Assessing Marketplace Coverage for Parents and Children

Changes between 2019 and 2025

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Since 2014, health insurance Marketplaces established by the Affordable Care Act (ACA) have offered a platform for purchasing private health insurance, with financial assistance available based on income in the form of premium tax credits (PTCs) and cost-sharing reductions to improve affordability. In response to the COVID-19 pandemic, Congress passed the American Rescue Plan Act in 2021, expanding available PTCs for individuals with family incomes between 100 and 400 percent of the federal poverty level (FPL) who were traditionally eligible, and extending subsidies to previously ineligible higher-income individuals.[1] The Inflation Reduction Act of 2022 extended the availability of enhanced PTCs through the end of 2025. Marketplace enrollment soared under this policy and accompanying policies aimed at increasing its accessibility, with data from the Centers for Medicare & Medicaid Services (CMS) indicating that total enrollment and enrollment among children more than doubled.[2]

These enrollment trends suggest the Marketplaces are serving as an increasingly important coverage source for families with children, potentially expanding their access to health care and protection against high medical bills. Because eligibility for Medicaid and the Children's Health Insurance Program (CHIP) is more expansive for children than parents in every state, Marketplace coverage would be expected to be a more important coverage source for parents than for children, especially in states that have not expanded Medicaid under the ACA, where parents must often have very low incomes to qualify for Medicaid and where parents are eligible for Marketplace PTCs when

their incomes are at least 100 percent of FPL (compared with 138 percent of FPL in expansion states) (Brooks et al. 2025).

The fate of the enhanced PTCs is currently being debated, with risks of substantial drops in Marketplace coverage among both children and adults if they expire (Buettgens et al. 2025a). In this analysis, we assess reliance on Marketplace coverage among parents and children, a topic that has received little attention to date. We analyze Marketplace coverage among parents and children from 2019 through 2024 and 2025, the most recent estimates available from the National Health Interview Survey (NHIS) and Current Population Survey Annual Social and Economic Supplement (CPS), respectively. Our key findings are as follows:

- According to administrative data from CMS, Marketplace enrollment more than doubled for both nonelderly adults and children between 2019 and 2025, and grew at a higher rate among children than adults.
- In 2025, 4.8 percent of parents and 3.4 percent of children had Marketplace coverage according to the CPS, and 5.9 percent of parents and 3.1 percent of children had Marketplace coverage in 2024 according to the NHIS. Children and parents combined accounted for about 4 in 10 of all nonelderly Marketplace enrollees, according to both surveys.
- The share of parents and children relying on Marketplace coverage rose by 33 percent and 48 percent, respectively, between 2019 and 2025, according to the CPS, and by 48 percent and 59 percent, respectively, between 2019 and 2024, according to the NHIS.
- Parents in states that have not expanded Medicaid under the ACA (i.e., nonexpansion states) experienced the largest increases in Marketplace coverage, rising from 4.6 percent in 2019 to 7.1 percent in 2025, according to the CPS.
- In 2025, parents in nonexpansion states were more likely to have Marketplace coverage at the time of the CPS survey (7.1 percent) than parents in states that expanded Medicaid between 2019 and 2023 (4.2 percent) or before 2019 (3.8 percent).
    - » Parents experienced decreases in uninsurance between 2019 and 2025 in states with recent Medicaid expansions (from 13.0 percent to 10.7 percent) and states that had not expanded Medicaid by 2025 (from 17.9 percent to 14.2 percent).
    - » Medicaid coverage rose over this period for parents in states with recent expansions (from 8.9 percent to 10.9 percent) but not in other states, and Marketplace coverage increased in states that had not expanded Medicaid by 2025 or that had expanded Medicaid before 2019.
- When focusing on people with incomes between 100 and 400 percent of FPL—the primary target group for Marketplace PTCs—we find that access to care and utilization of health care services among Marketplace-enrolled parents and children over the prior year were relatively similar to their counterparts with employer-sponsored insurance (ESI) and better than comparable uninsured people.

    - » These results generally held true both with and without adjustment for differences in socioeconomic and demographic characteristics across groups with different coverage statuses.
    - » One exception was related to dental care, which Marketplace plans generally do not cover. Parents with Marketplace coverage were more likely to have unmet or delayed dental care needs than similar ESI enrollees.
- Marketplace coverage was higher among parents in the South than in the Midwest and West, likely because of a greater number of states in the South not participating in the ACA's Medicaid expansion, and higher among parents with incomes below 250 percent of FPL than those with higher incomes. Differences by region and income were smaller among children than among parents.

Although fewer parents and children have Marketplace coverage compared with other coverage types like ESI and Medicaid/CHIP, these findings show that the importance of Marketplaces has risen steeply over recent years for families with children, particularly for parents, especially those in nonexpansion states. As Congress considers whether to extend the enhanced PTCs, and 4.8 million people are projected to become uninsured if they are discontinued (Buettgens et al. 2025a), this analysis suggests that the resulting coverage losses would increase unmet health care needs and out-of-pocket spending burdens among parents and children.

We first provide background on Marketplaces and changes in the Marketplace landscape over recent years, followed by a description of our methodology, main findings from the analysis, and a discussion of policy implications.

Background

ACA Marketplaces

The ACA greatly expanded access to publicly subsidized health insurance coverage. Starting in 2014, states could choose to expand Medicaid eligibility to adults with incomes below 138 percent of FPL. The ACA also established Marketplaces for the purchase of health insurance coverage, with states allowed to use the federally facilitated Marketplace (FFM) or establish their own state-based Marketplace (SBM). For children, Marketplace coverage offers fewer benefits than Medicaid, but Marketplace plans are required to cover essential health benefits, including preventive care and hospitalizations (Whitener et al. 2016). Although they must cover pediatric dental care if no stand-alone dental plan is available, only some Marketplace plans cover adults' dental care; enrollees can purchase stand-alone dental coverage without subsidies, but enrollment in such plans is relatively low (Celik et al. 2025; Whitener et al. 2016).

When Marketplaces were established, subsidies in the form of PTCs for those with incomes between 100 and 400 percent of FPL, as well as additional cost-sharing reductions for out-of-pocket

medical expenses for people with incomes below 250 percent of FPL, were made available for people who do not qualify for Medicaid and whose employers do not offer coverage that is deemed "affordable."[3] Marketplace subsidies were open to citizens and lawfully present noncitizens, including lawfully present noncitizens with incomes below the FPL who were ineligible for Medicaid because of their immigration status.

Marketplace plan selections exceeded 8 million in the first open enrollment period (OEP) and 12 million by 2016.[4] Medicaid expansion and the establishment of Marketplaces with PTCs contributed to rising coverage rates under the ACA, with Marketplaces accounting for an estimated 40 percent of the initial coverage increase (Frean, Gruber, and Sommers 2017). Marketplace coverage has been found to be associated with increased access to care and improved economic conditions for enrollees (ASPE 2022).

