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A DECADE OF THE ACA: THE PROGRESS, OBSTACLES, AND SUCCESSES

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Tens of millions of Americans struggled with a variety of health care issues before the Affordable Care Act (ACA) was signed into law on March 23, 2010, and was fully implemented on January 1, 2014. Effects were seen across the healthcare industry, from uninsured rates to Medicare and Medicaid, to insurer participation and competition, premiums, and cost-sharing. The ACA's intent was to guarantee access to affordable health insurance coverage. Before the signing of the ACA, people could be refused health insurance based on preexisting conditions, and insurers could deny payment for services for even the smallest of errors. There were even struggles for those that were insured. Preventative services were often not covered and expensive, and insurer's annual and lifetime out-of-pocket limits were an ever-present concern for those who were chronically ill.

The United States Census Bureau estimated that the number of Americans who did not have health insurance in 2010 was 49.9 million Americans, a rate of 16.3%.[1,2] For those under age 65, the uninsured rate was 18.4%. As of 2019, the uninsured estimate was 26.1 million for all ages, a rate of 8%, marking a total decrease from 2010 of nearly 24 million.[3]

Insurer participation in the exchanges has changed course multiple times since 2014. There was an overall net decrease in participation as of 2020 from 2014 of just over 13%, with steady increases in 2019 and 2020.[4] When comparing the 2020 average national cost for the second-lowest-cost silver level (i.e., the benchmark plan) Marketplace plan to the average estimate of the 2013 individual market premium, premiums have increased by over 99%.[5,6]

Advantages beyond lowering the uninsured rate included improved benefits for people on Medicare, improved economic stability, with hospitals employing a growing share of physicians, improved financial wellbeing, and a reduced likelihood of hospital closures in Medicaid-expansion states, particularly for safety-net hospitals.[7,8,9,10] By 2018, the rates of nonelderly people who

[1] Defined as a person who did not have health insurance at any point during the year, according to Current Population Survey Annual Social and Economic Supplement (CPS ASEC) data.
[2] Carmen DeNavas-Walt, Bernadette Proctor, and Jessica Smith, "Income, Poverty, and Health Insurance Coverage in the United States: 2010," *United States Census Bureau*, September 2011, https://www2.census.gov/library/publications/2011/demo/p60-239/p60-239.pdf.
[3] Katherine Keisler-Starkey and Lisa Bunch, "Health Insurance Coverage in the United States: 2019," *United States Census Bureau*, September 2020, https://www.census.gov/content/dam/Census/library/publications/2020/demo/p60-271.pdf.
[4] "Insights into the 2020 Individual Market—Increased Consumer Choice and Decreased Premiums | McKinsey," www.mckinsey.com (McKinsey & Company, February 21, 2020), https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/insights-into-the-2020-individual-market.
[5] "Marketplace Average Benchmark Premiums," KFF, October 29, 2020, https://www.kff.org/health-reform/state-indicator/marketplace-average-benchmark-premiums/.
[6] "Individual Market Premium Changes: 2013 – 2017," *Department of Health and Human Services*, May 23, 2017, https://aspe.hhs.gov/system/files/pdf/256751/IndividualMarketPremiumChanges.pdf.
[7] Louise Norris, "Medicare and the Affordable Care Act," medicareresources.org, May 14, 2019, https://www.medicareresources.org/basic-medicare-information/health-reform-and-medicare/.
[8] Carol Kane, "Updated Data on Physician Practice Arrangements: Physician Ownership Drops Below 50 Percent," *Www.Ama-Assn.Org*, 2017, https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/health-policy/PRP-2016-physician-benchmark-survey.pdf.
[9] Luojia Hu et al., "The Effect of the Patient Protection and Affordable Care Act Medicaid Expansions on Financial Wellbeing," *Www.Nber.Org*, April 2016, https://www.nber.org/system/files/working_papers/w22170/w22170.pdf.
[10] Richard Lindrooth et al., "Understanding The Relationship Between Medicaid Expansions And Hospital Closures," *Health Affairs (Project Hope)* 37, no. 1 (January 2018): 111–20, https://doi.org/10.1377/hlthaff.2017.0976.

didn't fill a prescription due to cost, decreased by 27%, decreased by 24% for those who skipped a treatment or test, and decreased by 19% for those who didn't visit a provider when needing care.[11]

A handful of lawsuits made their way up to the Supreme Court of the United States since the ACA was passed, including the ongoing *California v. Texas*, and some victories in the Court effectively altered provisions.[12] An attempt to repeal and replace the ACA occurred during 2017 and 2018 after President Trump took office, with some major changes occurring with the new administration.[13] Through every obstacle, the ACA has endured, bolstered by resilient regulators, insurers, and providers, and persistent consumer support.

Affordability, Accessibility, and Stability

Although full ACA implementation did not occur until January 1, 2014, multiple ACA provisions and protections were implemented from the time the law was passed, in 2010.[14,15] Stability within the individual Health Insurance Marketplace remained integral throughout the enactment.

Healthcare Industry Changes Prior To and After Full ACA Implementation

Within the first month after the ACA was signed, a handful of provisions were initiated, from the Patient's Bill of Rights to tax credits for millions of eligible small businesses to provide insurance benefits to their employees. States were given the opportunity to receive federal matching funds for covering additional people under Medicaid, including some low-income individuals and families. In June 2010, employers could apply to expand coverage for early retirees aged 55 to 64, so their employment-sponsored insurance could continue until the exchanges were in place in 2014.

Effective for health plan years beginning on or after September 23, 2010, several new provisions launched, including the essential health benefits (EHB) requirement that included free preventative care for all new plans. Children under the age of 19 could not be denied coverage due to preexisting conditions, and young adults who were not offered insurance through their employer could stay on their parents' plan until they turned 26 years old. Insurers could no longer deny payment or rescind coverage based on application errors or technical mistakes, and decisions made by insurers could be appealed. Lifetime limits on essential benefits, such as hospital stays, were eliminated, and annual limits were regulated.

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[11] "Chart Book: Accomplishments of Affordable Care Act," Center on Budget and Policy Priorities, March 19, 2019, https://www.cbpp.org/research/health/chart-book-accomplishments-of-affordable-care-act.
[12] "Updates on ObamaCare Related Lawsuits: Subsidies, NFIB, Hobby Lobby, John Boehner, and More.," Obamacare Facts, August 7, 2014, https://obamacarefacts.com/obamacare-lawsuit/.
[13] Timothy Jost, "Examining The Final Market Stabilization Rule: What's There, What's Not, And How Might It Work? (Updated)," *Following the ACA* (blog), April 14, 2017, https://www.healthaffairs.org/do/10.1377/hblog20170414.059646/full/.
[14] Michael T. French et al., "Key Provisions of the Patient Protection and Affordable Care Act (ACA): A Systematic Review and Presentation of Early Research Findings," *Health Services Research* 51, no. 5 (June 5, 2016): 1735–71, https://doi.org/10.1111/1475-6773.12511.
[15] "Key Features of the Affordable Care Act by Year," Nih.gov (National Academies Press (US), August 27, 2014), https://www.ncbi.nlm.nih.gov/books/NBK241401/.

As of 2014, when the Health Insurance Marketplaces, or Health Insurance Exchanges, were fully implemented, guaranteed issue meant insurers were not just prohibited from denying coverage or refusing to renew policies due to any preexisting conditions but prohibited in the individual and small-group market from charging higher rates due to gender or health status. Insurers could only vary rates based on the geography, family size, tobacco use, and age. States could open their own exchanges or use the federal government operated platform.[16] Each state's defined 10 EHBs were a requirement for all plans offered on an exchange, including mental health and substance use disorder services, pregnancy and maternity services, prescription drugs, emergency services, and hospitalization.[17,18] At least 1 in 10 health plans prior to the ACA did not include coverage for preferred brand, non-preferred brand, or specialty prescription drugs, and 6% of plans did not include generic drugs.[11]

An early 2016 Department of Health and Human Services (HHS) brief noted several highlights of the ACA, from the uninsured population to coverage gains across racial and ethnic groups.[19] An estimated 20 million people gained health insurance coverage under the ACA, of which 6.1 million were young adults aged 19 to 25. For 2016 Marketplace enrollment, nearly 5 million new consumers enrolled, and approximately 10.5 million enrollees qualified for an advance premium tax credit (APTC) subsidy.[20] Between 2010 and 2018, the share of nonelderly adults who skipped a test or treatment fell 24%, those who didn't fill a prescription fell 27%, those who didn't visit a provider when needing care fell 19%, and those with a problem paying a medical bill fell 17%.[11]

ACA Effects on Uninsured Rates

As previously mentioned, the 2019 uninsured estimate was 26.1 million, a rate of 8%, marking a total decrease from 2010 of nearly 24 million from the peak of 49.9 million in 2010, as shown in Figure 1. From October 2013, when open enrollment began, to early 2016, the nonelderly (ages 18 to 64) uninsured rate dropped from 20.3% to 11.5%, with women experiencing a greater reduction in the uninsured rate.[19] Coverage gains for the nonelderly in the same period included a decrease from 22.4% to 10.6% among Black non-Hispanics, a decrease from 41.8% to 30.5% among Hispanics, and a decrease from 14.3% to 7% for White non-Hispanics. The overall

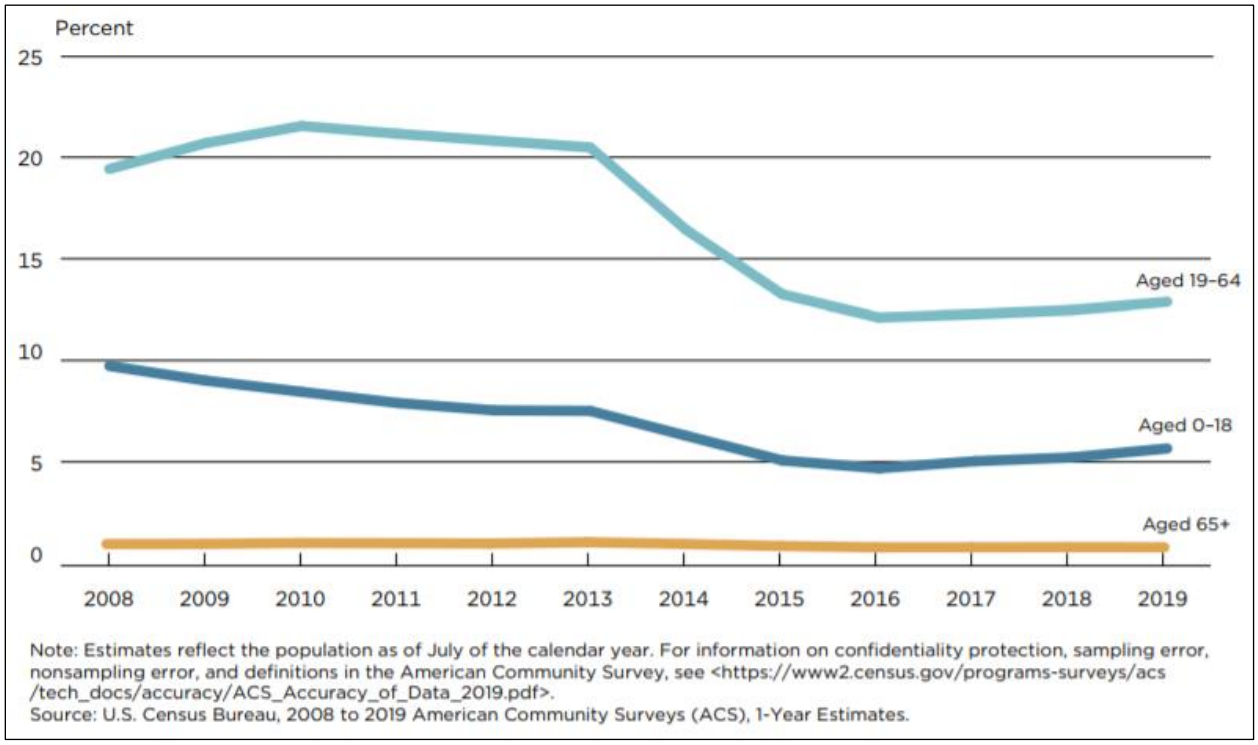
[16] "Health Insurance Marketplace," HealthCare.gov, n.d., https://www.healthcare.gov/.
[17] The Affordable Care Act requires non-grandfathered health plans in the individual and small group markets to cover essential health benefits (EHB), which include items and services in the following ten benefit categories: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care.
[18] "Find out What Marketplace Health Insurance Plans Cover," HealthCare.gov, 2019, https://www.healthcare.gov/coverage/what-marketplace-plans-cover/.
[19] Namrata Uberoi, Kenneth Finegold, and Emily Gee, "Health Insurance Coverage and the Affordable Care Act, 2010–2016," *Department of Health and Human Services*, March 3, 2016, https://aspe.hhs.gov/system/files/pdf/187551/ACA2010-2016.pdf.
[20] "Health Insurance Marketplaces 2016 Open Enrollment Period: Final Enrollment Report," *Department of Health and Human Services*, March 11, 2016, https://aspe.hhs.gov/system/files/pdf/187866/Finalenrollment2016.pdf.

uninsured rate has remained under 9% since 2017, according to the U.S. Census Bureau.[3,21,22] In the decade since the ACA was signed, tens of millions of people in all age groups have benefited.

