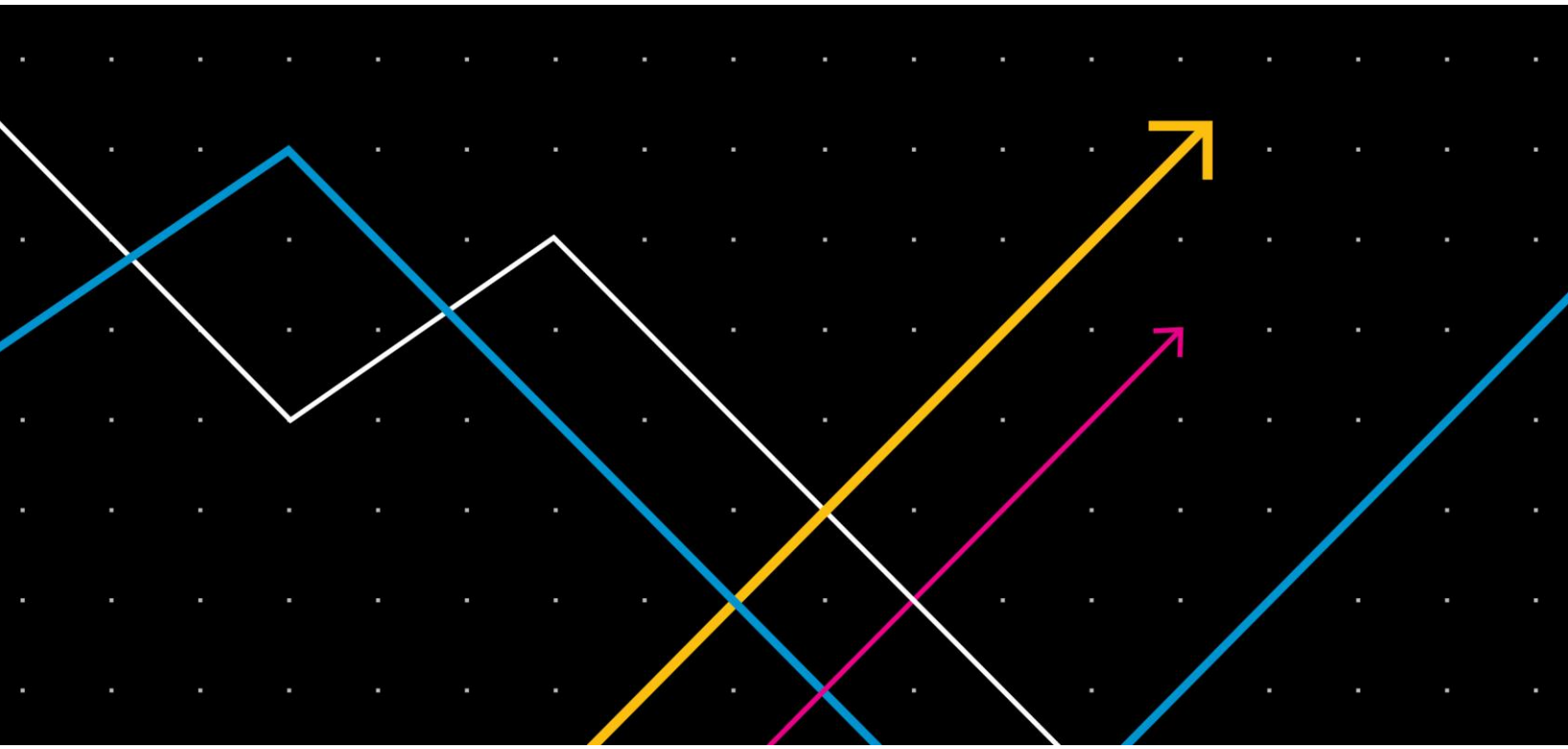

RESEARCH REPORT

The ACA's Transformation of Private Health Insurance

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May 2024

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Acknowledgments

This report was supported by Arnold Ventures. We are grateful to them and to all our funders, who make it possible for Urban to advance its mission.

The views expressed are those of the authors and should not be attributed to the Urban Institute, its trustees, or its funders. Funders do not determine research findings or the insights and recommendations of Urban experts. Further information on the Urban Institute's funding principles is available at urban.org/fundingprinciples.

Michael Simpson produced the data on the characteristics of those receiving federal financial assistance for the purchase of insurance through the ACA's Marketplaces and the value of the assistance they receive (table 3). Michael Karpman and Julia Long produced the data on the characteristics of nongroup market enrollees in 2009 and 2022 (table 2). Erik Wengle produced the data on insurer participation in Marketplaces (table 4). Avani Pugazhendhi assisted with the references. Devlan O'Connor and Sarah LaCorte provided editorial assistance. The authors are grateful for their contributions to this work and for helpful comments and suggestions from Sabrina Corlette, Chris Jennings, and Kevin Lucia.

Executive Summary

Ten years since full implementation of the Affordable Care Act (ACA) and seven years after the failure of the last serious attempt to repeal it, presidential candidate Donald Trump is again calling emphatically for the law's repeal.[1] At the same time, a group representing three-quarters of Republicans in the House of Representatives has detailed an approach for cutting federal funding for Medicaid, the Children's Health Insurance Program, and ACA premium assistance by more than 50 percent; restructuring of the Medicare program is also included in the package (RSC 2024). Such dramatic cuts would result in increases in the uninsured, the underinsured, and barriers to necessary care for many people in need who currently receive significant support. With President Joe Biden and many congressional Democrats intent on making permanent the temporary increases in federal financial assistance for coverage implemented under the Inflation Reduction Act,[2] the outcome of the 2024 elections has expansive implications for the country's health insurance system.

Many people, including young adults and those unfamiliar with private insurance before 2014, may be unaware of the profound effects the ACA has had in enhancing accessibility, affordability, and adequacy in these markets. Before the ACA, private nongroup insurance markets in particular failed to serve the needs of large swaths of actual and potential customers in many ways. We summarize these failings, the ways in which the ACA addressed them, and the evidence of the law's effects on enrollment, insurer participation, and premiums.

How the ACA Transformed Private Insurance Markets

Beginning January 1, 2014, the ACA changed the rules under which all private insurance was sold and operated, with the greatest changes made for nongroup (sometimes called individually purchased) health insurance, along with substantial changes made for fully insured plans sold to small employers (fewer than 50 workers).

All Private Insurance Markets, Including Self-Insured Plans[3]

The ACA prohibited all preexisting condition exclusions for employer-based insurance (both fully insured and self-insured plans) and insurance purchased through the newly regulated nongroup insurance markets. The law also limited employer-based insurance waiting periods to no longer than 90 days.

The law prohibited rescissions (retroactive cancellations) of insurance coverage except those resulting from fraud and intentional misrepresentation. It also eliminated all annual and lifetime dollar benefit limits across employer and nongroup insurance markets.

The ACA newly required private health insurance plans, including employer-based plans, to include young adults on their parents' family policies up to age 26. It required all employer and nongroup insurance policies, as well as the Medicare and Medicaid programs, to cover a set of preventive services at no out-of-pocket cost to enrollees using in-network clinicians. The ACA set minimum medical loss ratios for employer and nongroup insurance plans and required employers to make these public. Under these limits, insurers could no longer devote exorbitant shares of premiums to administration and company profits, increasing plan value to consumers.

For the first time, under the ACA, insurers are required to provide consumers with simple, clear summaries of the plans they are considering, including any benefit exclusions and cost-sharing requirements. These Summaries of Benefits and Coverage use lay language to help consumers compare plan options and be fully informed purchasers.

Nongroup Insurance Markets

The ACA required all private nongroup insurance policies to accept all applicants without regard to age or health status (i.e., guaranteed issue), thereby prohibiting the widespread practice of denying insurance to those expected to use significant amounts of care. At the same time, the law eliminated medical underwriting, the practice of charging insurance applicants widely different prices for coverage depending upon their gender, age, prior use of health care, health status, industry of employment, recreational activities, and other characteristics. The ACA's modified community rating pricing rules allow only limited variation by enrollees' age and tobacco use.

The ACA's essential health benefit requirements and actuarial value standards ensure that enrollees have coverage for necessary care, regardless of health status, and that the insured costs are spread broadly across all people covered in those markets. Actuarial value standards limit the out-of-

pocket costs consumers incur when they receive care, with four tiers allowing consumers to choose the option best suited to their needs and preferences.

To reduce the number of people without insurance and make comprehensive private health insurance coverage affordable, the ACA includes significant income-related financial assistance for the purchase of private insurance. This financial assistance takes the form of tax credits that lower the premiums enrollees pay for their chosen plan, as well as cost-sharing reductions that lower eligible consumers' direct payments for accessing health care services. The Inflation Reduction Act increased the premium assistance and extended it to more people until the end of the 2025 plan year.

The ACA created nongroup insurance Marketplaces that provide consumers with information on their plan options (prices, benefits, quality) and the financial assistance available to them. Consumer-friendly websites, along with navigators and call centers, provide applicants with one-on-one assistance and objective comparisons of plans while enhancing competition.

Small-Group Insurance for Employers of 50 or Fewer Workers

Small employers have always been disadvantaged in purchasing health insurance for their workers compared with their large-employer counterparts. Consequently, many reforms instituted in nongroup insurance markets, detailed above, were also applied to small-group insurance, including modified community rating, essential health benefit requirements, and minimum medical loss ratios. Financial assistance and other consumer protections in nongroup insurance markets, along with small employers' exemptions from ACA employer penalties, mean that small-firm workers have ample access to subsidized comprehensive insurance outside the employment context when desired.

The ACA Record

The ACA has affected the US insurance system in a host of measurable ways. Here are just a few examples.

