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Premiums, Choices, Deductibles, Care Access, and Government Dependence Under the Affordable Care Act: 2021 State-by-State Review

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KEY TAKEAWAYS

Americans deserve more health care options. Obamacare did not help. It increased premiums and deductibles while limiting plans and restricting physician networks.

Not only has Obamacare made insurance more expensive, but it also provides fewer coverage choices and pushed more Americans into government-run health programs.

Some states have reduced premiums through deregulatory actions; Congress should enact further reforms that build on that success.

This year marks 11 years since the passage of the Affordable Care Act (ACA)—also known as Obamacare—and seven 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 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 2019, the national average premium paid in the individual market was $558 (per member, per month). This is a 129 percent increase from 2013 to 2019.[2] Over the same period in the large-employer market, national average premiums paid per member per month grew by only 29 percent (from $363 to $558).[3] This means premiums for individual market coverage under the ACA effectively doubled between 2013 and 2019.

Premium changes varied by state. (See Appendix Table 2.) In nearly every state, consumers on average paid higher premiums under the ACA. In 40 states, the average monthly premium for individual-market coverage more than doubled by 2019—and it more than tripled in five of them (Alabama +244 percent, Nebraska +212 percent, Missouri +202 percent, West Virginia +243 percent, and Wyoming +201 percent). States with the smallest premium increases over this period—New Jersey (+20 percent), New York (+24 percent), Rhode Island (+40 percent), and Vermont (+44 percent)—were ones that had imposed costly regulations on their individual markets before the ACA and consequently already had high average premiums in 2013. Only one state, Massachusetts, saw a decline (–5 percent) in average premiums paid over this period. That was because almost all the ACA's new mandates and regulations, along with a similar set of income-related subsidies, were already in place in the Massachusetts individual market before the ACA took effect. Massachusetts was the state with the highest average monthly premium pre-ACA ($422 in 2013).

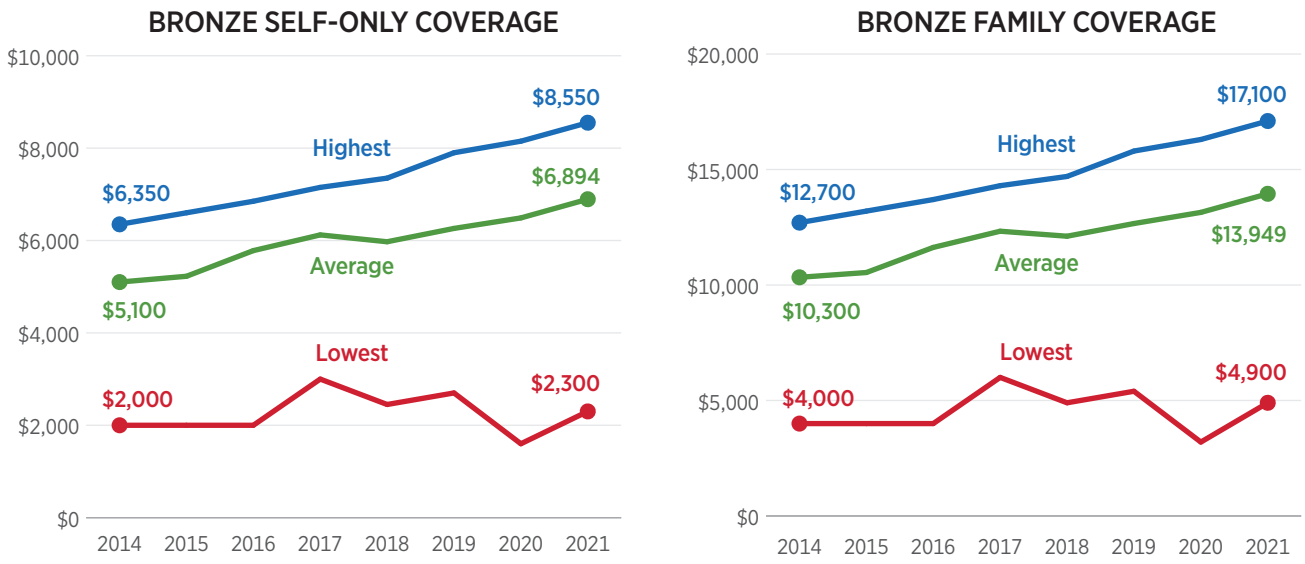
Higher Deductibles

At the same time that premiums more than doubled in the individual market, deductibles for ACA-compliant coverage also significantly increased.[4] Deductibles for bronze-level plans sold on the federal exchange

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. Authors' calculations using data from medical loss ratio filings with the Centers for Medicare and Medicaid Services (CMS), "Medical Loss Ratio Data and System Resources," https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr.html (accessed October 14, 2021). For a more extensive analysis, see Edmund F. Haislmaier and Abigail Slagle, "Obamacare Has Doubled the Cost of Individual Health Insurance," Heritage Foundation *Issue Brief* No. 6068, March 21, 2021, https://www.heritage.org/health-care-reform/report/obamacare-has-doubled-the-cost-individual-health-insurance.
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.
4. 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. Thus, most enrollees in silver plans have real deductibles that are lower than their plans' stated deductibles. 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.