Figure 1

Percentage of People Without Health Insurance Coverage, by Age: 2008 – 2019

(Civilian noninstitutionalized population)



Note: Estimates reflect the population as of July of the calendar year. For information on confidentiality protection, sampling error, nonsampling error, and definitions in the American Community Survey, see <https://www2.census.gov/programs-surveys/acs/tech_docs/accuracy/ACS_Accuracy_of_Data_2019.pdf>.
Source: U.S. Census Bureau, 2008 to 2019 American Community Surveys (ACS), 1-Year Estimates.

Uninsured Rate Projections and Results

The Congressional Budget Office (CBO) and the staff of the Joint Committee on Taxation (JCT) provided a report to Congress days before the ACA was signed in 2010, which included estimates of the ACA's impacts on costs, revenues, and uninsured rates.[23] They estimated the total uninsured for the nonelderly population without the ACA would reach 54 million by 2019, including unauthorized immigrants and people who are eligible for, but not enrolled in, Medicaid. Their estimates, with the implementation of the ACA for the same group of people, were 31 million in 2014 and 23 million in 2019, compared to actual results of 33 million and 26.1 million,

[21] Edward Berchick, Emily Hood, and Jessica Barnett, "Health Insurance Coverage in the United States: 2017" (United States Census Bureau, September 2018), https://www.census.gov/content/dam/Census/library/publications/2018/demo/p60-264.pdf.

[22] Edward Berchick, Jessica Barnett, and Rachel Upton, "Health Insurance Coverage in the United States: 2018" (United States Census Bureau, November 2019), https://www.census.gov/content/dam/Census/library/publications/2019/demo/p60-267.pdf.

[23] Douglas Elmendorf, "Manager's Amendment to Reconciliation Proposal," March 20, 2010, https://www.cbo.gov/sites/default/files/111th-congress-2009-2010/costestimate/amendreconprop.pdf.

respectively.[1,3,24] For the 2019 estimate, an estimate that 92% of the nonelderly population would have health insurance coverage matched the actual 2019 value.[1]

Impact on the Uninsured in Medicaid Expansion and Non-Expansion States

The ACA originally required Medicaid expansion, but the judgment of the Supreme Court in June 2012 decided the threat of cutting off all Medicaid funding to non-compliant states was unconstitutional, effectively making Medicaid expansion optional.[25] Twelve states continue to opt-out as of 2020, and are referred to as Medicaid non-expansion states.[26] At the start of 2014, there were 26 non-expansion states, however 14 of these states would later expand (or made plans to expand) over the course of 2014 through 2020, and expectations of expansion in 2021.[27] In Medicaid-expansion states, Americans earning less than 133% federal poverty level (effectively 138%, with some states varying in income limits) were eligible to enroll in Medicaid.[28,29]

One study found 19 states with uninsured rates of 15% or higher, and 13 of those were non-expansion states in 2020. This included 2 states that implemented expansion plans for July 2021, Missouri and Oklahoma.[30] The same study found 8 states with rates of 20% or higher of uninsured nonelderly adults in 2020, and 7 of these states are among the 14 Medicaid non-expansion states in 2020, with the highest rate being 29% in Texas.

In 2014, a study from the National Center for Health Statistics (a branch of the HHS) estimated a higher percentage of nonelderly adults without a usual place of medical care in Medicaid non-expansion states.[31] A study ranging from September 2013, just prior to the first Marketplace open enrollment period, to March 2015 revealed nonelderly adults with problems in accessing care were more likely to be low-income, Hispanic, younger, female, and in poorer health.[32]

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[24] Jessica Smith and Carla Medalia, "Health Insurance Coverage in the United States: 2014," *United States Census Bureau*, September 2015, https://www.census.gov/content/dam/Census/library/publications/2015/demo/p60-253.pdf.
[25] National Federation of Independent Business et al. v. Sebelius, Secretary of Health and Human Services, et al. (Supreme Court of the United States June 28, 2012).
[26] Medicaid non-expansion states: Alabama, Florida, Georgia, Kansas, Mississippi, North Carolina, South Carolina, South Dakota, Tennessee, Texas, Wisconsin, and Wyoming
[27] "Status of State Medicaid Expansion Decisions: Interactive Map," The Henry J. Kaiser Family Foundation, August 2, 2019, https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/.
[28] Medicaid expansion states: Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, Utah, Vermont, Virginia, Washington, and West Virginia
[29] "How Medicaid Health Care Expansion Affects You," HealthCare.gov, n.d., https://www.healthcare.gov/medicaid-chip/medicaid-expansion-and-you/.
[30] Stan Dorn, "The COVID-19 Pandemic and Resulting Economic Crash Have Caused the Greatest Health Insurance Losses in American History," *Www.Familiesusa.Org*, July 17, 2020, https://www.familiesusa.org/wp-content/uploads/2020/07/COV-254_Coverage-Loss_Report_7-17-20.pdf.
[31] Lindsey Black and Jeannine Schiller, "State Variation in Health Care Service Utilization: United States, 2014," *Www.Cdc.Gov*, May 2016, https://www.cdc.gov/nchs/data/databriefs/db245.pdf.
[32] Adele Shartzer, Sharon Long, and Nathaniel Anderson, "Access to Care and Affordability Have Improved Following Affordable Care Act Implementation; Problems Remain," *Health Affairs* 35, no. 1 (January 2016): 161–68, https://doi.org/10.1377/hlthaff.2015.0755.

From 2013 to 2017, the largest declines in the uninsured rates were found in Medicaid expansion states, and research indicates Medicaid expansion positively affects access to care, utilization of services, affordability of care, financial security, self-reported health, and certain measures of health outcomes among the low-income population.[33] Medicaid coverage for pregnant women and children contributed to dramatic declines in infant and child mortality. Increasingly, studies show childhood Medicaid eligibility has long-term positive impacts, including reduced teen mortality, reduced disability, reduced rates of emergency department visits and hospitalization in later life, and improved long-run education attainment.[34,35] Downstream benefits are also present, from reduced earned income tax credit payments and increased tax collections due to higher adulthood earnings.[35] Studies through January 2020 support all previously noted findings of expansion, including increased utilization of health services and diagnosis and treatment of health ailments, including cancer, mental illness, and substance use disorder.[36]

Impacts on the Uninsured in Rural Areas, Across Poverty Levels, and Among Racial and Ethnic Groups

Prior to the ACA, Medicaid eligibility for parents was limited to those with very low incomes (often below 50% FPL,) and adults without dependent children were ineligible under federal rules.[37] The ACA expanded Medicaid eligibility to nearly all low-income individuals at or below 138% FPL, set at $12,760 for an individual in 2020.[38] Uninsured rates for nonelderly people with incomes between 138% and 400% FPL have fallen dramatically, from 19.2% in 2013 to 12.5% in 2017.[39] As of June 2019, 33 states plus D.C. expanded Medicaid, with 14.8 million enrolling in Medicaid under expansion, of which 12 million were newly eligible.[40] The 2.8 million who would have been eligible pre-ACA indicates enrollment due to a mix of better coverage awareness, lower premium rates, and improved plan value.

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[33] Robin Rudowitz and Larisa Antonisse, "Implications of the ACA Medicaid Expansion: A Look at the Data and Evidence," The Henry J. Kaiser Family Foundation, May 23, 2018, https://www.kff.org/medicaid/issue-brief/implications-of-the-aca-medicaid-expansion-a-look-at-the-data-and-evidence/.

[34] Andrew Goodman-Bacon, "Public Insurance and Mortality: Evidence from Medicaid Implementation," November 25, 2015, http://www-personal.umich.edu/~ajgb/medicaid_ajgb.pdf.

[35] Bruce Meyer and Laura Wherry, "Saving Teens: Using a Policy Discontinuity to Estimate the Effects of Medicaid Eligibility," www.nber.org, August 17, 2012, http://www.nber.org/papers/w18309.

[36] Madeline Guth, Rachel Garfield, and Robin Rudowitz, "The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review," The Henry J. Kaiser Family Foundation, March 17, 2020, https://www.kff.org/medicaid/report/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review/.

[37] Martha Heberlein et al., "Getting into Gear for 2014: Shifting New Medicaid Eligibility and Enrollment Policies into Drive," KFF, November 21, 2013, https://www.kff.org/medicaid/report/getting-into-gear-for-2014-shifting-new-medicaid-eligibility-and-enrollment-policies-into-drive/.

[38] "Federal Poverty Level (FPL) - HealthCare.Gov Glossary," HealthCare.gov, n.d., https://www.healthcare.gov/glossary/federal-poverty-level-fpl/.

[39] Aviva Aron-Dine and Matt Broaddus, "Improving ACA Subsidies for Low- and Moderate-Income Consumers Is Key to Increasing Coverage," Center on Budget and Policy Priorities, March 21, 2019, https://www.cbpp.org/research/health/improving-aca-subsidies-for-low-and-moderate-income-consumers-is-key-to-increasing.

[40] "Medicaid Expansion Enrollment," KFF, September 22, 2020, https://www.kff.org/health-reform/state-indicator/medicaid-expansion-enrollment/.

The median income limit for parents in non-expansion states is 40% FPL, with the lowest rate of 17% FPL eligibility in Texas, equating to annual incomes of $8,688 and $3,692, respectively, for a family of three in 2020.[41] Since the ACA envisioned low-income people could receive Medicaid coverage through expansion, it does not provide financial assistance for other coverage options to people below poverty. This causes childless adults in non-expansion states to fall into a "coverage gap," about 2.3 million in 2018, with incomes above Medicaid eligibility limits but below the FPL, which is the lower limit for Marketplace APTCs.[42]

Nationwide, nearly 2 million people in rural areas in Medicaid expansion states gained health insurance coverage between 2013 and 2015, representing a 7% decrease in the rural uninsured rate.[43] Coverage was provided to 22.5% of rural residents through Medicaid in 2015, and in Medicaid expansion states, coverage rates increased to more than 25%, compared to just over 17% among non-Medicaid expansion states.[44] One study found the uninsured rate from 2008 to 2016 for low-income (below 138% FPL) adults in small towns and rural areas of Medicaid expansion states experienced the sharpest declines, dropping from 35% to 16%, compared to a decline from 38% to 32% in non-expansion states, as shown in Figure 2.[45]

[41] "Medicaid Income Eligibility Limits for Adults as a Percent of the Federal Poverty Level," KFF, April 1, 2020, https://www.kff.org/health-reform/state-indicator/medicaid-income-eligibility-limits-for-adults-as-a-percent-of-the-federal-poverty-level/.

[42] Rachel Garfield, Kendal Orgera, and Anthony Damico, "The Coverage Gap: Uninsured Poor Adults in States That Do Not Expand Medicaid," The Henry J. Kaiser Family Foundation, January 14, 2020, https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/.