Both Medicaid expansion and Marketplaces were primarily targeted toward adults, whose uninsured rates had been much higher than for children. Eligibility for Medicaid/CHIP for adults had traditionally been much more limited than for children—before ACA implementation, the median eligibility level for children in Medicaid/CHIP was 235 percent of FPL, compared with below 100 percent of FPL for parents, with no available publicly subsidized coverage in most states for nonparents who were not disabled or pregnant (Heberlein et al. 2013). Still, by 2016, about a million children had Marketplace coverage (Whitener et al. 2016). Marketplaces are also more important coverage sources for adults in states that have not expanded Medicaid under the ACA, as Medicaid eligibility is much more restrictive for adults in those states (Brooks et al. 2025). Medicaid/CHIP income eligibility levels also tend to be lower for children in those states: In 2025, the median state's eligibility level for children was 255 percent of FPL, with the median expansion state covering children up to 266 percent of FPL compared with 234 percent of FPL in nonexpansion states (Brooks et al. 2025).

Policy Changes in Recent Years

Several policy changes between 2019 and early 2025 have affected the affordability of Marketplace coverage and access to Medicaid:

- ***Expanded size and reach of Marketplace subsidies***. Starting in 2021, the American Rescue Plan Act increased PTC amounts for individuals with family incomes between 100 and 400 percent of FPL. The law also expanded the availability of PTCs to people with incomes above 400 percent of FPL, capping their out-of-pocket premium costs for a benchmark silver plan at 8.5 percent of their income. These enhancements were later extended through 2025 under the Inflation Reduction Act of 2022. The enhanced PTCs increased the share of enrollees who had the option of plans with very low—or even $0—monthly premiums (ASPE 2024; Branham et al. 2021).[5]
- ***Medicaid continuous coverage requirement and unwinding***. In March 2020, as part of COVID-19 relief for states enacted in the Families First Coronavirus Response Act, Congress increased the federal share of Medicaid funding to states if they met a "continuous coverage" requirement

that prevented them from disenrolling most Medicaid enrollees until after the end of the public health emergency. Continuous coverage allowed millions of people to maintain Medicaid coverage during the pandemic and contributed to reductions in uninsurance (Lee et al. 2022). Congress ended the continuous coverage requirement on March 31, 2023, leading to states' resumption of Medicaid redeterminations, known as "unwinding" the requirement. As people were found no longer eligible for Medicaid, millions of enrollees were projected to be at risk of becoming uninsured, either because they no longer qualified or because of challenges completing renewal processes (ASPE 2022; Buettgens and Green 2022). Many were anticipated to transition to other coverage, including through the Marketplace.[6]

- ***State policy changes***. Five states—Nebraska (10/1/2020), Oklahoma (7/1/2021), Missouri (10/1/2021), South Dakota (7/1/2023), and North Carolina (12/1/2023)—adopted Medicaid expansion during the continuous coverage and unwinding periods. This followed four states—Virginia (1/1/2019), Maine (1/10/2019), Idaho (1/1/2020), Utah (1/1/2020)—that did so in the months leading up to the public health emergency. Adoption of Medicaid expansion resulted in some people with incomes between 100 and 138 percent of FPL transitioning from eligibility for Marketplace PTCs to eligibility for Medicaid. Along with expanding eligibility for adults, research shows that adult expansions have "welcome mat" effects for children, whereby Medicaid/CHIP enrollment for children increases when eligibility is expanded for their parents (Hudson and Moriya 2017). Other Medicaid policy changes more directly affected children. Four states (Arizona, Kansas, Maine, and North Dakota) expanded Medicaid/CHIP eligibility limits for children during this period;[7] several states implemented multiyear continuous Medicaid/CHIP eligibility for young children;[8] and as of January 2024, all states were required to provide 12 months of continuous Medicaid/CHIP coverage for enrolled children.[9]
- ***More states establishing SBMs***. In 2019, 34 states used the FFM; five states had SBMs using the federally facilitated Healthcare.gov platform, and 12 states (including the District of Columbia) had established SBMs using their own enrollment platforms. By 2025, the number of states relying on the FFM fell to 28, while three states had SBMs using the federally facilitated platform, and 20 states had SBMs.[10] Though shifts between FFMs and SBMs do not change the availability of coverage for enrollees, some SBMs have established innovative policies to increase affordability through additional subsidies, improve enrollment processes, and encourage market competition (ASPE 2024), which could support enrollment among eligible people.
- ***Federal actions affecting Marketplace enrollment***. The Biden administration established several changes to streamline Marketplace enrollment, including an Executive Order on *Strengthening Medicaid and the Affordable Care Act*,[11] new special enrollment periods for people with incomes at or below 150 percent of FPL or disenrolled from Medicaid during unwinding, and dramatically increased funding for navigator programs that help people enroll in coverage (ASPE 2024). However, the Trump administration rescinded the Executive Order in January 2025 and cut navigator funding by 90 percent in February 2025.[12] An additional rule change under the Biden administration in 2023, known as the "family glitch" fix, expanded access to

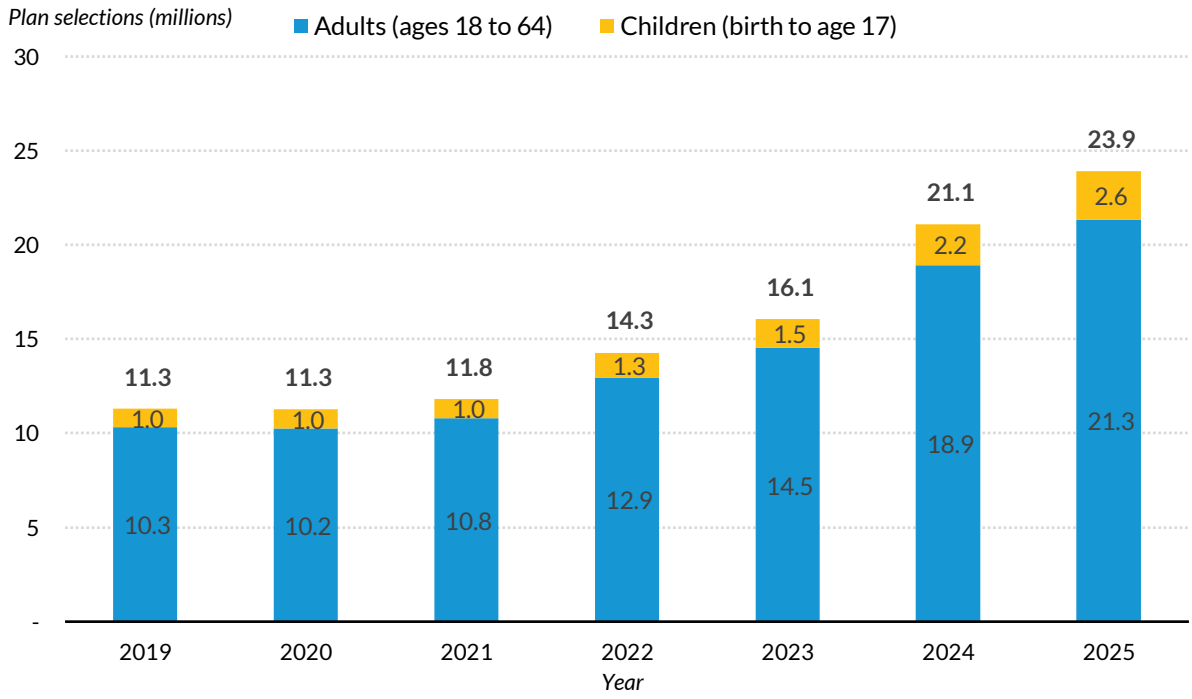
PTCs by redefining calculations of affordability of employer-sponsored coverage to include family coverage.[13]

Marketplace Enrollment Growth in Recent Years

Under enhanced subsidies and other policy changes, Marketplace plan selections among people younger than age 65 more than doubled from 11.3 million to 23.9 million between the 2019 and 2025 OEPs, an increase of 12.6 million (figure 1). Most of this increased enrollment was among adults ages 18 to 64, who accounted for 11 million of the additional plan selections, compared with 1.6 million among children younger than 18. However, the percent increase was higher for children at 161 percent compared with 107 percent for adults, and enrollment among children rose from 1.0 million in the 2019 OEP to 2.6 million in the 2025 OEP. According to the administrative data, the share of nonelderly Marketplace enrollees who are children increased from 9.5 percent in 2019 to 12.0 percent in 2025. Growth in Marketplace enrollment according to administrative data was also found to be concentrated in ACA nonexpansion states (Cox and Ortaliza 2024; Tolbert et al. 2025).