According to the National Health Interview Survey's most recently released data from the second quarter of 2023, uninsurance has fallen to 23.7 million people, a historic low rate of 7.2 percent across all ages. In 2009, the year before the passage of the ACA, 46.3 million people, or 15.4 percent, were uninsured. About half of the drop is attributable to increases in private insurance, and a majority of adults and children remain insured by private coverage (ASPE 2023).

Coverage through the private nongroup health insurance market has grown markedly under the ACA, rising from 13.1 million people under age 65 in 2009 to 21.6 million in 2022, based on the most recently available National Health Interview Survey.[4] The increase is likely noticeably higher as of 2024, given record-high enrollment in the Marketplaces this year. This growth reflects that the ACA's financial assistance and reforms have allowed those with modest means, older adults, and those with health problems to obtain valued coverage, thereby increasing enrollment.

Nongroup insurance enrollment in the ACA Marketplaces themselves (i.e., not counting those enrolling in individual coverage outside the Marketplaces) has grown substantially since their first year in operation, from 8.0 million enrollees in 2014[5] to 21.3 million in 2023.[6]

Importantly, the particular structure of the premium tax credits increases the dollar value of the assistance for people living in higher-premium markets than those living in lower-premium markets. In this way, premium tax credits make coverage affordable under the ACA's standards regardless of where someone lives, whether in a high-priced or a low-priced market. The average person receiving a premium tax credit receives more than $6,000 to lower their insurance premium in 2024.

Insurer participation in the nongroup Marketplaces has increased markedly over the years, meaning 2024 consumers have more options than ever. Though variable across states and rating areas within states, premiums in the Marketplaces have grown more slowly and are typically lower than those for employer-based insurance.

Conclusions

The ACA has transformed private insurance in myriad ways, especially for coverage sold through private nongroup insurance markets. These reforms are now inextricably entwined across the US health insurance and health care systems. Changes to insurance market rules, increased consumer protections, provision of premium and cost-sharing subsidies, and expansions of the Medicaid program in all but nine states[7] have resulted in the highest rates of health insurance coverage in the country's history. Affordability and access to care have greatly improved, particularly for people in need of significant medical services. In addition, the transformation of private nongroup insurance markets created true competition based on price and quality, as opposed to competition for the healthiest enrollees, for the first time. Attempting to repeal these reforms would cause widespread harm to consumers, significantly lower provider revenue, and substantially increase administrative and financial burdens on state and local governments.

The ACA's Transformation of Private Health Insurance

Ten years since full implementation of the Affordable Care Act (ACA) and seven years after the failure of the last serious attempt to repeal it, presidential candidate Donald Trump is again calling emphatically for the law's repeal.[8] At the same time, a group representing three-quarters of Republicans in the House of Representatives has detailed an approach for cutting federal funding for Medicaid, the Children's Health Insurance Program, and ACA premium assistance by more than 50 percent; restructuring of the Medicare program is also included in the package (RSC 2024). Such dramatic cuts would result in increases in the uninsured, the underinsured, and barriers to necessary care for many people in need who currently receive significant support. With President Joe Biden and many congressional Democrats intent on making permanent the temporary increases in federal financial assistance for coverage implemented under the Inflation Reduction Act,[9] the outcome of the 2024 elections has expansive implications for the country's health insurance system.

Consequently, it is worth reviewing the myriad ways the ACA has transformed the private health insurance system. We highlight the advances at stake should the law be repealed or substantially curtailed via legislation or presidential administrative action.

As we have noted in the past, the primary objective of the ACA was to increase the accessibility, affordability, and availability of health insurance coverage, thereby expanding access to necessary medical care (McMorrow, Blumberg, and Holahan 2020). The primary policies implemented to expand access were a substantial expansion of Medicaid eligibility for those with the lowest incomes (adults and children up to 138 percent of the federal poverty level) and subsidized private health insurance coverage for those with modest incomes above the public insurance eligibility level, coupled with regulatory reforms that broadened sharing of health care risk in private markets.

Although a 2012 Supreme Court decision made the Medicaid expansion optional to states, as of 2024, 41 states (including the District of Columbia) have taken up the expansion option, and one more (Wisconsin) has implemented a partial expansion that provides Medicaid to all residents up to 100 percent of the federal poverty level (FPL).[10] In addition, the Inflation Reduction Act of 2022 increased the generosity of the premium tax credits used to subsidize private health insurance coverage through

2025. More people are currently eligible for assistance, and assistance has increased for those already eligible under the ACA.

Financial support to purchase public and private insurance has been critical to the US achieving historically high rates of insurance coverage by significantly improving affordability. At the same time, the array of regulatory reforms to private insurance coverage implemented along with the financial assistance has substantially improved the value of insurance coverage, the adequacy of benefits provided, and the accessibility of coverage for those who are experiencing or who have experienced significant health problems in the past. In addition, the reforms have catalyzed private insurer price competition in the private nongroup insurance markets in many areas of the country, competition largely absent before 2014.

Because the effects of the Medicaid expansion have been clearly delineated elsewhere,[11] we focus this overview on the ACA's importance for private insurance markets. We first review the landscape of private health insurance before the implementation of the ACA. This review serves as a reminder of the many ways private nongroup insurance markets in particular failed to serve the needs of large swaths of actual and potential consumers. We next reflect on how the ACA altered these markets to address the host of problems that characterized them. We then summarize evidence of ACA's effects on private insurance markets in terms of enrollment, insurer participation, and premiums.

How the ACA Transformed Private Insurance Markets

Beginning January 1, 2014, the ACA changed the rules under which most private insurance was sold and operated. However, the largest changes were made for nongroup (sometimes called individually purchased) health insurance. Substantial changes were also made for fully insured plans sold to small employers (1 to 50 workers).[12]

All Private Insurance Markets, Including Self-Insured Plans[13]

We start by delineating the issues of concern across all private insurance markets and the ACA's response to them. We then move on to issues and reforms specific to nongroup and small-group insurance markets.

PREEXISTING CONDITION EXCLUSIONS

Before implementation of the ACA, it was common for private insurance policies provided through employers to exclude coverage for a defined period for the treatment of previously diagnosed medical conditions. Employer exclusion periods could be as long as 12 months at that time. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) required employers to reduce their exclusion periods month-for-month for workers who had continuous creditable coverage[14] (no gap in coverage of more than 63 days) before enrolling. Nongroup insurance plans, however, frequently had permanent coverage exclusions for preexisting conditions.

In other words, enrollees with asthma might have had any care related to asthma or their pulmonary system permanently excluded from their nongroup coverage, depending upon the presence or absence of state regulations.[15] In states prohibiting permanent exclusions, plans universally excluded coverage for defined periods, sometimes significantly longer than those used by employer-based plans. Consequently, people newly enrolling in private health insurance could face long periods in which they were paying premiums for coverage but not eligible for reimbursement when they sought care for existing conditions. Often, particularly in the nongroup insurance market, exclusion periods applied to previously undiagnosed conditions when insurers deemed that such conditions should have been known, a practice referred to as "post-claims underwriting."

As of January 1, 2014, the ACA prohibited all preexisting condition exclusions for employer-based insurance (fully insured and self-insured plans) and insurance purchased through the newly regulated nongroup insurance markets. This blanket prohibition eliminated the problem of people paying for coverage that would not be reimbursed for the care they needed for chronic or acute conditions that began before their enrollment. In addition, the law limited employer-based insurance waiting periods (the time between beginning work and becoming eligible for the employer's health insurance plan) to no longer than 90 days.

RESCISSIONS OF COVERAGE

Rescissions were the practice of retroactively canceling an insurance policy. Commonly, such rescissions occurred when enrollees filed claims for expensive care, and insurers subsequently reviewed the original applications for errors that could be used to declare the insurance contract null and void, releasing the insurers from paying sizable claims. These errors could seemingly be intentional or unintentional, related to the condition for which a claim was being made, or completely unrelated. In one 2009 congressional hearing, three insurers reported avoiding paying $300 million in claims over

five years using this strategy. Under pressure from legislators, the witnesses made clear that they had no intention of changing the practice.[16]

The ACA prohibited all health insurance rescissions, with the only exception being fraud or intentional misrepresentation of material fact as prohibited under the plan's terms of coverage. Rescissions were unusual in the large-group market even before implementation of the ACA because workers generally did not fill out health questionnaires when enrolling in large-employer plans. However, the 2010 prohibition applies to all private health insurance plans in the group and nongroup markets.

ANNUAL AND LIFETIME DOLLAR LIMITS ON BENEFITS

Private insurance coverage in the nongroup and employer group markets frequently included annual or lifetime limits on the value of benefits provided to any insured person. Annual and lifetime limits had the greatest ramifications for people with serious medical conditions, hampering their ability to afford necessary medical care. These limits sometimes took the form of overall dollar limits, for example, $500,000 in annual claims and $1 million in claims over a lifetime. Alternatively, dollar limits could take the form of specified amounts on particular types of care. The Kaiser Family Foundation 2009 Employer Health Benefits Survey found that 59 percent of employers provided their workers with policies that included lifetime benefit maximums (Claxton et al. 2009). Such maximums were even more common and typically lower in nongroup insurance policies.

The ACA eliminated all annual and lifetime dollar benefit limits across employer and nongroup markets.

EXTENSION OF FAMILY COVERAGE TO ADULT CHILDREN UP TO AGE 26

Young adults have historically been the most likely to be uninsured. In 2009, the year before the ACA was passed, 31.7 percent of 19- to 25-year-olds were uninsured (Rodean 2012), compared with 17.3 percent of all those below age 65.[17] These differences were thought to be the result of a combination of causes, including younger adults having lower-paid jobs with lower rates of employer-based offers of insurance than older adults and lower demand for insurance as a function of greater expectations of good health. In addition, public program eligibility, through Medicaid and the Children's Health Insurance Program, was broadly available for children, but eligibility was limited for adults without dependent children of their own.

