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Premiums, Choices, and Government Dependence Under the Affordable Care Act: A State-by-State Review

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KEY TAKEAWAYS

Nationally, Obamacare more than doubled premiums for individual plans, halved individual insurer offerings, and increased enrollment in government programs.

Obamacare increased premiums in 49 of 50 states. Some states experienced premium increases of less than 50 percent, while others saw insurance premiums triple.

Some states have reduced premiums through deregulatory actions; Congress should build on that success by giving states more flexibility.

2020 marks 10 years since the passage of the Affordable Care Act (ACA)—also known as Obamacare—and six years since its key elements took effect. In that time, health insurance premiums spiked, coverage options fell, and more Americans became dependent on government-run health care. This *Backgrounder* examines the changes in these three areas—premiums, choice, and government-run care—and outlines ways that Congress can reverse this trend. (For a summary of changes in all three metrics, see Appendix Table 1.)

Rising Health Insurance Premiums and Deductibles in the Individual Market

Comparing premium changes in the individual market before and after the ACA is a key measure of the law's financial effect on consumers. In 2013, the

national average premium paid in the individual (non-group) market was $244 (per member, per month).[1] In 2018, the national average premium paid in the individual market was $550 (per member, per month). This is a 125 percent increase from 2013 to 2018.[2] Over the same period in the large employer market, national average premiums paid per member, per month grew by only 24.7 percent (from $363 to $453).[3]

The premium increases varied by state. (See Appendix Table 2.) In nearly every state, consumers on average paid higher premiums under the ACA. States with the largest increase over this period are Alabama (+246 percent), Tennessee (+222 percent), West Virginia (+214 percent), Oklahoma (+204 percent), and Wyoming (+199 percent). States with the smallest increase over this period are New York (+19 percent), Vermont (+30 percent), Rhode Island (+33 percent), and New Jersey (+33 percent). Only one state, Massachusetts, saw a decline (–6 percent) in average premiums paid over this period.[4]

The sharpest increase in premiums in the individual market occurred in 2014, the first year that new ACA rules took effect. In the following year, 2015, 10 states had declines in the average premium paid by consumers, though in nine of those states the declines were modest.[5] In subsequent years, 15 additional states also saw at least one year of decline. In most cases the declines were short lived. In 19 of the 25 states that experienced any year-over-year reduction in average premiums paid since 2014, the decline was for only one year.[6]

At the same time that premiums more than doubled in the individual market, deductibles for ACA-compliant coverage also significantly increased.[7] Deductibles for bronze-level plans sold on the federal exchange increased from an average of $5,089 in 2014 to an average of $6,165 in 2019—an increase of 21.2 percent.[8] States with the greatest deductible increases were West Virginia (+59.5 percent), Indiana (+56.3 percent), Wyoming (+44.3 percent), North Carolina (+39.0 percent), and Wisconsin (+33.5 percent). States with the smallest deductible increases were Delaware (+1.5 percent), Alaska (+5.2 percent), and New Hampshire (+6.6 percent). Only three states—Illinois, Kansas, and Oklahoma—saw declines in average bronze deductibles (–5.3 percent, –0.5 percent and –1.8 percent, respectively).[9]

Fewer Choices and Less Competition in the ACA Exchanges

As consumers paid higher premiums, fewer insurers offered plans on the ACA exchanges. In 2019, half as many insurers offered plans through the ACA exchanges as offered plans in the pre-ACA individual market (when measuring insurers offering coverage at the state level).[10] In 2013,

there were 395 insurers offering coverage in the individual market at the state level. In 2019, there are only 202 insurers offering coverage available through the ACA exchanges at the state level, a 49 percent decrease.

Appendix Table 3 displays the percentage change in insurer competition in the 2013 individual market and the 2019 ACA exchanges, by state. In 2013, there was no state that had fewer than two insurers offering coverage, and two states (Florida and Texas) had 18 insurers offering coverage.

By 2019, five states (Alaska, Delaware, Mississippi, Nebraska, and Wyoming) each had only one insurer on the ACA exchange, and 16 states had only two insurers. It is also worth noting that 38 states and the District of Columbia have not had an increase in the number of insurers participating since 2013.