FIGURE 1

Marketplace Plan Selections during Open Enrollment among Nonelderly People, 2019–25



Source: "2025 Marketplace Open Enrollment Period Public Use Files," CMS, accessed October 22, 2025.
Notes: Data reflect plan selections made during the open enrollment period for each year and not effectuated enrollment. The dates of the open enrollment period vary slightly for each year, but usually range from November of the prior year to mid-December or mid-January of the current year.

Risks to Marketplace Coverage Ahead

A recently finalized CMS rule[14] introduces new administrative barriers to enrollment in Marketplace coverage. Though some of the rule's provisions have been stayed by a federal District Court judge, others remain in place, including some affecting the 2025 OEP.[15] Recent reconciliation legislation, known as the One Big Beautiful Bill Act (OBBBA), also adds new restrictions on eligibility for both Medicaid and Marketplace coverage and additional enrollment barriers and is expected to reduce Marketplace enrollment (Buettgens et al. 2025b). The Congressional Budget Office estimated that the OBBBA Marketplace provisions would increase the number of uninsured by 2.4 million by 2034 (Park and Corlette 2025). Some provisions affect particular categories of Marketplace enrollees. For instance, the reconciliation law eliminates Marketplace subsidies and Medicaid eligibility for refugees, asylees, victims of human trafficking, and certain other lawfully present noncitizens and no longer allows PTCs for lawfully present noncitizens with incomes below the FPL who are income-eligible for Medicaid but not eligible to enroll because of their immigration status (Boozang, Dervan, and Straw 2025).

In addition, the enhanced Marketplace subsidies in place since 2021 are set to expire at the end of 2025 unless Congress extends them, which would lead to substantial increases in premiums for many enrollees and eliminate subsidies for people with incomes over 400 percent of the FPL. Recent research projects that under expiration of the enhanced PTCs, average net premiums would be more than four times higher (from $169 to $919) for people with incomes below 250 percent of FPL, would more than double (from $1,171 to $2,455) for people with incomes of 250 to 400 percent of FPL, and would nearly double (from $4,436 to $8,471) for people with incomes above 400 percent of FPL. This research also finds that enrollment in subsidized Marketplace plans would fall by 7.3 million in 2026, and uninsurance would rise by 4.8 million if the PTC enhancements expire. Such effects would be felt by both adults and children, with an estimated 453,000 more children projected to be uninsured under standard PTCs compared with enhanced PTCs in 2026 (Buettgens et al. 2025a).[16]

Data and Methods

We use data from two nationally representative surveys for this analysis: the NHIS and the CPS. In both surveys, we limit our samples to parents ages 19 to 64 and children age 18 and younger. Comparing two nationally representative surveys allows us to assess trends in Marketplace coverage using different data sources, methodologies, and questions about coverage. Both surveys assess coverage status at the time of the survey (an annual average for each year of the NHIS and early in each year in the CPS). The NHIS also allows us to examine health care access and service use among parents and children with Marketplace coverage, while the CPS provides information on state of residence, which allows us to assess coverage according to whether and when states expanded Medicaid under the ACA. We also use data from the CMS Marketplace Open Enrollment Period Public Use Files for 2019 through 2025 to assess changes in Marketplace plan selections during each OEP as reported in administrative data.[17]

The NHIS collects data on the health of the noninstitutionalized civilian population across the country. We use publicly available data from both the adult and child interviews for 2019, 2023, and

2024. Because respondents may report more than one type of health insurance coverage, we construct a hierarchy of insurance coverage to assign respondents to mutually exclusive categories, with Marketplace coverage at the top, followed by employer-sponsored, direct purchase, other private, Medicare, Medicaid/CHIP, and other public insurance. In this definition, respondents are categorized as having Marketplace coverage if they report any Marketplace coverage, regardless of other coverage they may report. The NHIS considers a respondent to have Marketplace coverage if they report having a private, nonemployment-based, directly purchased plan. The plan name must be a Marketplace plan, portal, or company name, and the respondent indicates that the plan is through the Health Insurance Marketplace or state-based exchange, or, if the plan name was unknown or refused, the respondent indicated that the plan was obtained through the Health Insurance Marketplace or state-based exchange (Blewett et al. 2016).[18]

The CPS is the primary source of labor force statistics for the US and collects data for other important economic and social well-being indicators through a set of questions that are supplemental to the monthly basic CPS questions. The CPS Annual Social and Economic Supplement (ASEC) is fielded between February and April and collects detailed information on health insurance coverage, among other questions. We use publicly available ASEC data for 2019, 2023, 2024, and 2025. The ASEC asks about health insurance coverage at both the time of the survey and during the prior calendar year. We focus our analysis on coverage at the time of the survey for comparability with NHIS estimates. Since the CPS provides information about respondents' state of residence, we also assess variation in coverage changes over time according to state Medicaid expansion status in three groups—those that expanded before 2019 (32 states including the District of Columbia), those that expanded between 2019 and 2023 (nine states), and those that have not expanded as of 2025 (10 states).

In both surveys, we define parents as adults ages 19 to 64 living with their child or children ages 17 or younger in the NHIS and ages 18 or younger in the CPS. We first look at changes in Marketplace coverage for parents and children in both surveys to assess the extent to which these populations rely on Marketplace insurance. We examine the coverage rates for parents by Medicaid expansion status using only the CPS data.

Next, we assess the rates of health service use, health care access, and health care affordability among Marketplace-covered parents and children compared with other coverage types using two years of pooled data from the 2023 and 2024 NHIS. Measures of health service use for both parents and children include whether the respondent received a flu vaccine, saw a doctor, had a wellness visit, saw a mental health provider, and visited the hospital emergency department (ED) in the past 12 months. We report an additional measure of whether parents are currently receiving mental health counseling, but this is not measured for children on the NHIS. Measures of health care access and affordability include (1) whether the respondent has a usual source of care that is not the ED; (2) any delayed or unmet need because of cost in the past 12 months for medical care, mental health care (excluding children younger than 2), prescription medicines (defined as skipping medication doses, taking less medication, or delaying filling a prescription to save money, or needing prescription medication and not getting it because of cost), or any of these; and (3) delayed or unmet need because of cost for dental care (analysis

of delayed or unmet dental needs uses 2023 data only because this question was not included in the 2024 survey data).