CHART 1

Obamacare Increased Average Deductibles by 35%



NOTES: Data are for bronze plans offered on the exchange in the 36 states that have consistently used the federal exchange platform, healthcare.gov. Bronze plans are the most relevant for measuring changes in deductibles as they are not subject to the cost-sharing reductions that result in most silver plan enrollees having a real deductible that is lower than their plan's stated deductible.
SOURCE: HealthCare.gov, "FFM QHP Landscape Files: Health and Dental Datasets for Researchers and Issuers," https://www.healthcare.gov/health-and-dental-plan-datasets-for-researchers-and-issuers/ (accessed October 27, 2021).

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increased by more than one-third (35 percent) under the ACA. For self-only coverage, deductibles rose from an average of $5,100 in 2014 to $6,894 in 2021, while the average deductible for family coverage increased from $10,333 in 2014 to $13,949 in 2021.[5] (See Chart 1.)

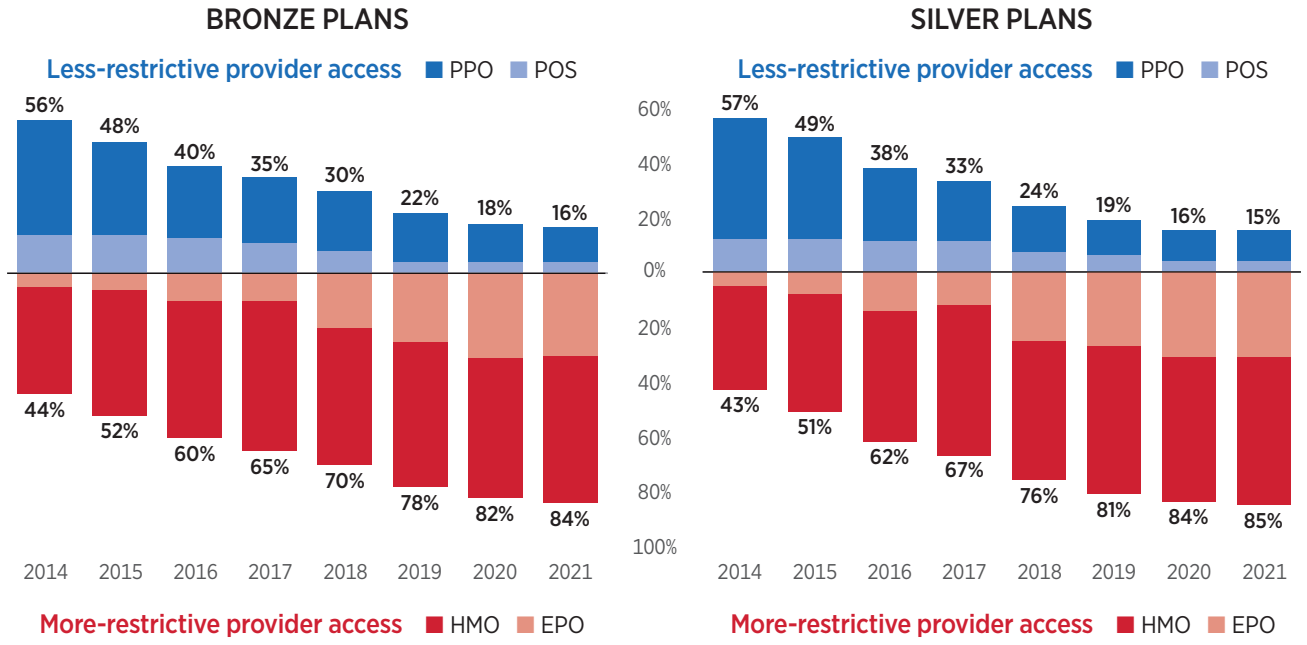
Narrower Networks

While Obamacare enrollees have been paying more in premiums and out-of-pocket costs, their access to medical providers has also been shrinking. During the 2014 plan year, 44 percent of bronze plan offerings had more

5. Authors' calculations based on medical deductibles data for bronze plans offered on the exchange in the 36 states that have consistently used a federally facilitated exchange (healthcare.gov) since 2014. In recent years some carriers have offered bronze plan designs that impose a high deductible for prescription drugs but no medical deductible. We excluded those plan designs from our analysis.