Greater Dependence on Government Coverage

Not only did the ACA increase the cost of private coverage and reduce its availability, it also significantly expanded government-run coverage through Medicaid. Historically, Medicaid provided health care coverage to the vulnerable poor: children, pregnant women, the elderly, and people with disabilities. The ACA, however, expanded the scope of eligibility to include lower-income able-bodied adults, predominantly those without dependent children. Furthermore, the ACA offered states a much higher level of federal financing for this new population (100 percent in the first three years, eventually declining to 90 percent over subsequent years) than for their existing Medicaid populations.[11]

Since 2014, when the ACA took full effect, Medicaid and Children's Health Insurance Program (CHIP) enrollment has increased by 11 million.[12] In December 2013, national Medicaid and CHIP enrollment was 61.1 million. By December 2018, 72.2 million people were enrolled in Medicaid and CHIP—an increase of 18 percent.[13] Medicaid and CHIP enrollment reached its highest level to date in the first half of 2017, during which monthly enrollment fluctuated just above and below 75 million.

The enrollment increases varied by state. (See Appendix Table 4.) Most states saw an increase in Medicaid and CHIP enrollment during this period. States with the greatest percentage increase in enrollment over this period were Montana (+88.8 percent), Nevada (+80.4 percent), Alaska (+79.7 percent), Rhode Island (+63.8 percent), and Oregon (+54.2 percent). Texas had the smallest percentage increase in enrollment (+1.2 percent) over the five years, while ten states had Medicaid and CHIP enrollment that was lower at the end of 2018 than it was at the end of 2013.[14]

States that expanded Medicaid had the greatest enrollment growth. Between December 2013 and December 2018, the 32 expansion states (including the District of Columbia) saw a 25.9 percent collective net increase in Medicaid and CHIP enrollment, with 19 expansion states experiencing enrollment growth of at least 25 percent.[15] By contrast, the 19 non-expansion states saw a collective net increase of 2.4 percent, ranging from a decrease of 19.3 percent in Wyoming to an increase of 23.6 percent in South Carolina.[16]

Expansion states saw the greatest Medicaid enrollment growth in the first 12 months to 24 months after initial expansion implementation, followed by a leveling off of enrollment. For example, states that expanded Medicaid on January 1, 2014, had an average enrollment increase of 26.6 percent from December 2013 to December 2014. The following year, the same states had only a 4.5 percent average increase in enrollment. States that expanded before December 2018 had an average increase of 31.9 percent between the last December before expansion and the second December after expansion. These 24-month increases ranged from 6.8 percent (Illinois) to 69.2 percent (Nevada). From December 2013 to December 2018, overall enrollment increases in expansion states ranged from 8.0 percent in Hawaii to 88.8 percent in Montana.[17]

Health Care Choices: A Plan to Lower Premiums, Increase Choice, and Protect the Vulnerable

The ACA led to higher premiums, fewer choices, and greater government dependence. To reverse these consequences, policymakers need to provide relief from the ACA mandates that contributed to the problem. As a start, the Trump Administration provided new flexibilities to mitigate some of these issues. A critical step included changes to the law's Section 1332 waivers, which allow states to seek waivers from certain federal ACA requirements.[18] The results, thus far, are encouraging.[19]

Seven states had 1332 waivers in effect by 2019, and five additional states were approved to implement waivers in 2020.[20] In the initial seven states, first-year premium reductions (relative to projected rates) ranged from 6 percent (Oregon) to 43.4 percent (Maryland) with an average reduction of 19.9 percent across the seven states.[21] All five states with waivers taking effect in 2020 projected similar premium reductions.[22]

Given the proven relief that waivers provide from high premiums, policymakers in other states should consider similar waivers.

However, more needs to be done. Congress should build on the Trump Administration's regulatory changes and provide additional relief from the ACA's burdensome and costly regulations.

One such approach, the Health Care Choices Proposal, would do just that. Under the proposal, Congress would eliminate key regulations that led to increased costs and reduced the ability of private companies to offer products people want to buy. It also would change another key aspect of Obamacare that led to higher costs and reduced choices: the current ACA subsidy structure that gives taxpayer dollars to insurance companies and increases those subsidies as insurance companies raise premiums.[23] Instead, states would receive that funding in the form of grants to help the low-income and those with pre-existing conditions access coverage. Finally, unlike Obamacare (which put most subsidized individuals on Medicaid), subsidized individuals would be able to apply their subsidy dollars toward private coverage of their choice.[24]

The Center for Health and Economy estimated that the Health Care Choices Proposal would lower premiums by as much as 32 percent, increase private coverage, and keep overall coverage numbers steady.[25]

Conclusion

Since taking effect, the ACA more than doubled premiums in the individual market, while cutting the number of participating insurers in half. It also led to a significant increase in the number of people dependent on government-run health care. To reverse these trends, Congress should build on promising improvements made possible by the Trump Administration's deregulatory agenda, and consider the Health Care Choices Proposal, which would lower costs, increase choices, and protect the vulnerable.

