



## Health Insurance Marketplaces: 10 Years of Affordable Private Plan Options

The Health Insurance Marketplaces established by the Affordable Care Act (ACA) were designed to harness the beneficial effects of consumer choice and insurer competition, while addressing fundamental problems of market failure that had long plagued the individual health insurance market. Between 2014 and 2024, the number of consumers selecting Marketplace plans has grown from 8 million to 21.4 million.

### KEY POINTS

- The Affordable Care Act substantially transformed the market for non-group private health insurance by creating Health Insurance Marketplaces that provide a new transparent market. Consumers can shop for private coverage that meets consumer protection and coverage standards, includes a comprehensive array of benefits, and allows consumers to choose from among a variety of health insurance plans with financial support in the form of Advanced Premium Tax Credits and Cost Sharing Reductions.
- Over the first 10 years of the Marketplace, enrollment has grown from 8 million individuals selecting plans in 2014 to 21.4 million in 2024. Enrollment growth has been especially strong among Black and Hispanic enrollees in recent years. Marketplace enrollment growth, coupled with the ACA expansion of Medicaid, has contributed to the historic growth in health insurance coverage since 2014.
- The recent period of strong enrollment growth has been accompanied by improvements to the affordability of Marketplace coverage: the American Rescue Plan and the Inflation Reduction Act have increased the generosity of tax credits for enrollees who were already eligible and expanded tax credits to those with household incomes above 400 percent of the Federal Poverty Level (FPL).
- In 2024, 95 percent of all HealthCare.gov enrollees received advanced payments of the premium tax credits. In 2023, the average HealthCare.gov enrollee with household income between 100 and 250 percent of FPL paid 7 percent of their premium out of pocket while enrollees with household income between 250 and 400 percent FPL paid 29 percent of their premium out of pocket.
- The number of issuers participating in Marketplaces has grown in recent years providing nearly all Marketplace consumers (96 percent) with a choice of plans from at least three different issuers.

## INTRODUCTION

Enacted in March 2010, the Patient Protection and Affordable Care Act (ACA) provided for comprehensive health reform that made significant improvements to the U.S. health care system. Federal consumer protections provided for under the law such as modified community rating, which prevents health insurers from varying premiums based on factors like gender or health status; ten categories of essential health benefits that health insurance plans must cover; a ban on lifetime and annual coverage limits; allowing young adults to stay on a parent's health plan until the age of 26; closing the Medicare prescription drug coverage gap for seniors; and guaranteeing preventive services without cost sharing and maternity coverage for women, have helped ensure that private health coverage is not only more affordable, but also more comprehensive. In addition, the ACA provided states the opportunity to expand Medicaid coverage to low-income non-disabled, childless adults.

The Health Insurance Marketplaces began enrolling individuals in 2014, the same year that the ACA Medicaid expansion went into effect. The Marketplaces changed the landscape of the individual health insurance market, and additional policy changes that have been made since their launch further bolstered their impact. Since 2013, the ACA Marketplaces and Medicaid expansions have contributed to substantial gains in health insurance coverage, with 19 million fewer uninsured individuals as of the third quarter of 2023, compared to the end of 2013.<sup>1,2</sup> In the 2024 Open Enrollment Period, 21.4 million individuals selected plans through Marketplaces.<sup>3</sup> As a result of the ACA Marketplaces, Medicaid expansion, and the Basic Health Plan, over 45 million Americans are enrolled in health coverage under the provisions of the ACA, the highest total on record.<sup>4</sup> Gains in coverage under the ACA include self-employed individuals, small business owners, and others without access to affordable insurance through their employer or Medicaid/CHIP. These historic gains, which can be seen across all demographic groups, have reduced coverage disparities by race and ethnicity.<sup>5</sup>

The purpose of this Issue Brief is to highlight research findings on the impacts of the Health Insurance Marketplaces in their first ten years. In addition, administrative data is examined to highlight specific trends.

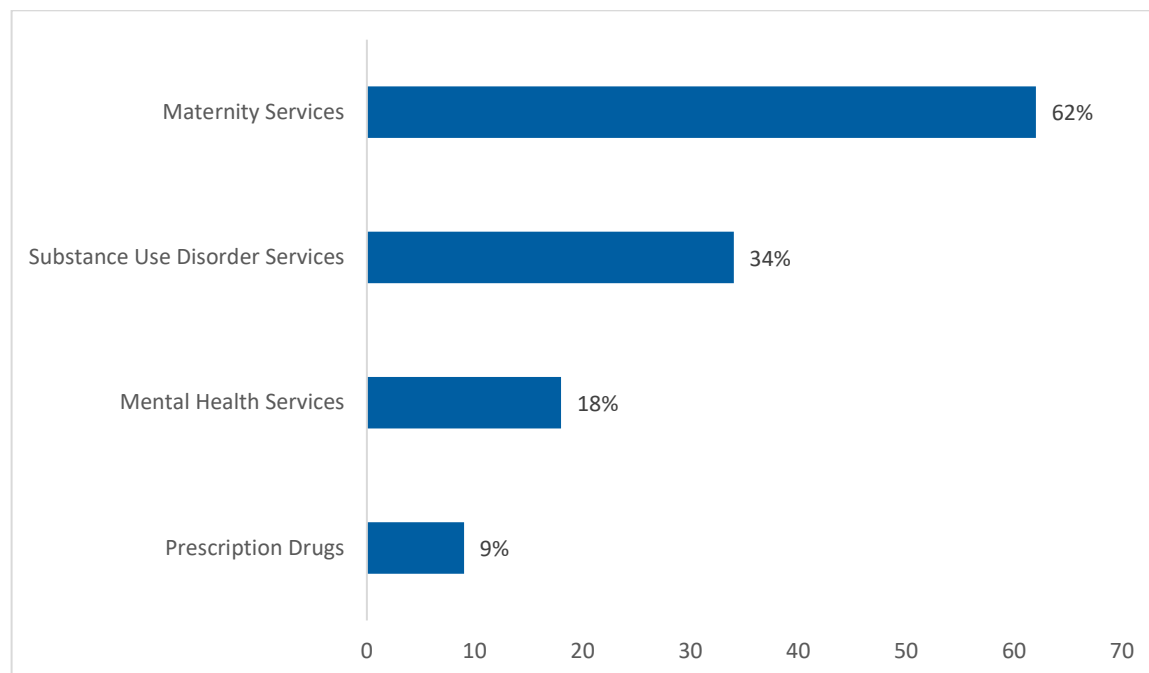
## BACKGROUND

The ACA included provisions to improve consumer access and affordability, addressing challenges in the individual health insurance market prior to the law's enactment. Before the ACA, individuals with pre-existing conditions could be denied health insurance coverage, charged more, or have limits placed on their benefits based on their health condition or gender. In 2001, an analysis found that a 24 year-old individual with hay fever was rejected 8 percent of the time and received a substandard offer of coverage 87 percent of the time; a 38 year-old breast cancer survivor was denied coverage 43 percent of the time and received a substandard offer of coverage 39 percent of the time; and a 36 year-old who was HIV-positive was denied coverage 100 percent of the time.<sup>6</sup> Insurers also often charged more based on gender, with 92 percent of best-selling plans using gender rating.<sup>7</sup> One study found that a woman could pay as much as 81 percent more for the same plan as a man of the same age, even without the plan covering maternity care.<sup>7</sup>

The ACA eliminated these discriminatory practices, requiring insurers to issue policies to all applicants (guaranteed issue) and preventing insurers from charging more based on health conditions or gender. The only risk factors that could be used to set premiums were age—the premium charged to the oldest consumers could be no more than three times the premium charged to a 20-year-old—geography, and smoking status. The law also required insurers to spend at least 80 or 85 percent of premium dollars on medical care (also known as a medical loss ratio), a standard that less than 50 percent of insurers in the individual market met before the ACA.<sup>8,9</sup>

Prior to the ACA, health plans also often limited the benefits they covered. In 2011, 62 percent of individual market enrollees did not have coverage for maternity services, 34 percent did not have coverage for substance use disorder services, 18 percent did not have coverage for mental health services, and 9 percent of enrollees did not have coverage for prescription drugs (Figure 1).<sup>10</sup> Coverage of preventive services was also limited. In 2013, 20 percent of men and 16 percent of women reported that they put off or postponed preventive services due to cost.<sup>11</sup> Individual market plans also frequently included annual and lifetime limits on the amount of coverage they would provide. In 2009, 89 percent of individual market plans included a lifetime limit, with limits averaging about \$5 million.<sup>12</sup>

**Figure 1: Percent of Individual Market Enrollees without Coverage of Specified Services Pre-ACA, 2011**



Source: Office of the Assistant Secretary for Planning and Evaluation, [Essential Health Benefits: Individual Market Coverage](#)

The ACA required small group and individual market health plans to cover 10 categories of essential health benefits, including ambulatory services; emergency services; hospitalization; pregnancy, maternity and newborn care; mental health and substance use disorder services; prescription drugs, rehabilitative and habilitative services and devices; laboratory services, preventive and wellness services; and pediatric services, including oral and vision care.<sup>13</sup> Importantly, preventive services must be covered with no cost-sharing. Today, these essential health benefits, including female contraception covered under the preventive health benefit, apply to the 150 million Americans who receive health insurance coverage through small and large groups and individual market insurance plans.<sup>14</sup> Lifetime limits, as well as limits on annual coverage, were eliminated under the ACA.

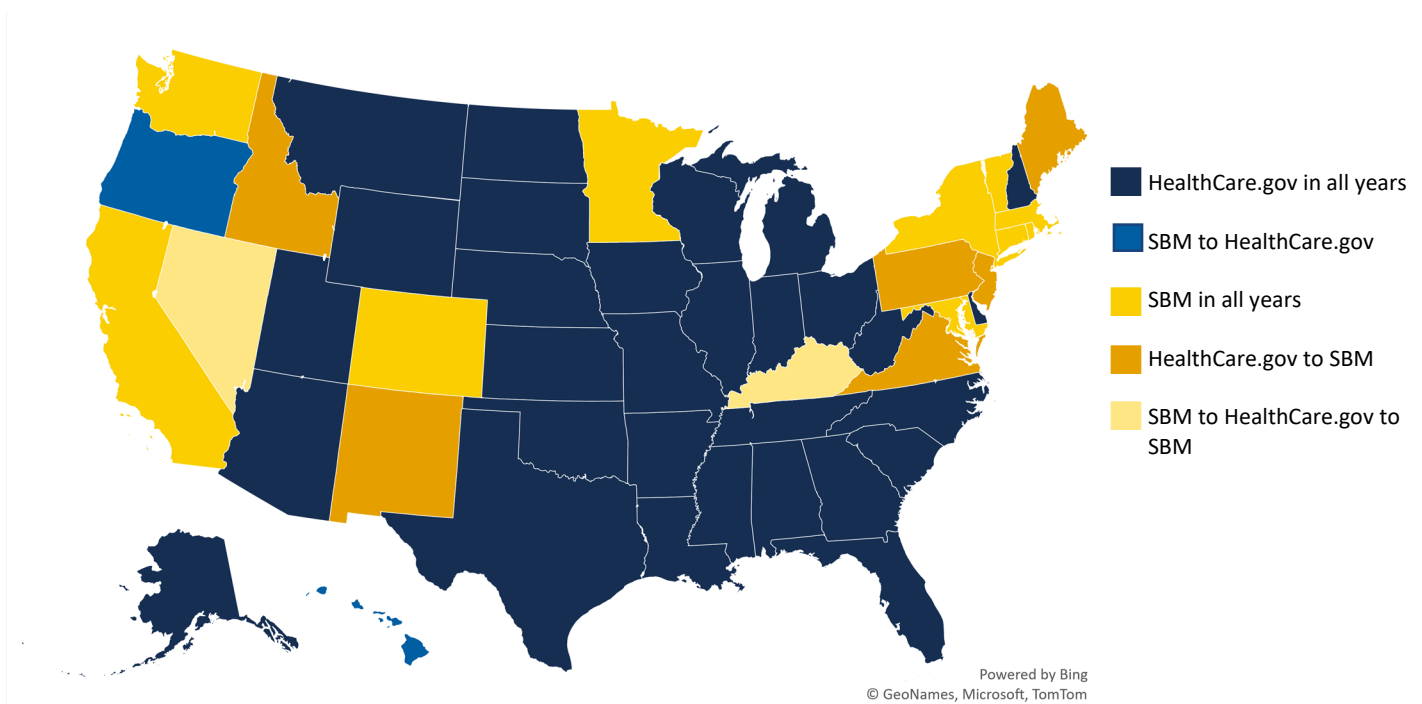
For healthy consumers who were able to obtain insurance pre-ACA, plan options were limited by high insurer concentration in many markets. In 2010, in 41 states and the District of Columbia, one issuer (Blue Cross Blue Shield) had more than 50 percent of the market share.<sup>15</sup> In 2013, the three largest insurers accounted for 75 percent or more of total non-group enrollment in 42 states.<sup>16</sup>