The ACA required private health insurance plans, including employer-based plans, to include young adults on their parents' family policies up to age 26. This expanded eligibility included adult children not

financially dependent on their parents as well as those not living at the same address as their parents. Although a limited number of states had similar laws in place when the ACA passed, state laws could not apply such expansions to self-insured employer plans because of restrictions in the Employee Retirement Income Security Act of 1974. Consequently, this provision of the ACA increased eligibility for employer-based insurance in states that had no such previous requirements in place, as well as those that did. According to the American Community Survey, uninsurance among people ages 19 to 25 had decreased to 14.9 percent by 2019 (Conway 2020).

DEFINED SET OF PREVENTIVE SERVICES WITH NO COST-SHARING REQUIREMENTS

Research evidence supports the assertion that greater use of proven preventive care services can significantly improve population health and save lives. In some cases, such services are cost-effective. However, use of these services has historically varied. For example, 2008 data published by the Centers for Disease Control and Prevention indicated that only about half of adults ages 50 to 75 had had at least one of three recommended colorectal cancer screening tests in the prior 1 to 10 years.[18]

In response to the underutilization of many valuable preventive services, the ACA required all employer and nongroup insurance policies, as well as Medicare and Medicaid programs, to cover a set of such services without any out-of-pocket cost to the enrollee, as long as the services are provided by an in-network clinician. The services included are those recommended by four medical bodies: the United States Preventive Services Task Force, the Advisory Committee on Immunization Practices, and the Health Resources and Services Administration's Bright Futures program and Women's Preventive Services Initiative.[19] The panel designates as A or B those services offering a substantial or moderate value. Examples of the services included are screenings for several cancers (including colorectal and breast cancer), depression, HIV, diabetes, and cholesterol.

MINIMUM MEDICAL LOSS RATIOS

Before the ACA, there was wide variation in the share of private health insurance premiums attributable to administrative costs, including company profits, versus claims reimbursement (i.e., payments to providers for the costs of care received). In general, the larger the employer, the lower the share of premiums attributable to administrative costs. At least one estimate found that the share of premiums used for administrative costs varied from 4 percent in plans for firms of more than 10,000 workers up to 34 percent in plans for the smallest firms (Karaca-Mandic, Abraham, and Phelps 2011). Nongroup insurance had the highest share of its premiums devoted to administrative costs, with some plans spending more than half of premium dollars on administration.[20] As a result, the value consumers

received for their premium dollars varied tremendously, and the absence of transparency prevented them from knowing which plans devoted more of each premium dollar to the provision of care.

The ACA set minimum medical loss ratios (MLRs) for fully insured employer and nongroup insurance plans and required employers to make these public. A plan's MLR under the ACA indicates the share of the insurance premium attributable to claims reimbursements or quality improvement activities for a particular health plan and its enrollees. Therefore, the lower the MLR, the more of the premium is devoted to administrative costs instead of spending on care for enrollees. Beginning in 2011, insurance companies selling coverage in the nongroup and small-group markets were required to have MLRs of 80 percent or higher, and those selling coverage in the large-group market were required to have MLRs of 85 percent or above. Violation of these minimums leads to required refunds of the difference to consumers. An estimated $11.9 billion has been returned to consumers between 2012 and 2023 through MLR rebates (Ortaliza, Amin, and Cox 2023).

SUMMARIES OF BENEFITS AND COVERAGE

Before implementation of the ACA, private insurers were not required to provide consumers with plan documents delineating the terms of coverage until a person enrolled in the plan and paid a premium. Even then, the documents were extremely long, written in legalese and other technical jargon virtually impossible for a layperson to understand. Consumers were frequently surprised by benefit exclusions and other limitations of a policy once they were enrolled and seeking care.[21] This lack of transparency of coverage details also made it difficult for consumers to compare one plan option with another when shopping for insurance.

Beginning January 1, 2014, all private insurance plans have been required to provide any interested consumer with a federally standardized, easily understandable form that details out-of-pocket cost requirements, benefit structure, and benefit exclusions. The form all plans must conform to is called the Summary of Benefits and Coverage.[22] It was designed specifically to use plain, consistent language and to permit straightforward comparisons across plans. The last page of the summary includes typical out-of-pocket costs under the plan for three health care scenarios—having a baby, developing type 2 diabetes, and experiencing a simple fracture—to further facilitate plan comparisons.

MAXIMUM OUT-OF-POCKET REQUIREMENTS

Before 2014, health insurance plans varied tremendously in the maximum amount enrollees would be liable to pay each year for services covered by their insurance. In fact, in 2009, about 20 percent of employer plans (Claxton et al. 2009) and far more nongroup insurance plans had no out-of-pocket

maximums at all. Many plans that did have annual maximums excluded substantial amounts of consumer spending (e.g., deductibles, physician copayments, prescription drug cost sharing) from their limits, such that consumer financial liabilities were even more open-ended than they seemed. Some also had separate maximums for different types of services, meaning that people required to spend substantial money out of pocket on hospital care, for example, could satisfy one plan maximum but still have to contribute substantially for outpatient care or prescription drugs. The lack of single comprehensive limits on the out-of-pocket costs health plans could impose on enrollees created particular financial hardship for people enrolled in all types of private health insurance when they incurred serious medical conditions and needed considerable amounts of care.

By January 2015, the ACA required nongroup, fully insured, and self-insured health insurance plans to use a single combined maximum out-of-pocket limit. This limit applies to services provided by in-network providers, and it varies with a formula each year. In 2024, the limit is $9,200 for a single policy and $18,400 for a family policy.[23] Plans can use lower limits if they choose. These inclusive limits allow consumers to plan financially for a "worst-case scenario" year and effectively constrain households' financial burdens should considerable medical needs arise.

Nongroup Insurance Markets[24]

The ACA's biggest changes to private insurance apply to nongroup insurance markets. Before the reforms, these markets were the least likely to provide adequate, accessible, and affordable insurance. This was particularly true for consumers with histories of health problems and significant utilization of medical services.

GUARANTEED ISSUE

Before 2014, in almost all states, nongroup insurance was not guaranteed issue to applicants, meaning that insurers could deny potential enrollees coverage. Denials could be based on actual, past, or expected health care use, industry of employment, or other factors. Substantial shares of applicants were denied coverage outright—19 percent by one estimate, on average—but denial rates varied tremendously across insurers, with one-quarter denying 40 percent or more of applicants (US GAO 2011). Agents and brokers discouraged many more consumers from even applying because of their health profiles or age, knowing they would be denied coverage if they applied.

As of 2013, only six states had guaranteed issue requirements written into state law for all insurance products sold in the state.[25] Seven more states had guaranteed issue of some products for

some people only, and five more states had Blue Cross Blue Shield insurers of last resort that would enroll any applicant in at least one plan in their portfolio. Even those states with at least one plan available to people with health conditions did not subsidize that coverage, meaning the premiums tended to be high and the benefits limited. A Kaiser Family Foundation study estimated, conservatively, that 27 percent of those under age 65 have medical conditions that would likely make them uninsurable in the pre-ACA nongroup insurance market, with these rates varying from a low of 22 percent in Colorado to a high of 37 percent in West Virginia (Claxton et al. 2016). Many states had high-risk pools available to some people deemed medically uninsurable, but those tended to have limited benefits, preexisting condition exclusion periods, and high premiums relative to standard market plans. Further, enrollment was frequently limited in number and to a specified list of conditions (Blumberg 2011; Pollitz 2017).

As of January 1, 2014, all private nongroup insurance policies are required to accept all applicants without regard to age or health status. Failure to pay premiums, application outside the open enrollment period, insufficient network capacity, or solvency concerns became the only accepted reasons for denying coverage.

MODIFIED COMMUNITY RATING

Before 2014, 43 states plus the District of Columbia allowed insurers to charge enrollees more because of their health status. Many of the states that imposed some limits on this practice still permitted considerable price differences across enrollees. Almost all states allowed premiums to vary at least to some degree by age and gender as well. Thirty-two states had no premium limits at all, allowing premiums to vary based on insurer choices alone. This meant that some people technically offered policies by an insurer could be effectively denied coverage by being charged unaffordable premiums.

Beginning January 1, 2014, the ACA required nongroup insurers to limit premium variation within each premium rating region to three factors: age, tobacco use, and family size. Premiums for the oldest adults covered in these markets (age 64 years and above[26]) can be no more than three times those for the youngest adult, and tobacco users can be charged no more than 1.5 times the premium for nonusers of the same age. Premiums can vary across rating regions because of differences in input costs of providing care (e.g., labor market differences) but may not vary by health status differences across rating regions within the same state.

ESSENTIAL HEALTH BENEFIT REQUIREMENTS AND ACTUARIAL VALUE STANDARDS

Before full implementation of the ACA, insurers had substantial flexibility in the benefits they covered. Although all states legislated some specific benefit mandates for policies sold by state-regulated insurers (Claxton et al. 2016), these mandates varied considerably across states. Moreover, some mandates applied to nongroup insurance while others applied to fully insured employer plans. The Employee Retirement Income Security Act prohibits states from applying such mandates to self-insured group plans, so large-employer plans were frequently exempt. Some mandates required that all regulated plans include particular services (e.g., mammography, bone marrow transplantation), conditions (e.g., alcoholism, mental health), or types of providers (e.g., chiropractors, psychologists). Others required insurers to offer at least one plan that included these benefits at a higher price. Still, benefit requirements generally did not specify how much coverage needed to be included in a policy.

Furthermore, benefit requirements on nongroup market plans were generally the lightest, and some states permitted nongroup insurers to permanently exclude coverage for applicants' preexisting conditions. For example, in a 2000 Kaiser Family Foundation Study of medical underwriting practices in the nongroup market, even people with seasonal allergies were usually (46 applications out of 60) offered policies that excluded related coverage (including offers that denied any benefits for the applicant's upper respiratory system) or imposed other benefit limits (Pollitz, Sorian, and Thomas 2001). Exclusions were even more common for more serious conditions.

