibles) as of December of the year for years through 2018. Beginning in 2019, Medicaid enrollment is based on monthly eligibility reports and reflects the average number of enrollees enrolled each month throughout the year. Medicaid enrollment includes CHIP but does not include Basic Health Plan enrollment.
- The "Employer and all other" bucket in Figures 2 and 3 reflects the total under-age-65 population from the ACS census data less estimates of uninsured individuals, total individual market enrollment and Medicaid enrollment. The vast majority of this enrollment represents employer-sponsored insurance coverage.
- Group enrollment through 2023 was estimated using American Community Survey totals.
- Large Group and Small Group insured enrollment are obtained from MLR reports.
- Total Group enrollment is split between Large Group and Small Group enrollment using the Medical Expenditure Panel Survey's Insurance Component, using takeup rates, distribution by employee-only coverage, employer plus one coverage, and family coverage, using an imputed estimate of the average enrollment in a family policy calibrated to be consistent with ACS estimates of total group enrollment. Self-funded coverage is estimated by subtracting insured coverage in each market from the MEPS-estimated total coverage.

A.2.4 UNDERWRITING GAIN/LOSS MARGIN

- Underwriting gain / loss margin was calculated from insurer MLR filings using the underwriting gain / loss margin formula prescribed in the NAIC Supplemental Health Care Exhibits.

[65] https://www.cdc.gov/nchs/data/nhis/earlyrelease/Quarterly_Estimates_2024_Q13.pdf

Appendix B Overview and History of the ACA

The ACA was signed into law on March 23, 2010, with the goal of improving access and affordability of healthcare for Americans. The law fundamentally changed the benefits, plan offerings, and premium-rating rules in the individual market, and expanded access to coverage under Medicaid in many states. Some of the law's provisions were implemented immediately, but the most significant changes to the individual and Medicaid markets became effective January 1, 2014.

B.1 PROVISIONS OF THE ACA

The provisions of the ACA were designed to improve affordability and accessibility, while at the same time taking steps to promote stability of the individual insurance markets. Table B-1 illustrates some of the most impactful changes affecting the individual and Medicaid markets under the ACA.[66]

Table B-1
PROVISIONS OF THE ACA

Provisions to Promote Affordability / Accessibility	Provisions to Promote Stability
Guaranteed issue—This is the requirement disallowing health insurers from denying coverage to individuals with pre-existing medical conditions or varying premium rates based on health status.	**Individual mandate**—U.S. citizens were generally required to obtain health insurance ("minimum essential coverage") or pay a tax penalty.
Medicaid expansion—Medicaid eligibility was to be expanded to 138% (with a 5% income disregard) of the federal poverty level (FPL). States also had the option to implement a Basic Health Program, expanding state-sponsored insurance coverage to 200% FPL.	**Risk adjustment—**This program transfers funds from insurers who enroll a disproportionate share of lower-risk enrollees to insurers who enroll a disproportionate share of higher-risk enrollees (measured by diagnosis-based risk scores and adjusted for factors that are allowed in premium rating).
Advanced premium tax credits—Subsidies in the form of advanced premium tax credits were made available to persons or households with income up to 400% FPL who purchase coverage through an exchange.	**Transitional reinsurance—**This temporary program operated from 2014–2016 and collected funds from insurers in all commercial markets and used them to cover a portion of the cost of high claimants in the individual market.
Cost-sharing reduction subsidies—Subsidies in the form of reductions in member cost sharing and out-of-pocket limits were made available to persons or households with income up to 250% FPL who purchased a silver plan through the exchange.	**Risk corridors**—This temporary program operated from 2014–2016 in the individual market and collected funds from insurers who were overpriced and transferred funds to insurers who were underpriced.
Market-rating requirements—These are new requirements that standardize how health insurers are required to price plans. The ACA also changed the way regulators review premium rates and increased the transparency of high rate increases.	
Essential health benefits—This is a requirement that plans cover a comprehensive set of services, including coverage for preventive services with no member cost sharing.	
Limitations on annual limits—Plans may no longer set lifetime or annual dollar coverage limits.	
Dependent coverage—This requirement allows children to be covered as a dependent on their parent's policy until age 26.	