## The Design and Structure of ACA Health Insurance Marketplaces

The launch of the Health Insurance Marketplaces established a competitive private health insurance market that provided “one-stop shopping” for individual consumers and small businesses. While the ACA initially envisioned Marketplaces to be developed by states (i.e., State-based Marketplaces (SBMs)), it alternatively provided states with the option to participate in the Federally Facilitated Marketplace (FFM) where HHS performs all Marketplace functions and consumers apply for and enroll in coverage through the HealthCare.gov platform. In addition to operating the state eligibility and enrollment website, SBMs have more control over policy options, including plan management and marketing and outreach, which may provide states with additional opportunities for state innovation.<sup>17</sup> A subset of states that use HealthCare.gov, known as SBMs using the federal platform (SBM-FP), also retain control over plan management and marketing and outreach functions for their state.

Figure 2 summarizes the choices that states made initially when Marketplaces were implemented and how those choices have changed over time. In 2014, 14 states and the District of Columbia chose to operate their own SBM. In 2024, there were 19 SBMs, though the change represents the net effect of states that initially used HealthCare.gov deciding to operate their own SBM and transitions in the opposite direction.

**Figure 2: States Using HealthCare.Gov and State-Based Marketplaces, Plan Years 2014-2024**



Source: Office of the Assistant Secretary for Planning and Evaluation, Health Insurance Marketplace Open Enrollment Reports for [2014](#), [2015](#), and [2016](#); Centers for Medicare & Medicaid Services, 2017-2024 Health Insurance Marketplace Open Enrollment Reports available at: [https://www.cms.gov/marketplace/resources/forms-reports-other#Health\\_Insurance\\_Marketplaces](https://www.cms.gov/marketplace/resources/forms-reports-other#Health_Insurance_Marketplaces).

Notes: SBM-FPs are counted as HealthCare.gov states. California, Colorado, Connecticut, the District of Columbia, Maryland, Massachusetts, Minnesota, New York, Rhode Island, Vermont, and Washington operated their own SBMs in all plan years; Idaho began operating their own SBM in 2015, New Jersey and Pennsylvania in 2021, Maine and New Mexico in 2022, and Virginia in 2024; Nevada switched from an SBM to HealthCare.gov as an SBM-FP in 2015 and resumed operating an SBM in 2020 and Kentucky switched from an SBM to HealthCare.gov in 2017 and resumed operating an SBM in 2022; Oregon switched from an SBM to HealthCare.gov as an SBM-FP in 2015 and Hawaii switched from an SBM to HealthCare.gov in 2016; Arkansas switched to HealthCare.gov as an SBM-FP in 2017.

In order to help consumers differentiate between how costs are split between them and their plans, the ACA included four levels of plans, known as metal levels, based on the plan’s actuarial value (AV), or the percentage

of total average costs for covered benefits that a plan will cover, as well as catastrophic plans.<sup>18,19</sup> Bronze plans, which have an actuarial value of 60 percent, generally have the lowest monthly premium, but the highest out-of-pocket (OOP) costs when care is received. Silver, gold and platinum plans have AVs of 70, 80 and 90 percent, respectively. Higher AV plans generally have higher premiums.<sup>20</sup>

The ACA also provided for two types of subsidies for Marketplace consumers based on their household incomes: Advanced payments of the Premium Tax Credit (APTC) and cost-sharing reductions (CSRs). APTC, which lower the monthly premium consumers are required to pay for metal level plans, were initially made available for consumers with household incomes between 100 percent and 400 percent of the FPL who do not have an affordable offer of employer-sponsored insurance and are not eligible for a government program like Medicare or Medicaid.<sup>21</sup> The amount of APTC a consumer is eligible to receive is calculated based on the difference between the second lowest-cost silver plan available to them and the consumer’s expected contribution, which is calculated based on their household income and family size.<sup>22</sup> APTC is paid directly to insurers and reconciled on the consumer’s taxes. CSRs, which limit consumers’ OOP payments, are made available to consumers with household incomes up to 250 percent of the FPL who qualify for APTC and are enrolled in a silver plan.<sup>23</sup> Initially, CSRs were paid by the federal government directly to health insurance plans to offset the costs associated with the required reduced cost-sharing.<sup>24</sup>

## Policy Changes Since the Implementation of the Affordable Care Act

### Federal Policy Changes

Since the implementation of the ACA, federal policy changes have bolstered or hindered the success of the Marketplaces. In 2015, the first year that some consumers faced the choice of staying in their existing plan or switching, the Centers for Medicare & Medicaid Services (CMS) established an auto-enrollment process for individuals who were already in the market. This allowed consumers who were currently enrolled through the Marketplaces to be automatically enrolled into a plan without actively selecting a plan.

**Figure 3: Key Health Insurance Marketplace Policy Changes**



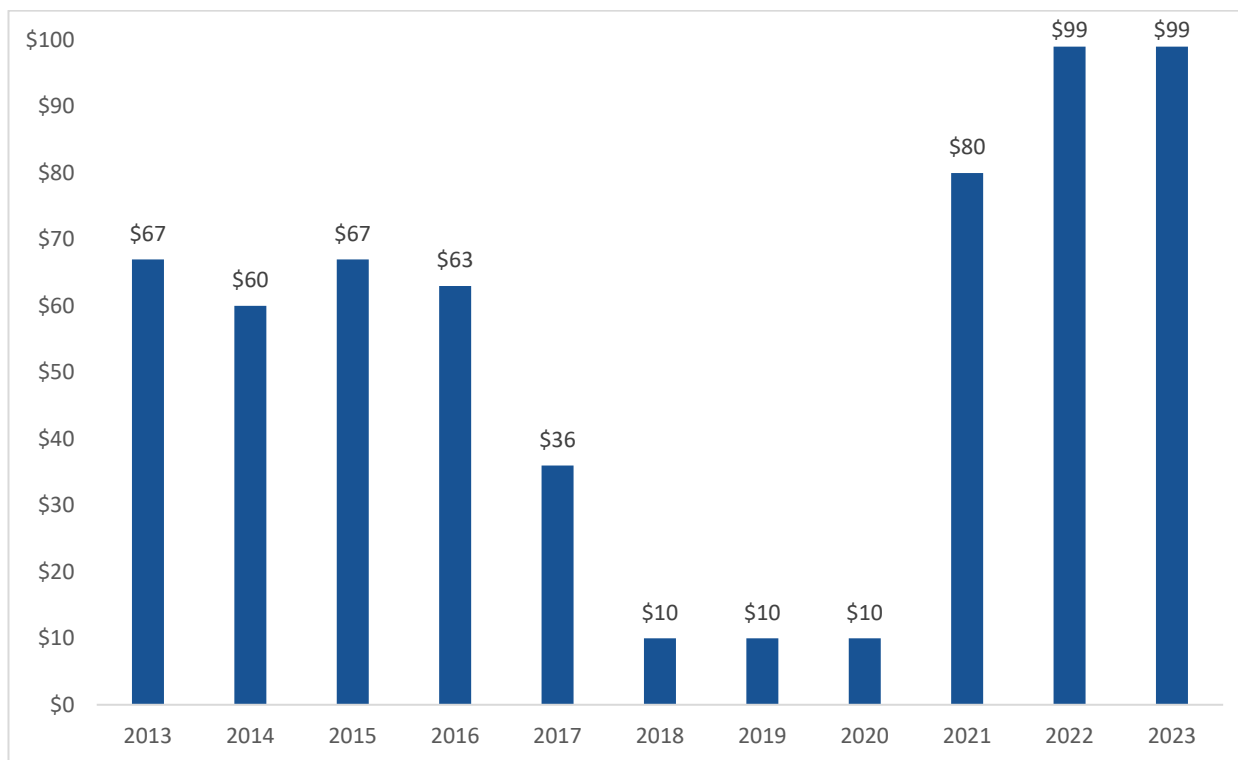
From 2017 through 2020 there were important policy changes that were seen as having negative effects on enrollment. One is a reduction in funding for marketing, outreach, and consumer education. When the Marketplaces were established, CMS funded grants to support Navigator programs in FFMs using HealthCare.gov that informed consumers of their coverage options and assisted them in making plan selections.<sup>†</sup> A number of studies have found that such efforts have important effects on coverage.<sup>25,26</sup> A 2015 study found greater awareness of the ACA was a strong predictor of applying for Medicaid or Marketplace coverage, while application assistance was a strong predictor of successful enrollment.<sup>27</sup> Despite this evidence,

\* Members of a federally recognized tribe or Alaska Native Claims Settlement Act (ANCSA) Corporation shareholders may qualify for additional CSRs for any metal level plan.

† SBMs and SBM-FPs are responsible for funding their Marketplace Navigator grants.

investments in FFM HealthCare.gov Marketplace Navigator grants were reduced by 85 percent between 2016 and 2018 (Figure 4) and spending on advertising was cut by \$90 million between 2016 and 2017.<sup>28</sup>

**Figure 4: Federal Investments in FFM HealthCare.gov Marketplace Navigator Grants, 2013-2023 (in millions)**



Source: Centers for Medicare & Medicaid Services, [In-Person Assistance in the Health Insurance Marketplaces](#)

Starting in 2021, the Biden-Harris Administration substantially increased funding for Navigators and instituted other policies aimed at reaching uninsured individuals and helping them enroll in coverage. The U.S. Department of Health and Human Services (HHS) launched targeted efforts to reach communities of color and other communities with disparities in health insurance coverage. Through “Weeks of Action,” HHS partnered with national organizations and provided tools to support outreach and enrollment for specific communities, such as Black Americans, Latinos, American Indians and Alaska Natives.<sup>29,30</sup> In 2023, more than 1,500 Navigators were available to assist consumers apply for and enroll in Marketplace coverage.<sup>31</sup> SBMs took additional steps to increase awareness of and enrollment in Marketplace coverage. As one example, a California program involving personalized phone calls was found to increase enrollment by 2.7 percentage points, providing a two-to-one return on investment.<sup>26</sup>

Additional special enrollment periods (SEPs), which allow people to enroll in coverage outside of the open enrollment period due to specific circumstances, have been added as well to provide new opportunities for people in need of insurance to get covered. Most notably, between February 2021 and August 2021 HealthCare.gov offered a SEP for all Marketplace-eligible consumers because of the exceptional circumstances of the COVID-19 public health emergency. Many SBMs offered similar SEPs. In 2022 and 2023, HealthCare.gov launched SEPs for certain consumers with household incomes at or below 150 percent of the FPL and those disenrolled from Medicaid due to the end of the continuous enrollment condition that had been in place during the COVID-19 public health emergency.<sup>32,33,34</sup>