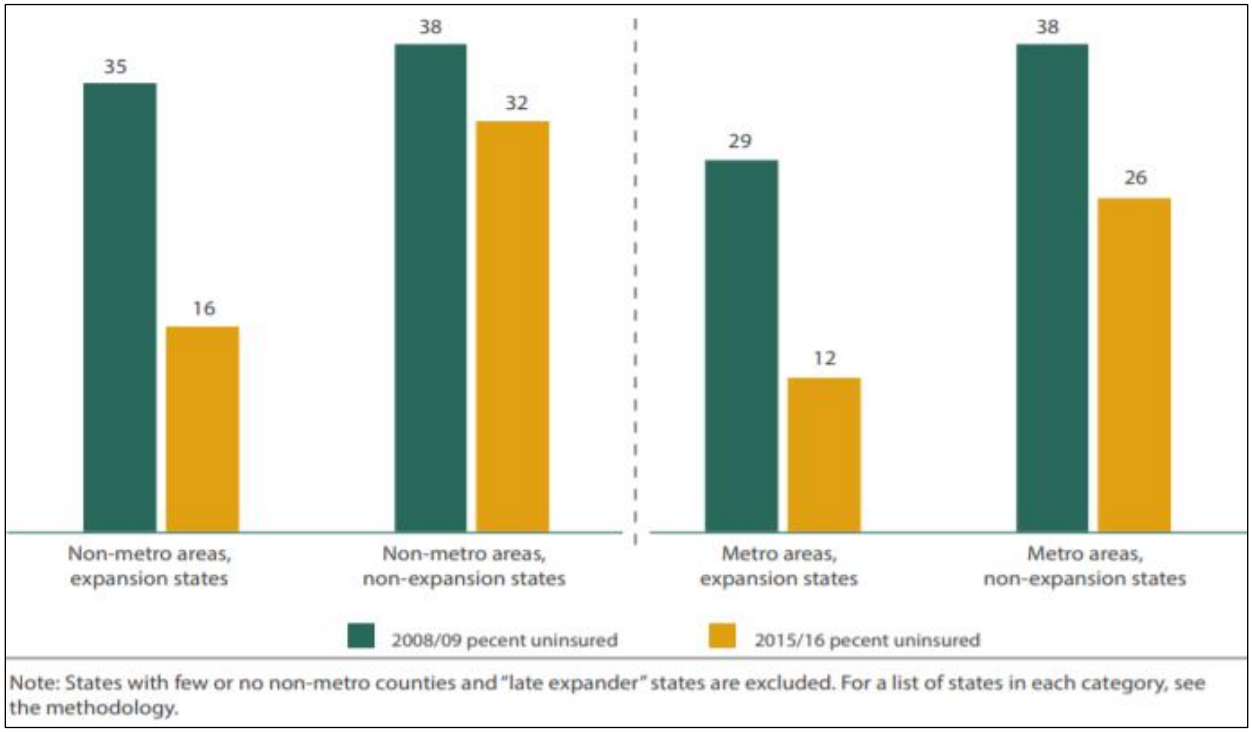
[43] "Changes in Insurance Coverage in Rural Areas under the ACA: A Focus on Medicaid Expansion States," KFF, May 4, 2017, https://www.kff.org/medicaid/fact-sheet/changes-in-insurance-coverage-in-rural-areas-under-the-aca-a-focus-on-medicaid-expansion-states/.

[44] Dee Mahan, "Cutting Medicaid Would Hurt Rural America," *Www.Familiesusa.Org*, March 2017, https://www.familiesusa.org/wp-content/uploads/2017/03/FUSA_MedicaidCutsInRuralAmerica.pdf.

[45] Joan Alker, Jack Hoadley, and Mark Holmes, "Health Insurance Coverage in Small Towns and Rural America: The Role of Medicaid Expansion," *Georgetown University Center for Children and Families*, September 2018, https://ccf.georgetown.edu/wp-content/uploads/2018/09/FINALHealthInsuranceCoverage_Rural_2018.pdf.

Figure 2

Decline in Uninsured Rate for Low-Income Citizen Adults, by State Expansion Status Among Non-Metro and Metro Areas, 2008/09 - 2015/16

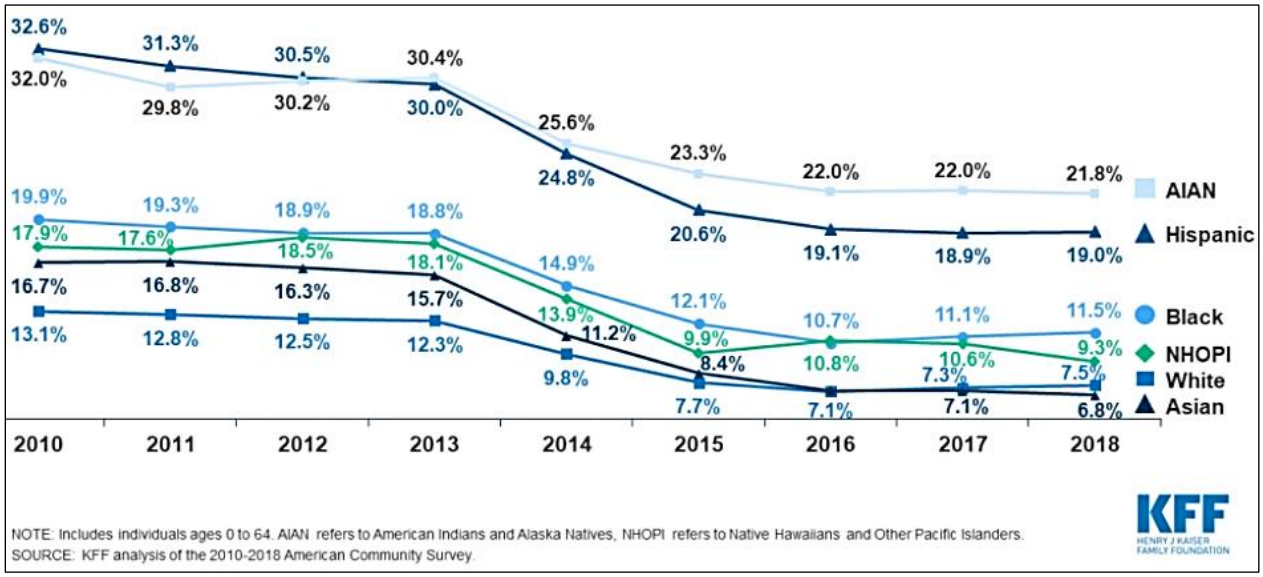


Minority groups experienced decreases in uninsured rates between 2010 and 2014, but after the full implementation of the ACA in 2014 through 2018, the largest increases in healthcare coverage for racial and ethnic groups occurred, with the largest coverage gains occurring from 2014 through 2016.[46] Hispanics had the largest percentage point increase in coverage, with their uninsured rate falling from 32.6% to 19.1% between 2010 and 2016, as shown in Figure 3. Blacks, Asians, and American Indians and Alaska Natives (AIANs) also had larger percentage point increases in coverage compared to Whites over that period.

[46] Samantha Artiga, Kendal Orgera, and Anthony Damico, "Changes in Health Coverage by Race and Ethnicity since the ACA, 2010-2018," KFF, March 5, 2020, https://www.kff.org/racial-equity-and-health-policy/issue-brief/changes-in-health-coverage-by-race-and-ethnicity-since-the-aca-2010-2018/.

Figure 3

Uninsured Rates for the Nonelderly Population by Race and Ethnicity, 2010 - 2018



ACA Effects on Competition

Although states had the choice to operate their own exchange, the federally operated Health Insurance Exchange was used by 35 states in 2014 and 39 states in 2019.[47] Numerous counties within states, or entire states, were often left with a single health insurance provider, becoming more pronounced in 2017 and 2018, but improved in 2019 and 2020.

Market rating requirements standardized how health insurers priced plans and how regulators review premium rates, increasing transparency of high rate increases. Qualified small business and small nonprofit organizations received larger tax credits, and the Small Business Health Options Program (SHOP) began by the end of 2014. Risk adjustment, reinsurance, and risk corridor (3R) programs went into effect to help stabilize premiums and reduce adverse selection. [14,15]

Competing for Market Share

Coverage tiers in the Marketplace are referred to as "metal levels" or "metal tiers" and are based on "actuarial value" or "AV" which is a measure of a plan's generosity (e.g., what the plan covers) for a standard population.[48] The bronze, silver, gold, and platinum metal tiers have actuarial values of 60%, 70%, 80%, and 90%, respectively. The higher the actuarial value, the higher the premium generally, but an enrollee's cost-sharing would be lower due to lower deductibles, copays, and coinsurance. Silver-level ACA plans cover roughly 17% more of an enrollee's health expenses

[47] "2019 Health Plan Choice and Premiums in HealthCare.Gov States," *Department of Health and Human Services*, October 26, 2018, https://aspe.hhs.gov/system/files/pdf/260041/2019LandscapeBrief.pdf.
[48] Larry Levitt and Gary Claxton, "What the Actuarial Values in the Affordable Care Act Mean," *KFF*, April 2011, https://www.kff.org/wp-content/uploads/2013/01/8177.pdf.

than pre-ACA plans did, on average.[49] However, because APTCs are fixed based on income, the value does not change based on the metal tier, so enrollees pay the full price difference for pricier metal plans. A study of data from 2014 through 2016 revealed "an increased likelihood that consumers, particularly those who are price sensitive, would be compelled to comparison-shop each year to find the most affordable health plan."[50]

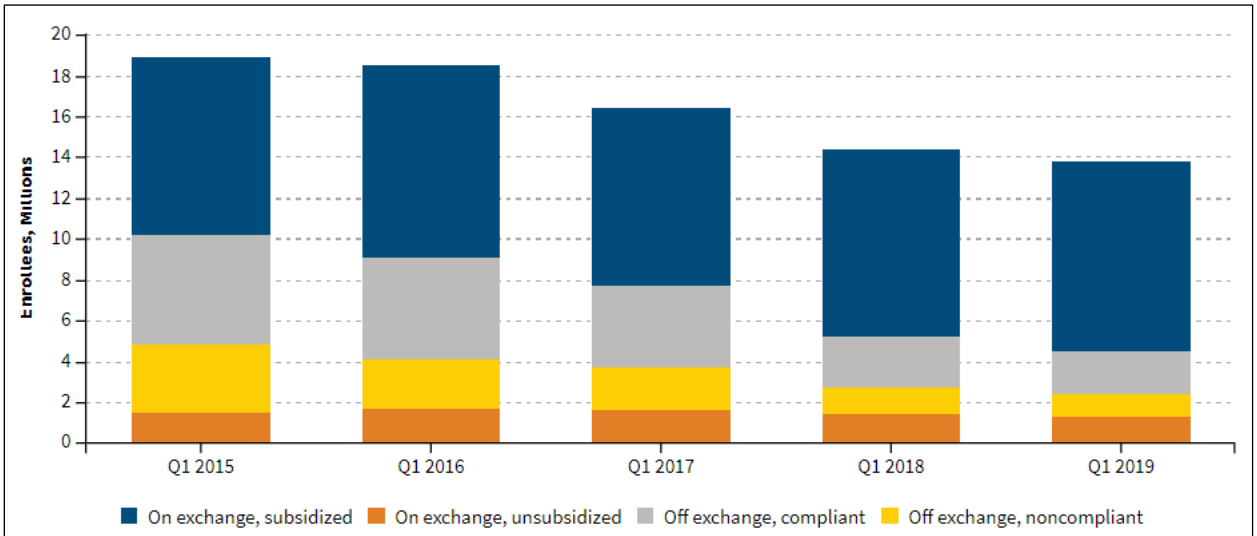
One analysis found that, despite financial losses affecting many insurers in 2014, about 32% of carriers reported gains after reinsurance and risk adjustment, with 35% of these being experienced individual market insurers.[51] Just over one-quarter of the insurers offering health plans on the exchanges in 2014 were new entrants, most with previous insurance experience in a non-individual market, and 22% of these new entrant carriers were among those reporting gains. The analysis further found new entrants to be price leaders for 19% of the qualified health plan-eligible population where their plans were available, rising to 46% in 2015.

For new entrants that had experience in another market, such as Medicaid or Medicare, advantages to enter the individual market were recognizable. Economies of scale, including the federally funded marketing of the exchanges, and standardization, from metal tiers to EHBs, provided the opportunity to expand without the high start-up costs that often plague new companies. Volume itself was a factor for all existing and new entrant insurers, as the individual mandate, APTCs, and cost-sharing reduction (CSR) subsidies guaranteed higher enrollment across the spectrum of plans in the individual market compared to the industry prior to the ACA's implementation, or provided reimbursement of costs directly to insurers.[52] Although the individual mandate penalty was set at $0 as of 2019 due to the 2017 Tax Cuts and Jobs Act, and CSR payments ended in the fall of 2017, enrollment declined annually from 2015 through 2019 in the individual market, as shown in Figure 4, with enrollees citing premium increases as the main driver, slowing in 2019 as premiums stabilized.

[49] Loren Adler and Paul Ginsburg, "Affordable Care Act Premiums Are Lower Than You Think," *Center for Health Policy at Brookings*, July 2016, https://www.brookings.edu/wp-content/uploads/2016/07/acapaper721.pdf.
[50] Caitlin McKillop et al., "Three Years in – Changing Plan Features in the U.S. Health Insurance Marketplace," *BMC Health Services Research* 18, no. 1 (June 15, 2018), https://doi.org/10.1186/s12913-018-3198-3.
[51] Erica Coe, Patrick Finn, and Jim Oatman, "Emerging Story on New Entrants to the Individual Health Insurance Exchanges," *McKinsey Center for U.S. Health System Reform*, August 2015, https://healthcare.mckinsey.com/wp-content/uploads/2020/02/Emerging-story-on-new-entrants-to-individual-exchanges_8.27.2015.pdf.
[52] David Dillon, Michael Lin, and Matthew Damiani, "Successes of the ACA," The Actuary Magazine, March 2020, https://theactuarymagazine.org/successes-of-the-aca/.

Figure 4

Individual Market Enrollment, Q1 2015 – 2019



Source: Kaiser Family Foundation. Enrollment in Individual Market Dips Slightly in Early 2019 after Repeal of Individual Mandate Penalty. *Kaiser Family Foundation*, August 21, 2019 (accessed December 15, 2019).