[66] This table is reproduced in its entirety from Fifty States, Fifty Stories: A Decade of Health Care Reform Under the Affordable Care Act Appendix B.

Medical loss ratio—This requires plans to maintain a medical loss ratio of at least 80% (85% in the large group market) or pay rebates to consumers.	
State marketplaces (exchanges)—This online platform (often referred to as an "exchange") is for purchasing health insurance coverage and obtaining subsidies in the individual market. States were allowed to set up their own state-based exchange or use the platform that the federal government operated.	

B.2 STAGES OF THE ACA OVER ITS FIRST DECADE

The ACA is a complex law containing intricate interactions that impact nearly all aspects of the U.S. healthcare system. Changes to one part of the law often have side effects with broad implications that may be difficult to predict or control. In the years since the ACA was passed, it has faced numerous legal and political challenges, with some impacting its most foundational elements. The evolution of the ACA and the disruptions it has faced over the years can be characterized by the following time periods. Black text in Table B-2 indicates a provision of the original law; teal text indicates actions taken to alter or change the law.

Table B-2
STAGES OF THE ACA FROM 2010–2024

Preparation and Implementation	2010	▪ ACA was signed into law on March 23. ▪ Certain provisions of the ACA went into effect (guaranteed issue for children, limitations on annual limits, dependent coverage). ▪ There was the option to grandfather existing plans (not subject to 2014 ACA market rules).
	2011	▪ Medical loss ratio requirements were implemented (80% minimum in the individual market).
	2012	▪ The Supreme Court ruled the mandated Medicaid expansion provision unconstitutional, making expansion optional to the states. ▪ The Supreme Court also ruled the individual mandate provision constitutional as a tax.
	2013	▪ Insurers file premium rates for ACA-compliant individual market plans for the 2014 benefit year. ▪ State and federal exchanges scheduled to go live in October for open enrollment. ▪ The U.S. Department of Health and Human Services announced a transitional policy allowing non-ACA-compliant plans to renew in 2014 (extended each year through 2019).
Rollout and Disruption	2014	▪ Primary ACA provisions (individual mandate, tax subsidies, market-rating requirements, Essential Health Benefits) were implemented. ▪ Risk adjustment, risk corridors, and transitional reinsurance programs went into effect. ▪ Medicaid expansion was implemented in 27 states (AR, AZ, CA, CO, CT, DC, DE, HI, IA, IL, KY, MA, MD, MI, MN, ND, NH, NJ, NM, NV, NY, OH, OR, RI, VT, WA, WV).
	2015	▪ Risk-corridor payments to issuers from the federal government were limited to amounts received from issuers paying into the program for the 2014 coverage year (contrary to other announcements). ▪ Medicaid expansion was implemented in Alaska, Indiana, and Pennsylvania. ▪ Minnesota launches the first Basic Health Program.
	2016	▪ The first Section 1332 State Innovation Waiver was approved in Hawaii (waives ACA Small Business Health Operations Program (SHOP) requirements). ▪ Medicaid expansion was implemented in Louisiana and Montana. ▪ Three large national insurers announced they were exiting certain exchanges in 2017. ▪ New York launches its Basic Health Plan.