Simplifying the shopping experience for Marketplace consumers can also make it easier for people to enroll in coverage. One way to do so is through the use of standardized health plans, which standardize cost sharing for

covered benefits.<sup>35</sup> Such plans make it easier for consumers to select a plan by reducing “choice overload” that may result from having an abundance of plan options with various cost-sharing features (deductibles, copays, and coinsurance) applied differently to different categories of benefits. That “choice overload” may make it challenging to understand and evaluate plan choices. In plan year (PY) 2023, CMS launched required standardized plan options on HealthCare.gov that offer the same cost-sharing features for certain benefits and the same out-of-pocket limits within the same health plan category.<sup>36</sup> This built on the “simple choice” plans that were available in PYs 2017 and 2018, which were standardized plans that issuers could choose to offer.<sup>37</sup> In PY 2024, CMS made further adjustments to continue to make it easier for consumers to select high-quality plans, limiting issuers to four non-standardized plan options per product network type, metal level, inclusion of dental and/vision coverage, and service area. In PY 2025 and beyond, two non-standardized plans will be allowed per product network type, metal level, inclusion of dental and/vision coverage, and service area.<sup>38</sup>

In addition to efforts to help new consumers enroll in coverage, there have been efforts to ensure covered individuals remain covered. As previously noted, in PY 2015, HealthCare.gov launched auto re-enrollment to automatically re-enroll consumers in a similar plan with their existing issuers to help more people remain covered.<sup>39</sup> This was subsequently updated in PY 2017 to automatically re-enroll consumers in a similar plan from a different issuer if their previous year’s issuer left the Marketplace and in PY 2024 to help more consumers take advantage of cost savings by re-enrolling certain individuals eligible for cost-sharing reductions into a silver, rather than bronze, plan.<sup>40,41</sup>

There have also been important efforts to make coverage more affordable. In 2021, the American Rescue Plan Act (ARP) increased Marketplace subsidies through 2022, and these increased subsidies were subsequently extended through 2025 by the Inflation Reduction Act of 2022 (IRA). These increased subsidies included lowering the percentage of income that consumers with household incomes between 100 and 400 percent of the FPL are expected to contribute towards their health insurance premiums and extending premium tax credits to household with household incomes above 400 percent of the FPL. ASPE estimated that in 2023, 13.3 million individual market enrollees received an increase in their premium tax credit, including those who newly received a tax credit as a result of the increased subsidies under the ARP.<sup>42</sup> In addition, in 2023, the Internal Revenue Service finalized a rule fixing the “family glitch,” which allows family members of workers who are offered employer-sponsored family coverage to qualify for premium tax credits if the offer of family coverage (instead of self-only coverage) is considered affordable based on household income.<sup>43</sup>

### ***State Innovations***

SBMs have the opportunity to implement innovations that go beyond that of the policy changes made on the federal level, including those that reduce barriers to enrollment, promote market competition, increase the affordability of coverage through financial assistance, and promote health equity. In order to reduce barriers to enrollment, nine states have undertaken action to streamline or automate enrollment, with five states creating “Easy Enrollment” programs that allow consumers to indicate if they are uninsured and interested in coverage on their tax forms and four states creating auto-enrollment programs.<sup>17</sup> In addition, eight states have established a Pregnancy SEP, which allows individuals to enroll in coverage after they learn they are pregnant.<sup>17</sup>

In order to promote market competition, six SBMs have implemented initiatives to require or incentivize insurer participation including requiring participation in the Marketplace for eligibility for other contracts (e.g., state employee benefit programs) or requiring that issuers participate in the Marketplace to sell individual market plans.<sup>17</sup> Some states have also built on the subsidies offered by the federal government in order to increase the affordability of plans for consumers in their states, with nine states offering additional marketplace subsidies or cost-sharing reductions for their residents through a variety of mechanisms and structures.<sup>44</sup> Several states have implemented requirements for plans to include equity-based design

requirements aimed at key disparities, for example, reducing or eliminating cost-sharing for services related to conditions like diabetes that are disproportionately prevalent among people of color.<sup>45</sup>

## DATA

The main source of data for this Issue Brief is the CMS HealthCare.gov administrative enrollment data, which includes information on HealthCare.gov plan selection premiums, metal type, APTC calculations, and enrollee level economic and demographic characteristics like household modified adjusted gross income (MAGI) and age. For some outcomes the most recent data available are from PY 2024. For others, the most recent data are from PY 2023.

A key limitation of the enrollment dataset is that it does not provide information for SBMs. As well, because the set of states using HealthCare.gov has changed over time, trends in enrollee characteristics and market outcomes should be interpreted with caution.

Individuals can voluntarily report their race and ethnicity when applying for coverage through the Marketplaces, but this information is not reported by many enrollees. For example, in 2023 over 45 percent of Marketplace enrollees have missing race and ethnicity information in 2023 HealthCare.gov administrative enrollment data. We impute missing race and ethnicity information using the modified Bayesian Improved First Name Surname Geocoding (mBIFSG) method developed by RAND. This approach has been validated and described in more detail in previous publications.<sup>46,47</sup>

## KEY INDICATORS OF MARKETPLACE PERFORMANCE

### *Trends in Marketplace Enrollment and Overall Insurance Coverage*

Figure 5 presents Marketplace enrollment from 2014 to 2024. To put these data in context, Figure 6 presents the national uninsured rate from 2000 to 2023 and Figure 7 presents changes in the uninsured rate between 2013 and 2023 by race and ethnicity.

In its first year of operation, 5.4 million people enrolled in Marketplace coverage in HealthCare.gov states and 2.6 million people enrolled in SBM states, for a total enrollment of 8 million. Enrollment grew by nearly 50 percent to 11.7 million in 2015. Research indicates that a large share of Marketplace enrollees would have otherwise been uninsured. One study using longitudinal data found that the establishment of the Marketplaces led to a large increase in insurance coverage among previously uninsured individuals with incomes just above the ACA Medicaid expansion income eligibility threshold of 138 percent of FPL and that this coverage gain translated to improved access to health care.<sup>48</sup> Another study estimated that Marketplace premium tax credits accounted for 40 percent of the ACA's immediate effect on insurance coverage gains, with the expansion of Medicaid accounting for roughly 60 percent.<sup>49</sup> Between 2013 and 2015, the national uninsured rate fell from 11.5 percent to 9.1 percent (Figure 6).<sup>50</sup>

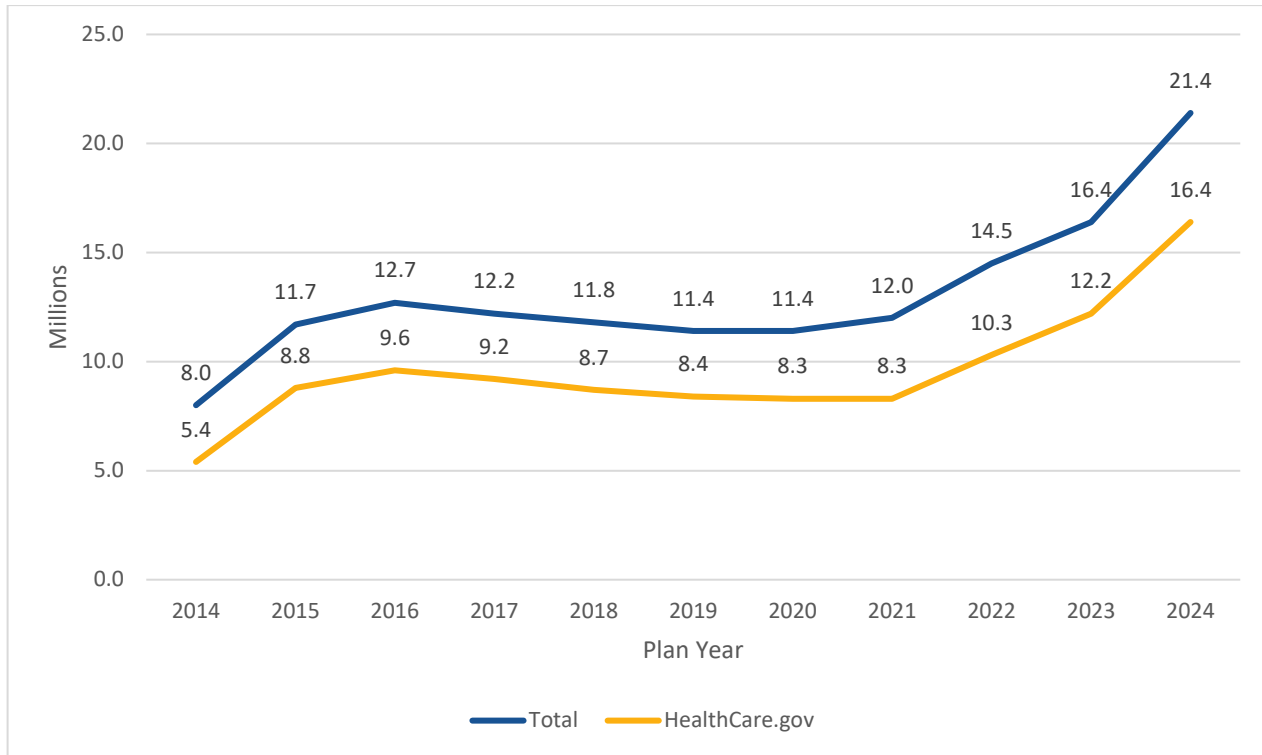
Between 2015 and 2016, Marketplace enrollment grew by 8.5 percent to 12.7 million before falling to 11.8 million in 2018. Enrollment remained below 12 million through 2020. The decrease in funding for Marketplace navigators, decrease in advertising plus premium rate increases associated with the elimination of federal cost sharing payments to issuers may have contributed to the lower enrollment after 2016. Between 2016 and 2020, the national uninsured rate increased from 9.0 to 9.7 percent (Figure 6).

As noted above, since 2021 there have been several important policies aimed at supporting Marketplace coverage. While it is not possible to separately identify the effect of the enhanced and expanded tax credits, increased funding for outreach and enrollment assistance, and the flexibility afforded by SEPs, the combined effect of these policies is evident in Figure 5. Marketplace enrollment increased by 2.5 million between 2021



and 2022 and by another 1.9 million in 2023. Between 2021 and the third quarter of 2023, the uninsured rate for all ages fell from 9.2 percent to 7.7 percent. In Q3 2023, the uninsured rate for non-elderly adults was 11.4 percent, down from 20.4 percent in 2013. Between 2013 and Q3 2023, the uninsured rate for children decreased from 6.5 percent to 3.4 percent.<sup>51,2</sup>

**Figure 5: Total Open Enrollment Plan Selections in all States and in HealthCare.gov States<sup>‡</sup>**

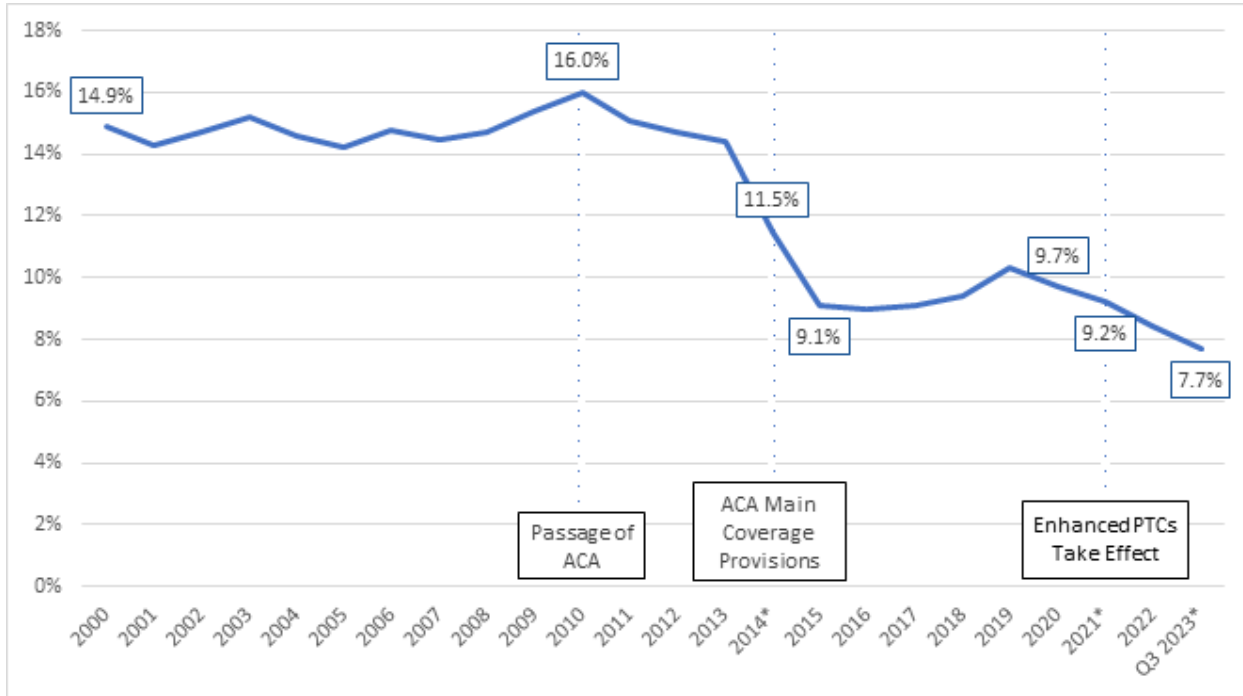


Source: Centers for Medicare & Medicaid Services, [2017-2024 Health Insurance Marketplaces Open Enrollment Reports](#)

