The Affordable Care Act at 15:
Policy Implications of the Experience to Date

A new report released by the Society of Actuaries Research Institute, *The ACA@15 – Tracking Prior and Emerging Results since its Inception*, examines the impacts of the Affordable Care Act (ACA) on its 15th anniversary. Among other goals, the ACA was designed to improve access to and the affordability of comprehensive health insurance coverage, increase insurer competition, and facilitate consumer choice.

Summary of findings

Although the impact of the ACA varies among states, and even within states, several common themes emerged.

Access and Affordability

- The ACA's combination of Medicaid expansion, individual market reforms, and premium tax credits reduced uninsured rates from 17% in 2013 to 10% in 2024.
  - Individual market enrollment more than doubled during this time period, with the highest increases in states that hadn't expanded Medicaid. Ninety percent of the Medicaid enrollment increases occurred in expansion states.
  - Recent individual market enrollment increases were largely due to enhanced premium tax credits.
  - State reinsurance programs via 1332 waivers in 18 states reduced premiums by about 15%, leading to increased enrollment among unsubsidized individuals, compared to states without such programs.
  - Average individual market premium rates remained remarkably stable for the past six years, with average annual premium increases (<1%) below average annual inflation (4%).

Insurer Competition and Consumer Choice

- Insurer participation is highest when the regulatory environment is stable and consistent and after periods of favorable financial results.
- Although there have been market exits and insolvencies, insurers of all types (e.g., national, regional, Blues, provider-based carriers, and Medicaid organizations) have been profitable in the individual market.

Policy implications

Based on the report's findings, several policy implications emerge.

Access and Affordability

- Non-expansion states have the opportunity to further reduce uninsured rates by expanding Medicaid or introducing a Basic Health Program.
- States that don't already have a reinsurance program under a 1332 waiver could improve affordability for unsubsidized individuals by adopting such a waiver.
- Extending enhanced premium tax credits would help maintain historically low uninsured rates. These premium tax credits are especially important in non-expansion states.

Insurer Competition and Consumer Choice

- Maintaining stable regulatory oversight that applies consistently to all competitors can help support and increase insurer competition in the individual market. This, in turn, can help support consumer choice.

Additional Resources from the American Academy of Actuaries

Ensuring Access, Affordability, Choice, and Competition in the Individual Health Insurance Market (March 2025)

The individual health insurance market is governed by various laws and regulations that are designed to support access to affordable coverage, consumer choice, and insurer competition. These governing provisions include a combination of uniform market rules, premium tax credits, cost-sharing reductions, and consumer protections. Changes that might affect the individual market require consideration of the impact on access, affordability, choice, and competition. Certain policies, such as allowing the enhanced premium tax credits to expire, increasing the availability of plans that do not adhere to existing rules, and selling insurance across state lines, could lead to higher premiums, and reduced insurer competition and consumer choice. Individual Coverage Health Reimbursement Arrangements (ICHRAs) and high-risk pools could improve the individual market but, if not carefully designed and implemented, could lead to higher premiums or market instability.

Medicaid Per Capita Caps: Design Considerations and Policy Implications (March 2025)

As is true for national health spending as a whole, spending in the Medicaid program, which is financed jointly by federal and state governments, is rising. Such spending trends increase pressure on federal and state budgets, and federal policymakers are considering alternative approaches to financing the Medicaid program that would relieve some of this pressure. One approach that has been considered is limiting the annual federal Medicaid contribution to a certain amount per enrollee, either overall or by category. Once the federal per capita cap is reached, all spending would be borne fully by the state. The implications of Medicaid per capita caps depend on the specific design features, especially how the initial payment level is determined and how the payment level changes over time. Although shifting more of the financial risk to states could encourage them to use their Medicaid dollars more cost effectively, if per capita caps do not keep up with health spending trends, states may need to reduce coverage for optional populations, optional benefits, and provider payments, or increase beneficiary premiums and cost sharing.

Medicaid Managed Care State-Directed Payments—A Primer (September 2022)

State-directed payments are a special type of payment arrangement regulated by the Centers for Medicare and Medicaid Services (CMS), which allow a state to direct expenditures to providers under managed care organization (MCO) contracts in certain situations. As the number of state-directed payments increases, so does the potential for higher Medicaid expenditures that flow through them. The increasing amounts of state-directed payments over time has attracted the attention of CMS and the Government Accountability Office. Depending on the state, actuaries might be involved in the development, review, and CMS approval process for a state-directed payment preprint. However, once a state-directed payment is included under an MCO contract, it must be reflected in the capitation rates to be in compliance with actuarial soundness requirements.

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