Insurer participation followed a wave-like trend from 2014 through 2020, as financial performance and federal policy changed in unpredictable ways. Nationwide, six parent insurance companies (often each comprised of independent and locally operated companies) captured just over 33% of the market share in 2015 and nearly 50% in 2019, with all other insurers capturing the remainder.[53,54] At the state level, including D.C., the three largest parent companies held 80% or more of the individual market share in 42 states in 2014, 39 states in 2016, and 46 states in 2018.[55] These findings are consistent with pre-ACA trends, where 33 states in 2011 and 39 states in 2013 had at least 80% of the market share belonging to the three largest insurers.[56]

Whether largely due to plan benefits, price, or a combination of both, nearly 46% of enrollees who had coverage in the Marketplace in 2018 switched to a plan during open enrollment for 2019.[57] This is lower than the 54% of enrollees who had coverage through the Marketplace in 2014 and switched their 2015 plan.[58] These reports do not specify if the people switched to a plan within

[53] The six parent companies are Centene, GuideWell, Kaiser Foundation, HCSC, Blue Shield of CA, and Anthem.
[54] "Market Share of Top Individual Health Insurers Increased 20% Over Past 5 Years," www.markfarrah.com, June 11, 2020, http://www.markfarrah.com/mfa-briefs/market-share-of-top-individual-health-insurers-increased-20-over-past-5-years-/.
[55] "Market Share and Enrollment of Largest Three Insurers – Individual Market," KFF, May 21, 2020, https://www.kff.org/private-insurance/state-indicator/market-share-and-enrollment-of-largest-three-insurers-individual-market/.
[56] John Dicken et al., "Enrollment Remains Concentrated among Few Issuers, Including in Exchanges," *United States Government Accountability Office*, March 2019, https://www.gao.gov/assets/700/697746.pdf.
[57] "2019 Marketplace Open Enrollment Period Public Use Files | CMS," *CMS*, n.d., https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/2019_Open_Enrollment.
[58] "Health Insurance Marketplaces 2015 Open Enrollment Period: March Enrollment Report," *Department of Health and Human Services*, March 10, 2015, https://aspe.hhs.gov/system/files/pdf/83656/ib_2015mar_enrollment.pdf.

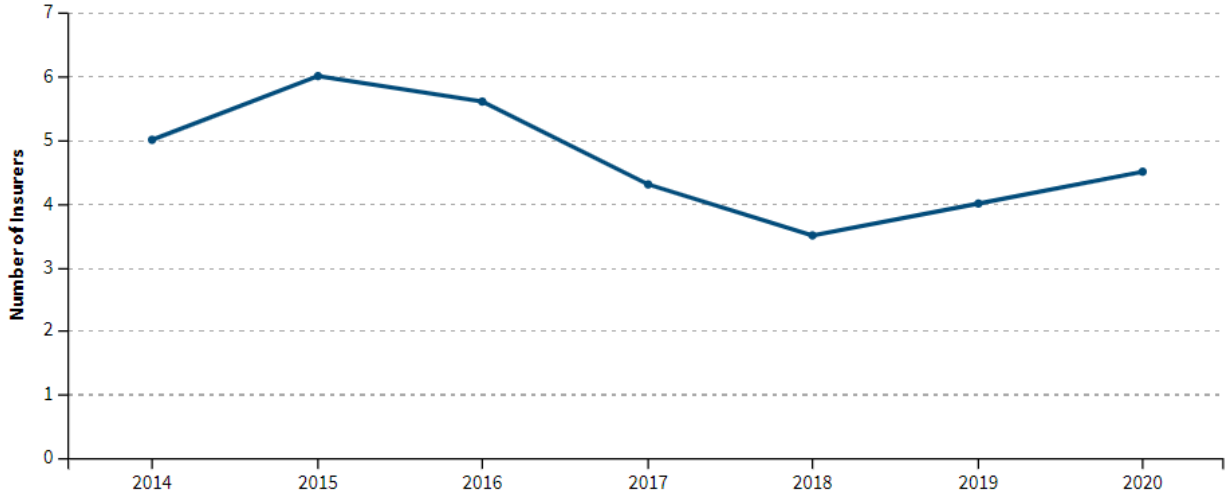
the same company, or if they switched issuers, but it is clear that consumers continue to be active comparison shoppers.

Participation Trends: Nationwide, State, and County Levels

States using just the federal Exchange observed the number of plan issuers peak in the individual market in 2016 and peak in the Marketplace nationwide in 2015.[47,59] Both the Marketplace and federal Exchange experienced the lowest insurer participation in 2018, although the largest decrease in participation occurred for the 2017 plan year, but participation increased in both 2019 and 2020, as shown in Figure 5.

Figure 5

Average Number of Exchange Insurers by State, 2014 – 2020



Source: Fehr, Rachel, Rabah Kamal, and Cynthia Cox. Insurer Participation on ACA Marketplaces, 2014–2020. *Kaiser Family Foundation*, November 21, 2019 (accessed December 15, 2019).

At the county level, insurer participation is lower in rural areas compared to metropolitan areas.[60] The number of counties or states limited to a single insurer on the exchanges varied from 2014 through 2020, but 2018 experienced the most enrollees and counties susceptible to just one insurer. In 2014, only 1 insurer was available to 6% of enrollees, including all counties in 2 states and most counties in 3 states, but 76% of enrollees in counties nationwide had access to 3 or more insurers. By 2015, only 1% of enrollees were forced to choose between the single insurer made available to them, or none, including all counties in 1 state, while 91% of enrollees nationwide had 3 or more options. Although 2016 experienced nearly the same rates as 2015, with 2% of enrollees with

[59] Daniel McDermott and Cynthia Cox, "Insurer Participation on ACA Marketplaces, 2014-2020," The Henry J. Kaiser Family Foundation, November 23, 2020, https://www.kff.org/private-insurance/issue-brief/insurer-participation-on-aca-marketplaces-2014-2020/.

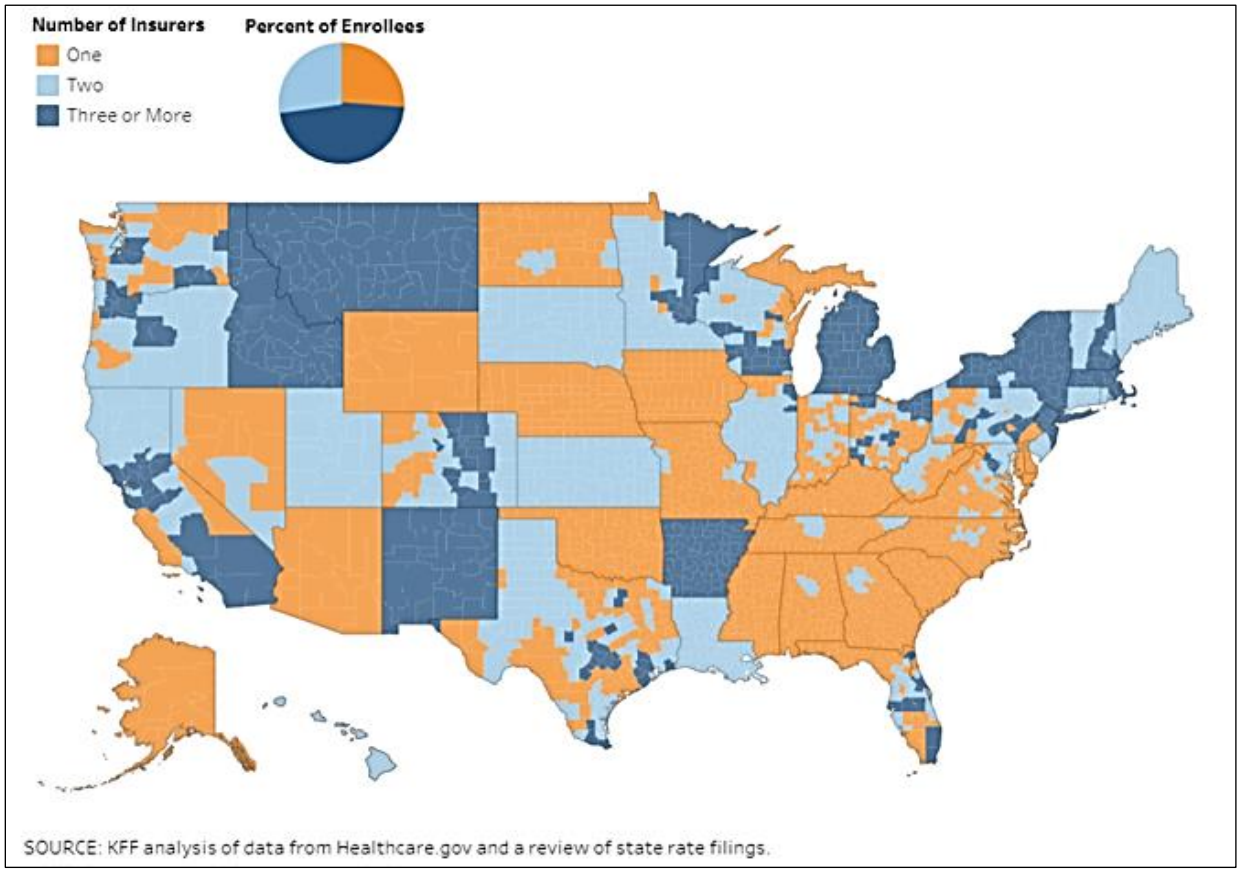
[60] "More Insurers Are Participating in the ACA Marketplaces in 2019," KFF, November 14, 2018, https://www.kff.org/health-reform/press-release/more-insurers-are-participating-in-the-aca-marketplaces-in-2019/.

access to a single provider and 85% with access to 3 or more, the locations of these enrollees changed substantially.

Disruptions to provider availability were striking in 2017 and 2018, with 21% of enrollees having access to a single insurer in 2017, and only 58% with access to 3 or more. Insurer participation worsened in 2018, with 52% of all counties nationwide reduced to a single insurer across 26% of enrollees, and for the first time since the exchanges opened, less than half (48%) of enrollees had access to 3 or more insurers, as shown in Figure 6.

Figure 6

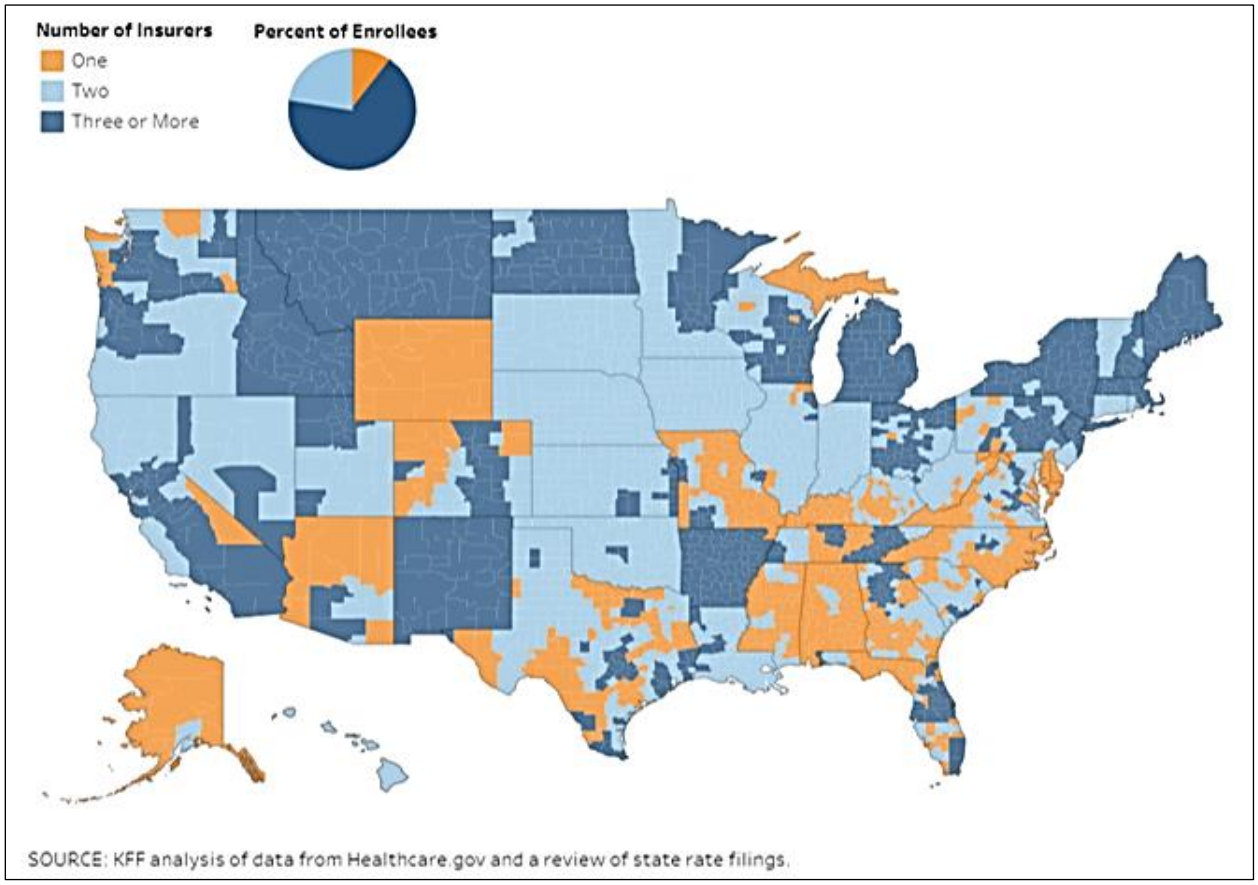
Insurer Participation on ACA Marketplaces, 2018



The individual market began to recover in 2019, with only 37% of counties in which had access to just a single insurer and with 608 counties gaining at least 1 additional insurer. By 2020, the number of counties with access to a single insurer decreased to 25% across just 10% of enrollees, with 67% of enrollees with access to 3 or more, as shown in Figure 7.