In this analysis, we focus on the group of parents and children with family incomes between 100 to 400 percent FPL and make comparisons between those with Marketplace coverage and those with ESI or who are without health insurance coverage, controlling for a variety of socioeconomic and demographic factors including sex; race/ethnicity (non-Hispanic white, non-Hispanic Black, non-Hispanic Asian, Hispanic, and other races); income (138 percent of FPL or less, between 139 and 250 percent of FPL, and 251 to 400 percent of FPL); citizenship status (US-born citizens, naturalized citizens, and noncitizens); census region (Northeast, Midwest, South, and West); survey year; and any disability relating to vision, hearing, walking, communicating, self-care, or remembering/concentrating. We also controlled for other factors that varied for parents and children, including age range (19–34, 35–49, and 50 or older for parents; 5 or younger, 6–12, and 13–18 for children) and health status (ever had diabetes or asthma for children, and ever had either of these conditions or hypertension, high cholesterol, coronary heart disease, heart attack, stroke, cancer, COPD, emphysema, or chronic bronchitis, angina, or arthritis for parents). Additional factors for parents include educational attainment (high school or less, some college, and bachelor's degree or more); employment status (usually works full-time, usually works part-time, and not working); marital status (married, widowed, divorced, or separated, living with a partner, and never married); number of adults in the family; and number of children in the family. Additional factors for children include highest educational attainment among adults in the child's family (high school or less, some college, and bachelor's degree or more); number of adults in the family who are working; and number of residential parents. Finally, we assess the rates of Marketplace coverage among subgroups of parents and children in the NHIS based on region and income. Where appropriate, we conduct tests of statistical significance on changes over time and differences across groups, and our calculation of standard errors accounts for the complex sample design of each survey. Changes and differences described in this brief refer to those that were statistically significant at the $p<.10$ level.

Limitations

This analysis has several limitations. First, as with all survey data analysis, insurance coverage and other characteristics are reported with error. Marketplace coverage may be particularly subject to measurement error, including because Marketplaces can refer to both the mechanism for purchasing coverage and the coverage itself, and may be known by various names (Pascale, Fertig, and Call 2019). Though the National Center for Health Statistics has developed an algorithm to assign Marketplace coverage as accurately as possible (Blewett et al. 2016),[19] some other types of coverage may be misclassified as Marketplace coverage. In particular, we find that children are a somewhat higher share of people with reported Marketplace coverage in the CPS and NHIS than is found in the CMS administrative data on plan selections during OEPs.

Second, although we present estimates from both the CPS and NHIS, we do not expect data from these two sources to align exactly, given differences in the survey methodologies and designs. As noted,

since the NHIS Marketplace indicator was specifically designed to provide as accurate an indicator as possible of Marketplace coverage (Blewett et al. 2016),[20] it might be expected to show higher rates of Marketplace coverage than the CPS.

Third, while we use regression adjustment in the analysis of differences in access and use by coverage status in NHIS to account for variation in characteristics observed in the data, we cannot adjust for all potentially important differences across groups, so we cannot draw causal inferences from the comparisons of access and use experiences by insurance status. Moreover, the access and use measures in the NHIS pertain to the prior 12-month period, whereas the coverage indicator pertains to the time of the survey, meaning the access and use measures may reflect experiences under another coverage type for people with multiple coverage types over the prior year. Finally, we note this analysis is descriptive and does not provide causal inferences.

Findings

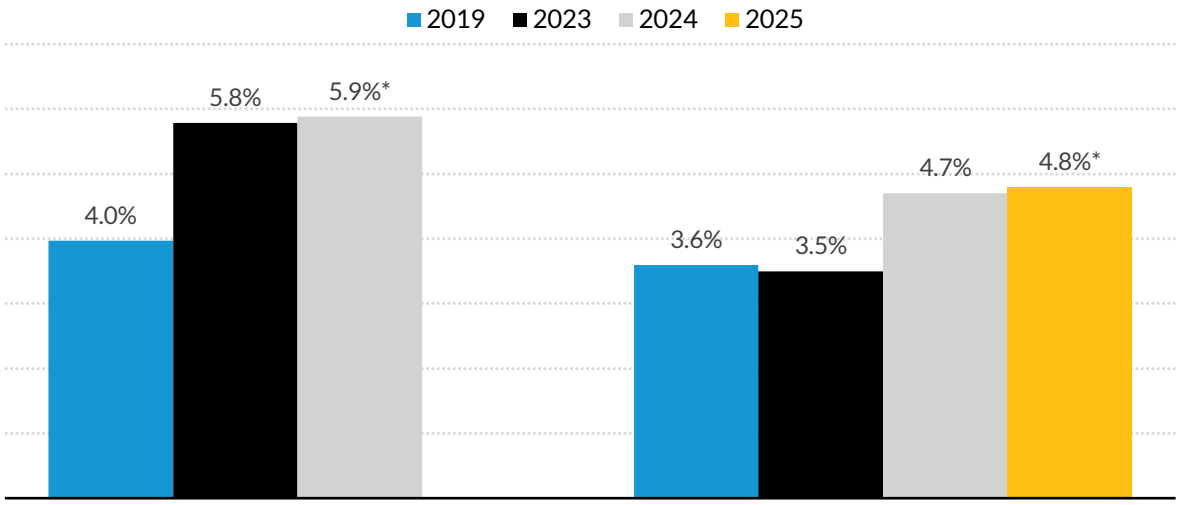
Marketplace Coverage Increased for Both Parents and Children Since 2019

Increases in Marketplace coverage were statistically significant for both parents and children between 2019 and the latest year of data available from the CPS and NHIS. The share of parents and children relying on Marketplace coverage rose by 33 percent and 49 percent, respectively, between 2019 and 2025, according to the CPS, and by 48 percent and 59 percent between 2019 and 2024, respectively, according to the NHIS.

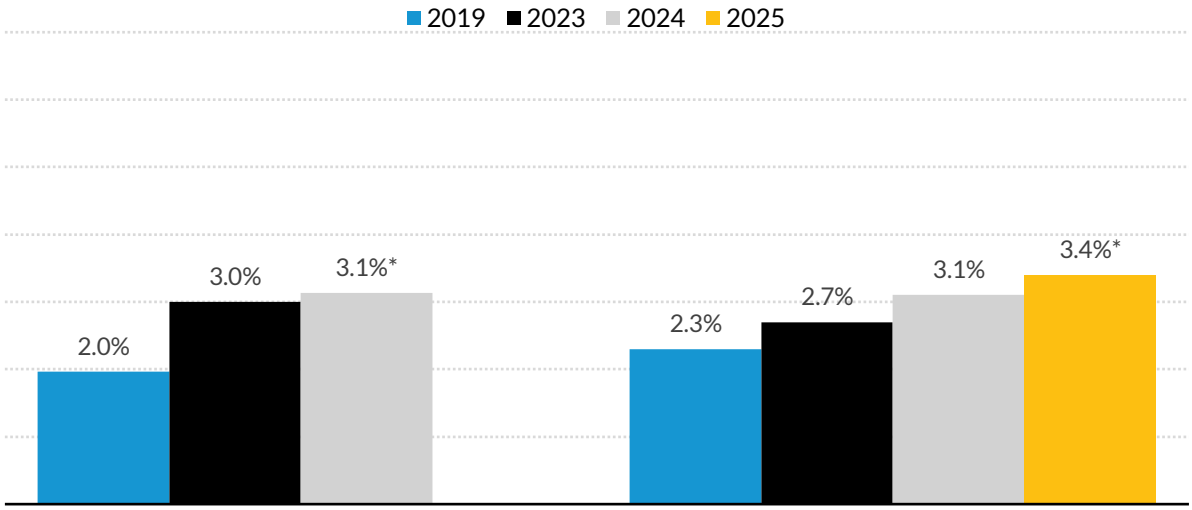
In 2025, 4.8 percent of parents and 3.4 percent of children had Marketplace coverage according to the CPS, while in 2024, 5.9 percent of parents and 3.1 percent of children had Marketplace coverage as measured in the NHIS (figure 2). In both data sources, Marketplace coverage rates were higher for parents than for children.