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APPENDIX TABLE 1

Changes in Premiums, Choice, and Government-Run Care Since ACA (Page 1 of 2)

State	Individual Market: Average Monthly Premium Paid, 2013–2018	Individual Market: Number of Insurers, 2013–2019	Medicaid and CHIP: Enrollment, 2013–2018
Alabama	246%	–50%	–3%
Alaska	133%	–75%	80%
Arizona	157%	–55%	32%
Arkansas	129%	–57%	35%
California	89%	–8%	24%
Colorado	137%	–50%	51%
Connecticut	130%	–71%	36%
Delaware	174%	–75%	14%
D.C.	57%	–50%	18%
Florida	133%	–72%	3%
Georgia	188%	–64%	5%
Hawaii	98%	0%	8%
Idaho	130%	–20%	8%
Illinois	143%	–58%	–3%
Indiana	98%	–82%	35%
Iowa	144%	–60%	32%
Kansas	141%	–67%	–4%
Kentucky	113%	–67%	44%
Louisiana	139%	–75%	34%
Maine	107%	–25%	–8%
Maryland	167%	–75%	24%
Massachusetts	–6%	0%	15%
Michigan	119%	–43%	20%
Minnesota	113%	–33%	22%
Mississippi	150%	–80%	–11%
Missouri	194%	–67%	5%
Montana	146%	50%	89%
Nebraska	198%	–75%	6%
Nevada	138%	–60%	80%
New Hampshire	97%	50%	25%
New Jersey	33%	0%	54%
New Mexico	167%	33%	43%
New York	19%	20%	16%
North Carolina	194%	–75%	4%
North Dakota	69%	0%	31%
Ohio	108%	–25%	19%
Oklahoma	204%	–75%	–3%
Oregon	129%	–50%	54%
Pennsylvania	171%	–57%	27%

APPENDIX TABLE 1

Changes in Premiums, Choice, and Government-Run Care Since ACA (Page 2 of 2)

State	Individual Market: Average Monthly Premium Paid, 2013–2018	Individual Market: Number of Insurers, 2013–2019	Medicaid and CHIP: Enrollment, 2013–2018
Rhode Island	33%	0%	64%
South Carolina	158%	–78%	24%
South Dakota	112%	–50%	–2%
Tennessee	222%	–50%	3%
Texas	134%	–56%	1%
Utah	181%	–67%	–10%
Vermont	30%	–33%	10%
Virginia	172%	–30%	10%
Washington	77%	–29%	49%
West Virginia	214%	–50%	39%
Wisconsin	160%	–20%	–2%
Wyoming	199%	–80%	–19%
U.S.	**125%**	**–49%**	**18%**

SOURCES:

- **Premium data:** Centers for Medicare and Medicaid Services, "Medical Loss Ratio Data and System Resources," https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr.html (accessed October 8, 2019).
- **Insurer participation data:** Heritage Foundation calculations based on federal and state information on exchange participation, and National Association of Insurance Commissioners data for 2013 market participation, accessed through Mark Farrah Associates, http://www.markfarrah.com.
- **Medicaid and CHIP enrollment data:** Centers for Medicare and Medicaid Services, "Monthly Medicaid & CHIP Application, Eligibility Determination, and Enrollment Reports & Data," https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/monthly-reports/index.html (accessed November 18, 2019). Data for 2013 are from Laura Snyder, Robin Rodwitz, Eileen Ellis, and Dennis Roberts, "Medicaid Enrollment: December 2013 Data Snapshot," Kaiser Commission on Medicaid and the Uninsured *Issue Brief*, June 2014, Table A-1, http://files.kff.org/attachment/medicaid-enrollment-snapshot-december-2013-issue-brief-download (accessed February 26, 2020).

APPENDIX TABLE 2

Average Premiums Paid in the Individual Market, by State (Page 1 of 2)

Dollar figures shown are average premiums paid per member, per month.