Figure 7

Insurer Participation on ACA Marketplaces, 2020



In 2017, there were 5 states with a single insurer each, although a sixth state, Arizona, had 2 companies within the state, but each county had just 1 insurer available to them. Eight states in 2018 had a single insurer, while two states, Arizona and Kentucky, had 2 insurers, but similar to 2017, each county had just 1 insurer available. Whole states with a single provider in 2019 decreased to 5, and to just 2 in 2020. By 2018, at least 2 out of 5 insurers had exited the exchanges. Most insurers, if not all, who chose not to participate in 2018 cited federal policy uncertainty as the key driver, or at least a contributing factor, in their decision to withdraw.[61] Hawaii and Vermont are the only 2 states to have the same number of providers annually (2) from 2014 through 2020.

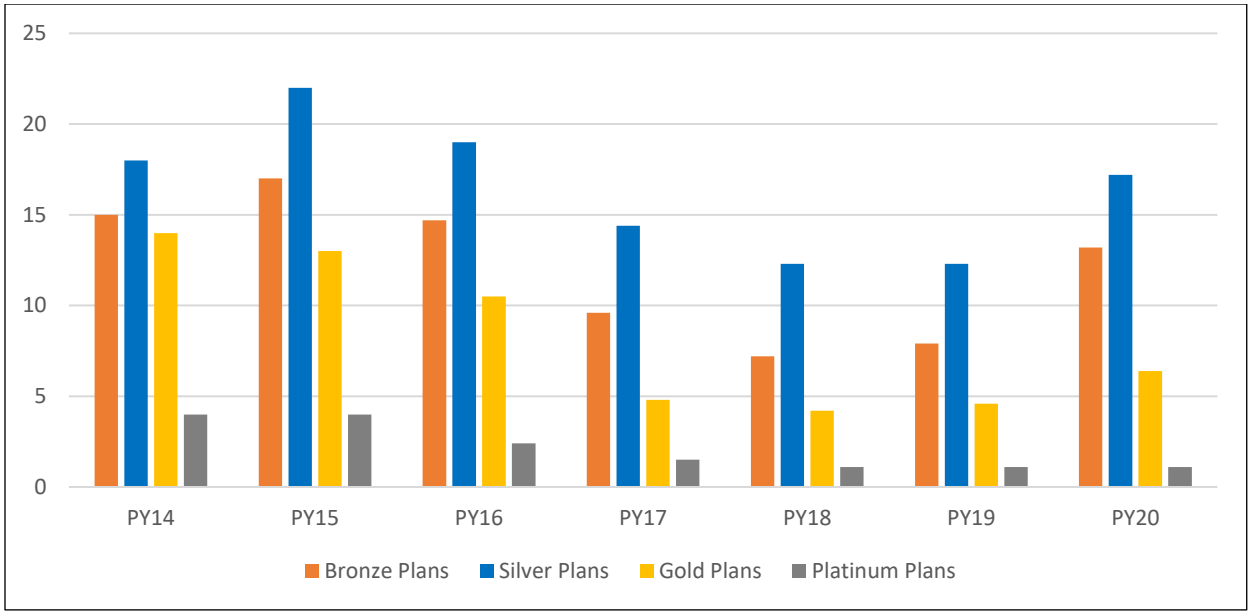
In comparing insurer competition to 2014, more insurers were available in 2020 than in 2014 in 10 states, while 26 states (including D.C.) had less insurers. The increase in insurer participation in 2019 and 2020 implied confidence in potential profitability, stability, and functionality.[62] Despite increasing insurer participation in 2019, the average number of QHPs continued to

[61] Aviva Aron-Dine, "Health Care: Issues Impacting Cost and Coverage," Center on Budget and Policy Priorities, September 12, 2017, https://www.cbpp.org/health/health-care-issues-impacting-cost-and-coverage.
[62] John Holahan, Erik Wengle, and Caroline Elmendorf, "Marketplace Premiums and Insurer Participation: 2017 – 2020," *Www.Urban.Org*, January 2020, https://www.urban.org/sites/default/files/publication/101499/moni_premiumchanges_final.pdf.

decrease across all metal levels on the federal Exchange.[47] However, ongoing increases in participation resulted in a rebound of QHPs across all metal levels in 2020, except Platinum, as shown in Figure 8.[63] Gold and platinum plan options decreased by more than 65%, and bronze by nearly half, compared to 2014 plan options. Silver plans decreased by a third of what was available in 2014, and by nearly half of what was available in 2015.

Figure 8

Average Number of Health Plan Options for Enrollees in HealthCare.gov States Across Plan Years (PY), PY14 – PY20



State Innovation Waivers

State Innovation Waivers allow states to use innovative methods to waive certain provisions, but states must provide coverage offering, at a minimum, at the same level of protections, affordability, and comprehensiveness guaranteed under the ACA, without increasing the federal deficit. This flexibility allows states to apply for waivers regarding provisions such as individual and employer mandates, essential health benefits, or coverage tiers. Other provisions cannot be waived, such as guaranteed issue, age rating, and prohibitions on health status and gender rating. The Trump administration changed guidance in October 2018, wherein prior to the change, waivers were mostly used to implement state-based reinsurance programs to assist in cost reduction of ACA-compliant individual market policies.[64]

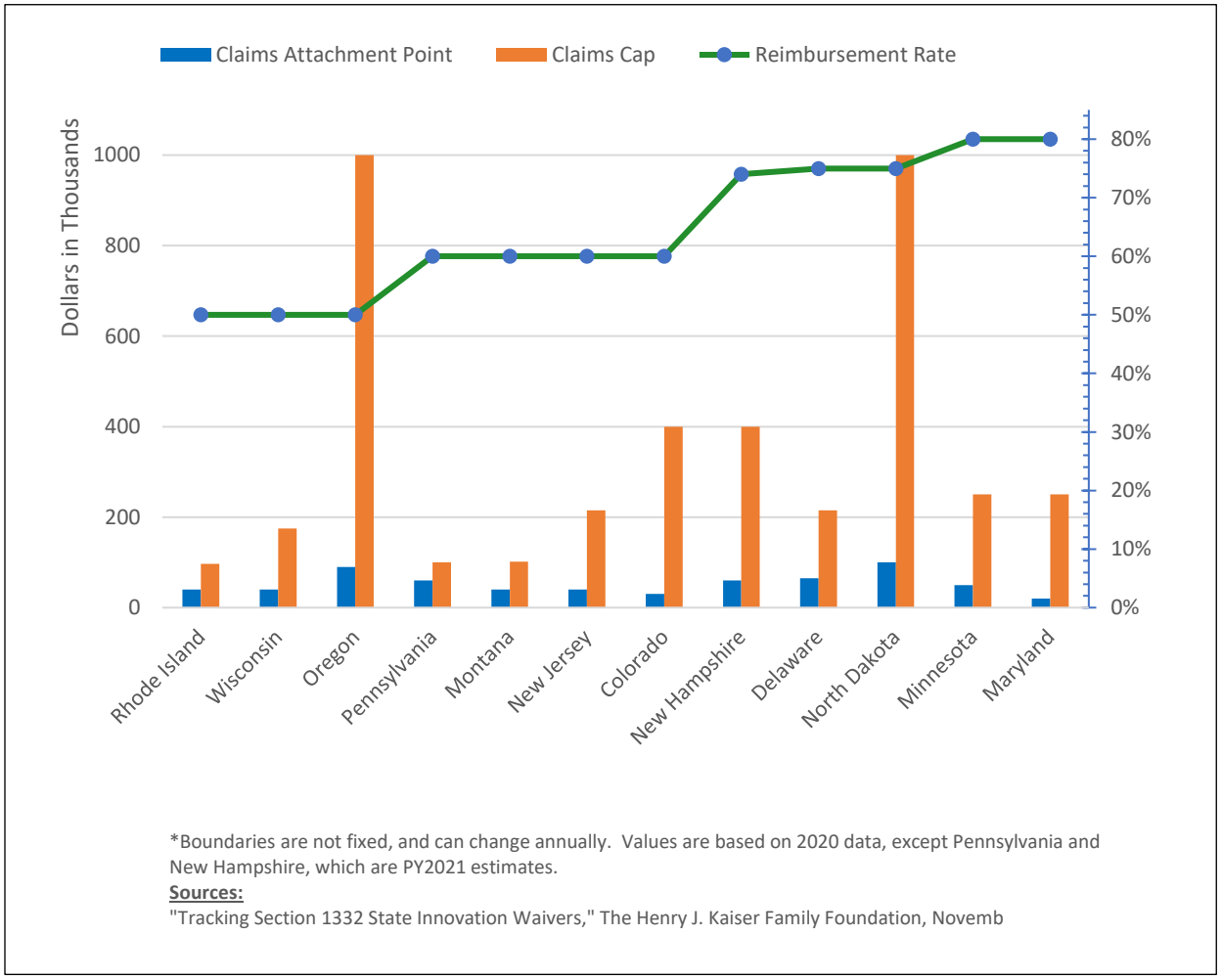
[63] "Plan Year 2020 Qualified Health Plan Choice and Premiums in HealthCare.Gov States," *CMS*, October 22, 2019, https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2020QHPPremiumsChoiceReport.pdf.
[64] Jennifer Tolbert and Karen Pollitz, "New Rules for Section 1332 Waivers: Changes and Implications," The Henry J. Kaiser Family Foundation, December 10, 2018, https://www.kff.org/health-reform/issue-brief/new-rules-for-section-1332-waivers-changes-and-implications/.

As of November 2020, 16 states had their waivers approved.[65] In December 2016, Hawaii was the first state to get approval, waiving the ACA's SHOP requirements that conflicted with their state's Prepaid Health Care Act, enacted in 1974 and it waived the requirement that the small business tax credits could only be available through SHOP. The other 15 state's approved waivers allowed their state-based reinsurance programs to receive federal pass-through funding. Twelve of these states, as shown in Figure 9, provide claims cost-based coinsurance (reimbursement) rates to insurers for incurred claims, ranging from 50% to 80%, on a variety of claims, ranging within boundaries of $30,000 to $1,000,000.[66,67,68,69]

[65] "Tracking Section 1332 State Innovation Waivers," The Henry J. Kaiser Family Foundation, November 1, 2020, https://www.kff.org/health-reform/fact-sheet/tracking-section-1332-state-innovation-waivers/.
[66] "State Relief and Empowerment Waivers: State-Based Reinsurance Programs," *CMS*, June 2020, https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/1332-Data-Brief-June2020.pdf.
[67] Boundaries defined as Claims Attachment Point (lower boundary) and Claims Cap (upper boundary.)
[68] Money is "passed through" the federal government to the state that would have been spent on advance premium tax credits (APTCs), cost-sharing reductions (CSRs), and small business tax credits.
[69] Pennsylvania and New Hampshire received approval in summer of 2020, and their reinsurance programs will be applied in plan year (PY) 2021.

Figure 9

State Reimbursement Rates and Claim Thresholds



Two states have slightly more unique reinsurance-based waivers. Alaska reimburses insurers under a conditions-based program for incurred claims for high-risk enrollees diagnosed with certain health conditions. Maine reimburses insurers under a hybrid claims cost-based and conditions-based program, with 90% coinsurance for claims ranging from $47,000 to $77,000 and 100% coinsurance for claims above $77,000 for high-risk enrollees diagnosed with certain health conditions, or who are referred by the insurer's underwriting judgment.

