

Ghostbusting ACA Fraud

Millions Who Don't Use Their Health Insurance Expose Abuse in the Program

By Niklas Kleinworth, Liam Sigaud, and John R. Graham

Individual coverage exchange plans created by the Affordable Care Act (ACA) have a glaring problem: nearly 12 million enrollees, or 35 percent of all exchange enrollees in 2024, do not use their benefits at all.² For these enrollees, known as zero-claim enrollees, health coverage did not translate to health care. Many zero-claim enrollees are known as “phantoms”—people who are enrolled but not practically in the market because they are enrolled in other coverage or are unaware of their exchange plan coverage. Large insurers benefit greatly from phantom enrollment, as they collect billions of dollars in taxpayer funds to cover individuals who cost them nothing.

Our analysis shows that these enrollees are not just healthy enrollees with no need for care. They are part of a larger story about how Biden COVID credits are driving perverse incentives. Insurers and middlemen are responding to these incentives, and unscrupulous brokers are enrolling anyone they can. Evidence shows millions of Americans fell victim to enrollment in fully subsidized plans without their knowledge or consent.³ This fraud harms patients who lose their health coverage or face penalties at tax time. It also harms taxpayers who foot the bill for these schemes.

This policy brief presents a state-by-state analysis describing how zero-claim enrollment corroborates much of Paragon's previous work on improper enrollment and fraud in the ACA exchanges. We also debunk claims that young, healthy enrollees

KEY TAKEAWAYS
Rising numbers of zero-claim enrollees—people who did not file a single medical claim—bolster evidence of rampant fraud in ACA exchanges. Many of these enrollees are phantoms—people unaware of their coverage or enrolled in other plans.
Biden COVID credits drove fraud by creating zero-dollar plans that are fully subsidized by taxpayers and require no enrollee contributions. Unscrupulous brokers enrolled many people without their knowledge and many others after manipulating information on applications to maximize subsidies.
The sharp increase in zero-claim enrollment from 2021 to 2024 is not explained by meaningfully higher enrollment among young, healthy beneficiaries.
Zero-claim enrollment numbers dwarf potential coverage loss estimates of not extending the COVID credits. This anomaly suggests that when the COVID credits expire on schedule at the end of 2025, they will likely have little to no negative effect on access to health care services or health. ¹
To curb fraudulent enrollment that harms both patients and taxpayers, Congress must allow the Biden COVID credits to expire on time.

without claims are serving to diversify the risk pool and improve the market.

Our work informs the debate in Congress about whether to extend the Biden COVID credits or allow them to expire as scheduled at the end of 2025. According to the Government Accountability Office (GAO), “Hundreds of billions of dollars were likely lost to fraud during the pandemic,” and “The full extent of fraud within the pandemic-relief programs will never be known with certainty.”⁴ Nevertheless, some argue that the coverage losses are too great to allow this temporary, pandemic-era government program to expire. Our analysis finds, however, that the number of zero-claim enrollees dwarfs coverage loss estimates, suggesting many who may lose coverage did not use it to pay for any medical services they received.

This brief illustrates how the Biden administration’s enrollment-at-any-cost strategies have not delivered on cultivating a healthier America but have actively harmed patients and taxpayers. Returning to the pre-pandemic subsidy status quo policy is the best avenue for taking meaningful steps against fraud in the ACA exchanges. Congress should permit the COVID credits to expire on schedule in order to curb the perverse incentives they create.

Biden COVID Credits Drive Rampant Fraud in the ACA Exchanges

During the height of the pandemic, the Biden administration offered enhanced subsidies for ACA exchange plans—often resulting in federal taxpayers footing the bill for all, or nearly all, premium costs for silver and bronze plans, as well as gold plans.⁵ Combined with regulatory changes that weakened income verification rules, these policies spawned rampant fraud schemes that resulted in an estimated 5.0 million people being

improperly enrolled in 2024.⁶ The problem worsened in 2025, with updated estimates revealing more than 6.4 million improper enrollees and a cost of improper enrollment reaching \$27 billion this year alone.⁷

Most commonly, this improper enrollment featured people misstating their income and unscrupulous brokers misstating applicants’ income to leverage higher federal subsidies for their health coverage. This practice was incentivized by lack of accountability since enrollees could keep most or all of the amount of the overpaid subsidies, while enjoying lower net premiums on the backs of the taxpayers.⁸

Enrollees are not always the beneficiaries of fraud schemes, however. A recent Bloomberg article illustrated that many were enrolled without their knowledge or consent, permitting insurers to pocket the subsidies and fraudsters to make big commissions.⁹ This resulted in millions of improperly enrolled people, including those who were shut out of better plans that covered their needs or found they owed penalties at tax time.