FIGURE 2

Marketplace Coverage Rates among Parents and Children, by Year and Data Source, 2019–24/25



Share of parents with Marketplace coverage, NHIS and CPS



Share of children with Marketplace coverage, NHIS and CPS

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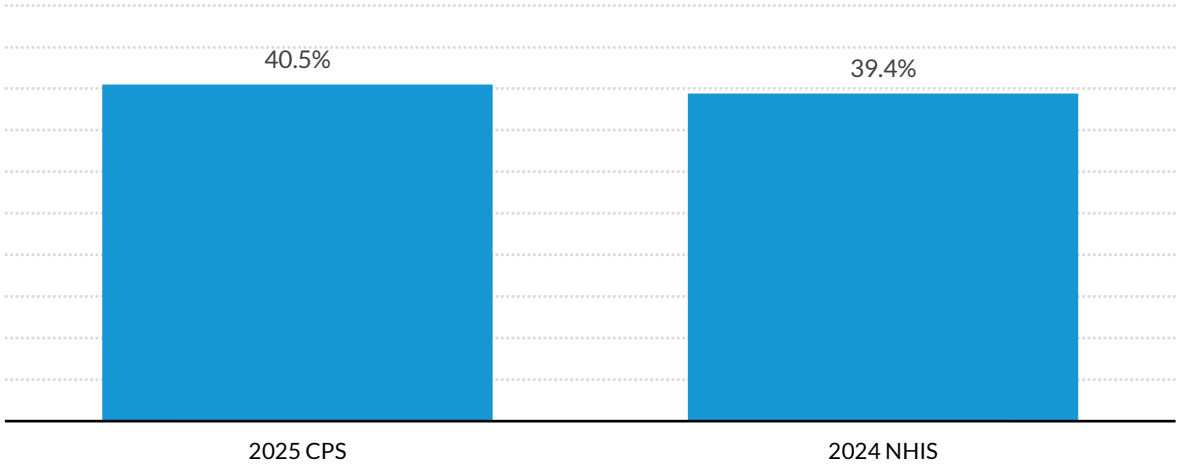
Source: Analysis of National Health Interview Survey (NHIS) and Current Population Survey Annual Social and Economic Supplement (CPS) data.

Notes: Parents are adults ages 19 to 64 living with dependent children younger than 18 in the NHIS and younger than 19 in the CPS. Children are ages 18 and younger in both surveys. *indicates estimate for latest available data year differs from estimate for 2019 at the $p<.05$ level.

Children and their families constituted a sizable minority of all nonelderly Marketplace enrollees in the latest available data from each data source. In the 2025 CPS, parents and children together were 40.5 percent of all nonelderly Marketplace enrollees, and in the 2024 NHIS, they were 39.4 percent (figure 3).[21]

FIGURE 3

Share of Nonelderly Marketplace Enrollees Who Are Children and Parents, by Data Source, 2024–25



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Source: Analysis of 2024 National Health Interview Survey (NHIS) and 2025 Current Population Survey Annual Social and Economic Supplement (CPS) data.
Notes: Parents are adults ages 19 to 64 living with dependent children younger than 18 in the NHIS and younger than 19 in the CPS. Children are ages 18 and younger in both surveys.

Parents in States That Had Not Expanded Medicaid under the ACA by 2025 Saw the Largest Increases in Marketplace Coverage between 2019 and 2025

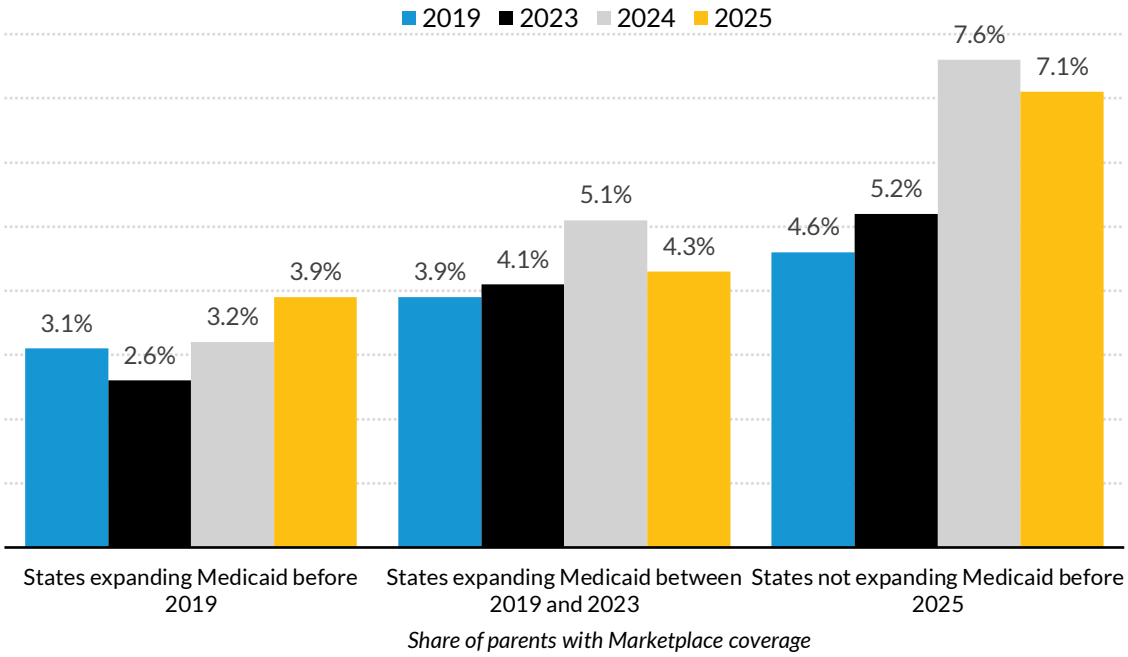
When assessing variation according to state ACA Medicaid expansion status in the CPS, we find that the Marketplace coverage gains for parents were concentrated in states that had yet to expand Medicaid by 2025, where Marketplace coverage rose from 4.6 percent to 7.1 percent between 2019 and 2025 (figure 4). Marketplace coverage also rose in states that expanded Medicaid before 2019, but the change was smaller (from 3.1 percent to 3.8 percent), and Marketplace coverage did not change significantly in states that newly expanded Medicaid after 2019 (at 3.9 percent in 2019 and 4.2 percent in 2025).

In 2025, 7.1 percent of parents in nonexpansion states had Marketplace coverage at the time of the CPS survey, compared with 3.8 percent in states that expanded before 2019 and 4.2 percent in states

that had recently expanded. Though Marketplace coverage had already been somewhat more prevalent in nonexpansion states, this difference grew between 2019 and 2025.[22]

FIGURE 4

Marketplace Coverage Rate among Parents, by Year and State Medicaid Expansion Status, 2019–25



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Source: Analysis of Current Population Survey Annual Social and Economic Supplement data.
Notes: Parents are adults ages 19 to 64 living with dependent children ages 18 and younger. *indicates estimate for 2025 differs from estimate for 2019 at the p<.05 level.