State	2013	2014	2015	2016	2017	2018	Change, 2013–2018
Alabama	$178	$320	$350	$402	$531	$617	246%
Alaska	$342	$584	$769	$840	$955	$796	133%
Arizona	$214	$299	$289	$318	$517	$549	157%
Arkansas	$185	$311	$336	$354	$363	$424	129%
California	$271	$388	$401	$406	$428	$511	89%
Colorado	$237	$345	$338	$388	$420	$560	137%
Connecticut	$291	$421	$464	$457	$524	$670	130%
Delaware	$272	$404	$439	$486	$554	$744	174%
D.C.	$268	$319	$350	$333	$352	$419	57%
Florida	$237	$351	$386	$391	$429	$554	133%
Georgia	$209	$332	$365	$394	$426	$600	188%
Hawaii	$265	$334	$324	$365	$435	$525	98%
Idaho	$199	$274	$318	$341	$381	$457	130%
Illinois	$247	$356	$357	$386	$492	$601	143%
Indiana	$241	$375	$434	$405	$408	$477	98%
Iowa	$251	$316	$324	$368	$419	$612	144%
Kansas	$234	$311	$311	$350	$434	$563	141%
Kentucky	$231	$345	$337	$351	$369	$493	113%
Louisiana	$250	$358	$388	$436	$514	$599	139%
Maine	$334	$446	$454	$427	$503	$693	107%
Maryland	$209	$273	$318	$336	$395	$559	167%
Massachusetts	$442	$525	$419	$387	$365	$414	–6%
Michigan	$212	$309	$359	$370	$385	$464	119%
Minnesota	$235	$335	$382	$428	$523	$501	113%
Mississippi	$214	$318	$360	$362	$401	$535	150%
Missouri	$197	$300	$332	$377	$431	$579	194%
Montana	$251	$408	$374	$417	$543	$618	146%
Nebraska	$238	$355	$371	$388	$502	$709	198%
Nevada	$205	$297	$357	$367	$369	$488	138%
New Hampshire	$300	$391	$374	$392	$460	$593	97%
New Jersey	$419	$464	$500	$500	$476	$558	33%
New Mexico	$190	$327	$346	$319	$368	$507	167%
New York	$377	$411	$412	$395	$407	$448	19%
North Carolina	$240	$362	$394	$456	$592	$706	194%
North Dakota	$276	$354	$396	$414	$405	$465	69%

APPENDIX TABLE 2

Average Premiums Paid in the Individual Market, by State (Page 2 of 2)

State	2013	2014	2015	2016	2017	2018	Change, 2013–2018
Ohio	$222	$324	$358	$380	$385	$461	108%
Oklahoma	$210	$306	$316	$365	$558	$638	204%
Oregon	$220	$395	$366	$366	$437	$505	129%
Pennsylvania	$241	$362	$376	$387	$512	$653	171%
Rhode Island	$325	$406	$376	$381	$371	$433	33%
South Carolina	$232	$341	$367	$399	$483	$599	158%
South Dakota	$246	$324	$335	$369	$437	$521	112%
Tennessee	$213	$288	$307	$361	$493	$684	222%
Texas	$221	$348	$359	$350	$403	$517	134%
Utah	$159	$248	$245	$266	$314	$445	181%
Vermont	$406	$478	$517	$514	$502	$529	30%
Virginia	$229	$310	$333	$370	$395	$623	172%
Washington	$279	$403	$404	$389	$399	$493	77%
West Virginia	$261	$418	$464	$519	$642	$820	214%
Wisconsin	$268	$433	$505	$452	$489	$695	160%
Wyoming	$301	$487	$596	$571	$590	$899	199%
U.S.	**$244**	**$353**	**$374**	**$389**	**$440**	**$550**	**125%**

NOTE: Averages are calculated using premium and enrollment data for all individual market plans, which include both ACA-compliant plans and "grandfathered" (pre-ACA) plans.
SOURCE: Centers for Medicare and Medicaid Services, "Medical Loss Ratio Data and System Resources," https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr.html (accessed October 8, 2019).

APPENDIX TABLE 3

Health Insurers Participating in the Pre-ACA Individual Market vs. in the Exchanges (Page 1 of 2)

Shown below are the number of insurer options at the state level.

	PRE-ACA	EXCHANGE						% CHANGE
State	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2013–2019**
Alabama	4	2	3	3	1	2	2	–50%
Alaska	4	2	2	1	1	1	1	–75%
Arizona	11	8	11	8	2	2	5	–55%
Arkansas	7	3	3	4	3	3	3	–57%
California	12	11	10	12	11	11	11	–8%
Colorado	14	10	10	8	7	7	7	–50%
Connecticut	7	3	4	4	2	2	2	–71%
Delaware	4	2	2	2	2	1	1	–75%
D.C.	4	3	3	2	2	2	2	–50%
Florida	18	8	10	7	5	4	5	–72%
Georgia	11	5	9	8	5	4	4	–64%
Hawaii	2	2	2	2	2	2	2	0%
Idaho	5	4	5	5	5	4	4	–20%
Illinois	12	5	8	7	5	4	5	–58%
Indiana	11	4	9	8	4	2	2	–82%
Iowa	5	4	3	4	4	1	2	–60%
Kansas	9	3	3	3	3	3	3	–67%
Kentucky	6	3	5	7	3	2	2	–67%
Louisiana	8	4	5	4	3	2	2	–75%
Maine	4	2	3	3	3	2	3	–25%
Maryland	8	4	5	5	3	2	2	–75%
Massachusetts	8	9	10	10	9	7	8	0%
Michigan	14	9	13	11	9	7	8	–43%
Minnesota	6	5	4	4	4	4	4	–33%
Mississippi	5	2	3	3	2	1	1	–80%
Missouri	12	3	6	6	4	3	4	–67%
Montana	2	3	4	3	3	3	3	50%
Nebraska	4	4	3	4	2	1	1	–75%
Nevada	5	4	5	3	3	2	2	–60%
New Hampshire	2	1	5	5	4	3	3	50%
New Jersey	3	3	5	5	2	3	3	0%
New Mexico	3	5	5	4	4	4	4	33%
New York	10	16	16	15	14	12	12	20%
North Carolina	12	2	3	3	2	2	3	–75%
North Dakota	3	3	3	3	3	2	3	0%
Ohio	12	11	15	14	10	8	9	–25%