The One Big Beautiful Bill (OB BB), enacted in July 2025, addressed many of the policy issues that caused these fraud rings.¹⁰ One such reform requires enrollees who underestimate their income to obtain more subsidy than which they are entitled to repay the full amount of the ACA subsidy. Other reforms include ending Biden-era rules that relaxed eligibility verification, pre-enrollment eligibility verification, and curbing abuse of special enrollment periods.¹¹

The Trump Administration took steps through rulemaking to rein-in cheating in the ACA exchanges.¹² The rule would have created a \$5 premium for plans made free by subsidies, increased verification for special enrollment periods (SEPs), and required income and

household verification through tax returns, among other provisions. However, most of the provisions in this rule were stayed by a federal district court, leaving ACA exchanges even more vulnerable to continued fraud.¹³

Despite these key policy reforms, Congress must ensure Biden COVID credits, the driver that enabled widespread fraud schemes in the ACA, are allowed to expire at the end of the year.¹⁴ So long as free or nearly free plans are available, fraudsters will continue to exploit this loophole to game the system, abuse innocent citizens, and collect billions from taxpayers.

Even absent the fraud and improper enrollment, zero-dollar premiums result in the social cost of distributing large subsidies to people who both place no value on the coverage or a very small value on the coverage relative to the cost. Without a financial stake, enrollees lack incentive to notify officials when they are enrolled in an exchange plan but have other coverage and in many cases, they may not even know of their continued enrollment in the exchange plan. They also have incentives to enroll in coverage so long as the value of the benefit exceeds the time investment of filing the paperwork to enroll. There are large incentives for brokers to overcome those burdens in order to access higher commissions. Likewise, insurers are incentivized to overcome those burdens to collect more government payments.

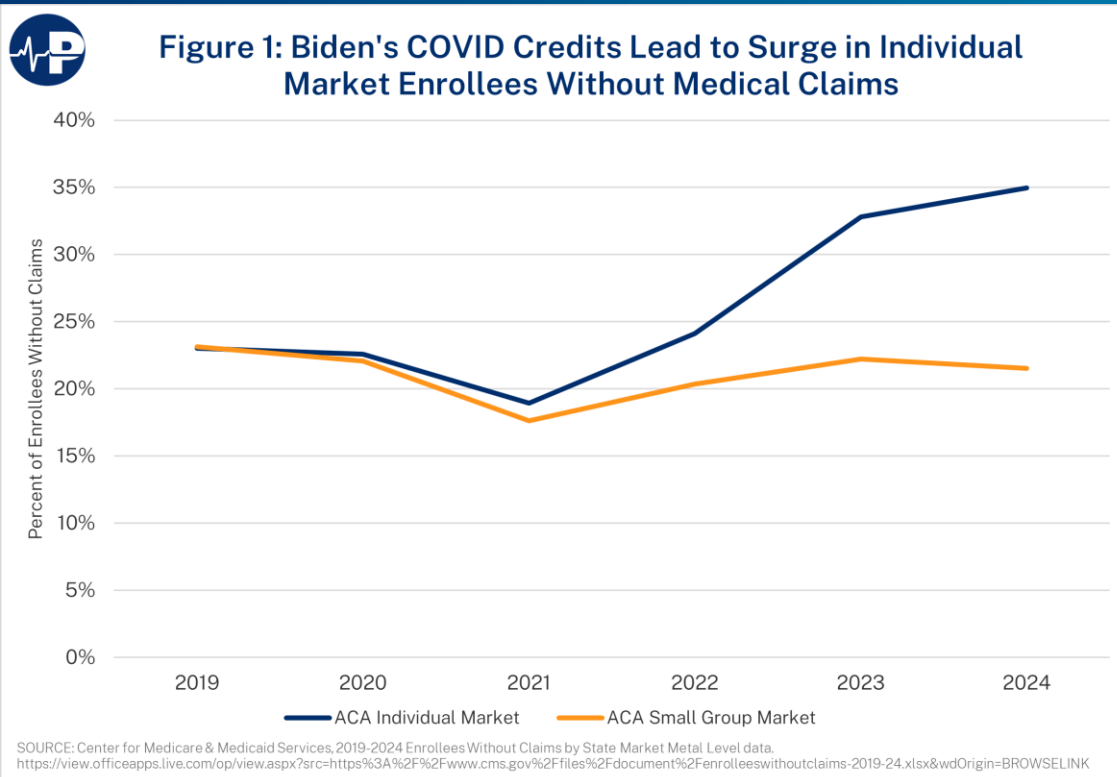
Zero-Claim Enrollees Corroborate Evidence of Fraud

New data from the Centers for Medicare and Medicaid Services showed a significant increase in the number of ACA enrollees who do not use their health insurance — no primary care visits, no prescriptions, and no other services.¹⁵ Zero-claim

enrollees reached 11.7 million in 2024, more than a threefold increase in just three years following the implementation of the Biden COVID credits. In 2024, zero-claim enrollees constituted more than one-third of all exchange enrollees and two-in-five on fully-subsidized plans. The increase is stark in contrast to a near flat percentage change in small group market enrollees with no claims during the same three-year period. Moreover, the typical number of zero-claims enrollees in private plans is generally around 15 percent.¹⁶ These numbers reveal a serious problem with ACA exchange enrollment: millions of these zero-claim enrollees are phantoms, unaware of their coverage and the fraud that is perpetrated using their identity. Billions in taxpayer-funded subsidies were expended for coverage they did not need or use. Meanwhile, all of the federal funding for these subsidies went directly to enrollment intermediaries and insurers.