As of the end of the annual Open Enrollment Period, 21.4 million individuals had made a Marketplace plan selection for 2024. More than 5 million open enrollment enrollees were new consumers, an increase of 41 percent from 2023.<sup>3</sup>

<sup>‡</sup> Effectuated enrollment as of February 2024 is estimated to be 20.5 million. These individuals paid the premium or otherwise completed enrollment for their first month of coverage. <https://aspe.hhs.gov/reports/aca-related-enrollment-february-2024>

**Figure 6: National Uninsured Rate, All Ages, 2000 – Q3 2023**



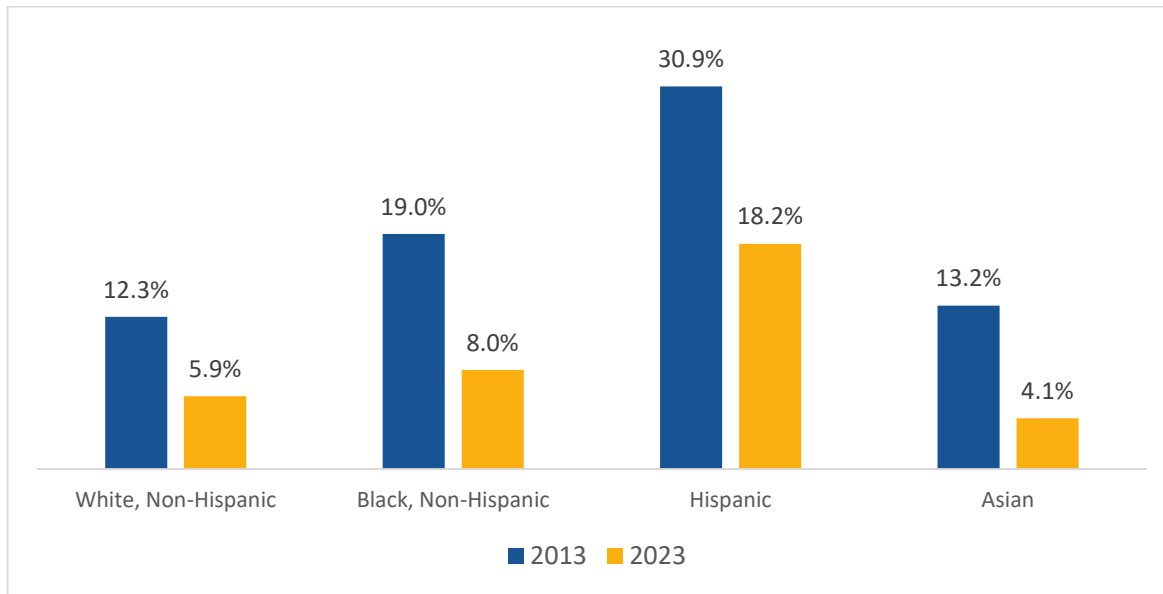
Source: National Center for Health Statistics, [National Health Interview Survey's Health Insurance Coverage Reports, 2000-2022](#); [Health Insurance Coverage: Early Release of Quarterly Estimates from the National Health Interview Survey, July 2022–September 2023](#).

Note: \*The ACA's individual and employer responsibility provisions, state insurance Exchanges, Medicaid expansions, and subsidies went into effect in 2014. The ARP's premium tax credit provisions were effective for PY2021 and PY2022, and the IRA extended these provisions for PY2023 through PY2025.

Figure 7 reports trends in the uninsured rate for White, Black, Asian, and Latino individuals under age 65 in the first six months of 2013, just before the main ACA coverage provisions went into effect, and the first 6 months of 2023. The uninsured rate decreased substantially for all groups, though the coverage gains were largest for Blacks and Latinos. As a result, disparities in coverage are significantly smaller than prior to the ACA, though large differences remain.

Appendix Table 1 presents state level Open Enrollment plan selections for the years 2020 to 2024. Nationally, plan selections more than doubled over this period. Between 2023 and 2024, 44 states experienced double-digit rates of plan selection growth, with three states—Florida, Georgia and Texas—accounting for roughly half of the total growth in Marketplace enrollment. In 2024, plan selections exceeded one million in each of those three states as well as in California and North Carolina.

**Figure 7. Uninsured Rate, Ages 0-64 Without Insurance by Race and Ethnicity, 2013 and 2023**



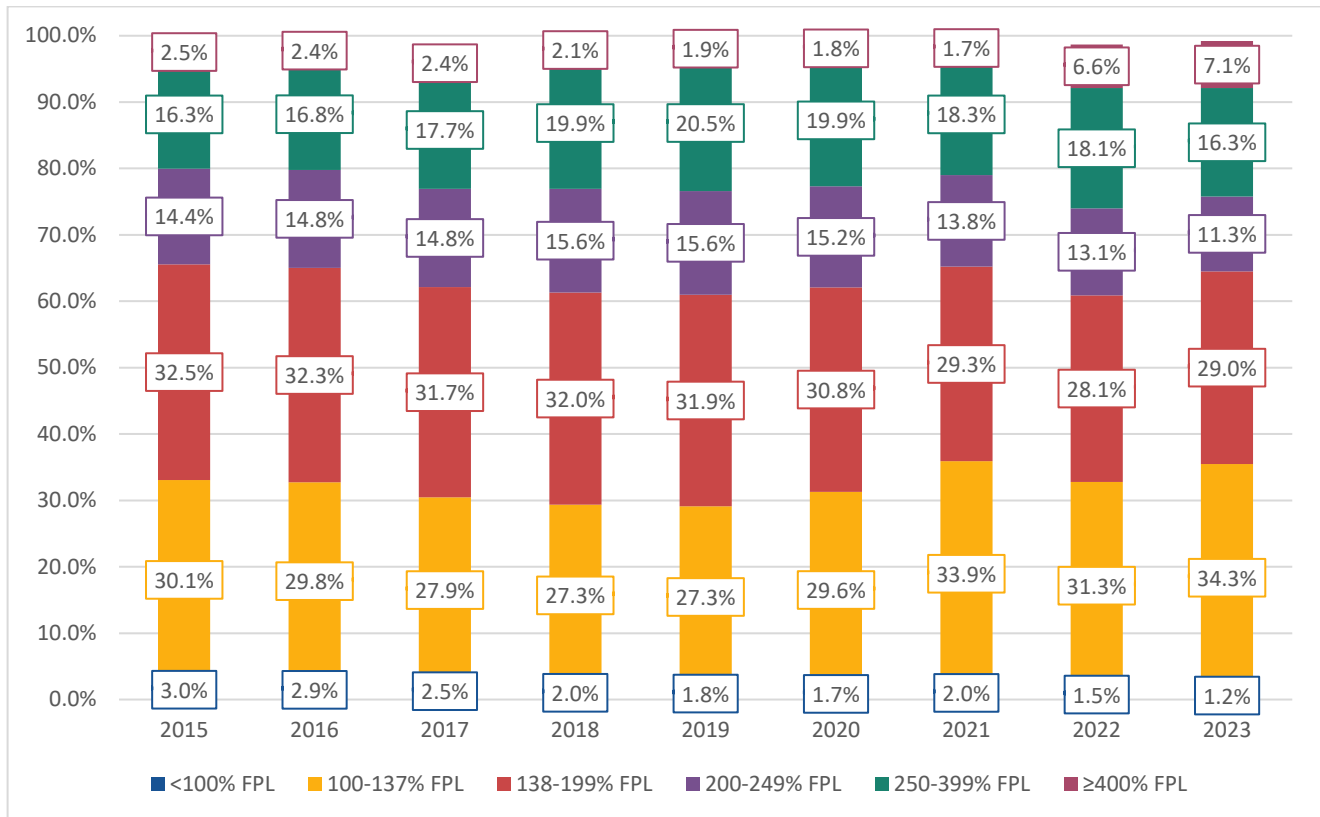
Source: National Center for Health Statistics, [National Health Interview Survey's Health Insurance Coverage Report, 2013](#); National Center for Health Statistics, [Health Insurance Coverage: Early Release of Quarterly Estimates From the National Health Interview Survey, July 2022–September 2023](#)

### *Enrollee Characteristics*

Figure 8 presents information on how the income distribution of HealthCare.gov Marketplace enrollment has changed since 2015. In all years, a majority of consumers had household incomes between 100 and 200 percent of FPL. In the early years, there were relatively few consumers in the lowest income category (less than 100 percent FPL) and highest income category (above 400 percent FPL), neither of which qualified for APTC.<sup>§</sup> The number and share of enrollees in the lowest income category, which includes individuals in states that chose not to expand Medicaid under the ACA, fell slightly over time. The share of HealthCare.gov consumers with incomes above 400 percent of FPL remained low from 2015 to 2021 before increasing in 2022, from 1.7 percent to 6.6 percent, coincident with the extension of APTC eligibility to higher income households as a result of the ARP.

<sup>§</sup> Immigrant applicants who are ineligible for Medicaid due to immigration status are not ineligible for APTC with annual household income below 100% FPL.