CHART 2

Obamacare Plans Reduced Access to Medical Providers



PPO—Preferred Provider Organization EPO—Exclusive Provider Organization POS—Point of Service HMO—Health Maintenance Organization
NOTES: Authors' calculations from plan design data for plans offered on the exchange in the 36 states that have consistently used the federal exchange platform, healthcare.gov. Ninety percent of exchange enrollments are in either bronze (35%) or silver (55%) plans.
SOURCE: HealthCare.gov, "FFM QHP Landscape Files: Health and Dental Datasets for Researchers and Issuers," https://www.healthcare.gov/health-and-dental-plan-datasets-for-researchers-and-issuers/ (accessed October 25, 2021).

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restrictive provider networks,[6] but by 2021 that figure has increased to 84 percent. Silver plans experienced the same effect, moving from just 43 percent of the plans having more restrictive networks in 2014 to 85 percent of plan designs in 2021.[7] (See Chart 2.)

6. Provider access varies by plan network designs. The four basic plan designs, ordered from least to most restrictive are Preferred Provider Organization (PPO), Point of Service (POS), Exclusive Provider Organization (EPO), and Health Maintenance Organization (HMO). Under a PPO plan, you pay less if you use providers in the plan's network. For an additional cost you can use a non-network provider and can do so without needing a referral approved by the plan. POS plans are like PPO plans with the exception that for the plan to reimburse treatment by a specialist, you must first get a referral from your primary care doctor. An EPO is a managed care plan that (except in an emergency) reimburses only for the services of those providers in the plan's network. Like an EPO, an HMO is a managed care plan that pays only for treatment by providers who work for or contract with the plan and requires you to get referrals from your primary care doctor for specialists and (non-emergency) hospitalization. Typically, to be eligible for coverage through an HMO, you must also either live or work within its geographic service area.
7. Authors' calculations based on data on plan networks for plans offered on the exchange in the 36 states that have consistently used a federally facilitated exchange (healthcare.gov) since 2014.

Insurers have essentially responded to the higher claims costs resulting from Obamacare's regulations by increasing premiums and enrollee cost sharing while narrowing the networks of providers that their plans will reimburse.

The result: enrollees with Obamacare coverage have been paying more while getting less access to doctors and hospitals.

This is anomalous to both employer-group health insurance plans and the pre-ACA individual market. Prior to Obamacare, insurers generally offered—and customers generally expected—a rough trade-off in plan design to provide customers value for their purchase. Typically, plans with higher out-of-pocket costs offered a broader choice of providers, while plans with limited provider choice offered lower out-of-pocket costs. However, Obamacare has managed to force insurers into offering plans characterized by both limited provider choice and high out-of-pocket costs.

Fewer Choices and Less Competition in the ACA Exchanges

As consumers paid higher premiums and experienced narrower networks, fewer insurers offered plans on the ACA exchanges. Individual insurance markets are about one-third less competitive than they were before the ACA took effect.[8] In 2013, there were 395 insurers offering coverage in the individual market at the state level. By 2018, insurer competition had fallen by more than half (54 percent), with only 181 insurers offering coverage on the Obamacare exchanges, and there were eight states in which only one insurer offered exchange coverage that year. Over the past three years, insurer competition has partially rebounded in response to steps the Trump Administration took to stabilize the market. In 2021, there are 253 insurers offering exchange coverage, though this is still 36 percent fewer than before the implementation of Obamacare.

Appendix Table 3 displays the percentage change in insurer competition in the 2013 individual market and the 2021 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. Despite insurers reentering the exchanges in recent years, for 2021 Delaware still has only one insurer offering exchange coverage, and 12 states and the

8. 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. Data for 2013 includes only insurers with 1,000 or more covered lives in the applicable state. Figures for 2014 and subsequent years do not include insurers selling exclusively off the exchanges.

District of Columbia still have only two insurers offering exchange coverage. Only five states have more insurers participating in their exchange in 2021 than they had offering coverage in their individual market in 2013.[9]

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.[10]

Between 2013—the last year before the ACA took full effect—and 2019, enrollment in Medicaid and the Children's Health Insurance Program (CHIP) increased by 10 million individuals.[11] Enrollment in those programs jumped by a further 9 million individuals in 2020.