APPENDIX TABLE 3

Health Insurers Participating in the Pre-ACA Individual Market vs. in the Exchanges (Page 2 of 2)

	PRE-ACA	EXCHANGE						% CHANGE
State	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2013–2019**
Oklahoma	8	4	4	2	1	1	2	–75%
Oregon	10	11	10	9	6	5	5	–50%
Pennsylvania	14	7	9	7	5	5	6	–57%
Rhode Island	2	2	3	3	2	2	2	0%
South Carolina	9	3	4	3	1	1	2	–78%
South Dakota	4	3	3	2	2	2	2	–50%
Tennessee	10	4	5	4	3	3	5	–50%
Texas	18	11	14	16	10	8	8	–56%
Utah	9	6	6	4	3	2	3	–67%
Vermont	3	2	2	2	2	2	2	–33%
Virginia	10	5	6	7	8	6	7	–30%
Washington	7	7	9	10	7	5	5	–29%
West Virginia	4	1	1	2	2	2	2	–50%
Wisconsin	15	13	15	16	14	11	12	–20%
Wyoming	5	2	2	1	1	1	1	–80%
U.S.	**395**	**253**	**308**	**288**	**218**	**181**	**202**	**–49%**

NOTES: Insurer participation is counted at the parent company level. Figures for 2013 are for insurers with 1,000 or more covered lives in the applicable state. Figures for 2014 through 2019 are for exchange participating insurers and do not include any insurers selling policies exclusively off of the exchanges.
SOURCES: Heritage Foundation calculations based on federal and state information on exchange participation, and National Association of Insurance Commissioners data for 2013 market participation, accessed through Mark Farrah Associates, http://www.markfarrah.com.

APPENDIX TABLE 4

December Medicaid and CHIP Enrollment by State (Page 1 of 2)

State	2013	2014	2015	2016	2017	2018	Change, 2013–2018
Alabama	941,815	876,485	888,024	892,753	899,576	911,983	-3.2%
Alaska	117,933	127,888	137,868	176,799	200,369	211,912	79.7%
Arizona	1,288,495	1,496,616	1,681,587	1,739,041	1,716,236	1,700,470	32.0%
Arkansas	630,196	824,682	839,277	948,181	913,552	850,695	35.0%
California	9,590,645	11,919,314	12,166,109	12,405,352	12,220,546	11,927,676	24.4%
Colorado	862,549	1,183,251	1,324,115	1,387,165	1,357,645	1,305,951	51.4%
Connecticut	631,274	760,584	746,047	761,310	836,906	855,943	35.6%
Delaware	217,801	235,047	241,704	241,664	247,948	248,964	14.3%
District of Columbia	220,556	256,282	263,296	264,849	264,016	259,243	17.5%
Florida	3,603,561	3,373,853	3,576,023	4,337,514	4,297,880	3,703,423	2.8%
Georgia	1,736,905	1,749,519	1,782,498	1,755,450	1,812,561	1,821,852	4.9%
Hawaii	306,542	308,567	339,044	345,975	346,747	331,075	8.0%
Idaho	258,950	287,585	282,440	299,841	297,688	280,570	8.3%
Illinois	2,934,163	3,126,814	3,134,109	3,065,331	3,062,268	2,860,188	-2.5%
Indiana	1,073,116	1,216,683	1,437,538	1,508,219	1,478,130	1,450,933	35.2%
Iowa	525,340	572,104	608,837	622,071	668,047	691,918	31.7%
Kansas	405,965	400,885	407,388	408,885	389,441	389,535	-4.0%
Kentucky	847,848	1,073,384	1,179,314	1,230,475	1,272,976	1,222,239	44.2%
Louisiana	1,176,564	1,044,151	1,077,109	1,415,385	1,455,541	1,577,428	34.1%
Maine	279,318	287,807	279,000	269,428	263,741	256,900	-8.0%
Maryland	1,063,575	1,143,810	1,162,313	1,281,890	1,323,306	1,316,115	23.7%
Massachusetts	1,396,037	1,586,233	1,676,400	1,655,529	1,683,846	1,598,878	14.5%
Michigan	1,939,665	2,253,958	2,311,459	2,330,154	2,366,223	2,333,409	20.3%
Minnesota	874,883	1,213,607	1,070,731	1,049,566	1,082,484	1,069,346	22.2%
Mississippi	695,324	714,084	693,365	684,094	674,933	620,567	-10.8%
Missouri	845,600	855,487	948,576	976,256	957,642	888,597	5.1%
Montana	148,107	167,328	185,716	245,360	274,234	279,675	88.8%
Nebraska	233,321	240,058	237,979	243,657	245,863	247,510	6.1%
Nevada	352,589	548,377	596,516	623,574	638,420	636,208	80.4%
New Hampshire	147,932	167,330	189,687	191,363	189,811	184,476	24.7%
New Jersey	1,129,849	1,672,822	1,737,333	1,795,251	1,780,672	1,738,183	53.8%
New Mexico	508,825	687,942	738,231	775,020	743,780	728,327	43.1%
New York	5,626,023	6,300,006	6,620,649	6,420,227	6,477,870	6,523,404	16.0%
North Carolina	1,699,903	1,821,459	2,000,804	2,083,547	2,101,517	1,763,338	3.7%
North Dakota	69,365	86,120	89,240	94,681	93,983	91,072	31.3%
Ohio	2,227,864	2,900,815	2,932,001	2,910,351	2,845,785	2,651,092	19.0%