**Figure 8. HealthCare.gov Marketplace Open Enrollment Plan Selections by Income Category, 2015 to 2023**



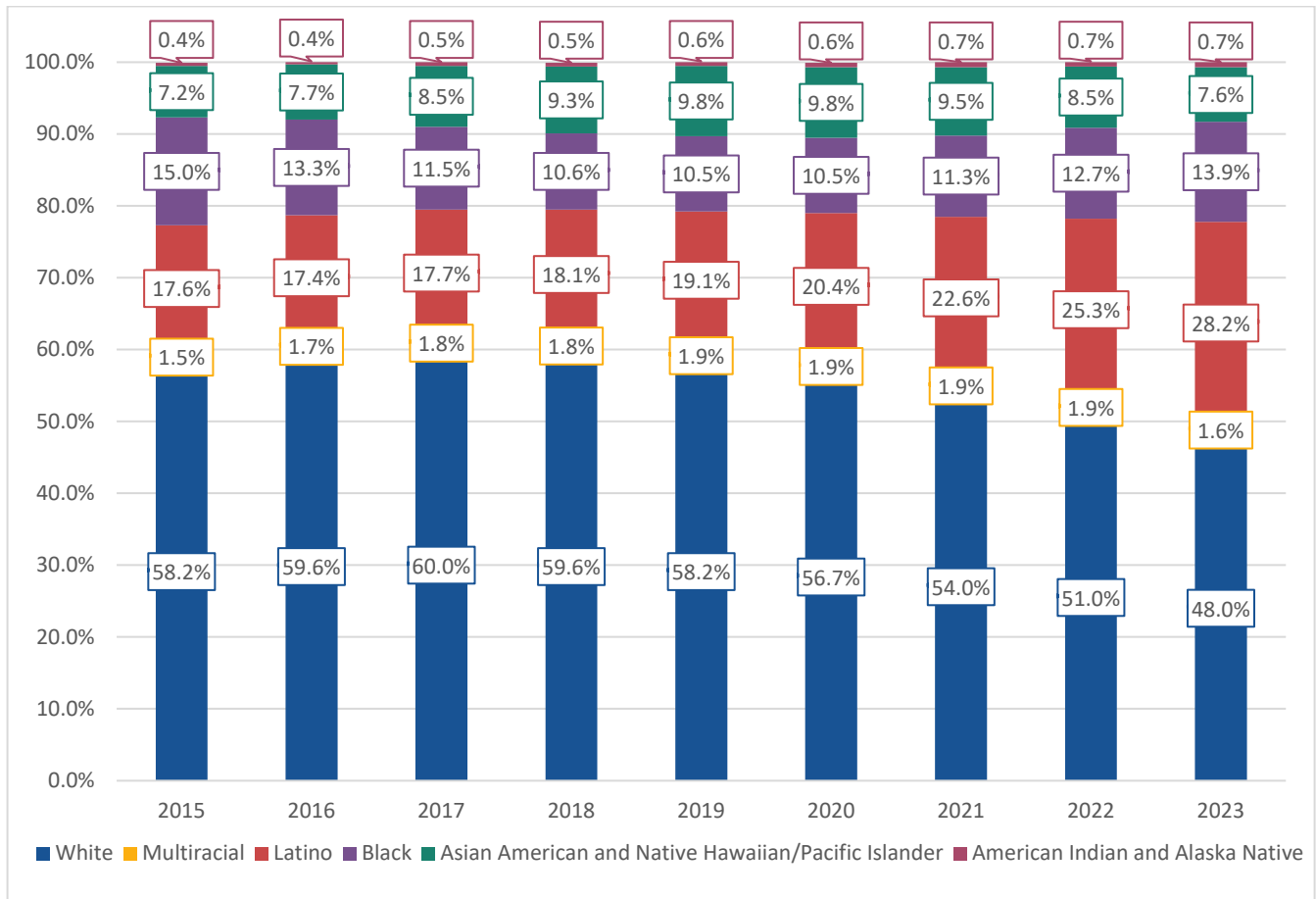
Source: ASPE analysis of HealthCare.gov data Open Enrollment Periods, 2015-2023.

Notes: Sample excludes enrollees with unknown income, including those who do not request APTC. Income categories are based on attested income.

Another ASPE Issue Brief provides detailed information on trends in HealthCare.gov plan selections by race and ethnicity from 2015 to 2023.<sup>52</sup> Results presented there indicate that between 2020 and 2023 plan selections among Black and Latino populations roughly doubled, and all other identified groups experienced double-digit rates of enrollment growth. These gains suggest the success of HHS’s targeted outreach efforts aimed at communities of color.

Figure 9 presents information on how the race and ethnicity composition of HealthCare.gov enrollment evolved from 2015 to 2023. The percentage of enrollees who are White was roughly 60 percent in the early years, declining to 48 percent in 2023. Latinos experienced the greatest growth in their share of total enrollment, rising from just under 18 percent in 2015 to over 28 percent in 2023. Because of the substantial enrollment growth among Blacks between 2020 and 2023, the percentage share of enrollees who are Black increased by over 3 percentage points, though the share of total enrollment is still lower than in 2015 (13.9 vs. 15.0). The Asian American and Native Hawaiian/Pacific Islander share of HealthCare.gov enrollment fluctuated between 7 and 10 percent over the period shown.

**Figure 9. HealthCare.gov Marketplace Open Enrollment Plan Selections by Race and Ethnicity, 2015 to 2023**



Source: ASPE analysis of HealthCare.gov data Open Enrollment Periods, 2015-2023. <https://aspe.hhs.gov/reports/marketplace-enrollment-race-ethnicity2015-2023>

### Insurer Participation and Plan Choice

The design of the Marketplaces is based on the concept of managed competition.<sup>53</sup> A basic tenet of this model is that competition among plans on the basis of price and quality will control costs and maximize consumer welfare. Empirical research indicates that more insurers competing in a market leads to lower premiums and lower premium growth.<sup>54,55,56,57,58</sup> Therefore, the number of insurers participating in the market is an important performance indicator.

Table 1 provides summary information on insurer participation and its implications for consumers. The table gives the county-level distribution of plan issuers\*\* weighted by Open Enrollment plan selections in each county. In the early years of the Marketplaces, there was concern that low participation would mean that in some markets, consumer options would be limited, and competition would be insufficient to hold down premiums. In the first year of operations, three-quarters of Marketplace consumers lived in markets with three or more participating issuers, while 7 percent were in markets with only one. In the next two years, options available to consumers expanded and by 2016, only 2 percent lived in markets with only a single issuer.

\*\* Issuer refers to the unique Center for Consumer Insurance and Oversight Office’s Health Insurance Oversight System (HIOS) ID. A HIOS ID is state-specific and a parent organization may have more than one HIOS ID in a state, for example, a HIOS ID for its PPO and another HIOS ID for its HMO.

This favorable trend reversed in 2017 as some insurers exited the ACA Marketplaces. In 2017, the percentage of consumers living in markets with just one issuer increased from 2 percent to 21 percent and the percentage in markets with three or more participating issuers fell by 30 percentage points, to 56 percent. In 2018, there were over 1000 counties in Healthcare.gov states, accounting for 29 percent of enrollment, with only one issuer.

Between 2019 and 2020, the total number of issuers participating in the ACA Marketplaces increased from 155 to 175 and the percentage of Marketplace enrollees in markets with only one issuer declined from 20 to 12 percent. The number of participating issuers increased in each of the next two years, before falling slightly in 2024. In 2024, 96 percent of Marketplace consumers can choose from a menu that includes plans offered by at least three different issuers. However, while the number of issuers participating in the Marketplaces has increased, the individual and small group health insurance markets in most states remain highly concentrated.<sup>59</sup>

**Table 1: Number of Issuers Participating in HealthCare.gov States in Plan Years 2014 - 2024**

Plan Year	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Total Number of HealthCare.gov States	34	34	38	39	39	39	38	37	33	33	32
Total Number of Issuers	191	252	237	167	132	155	175	181	213	219	210
States with only 1 issuer	2	1	1	5	8	5	1	1	1	0	0
States with counties with 1 issuer	15	10	7	23	27	24	27	15	10	9	9
Percentage of Enrollees with choice of only 1 issuer	7%	2%	2%	21%	29%	20%	12%	4%	2%	1%	<1%
Percentage of Enrollees with choice of 2 issuers	18%	8%	11%	23%	26%	22%	20%	17%	9%	6%	4%
Percentage of Enrollees with choice of 3+ Issuers	75%	90%	87%	56%	44%	58%	68%	78%	89%	92%	96%

Source: Centers for Medicare & Medicaid Services, [2024 QHP Premiums Choice Appendix](#)

The Marketplace brought the opportunity for new issuers to enter the individual insurance market. Plans offering only Medicaid coverage that did not offer individual insurance market coverage prior to the ACA, began offering individual coverage and participating in the Marketplaces. In 2014 such plans had only four to five percent of the total enrollment on HealthCare.gov but grew to 31 percent by PY 2021.<sup>60</sup> These plans include for-profit companies like Centene and Molina as well as regional and state nonprofit issuers such as CareSource, Intermountain, and Baylor. Marketplace issuers with little or no prior individual market experience also include non-profit CO-OPs,<sup>††</sup> as well as tech-oriented start-ups, such as Oscar. Large national companies such as Aetna, Anthem, Cigna and UnitedHealthcare, that participated in early years and then stopped offering plans in some or all counties, later re-entered with more competitive premiums.<sup>61</sup> Blue Cross Blue Shield issuers continue to remain the largest type of issuer with 34 percent of HealthCare.gov enrollment in PY 2022.

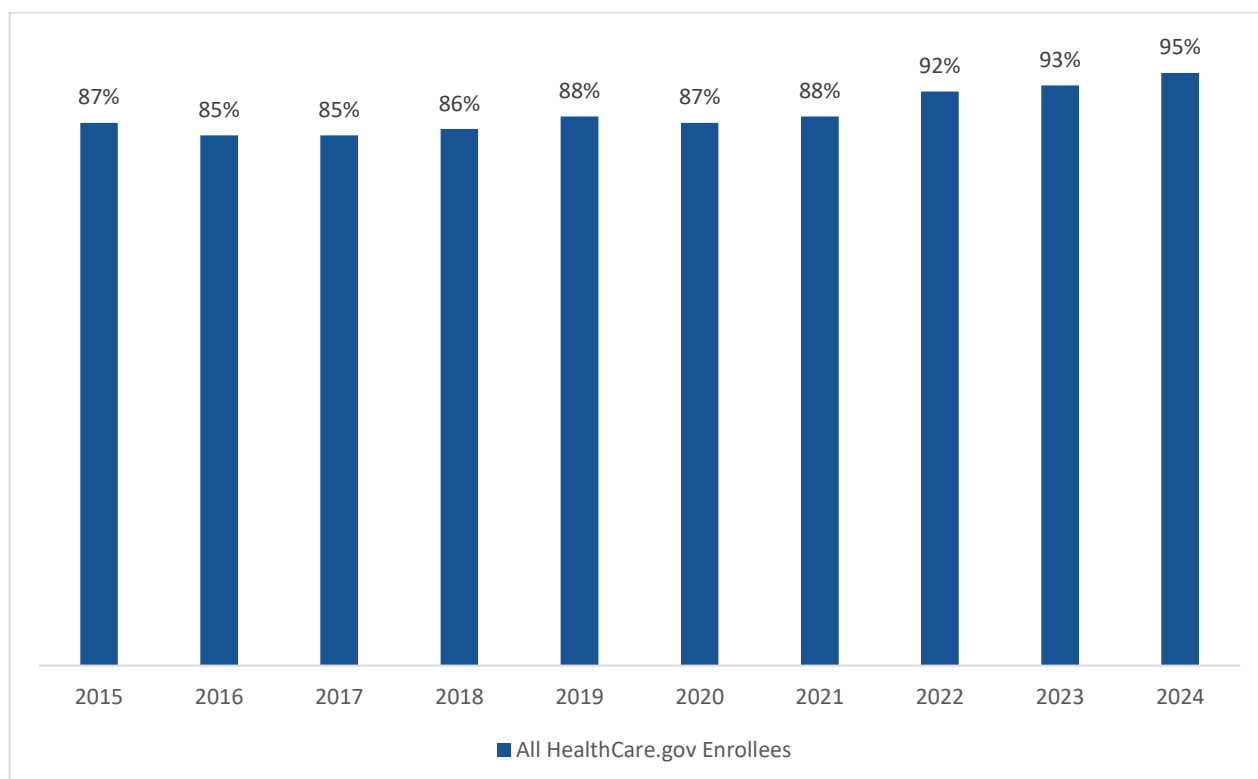
<sup>††</sup>There were 23 nonprofit CO-OPs in PY 2014 but only 3 CO-OPs in PY 2024 operating in five states.

### Advanced Payments of the Premium Tax Credits and Average Premiums

Since the Marketplaces were first established, the vast majority of enrollees in HealthCare.gov received APTC to cover some or all of their premium payments. Figure 10 presents data from 2015 to 2023 on the percentage of HealthCare.gov enrollees receiving APTC. From 2015 to 2020, the percentage ranged from 85 to 87 percent. As a result of the expansion of APTC eligibility to consumers with household incomes above 400 percent of FPL, the percentage increased to 92 percent in 2022 and 93 percent in 2023. This includes 99 percent of enrollees with household incomes between 100 and 249 percent of FPL, 96 percent of enrollees with household incomes between 250 and 400 percent of FPL and 70 percent of enrollees with household incomes greater than 400 percent of FPL (data not shown). By 2024, 95% of HealthCare.gov enrollees received APTC.