Of course, it is reasonable to expect that some proportion of insurance beneficiaries will not use their coverage. For some, it may be because of good health. For others it may be because they are judicious about their health care consumption. Indeed, this is how insurance is designed to work: All the enrollees in a risk pool pay premiums but there is a wide variance in claims, with some enrollees not using any services.

Health insurance is different from other types of insurance, however, because insurers process many claims that are not catastrophically expensive. Insurance covers many routine medical expenses, including check-ups, lab tests, and pharmaceuticals. Nevertheless, what makes the number of zero-claim enrollees so staggering is that their numbers are far above what is seen in other private health insurance plans, particularly in small-group plans. The small-group market serves as a useful comparison group to assess the



trends in the ACA individual market. Paragon previously highlighted how, in these plans, the proportion of zero-claim enrollees remained comparably steady relative to ACA plans, which are shaped by the Biden COVID credits since 2021 (see Figure 1).¹⁷

Correlation Between Zero-claim Enrollees and Improper Enrollees

As mentioned, previous Paragon research estimated 6.4 million more people enrolled in ACA plans claiming income between 100 and 150 percent of the federal poverty level (FPL) than people who have that income in 2025.¹⁸ We refer to them as fraudulent enrollees. This is an increase of more than 1.4 million individuals since 2024, due in part to automatic reenrollments. The methods supporting these findings were

corroborated by the Centers for Medicare and Medicaid Services.¹⁹

Naturally, those who are unaware of their health coverage are unlikely to utilize it to pay for health care services. Consistent with this prediction, we find the presence of zero-claim enrollees by state correlates strongly with the number of fraudulent enrollees.²⁰ In Table 1, we rank the 41 states with available data by the proportion of fraudulent enrollees. Five of the top 10 states with zero-claim enrollees also ranked in the top 10 for fraudulent enrollees.²¹ Expanding this to the top 20 states with zero-claim enrollees, 15 of them also ranked in the top 20 for fraudulent enrollment.

A more formal analysis of the correlation between the presence of fraudulent enrollees and the rise of zero-claim enrollees bolsters the comparison in



Table 1: Substantial Overlap Between States with the Highest Rates of Fraudulent Enrollment and Zero-Claim Enrollment in 2024

State	% Enrollees Without Claims	Enrollees Without Claims Ranking	% Enrollees Who Were Fraudulent	Enrollees Who Were Fraudulent Ranking
Louisiana	49%	1	48%	7
Ohio	46%	2	41%	12
Texas	46%	3	51%	5
South Carolina	46%	4	47%	10
Arizona	45%	5	32%	15
Indiana	44%	6	41%	13
Oklahoma	44%	7	48%	8
Tennessee	44%	8	41%	11
North Carolina	42%	9	72%	2
Massachusetts	41%	10	0%	24 (tied)
Georgia	41%	11	60%	4
Illinois	41%	12	10%	22
Missouri	40%	13	48%	6
Delaware	39%	14	17%	21
Iowa	38%	15	0%	24 (tied)
Alabama	38%	16	29%	17
Florida	38%	17	77%	1
Kansas	38%	18	0%	24 (tied)
Michigan	38%	19	30%	16
Nebraska	38%	20	26%	18
Utah	37%	21	71%	3
Virginia	34%	22	33%	14
Montana	33%	23	0%	24 (tied)
Mississippi	33%	24	48%	9
California	33%	25	0%	24 (tied)
Washington	32%	26	0%	24 (tied)
Wisconsin	30%	27	0%	24 (tied)
New Jersey	27%	28	1%	23
Arkansas	25%	29	20%	19
Maryland	25%	30	0%	24 (tied)
New Hampshire	25%	31	19%	20
New Mexico	25%	32	0%	24 (tied)
Pennsylvania	25%	33	0%	24 (tied)
Colorado	24%	34	0%	24 (tied)
North Dakota	24%	35	0%	24 (tied)
Nevada	24%	36	0%	24 (tied)
Idaho	23%	37	0%	24 (tied)
South Dakota	23%	38	0%	24 (tied)
Kentucky	23%	39	0%	24 (tied)
Connecticut	22%	40	0%	24 (tied)
Maine	15%	41	0%	24 (tied)