APPENDIX TABLE 4

December Medicaid and CHIP Enrollment by State (Page 2 of 2)

State	2013	2014	2015	2016	2017	2018	Change, 2013–2018
Oklahoma	753,233	799,478	781,927	804,355	780,488	728,153	-3.3%
Oregon	635,112	1,036,190	1,044,686	986,111	976,182	979,447	54.2%
Pennsylvania	2,322,189	2,403,656	2,769,810	2,918,260	2,986,599	2,949,567	27.0%
Rhode Island	189,977	263,426	280,350	298,148	312,705	311,254	63.8%
South Carolina	844,564	995,296	936,141	996,551	1,009,409	1,044,270	23.6%
South Dakota	113,463	116,878	118,295	119,956	118,085	110,749	-2.4%
Tennessee	1,356,284	1,425,497	1,564,417	1,636,770	1,548,572	1,396,302	3.0%
Texas	4,256,160	4,704,853	4,727,969	4,799,893	4,474,461	4,308,644	1.2%
Utah	318,885	298,773	311,057	311,117	302,585	288,403	-9.6%
Vermont	145,219	177,819	191,415	169,092	163,649	160,114	10.3%
Virginia	957,110	958,583	955,868	993,220	1,028,297	1,053,309	10.1%
Washington	1,164,459	1,644,648	1,779,640	1,818,225	1,782,832	1,739,111	49.3%
West Virginia	375,057	522,491	548,380	567,064	549,678	520,656	38.8%
Wisconsin	1,037,425	1,034,899	1,044,478	1,037,863	1,034,480	1,020,034	-1.7%
Wyoming	71,977	71,535	64,508	61,925	60,042	58,118	-19.3%
U.S.	**61,149,512**	**69,934,959**	**72,701,268**	**74,954,758**	**74,610,247**	**72,197,226**	**18%**

NOTES: Figures are counts of the unduplicated number of individuals enrolled in Medicaid or CHIP as of the last day of the reporting period, including those with retroactive, conditional, or presumptive eligibility. For 2014 and subsequent years, figures are for only those individuals eligible for comprehensive benefits.

SOURCES: Centers for Medicare and Medicaid Services, "Monthly Medicaid & CHIP Application, Eligibility Determination, and Enrollment Reports & Data," https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/monthly-reports/index.html (accessed November 18, 2019). Data for 2013 are from Laura Snyder, Robin Rodwitz, Eileen Ellis, and Dennis Roberts, "Medicaid Enrollment: December 2013 Data Snapshot," Kaiser Commission on Medicaid and the Uninsured *Issue Brief*, June 2014, Table A-1, http://files.kff.org/attachment/medicaid-enrollment-snapshot-december-2013-issue-brief-download (accessed February 26, 2020).