In addition, in 2024, 50 percent of all Marketplace enrollees—53 percent in HealthCare.gov and 39 percent in SBMs – received a CSR to help offset the costs associated with their deductible, co-insurance, and co-payments. For roughly three-quarters of HealthCare.gov enrollees receiving a CSR, the CSR raised the effective AV of their selected plan to 94 percent.<sup>3</sup>

**Figure 10: Share of Enrollees Receiving APTC, 2015-2023 (States using HealthCare.gov)**



Source: Marketplace Plan Selection Data for PY 2015-2024, HealthCare.gov States.

Notes: Analysis excludes enrollees selecting catastrophic plans.

Figure 11, which plots average Marketplace premiums before and after the application of APTC, illustrates how APTC, which are directly related to the second lowest cost silver plan premium, protect consumers from premium increases.

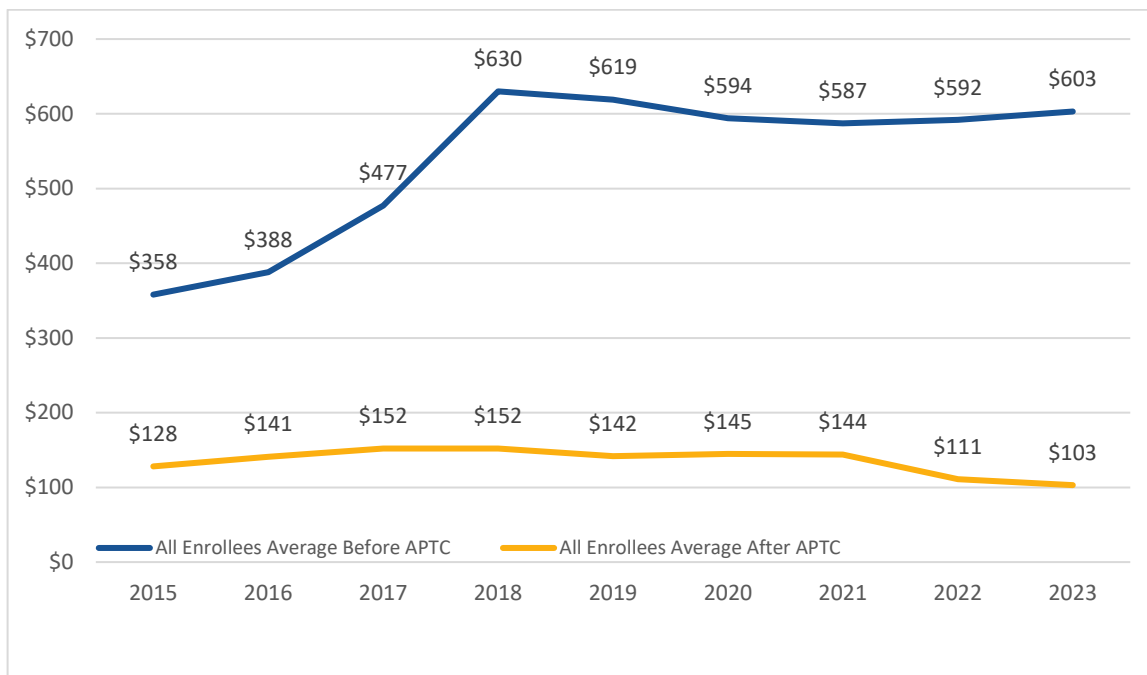
In addition to factors that generally affect health insurance premiums, several policy changes contributed to higher premiums starting in 2016. Legislation passed in December 2014 limited the funding sources available for the Risk Corridor program, which was designed to stabilize the market by compensating insurers that experienced high medical claims relative to the premiums they collected. One study found that this policy

change contributed significantly to higher premiums in 2016 and 2017.<sup>62</sup> In October 2017, HHS ceased making CSR payments to issuers, though issuers were still required to provide CSRs to enrollees qualifying them. To cover the cost of these benefits, insurers in most states<sup>63</sup> raised premiums for silver plans, a practice referred to as “silver loading.” Cessation of CSR payments was estimated to increase silver premiums by 10 percent.<sup>64</sup> Other research concludes that the elimination of the individual mandate penalty and the introduction of rules allowing more non-comprehensive coverage options (short-term limited duration insurance and association health plans) also contributed to higher Marketplace premiums.<sup>65</sup>

These increases in premiums increased the financial burden on Marketplace enrollees who did not qualify for APTC.<sup>66</sup> However, the vast majority of enrollees were shielded from these increases because they received APTC. As a result, average out-of-pocket premiums changed very little between 2016 and 2018.

Average premiums, both before and after APTC, began to fall in 2019, perhaps as a result of increased issuer participation in many markets. The expansion of APTC to enrollees with higher household income and the increase in APTC generosity for those already eligible led to a larger decrease in average net premiums in 2022 and 2023. In 2015, the average net premium was 36 percent of the average gross premium. In 2023, this ratio was down to 17 percent.

**Figure 11. Average Gross (before APTC) and Net (after APTC) Marketplace Premiums, 2015-2023**



Source: Marketplace Plan Selection Data for PY 2015-2023, Healthcare.gov States.

Notes: Analysis excludes enrollees selecting catastrophic plans. Due to this exclusion, numbers may differ slightly from those reported in [CMS Health Insurance Marketplaces Open Enrollment Reports](#).

Table 2 reports the average APTC received and the average share of premium paid OOP by income category from 2015 to 2023. In 2015, the average APTC received by enrollees with household incomes between 100 and 249 percent of FPL was \$271 per month, which covered roughly three-quarters of the total premium for their selected plan. As gross premiums increased, the average APTC received by this income group more than doubled between 2015 and 2018 and the share of premiums paid OOP fell from 26 percent to 15 percent. The share of premiums paid by this income group decreased to 9 percent in 2022 as a result of the ARP. In 2023, the average HealthCare.gov enrollee with household income between 100 and 250 percent of FPL paid 7 percent of their premium OOP. The average APTC received by HealthCare.gov enrollees with household



incomes between 250 and 400 percent of FPL increased by 170 percent between 2015 and 2018, causing the share of premiums paid OOP to fall from 62 to 35 percent over this period. By 2023, APTC covered 71% of the premium for plans selected by HealthCare.gov enrollees in this income group.

As noted, individuals with household incomes above 400 percent of FPL were not eligible for APTC prior to the ARP expansion, which went into effect in 2022. That year the average HealthCare.gov enrollee in this income category received APTC of \$225, which covered one third of the premium for their selected plan.

**Table 2: APTC Amount Received and Share of Premium Paid OOP, By Income Level, 2015-2023 (States using HealthCare.gov)**

Plan Year	2015	2016	2017	2018	2019	2020	2021	2022	2023
Share of Premium Paid OOP (100-249% FPL)	26%	25%	21%	15%	14%	15%	15%	9%	7%
Share of Premium Paid OOP (250-400% FPL)	62%	62%	53%	35%	35%	37%	39%	30%	29%
Share of Premium Paid OOP (>400% FPL)	100%	100%	100%	100%	100%	100%	100%	67%	67%
APTC Amount (100-249% FPL)	\$271	\$296	\$385	\$556	\$549	\$519	\$514	\$546	\$561
APTC Amount 250-400% FPL)	\$163	\$182	\$274	\$441	\$430	\$398	\$375	\$418	\$430
APTC Amount (> 400% FPL)	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$225	\$241

Source: Marketplace Plan Selection Data for PY 2015-2023, Healthcare.gov States.

Notes: Sample does not include enrollees who do not request financial assistance who do not report their income or enrollees selecting catastrophic plans.

Because of the way that the APTC was enhanced and expanded under the ARP and the IRA, significantly more Marketplace enrollees are able to enroll in plans with low premiums. A 2021 ASPE report calculated the change in the availability of \$0 premium plans and plans with premiums of \$50 or less per month for HealthCare.gov enrollees after the new APTC policy went into effect.<sup>67</sup> Prior to the ARP enhancements, roughly 90 percent of HealthCare.gov enrollees with household incomes between 100 and 200 percent of FPL could select a \$0 premium plan and nearly all had the option of at least one plan with a premium of less than \$50 per month. After the ARP, the percentage of enrollees in this income group able to select a \$0 plan increased to 95 percent. The ARP had the greatest effect on the availability of low-premium options for enrollees with slightly higher household incomes. For example, the percentage of enrollees with household incomes between 200 and 250 percent of FPL able to select a \$0 premium plan increased from 53 to 86 percent as a result of the ARP. Overall, the percentage of HealthCare.gov enrollees able to select a \$0 premium plan increased from 66 to 79 percent as a result of the ARP. In the 2024 Open Enrollment Period, four out of five consumers could choose a plan with a \$10 monthly premium after APTC on HealthCare.gov.<sup>68</sup>

## CONCLUSIONS

The Health Insurance Marketplaces established by the ACA were designed to provide affordable private health insurance options for individuals and families who were not eligible for Medicaid or other public health coverage and did not have access to affordable employer-sponsored coverage. The Marketplaces were designed to harness the beneficial effects of consumer choice and insurer competition, while addressing fundamental problems of market failure that had long plagued the individual health insurance market.

In the decade since they were first established, Marketplace enrollment has nearly tripled. In the 2024 Open Enrollment period, 21.4 million consumers selected Marketplace plans. Issuer participation has increased over time and in 2024, over 95 percent of enrollees have a choice of plans offered by at least three distinct issuers.

Over 90 percent of Marketplace enrollees receive tax credits to defray the cost of coverage. Because tax credits are based on the premium for the second-lowest cost silver plan in the market, Marketplace enrollees are shielded from year-to-year premium increases. The financial support available to Marketplace enrollees increased substantially starting in 2021 as a result of legislation—first the ARP and then the IRA—that expanded eligibility for and increased the generosity of the APTC. For lower-income enrollees, this financial assistance is substantial, ensuring access to \$0 or low premium plans. Additional finance support in the form of cost sharing reductions limits enrollee exposure to out-of-pocket costs when they seek care.

If the expanded subsidies made available under the ARP and IRA are not extended, enrollees would face greater costs, resulting in a significant decrease in the number of consumers with access to low premium plans. Such increasing costs would make health insurance less affordable to Marketplace consumers and could impact the recent coverage gains.

## APPENDIX

Appendix Table 1: Marketplace Plan Selections by State, 2020 to 2024

State	2020	2021	2022	2023	2024
Alabama	160,429	169,119	219,314	258,327	386,195
Alaska	17,696	18,184	22,786	25,572	27,464
Arizona	153,020	154,504	199,706	235,229	348,055
Arkansas	64,360	66,094	88,226	100,407	156,607
California	1,538,819	1,625,546	1,777,442	1,739,368	1,784,653
Colorado	166,852	179,607	198,412	201,758	237,106
Connecticut	107,833	104,946	112,633	108,132	129,000
Delaware	23,961	25,320	32,113	34,742	44,842
Dist. Of Columbia	17,538	16,947	15,989	14,768	14,799
Florida	1,913,975	2,120,350	2,723,094	3,225,435	4,211,902
Georgia	463,910	517,113	701,135	879,084	1,305,114
Hawaii	20,073	22,903	22,327	21,645	22,170
Idaho	78,431	68,832	73,359	79,927	103,783
Illinois	292,945	291,215	323,427	342,995	398,814
Indiana	140,931	136,593	156,926	185,354	295,772
Iowa	54,586	59,228	72,240	82,704	111,423
Kansas	85,837	88,627	107,784	124,473	171,376
Kentucky	83,139	77,821	73,935	62,562	75,317
Louisiana	87,748	83,159	99,626	120,804	212,493
Maine	62,031	59,738	66,095	63,388	62,586
Maryland	158,934	166,038	181,603	182,166	213,895
Massachusetts	319,612	294,097	268,023	232,621	311,199
Michigan	262,919	267,070	303,550	322,273	418,100
Minnesota	110,042	112,804	121,322	118,431	135,001
Mississippi	98,892	110,966	143,014	183,478	286,410
Missouri	202,750	215,311	250,341	257,629	359,369
Montana	43,822	44,711	51,134	53,860	66,336
Nebraska	90,845	88,688	99,011	101,490	117,882
Nevada	77,410	81,903	101,411	96,379	99,312
New Hampshire	44,412	46,670	52,497	54,557	65,117
New Jersey	246,426	269,560	324,266	341,901	397,942
New Mexico	42,714	42,984	45,664	40,778	56,472
New York	272,948	215,889	221,895	214,052	288,681
North Carolina	505,275	535,803	670,223	800,850	1,027,930
North Dakota	21,666	22,709	29,873	34,130	38,535
Ohio	196,806	201,069	259,999	294,644	477,793
Oklahoma	158,642	171,551	189,444	203,157	277,436
Oregon	145,264	141,089	146,602	141,963	145,509
Pennsylvania	331,825	337,722	374,776	371,516	434,571