The 2020 sharp increase was largely due to effects of the COVID-19 pandemic. When governments responded to COVID-19 by imposing restrictions on businesses and the public, the resulting adverse economic impacts fell disproportionately on industries that employ more low-wage workers, such as hospitality, personal services, and retail. Consequently, lower-income workers were more likely to suffer economic dislocation and seek assistance from safety-net programs. Also, in March 2020 Congress enacted a temporary increase in federal funding for state Medicaid programs conditioned on states continuing to cover, for the duration of

9. For a more extensive analysis, see Edmund F. Haislmaier and Abigail Slagle, "Obamacare's Health Insurance Exchanges in 2021: Increased Options, but Still Less Than Pre-ACA," Heritage Foundation *Issue Brief* No. 6066, March 16, 2021, https://www.heritage.org/health-care-reform/report/obamacares-health-insurance-exchanges-2021-increased-options-still-less.

10. 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, https://www.heritage.org/health-care-reform/report/the-supreme-courts-medicaid-decision-the-obamacare-mess-just-got-messier.

11. Centers for Medicare and Medicaid Services, "Monthly Medicaid and CHIP Application, Eligibility Determination, and Enrollment Reports and Data," https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/monthly-reports/index.html (accessed October 14, 2021). For 2013 data, see Laura Snyder et al., "Medicaid Enrollment: December 2013 Data Snapshot," Kaiser Commission on Medicaid and the Uninsured, June 2014, Table A-1, http://files.kff.org/attachment/medicaid-enrollment-snapshot-december-2013-issue-brief-download (accessed October 14, 2021).

the health emergency, all individuals who were already on Medicaid. In December 2013, national Medicaid and CHIP enrollment was 61.1 million. By December 2020, 80.2 million people were enrolled in Medicaid and CHIP—an increase of 31.1 percent from 2013 and of 12 percent from the end of March 2020 (the start of the widespread national COVID-19 response).[12]

Due to the effects of the COVID-19 response, all states and the District of Columbia experienced increased Medicaid enrollment in 2020. (See Appendix Table 4.) While the increases varied by state, Medicaid enrollment surged in both expansion and non-expansion states. For instance, while both California and New York adopted the ACA Medicaid expansion, neither Texas nor Florida have done so. In 2020 Medicaid enrollment jumped in all four states, growing by 903,000 individuals in California; 689,000 in New York; 630,000 in Texas; and 492,000 in Florida.

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 regulations implementing the law's Section 1332 waivers, which allow states to seek waivers from certain federal ACA requirements.[13] The results, thus far, are encouraging.[14]

Seven states had 1332 waivers in effect by 2019, and five additional states were approved to implement waivers in 2020.[15] In the initial seven states,

12. Ibid. For a more extensive discussion see Edmund F. Haislmaier, "COVID-19: Effects of the Response on Health Insurance Coverage in 2020," Heritage Foundation *Issue Brief* No. 6079, May 14, 2021, https://www.heritage.org/public-health/report/covid-19-effects-the-response-health-insurance-coverage-2020.
13. 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/; and 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/.
14. 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.
15. Center for Consumer Information and 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 14, 2021).

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.[16] All five states with waivers taking effect in 2020 projected similar premium reductions.[17]

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,[18] 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 would also 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.[19] 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.

The Center for Health and Economy estimated that the Health Care Choices Proposal would lower premiums by as much as 24 percent and result in nearly 4 million more people purchasing insurance by 2030, with more people enrolling in private coverage versus public insurance over the same period.[20]

16. 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 14, 2021).
17. Colorado projected a 16 percent premium reduction, Delaware 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 and Insurance Oversight, "Section 1332: State Innovation Waivers." Data on the effects of these waivers on 2020 premium payments will not be available until November or December 2021.
18. For more information, see Health Policy Consensus Group, "Health Care Choices 2020: A Vision for the Future," November 2020, https://www.healthcarechoices2020.org/wp-content/uploads/2020/10/HEALTH-CARE-CHOICES-2020_A-Vision-for-the-Future_FINAL-002-1.pdf (accessed October 14, 2021).
19. Ibid.
20. Center for Health and Economy, "The Health Care Choices Proposal," October 22, 2020, https://www.healthcarechoices2020.org/wp-content/uploads/2020/10/The-Health-Care-Choices-Proposal-Score.pdf (accessed October 14, 2021).