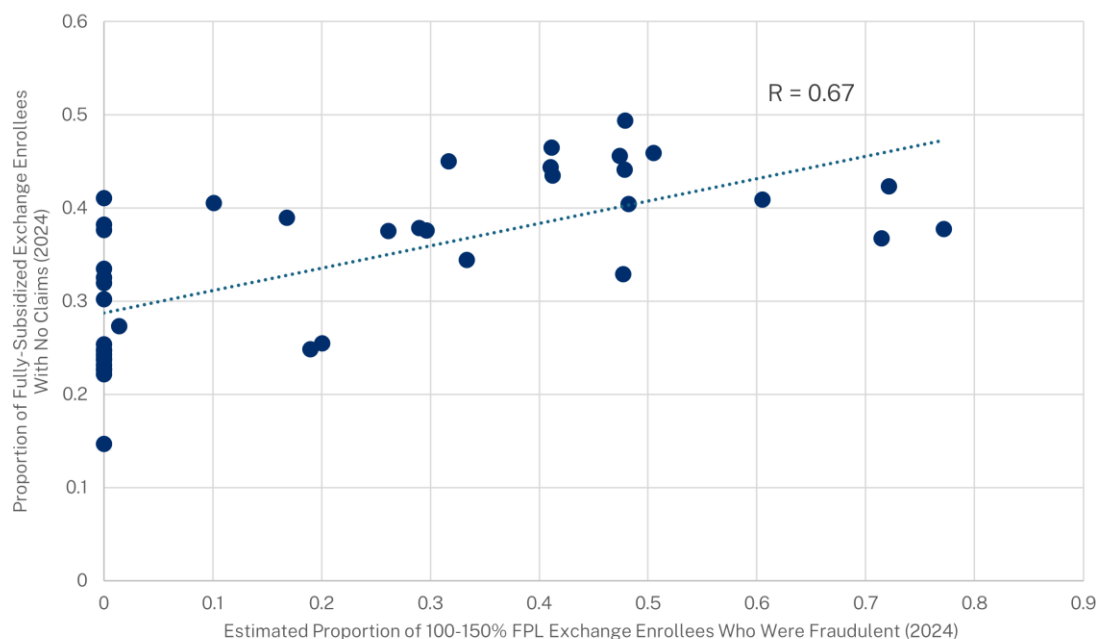
NOTES: Some states omitted due to missing data. SOURCE: Data on fraudulent enrollment comes from Brian Blase et al., "The Greater Obamacare Enrollment Fraud: The Fraud Got Much Worse in 2025," Paragon Health Institute, 2025, <https://paragoninstitute.org/private-health/the-greater-obamacare-enrollment-fraud/>.

Table 1. We compared the proportion of exchange enrollees between 100 and 150 percent of FPL who were fraudulently enrolled to the proportion of those with zero claims on fully subsidized plans (i.e., those enrolled in silver plans with 94% actuarial value due to Biden COVID credits) for the 41 states where data was available (Figure 2). Our

analysis finds these variables have a correlation coefficient of 0.67 — a strong positive statistical relationship.²² This result comes despite the inclusion of several states for which we assumed no fraudulent enrollment.²³ This does not necessarily mean there is no fraudulent enrollment in these states as there is likely some



Figure 2: Strong Correlation Between Estimated Fraudulent Exchange Enrollment and Enrollees With No Claims in 2024



SOURCE: "2019-2024 Enrollees Without Claims by State Market Metal Level," CMS, Aug. 8, 2025.

level of fraud in every state. But our statistical method, which compared the number of enrollees claiming they have income between 100 and 150 percent FPL to the actual number of people in that income range, did not detect evidence of fraud.

Young, Healthy Enrollees Do Not Explain Surge in Zero-Claim Enrollees

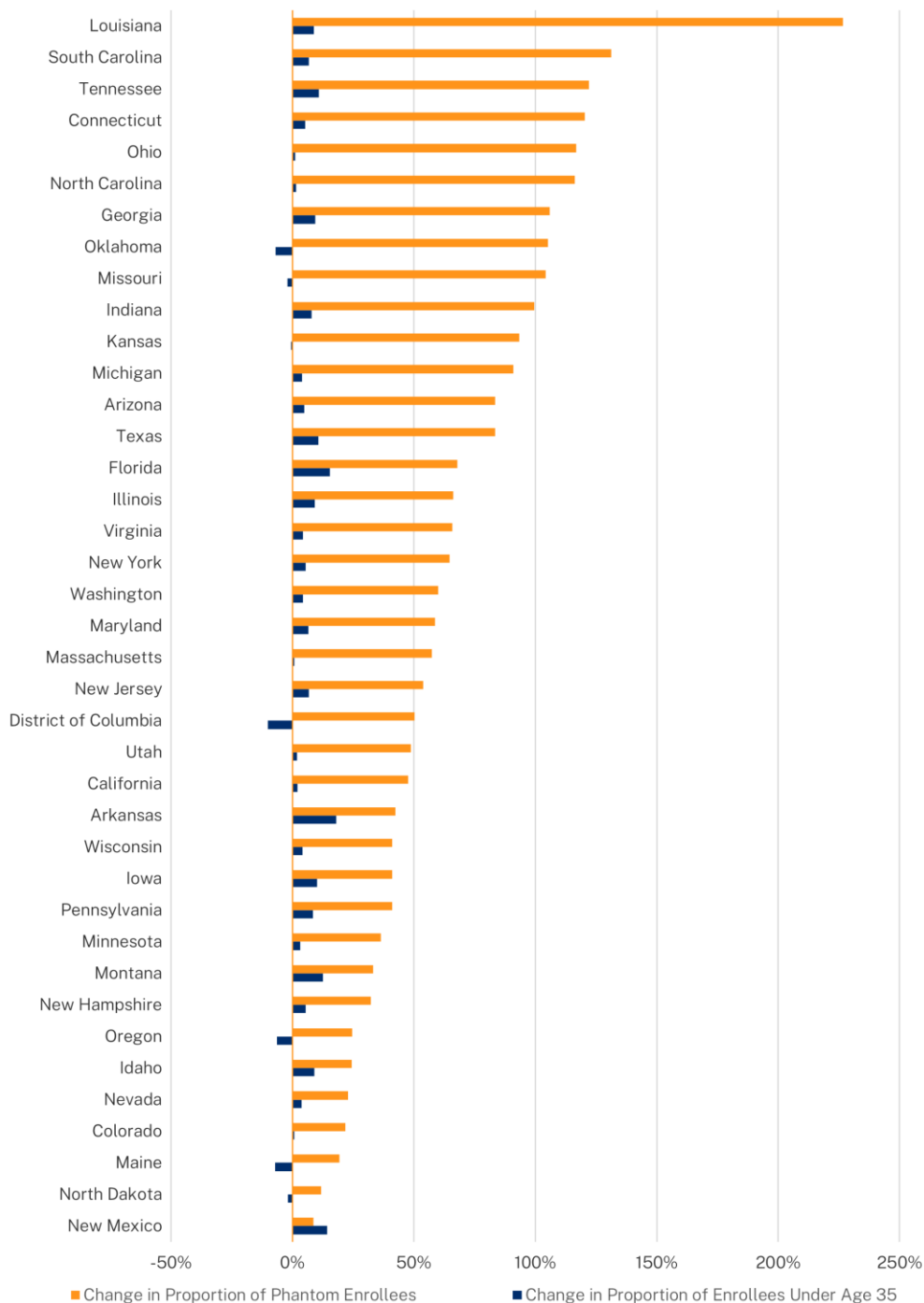
Some assert that the increase in phantom enrollees is due, not to fraud, but to a positive shift in the structure of the ACA risk pool. Perhaps enrollees are not using their health coverage because they are healthier. But this claim is not supported by a key data point. Generally, age is a key predictor for health care utilization and spending, as those who are younger tend to have fewer chronic conditions, risk factors, and acute care needs. Analyzing new enrollees in ACA plans