The New Three Rs: Repeal, Replace and Retrench	2017	▪ Congressional bills proposed a partial repeal of the ACA. (These bills did not pass both chambers of Congress.) ▪ Executive orders directed federal agencies to expand access to short-term limited-duration policies and association health plans. ▪ The federal government announced it would no longer fund cost-sharing reduction subsidies. ▪ The open enrollment period for 2018 individual market coverage was shortened to six weeks (from three months in prior years), alongside significant reductions in marketing and grants to Navigators. ▪ Final risk-corridor results received; total reimbursements constituted less than 20% of 2014 payments owed, with no funding for 2015 or 2016. ▪ Section 1332 State Innovation Waivers (state-based reinsurance programs) were approved in Alaska, Oregon, and Minnesota.
	2018	▪ Section 1332 State Innovation Waivers (state-based reinsurance programs) were approved in Wisconsin, Maryland, New Jersey, and Maine. ▪ Federal government begins permitting work requirements in Medicaid. ▪ Final rule expanding permissible duration for short-term limited duration coverage released. ▪ Final rule updating the definition of bona fide association increases public awareness of Association Health Plans and expands the pool of organizations eligible to offer these plans.
	2019	▪ The tax penalty for noncompliance with the individual mandate was repealed (enacted in 2017, effective January 2019). ▪ Section 1332 State Innovation Waivers (state-based reinsurance programs) were approved in Colorado, Delaware, Montana, North Dakota, and Rhode Island. ▪ A final rule allowed employers to establish health reimbursement arrangements (HRAs) for employees to use to pay premiums and cost sharing in the individual market and Medicare beginning January 1, 2020. ▪ Medicaid expansion was implemented in Maine and Virginia. Nebraska submitted an application for expansion. ▪ Federal courts strike down the new AHP definition.
COVID Consequences	2020	▪ The Healthy Adult Opportunity proposal was released by CMS offering states increased flexibility in designing and implementing Medicaid programs under a block grant funding structure. ▪ Medicaid expansion was implemented in Idaho, Utah, and Nebraska. ▪ COVID-19 outbreak results in lock downs, business closures, potential loss of health coverage for millions. ▪ The federal government provided several rounds of relief, including the FFCRA, CARES, and the Paycheck Protection Program and Health Care Enhancement Act (PPPHCEA), which include a wide range of public health and coverage requirements. Most notably for this paper, the federal match rate for state Medicaid expenditures increased in exchange for continuous coverage of beneficiaries through the end of the public health emergency.
	2021	▪ The American Rescue Plan Act of 2021 (ARPA) is passed in March of 2021, providing for enhanced federal premium tax credits on the individual market exchanges (both state and federal), along with a special enrollment period for individuals to take advantage of the expanded eligibility and/or increased amounts. ▪ ARPA also provided an additional two-year Medicaid funding boost incentive for any holdout states that newly expand Medicaid. ▪ The Supreme Court again preserves the ACA, this time by ruling a potential complaint moot by denying standing to the individuals challenging the constitutionality of the law.
	2022	▪ The Inflation Reduction Act of 2022 adds three more years of ARPA's subsidies, extending them through 2025, redesigns the Medicare Part D benefit, and institutes a range of reforms targeted at drug prices in Medicare, including inflation rebates for Part B and Part D drugs and a gradual phase in of price negotiation for high volume brand medications without generic competitors. ▪ The year end funding bill schedules an end to Medicare's continued coverage requirement in exchange for a gradual phase down of enhanced funding scheduled over the following year. ▪ 1332 waiver applications approved for Idaho and Washington.

Aftermath	2023	▪States begin the long process of redetermining the over 90 million beneficiaries enrolled in Medicaid at the end of March. ▪Federal regulators look for avenues to streamline the process for individuals losing Medicaid coverage to gain access to other options, including exchange coverage. Many states implement programs designed to give eligible enrollees a smooth pathway into the marketplace. ▪1332 waiver application approved for New York. ▪South Dakota and North Carolina implement Medicaid expansion.
	2024	▪Final rule shortening the maximum duration of short-term limited duration plans released. ▪States largely complete Medicaid redeterminations. Federal regulators ceased enhanced monitoring and reporting associated with the redetermination process. ▪Record enrollment in exchanges is accompanied by significant concern about validity and sustainability of these levels in light of the potential expiration of subsidies after 2025. ▪New York converts from a Basic Health Plan to a 1332 waiver. Oregon launches its Basic Health Plan.

Appendix C Select Supporting Detail

This appendix contains supporting data that expands upon elements discussed in the main body of this research paper.

Table C-1

HISTORY OF STATE MEDICAID EXPANSIONS

Year	# of States Expanding	List of States
2014	27	California, New York, Illinois, Ohio, Michigan, Massachusetts, New Jersey, Arizona, Washington, Minnesota, Maryland, Colorado, Oregon, Connecticut, Kentucky, Arkansas, Iowa, New Mexico, West Virginia, Nevada, Hawaii, District of Columbia, Delaware, Rhode Island, Vermont, New Hampshire, North Dakota,
2015	3	Alaska, Indiana, Pennsylvania
2016	2	Louisianna, Montana
2017-2018	0	
2019	2	Maine, Virginia
2020	4	Utah, Idaho, Nebraska, North Dakota
2021	2	Oklahoma, Missouri
2022	0	
2023	2	South Dakota, North Carolina
2024	0	

Source: https://www.kff.org/status-of-state-medicaid-expansion-decisions/

Table C-1 summarizes Medicaid State Expansion decisions by year of implementation. This information can also be seen in Table B-2 in Appendix B. The data expand on Table 5 in subsection 2.2 Effects of Medicaid Expansion on Coverage and Uninsured Rate.