<b>Rhode Island</b>	34,634	31,174	32,345	29,626	36,121
<b>South Carolina</b>	214,030	230,050	300,392	382,968	571,175
<b>South Dakota</b>	29,331	31,375	41,339	47,591	52,974
<b>Tennessee</b>	200,445	212,052	273,680	348,097	555,103
<b>Texas</b>	1,116,293	1,291,972	1,840,947	2,410,810	3,484,632
<b>Utah</b>	200,261	207,911	256,932	295,196	366,939
<b>Vermont</b>	27,335	24,866	26,705	25,664	30,027
<b>Virginia</b>	269,474	261,943	307,946	346,140	400,058
<b>Washington</b>	212,188	222,731	239,566	230,371	272,494
<b>West Virginia</b>	20,066	19,381	23,037	28,325	51,046
<b>Wisconsin</b>	195,498	191,702	212,2029	221,128	266,327
<b>Wyoming</b>	24,574	26,728	34,762	38,565	42,293
<b>US Total</b>	11,409,447	12,004,365	14,511,077	16,357,030	21,446,150

Source: Centers for Medicare & Medicaid Services Open Enrollment Public Use Files, 2020-2024

## REFERENCES

---

- <sup>1</sup> Cohen RA, Martinez ME. Health insurance coverage: Early release of estimates from the National Health Interview Survey, 2013. National Center for Health Statistics. June 2014. Accessed at: <https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201406.pdf>
- <sup>2</sup> National Uninsured Rate Remains Largely Unchanged at 7.7 Percent in the Third Quarter of 2023. (Issue Brief No. HP-202402). Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. February 2024. Accessed at: <https://aspe.hhs.gov/reports/national-uninsured-rate-q3-2023>
- <sup>3</sup> Health Insurance Marketplaces 2024 Open Enrollment Report. Centers for Medicare & Medicaid Services. March 2024. Accessed at: [https://www.cms.gov/marketplace/resources/forms-reports-other#Health\\_Insurance\\_Marketplaces](https://www.cms.gov/marketplace/resources/forms-reports-other#Health_Insurance_Marketplaces)
- <sup>4</sup> Health Coverage Under the Affordable Care Act: Current Enrollment Trends and State Estimates. Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. (Issue Brief No. HP-2024-08). March 2024. Accessed at: <https://aspe.hhs.gov/reports/aca-related-enrollment-february-2024>.
- <sup>5</sup> HealthCare.gov Enrollment by Race and Ethnicity, 2015-2023 (Issue Brief No. HP-2024-07). Office of the Assistant Secretary for Planning and Evaluation. U.S. Department of Health and Human Services, March 2024. Accessed at: <https://aspe.hhs.gov/reports/marketplace-enrollment-race-ethnicity2015-2023>
- <sup>6</sup> How Health Insurers Responded to Applicants with Pre-existing Conditions Before and After the Affordable Care Act. Kaiser Family Foundation. September 30, 2020. Accessed at: <https://www.kff.org/affordable-care-act/slide/how-health-insurers-responded-to-applicants-with-pre-existing-conditions-before-and-after-the-affordable-care-act/>
- <sup>7</sup> Turning to Fairness. National Women's Law Center. March 1, 2012. Accessed at <https://nwlc.org/resource/turning-to-fairness-insurance-discrimination-against-women-today-and-the-affordable-care-act/>
- <sup>8</sup> Medical Loss Ratio. Centers for Medicare & Medicaid Services. September 6, 2023. Accessed at: <https://www.cms.gov/marketplace/private-health-insurance/medical-loss-ratio#:~:text=The%20Affordable%20Care%20Act%20requires%20insurance%20companies%20to%20spend%20at,on%20health%20insurance%20rate%20increases>.
- <sup>9</sup> Explaining Health Care Reform: Medical Loss Ratio (MLR). Kaiser Family Foundation. February 29, 2012. Accessed at: <https://www.kff.org/affordable-care-act/fact-sheet/explaining-health-care-reform-medical-loss-ratio-mlr/>
- <sup>10</sup> Essential Health Benefits: Individual Market Coverage. Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. December 2011. Accessed at: [https://aspe.hhs.gov/sites/default/files/migrated\\_legacy\\_files//43706/ib.pdf](https://aspe.hhs.gov/sites/default/files/migrated_legacy_files//43706/ib.pdf)
- <sup>11</sup> Preventive Services Covered by Private Health Plans Under the Affordable Care Act. Kaiser Family Foundation. August 2015. Accessed at: <https://files.kff.org/attachment/preventive-services-covered-by-private-health-plans-under-the-affordable-care-act-fact-sheet>
- <sup>12</sup> Adler L, Ginsburg PB. Health Insurance as Assurance: The Importance of Keeping the ACA's Limits on Enrollee Health Costs. Brookings. January 17, 2017. Accessed at: <https://www.brookings.edu/articles/health-insurance-as-assurance-the-importance-of-keeping-the-acas-limits-on-enrollee-health-costs/>
- <sup>13</sup> Health Benefits & Coverage, What Marketplace Health Insurance Plans Cover. HealthCare.gov. Accessed at: <https://www.healthcare.gov/coverage/what-marketplace-plans-cover/>
- <sup>14</sup> Access to Preventive Services without Cost-sharing: Evidence from the Affordable Care Act (Issue Brief No. HP-202201). Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. January 2022. Accessed at: <https://aspe.hhs.gov/sites/default/files/documents/786fa55a84e7e3833961933124d70dd2/preventive-services-ib-2022.pdf>
- <sup>15</sup> Why Are the Health Insurance Marketplaces Thriving in Some States but Struggling in Others? The Commonwealth Fund. November 15, 2018. Accessed at: <https://www.commonwealthfund.org/publications/issue-briefs/2018/nov/marketplaces-thriving-some-states-struggling-others>
- <sup>16</sup> Government Accountability Office. Private Health Insurance Concentration of Enrollees among Individual, Small Group, and Large Group Insurers from 2010 to 2013 (GOA-15-101R). December 1, 2014. Accessed at: <https://www.gao.gov/products/gao-15-101r>

- 
- <sup>17</sup> Schwab R, Swindle R, Clark J, Giovannelli J. Policy Innovations in the Affordable Care Act Marketplaces. The Commonwealth Fund. November 21, 2023. Accessed at: <https://www.commonwealthfund.org/publications/issue-briefs/2023/nov/policy-innovations-affordable-care-act-marketplaces>
- <sup>18</sup> HealthCare.gov. Glossary – Health plan categories. Accessed at: <https://www.healthcare.gov/glossary/health-plan-categories/>
- <sup>19</sup> HealthCare.gov. Glossary - Actuarial Value. Accessed at: <https://www.healthcare.gov/glossary/actuarial-value/#:~:text=The%20percentage%20of%20total%20average, costs%20of%20all%20covered%20benefits.>
- <sup>20</sup> HealthCare.gov. How to pick a health insurance plan. Accessed at: <https://www.healthcare.gov/choose-a-plan/plans-categories/>
- <sup>21</sup> Internal Revenue Service. The Premium Tax Credit – The Basics. October 23, 2023. Accessed at: <https://www.irs.gov/affordable-care-act/individuals-and-families/the-premium-tax-credit-the-basics>
- <sup>22</sup> Office of the Assistant Secretary for Planning and Evaluation. Health Insurance Marketplaces 2016 Open Enrollment Period: Final Enrollment Report. U.S. Department of Health and Human Services. March 11, 2016. Accessed at: <https://aspe.hhs.gov/reports/health-insurance-marketplaces-2016-open-enrollment-period-final-enrollment-report>
- <sup>23</sup> Congressional Research Service. Health Insurance Premium Tax Credit and Cost-Sharing Reductions. February 14, 2024. Accessed at: <https://crsreports.congress.gov/product/pdf/R/R44425>
- <sup>24</sup> Levitt L, Cox C, Claxton G. The Effects of Ending the Affordable Care Act’s Cost-Sharing Reduction Payments. Kaiser Family Foundation. April 25, 2017. Accessed at: <https://www.kff.org/affordable-care-act/issue-brief/the-effects-of-ending-the-affordable-care-acts-cost-sharing-reduction-payments/>
- <sup>25</sup> Orzol S, Hula L. Impact of Enroll America on the Number of Individuals Covered through the Federally Facilitated Marketplace. December 2016. Health Services Research: 53(1): 341-365. Accessed at: <https://doi.org/10.1111/1475-6773.12630>
- <sup>26</sup> Myerson R, Tilipman N, Feher A, Li H, Yin W, Meashe I. Personalized Telephone Outreach Increased Health Insurance Take-Up for Hard-To-Reach Populations, But Challenges Remain. Health Affairs 41(1): 129-137. January 2022. Accessed at: <https://www.healthaffairs.org/doi/epdf/10.1377/hlthaff.2021.01000>
- <sup>27</sup> Sommers BD, Maylone B, Nguyen KH, Blendon RJ, Epstein AM. The Impact of State Policies on ACA Applications and Enrollment Among Low-Income Adults in Arkansas, Kentucky, and Texas. June 2015. Health Affairs: 34(6). Accessed at: <https://www.healthaffairs.org/doi/10.1377/hlthaff.2015.0215>
- <sup>28</sup> Jost T. CMS Cuts ACA Advertising By 90 Percent Amid Other Cuts To Enrollment Outreach. Health Affairs Blog, August 31, 2017. Accessed at: <https://www.healthaffairs.org/content/forefront/cms-cuts-aca-advertising-90-percent-amid-other-cuts-enrollment-outreach>
- <sup>29</sup> HHS, National Partners Combine to Boost Black American Enrollment at HealthCare.gov. Centers for Medicare & Medicaid Services. April 26, 2021. Accessed at: <https://www.cms.gov/newsroom/press-releases/hhs-national-partners-combine-boost-black-american-enrollment-healthcaregov>
- <sup>30</sup> Marketplace Open Enrollment November 1-January 15. Centers for Medicare & Medicaid Services. 2022. Accessed at: <https://www.cms.gov/files/document/aian-openenroll2022pdf.pdf>
- <sup>31</sup> Biden-Harris Administration Makes Largest Investment Ever in Navigators Ahead of HealthCare.gov Open Enrollment Period. August 26, 2022. U.S. Department of Health and Human Services. Accessed at: <https://www.hhs.gov/about/news/2022/08/26/biden-harris-administration-makes-largest-investment-ever-in-navigators-ahead-of-healthcare-gov-open-enrollment-period.html>
- <sup>32</sup> 2021 Special Enrollment Period in Response to the COVID-19 Emergency. Centers for Medicare & Medicaid Services. January 28, 2021. Accessed at: <https://www.cms.gov/newsroom/fact-sheets/2021-special-enrollment-period-response-covid-19-emergency>
- <sup>33</sup> Special Enrollment Periods (SEPs) Information. Centers for Medicare & Medicaid Services. December 15, 2023. Accessed at: <https://www.cms.gov/marketplace/in-person-assisters/technical-resources/special-enrollment-periods>
- <sup>34</sup> FAQs for Agents & Brokers. Centers for Medicare & Medicaid Services. October 6, 2023. Accessed at: <https://www.agentbrokerfaq.cms.gov/s/article/What-is-the-150-SEP-and-when-can-consumers-access-it>
- <sup>35</sup> Chu RC, Rudich J, Lee A, Peters C, De Lew N, Sommers BD. Facilitating Consumer Choice: Standardized Plans in Health Insurance Marketplaces (Issue Brief No. HP-2021-29). Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. December 2021. Accessed at: <https://aspe.hhs.gov/reports/standardized-plans-health-insurance-marketplaces>