We also assessed variation in Marketplace coverage for children according to state expansion status. Marketplace coverage rose since 2019 for children in all three state groups, but differences by state group and changes over time were smaller than for parents. According to the CPS, the increases in Marketplace coverage between 2019 and 2025 were 0.7, 1.8, and 1.8 percentage points in states that had expanded Medicaid before 2019, states that expanded between 2019 and 2023, and nonexpansion states, respectively. By 2025, 3.1, 3.7, and 4.0 percent of children were relying on Marketplace coverage in states that expanded before 2019, states that expanded between 2019 and 2023, and nonexpansion states, respectively (data not shown).

As shown in table 1, uninsurance among parents shifted differentially according to state expansion status over this period. Marketplace coverage gains appeared to contribute to declines in uninsurance in states that had not expanded Medicaid. Parents in nonexpansion states, who experienced rising Marketplace coverage, saw uninsurance fall from 17.9 percent to 14.2 percent between 2019 and 2025. Parents in states with recent Medicaid expansions also experienced decreases in uninsurance from 13.0

percent in 2019 to 10.7 percent in 2025—though their Marketplace coverage rates were unchanged, Medicaid coverage rose from 8.9 percent to 10.9 percent, suggesting that Medicaid expansion contributed to the drop in uninsurance. Among parents in states that had expanded before 2019, Marketplace coverage rose slightly, but overall coverage shifted very little during this period.

TABLE 1

Health Insurance Coverage among Parents, by Year and State Medicaid Expansion Status, 2019 and 2025

	2019	2025	
States expanding Medicaid before 2019			
Uninsured	8.2%	7.8%	
ESI/military	68.8%	69.4%	
Medicare	1.1%	0.7%	***
Nongroup	5.9%	5.8%	
Marketplace	3.1%	3.8%	**
Non-Marketplace nongroup	2.8%	2.0%	***
Medicaid/CHIP/other means-tested	15.9%	16.2%	
States expanding Medicaid between 2019 and 2023			
Uninsured	13.0%	10.7%	**
ESI/military	70.4%	71.1%	
Medicare	1.1%	0.7%	
Nongroup	6.5%	6.5%	
Marketplace	3.9%	4.2%	
Non-Marketplace nongroup	2.7%	2.3%	
Medicaid/CHIP/other means-tested	8.9%	10.9%	**
States not expanding Medicaid before 2025			
Uninsured	17.9%	14.2%	***
ESI/military	64.9%	66.4%	
Medicare	0.8%	0.9%	
Nongroup	8.2%	10.2%	***
Marketplace	4.6%	7.1%	***
Non-Marketplace nongroup	3.6%	3.1%	
Medicaid/CHIP/other means-tested	8.2%	8.3%	

Source: Analysis of Current Population Survey Annual Social and Economic Supplement data.

Notes: ESI = employer-sponsored insurance; CHIP = Children's Health Insurance Program. Parents are adults ages 19 to 64 living with dependent children ages 18 and younger. ***/**indicates estimate differs from estimate for 2019 at the $p<0.01/0.05$ level.

Health Care Access and Use for Marketplace-Enrolled Parents and Children Appears Better than Those Who Are Uninsured and Relatively Similar to Those with ESI

Table 2 presents rates of several health care access and utilization measures during the prior 12 months among parents and children with Marketplace coverage in the 2023–24 NHIS who have incomes between 100 and 400 percent of FPL—the primary target group for Marketplace subsidies. In addition, it presents shares for similarly situated people with ESI and people who are uninsured, adjusting for other observed demographic and socioeconomic differences across groups of people with these different insurance coverage statuses.[23] We find that access to care and utilization of health care

services among Marketplace-enrolled parents and children are relatively similar to those of their counterparts with ESI and consistently better than those of comparable uninsured people. For instance, Marketplace-enrolled parents had comparable rates of seeing a doctor, having a wellness visit, seeing a mental health provider, and receiving mental health counseling as similarly situated parents with ESI and higher rates of each of these compared with uninsured parents. Likewise, Marketplace-enrolled children's rates of seeing a doctor or having a wellness visit were about the same as those of similar children with ESI and higher than those of similar uninsured children. However, both children and parents with Marketplace coverage were less likely than their counterparts with ESI to report having received a flu vaccine.

Marketplace-enrolled parents and parents with ESI were about equally likely to have delayed or unmet medical care, mental health care, or prescription drug needs because of cost. This held true for a measure of delayed or unmet needs for any of these types of care and for each type of care individually. However, parents with Marketplace coverage experienced higher rates of unmet or delayed dental health care needs.[24] As noted above, Marketplace plans do not often include dental coverage for adults. Reported rates of unmet or delayed needs were generally not significantly different for children with Marketplace versus ESI coverage.[25]

Delayed and unmet needs were much lower for those with Marketplace coverage than for similar parents and children who were uninsured. Uninsured parents were nearly twice as likely as parents with Marketplace coverage, and uninsured children were nearly three times as likely as children with Marketplace coverage, to have delayed or unmet medical care, mental health care, or prescription drug needs because of cost. Unmet and delayed care needs were also higher for all the types of care we examined individually for parents, and for nearly all the types of care we examined for children.

TABLE 2

Regression-Adjusted Health Care Access and Utilization among Parents and Children with Marketplace Coverage, ESI, and No Insurance Coverage, 2023–24

	Parents (age 19–64)						Children (birth to age 18)					
	Marketplace	ESI		Uninsured			Marketplace	ESI		Uninsured		
	%	%		%			%	%		%		
Health service use												
Received flu vaccine, past 12 months	22.2%	33.4%	***	20.4%			35.0%	43.8%	**	25.6%	**	
Saw a doctor, past 12 months	82.5%	83.1%		61.2%	***		93.7%	93.8%		77.0%	***	
Had a wellness visit, past 12 months	76.7%	76.6%		53.9%	***		89.7%	92.1%		70.5%	***	
Saw mental health provider, past 12 months	13.5%	14.0%		9.2%	**		11.7%	11.2%		10.7%		
Currently receiving mental health counseling	7.8%	8.6%		4.7%	**		--	--		--		
Visited the hospital ED, past 12 months	21.9%	20.7%		20.0%			17.9%	15.0%		13.8%		
Health care access and affordability												
Has a usual source of care that is not the ED	89.3%	87.5%		68.4%	***		96.3%	97.8%		80.7%	***	
Any delayed or unmet need because of cost (services below), past 12 months	21.5%	20.2%		37.7%	***		4.8%	3.7%		13.6%	***	
Medical care	13.8%	12.1%		30.3%	***		3.4%	1.4%		10.4%	***	
Mental health care	11.4%	9.4%		15.4%	**		2.7%	2.0%		3.6%		
Prescription medicines	9.8%	10.3%		17.1%	***		0.7%	2.5%	***	5.7%	***	
Delayed or unmet need for dental care because of cost, past 12 months	35.3%	27.2%	*	46.1%	**		10.6%	6.2%		21.9%	**	

Source: Analysis of National Health Interview Survey data.