In November 2020, Georgia became the most recent state to receive waiver approval, with a dual-phase program. Their first phase will be applicable in PY2022, and will reimburse insurers a percentage of claims ranging from $20,000 to $500,000 with a three-tiered reimbursement structure based on geography, similar to Colorado, with greater coinsurance rates for regions with the highest premiums.[70] Georgia's second phase will end the state's use of the federal Marketplace in PY2023 in favor of privately operated direct enrollment, using private web brokers or directly

[70] Reimbursement rate is TBD. Structure: 15% for low-cost regions, 45% for mid-cost regions, and 80% for high-cost regions.

through insurers, known as the Georgia Access Model.[71] All individual health plans, including Qualified Health Plans (QHPs) and non-QHPs offering a more limited set of benefits, will be available for purchase. Only QHP enrollees will have APTCs made available to them, and Georgia will conduct eligibility determinations for APTCs using the state's same platform used for Medicaid and other social service programs.

ACA Effects on Premiums

The ACA sparked a drastic health insurance enrollment increase in 2014 and 2015, but insurers did not have access to actual claims experience to help project healthcare utilization and costs. This contributed to a reduction in profits and increases in losses through 2016, which in turn resulted in dozens of companies exiting the ACA market in 2017 and 2018. Increased premiums in 2017 and 2018 were the combined result of improved claims experience and terminated cost-sharing reduction (CSR) subsidy payments. Consumer price sensitivity caused declines in unsubsidized enrollment, despite premiums stabilizing in 2019 and 2020.

Advance premium tax credits (APTCs) were subsidies that lowered monthly premiums for persons or households with income between 100% and 400% FPL (who were not eligible for other affordable coverage) and purchase coverage through an exchange. CSR subsidies were made available for persons or households with income up to 250% FPL who purchase an exchange's silver plan, with reimbursements paid to the insurers.

The shared responsibility payment, known as the individual mandate, began in 2014. This payment was intended as a penalty paid to the IRS for people who did not maintain a minimum level of health insurance coverage. The passage of the Tax Cuts and Jobs Act in 2017 resulted in the individual mandate penalty to be set at zero dollars as of 2019, yet enrollment did not decline as initially expected as result of this change, but rather due to premium increases.

Premium Rate Impacts on Insurer's Gains and Losses

The ACA created the first uniform minimum Medical Loss Ratio (MLR) standard, with reporting commencing in 2010, and as of 2011, requiring insurers in the individual and small employer markets to spend at least 80% of their premium income on medical care and health care quality improvement, and at least 85% for the large employer market.[72] The remaining balance of premium is available for an insurer's sales and marketing, profit, and overhead costs. An insurer's failure to meet this annual aggregate performance threshold within each market (individual, small group, or large group) is required to pay annual rebates to enrollees, thereby protecting consumers from excessive profiteering on the insurer's end via overpriced plans. Rebates are based on a 3-year average, for example, 2016, 2017, and 2018 financial data was used to calculate 2019 calendar

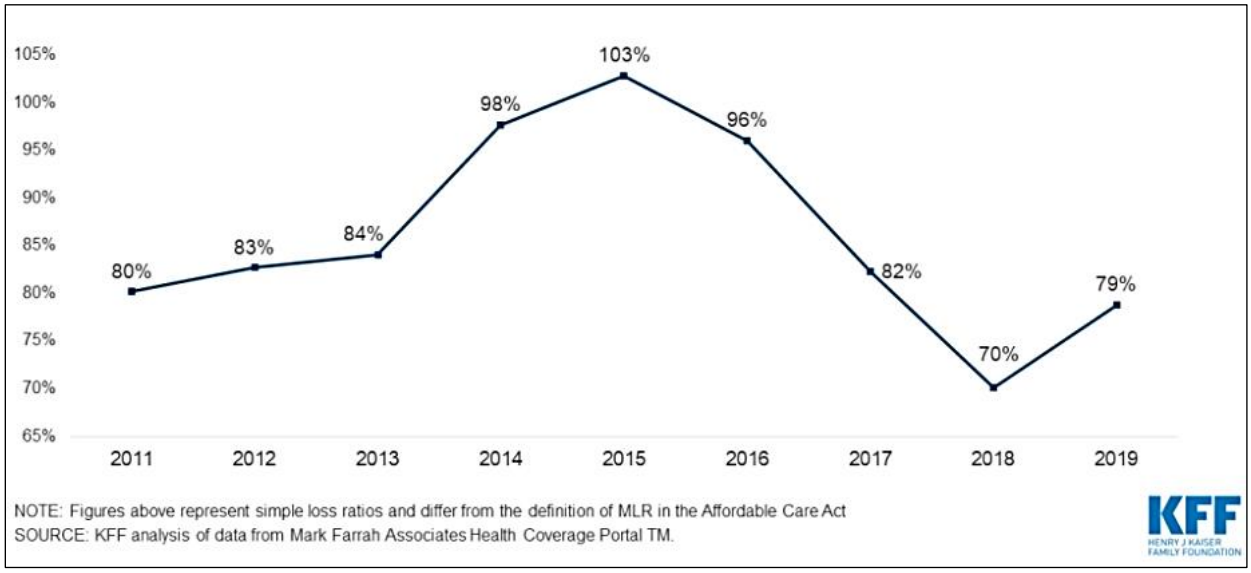
[71] "Georgia: State Innovation Waiver under Section 1332 of the PPACA," *CMS*, November 1, 2020, https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers-/1332-GA-Fact-Sheet.pdf.
[72] "Medical Loss Ratio," content.naic.org, May 20, 2020, https://content.naic.org/cipr_topics/topic_medical_loss_ratio.htm.

year rebates. Rebates can be in the form of premium credits, check payment, or they can be shared between the employer and employee with employer-sponsored plans.[73]

In the first three years of the ACA's full implementation, the health insurance market suffered significant losses. Average individual market MLRs increased in 2014, 2015, and 2016, as shown in Figure 10, with modest increases in premium rates through 2016. These are interpreted as simple loss ratios, or the share of premium income paid out in claims, but actual rebates can be adjusted for various taxes, licenses, and other fees. The high loss ratios from 2014 through 2016 left minimal, if no, room for the remainder of an insurer's expenses, forcing Marketplace exits in 2017 and 2018 due to profit loss.

Figure 10

Average Individual Market Loss Ratios, 2011 - 2019



Most plan issuers in Government Accountability Office (GAO) studies revealed unexpected claims costs from 2014 through 2016, citing projection difficulties in a new and changing market, affecting the risk pool morbidity, utilization of services, and costs of services.[74] Actual per member per month (PMPM) claims costs in 2014 were about 6% to 10% higher than expected, with variation in actual PMPM costs ranging from 4% higher for the lowest claims' quartile, to 35% higher for the highest claims' quartile. Various insurers reported actual 2014 numbers far exceeding projections, such as utilization of outpatient visits being up to 40% higher than projected, inpatient stays 30% longer than expected, and professional visit costs 23% higher than expected.

[73] Rachel Fehr and Cynthia Cox, "Data Note: 2020 Medical Loss Ratio Rebates," KFF, April 17, 2020, https://www.kff.org/private-insurance/issue-brief/data-note-2020-medical-loss-ratio-rebates/.
[74] John Dicken et al., "Health Insurance Exchanges Claims Costs and Federal and State Policies Drove Issuer Participation, Premiums, and Plan Design," *United States Government Accountability Office*, January 2019, https://www.gao.gov/assets/700/696603.pdf.

Equipped with claims experience when pricing 2017 plans, the health insurance markets began to stabilize.[75] The average individual market MLRs in 2017, 2018, and 2019 down to 82%, 70%, and 79%, respectively, and stabilized financial performance among insurers. When it was announced at the end of 2017 that CSR payments would be eliminated, insurers increased rates to offset the termination of these federal cost-sharing subsidy payments, since insurers were still required by law to provide cost-sharing funding to eligible enrollees. The result of increasing premiums in 2018 also caused APTCs to increase because the benchmark plan rate increased, as shown in Figure 11, allowing subsidized enrollment to remain steady, which in turn helped insurer gains, drive up insurer participation, and reduce net premiums to consumers.[47]

Figure 11

Average Monthly Advance Premium Tax Credit (APTC) in HealthCare.gov States, PY14 – PY19

	Average Monthly APTC	Annual Growth	Cumulative Growth
PY14	$259	-	-
PY15	$263	2%	2%
PY16	$289	10%	12%
PY17	$382	32%	47%
PY18	$558	46%	115%
PY19	$544	-3%	110%

Source: Plan information is from the plan landscape files and active plan selections in the Centers for Medicare and Medicaid Services (CMS) Multidimensional Insurance Data Analytics System (MIDAS) for states using the HealthCare.gov platform between PY14 and PY19.

Coverage Affordability: APTCs, the Non-Subsidized Individual Market, and the Premium Plateau

Subsidies from APTCs for qualified enrollees drastically reduce the average monthly premium, which was an average of $105 after the APTC for 2015 plans, a 72% average premium reduction, according to one HHS report.[76] Another study of the second-lowest cost silver level (benchmark) Marketplace plan showed 2014 premiums were 10% to 21% lower than average individual market premiums in 2013, and despite premium rate increases, 2016 premium rates were still lower than those in 2013.[49]

An HHS report noted the average 2017 premium in the 39 states using the federal Exchange was 105% higher than in 2013, with a 108% median increase, as shown in Figure 12.[6] This same report highlighted the changing enrollee mix, consisting of an individual market risk pool with larger shares of older and less healthy people, and adverse selection pressure, resulting from the claims experience data since 2014, were likely significant causes of the large average premium increases over this four-year period. The report clarified premiums increased annually from 2013 to 2017

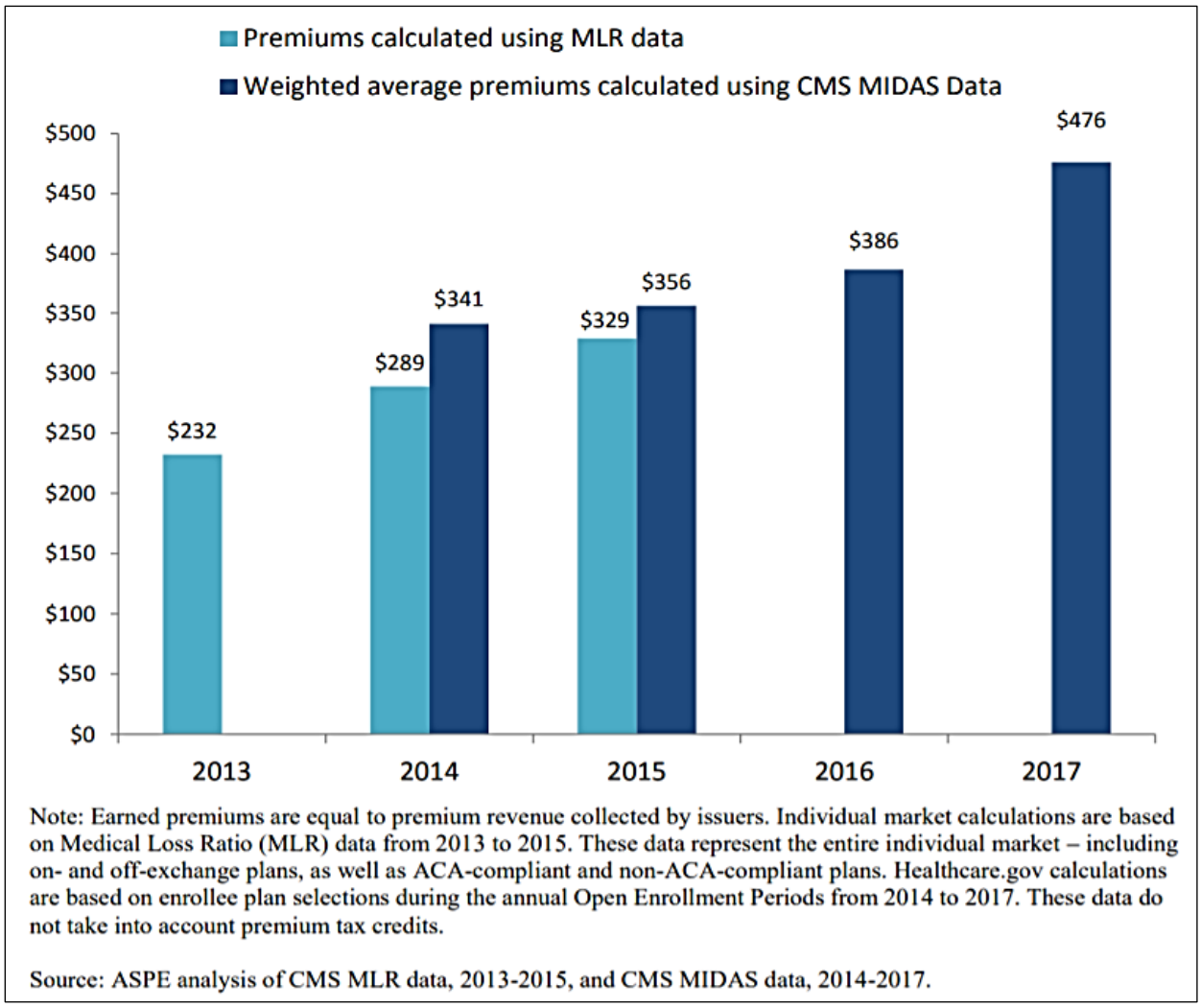
[75] Mark Hall and Michael McCue, "How the ACA's MLR Rule Protects Consumers and Insurers | Commonwealth Fund," www.commonwealthfund.org, July 2, 2019, https://www.commonwealthfund.org/publications/issue-briefs/2019/jul/how-aca-medical-loss-ratio-rule-protects-consumers-insurers.