In addition to benefit exclusions and limits, nongroup insurers typically offered plans with actuarial values[27] well below those typical of employer insurance plans. However, underwriters considered consumers who enrolled in higher actuarial value plans and plans covering more comprehensive benefits to be high future users of medical services. This meant that the premiums charged increased commensurate with insurers' expectations that such enrollees would utilize high levels of care, not that policies had broader coverage and, therefore, a higher objective value. Thus, the prices of comprehensive plans were typically beyond what was affordable for most consumers.

The ACA defined federal essential benefit requirements along with actuarial value standards to ensure that necessary care would be covered, regardless of health status, and that the insured costs of the markets' enrollees would be spread broadly across all people insured in those markets.[28] Insurers are prohibited from excluding coverage for benefits deemed essential, regardless of the timing of condition onset. These benefits are set to be equivalent to those in typical employer-based plans. Actuarial value standards limit out-of-pocket costs based on the tier of coverage consumers purchase (from 60 percent to 90 percent actuarial value). And because all plans across all actuarial value tiers of coverage are considered to be in the same risk pool,[29] insurers are limited in how much higher premiums

in one tier can be compared with others. These changes have particularly advantaged people with significant health care needs, ensuring that the costs of their care are spread more broadly across the insured population instead of disproportionately falling on those in bad health themselves.

INCOME-RELATED SUBSIDIES TO LOWER PREMIUMS AND COST-SHARING RESPONSIBILITIES

Although the aforementioned changes to the nongroup insurance market made coverage offered there more valuable to consumers, the actuarially fair premiums would be unaffordable for many consumers, particularly those with low to middle incomes. The more benefits covered and the lower the out-of-pocket costs (i.e., deductibles, copayments, coinsurance, out-of-pocket maximums) associated with a plan, the higher the premium. Even the lower out-of-pocket requirements associated with the ACA's actuarial value tiers compared with prereform nongroup plans would be a barrier to accessing necessary care for low-income consumers. In addition, the larger the pool of enrollees taking up coverage through the reformed nongroup markets, the more likely the markets would be to cover a balance of the wider population's health care risks, both those with health problems and those healthier. Health insurance risk pools with a healthier balance of enrollees would mean lower premiums, considering the premiums reflect the expected average health care use of the people covered. This made strategies to increase the number of enrollees important.

To reduce the number of people without insurance and make comprehensive private health insurance coverage affordable, the ACA includes significant income-related financial assistance for legal residents ineligible for Medicaid or Medicare. This financial assistance takes the form of premium tax credits that lower the premiums enrollees have to pay, as well as cost-sharing reductions that lower consumers' direct payments when accessing health care services. The value of premium tax credits decreases as household income increases, and the value of these credits has been increased above their original level, at least through the 2025 plan year. The credits are structured to limit the share of income an enrollee must pay for a standard level of coverage (silver, 70 percent actuarial value). In this way, the credit adjusts to pay more in high-priced areas than it does in low-priced areas, shielding the consumer to a significant degree from such geographic variations in the cost of medical care. The percentage-of-income caps in the original law and the current caps are shown in table 1.

TABLE 1

Premium Tax Credit and Cost-Sharing Reductions under the Original ACA and IRA Enhancements

Percent

Premium Tax Credit Percentage-of-Income Limits for Benchmark Coverage		
Income (% of FPL)	**Pre-ARPA schedule**	**IRA/ARPA schedule**
<138	2.07	0.0
138–150	3.10–4.14	0.0
150–200	4.14–6.52	0.0–2.0
200–250	6.52–8.33	2.0–4.0
250–300	8.33–9.83	4.0–6.0
300–400	9.83	6.0–8.5
>400	n/a	8.5

Cost-Sharing Reductions: Actuarial Value of Plans for Those Enrolling in Silver-Level Coverage		
Income (% of FPL)	**Pre-ARPA schedule**	**IRA/ARPA schedule**
<138	94	94
138–150	94	94
150–200	87	87
200–250	73	73
>250	70	70

Source: Internal Revenue Service; US Department of Health and Human Services; and American Rescue Plan Act of 2021, Pub. L. No. 117-2.

Notes: ACA = Affordable Care Act; ARPA = American Rescue Plan Act; FPL = federal poverty level; IRA = Inflation Reduction Act; n/a = not applicable (no subsidies are available at this income level). Pre-ARPA caps are from 2021 and are indexed each year. The ARPA and enhanced subsidy schedules' percentage-of-income limits are not indexed.

The cost-sharing reductions effectively increase the actuarial value of silver coverage to 73 percent (for those with incomes from 200 to 250 percent of FPL), 87 percent (for those with incomes from 150 to 200 percent of FPL), or 94 percent (for those with incomes up to 150 percent of FPL), thereby lowering their direct payments when using care.

CREATION OF INSURANCE MARKETPLACES

Shopping for insurance in the nongroup market before 2014 was challenging and time-consuming. There was no source that provided comparisons of all insurance options available in a person's area of residence. As a result, most consumers were left to rely on agents and brokers who are paid on commission, giving them a significant financial stake in a client's insurance choices. Consequently, agents and brokers do not necessarily provide complete information or information that is easily comparable across plans. In addition, because insurers could vary benefits and prices across applicants based on health status and past medical utilization, consumers typically had no way to know what plans they would be offered and at what price until they went through a detailed application for each insurer of interest.

Marketing and sales activities in group health insurance markets were directed to enroll people with the lowest health care risk, strategies consistent with the insurers' legal ability at the time to medically underwrite applicants and deny coverage outright. There could not be competitive nongroup insurance markets because information was limited and prices were time-consuming to obtain (after each insurer's required underwriting process). Moreover, the wide variation in the options available made it difficult for consumers to compare them, even in the best of circumstances.

The ACA created nongroup insurance Marketplaces (also called exchanges), some designed and run by states themselves (state-based Marketplaces) and others administered by the federal government (federally funded Marketplaces).[30] Each Marketplace provides web-based access to information in a consumer-friendly format on all nongroup insurance policies offered to residents in a given area for which insurers agreed to accept the new federally funded premium tax credits and cost-sharing reductions.

The Marketplaces allow prospective consumers to input their address, age, tobacco use status, and, if they choose to be considered for financial assistance, their income, and are then provided with their insurance choices, premiums (net of any applicable subsidies), detailed information on benefits and cost-sharing structure, quality ratings, links to provider networks, plan comparison tools, and other information of interest, including each plan's Summary of Benefits and Coverage. Should a shopper choose to enroll in a plan, they can do so directly through the website. Contact information for call centers and navigators (government-funded consumer assisters), as well as listings of local agents and brokers, are also provided for those who have questions or are uncomfortable using the online system independently.

In addition, the Marketplaces do their own outreach and marketing to increase awareness of coverage and subsidy options, broadening and diversifying the enrollment population. The websites and assisters determine subsidy eligibility and guide those eligible for Medicaid or the Children's Health Insurance Program to the appropriate programs. In these ways, Marketplaces facilitate competition based on price, benefit structures, and quality ratings, as opposed to plans competing to enroll the healthiest consumers.

Small-Group Insurance (for Employers of 1–50 Workers)[31]

Small employers have always been disadvantaged in purchasing health insurance for their workers compared with their large-employer counterparts. Lacking the large employers' economies of scale, small firms have always had to pay more per worker to buy the same benefits because these firms have

fewer workers across whom to spread fixed administrative costs. With smaller numbers of enrollees, small firms could not effectively spread health care risk, leading to higher premiums for many and greater year-to-year premium variation. Average wages of small-firm workers are lower than those of large-firm workers, making it more difficult for small employers to pass the costs of providing insurance back to their workers through reduced wages. These factors, taken together, led to substantially lower percentages of small employers offering coverage to their employees and higher rates of uninsurance among their workers (Nichols et al. 1997).

The ACA used several strategies to increase coverage among workers in small firms and their dependents. First, the reforms instituted in nongroup insurance markets, detailed above, were also applied to small-group insurance. These include modified community rating, essential health benefit requirements, and minimum MLRs. Guaranteed issue was already required for small-group plans before the ACA. The ACA also created small-group Marketplaces, known as Small Business Health Options Program, or SHOP, exchanges and provided temporary subsidies to small employers offering health insurance through a SHOP, with those subsidies increasing with decreasing size and average wage. The law also exempts small firms from any penalties for not offering health insurance to their workers.

Although the reforms remain in place, an increase in self-insuring small employers has decreased the ACA's ability to spread health care risk as broadly across small-group markets as originally intended. Administrative challenges and quickly decreasing subsidy amounts as size and wages increase mean that fewer small employers took advantage of small-group subsidies than was expected. However, financial assistance and other consumer protections in nongroup insurance markets, along with small employers' exemptions from ACA employer penalties, mean that small-firm workers have ample access to subsidized comprehensive insurance outside the employment context when desired.

The ACA Record

First, we describe how the ACA's affordability measures, combined with recent enhancements legislated by the Inflation Reduction Act, have dramatically increased enrollment in private nongroup insurance and made comprehensive coverage more affordable for consumers of all types. Second, we address how well the ACA Marketplaces have functioned in controlling spending and fostering insurer participation in nongroup insurance markets.

Affordability and Adequacy of Nongroup Insurance Coverage

Experience over the last 10 years has provided considerable evidence of the importance of the ACA's reforms for private insurance markets and their enrollees.