Endnotes

1. "Average premium paid" is calculated as total premium revenues divided by total member months for a given market or market segment. This measure reflects what consumers actually paid for insurance, as opposed to list prices, which vary by the type of plan, location, and age of the enrollee.
2. Author's calculations using data from medical loss ratio filings with the Centers for Medicare and Medicaid Services (CMS).
3. Ibid. Because the regulation of large-employer plans was little affected by the ACA, changes in average premiums paid for large-employer, fully insured coverage can be presumed to reflect primarily changes in plan design and medical trend. Consequently, those figures are provided for comparison purposes.
4. Massachusetts had the highest per capita average premium paid over any other states prior to the ACA and its underlying policy design closely followed the ACA. While Massachusetts did see a rise in average premiums paid in the first year of the ACA, it required less overall adjustment to the structure of the ACA than other states. Thus, Massachusetts was able to see declines for 2015 through 2017.
5. Massachusetts experienced an 18.8 percent increase in 2014, followed by a 20.3 percent decrease in 2015. For the other nine states with 2015 premium decreases, the declines ranged from 1.3 percent in Utah to 8.3 percent in Montana.
6. Oregon and Vermont saw average premiums paid fall for two consecutive years before they increased again; Rhode Island had two non-sequential years of decrease; and Massachusetts, which had three consecutive years of decreases in average premiums paid, saw an increase in 2018. Alaska and Minnesota both saw average premiums paid fall in 2018, the year that Section 1332 waivers took effect in those two states. See discussion of Section 1332 waivers later in this *Backgrounder.*
7. This *Backgrounder* uses bronze plans, rather than silver plans, as the basis for measuring changes in deductibles. Most subsidized consumers purchase silver plans, which are subject to cost-sharing reductions. Furthermore, few consumers purchase gold or platinum plans. Thus, for measuring changes over time in deductibles, the most relevant level is bronze plans which are the choice of most of the customers who do not qualify for cost-sharing reductions. They are the plans purchased by the most price-sensitive consumers; those who must pay any additional cost out of their own pockets.
8. Averages calculated by plan type and state (using CMS-assigned plan identifiers) for qualified health plans in the 35 states that have consistently used the federal marketplace since 2014. Averages calculated for all bronze and expanded bronze plans (in 2019, n=846), encompassing plans with separate prescription drug deductibles (in 2019, n=61), as well as plans for which prescription drugs are included in the overall medical deductible (in 2019, n=785). See 2014 data at HealthCare.gov, "2014 FFM QHP data sets for researchers," https://www.healthcare.gov/health-plan-information/ (accessed November 12, 2019). See 2019 data at HealthCare.gov, "2019 QHP Landscape Data," https://www.healthcare.gov/health-plan-information-2019/ (accessed November 12, 2019).
9. While the data showed a broad trend of increase in deductibles over time, the extent varied among individual states. This was largely due to differences among the states in insurers with different plan designs entering and exiting the market, as well as cases where an insurer consistently offered plans in the state, but changed plan designs over time.
10. Heritage Foundation calculations based on federal and state information on exchange participation, and National Association of Insurance Commissioners data for pre-ACA market participation (accessed through Mark Farrah Associates subscription service). Insurer offerings are counted based on parent companies. 2013 data includes only insurers with 1,000 or more covered lives in the applicable state. 2019 figures do not include data for insurers selling exclusively off the exchange.
11. Medicaid and CHIP Payment and Access Commission, "State and federal spending under the ACA," https://www.macpac.gov/subtopic/state-and-federal-spending-under-the-aca/ (accessed February 13, 2020). Originally, the ACA would have compelled states to offer Medicaid to the expansion eligibility group, or lose their Medicaid funding. However, after litigation, expansion is optional. See Nina Owcharenko Schaefer, "The Supreme Court's Medicaid Decision: The ACA Mess Just Got Messier," Heritage Foundation *Issue Brief* No. 3663, July 11, 2012, http://thf_media.s3.amazonaws.com/2012/pdf/ib3663.pdf.
12. Enrollment includes Medicaid and CHIP. Centers for Medicare and Medicaid Services, "Monthly Medicaid & CHIP Application, Eligibility Determination, and Enrollment Reports & Data," https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/monthly-reports/index.html (accessed November 18, 2019). 2013 data: Laura Snyder, Robin Rodwitz, Eileen Ellis, and Dennis Roberts, "Medicaid Enrollment: December 2013 Data Snapshot," Kaiser Commission on Medicaid and the Uninsured *Issue Brief,* June 2014, Table A-1, http://files.kff.org/attachment/medicaid-enrollment-snapshot-december-2013-issue-brief-download (accessed February 26, 2020).
13. Ibid.
14. Ibid.
15. Ibid. 31 states and the District of Columbia had the Medicaid expansion in effect as of December 2018. Subsequently, Maine and Virginia implemented Medicaid expansion beginning in 2019, and Utah and Idaho implemented Medicaid expansion in January 2020. Nebraska has also adopted the Medicaid expansion but has not yet implemented it.
16. Ibid. Some portion of state-level enrollment changes (in both expansion and non-expansion states) are likely attributable to factors unrelated to expansion, such as other state-specific program changes and population and economic changes. Additionally, the "woodwork effect" accounts for some increases, as enrollment outreach under the ACA likely identified individuals who were already eligible but not enrolled in the program. See Edmund F. Haislmaier and Drew Gonshorowski, "State Lawmaker's Guide to Evaluating Medicaid Expansion Projections," Heritage Foundation *Issue Brief* No. 3720, September 7, 2012, https://www.heritage.org/health-care-reform/report/state-lawmakers-guide-evaluating-medicaid-expansion-projections.