Table C-2

E1332 WAIVER STATES BY YEAR OF IMPLEMENTATION AND RATE IMPACT

State	Statewide Reduction by Year						
	2018	2019	2020	2021	2022	2023	2024
Alaska	30.2%	34.0%	37.1%	41.2%	38.0%	38.8%	30.0%
Minnesota	16.8%	20.2%	21.3%	21.3%	14.4%	20.4%	20.0%
Oregon	7.2%	6.7%	8.0%	8.0%	8.1%	8.6%	8.0%
Maine		13.9%	7.2%	9.1%	10.9%	12.5%	8.5%
Maryland		39.6%	35.8%	34.0%	29.8%	32.6%	33.3%
New Jersey		15.5%	16.9%	16.0%	16.0%	14.6%	16.0%
Wisconsin		9.9%	11.0%	13.0%	13.1%	12.5%	10.0%
Colorado			22.4%	18.5%	21.7%	19.7%	20.0%
Delaware			13.8%	15.8%	15.0%	15.6%	18.0%
Montana			8.9%	9.4%	9.2%	8.3%	8.0%
North Dakota			20.0%	12.1%	10.7%	8.40%	8.0%
Rhode Island			3.8%	6.4%	5.0%	5.50%	4.0%
Pennsylvania				4.9%	5.9%	4.3%	4.0%
New Hampshire				13.9%	14.0%	13.4%	10.0%
Georgia					16.7%	19.2%	14.0%
Virginia						17.1%	17%
Idaho						12.5%	16.0%
Overall State Average	12.7%	17.8%	17.7%	14.1%	14.5%	15.2%	15.0%

Sources: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products
https://www.cms.gov/marketplace/states/section-1332-state-innovation-waivers

Table C-2 contains average statewide reduction in premium rates by year for states with an individual market state waiver under Section 1332 of the ACA. This data supports the analysis following Figure 21 in subsection 2.3 Effects of Section 1332 Waivers On Individual Marketplace Enrollment.

Table C-3
EXAMPLES OF REINSURANCE IMPACTS ON PREMIUM, BY INCOME LEVEL

	Low-Income (150% FPL)	Mid-Income (320% FPL)	High-Income (500% FPL)
Income	$22,500	$48,000	$75,000
Income Limit (ARPA)	0.00%	6.50%	8.50%
Monthly Premium Limit	$0.00	$260.00	$531.25
Second Lowest Cost Silver (SLCS) Scenario 1	$300.00	$300.00	$300.00
Subsidy	$300.00	$40.00	$0.00
Net Premium	$0.00	$260.00	$300.00
SLCS Scenario 2 (15% Lower)	$255.00	$255.00	$255.00
Subsidy	$255.00	$0.00	$0.00
Net Premium	$0.00	$255.00	$255.00
$ Change in Net Premium	$0	-$5	-$45
% Change in Net Premium	**0.0%**	**-1.9%**	**-15.0%**

Source: Authors' calculations

Table C-3 provides an illustration of the "subsidy shield" dynamic as it applies to member net premiums in a state with a 1332 waiver, demonstrating the effects of the waiver on net premiums for three members

enrolled in benchmark silver coverage with different income levels. This expands upon observations in subsection 2.3 Effects of Section 1332 Waivers On Individual Marketplace Enrollment and subsection 4.2 The Affordability of Subsidized Coverage. The hypothetical scenario illustrated in Table C-3 demonstrates that:

- For low-income individuals, 1332 waivers will have no impact on the net premium (i.e., post subsidy) the enrollee will pay as the subsidized net premium is set low enough as a percentage of income that it remains unaffected by the reduction in gross prices. Only premium subsidies are reduced.
- Individuals who have lighter subsidies (slightly higher income) could see reductions in their after-subsidy net premium depending on the size of the reduction to gross premiums stemming from a reinsurance program. However, the savings from the program are shared with the federal government. Thus, these higher income subsidized enrollees see some benefit from the waiver (1.9% reduction).
- And finally, unsubsidized enrollees benefit the most as they are paying the full gross premiums and will realize 100% of the gross premium reduction because of the reinsurance program (15% reduction).