[76] Arpit Misra and Thomas Tsai, "Health Insurance Marketplace 2015: Average Premiums After Advance Premium Tax Credits Through January 30 in 37 States Using the HealthCare.Gov Platform," *Department of Health and Human Services*, February 9, 2015, https://aspe.hhs.gov/system/files/pdf/33776/ib_APTC.pdf.

across the entire individual market, including on- and off-exchange plans, as well as ACA-compliant and non-ACA-compliant plans.

Figure 12

Average Monthly Premiums in the Individual Market for Healthcare.gov States



Note: Earned premiums are equal to premium revenue collected by issuers. Individual market calculations are based on Medical Loss Ratio (MLR) data from 2013 to 2015. These data represent the entire individual market – including on- and off-exchange plans, as well as ACA-compliant and non-ACA-compliant plans. Healthcare.gov calculations are based on enrollee plan selections during the annual Open Enrollment Periods from 2014 to 2017. These data do not take into account premium tax credits.

Source: ASPE analysis of CMS MLR data, 2013-2015, and CMS MIDAS data, 2014-2017.

Followed by high premium rate increases in 2018 due to the elimination of the federal CSR payment (affecting silver plans only), premiums increased an average of 35% nationwide for the benchmark plan from 2017, with one study noting a 30% increase and another noting a 32% increase for the lowest-cost silver plan.[5,62,77] However, increases in other metal plans were seen in 2018, with the lowest-cost bronze and gold plans seeing a 17% and 18% average increase, respectively, from 2017. Despite a projected $8 billion reimbursement loss to insurers from the

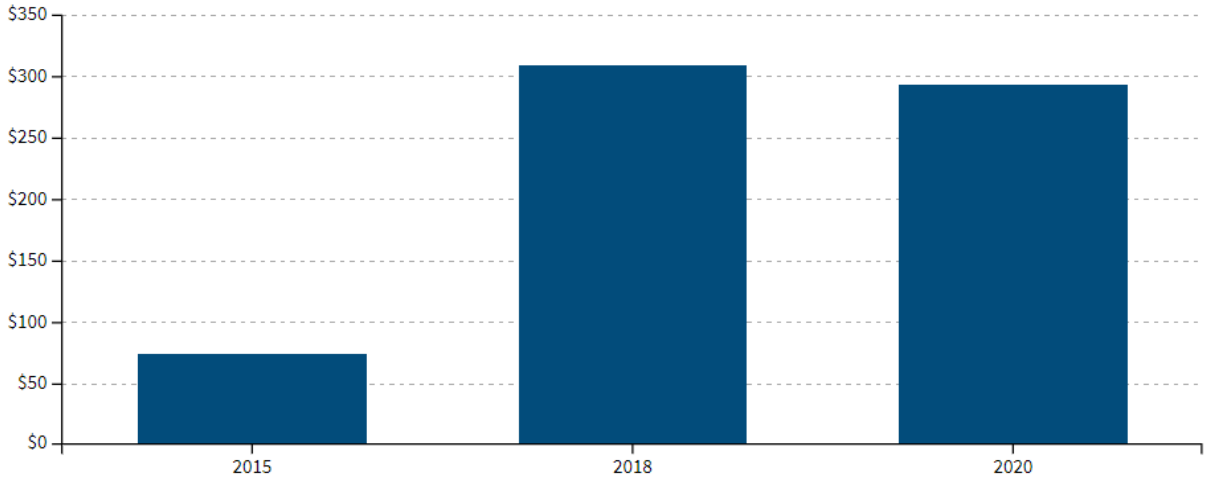
[77] Ashley Semanskee, Gary Claxton, and Larry Levitt, "How Premiums Are Changing In 2018," The Henry J. Kaiser Family Foundation, November 29, 2017, https://www.kff.org/health-costs/issue-brief/how-premiums-are-changing-in-2018/.

government for the CSR subsidies, enrollees eligible for APTCs were projected to receive an extra $6 billion in tax credits to assist with premium rate hikes.[78]

Unfortunately, premium rate increases were exacerbated in rural areas.[52] Premium rates in rural regions increase more substantially than in urban areas, as shown in Figure 13, with data from the U.S. Census Bureau showing the uninsured rate has changed relatively uniformly in rural areas relative to urban areas since 2013.[79] Unsubsidized enrollment for on-and off-exchange plans declined 20% in 2017, 24% in 2018, but only 9% in 2019, an almost equal and opposite reaction to premium rate increases.[78] In 2018 and 2019, 87% of the effectuated (enrollees with active polices and paying the premium) Marketplace enrollment received ATPCs, and 86% in 2020, the remainder (the unsubsidized) paying full price for premiums.[80]

Figure 13

Expected Difference in Premium Rates PMPM Between Urban and Rural Areas



Sources:
Centers for Medicare & Medicaid Services. 2015 QHP Landscape Individual Market Medical. *Data.Healthcare.gov*, August 19, 2015 (accessed February 24, 2020).
Centers for Medicare & Medicaid Services. QHP PY2018 Medi- Indi- Land. *Data.Healthcare.gov*, February 18, 2019 (accessed February 24, 2020).
Centers for Medicare & Medicaid Services. QHP Landscape PY2020 Individual Medical Zip File. *Data.Healthcare.gov*, February 24, 2020 (accessed February 24, 2020).

As claims experience increased, subsidized enrollment in the Marketplace steadied, insurer participation increased, and MLRs stabilized, premiums began to plateau in 2019 and 2020, with

[78] Sabrina Corlette, Kevin Lucia, and Maanasa Kona, "States Protect Consumers After CSR Payment Cuts," www.commonwealthfund.org, October 27, 2017, https://www.commonwealthfund.org/blog/2017/states-step-protect-consumers-wake-cuts-aca-cost-sharing-reduction-payments.
[79] Ryan Mueller, "The ACA's Impact on Rural Areas," The Actuary Magazine, March 9, 2020, https://theactuarymagazine.org/the-acas-impact-on-rural-areas/.
[80] "Marketplace Effectuated Enrollment and Financial Assistance," KFF, September 2, 2020, https://www.kff.org/other/state-indicator/effectuated-marketplace-enrollment-and-financial-assistance/.

slight decreases in rates.[62,81] The decrease in 2019 premium rates was the first occurrence of declining premium rates since the full ACA implementation in 2014.[82] The percentage of enrollees by the monthly premium of the lowest-cost plan available was 62% in 2015 for plans priced above $200, but had shifted to 94% in 2018, and up to 95% in 2019.[6] In 2018, the percentage for plans priced above $400 had increased to 48%, compared to just 17% in 2015, and increased to 49% in 2019.

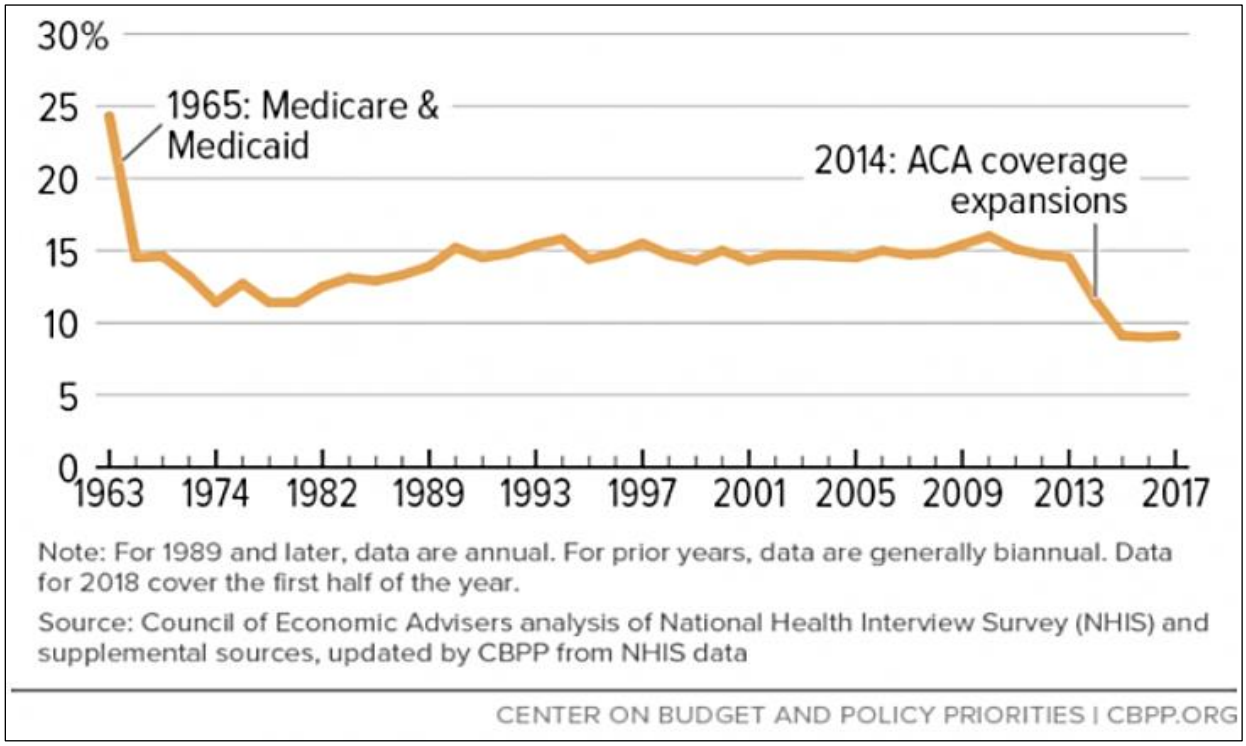
Overall Successes of the ACA

Previously noted was the increase in health insurance coverage to over 20 million people, but the successes go beyond what has been discussed thus far. Among the numerous successes of the ACA are the lower-income population experiencing improved health and medical care, hospitals in Medicaid expansion states are experiencing economic stability from decreases in uncompensated care and employing a growing share of physicians.[83,84,11] There is also evidence of improved financial wellbeing among those who gained coverage through a reduction in debt.[9,11] Coverage gains occurred in both expansion and non-expansion states across racial and ethnic groups, and uninsured rates have hit historic lows since 2014, as shown in Figure 14.[11,46] Nearly 30% of people within groups aged 19 to 25 and 26 to 34 in 2010 made up the largest portion of uninsured in 2010.[2] By 2014, the year the ACA was fully implemented, less than 20% of people in these age groups were uninsured.[24]

[81] "Average Marketplace Premiums by Metal Tier, 2018-2021," KFF, October 29, 2020, https://www.kff.org/health-reform/state-indicator/average-marketplace-premiums-by-metal-tier/.
[82] "Premiums on the Federally-Facilitated Exchanges Drop in 2019 | CMS," CMS, October 11, 2018, https://www.cms.gov/newsroom/press-releases/premiums-federally-facilitated-exchanges-drop-2019.
[83] Benjamin Sommers et al., "Three-Year Impacts of The Affordable Care Act: Improved Medical Care and Health Among Low-Income Adults," *Health Affairs* 36, no. 6 (June 2017): 1119–28, https://doi.org/10.1377/hlthaff.2017.0293.
[84] Andis Robeznieks, "How Medicaid Expansion Has Improved Care Access, Outcomes," American Medical Association, September 27, 2018, https://www.ama-assn.org/delivering-care/patient-support-advocacy/how-medicaid-expansion-has-improved-care-access-outcomes.

Figure 14

Uninsured Rates, 1963 - 2018



People with preexisting conditions are protected from being denied coverage, and an estimate of this group in the U.S. by the HHS was 133 million in 2017 when using the "broader definition closer to the underwriting criteria used by insurers prior to the ACA."[85] Gender rating was eliminated, where women were charged 1.5 times more than men for health insurance, and insurers could no longer deny coverage to women for pregnancy, which was classified as a preexisting condition.[86] Adults with severe mental disorders were more likely to be uninsured, and nearly 1 in 5 adults in the U.S. have a mental illness.[87] The ACA improved access, coverage, and outcomes for mental health patients, specifically younger adults in regards to out-of-pocket spending and self-reported mental health.[88] Funding for prevention and public health programs to keep Americans healthy, from smoking cessation to combating obesity, began. New incentives were

[85] "Health Insurance Coverage for Americans with Pre-Existing Conditions: The Impact of the Affordable Care Act," *Department of Health and Human Services*, January 5, 2017, https://aspe.hhs.gov/system/files/pdf/255396/Pre-ExistingConditions.pdf.