17. Ibid. Among states that implemented Medicaid expansion prior to December 2018. One expansion state (Illinois) saw an overall decrease of 2.5 percent.
18. Additionally, the Trump Administration has offered greater flexibility on coverage arrangements including short-term limited duration plans, association health plans, and health reimbursement arrangements. Each of these promotes greater choice for consumers. However, some states do not currently allow consumers in the state to benefit from the full range of the new flexibility. For more information, see Doug Badger and Whitney Jones, "Five Steps Policymakers Can Take to Permit the Sale and Renewal of Affordable Alternative to Obamacare Policies," Heritage Foundation *Backgrounder* No. 3310, April 26, 2018, https://www.heritage.org/health-care-reform/report/five-steps-policymakers-can-take-permit-the-sale-and-renewal-affordable; Robert E. Moffit, "Trump's Expansion of Health Reimbursement Accounts Improves Health Care Choices," The Daily Signal, June 14, 2019, https://www.dailysignal.com/2019/06/14/trumps-expansion-of-health-reimbursement-accounts-improves-health-care-choices/ (accessed December 3, 2019); Robert E. Moffit, "Trump's New Health Initiative Will Spell Relief for Americans," The Daily Signal, June 19, 2018, https://www.dailysignal.com/2018/06/19/trumps-new-health-initiative-will-spell-relief-for-americans/ (accessed December 3, 2019).
19. Doug Badger, "How Health Care Premiums Are Declining in States That Seek Relief from the ACA's Mandates," Heritage Foundation *Issue Brief* No. 4990, August 13, 2019, https://www.heritage.org/health-care-reform/report/how-health-care-premiums-are-declining-states-seek-relief-obamacares.
20. Center for Consumer Information & Insurance Oversight, "Section 1332: State Innovation Waivers," https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_state_Innovation_Waivers-.html#Section%201332%20State%20Application%20Waiver%20Applications (accessed October 8, 2019).
21. Alaska, 2017: –34.7 percent; Minnesota, 2018: –20 percent; Oregon, 2018: –6 percent; Maine, 2019: –9.4 percent; Maryland, 2019: –43.4 percent; New Jersey, 2019: –15.1; and Wisconsin, 2019: –10.6 percent. See Chris Sloan, Neil Rosacker, and Elizabeth Carpenter, "State-Run Reinsurance Programs Reduce ACA Premiums by 19.9% on Average," Avalere, March 13, 2019, https://avalere.com/press-releases/state-run-reinsurance-programs-reduce-aca-premiums-by-19-9-on-average (accessed October 8, 2019).
22. Colorado projected a 16 percent premium reduction; Delaware projected a 13.7 percent reduction; Montana, an 8 percent reduction; North Dakota, a 19.8 percent reduction; and Rhode Island, a 5.9 percent reduction. See Center for Consumer Information & Insurance Oversight, "Section 1332: State Innovation Waivers."
23. Health Policy Consensus Group, "Health Care Choices Proposal," June 19, 2018, https://www.healthcarechoices2020.org/wp-content/uploads/2018/06/Proposal-06-19-18.pdf (accessed September 10, 2019).
24. For data on ACA enrollment effects, see: Edmund F. Haislmaier, "2017 Health Insurance Enrollment: Little Net Change, But Large Drop in Non-Group Coverage," Heritage Foundation *Issue Brief* No. 4913, October 30, 2018, https://www.heritage.org/health-care-reform/report/2017-health-insurance-enrollment-little-net-change-large-drop-non-group.
25. Center for Health and Economy, "The Health Care Choices Proposal," October 3, 2018, https://healthandeconomy.org/the-health-care-choices-proposal/ (accessed October 8, 2019).