Conclusion

Since taking effect, the ACA more than doubled premiums in the individual market while cutting the number of participating insurers by one-third. It also led insurers to raise plan deductibles and narrow their provider networks while at the same time significantly increasing the number of people dependent on government-run health care. To reverse those 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 2013–2019	Individual Market: Number of Insurers 2013–2021	Medicaid and CHIP: Enrollment 2013–2020
Alabama	244%	-50%	6%
Alaska	116%	-50%	103%
Arizona	150%	-55%	52%
Arkansas	136%	-57%	42%
California	106%	-8%	30%
Colorado	147%	-43%	72%
Connecticut	117%	-71%	47%
Delaware	198%	-75%	17%
D.C.	78%	-50%	19%
Florida	143%	-56%	14%
Georgia	183%	-45%	21%
Hawaii	104%	0%	26%
Idaho	137%	0%	45%
Illinois	147%	-33%	10%
Indiana	101%	-73%	66%
Iowa	153%	-40%	43%
Kansas	159%	-33%	6%
Kentucky	132%	-67%	80%
Louisiana	125%	-63%	46%
Maine	95%	-25%	12%
Maryland	146%	-63%	37%
Massachusetts	-5%	0%	23%
Michigan	120%	-43%	37%
Minnesota	84%	-17%	34%
Mississippi	149%	-60%	-2%
Missouri	202%	-33%	21%
Montana	157%	50%	88%
Nebraska	212%	-50%	31%
Nevada	137%	0%	112%
New Hampshire	76%	50%	45%
New Jersey	20%	0%	69%
New Mexico	161%	67%	61%
New York	24%	20%	19%
North Carolina	183%	-50%	18%
North Dakota	78%	0%	55%
Ohio	125%	-25%	33%
Oklahoma	198%	-25%	15%
Oregon	144%	-50%	81%
Pennsylvania	151%	-50%	40%

APPENDIX TABLE 1

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

State	Individual Market: Average Monthly Premium Paid 2013–2019	Individual Market: Number of Insurers 2013–2021	Medicaid and CHIP: Enrollment 2013–2020
Rhode Island	40%	0%	71%
South Carolina	167%	-56%	34%
South Dakota	123%	-50%	8%
Tennessee	173%	-40%	16%
Texas	136%	-44%	13%
Utah	171%	-44%	22%
Vermont	44%	-33%	19%
Virginia	186%	-20%	71%
Washington	98%	29%	64%
West Virginia	243%	-50%	49%
Wisconsin	151%	-13%	18%
Wyoming	201%	-60%	-10%
U.S.	**129%**	**-36%**	**31%**

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 22, 2021).
- **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 (accessed October 22, 2021).
- **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 October 22, 2021). 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, https://www.kff.org/report-section/medicaid-enrollment-snapshot-decem- ber-2013-tables/ (accessed October 22, 2021).

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	2019	CHANGE 2013–2019
Alabama	$178	$320	$350	$402	$531	$618	$613	244%
Alaska	$342	$584	$769	$840	$956	$796	$737	116%
Arizona	$214	$299	$289	$318	$517	$549	$534	150%
Arkansas	$185	$311	$336	$354	$363	$424	$437	136%
California	$271	$388	$401	$406	$428	$511	$557	106%
Colorado	$237	$345	$338	$388	$420	$560	$586	147%
Connecticut	$291	$421	$464	$457	$524	$670	$631	117%
Delaware	$272	$404	$439	$486	$554	$744	$811	198%
D.C.	$268	$319	$350	$333	$352	$419	$474	78%
Florida	$237	$351	$386	$391	$429	$554	$577	143%
Georgia	$209	$332	$365	$394	$426	$600	$591	183%
Hawaii	$265	$334	$324	$365	$435	$525	$541	104%
Idaho	$199	$274	$318	$341	$381	$457	$471	137%
Illinois	$247	$356	$357	$386	$492	$601	$609	147%
Indiana	$241	$375	$434	$405	$408	$477	$484	101%
Iowa	$251	$316	$324	$368	$419	$612	$635	153%
Kansas	$234	$311	$312	$350	$434	$564	$606	159%
Kentucky	$231	$345	$337	$351	$370	$493	$537	132%
Louisiana	$250	$358	$388	$436	$514	$599	$562	125%
Maine	$334	$446	$454	$427	$503	$693	$650	95%
Maryland	$209	$273	$318	$336	$396	$559	$514	146%
Massachusetts	$442	$525	$419	$387	$365	$414	$420	-5%
Michigan	$212	$309	$359	$370	$385	$464	$467	120%
Minnesota	$235	$335	$382	$428	$525	$501	$433	84%
Mississippi	$214	$318	$360	$362	$401	$535	$532	149%
Missouri	$197	$300	$332	$377	$431	$579	$595	202%
Montana	$251	$408	$374	$417	$543	$618	$645	157%
Nebraska	$238	$355	$371	$388	$502	$709	$743	212%
Nevada	$205	$297	$357	$367	$369	$489	$485	137%
New Hampshire	$300	$391	$374	$392	$460	$593	$529	76%
New Jersey	$419	$464	$500	$500	$476	$558	$502	20%
New Mexico	$190	$327	$346	$319	$368	$507	$496	161%
New York	$377	$412	$412	$395	$407	$448	$466	24%
North Carolina	$240	$362	$394	$456	$592	$706	$680	183%
North Dakota	$276	$354	$396	$414	$405	$465	$492	78%
Ohio	$222	$324	$358	$380	$385	$461	$500	125%