[86] Nicole Rapfogel, Emily Gee, and Maura Calsyn, "10 Ways the ACA Has Improved Health Care in the Past Decade," Center for American Progress, March 23, 2020, https://www.americanprogress.org/issues/healthcare/news/2020/03/23/482012/10-ways-aca-improved-health-care-past-decade/.

[87] Rachel Garfield et al., "The Impact of National Health Care Reform on Adults with Severe Mental Disorders," *American Journal of Psychiatry* 168, no. 5 (May 2011): 486–94, https://doi.org/10.1176/appi.ajp.2010.10060792.

[88] Jesse Baumgartner, Gabriella Aboulafia, and Audrey McIntosh, "The ACA at 10: How Has It Impacted Mental Health Care?" www.commonwealthfund.org, April 3, 2020, https://www.commonwealthfund.org/blog/2020/aca-10-how-has-it-impacted-mental-health-care.

created to expand the number of primary care doctors, nurses, and physician assistance, from scholarships to loan repayments for those working in underserved areas.

Payments were increased to primary care providers (PCPs) in rural communities and underserved areas to expand and build new community health centers to serve some 20 million new patients. The Community Health Center Fund (CHCF) more than doubled funding for health centers by 2015, and from 2015 through 2019, was the source of more than 70% of funding for health centers.[89] In 2019, health centers served 29.8 million people across nearly 13,000 service delivery sites, including 1 in 3 living in poverty, 1 in 5 uninsured, and 1 in 5 rural residents, up from 18.8 million served across nearly 7,000 sites in 2009.[90,91]

Beyond the successes of increased benefits coverage, expanded plan options for low-income individuals, and APTCs, the success of silver loading because of CSR subsidy reimbursement termination also continues to hold strong in 2020.[52] In the silver plan, CSRs increased the 70% average insurer cost to 94%, depending on the individual's income level, through direct remuneration to the insurer through the federal government. Health insurers added back the cost of CSRs into silver plan premiums. Since APTCs are linked to actual silver premium levels via the benchmark plan, the increasing silver plan premiums in 2018 resulted in increased APTCs. Increases in the other metal levels were lower than what silver premiums experienced in 2018, so the increased APTCs allowed subsidized consumers to obtain gold or platinum level plans with greater premium savings, with additional benefits and reduced cost-sharing.[80] This increased the benefit APTCs give enrollees beyond the silver plan level, including obtaining nearly free coverage through greatly reduced bronze plan premiums.

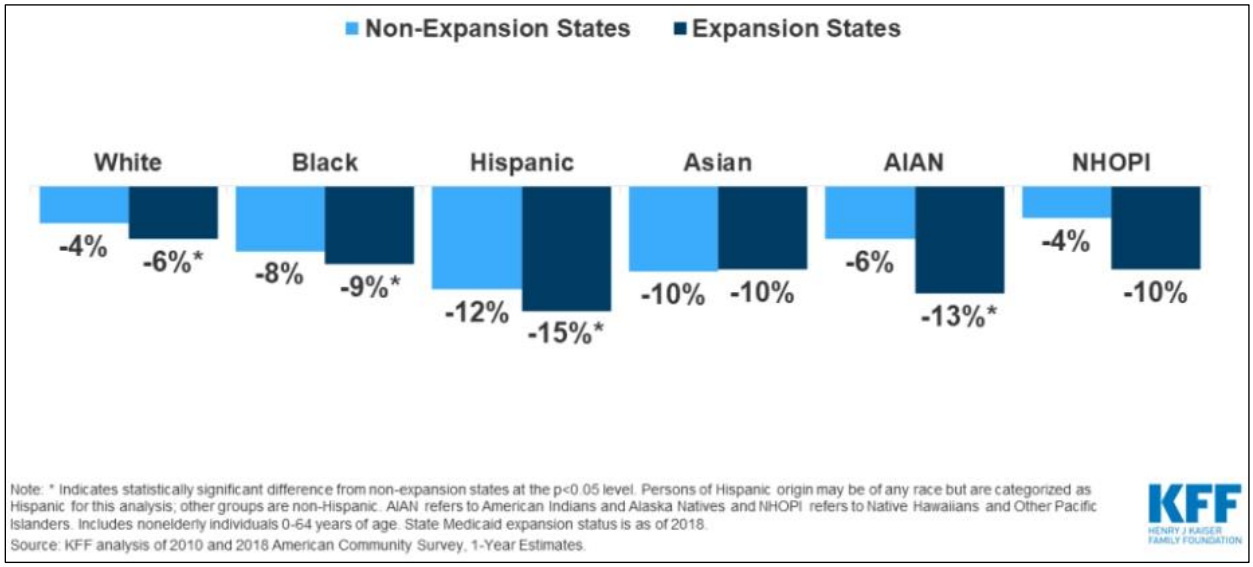
Potential Areas of Improvement for the ACA

By March of 2012, any ongoing or new federal health program was required to collect and report racial, ethnic, and language data to better understand, identify, and reduce disparities. Although disparities among racial and ethnic groups have improved, as of 2018, minority groups still have a higher likelihood of being uninsured compared to Whites, with Hispanics and AIANs most likely to be uninsured at rates of 19% and 22%, respectively for the nonelderly age group.[46] Blacks, Whites, Hispanics, and AIANs had larger percentage point declines in their uninsured rate in Medicaid expansion states compared to the declines in non-expansion states, as shown in Figure 15, and higher percentages of Black people populate Medicaid non-expansion states.

[89] "Federal Grant Funding," NACHC, 2020, https://www.nachc.org/focus-areas/policy-matters/health-center-funding/federal-grant-funding/.
[90] "Health Center Program: Impact and Growth," Bureau of Primary Health Care, August 20, 2018, https://bphc.hrsa.gov/about/healthcenterprogram/index.html.
[91] "Community Health Center Chartbook," NACHC, January 2019, http://www.nachc.org/wp-content/uploads/2019/01/Community-Health-Center-Chartbook-FINAL-1.28.19.pdf.

Figure 15

Percentage Point Change in Uninsured Rates by Race/Ethnicity and State Medicaid Expansion Status, 2010 - 2018



Improving the disparities and further reducing the uninsured rate requires several steps, in part, reinstating the decreased funding for outreach and enrollment assistance, expanding Medicaid without restriction in all states, or otherwise filling the Medicaid coverage gap via subsidy expansion for those whose incomes are too high to be Medicaid-eligible, but below the 100% FPL to qualify for APTCs.[92] Further considerations would be to eliminate differential access to care, consider social determinants of health, and close knowledge gaps in preventive health services utilization.[93,94] These steps won't just reduce disparities, they will help the majority of the uninsured overall, including the unsubsidized who bear the full cost of premium increases, most notably by closing the coverage gap for those with incomes outside the 100% FPL and 400% FPL subsidy caps.[52]

Medicaid non-expansion states are at the heart of another area of improvement. Hospital closures are more detrimental to rural communities than in urban areas, and rural premium rates are higher than in urban areas due to lack of insurer competition. A GAO study found a disproportionate number of rural hospital closures occurring in Medicaid non-expansion states, and affirms research showing "hospital closures can affect rural residents' access to health care services and that certain

[92] Jesse Baumgartner et al., "How ACA Narrowed Racial Ethnic Disparities Access to Health Care | Commonwealth Fund," *Commonwealthfund.Org*, January 16, 2020, https://doi.org/https://doi.org/10.26099/kx4k-y932.
[93] Social determinants of health defined as conditions in the places where people live, learn, work, and play that affect a wide range of health and quality of life risks and outcomes.
[94] Omolola Adepoju, Michael Preston, and Gilbert Gonzales, "Health Care Disparities in the Post–Affordable Care Act Era," *American Journal of Public Health* 105, no. S5 (November 2015): S665–67, https://doi.org/10.2105/ajph.2015.302611.

rural residents— particularly those who are elderly and low income—may be especially affected by rural hospital closures."[95]

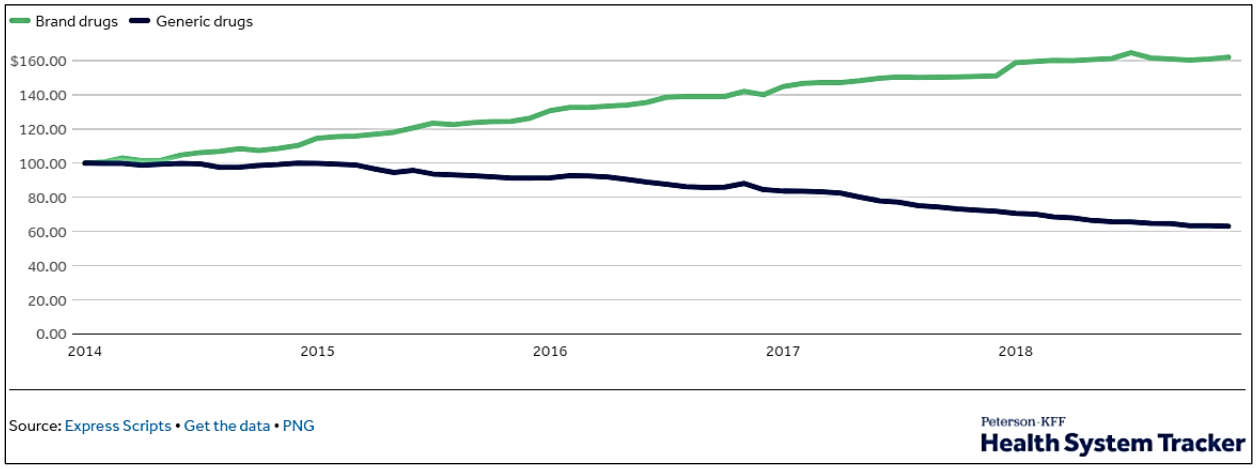
Hospitals operating in Medicaid expansion states generally improved their financial position.[82] Another analysis found Medicaid expansion was associated with not only improved hospital financial performance, but a substantially lower likelihood of closure, especially in rural markets and counties.[10]

Prescription drug costs have increased over the last decade largely as a result of provisions that did not get included in the ACA that would have kept costs down, so-called "missed opportunities."[96] As a result, and despite increased coverage to enrollees and a solid pace of drug development, prices have ballooned.[97] Express Scripts, a pharmacy benefit management (PBM) company serving more than 100 million Americans, shows how the increase specifically affects branded drugs, as seen in Figure 16.[98] To address this growing concern, it's suggested policymakers should cap out-of-pocket drug spending, address misaligned incentives reinforcing high drug prices, such as programs that reward physicians for using more expense alternative drugs, and consider implementing drug pricing review boards to analyze the effectiveness and cost-effectiveness to determine coverage and reimbursement policies.

[95] James Cosgrove et al., "Rural Hospital Closures Number and Characteristics of Affected Hospitals and Contributing Factors," *United States Government Accountability Office*, August 2018, https://www.gao.gov/assets/700/694125.pdf.
[96] Rena Conti, Stacie Dusetzina, and Rachel Sachs, "How the ACA Reframed the Prescription Drug Market and Set the Stage for Current Reform Efforts," *Health Affairs* 39, no. 3 (March 1, 2020): 445–52, https://doi.org/10.1377/hlthaff.2019.01432.
[97] "Prescription Drugs - Health Policy Institute," Georgetown University Health Policy Institute, 2019, https://hpi.georgetown.edu/rxdrugs/.
[98] Rabah Kamal, Cynthia Cox, and Daniel McDermott, "What Are the Recent and Forecasted Trends in Prescription Drug Spending?," Peterson-Kaiser Health System Tracker, February 20, 2019, https://www.healthsystemtracker.org/chart-collection/recent-forecasted-trends-prescription-drug-spending/#item-prices-for-common-generic-drugs-have-dropped-by-37-since-2014-while-branded-drug-prices-have-increased-by-over-60_2019.

Figure 6

Express Scripts Overall Prescription Price Index, 2014 – 2018



A Decade of the ACA

The ACA directly impacted millions of consumers and the entire healthcare industry, but despite huge benefits, there is absolutely room for improvement. The ACA made strong gains in improving lives across the U.S., driving the importance of coordination between providers, educating consumers about the impact of their own decisions on their health, and encouraging people and providers to be more involved in improving health outcomes with facilitated effort. However, healthcare reform is by no means complete. Ample regulatory oversight and participation from all stakeholders will be needed to achieve a long-term balance between industry survival and sufficient health care. Regardless of setbacks that may occur legislatively, politically, or judicially in the future, it is evident that consumers continue to demand, and benefit from, attempts to improve accessibility and affordability of their health care.