Notes: Parents are adults ages 19 to 64 living with dependent children younger than 18. Children are ages 18 and younger. ESI = employer-sponsored insurance; ED = emergency department. Controls for variation in sex; age; race/ethnicity; income; citizenship status; educational attainment; employment status; number of adults/children in the family; disability (relating to vision, hearing, walking, communicating, self-care, or remembering/concentrating); health status; region; and survey year. ***/**/* indicates percentage point differences from the Marketplace group are statistically significant at the $p<.01/.05/.10$ level. Estimates of delayed or unmet need for dental care because of cost are for 2023 only. See Data and Methods section for details on how measures are defined.

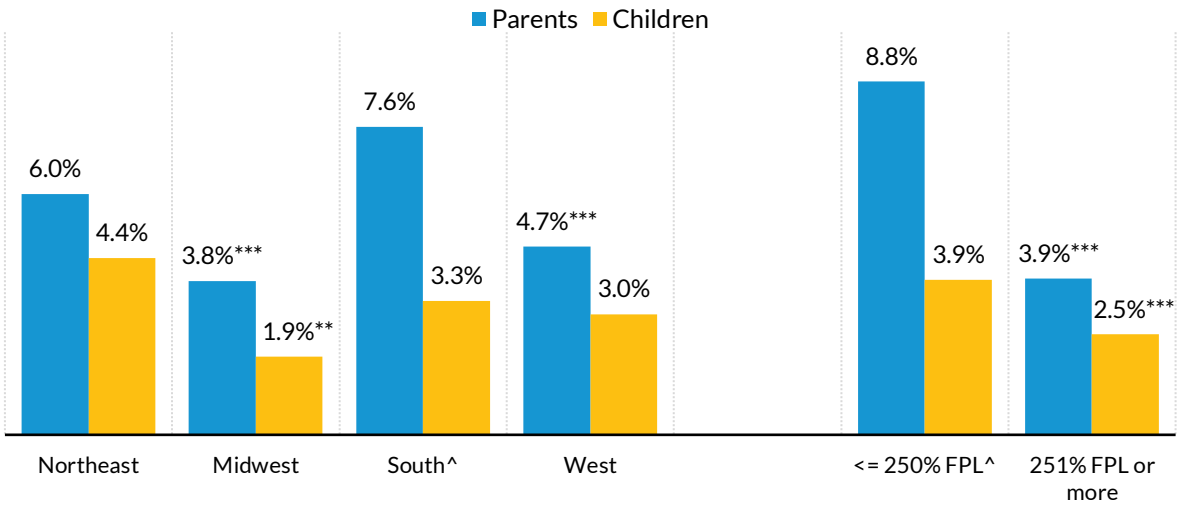
Certain Subgroups Were More Likely to Have Marketplace Coverage in 2024

Finally, we assessed how Marketplace coverage rates reported in the 2024 NHIS varied across regions and income subgroups of parents and children, highlighting the importance of this coverage type for particular subgroups of the population (figure 5).

Across regions, Marketplace coverage was higher among parents in the South than in the Midwest and the West. This is likely because of more states in the South not participating in the ACA's Medicaid expansion, increasing the number of low-income parents who are ineligible for Medicaid and instead qualify for Marketplace subsidies. Marketplace plans covered 8.8 percent of parents with incomes at or below 250 percent of FPL, compared with 3.9 percent of parents with incomes above 250 percent of FPL.

FIGURE 5

Marketplace Coverage Rates for Parents and Children by Region and Family Income, 2024



Share of parents and children with Marketplace coverage

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Source: Analysis of National Health Interview Survey data.
Notes: Parents are adults ages 19 to 64 living with dependent children younger than 18. Children are ages 18 and younger. ***/**/* indicates percentage point differences from the reference group are statistically significant at the p<.01/.05/.10 level. ^ indicates reference group.

Discussion

According to the latest available data from two national surveys, 5 to 6 percent of parents and about 3 percent of children had Marketplace coverage in 2024 and early 2025, shares that had risen by 33 to 48 percent among parents and 48 to 59 percent among children since 2019. Not unexpectedly, the coverage estimates from the two surveys differ, but both show that parents rely on Marketplace

coverage at higher rates than children, and that Marketplace coverage grew rapidly for both parents and children since 2019.

Consistent with administrative data that showed higher growth in Marketplace coverage among adults over this period in states that had not expanded Medicaid by 2025 (Cox and Orteliza 2024, Tolbert et al. 2025), we find that reliance on Marketplace coverage among parents increased more between 2019 and 2025 in nonexpansion states than in expansion states. Among parents, Marketplace coverage was a much more important coverage source in nonexpansion states than in expansion states in 2025. Increases in Marketplace coverage underlay the uninsurance declines in states that have not expanded Medicaid, while Medicaid coverage gains accompanied the declines in uninsurance among parents in states that expanded Medicaid after 2019.

If enhanced PTCs expire at the end of 2025, millions of Marketplace enrollees, including parents and children, are projected to lose coverage, with most becoming uninsured (Buettgens et al. 2025a).[26] Parents in nonexpansion states, who are concentrated in the South, would be especially likely to be affected, given their high rates of reliance on Marketplace coverage and large increases in Marketplace coverage under the enhanced PTCs. Patterns of access and utilization observed in this study suggest that losing Marketplace coverage and becoming uninsured would negatively affect parents' and children's access and use of health care, leading to higher unmet and delayed health care under expiration of the PTC enhancements. Given the importance of children's coverage for their access to health care and growth and development, and the importance of parents' coverage for children's well-being, these changes could have substantial implications for children in both the short and long term (Boudreaux, Golberstein, and McAlpine 2016; Burak 2019; Schmitt and Matthews 2017; Venkataramani et al. 2017; Wherry et al. 2018).

Such effects would compound the effects of other changes under the OBBBA that will affect low- and moderate-income families. For instance, analysis of an earlier version of the reconciliation legislation found that it would cause 22.3 million families to lose some or all their SNAP benefits, and increased cost-shifting to states could cause some states to eliminate their SNAP programs altogether (Wheaton et al. 2025).[27] Although the law specifically exempts some families with younger children from one of the Medicaid provisions, many families would feel the effects of other changes in Medicaid. For instance, all parents enrolled under the expansion pathway will undergo more frequent eligibility determinations, and many will also be subject to work requirements if they are noncustodial parents or have no children younger than 14, and even parents nominally exempt from requirements may face the risk of coverage losses.[28]

Under the OBBBA, many legally present noncitizens are losing eligibility for Marketplace subsidies and Medicaid in 2026 and 2027, so their coverage rates are expected to decline even if PTC enhancements continue. Moreover, the law also restricts eligibility for these groups' access to SNAP, increases fees for immigration applications and processing, and excludes people without Social Security numbers from several tax benefits (Altman, Broder, and D'Avanzo 2025). Therefore, their ability to purchase coverage without subsidies may be even more restricted, causing them to become uninsured. Some members of immigrant households who remain eligible may also avoid government benefits for

themselves and their children because of concerns about adverse immigration-related consequences (Gonzalez et al. 2025). Effects on children could be large, given that 1 in 4 children in the US live in immigrant families (Haley et al. 2025).

With both surveys finding that about 4 in 10 Marketplace enrollees are parents and children and showing the growing importance of Marketplace coverage for these groups, Marketplace plans have become a critical part of the health insurance landscape for families. Our findings also indicate that Marketplace-enrolled parents and children would likely face far greater access and utilization barriers if they became uninsured, and that, if Marketplace coverage declines, more families will go without the care they need and face greater financial burdens in meeting those needs.