APPENDIX TABLE 2

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

State	2013	2014	2015	2016	2017	2018	2019	CHANGE 2013–2019
Oklahoma	$210	$306	$316	$365	$558	$638	$626	198%
Oregon	$220	$395	$366	$366	$437	$504	$537	144%
Pennsylvania	$241	$362	$376	$387	$512	$653	$604	151%
Rhode Island	$325	$406	$376	$381	$371	$433	$456	40%
South Carolina	$232	$341	$367	$399	$483	$599	$620	167%
South Dakota	$246	$324	$335	$369	$437	$521	$548	123%
Tennessee	$213	$288	$307	$361	$493	$684	$581	173%
Texas	$221	$348	$359	$350	$403	$517	$521	136%
Utah	$159	$248	$245	$266	$314	$445	$431	171%
Vermont	$406	$478	$517	$514	$502	$529	$585	44%
Virginia	$229	$310	$333	$370	$395	$623	$655	186%
Washington	$279	$403	$404	$389	$399	$493	$553	98%
West Virginia	$261	$418	$464	$519	$642	$820	$894	243%
Wisconsin	$268	$433	$505	$452	$489	$695	$673	151%
Wyoming	$301	$487	$596	$571	$590	$899	$906	201%
U.S.	**$244**	**$353**	**$374**	**$389**	**$440**	**$550**	**$558**	**129%**

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 22, 2021).

APPENDIX TABLE 3

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

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

	PRE-ACA	ACA EXCHANGE								CHANGE
State	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2013–2021**
Alabama	4	2	3	3	1	2	2	2	2	–50%
Alaska	4	2	2	1	1	1	1	2	2	–50%
Arizona	11	8	11	8	2	2	5	5	5	–55%
Arkansas	7	3	3	4	3	3	3	3	3	–57%
California	12	11	10	12	11	11	11	11	11	–8%
Colorado	14	10	10	8	7	7	7	8	8	–43%
Connecticut	7	3	4	4	2	2	2	2	2	–71%
Delaware	4	2	2	2	2	1	1	1	1	–75%
D.C.	4	3	3	2	2	2	2	2	2	–50%
Florida	18	8	10	7	5	4	5	7	8	–56%
Georgia	11	5	9	8	5	4	4	6	6	–45%
Hawaii	2	2	2	2	2	2	2	2	2	0%
Idaho	5	4	5	5	5	4	4	4	5	0%
Illinois	12	5	8	7	5	4	5	5	8	–33%
Indiana	11	4	9	8	4	2	2	2	3	–73%
Iowa	5	4	3	4	4	1	2	2	3	–40%
Kansas	9	3	3	3	3	3	3	3	6	–33%
Kentucky	6	3	5	7	3	2	2	2	2	–67%
Louisiana	8	4	5	4	3	2	2	3	3	–63%
Maine	4	2	3	3	3	2	3	3	3	–25%
Maryland	8	4	5	5	3	2	2	2	3	–63%
Massachusetts	8	9	10	10	9	7	8	8	8	0%
Michigan	14	9	13	11	9	7	8	8	8	–43%
Minnesota	6	5	4	4	4	4	4	4	5	–17%
Mississippi	5	2	3	3	2	1	1	2	2	–60%
Missouri	12	3	6	6	4	3	4	7	8	–33%
Montana	2	3	4	3	3	3	3	3	3	50%
Nebraska	4	4	3	4	2	1	1	2	2	–50%
Nevada	5	4	5	3	3	2	2	3	5	0%
New Hampshire	2	1	5	5	4	3	3	3	3	50%
New Jersey	3	3	5	5	2	3	3	3	3	0%
New Mexico	3	5	5	4	4	4	4	4	5	67%
New York	10	16	16	15	14	12	12	12	12	20%
North Carolina	12	2	3	3	2	2	3	4	6	–50%
North Dakota	3	3	3	3	3	2	3	3	3	0%
Ohio	12	11	15	14	10	8	9	9	9	–25%