UNINSURANCE RATES

In 2009, the year before the ACA was passed and before any of the ACA's provisions were implemented, 15.4 percent of the US population—46.3 million people—was uninsured, according to the National Health Interview Survey (NHIS) (ASPE 2023). This translated into 17.5 percent of all people below age 65, 21.1 percent of adults ages 18 to 64, and 8.2 percent of children under age 18. According to the NHIS's most recently released data from the second quarter of 2023, the rate of uninsurance has fallen to 7.2 percent (23.7 million people) across all ages, 10.4 percent among adults ages 18 to 64, and 3.7 percent among children under age 18. Uninsurance rates have been cut by more than half, dropping to the lowest levels seen (Cohen, Martinez, and Ward 2010). Although the expansion of Medicaid contributed significantly to these dramatic cuts—slightly more than 50 percent of coverage gains by one estimate (Blumenthal, Collins, and Fowler 2020)—a majority of adults and children were insured by private coverage (employer-based or nongroup) as of early 2023.

NONGROUP MARKET ENROLLMENT

The private nongroup health insurance market has grown markedly under the ACA, rising from 13.1 million people under age 65 in 2009 to 21.6 million in 2022, the most recent estimates on nongroup coverage released from the NHIS.[32] Not only has enrollment in these markets grown by 60 percent (likely more given the record enrollment in 2024 Marketplaces noted below), but the composition has changed markedly as well.

As table 2 shows, lower-income people, particularly those with incomes between 100 percent and 250 percent of FPL, now comprise a larger share of nongroup insurance enrollment. This change reflects the provision of significant financial assistance (premium tax credits and cost-sharing reductions) that has made coverage more affordable and valuable to those of modest means. People with significant health needs, including those who do not report being in excellent or very good health, those who report specific conditions (e.g., hypertension, cancer, diabetes, asthma), and adults ages 50 to 64, also account for a larger share of nongroup insurance enrollment. This compositional shift is a consequence of the ACA eliminating medical underwriting in the regulated markets; the law's requiring provision of comprehensive benefits, maximum out-of-pocket limits, and minimum MLRs; and limits

placed on age rating of premiums, all of which combine to make coverage more affordable, accessible, and adequate to meet enrollees' health care needs.

TABLE 2

Characteristics of People under Age 65 Enrolled in Private Nongroup Coverage, 2009 and 2022

Percent

	2009	2022	
Family income (% of FPL)			
≤100	5.8	7.9	*
100–138	4.4	7.2	***
138–250	16.1	25.1	***
250–400	25.3	22.7	
>400	48.4	37.1	***
Self-reported health status			
Fair/poor	3.7	10.1	***
Good	16.1	24.6	***
Excellent/very good	80.2	65.3	***
Race/ethnicity			
White, non-Hispanic	82.0	59.6	***
Black, non-Hispanic	3.1	8.5	***
Hispanic	6.5	20.7	***
Asian, non-Hispanic	8.0	8.9	
Additional races, non-Hispanic	0.4	2.3	***
Age			
0–5	7.5	3.7	***
6–12	7.5	6.9	
13–17	7.1	5.2	**
18–34	25.1	21.7	**
35–49	21.7	24.4	*
50–64	31.1	38.2	***
Diagnosed chronic conditions[a]			
Hypertension	18.1	25.4	***
Coronary heart disease	1.9	3.1	
Angina	1.5	0.9	
Heart attack	1.5	1.6	
Stroke	0.2	0.7	*
Cancer	4.3	7.5	***
Arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia	15.8	16.0	
Diabetes	4.4	7.5	**
Asthma	10.8	13.6	*

Source: Urban Institute analysis of National Health Interview Survey, 2009 and 2022.

Notes: ESI = employer-sponsored health insurance; FPL = federal poverty level. People reporting more than one type of coverage are assigned to mutually exclusive coverage-type categories based on the following hierarchy: ESI/military, public coverage, nongroup coverage, other private coverage. Chronic conditions in 2009 are for sample adults only. The National Health Interview Survey instrument changed modestly between 2009 and 2022. However, these changes are not enough to alter the significant differences in the composition of nongroup markets across this time period.

[a]Diagnosed chronic conditions are reported for adults ages 18–64.

*/**/*** = 2022 estimate differs significantly from the 2009 estimate at the 0.10/0.05/0.01 level, using two-tailed tests.

MARKETPLACE ENROLLMENT

Nongroup insurance enrollment in the ACA's nongroup Marketplaces (i.e., not counting those enrolling in individual coverage outside the Marketplaces) has grown substantially since their first year in operation, from 8.0 million enrollees in 2014[33] to 21.3 million in 2023.[34] This astounding growth of 166 percent in 10 years is attributable to growing efficiency of the Marketplace eligibility determination and enrollment systems, increased awareness of the financial assistance available to consumers, increased insurer participation (discussed below), and the expanded financial assistance available through the Inflation Reduction Act.

FINANCIAL ASSISTANCE FOR MARKETPLACE NONGROUP COVERAGE

The premium tax credits provided through the ACA made significant financial assistance available to nongroup insurance purchasers for the first time.[35] As noted earlier (see table 1), these tax credits are structured to limit enrollees' required contributions for a benchmark (i.e., second lowest priced silver) plan to a specified percentage of family income. In this way, tax credits provide substantial discounts on the price of health insurance coverage, even bringing premiums down to zero or close to it for many enrollees.[36]

In 2024, a person or family with income up to 150 percent of FPL (e.g., up to $21,870 for a single adult or $45,000 for a family of four) would be eligible to enroll in a benchmark private nongroup Marketplace plan with an actuarial value of 94 percent at $0 premium. Although the financial assistance available declines as income increases, even those with higher incomes are eligible for premium tax credits that limit their premium contributions for the benchmark plan in their area to no more than 8.5 percent of income. This protection at incomes above the ACA's original cap of 400 percent of FPL, provided through the 2025 plan year by the Inflation Reduction Act, is particularly important for adults as they age. This is because nongroup insurance plans can increase premiums significantly with age, such that premiums for a 64-year-old can be three times those for a 20-year-old.[37] If no premium tax credits were offered to those with incomes above 400 percent of the poverty level, premiums for modest-income older adults could consume 20 percent of income plus out-of-pocket costs when using medical care. The premium tax credits fall to zero naturally as income increases and premiums account for less than 8.5 percent of income.

PREMIUM TAX CREDITS FOR CONSUMERS IN HIGHER-COST INSURANCE MARKETS

The particular structure of the premium tax credits increases the dollar value of the assistance for people living in higher-premium markets compared with those living in lower-premium markets, making coverage more affordable under the ACA's standards regardless of where someone lives. For example,

the average monthly benchmark premium, before subsidies, is $346.00 per month in Maryland and $847.00 per month in Wyoming.[38] Therefore, making coverage affordable to people in the same circumstances in Maryland and Wyoming requires significantly different levels of assistance.

Using the Maryland and Wyoming average benchmark premiums for illustrative purposes, we see that under current premium tax credit levels, a single adult with income of twice the FPL ($29,160 in 2024) would have the cost of benchmark coverage limited to 2.0 percent of income, or $48.60 per month. This coverage would include a cost-sharing reduction subsidy that would increase the actuarial value of a silver plan from 70 percent to 87 percent, significantly lowering the enrollee's out-of-pocket costs for obtaining medical services. In Maryland, the value of the premium tax credit for average benchmark coverage would be $346.00 (the total premium) less $48.60 (the enrollee's contribution), or $297.40 per month. In Wyoming, however, the premium tax credit would be $847.00 less the same $48.60, or $798.40, well more than twice the credit provided to a person in the same circumstances in the much less expensive Maryland market. In this way, affordability is not compromised for consumers who live in states with less competition in their insurer and provider markets or where other factors lead to higher costs of obtaining care.

VALUE OF ACA PREMIUM TAX CREDITS AND COST-SHARING REDUCTIONS FOR ENROLLEES

Premium tax credits lower the premium of each eligible enrollee's coverage by $6,174 on average (table 3). The value of the assistance increases as the enrollee's income falls, such that the average subsidized enrollee with income below 200 percent of FPL receives $7,408 in premium assistance. Of Marketplace enrollees receiving financial assistance, almost half fall into this low-income category. Fully 85 percent have incomes below 400 percent of the poverty level. Sixteen percent of tax credit recipients have higher incomes, and these people tend to be older, live in high-premium areas of the country, and have large families; they receive an average of $3,247 in assistance per person. Average premium tax credits are consistent across the spectrum of race/ethnicity groups.

Premiums for older adults can be up to three times those for the youngest adults: on average, premium tax credits for 55- to 64-year-olds are $9,002, whereas those for 19- to 34-year-olds are $4,829 (table 3). Reflecting that older adults are less likely to report being in good health than are younger people, average assistance for those in fair or poor health is considerably higher than for those in better health. The largest group of people receiving assistance (61 percent) have at least one full-time worker in the family, and each of these enrollees receives financial assistance exceeding $5,000 on average.

TABLE 3

Characteristics of People in the Marketplace Receiving Financial Assistance (Premium Tax Credits), 2024

	Marketplace Enrollment with PTCs	
	Those receiving PTCs (%)	Average PTC ($)
Total	100	6,174
Income (% of FPL)		
<200	48	7,408
200–400	37	5,533
400–600	11	4,175
>600	5	3,247
Race/ethnicity		
American Indian/Alaska Native	1	6,406
Asian and Pacific Islander	6	6,128
Black, non-Hispanic	12	6,248
Hispanic	16	6,197
White, non-Hispanic	63	6,175
More than one race	1	5,121
Age		
0–18	7	2,746
19–34	29	4,829
35–54	37	5,863
55–64	26	9,002
Health status		
Excellent	22	5,486
Very good	31	5,982
Good	33	6,338
Fair	11	7,203
Poor	3	7,636
Family work status		
No worker in family	18	7,605
Only part-time worker in family	8	6,890
One full-time worker in family	61	5,818
More than one full-time worker in family	12	5,315
Region		
Northeast	15	6,864
Midwest	13	5,885
South	53	6,222
West	19	5,689
Urban/Rural		
Urban	78	5,967
Mixed	8	7,094
Rural	14	6,790

Source: Urban Institute, Health Insurance Policy Simulation Model (HIPSM), 2024.