who were under 35 years old between 2021 and 2024, we find the growth in this age group to be far too small to explain the rise in phantom enrollment (Figure 3).²⁴

All states included in our analysis saw an increase in the proportion of zero-claim enrollees, while six states saw a decline in their enrollees under 35 years of age. In most states, the proportionate growth of zero-claim enrollees is more than double the growth in enrollees under 35. New Mexico was the only example of a state where the change in the proportion of those under 35 outpaced the change in the proportion of phantom enrollees in the ACA marketplace.



Figure 3: Shift Toward Younger Exchange Enrollees Cannot Explain Growth in Zero-Claim Enrollees (2021-2024)



NOTES: Plotted values reflect 2021-2024 changes. Age data on exchange enrollees was obtained from OEP State-Level Public Use Files released by CMS.

Coverage Losses Dwarfed by Zero-Claims Enrollee Numbers

Proponents of continuing the Biden COVID credits often stress the impending coverage losses that could come from allowing these temporary, pandemic-era subsidies to end—with some predicting adverse health consequences. These claims are at odds with the best available evidence. As Zinberg and Sigaud discussed in a 2024 Paragon paper, the most credible studies — based on randomized experiments — show that the causal connection between health insurance and health outcomes is weak, with virtually no differences in physical health indicators between those with and without health insurance.²⁵ Yet the health benefits of extending the Biden COVID credits would be even smaller than these studies suggest, because, unlike the subjects of the experiments, many zero-claim enrollees are not even aware of their coverage and many others use no services with that coverage. The scale of phantom enrollment demonstrates the dangers of conflating health coverage with health care or well-being, especially in government programs prone to fraud and abuse. With many enrollees not utilizing their plans at all, the Biden COVID credits, which drove large zero-claim enrollees, likely matter little to overall health outcomes for Americans.