Table C-4
YEARS TO PROFITABILITY FOR NEW ENTRANTS

	Entry Year	2015	2016	2017	2018	2019	2020	2021	2022
	New Entrants	**69**	**34**	**14**	**7**	**24**	**27**	**38**	**52**
Years to Profitable	1	12	5	5	2	14	9	13	35
	2	11	8	6	2	3	1	12	0
	3	9	4	2	0	1	5	0	0
	4	5	2	1	1	3	0	0	0
	5	2	0	0	1	0	0	0	0
	6	0	0	0	0	0	0	0	0
	7	0	3	0	0	0	0	0	0
	Never	30	12	0	1	3	12	13	17
	First Year	17%	15%	36%	29%	58%	33%	34%	67%
	First Three Years	46%	50%	93%	57%	75%	56%		
	Never	43%	35%	0%	14%	13%	44%		

Source: https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr

Table C-4 illustrates specific durations to profitability for new individual market entrants by year of market entry. This data supports Figure 29 in subsection 3.1 Overall Insurer Participation, Rate Increases and Operating Gain.

Table C-5

AVERAGE RATE INCREASES[67] BY METAL IN THE INDIVIDUAL MARKET

	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	Total
Gold	5.4%	8.2%	27.9%	19.6%	-0.1%	-2.3%	-4.1%	-3.6%	2.6%	4.7%	69%
Silver	3.6%	8.0%	18.8%	33.2%	1.1%	-2.3%	-2.4%	-2.3%	4.7%	4.2%	82%
Silver (no CSR Loading)†	**3.6%**	**8.0%**	**18.8%**	**12.8%**	**1.1%**	**-2.3%**	**-2.4%**	**-2.3%**	**4.7%**	**4.2%**	**54%**
Bronze	4.9%	7.6%	24.7%	18.3%	1.0%	-2.1%	-3.0%	0.9%	4.6%	7.2%	81%
Composite (including CSR Loading)	4.1%	7.9%	20.8%	29.1%	1.0%	-2.2%	-2.7%	-1.3%	4.5%	5.2%	80%
Comparative Metrics:											
Consumer Price Index-All Items	0.2%	0.8%	1.7%	2.9%	1.8%	1.0%	5.4%	8.5%	3.2%	2.9%	32%
FPL	1.3%	1.7%	0.2%	1.2%	2.0%	2.6%	1.7%	1.1%	4.7%	8.1%	27%

† The market cost of rate increases attributable to the end of federal funding of CSRs is estimated using data published by HHS in response to the administrative order requiring the department to update BHP payment rates in light of CSR defunding.

Sources: https://hixcompare.org ; https://www.healthcare.gov/health-and-dental-plan-datasets-for-researchers-and-issuers

Inflation data is per the U.S. Bureau of Labor Statistics; FPL data is per the HHS Assistant Secretary for Planning and Evaluation

Table C-5 provides average rate increases by metal tier for the lowest cost plan in each metal tier, along with composites for each year shown. Trends shown are with respect to coverage for the preceding year. This figure supports Figure 40 in subsection 4.1 The Cost of Unsubsidized Coverage. This report does not specifically address premium trends from 2013 to 2014 in the individual market due to the distinct difference in the scope of coverage offered in 2013 versus 2014 and are not directly comparable to trends beginning with 2014 to 2015.[68]

[67] It is important to note that rate increases by insurer and even by plan and, therefore, for any individual or family seeking to retain their current coverage, may be significantly higher or lower than the average values show.

[68] As noted in Appendix A, data published by Avik Roy via Forbes can be paired with survey-driven demographic distributions to develop a rough measure of premium growth, showing a 31% increase in states that expanded Medicaid in 2014 versus a 5% increase in states that did not. This contrasts with National Health Expenditure Accounts data that indicates per capita premiums for individual coverage roughly doubled. This suggests changes to demographic makeup played a large role in rate increases in 2014.

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