Notes: FPL = federal poverty level; PTC = premium tax credit. PTCs are per person within a household. Region is the census region. These estimates rely on the Urban Institute's 2023 HIPSM baseline estimates for 2024 and, as such, do not account for the higher-than-expected enrollment in Marketplace coverage that year.

Nonurban areas of the country tend to have less provider and insurer competition, meaning hospital and medical professional prices are higher in those areas, and these higher prices lead to higher

premiums. Reflecting these typical price differences, average assistance to those enrollees living in urban areas is lower, on average, compared with assistance to those in rural or mixed urban and rural areas (table 3). Because more people live in urban than in rural areas, people living in urban areas are the largest group of those receiving Marketplace financial assistance.

Private Nongroup Insurance Markets

Data show that establishing Marketplaces has allowed for effective competition among private insurers in most markets. A wide variety of plans, including Blue Cross Blue Shield–affiliated plans, national commercial insurers such as Aetna and UnitedHealthcare, local insurers, previously Medicaid-only insurers, and provider-sponsored plans have all entered at least some Marketplaces throughout the country, and insurer participation continues to grow. The results summarized below show that, even after the ACA eliminated denials of coverage for preexisting conditions, benefit limitations, and experience rating, premiums are relatively modest by comparison with employer-sponsored insurance. In addition, premium increases between 2019 and 2024 have been low according to several metrics.

Thus, the effort to establish a well-functioning nongroup market with considerable choice of insurers and control over spending has generally been successful. The exceptions are found in markets in which the population is too small to support effective competition. However, even these smaller markets remain sound and cover many people of diverse health status, although their premiums tend to be higher and grow faster than in other areas of the country. As noted above, this is the result of ACA financial assistance lowering enrollees' net premiums in a manner that ensures even consumers living in high-priced areas can afford comprehensive insurance coverage.

INSURER PARTICIPATION

As a sign of the growing stability of the ACA nongroup Marketplaces, the number of insurers participating has grown. We examined a sample of 43 rating regions in 28 states. As detailed in table 4, across these regions were 153 insurer participants in Marketplaces in 2017 (counting each insurer participating in a given region as one participant), an average of 3.6 distinct insurers per region. The number of insurers participating in these same regions grew to 161 in 2020, 227 in 2022, and 236 by 2023 to an average of about 5.5 distinct insurers per region.

Between 2022 and 2024, two local insurers, Bright Health and Friday Health Plans, which offered plans in 19 of our study's rating regions in 2022, left the markets because of insolvency. Without those exits, the increase in participation by other insurers would be even more notable. Prominently, two

national insurers—Aetna, increased its participation from zero markets in 2020 to 17 rating regions in 2024, and United Healthcare, participated in three regions in 2020 and increased its participation to 26 rating regions in 2024. The number of rating areas in which provider-sponsored plans participated also increased, from 10 to 24 rating regions between 2020 and 2024.

TABLE 4

Insurer Participation in Rating Regions, Select Study Regions, by Insurer, 2017–24

Insurer	2017	2018	2019	2020	2022	2024
Aetna	2	0	0	0	8	17
Anthem	9	4	4	5	9	9
Blue Cross Blue Shield[a]	36	36	36	38	38	38
CareSource	4	4	4	5	5	5
Centene (Ambetter, HealthNet, Fidelis Care, Coordinated Care)	20	21	22	24	30	31
Cigna	5	4	5	6	10	12
Friday and Bright Health	0	1	3	6	19	0
Humana	6	0	0	0	0	0
Kaiser Permanente	9	9	9	9	9	8
Molina Healthcare	12	10	10	10	11	12
Oscar	3	7	11	16	21	19
UnitedHealthcare	4	2	3	3	19	26
Provider	14	11	11	10	19	24
Other	29	27	29	29	29	35
Total	153	136	147	161	227	236

Source: Urban Institute analysis of data from Healthcare.gov and relevant state-based Marketplace websites, updated with data from the 2024 plan year, from John Holahan, Eric Wengle, and Claire O'Brien, "Changes in Marketplace Premiums and Insurer Participation, 2022–2023" (Washington, DC: Urban Institute. 2023), https://www.urban.org/research/publication/changes-marketplace-premiums-and-insurer-participation-2022-2023.

[a]Blue Cross Blue Shield excludes Anthem.

PREMIUM LEVELS

Table 5 shows that the average benchmark (second lowest cost silver) premium nationally for a single 40-year-old nonsmoker was $473 per month in 2024, before application of premium subsidies. A few states, such as Alaska, West Virginia, and Wyoming, have extremely high premiums, averaging over $800 per month. Others, such as Alabama, Connecticut, Louisiana, Nebraska, and South Dakota, are also fairly high. Two others, New York and Vermont, appear high in table 5. However, premiums in New York and Vermont are not comparable with others because both states prohibit premium variation by age, so the states' premiums reflect an average across all enrolled adults, which is higher than 40 years.

At the other extreme, several states have benchmark premiums of $400 or below per month. These include Arizona, Maryland, Michigan, Minnesota, New Hampshire, and Virginia. These lower-priced states tend to have many insurers participating. Variation also exists within states across rating regions, but that detail is not shown here.

TABLE 5

Average Monthly Benchmark Premium for a 40-Year-Old Nonsmoker and Percent Change from 2019 to 2024, by State, From Highest 2024 Premium to Lowest

	Average Benchmark Premium ($)			Annual Percent Change (%)		
	2019	2023	2024	2019–23	2023–24	2019–24
US average	**468**	**454**	**473**	**–0.7**	**4.2**	**0.2**
Vermont[a]	517	841	950	14.3	12.9	14.0
Alaska	714	760	886	1.7	16.5	4.7
West Virginia	585	835	854	9.4	2.3	8.0
Wyoming	860	802	818	−1.5	1.9	−0.8
Connecticut	472	623	657	7.5	5.4	7.1
New York[a]	572	621	622	2.1	0.1	1.7
South Dakota	526	591	571	3.0	−3.3	1.7
Nebraska	825	545	568	−9.6	4.2	−6.9
Alabama	544	562	557	0.9	−1.0	0.5
Louisiana	461	552	553	4.8	0.2	3.8
Delaware	685	549	533	−4.9	−3.0	−4.5
DC	393	428	532	2.4	24.2	6.7
Maine	530	458	516	−3.3	12.8	−0.1
Missouri	490	476	502	−0.6	5.5	0.6
Tennessee	545	474	502	−3.3	6.0	−1.4
Montana	553	468	499	−3.9	6.8	−1.8
Utah	540	468	499	−3.4	6.7	−1.4
South Carolina	557	498	499	−2.4	0.2	−1.9
Florida	485	474	491	−0.6	3.8	0.3
North Carolina	609	503	491	−4.5	−2.3	−4.1
Oklahoma	661	469	486	−7.9	3.7	−5.6
Mississippi	522	468	486	−2.6	3.8	−1.3
Kansas	527	465	482	−3.0	3.7	−1.7
Oregon	433	454	480	1.2	5.7	2.1
New Mexico	366	449	477	5.7	6.0	5.7
Texas	419	455	475	2.1	4.4	2.6
New Jersey	348	453	474	7.0	4.6	6.5
Illinois	473	453	472	−0.9	4.0	0.1
Hawaii	503	471	470	−1.5	−0.4	−1.3
California	447	427	465	−1.1	8.7	0.9
Wisconsin	519	445	464	−3.6	4.1	−2.0
Pennsylvania	458	450	463	−0.3	2.7	0.3
Georgia	457	402	453	−2.8	12.7	0.3
Iowa	731	469	445	−9.7	−5.0	−8.7
Colorado	496	351	440	−7.7	25.2	−1.1
North Dakota	396	421	438	2.8	4.1	3.1
Kentucky	432	426	437	−0.1	2.6	0.4
Ohio	366	412	432	3.1	5.0	3.5
Arkansas	380	416	427	2.4	2.8	2.5
Massachusetts	330	415	425	5.9	2.4	5.2
Idaho	485	419	417	−3.4	−0.6	−2.8
Washington	380	386	403	0.4	4.4	1.2
Rhode Island	336	379	400	3.1	5.5	3.6
Indiana	338	395	400	4.2	1.3	3.6
Arizona	463	400	398	−3.5	−0.3	−2.8
Nevada	413	388	391	−1.4	0.7	−1.0
Michigan	373	353	373	−1.3	5.5	0.1
Virginia	557	367	372	−9.7	1.4	−7.5
Maryland	419	333	346	−5.4	3.8	−3.6

	Average Benchmark Premium ($)			Annual Percent Change (%)		
	2019	2023	2024	2019–23	2023–24	2019–24
Minnesota	333	331	343	−0.1	3.5	0.7
New Hampshire	402	323	335	−5.0	3.9	−3.2

Source: Urban Institute analysis of data from Healthcare.gov and relevant state-based Marketplace websites, adapted from John Holahan, Eric Wengle, and Claire O'Brien, "Targeting Highly Concentrated Insurer and Provider Markets for Rate Regulation" (Washington, DC: Urban Institute, 2024), https://www.urban.org/research/publication/targeting-highly-concentrated-insurer-and-provider-markets-rate-regulation.

Note: State average is the average of the second-lowest cost silver premium offered in each rating area weighted by rating area population size.

[a]Premiums for Vermont and New York, which have community rating, are not strictly comparable with other states.