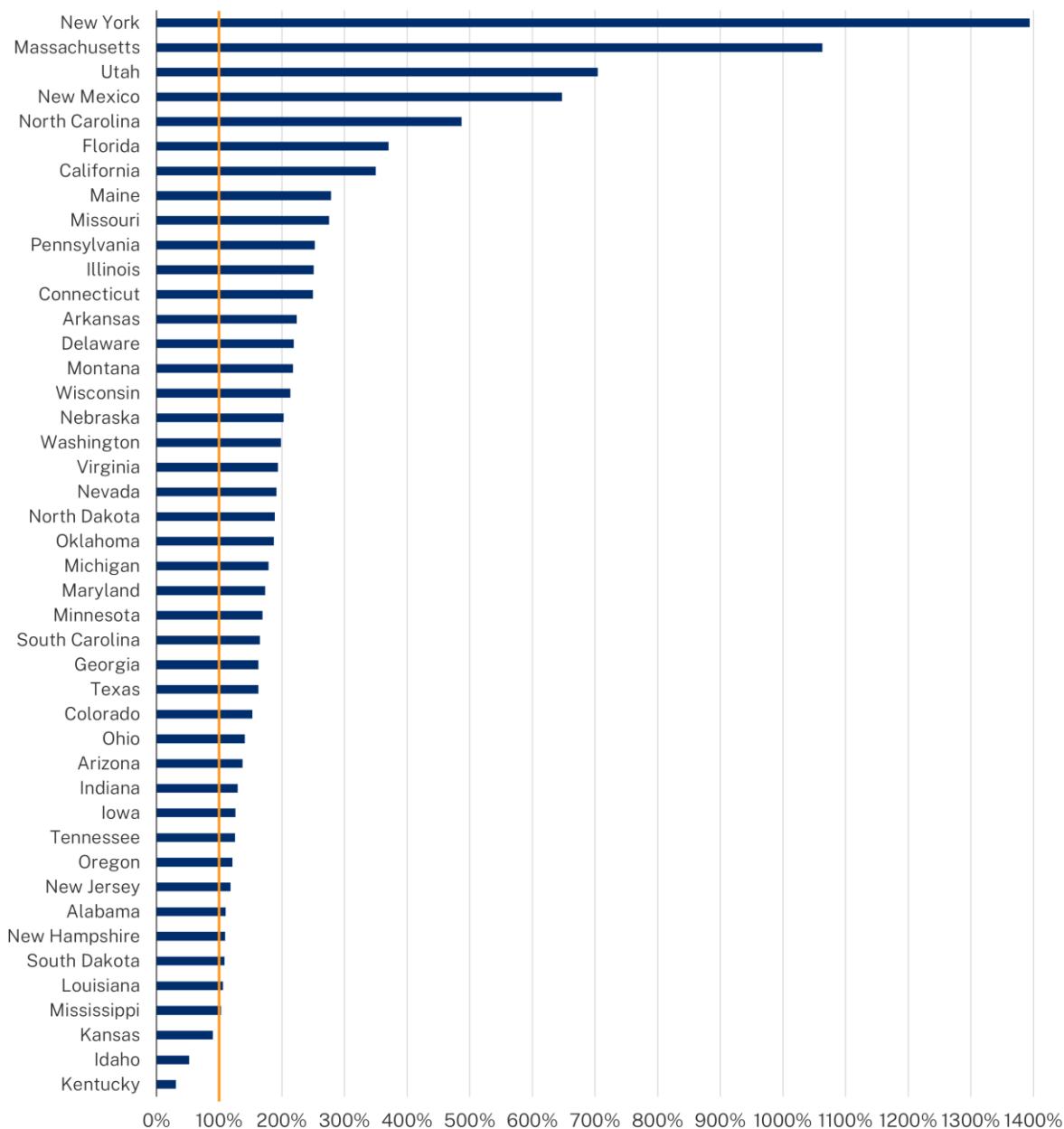
To assess how these claims play into the revelations about phantom enrollment, we use data from the Urban Institute to estimate how coverage losses in each state compare to the number of phantom enrollees. Based on an analysis published last year, the Urban Institute estimates that the expiration of the Biden COVID credits would result in nearly 4 million additional uninsured individuals.²⁶ This figure is similar to what the CBO projects — estimating coverage loss

of 3.5 million people.²⁷ This is a net figure including those who lose subsidized coverage but gain coverage from the unsubsidized individual market or obtain employer-based coverage. Unlike CBO, however, the Urban Institute provides state-level estimates of coverage loss, enabling us to compare zero-claim enrollment and the projected change in the number of uninsured individuals by state.

To ensure comparability, we annualize the number of zero-claim enrollees because the figure of 11.7 million measures all people enrolled at any point in the year. In keeping with previous Paragon analyses, we multiplied by two-thirds the total number of zero-claim enrollees who have ever been enrolled. This gives us an estimate of the annualized phantom enrollees at 7.8 million. When comparing the number of zero-claim enrollees to the number of enrollees projected to lose coverage, we find all but three of the 45 states with available data boast more phantoms than coverage losses. In 17 states, the number of phantoms is more than twice the projected coverage losses. In two states—Massachusetts and New York—there are *more than 10 times* as many zero-claim enrollees as projected coverage losses.²⁸

Not all disenrollments will involve phantoms. However, most coverage losses will likely come from two groups: People who enrolled because coverage was free but never used it or individuals unknowingly enrolled by fraudsters, unaware they had ACA coverage. Those who enrolled in plans just because they are free are unlikely to reenroll in an ACA plan since they place so little value on this coverage that they would rather be uninsured than pay even a nominal share of the premium.²⁹ Likewise, those who were unknowingly enrolled by fraudsters are unlikely to reenroll in an ACA

Figure 4: Zero-Claim Enrollment Far Exceeds Projected Coverage Losses from Expiration of Biden's COVID Credits in Nearly Every State
Ratio of No Claim Enrollees to Estimates of Coverage Losses in the Exchanges from Allowing Biden's COVID Credits to Expire



SOURCE: "Who Would Lose Coverage if the Enhanced Premium Tax Credits Expire," Urban Institute, Nov. 2024.

NOTES: Projected coverage losses are based on authors' calculations of data from the Urban Institute. Projections are for 2026. Phantom enrollment data is for 2024, the most recent year available. Phantom enrollment is annualized based on an average coverage spell of 8 months. Some states are omitted due to lack of data. The District of Columbia is omitted because the Urban Institute projects no change in the number of uninsured individuals from the expiration of the Biden COVID credits.

plan since they never knew about or wanted ACA coverage in the first place.

Congress Should Allow Biden COVID Credits to Expire

The Biden COVID credits merely continued the administration's enrollment-at-any-cost policies, with harmful results to program integrity and fiscal responsibility. Middlemen and insurers alike benefit from this blind spending of taxpayer dollars, while enrollees and taxpayers fall victim to fraud schemes that cost billions to subsidize.