Notes

[1] American Rescue Plan Act, Pub. L. No. 117–2 (2021).

[2] "Over 24 Million Consumers Selected Affordable Health Coverage in ACA Marketplace for 2025," CMS, January 17, 2025, https://www.cms.gov/newsroom/press-releases/over-24-million-consumers-selected-affordable-health-coverage-aca-marketplace-2025; and Edwin Park, "Child Enrollment in the Marketplaces Rose by Nearly 40 Percent During 2024 Open Enrollment but Increase Offsets Only Modest Share of Child Medicaid Unwinding Enrollment Losses," *Say Ahhh!* (blog), March 25, 2024, Georgetown University Center for Children and Families, https://ccf.georgetown.edu/2024/03/25/child-enrollment-in-the-marketplaces-rose-by-nearly-40-percent-during-2024-open-enrollment-but-increase-offsets-only-modest-share-of-child-medicaid-unwinding-enrollment-losses/.

[3] "Questions and Answers on the Premium Tax Credit," IRS.gov, accessed October 22, 2025, https://www.irs.gov/affordable-care-act/individuals-and-families/questions-and-answers-on-the-premium-tax-credit.

[4] "Marketplace Enrollment, 2014–2025," KFF, accessed October 22, 2025, https://www.kff.org/affordable-care-act/state-indicator/marketplace-enrollment/.

[5] "American Rescue Plan and the Marketplace," CMS.gov, March 12, 2021, https://www.cms.gov/newsroom/fact-sheets/american-rescue-plan-and-marketplace.

[6] Rachel Swindle, and Sabrina Corlette, "What States are Doing to Keep People Covered as Medicaid Continuous Enrollment Unwinds," The Commonwealth Fund (blog), December 6, 2023, https://www.commonwealthfund.org/blog/2023/what-states-are-doing-keep-people-covered-medicaid-continuous-enrollment-unwinds.

[7] "Medicaid/CHIP Upper Income Eligibility Limits for Children, 2000–2024," KFF, accessed October 22, 2025, https://www.kff.org/medicaid/state-indicator/medicaidchip-upper-income-eligibility-limits-for-children/D.

In addition, some states broadened immigration-related rules for legally present immigrant children with fewer than five years of residency, otherwise known as adopting the Immigrant Children's Health Improvement Act option, or began offering state-funded Medicaid-like coverage to children excluded from federally financed Medicaid/CHIP based on immigration status. See: "Annual Updates on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and CHIP," KFF, April 1, 2025, https://www.kff.org/medicaid/report/annual-updates-on-eligibility-rules-enrollment-and-renewal-procedures-and-cost-sharing-practices-in-medicaid-and-chip/.

[8] Elizabeth Wright Burak, "North Carolina and Hawaii Make 10: States Advancing Medicaid/CHIP Multi-Year Continuous Eligibility for Young Children," *Say Ahhh!* (blog), November 16, 2023, Georgetown University Center for Children and Families, https://ccf.georgetown.edu/2023/11/16/north-carolina-and-hawaii-make-10-states-advancing-medicaid-chip-multi-year-continuous-eligibility-for-young-children/.

[9] Consolidated Appropriations Act, 2023, Pub. L. No. 117–328 (2022).

[10] "State Health Insurance Marketplace Types," KFF, accessed October 22, 2025, https://www.kff.org/affordable-care-act/state-indicator/state-health-insurance-marketplace-types/.

[11] "Strengthening Medicaid and the Affordable Care Act," *Federal Register* 86 (20), February 2, 2021.

[12] "Initial Rescissions of Harmful Executive Orders and Actions," The White House, January 20, 2025, https://www.whitehouse.gov/presidential-actions/2025/01/initial-rescissions-of-harmful-executive-orders-and-actions/; and Rachel Swindle, Jalisa Clark, and Justin Giovannelli, "New Administration Plans to Reinstate Cuts to Funding for ACA Outreach and Enrollment," The Commonwealth Fund (blog), March 27, 2025, Assistancehttps://www.commonwealthfund.org/blog/2025/new-administration-plans-reinstate-cuts-funding-aca-outreach-and-enrollment-assistance.

[13] "Affordability of Employer Coverage for Family Members of Employees," *Federal Register* 87 (197), October 13, 2022.

[14] "Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability," *Federal Register* 90 (120), June 25, 2025.

[15] Jason Levitis and Sabrina Corlette, "Ruling in Challenge to Marketplace Rule: Initial Analysis and Implications for States," State Health and Value Strategies, September 26, 2025, https://shvs.org/ruling-in-challenge-to-marketplace-rule-initial-analysis-and-implications-for-states/.

[16] Phillip L. Swagel, "Re: The Estimated Effects of Enacting Selected Health Coverage Policies on the Federal Budget and on the Number of People With Health Insurance," Congressional Budget Office, September 18, 2025.

[17] Most, but not all, plan selections during OEP become effectuated enrollment (including the payment of premiums, if applicable). In the 2021–25 period, effectuated enrollment represented 94 to 97 percent of consumers making plan selections during OEP. See: "Effectuated Enrollment: Early 2025 Snapshot and Full Year 2024 Average," CMS, accessed October 22, 2025.

[18] "Detailed Exchange Editing Rules," CDC.gov, accessed October 22, 2025.

[19] "Detailed Exchange Editing Rules," CDC.gov.

[20] "Detailed Exchange Editing Rules," CDC.gov.

[21] As noted above, measurement of health insurance coverage is subject to measurement error.

[22] The increase in Marketplace coverage found in the CPS between 2019 and 2025 was significantly larger for nonexpansion states than for states that expanded before 2019 or between 2019 and 2023, and significantly larger for states that expanded before 2019 than for states that expanded between 2019 and 2023.

[23] We also examined these patterns without adjustment for demographic and socioeconomic differences across groups according to coverage status (data not shown). We found that the differences across coverage groups were relatively similar, but more of the differences between children with ESI and children with Marketplace coverage were statistically significant.

[24] A similar pattern is evident for children, though this estimate is measured with less precision. Children with Marketplace coverage were reported to have somewhat higher delayed or unmet needs for dental care, though the *p*-value for this difference was 0.15, not statistically significant at conventional levels.

[25] The *p*-value for this difference was 0.14, not statistically significant at conventional levels.

[26] John Thune, William Cassidy, Lindsey Graham, and Mike Crapo, "Re: The Estimated Effects of Enacting Selected Health Coverage Policies on the Federal Budget and on the Number of People With Health Insurance," Congressional Budget Office, September 18, 2025.

[27] Miguel Villa and Stephanie Scott, "SNAP Changes Will Upend State Budgets," Georgetown Law Center on Poverty and Inequality (blog), September 29, 2025, https://www.georgetownpoverty.org/issues/snap-changes-will-upend-state-budgets/.

[28] Jennifer M. Haley, Genevieve M. Kenney, Eva H. Allen, and Michael Karpman, "Medicaid Work Requirements Could Threaten Parents' and Children's Coverage and Well-Being," *Say Ahhh!* (blog), May 19, 2025, Georgetown University Center for Children and Families, https://ccf.georgetown.edu/2025/05/19/medicaid-work-requirements-could-threaten-parents-and-childrens-coverage-and-well-being/.

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