In a 2016 analysis, we compared benchmark premiums in the Marketplace with employer-sponsored insurance premiums (Blumberg, Holahan, and Wengle 2016). Employer-sponsored insurance plans typically have actuarial values greater than 70 percent. In addition, utilization of services by enrollees tends to be higher than for nongroup insurance enrollees because cost sharing is typically lower. The employer insurance–enrolled population also tends to be younger than the nongroup enrolled. After adjusting for these factors, we found that, nationally, Marketplace premiums were 10 percent below premiums for employer-sponsored insurance, on average. Average Marketplace premiums were lower in 39 out of 50 states.

We updated this work using 2022 data following the same methods (Holahan and Wengle, forthcoming). We again adjusted for the lower actuarial value of Marketplace plans, for the higher utilization associated with lower cost sharing, and for Marketplace populations being older. We also adjusted for the cost-sharing reductions now built into silver Marketplace premiums. We found the difference between Marketplace and employer premiums was even larger in 2022 than in 2016, as employer premiums have continued to grow faster than those in the nongroup market. The age adjustment also has a larger effect because Marketplace enrollees became somewhat younger and ESI enrollees somewhat older. We find that Marketplace premiums in 2022, when adjusted as described, are 28 percent below premiums in the small-group market and 23 percent below premiums in the large-group market (Holahan and Wengle, forthcoming; data not shown in table). Such differences hold in almost all states, the exceptions being states with less competitive Marketplaces and thus higher benchmark nongroup premiums.

PREMIUM INCREASES

Table 5 shows the increase in benchmark nongroup premiums between 2019 and 2024. The plan with the benchmark premium can change from year to year if the insurer offering the second-lowest priced plan changes. The change in the benchmark premium is generally lower than the change in the average

premium, year to year. Because premium tax credits are tied to the benchmark plan's premium, lower benchmark premiums lower federal government costs for premium tax credits.

2019 is a useful starting point for assessing nongroup Marketplace premium increases. That year, the Trump administration ended direct federal reimbursement of insurers' costs associated with ACA cost-sharing reductions, leading to a spike in premiums. In 2018, states generally permitted insurers to incorporate costs attributable to the legally required cost-sharing reductions for low-income consumers into silver-level plan premiums, a strategy designed to prevent insurers from facing large financial losses.[39] That practice significantly increased silver-level plan premiums and became accepted nationwide by 2019, resulting in a new, higher equilibrium level of silver plan premiums in all states.

Table 5 shows the average annual premium increase between 2019 and 2023 was −0.7 percent; this small average annual decrease was followed by a 4.2 percent increase between 2023 and 2024, or a 0.2 percent average annual increase per year between 2019 and 2024. This low average annual increase in Marketplace premiums was smaller than the increase in the consumer price index (4.1 percent) and gross domestic product (5.6 percent).[40] The increase in Marketplace premiums was also substantially below increases in employer-sponsored insurance premiums.

The average drop in Marketplace premiums of 2.2 percent between 2019 and 2023 compares with an average increase in employer-sponsored plan single premiums of 17.3 percent over the same period.[41] Between 2023 and 2024, Marketplace premium increases were 4.2 percent. This compares with higher estimates of increases of 6.6 percent[42] to 7.0 percent[43] for employer premiums, and 7.7 percent for federal employee health plans.[44]

Conclusions

The Affordable Care Act has transformed private insurance in myriad ways, especially for coverage sold through private nongroup insurance markets. These reforms are now inextricably entwined across the breadth of the US health insurance and health care systems.

Challenges to private insurance markets remain, and further reforms will be needed to address them. For example, opponents of the law continue to bring legal actions such as *Braidwood Management Inc. v. Xavier Becerra*,[45] cases that threaten particular components of the ACA. In the case of Braidwood, an ultimate finding for the plaintiffs would significantly reduce the number of preventive benefits insurance enrollees receive without out-of-pocket costs.

Other challenges include insurers often achieving low premiums by establishing plans with narrow provider networks (which include, for example, providers willing to accept lower payment rates), which could result in problems of access for some enrollees. In addition, the end of direct federal funding for cost-sharing reductions increased silver premiums but lowered premiums for high-deductible bronze plans. A large share of enrollees then switched to bronze plans, and they often face unexpectedly high levels of cost sharing as a result. The share of Marketplace enrollees in bronze plans increased from 20.7 percent in 2016 to 33.0 percent in 2023 (Holahan, Wengle, and O'Brien 2023).

Evidence also indicates that some insurers overuse claims denials to keep their costs down, warranting further oversight and potential government intervention (Pollitz et al. 2023). In addition, the higher premium tax credits the Inflation Reduction Act provides to nongroup insurance enrollees, which have further increased coverage and reduced household financial burdens, are set to expire at the end of the 2025 plan year. These issues go beyond the limits of the ACA, however, and do not take away from the fact that the 2010 law has and continues to fulfill much of its original promise.

Changes to insurance market rules, increased consumer protections, provision of premium and cost-sharing subsidies, and expansions to the Medicaid program in all but nine states[46] have resulted in the highest rates of health insurance coverage in the country's history. Affordability and access to care have improved, particularly for people when they are in need of significant medical services. In addition, the transformation of private nongroup insurance markets created true competition based on price and quality, as opposed to competition for the healthiest enrollees, for the first time.

Further, the ACA has demonstrated the importance of having broad insurance protections and eligibility for financial assistance in the face of health and financial crises. During the COVID-19 pandemic and associated recession, the law's Medicaid expansion (available in most states), combined with subsidized private Marketplace coverage (available nationwide), was critical to keeping millions of people insured with affordable access to necessary medical services at a high-risk time. In addition, the ACA's protections guarantee that insurers cannot deny coverage for care based on COVID infection or any other diagnosis. The COVID experience, along with the 10 years since full ACA implementation, have demonstrated that the ACA's structure and standards provide a strong base on which to build as policymakers consider further health system improvements in equity, access, and affordability of medical care.

Notes

[1] Jill Colvin and Zeke Miller, "Trump Says He Will Renew Efforts to Replace 'Obamacare' If He Wins a Second Term," *Associated Press*, November 27, 2023, https://apnews.com/article/trump-obamacare-health-care-biden-c2b1f5776310870deed2fb997b07fc2c; Sahil Kapur, "Trump Doubles Down, Saying 'Obamacare Sucks' and Must Be Replaced," *NBC News*, November 29, 2023, https://www.nbcnews.com/politics/congress/trump-doubles-saying-obamacare-sucks-must-replaced-rcna126978; Tami Luhby, "Obamacare Would Be Even Harder to Kill Now, but Trump Promises to Try Anyway," *CNN*, January 7, 2024, https://www.cnn.com/2024/01/07/politics/obamacare-health-insurance-ending-trump/index.html.

[2] White House, "Fact Sheet: Biden Takes New Steps to Lower Prescription Drug and Health Care Costs, Expand Access to Health Care, and Protect Consumers," March 2024, https://www.whitehouse.gov/briefing-room/statements-releases/2024/03/06/fact-sheet-president-biden-takes-new-steps-to-lower-prescription-drug-and-health-care-costs-expand-access-to-health-care-and-protect-consumers/.

[3] "All insurance markets, including self-insured plans," excludes short-term limited duration policies purchased by individuals. These plans were excluded from the ACA's regulations as the legislators intended that they serve as "gap fillers" for those enrolling in coverage outside the ACA's annual open enrollment period. Federal regulation of these short-term policies has varied across the Obama, Trump, and Biden administrations, with the Trump administration attempting to increase access to these far less regulated policies, whereas the Biden administration has attempted to further limit their availability. See Dong Ding and Sherry A. Glied, "Tightening the Rules around Short-Term Health Insurance Plans Won't Lead to More People Going without Insurance," *To the Point* (blog), Commonwealth Fund, October 5, 2023, https://www.commonwealthfund.org/blog/2023/tightening-rules-around-short-term-health-insurance-plans-wont-lead-more-people-going.

[4] Robin A. Cohen, "Long-Term Trends in Health Insurance Coverage: Estimates From the National Health Interview Survey, 1968–2022," National Center for Health Statistics, 2022.

[5] "Marketplace Enrollment, Timeframe: 2024," State Health Facts, KFF, https://www.kff.org/affordable-care-act/state-indicator/marketplace-enrollment/.

[6] Centers for Medicare & Medicaid Services, "Historic 21.3 Million People Choose ACA Marketplace Coverage," press release, January 24, 2024, https://www.cms.gov/newsroom/press-releases/historic-213-million-people-choose-aca-marketplace-coverage.

[7] Here, we count Wisconsin as a state that has expanded its Medicaid program since the implementation of the ACA. While not expanding eligibility up to 138 percent of the federal poverty level under the ACA's rules, Wisconsin expanded eligibility for all adults up to 100 percent of the federal poverty level, the income level at which people become eligible for premium tax credits and cost-sharing reductions. Wisconsin implemented this expansion with state dollars instead of expanding to the higher income level required to use largely federal funding for the expansion population.

[8] Colvin and Miller, "Trump Will Renew Efforts"; Kapur, "Trump Doubles Down"; and Luhby, "Obamacare Harder to Kill."

[9] White House, "Biden Takes New Steps."

[10] Federal premium tax credits subsidizing private coverage purchased through the ACA Marketplaces are available to those who are ineligible for public coverage and have incomes beginning at 100 percent of FPL. Wisconsin's more limited expansion approach means that low-income state residents are not subject to the eligibility gap that persists in the nine other nonexpansion states (Alabama, Florida, Georgia, Kansas, Mississippi, South Carolina, Tennessee, Texas, and Wyoming). In those states, adults without dependent children who have incomes below the poverty level are ineligible for any financial assistance to obtain health insurance. Even the

Medicaid eligibility cutoffs for adults with dependent children are well below the poverty level in these states. For example, in Alabama, parents are eligible for Medicaid up to 18 percent of FPL. In Texas, parents are eligible up to 16 percent of FPL.