A high percentage of zero-claim enrollees bolster evidence of fraud, particularly since they are most prevalent in states with the most evidence of fraudulent enrollment. In fact, the number of zero-claims enrollees far outpaces coverage loss estimates for ending the COVID credits — with more than twice as many zero-claims enrollees as those projected to lose coverage in 17 states.

Though Congress addressed some abuses in the One Big Beautiful Bill, the economic incentives driving much of the fraud in these plans will remain so long as the Biden COVID credits enable zero-dollar premiums. With millions of “phantoms” enrolled in plans that lie dormant, the claim that America will be made healthier by giving people free insurance coverage on the backs of the taxpayers is nothing more than a ghost story. To curb the abuse Congress must empower real patients, rather than direct taxpayer money to powerful insurers and middlemen. This means letting the temporary COVID credits expire for good.

About the Authors

Niklas Kleinworth is a Policy Analyst at the Paragon Health Institute, focusing on Medicaid

and state policy initiatives. He has served in state and federal policy roles since 2021. Prior to joining the team full-time, Niklas contracted with Paragon for nearly two years, covering issues including pandemic unwinding in Medicaid and Medicaid finance reform. Concurrently, he served as the Policy Director for a state-level policy think tank in his home state of Idaho. There, he covered an eclectic collection of free-market policy issues, writing extensively on healthcare, state budgeting, monetary policy, and public education. He is credited with advancing reforms on issues including Medicaid, medical education, and deregulation.

Liam Sigaud is an Adjunct Scholar at the Paragon Health Institute and a Research Analyst at the Knee Regulatory Research Center at West Virginia University. His work focuses on state and federal health policy. He has published peer-reviewed research in the *Southern Economic Journal*, *Social Science & Medicine* and *Maine Policy Review* and his popular writing has appeared in *The Wall Street Journal*, *The Hill*, and many other publications. Sigaud holds a master's degree in economics from the University of Maine.

John R. Graham is a Visiting Fellow who contributes nearly three decades of health policy expertise to research across all of Paragon's initiatives. He worked on Capitol Hill from 2021 to 2024 as a Professional Staff Member on the Senate Special Committee on Aging and the House Committee on Ways & Means. From 2018 to 2021, he served as the U.S. Department of Health & Human Services (HHS) Regional Director for Region 10 (Washington State, Oregon, Idaho, and Alaska), where he managed relationships with state governments and the private sector. In 2017-2018, John was the HHS Acting Assistant Secretary for Planning & Evaluation.

¹ Dr. Joel Zinberg and Liam Sigaud, "What Matters for Health: Insurance is Less Important Than You Think," Paragon Health Institute, December 2024, <https://paragoninstitute.org/public-health/what-matters-for-health-insurance-is-less-important-than-you-think/>.

² Brian Blase, "The Rise of Phantom Obamacare Enrollees: Biden COVID Credits Drive Massive Increases in Individual Market Enrollees with No Medical Claims," Paragon Health Institute, August 13, 2025, <https://paragoninstitute.org/paragon-prognosis/the-rise-of-phantom-obamacare-enrollees-biden-covid-credits-drive-massive-increase-in-individual-market-enrollees-with-no-medical-claims/>.

³ Zeke Faux & Zachary Mider, "Chasing Big Money with the Health-Care Hustlers of South Florida," June 5, 2025, Bloomberg News, <https://www.bloomberg.com/features/2025-deepfake-ads-fueled-florida-health-insurance-scheme/>; Gabrielle Kalisz, "Victims of Biden's Enrollment-At-Any-Cost Exchange Strategy," Paragon Health Institute, July 18, 2025, <https://paragoninstitute.org/paragon-prognosis/victims-of-bidens-enrollment-at-any-cost-exchange-strategy/>.

⁴ U.S. Government Accountability Office (GAO), "COVID-19 Relief: Consequences of Fraud and Lessons for Prevention," GAO-25-107746, April 9, 2025, <https://www.gao.gov/products/gao-25-107746>.

⁵ In some cases, gold plans have a lower premium than the benchmark plan because silver-loading has massively increased the benchmark premium. Since the premium tax credit (PTC) is a function of the benchmark plans, this means gold plans are available for free or nearly free for enrollees. Silver-loading refers to insurers inflating the cost of ACA silver plans to pay for the expense of cost-sharing reduction program versions of other silver plans.

⁶ Brian Blase, Chris Medrano, Niklas Kleinworth, and Jackson Hammond, "The Greater Obamacare Enrollment Fraud," Paragon Health Institute, June 2025, <https://paragoninstitute.org/private-health/the-greater-obamacare-enrollment-fraud/>.

⁷ Ibid.

⁸ Prior to the passage of the OBBB, the federal government was limited in how much of the overpaid ACA subsidies they could recover from enrollees. Those below the poverty level were not subject to any subsidy recapture (which does not appear to have been changed by the OBBB). Unmarried individuals earning more than the federal poverty level were subject to the following limits: \$375 if below 200 percent FPL, \$975 if below 300 percent FPL, \$1,625 if below 400 percent FPL, and no limit if above 400 percent FPL. For all other taxpayers, all limits doubled, meaning those between 100 and 200 percent FPL were subject to a \$750 limit, for example.