APPENDIX TABLE 3

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

	PRE-ACA	ACA EXCHANGE								CHANGE
State	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2013–2021**
Oklahoma	8	4	4	2	1	1	2	3	6	–25%
Oregon	10	11	10	9	6	5	5	5	5	–50%
Pennsylvania	14	7	9	7	5	5	6	7	7	–50%
Rhode Island	2	2	3	3	2	2	2	2	2	0%
South Carolina	9	3	4	3	1	1	2	4	4	–56%
South Dakota	4	3	3	2	2	2	2	2	2	–50%
Tennessee	10	4	5	4	3	3	5	5	6	–40%
Texas	18	11	14	16	10	8	8	8	10	–44%
Utah	9	6	6	4	3	2	3	5	5	–44%
Vermont	3	2	2	2	2	2	2	2	2	–33%
Virginia	10	5	6	7	8	6	7	8	8	–20%
Washington	7	7	9	10	7	5	5	7	9	29%
West Virginia	4	1	1	2	2	2	2	2	2	–50%
Wisconsin	15	13	15	16	14	11	12	12	13	–13%
Wyoming	5	2	2	1	1	1	1	1	2	–60%
U.S.	**395**	**253**	**308**	**288**	**218**	**181**	**202**	**225**	**253**	**–36%**

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 2021 are for exchange-participating insurers and do not include any insurers selling policies exclusively on the exchanges.
SOURCES: Heritage Foundation calculations based on federal and state information on exchange participation, and National Association of Insurance Com-missioners data for 2013 market participation, accessed through Mark Farrah Associates, http://www.markfarrah.com (accessed October 22, 2021).

APPENDIX TABLE 4

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

State	2013	2014	2015	2016	2017	2018	2019	2020	CHANGE in 2020	CHANGE 2013–2020
Alabama	941,815	876,485	888,024	892,753	899,576	911,983	921,100	1,001,444	8.7%	6.3%
Alaska	117,933	127,888	137,868	176,799	200,369	211,912	223,065	239,981	7.6%	103.5%
Arizona	1,288,495	1,496,616	1,681,587	1,739,041	1,716,236	1,700,470	1,708,073	1,963,007	14.9%	52.3%
Arkansas	630,196	824,682	839,277	948,181	913,552	850,695	811,360	892,423	10.0%	41.6%
California	9,590,645	11,919,314	12,166,109	12,405,352	12,220,546	11,927,676	11,588,323	12,491,149	7.8%	30.2%
Colorado	862,549	1,183,251	1,324,115	1,387,165	1,357,645	1,305,951	1,286,739	1,484,080	15.3%	72.1%
Connecticut	631,274	760,584	746,047	761,310	836,906	855,943	850,657	927,770	9.1%	47.0%
Delaware	217,801	235,047	241,704	241,664	247,948	248,964	230,983	254,739	10.3%	17.0%
D.C.	220,556	256,282	263,296	264,849	264,016	259,243	253,546	262,327	3.5%	18.9%
Florida	3,603,561	3,373,853	3,576,023	4,337,514	4,297,880	3,703,423	3,613,005	4,104,699	13.6%	13.9%
Georgia	1,736,905	1,749,519	1,782,498	1,755,450	1,812,561	1,821,852	1,816,358	2,093,853	15.3%	20.6%
Hawaii	306,542	308,567	339,044	345,975	346,747	331,075	326,337	385,887	18.2%	25.9%
Idaho	258,950	287,585	282,440	299,841	297,688	280,570	267,602	376,688	40.8%	45.5%
Illinois	2,934,163	3,126,814	3,134,109	3,065,331	3,062,268	2,860,188	2,812,371	3,238,003	15.1%	10.4%
Indiana	1,073,116	1,216,683	1,437,538	1,508,219	1,478,130	1,450,933	1,485,826	1,779,627	19.8%	65.8%
Iowa	525,340	572,104	608,837	622,071	668,047	691,918	679,651	750,018	10.4%	42.8%
Kansas	405,965	400,885	407,388	408,885	389,441	389,535	376,289	429,274	14.1%	5.7%
Kentucky	847,848	1,073,384	1,179,314	1,230,475	1,272,976	1,222,239	1,288,288	1,529,906	18.8%	80.4%
Louisiana	1,176,564	1,044,151	1,077,109	1,415,385	1,455,541	1,577,428	1,468,338	1,718,400	17.0%	46.1%
Maine	279,318	287,807	279,000	269,428	263,741	256,900	264,424	312,227	18.1%	11.8%
Maryland	1,063,575	1,143,810	1,162,313	1,281,890	1,323,306	1,316,115	1,328,704	1,461,878	10.0%	37.4%
Massachusetts	1,396,037	1,586,233	1,676,400	1,655,529	1,683,846	1,598,878	1,567,780	1,720,365	9.7%	23.2%
Michigan	1,939,665	2,253,958	2,311,459	2,330,154	2,366,223	2,333,409	2,320,304	2,650,886	14.2%	36.7%
Minnesota	874,883	1,213,607	1,070,731	1,049,566	1,082,484	1,069,346	1,044,160	1,173,856	12.4%	34.2%
Mississippi	695,324	714,084	693,365	684,094	674,933	620,567	616,093	680,078	10.4%	–2.2%
Missouri	845,600	855,487	948,576	976,256	957,642	888,597	847,982	1,022,258	20.6%	20.9%
Montana	148,107	167,328	185,716	245,360	274,234	279,675	260,710	279,013	7.0%	88.4%
Nebraska	233,321	240,058	237,979	243,657	245,863	247,510	247,737	304,573	22.9%	30.5%
Nevada	352,589	548,377	596,516	623,574	638,420	636,208	626,078	749,040	19.6%	112.4%
New Hampshire	147,932	167,330	189,687	191,363	189,811	184,476	181,753	213,815	17.6%	44.5%
New Jersey	1,129,849	1,672,822	1,737,333	1,795,251	1,780,672	1,738,183	1,706,298	1,905,205	11.7%	68.6%
New Mexico	508,825	687,942	738,231	775,020	743,780	728,327	743,312	818,279	10.1%	60.8%
New York	5,626,023	6,300,006	6,620,649	6,420,227	6,477,870	6,523,404	5,997,950	6,686,686	11.5%	18.9%
North Carolina	1,699,903	1,821,459	2,000,804	2,083,547	2,101,517	1,763,338	1,772,156	2,012,555	13.6%	18.4%
North Dakota	69,365	86,120	89,240	94,681	93,983	91,072	89,370	107,199	19.9%	54.5%
Ohio	2,227,864	2,900,815	2,932,001	2,910,351	2,845,785	2,651,092	2,609,614	2,955,796	13.3%	32.7%