[11] See, for example, Madeline Guth, Rachel Garfield, and Robin Rudowitz, "The Effects of Medicaid Expansion under the ACA: Studies from January 2014 to January 2020," KFF, March 17, 2020, https://www.kff.org/medicaid/report/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review/; and Madeline Guth and Meghana Ammula, "Building on the Evidence Base: Studies on the Effects of Medicaid Expansion, February 2020 to March 2021," KFF, May 6, 2021, https://www.kff.org/medicaid/report/building-on-the-evidence-base-studies-on-the-effects-of-medicaid-expansion-february-2020-to-march-2021/.

[12] Federal law excludes sole proprietors from eligibility to purchase small-group insurance plans. They may buy coverage through the nongroup/individually purchased market.

[13] "All insurance markets, including self-insured plans," excludes short-term limited duration policies purchased by individuals. These plans were excluded from the ACA's regulations as the legislators intended that they serve as "gap fillers" for those enrolling in coverage outside the ACA's annual open enrollment period. Federal regulation of these short-term policies has varied across the Obama, Trump, and Biden administrations, with the Trump administration attempting to increase access to these far less regulated policies, whereas the Biden administration has attempted to further limit their availability. See Ding and Glied, "Tightening the Rules." Some additional grandfathered and grandmothered plans (i.e., plans in place before implementation of the ACA's reforms that have not changed significantly since implementation) were also excluded from some of these reforms. In addition, independent, noncoordinated excepted benefits (e.g., coverage for only a specified disease, fixed indemnity policies) are excluded from the reforms.

[14] Creditable coverage includes employer-based insurance, individual insurance, Medicare, Medicaid, military health care, the Indian Health Service, state health benefits risk pools, the Federal Employee Health Benefits Program, State Children's Health Insurance Programs, and so on. See CRS (2005).

[15] HIPAA included much narrower portability protections for nongroup insurance enrollees; these protections were more difficult for consumers to access than were the continuous coverage protections for group insurance enrollees. For example, the consumer would have to be continuously covered by employer-based insurance for the prior 18 months, and any worker eligible for COBRA (an expense that many cannot afford) would need to exhaust COBRA coverage before becoming eligible for nongroup coverage without a preexisting condition exclusion period.

[16] Lisa Girion, "Blue Cross Praised Employees Who Dropped Sick Policyholders, Lawmaker Says," *Los Angeles Times*, June 17, 2009, https://www.latimes.com/archives/la-xpm-2009-jun-17-fi-rescind17-story.html.

[17] "Uninsured Rates for the Nonelderly by Age, Timeframe: 2009" State Health Facts, KFF, https://www.kff.org/uninsured/state-indicator/nonelderly-uninsured-rate-by-age/.

[18] "Behavioral Risk Factor Surveillance System Survey," Centers for Disease Control and Prevention, https://www.cdc.gov/brfss/annual_data/annual_2010.htm.

[19] "Preventive Services Covered by Private Health Plans under the Affordable Care Act," Fact Sheet, KFF, February 28, 2024, https://www.kff.org/womens-health-policy/fact-sheet/preventive-services-covered-by-private-health-plans/.

[20] "Medical Loss Ratio: Getting Your Money's Worth on Health Insurance," Centers for Medicare & Medicaid Services, November 22, 2010, https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/medical-loss-ratio.

[21] Karen Pollitz and Larry Levitt, "Health Insurance Transparency under the Affordable Care Act," KFF, March 8, 2012, https://www.kff.org/affordable-care-act/perspective/health-insurance-transparency-under-the-affordable-care-act/.

[22] "Summary of Benefits and Coverage: What This Plan Covers and What You Pay for Covered Services," US Department of Labor, accessed May 1, 2024.

[23] There is a lower limit for high-deductible health plans that qualify for Health Savings Accounts ($8,050 and $16,100 in 2024).

[24] Again, "nongroup insurance markets" excludes short-term, limited-duration policies purchased by individuals.

[25] "Individual Market Guaranteed Issue (Not Applicable to HIPAA Eligible Individuals), Timeframe: 2013," State Health Facts, KFF, June 1, 2013, https://www.kff.org/other/state-indicator/individual-market-guaranteed-issue-not-applicable-to-hipaa-eligible-individuals/.

[26] Although the vast majority of US residents age 65 and above are covered by the Medicare program, a small percentage of older adults are ineligible for Medicare because they or their spouse did not work a sufficient number of quarters to qualify. Those adults are eligible for nongroup insurance coverage and potentially eligible for Marketplace subsidized coverage (depending upon their income) as long as they are legal residents of the US. Their premiums would be rated the same as for those age 64 in the nongroup insurance rating region in which they live.

[27] Actuarial value is the average percentage of covered health care costs paid by an insurance plan (as opposed to the share of total expenses paid by the enrollees through deductibles, copayments, and coinsurance requirements).

[28] "What Marketplace Health Insurance Plans Cover," HealthCare.Gov, n.d., https://www.healthcare.gov/coverage/what-marketplace-plans-cover/.

[29] All enrollees considered to be in a single risk pool means that the expected health costs for all nongroup insurance enrollees, regardless of whether they enroll in higher or lower cost-sharing plans or whether they enroll through an ACA Marketplace or through their insurer directly outside the Marketplaces, are averaged to calculate insurance premiums. For example, people enrolling in platinum-level coverage, the highest actuarial value level offered, pay higher premiums because they chose a plan that requires lower out-of-pocket costs. However, if this group of enrollees tends to use more health care services because they have more health care problems, this is not reflected in their premiums. Any differences in spending caused by differences in health care needs are averaged across the premiums of all nongroup enrollees.

[30] In some instances, states took on limited responsibilities within their federally funded Marketplaces.

[31] Again, the ACA's small-group reforms apply only to fully insured small-employer plans. Self-insuring small-employer plans are exempt.

[32] Cohen, "Long-Term Trends in Coverage."

[33] "Marketplace Enrollment, 2014–2024, Timeframe: 2024," KFF.

[34] Centers for Medicare & Medicaid Services, "Historic 21.3 Million People Choose ACA Marketplace Coverage," press release, January 24, 2024, https://www.cms.gov/newsroom/press-releases/historic-213-million-people-choose-aca-marketplace-coverage.

[35] Although tax subsidies for the self-employed to purchase nongroup insurance had long been available, such assistance was not offered to other consumers. The self-insured can deduct 100 percent of the costs of nongroup health insurance for themselves and their dependents from their self-employment income, effectively reducing the household's cost of obtaining insurance.

[36] Louise Norris, "Who's Getting Zero-Premium Health Insurance Plans?" Healthinsurance.org, January 8, 2024, https://www.healthinsurance.org/faqs/whos-getting-zero-premium-health-insurance-plans/.

[37] Massachusetts limits age rating to a 2:1 ratio, and New York and Vermont prohibit all age rating.

[38] "Average Marketplace Premiums by Metal Tier, 2018–2024, Timeframe: 2024," State Health Facts, KFF, https://www.kff.org/affordable-care-act/state-indicator/average-marketplace-premiums-by-metal-tier/.

[39] Sabrina Corlette, Kevin Lucia, and Maanasa Kona, "States Step Up to Protect Consumers in Wake of Cuts to ACA Cost-Sharing Reduction Payments," *To the Point* (blog), Commonwealth Fund, October 27, 2019, https://doi.org/10.26099/QHZY-P549.

[40] Urban Institute analysis of CBO (2023); "National GDP and Personal Income," Bureau of Economic Analysis, US Department of Commerce, March 29, 2024, https://www.bea.gov/itable/national-gdp-and-personal-income; and "Consumer Price Index Databases," US Bureau of Labor Statistics, n.d., https://www.bls.gov/cpi/data.htm.

[41] Authors' calculations based on Claxton and others (2019, 2023).

[42] A Mercer team estimated that the employer premium increase would be somewhat lower than 6.6 percent—5.4 percent—following anticipated benefit cuts. Beth Umland, Suit Patel, and Tracy Watts, "Health Benefit Costs Expected to Rise 5.4% in 2024," *US Health News* (blog), Mercer, September 7, 2023, https://www.mercer.com/en-us/insights/us-health-news/health-benefit-cost-expected-to-rise-54-in-2024-mercer-survey/.

[43] Medical costs are to increase by 7 percent in 2024: Thom Bales, Derek Skoog, Phil Sclafani, Julian Levin, and In Sung Yuh, "Medical Cost Trend: Behind the Numbers 2024," PwC Health Research Institute, accessed May 1, 2024.

[44] Molly Weisner, "What's Driving Rate Hikes for Federal Employee Health Premiums?" *Federal Times*, November 21, 2023, https://www.federaltimes.com/management/pay-benefits/health-care/2023/11/21/whats-driving-rate-hikes-for-federal-employee-health-premiums/.

[45] Andrew Twinamatsiko and Zachary Baron, "Sweeping Ruling Blocks Preventive Services Coverage Requirements Nationwide," *Health Affairs Forefront*, April 7, 2023, https://www.healthaffairs.org/content/forefront/sweeping-ruling-blocks-preventive-services-coverage-requirements-nationwide.

[46] Here, we count Wisconsin as a state that has expanded its Medicaid program since the implementation of the ACA. Although not expanding eligibility up to 138 percent of FPL under the ACA's rules, Wisconsin expanded eligibility for all adults up to 100 percent of FPL, the income level at which people become eligible for premium tax credits and cost-sharing reductions. Wisconsin implemented this expansion with state dollars instead of expanding to the higher income level required to use largely federal funding for the expansion population.

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Holahan has conducted significant work on Medicaid and Medicare reform, including analyses on the recent growth in Medicaid expenditures, implications of block grants and swap proposals on states and the federal government, and the effect of state decisions to expand Medicaid in the ACA on federal

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