Brian Blase and Jackson Hammond, "Policy Changes Needed to Reduce Massive Improper Affordable Care Act Subsidy Expenditures," Paragon Health Institute, July 2, 2025, <https://paragoninstitute.org/private-health/policy-changes-needed-to-reduce-massive-improper-affordable-care-act-subsidy-expenditures/>.

⁹ Faux & Mider, "Chasing Big Money," (2025).

¹⁰ Chris Medrano, Brian Blase, and Ryan Long, "What Made It Into Law: Health Provisions of the One Big Beautiful Bill," Paragon Health Institute, June 2025, <https://paragoninstitute.org/private-health/what-made-it-into-law-health-provisions-of-the-one-big-beautiful-bill/>.

¹¹ Ibid.

¹² Centers for Medicare and Medicaid Services, "2025 Marketplace Integrity and Affordability Final Rule," June 20, 2025, <https://www.cms.gov/newsroom/fact-sheets/2025-marketplace-integrity-and-affordability-final-rule>.

¹³ *City of Columbus v. Kennedy*, No. 1:25-cv-02114-BAH, Memorandum Opinion, U.S. District Court for the District of Maryland, Aug. 22, 2025, <https://democracyforward.org/wp-content/uploads/2025/08/35-City-of-Columbus-memorandum-opinion.pdf>.

¹⁴ Brian Blase and Trevor Carlsen, "Biden's COVID Credits Are an ObamaCare Expansion That Congress Should Allow To Expire," Paragon Health Institute and Foundation for Government Accountability, September 2025, <https://paragoninstitute.org/private-health/bidens-covid-credits-are-an-obamacare-expansion-that-congress-should-allow-to-expire/>.

¹⁵ Brian Blase, "The Rise of Phantom Obamacare Enrollees: Biden COVID Credits Drive Massive Increase in Individual Market Enrollees With No Medical Claims," Paragon Health Institute, August 2025, <https://paragoninstitute.org/paragon-prognosis/the-rise-of-phantom-obamacare-enrollees-biden-covid-credits-drive-massive-increase-in-individual-market-enrollees-with-no-medical-claims/>.

¹⁶ Blase, "The Rise of Phantom Obamacare Enrollees," Brian Blase, "Don't Believe AHIP — Improper and Phantom Obamacare Enrollees Are Both Major Problems," Paragon Health Institute, August 20, 2025, <https://paragoninstitute.org/newsletter/dont-believe-ahip-improper-and-phantom-obamacare-enrollees-are-both-major-problems/>.

¹⁷ Ibid.

¹⁸ Blase, Medrano, Kleinworth, and Hammond, "Greater Obamacare Enrollment Fraud," (2025).

¹⁹ Department of Health and Human Services, "Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability," Proposed Rule, Federal Register 90, no. 52 (March 19, 2025): <https://www.govinfo.gov/content/pkg/FR-2025-03-19/pdf/2025-04083.pdf>.

²⁰ Ibid.

²¹ Centers for Medicare and Medicaid Services, "2019-2024 Enrollees Without Claims by State Market Metal Level," ACA Risk Adjustment Program, August 8, 2025, <https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.cms.gov%2Ffiles%2Fdocument%2Fenrolleeswithoutclaims-2019-24.xlsx&wdOrigin=BROWSELINK>.

²² Haldun Akoglu, "User's guide to correlation coefficients," *Turkish Journal of Emergency Medicine* 8, no. 3 (August 7, 2018): 91-93, <https://pubmed.ncbi.nlm.nih.gov/30191186/>.

²³ Additional information about Paragon's methodology for estimating fraudulent ACA enrollment can be found in the paper, "The Greater Obamacare Enrollment Fraud: The Fraud Got Much Worse in 2025."

Brian Blase, Chris Medrano, Niklas Kleinworth, and Jackson Hammond, "The Greater Obamacare Enrollment Fraud: The Fraud Got Much Worse in 2025," Paragon Health Institute, June 2025, <https://paragoninstitute.org/private-health/the-greater-obamacare-enrollment-fraud/>.

²⁴ CMS, "2019-2024 Enrollees without Claims," 2025.

²⁵ Dr. Joel Zinberg and Liam Sigaud, "What Matters for Health: Insurance is Less Important Than You Think," Paragon Health Institute, December 2024, <https://paragoninstitute.org/public-health/what-matters-for-health-insurance-is-less-important-than-you-think/>.

²⁶ “Who Would Lose Coverage If Enhanced Premium Tax Credits Expire?” Urban Institute, November 14, 2024, <https://www.urban.org/data-tools/health-insurance-premium-tax-credit>.

²⁷ This figure is based on unpublished CBO analysis obtained by Paragon in September 2025.

²⁸ These large figures in New York and Massachusetts are likely due to the large number of phantoms relative to low projected coverage

loss estimates, likely due to alternative coverage options unique to those states.

²⁹ Adrianna McIntyre, Mark Shepard, and Timothy Layton, “Small Marketplace Premiums Pose Financial and Administrative Burdens: Evidence from Massachusetts, 2016-17,” Health Affairs, January 2024, <https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2023.00649?journalCode=hlthaff>.