APPENDIX TABLE 4

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

State	2013	2014	2015	2016	2017	2018	2019	2020	CHANGE in 2020	CHANGE 2013–2020
Oklahoma	753,233	799,478	781,927	804,355	780,488	728,153	713,247	863,285	21.0%	14.6%
Oregon	635,112	1,036,190	1,044,686	986,111	976,182	979,447	996,363	1,150,385	15.5%	81.1%
Pennsylvania	2,322,189	2,403,656	2,769,810	2,918,260	2,986,599	2,949,567	2,938,411	3,261,323	11.0%	40.4%
Rhode Island	189,977	263,426	280,350	298,148	312,705	311,254	292,050	325,713	11.5%	71.4%
South Carolina	844,564	995,296	936,141	996,551	1,009,409	1,044,270	1,044,183	1,129,165	8.1%	33.7%
South Dakota	113,463	116,878	118,295	119,956	118,085	110,749	108,795	122,896	13.0%	8.3%
Tennessee	1,356,284	1,425,497	1,564,417	1,636,770	1,548,572	1,396,302	1,452,381	1,575,722	8.5%	16.2%
Texas	4,256,160	4,704,853	4,727,969	4,799,893	4,474,461	4,308,644	4,180,368	4,810,748	15.1%	13.0%
Utah	318,885	298,773	311,057	311,117	302,585	288,403	309,812	390,385	26.0%	22.4%
Vermont	145,219	177,819	191,415	169,092	163,649	160,114	151,190	172,171	13.9%	18.6%
Virginia	957,110	958,583	955,868	993,220	1,028,297	1,053,309	1,414,239	1,639,534	15.9%	71.3%
Washington	1,164,459	1,644,648	1,779,640	1,818,225	1,782,832	1,739,111	1,728,648	1,908,464	10.4%	63.9%
West Virginia	375,057	522,491	548,380	567,064	549,678	520,656	507,398	560,146	10.4%	49.3%
Wisconsin	1,037,425	1,034,899	1,044,478	1,037,863	1,034,480	1,020,034	1,046,309	1,219,693	16.6%	17.6%
Wyoming	71,977	71,535	64,508	61,925	60,042	58,118	55,974	64,559	15.3%	–10.3%
U.S.	**61,149,512**	**69,934,959**	**72,701,268**	**74,954,758**	**74,610,247**	**72,197,226**	**71,171,704**	**80,171,173**	**12.6%**	**31.1%**

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 October 22, 2021). 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, https://www.kff.org/report-section/medicaid-enrollment-snapshot-december-2013-tables/ (accessed October 22, 2021).