- 
- <sup>36</sup> Marketplace 2023 Open Enrollment Fact Sheet. Centers for Medicare & Medicaid Services. October 2022. Accessed at: <https://www.cms.gov/files/document/102622-landscape-and-window-shopping-508.pdf>
- <sup>37</sup> Collins SR. The Trump Administration’s New Marketplace Rules: Regulatory Simplification or More Complexity for Consumers. The Commonwealth Fund. April 13, 2018. Accessed at: <https://www.commonwealthfund.org/blog/2018/trump-administrations-new-marketplace-rules-regulatory-simplification-or-more-complexity>
- <sup>38</sup> Marketplace Plan Year 2024 Open Enrollment Fact Sheet. Centers for Medicare & Medicaid Services. October 25, 2023. Accessed at: <https://www.cms.gov/newsroom/fact-sheets/marketplace-plan-year-2024-open-enrollment-fact-sheet>
- <sup>39</sup> Goodell S. Reenrollment. Health Affairs Health Policy Brief, December 22, 2014. Accessed at: <https://www.healthaffairs.org/doi/10.1377/hpb20141222.803024/>
- <sup>40</sup> Auto Re-enrollment for QHPs no longer available in the Marketplace: External FAQs. Centers for Medicare & Medicaid Services. June 2016. Accessed at: <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/Auto-Re-Enrollment-FAQ-06242016-FINAL.pdf>
- <sup>41</sup> Marketplace Plan Year 2024 Open Enrollment Fact Sheet. Centers for Medicare & Medicaid Services. October 25, 2023. Accessed at: <https://www.cms.gov/newsroom/fact-sheets/marketplace-plan-year-2024-open-enrollment-fact-sheet>
- <sup>42</sup> Branham DK, Eibner C, Girosi F, Liu J, Finegold K, Peters C, and Sommers BD. Projected Coverage and Subsidy Impacts If the American Rescue Plan’s Marketplace Provisions Sunset in 2023 (Data Point No. HP-2022-10). Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. March 23, 2022. Accessed at: <https://aspe.hhs.gov/reports/impacts-ending-american-rescue-plan-marketplace-provisions>
- <sup>43</sup> Affordability of Employer Coverage for Family Members of Employees. Federal Register October 13, 2022. Accessed at: <https://www.federalregister.gov/documents/2022/10/13/2022-22184/affordability-of-employer-coverage-for-family-members-of-employees>
- <sup>44</sup> Health Paying Marketplace Premiums: The Basics. Kaiser Family Foundation. Accessed at: <https://www.kff.org/faqs/faqs-health-insurance-marketplace-and-the-aca/can-states-offer-their-own-subsidies-or-cost-sharing-reductions/>
- <sup>45</sup> Palanker D, Gooding ND. What Four States Are Doing to Advance Health Equity in Marketplace Insurance Plans, The Commonwealth Fund. April 13, 2022. Accessed at: <https://www.commonwealthfund.org/publications/issue-briefs/2022/apr/what-four-states-are-doing-advance-health-equity-marketplace>
- <sup>46</sup> Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. Imputation of Race and Ethnicity in Health Insurance Marketplace Enrollment Data, 2015 – 2022 Open Enrollment Periods. (Contractor Project Report No. HP-2022-19). June 2022. Accessed at: <https://aspe.hhs.gov/reports/imputation-race-ethnicity-marketplace-enrollment-data>
- <sup>47</sup> Branham DK, Finegold K, Chen L, et al. Trends in Missing Race and Ethnicity Information After Imputation in HealthCare.gov Marketplace Enrollment Data, 2015-2021. JAMA Netw Open. 2022;5(6):e2216715. doi:10.1001/jamanetworkopen.2022.16715.
- <sup>48</sup> Goldman AL, McCormick D, Haas JS, Sommers BD. Effects Of The ACA’s Health Insurance Marketplaces On The Previously Uninsured: A Quasi-Experimental Analysis. April 2018. Health Affairs 37(4): 591-599. Accessed at: <https://doi.org/10.1377/hlthaff.2017.1390>
- <sup>49</sup> Frean M, Gruber J, Sommers BD. Premium subsidies, the mandate, and Medicaid expansion: Coverage effects of the Affordable Care Act. May 2017. Journal of Health Economics 53: 72-86. Accessed at: <https://doi.org/10.1016/j.jhealeco.2017.02.004>
- <sup>50</sup> National Uninsured Rate Remains Largely Unchanged at 7.7 Percent in the Third Quarter of 2023. (Issue Brief No. HP-202402). Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. February 2024. Accessed at: <https://aspe.hhs.gov/reports/national-uninsured-rate-q3-2023>
- <sup>51</sup> Conmy AB, Peters C, De Lew N, Sommers BD. Children’s Health Coverage Trends: Gains in 2020-2022 Reverse Previous Coverage Losses. (Issue Brief No. HP-2023-07). Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. March 2023 Accessed at: <https://www.aspe.hhs.gov/reports/childrens-health-coverage-trends>
- <sup>52</sup> HealthCare.gov Enrollment by Race and Ethnicity, 2015-2023 (Issue Brief HP-2024-07). Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. March 2024 Accessed at: <https://aspe.hhs.gov/reports/marketplace-enrollment-race-ethnicity2015-2023>

- 
- <sup>53</sup> Handle B, Kolstad J. The Affordable Care Act After a Decade: Industrial Organization of the Insurance Exchanges. August 2022. Annual Review of Economics 14:287-312. Accessed at: <https://www.annualreviews.org/doi/abs/10.1146/annurev-economics-051420-114714>
- <sup>54</sup> Dafny L, Gruber J, Ody C. More Insurers Lower Premiums: Evidence from Initial Pricing in the Health Insurance Marketplaces. Winter 2015. American Journal of Health Economics 1(1): 53-81. Accessed at: [https://doi.org/10.1162/ajhe\\_a\\_00003](https://doi.org/10.1162/ajhe_a_00003)
- <sup>55</sup> Agirdas C, Krebs RJ, Yano M. The effects of competition on premiums: using United Healthcare's 2015 entry into Affordable Care Act's marketplaces as an instrumental variable. July 2019. Health Economics, Policy, and Law 14(3): 374–399. Accessed at: <https://doi.org/10.1017/S1744133117000263>
- <sup>56</sup> Van Parys, J. ACA Marketplace Premiums Grew More Rapidly In Areas With Monopoly Insurers Than In Areas With More Competition. August 2018. Health Affairs 37(8). Accessed at: <https://doi.org/10.1377/hlthaff.2018.0054>
- <sup>57</sup> Sheingold S, Nguyen N, Chappel A. Competition and Choice in the Health Insurance Marketplaces, 2014-2015: Impact on Premiums. Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. July 29, 2015. Accessed at: <https://aspe.hhs.gov/reports/competition-choice-health-insurance-marketplaces-2014-2015-impact-premiums-0>
- <sup>58</sup> Holahan J, Wengle E, O'Brien C. Changes in Marketplace Premiums and Insurer Participation, 2022-2023. Urban Institute. April 2023. Accessed at: <https://www.urban.org/sites/default/files/2023-03/Changes%20in%20Marketplace%20Premiums%20and%20Insurer%20Participation%2C%202022-2023.pdf>
- <sup>59</sup> U.S. Government Accountability Office. Markets Remained Concentrated through 2020, with Increases in the Individual and Small Group Markets (GAO-23-105672). November 2022. Accessed at: <https://www.gao.gov/assets/gao-23-105672.pdf>
- <sup>60</sup> Calculations from issuer type and 2014-2022 enrollment data from <https://www.cms.gov/marketplace/resources/data/issuer-level-enrollment-data>.
- <sup>61</sup> Holahan, J., Wengle, E., and O'Brien, C., "Changes in Marketplace Premiums and Insurer Participation 2022-2023, Urban Institute. April 2023. Accessed as: [Changes in Marketplace Premiums and Insurer Participation, 2022-2023.pdf \(urban.org\)](https://www.urban.org/sites/default/files/2023-03/Changes%20in%20Marketplace%20Premiums%20and%20Insurer%20Participation%2C%202022-2023.pdf)
- <sup>62</sup> Sacks DW, Vu K, Huang T, Karaca-Madic P. The Effect of the Risk Corridors Program on Marketplace Premiums and Participation (NBER Working Paper No. 24129). December 2017. National Bureau of Economic Research. Accessed at: <http://www.nber.org/papers/w24129>
- <sup>63</sup> Kamal R, Semanskee A, Long M, Claxton G, Levitt L. How the Loss of Cost-Sharing Subsidy Payments is Affecting 2018 Premiums. Kaiser Family Foundation. October 27, 2017. Accessed at: <https://www.kff.org/affordable-care-act/issue-brief/how-the-loss-of-cost-sharing-subsidy-payments-is-affecting-2018-premiums/>
- <sup>64</sup> The Effects of Terminating Payments for Cost-Sharing Reductions. Congressional Budget Office, August 15, 2017. Accessed at: <https://www.cbo.gov/publication/53009>
- <sup>65</sup> Holahan J, Wengle E, O'Brien C. Changes in Marketplace Premiums and Insurer Participation, 2022-2023. Urban Institute. April 2023. Accessed at: <https://www.urban.org/sites/default/files/2023-03/Changes%20in%20Marketplace%20Premiums%20and%20Insurer%20Participation%2C%202022-2023.pdf>
- <sup>66</sup> Jacobs, P.D. and Hill, S.C. ACA Marketplaces Became Less Affordable Over Time for Many Middle-Class Families, Especially the Near-Elderly. November 2021. Health Affairs, 40(11): 1713-1721.
- <sup>67</sup> Branham DK, Conmy AB, DeLeire T, Musen J, Xiao X, Chu RC, Peters C, and Sommers BD. Access to Marketplace Plans with Low Premiums on the Federal Platform, Part III: Availability Among Current HealthCare.gov Enrollees Under the American Rescue Plan (Issue Brief No. HP-2021-09). Washington, DC: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. April 13, 2021. Accessed at: <https://www.aspe.hhs.gov/reports/access-marketplace-plans-low-premiums-current-enrollees-american-rescue-plan>
- <sup>68</sup> More than 4.5 Million Select Affordable Health Coverage in ACA Marketplace Coverage Since Start of Open Enrollment Period. U.S. Department of Health and Human Services. November 21, 2023. Accessed at: <https://www.hhs.gov/about/news/2023/11/21/more-than-4-million-select-affordable-health-coverage-aca-marketplace-coverage-start-open-enrollment-period.html#:~:text=%E2%80%9CThis%20year%2C%20four%20out%20of,at%20least%20three%20health%20insurers.>



## U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Office of the Assistant Secretary for Planning and Evaluation

200 Independence Avenue SW, Mailstop 447D  
Washington, D.C. 20201

For more ASPE briefs and other publications, visit:  
[aspe.hhs.gov/reports](https://aspe.hhs.gov/reports)



### SUGGESTED CITATION

Health Insurance Marketplaces: 10 Years of  
Affordable Private Plan Options (Issue Brief No. HP-2024-09).  
Office of the Assistant Secretary for Planning and Evaluation,  
U.S. Department of Health and Human Services.  
March 2024. Accessed at:  
<https://aspe.hhs.gov/reports/10-years-health-insurance-marketplaces>

### COPYRIGHT INFORMATION

All material appearing in this report is in the public domain and  
may be reproduced or copied without permission; citation as to  
source, however, is appreciated.

### DISCLOSURE

This communication was printed, published, or produced and  
disseminated at U.S. taxpayer expense.

---

Subscribe to ASPE mailing list to receive  
email updates on new publications:

<https://list.nih.gov/cgi-bin/wa.exe?SUBED1=ASPE-HEALTH-POLICY&A=1>

For general questions or general  
information about ASPE:

[aspe.hhs.gov/about](https://aspe.hhs.gov/about)