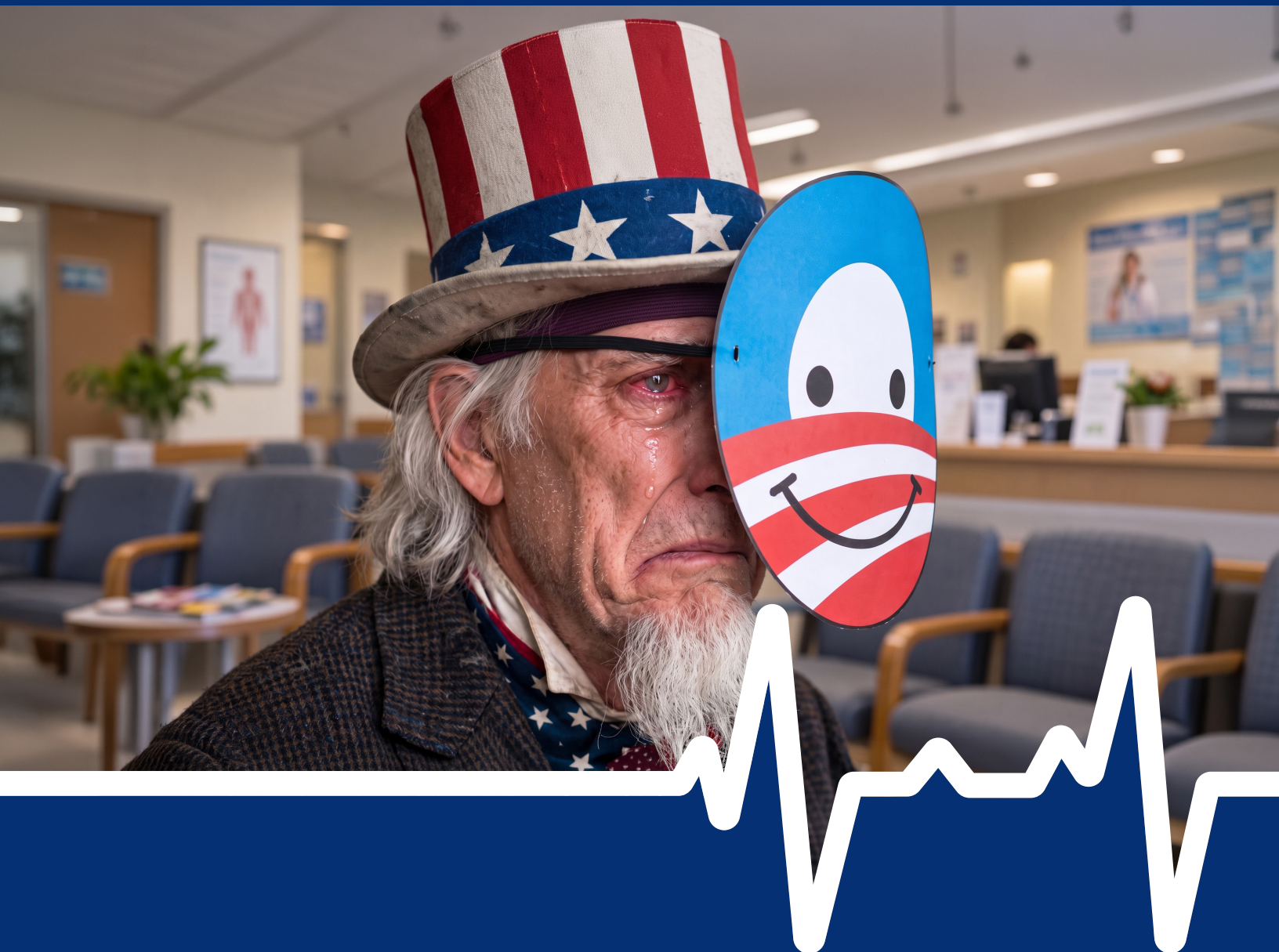




State of the Affordable Care Act Exchanges Heading into 2027

Rising Premiums, Exploding Subsidies, and Fewer Phantoms

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The authors are grateful to John R. Graham, Niklas Kleinworth, Liam Sigaud, and the Paragon team for their exceptional comments and work in review of the paper.

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Brian guided the House Committee on Oversight and Government Reform's health care and entitlement program oversight and investigation efforts from 2011 to 2014, and then served as the Senate Republican Policy Committee's health policy analyst from 2014 to 2015.

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EXECUTIVE SUMMARY

What We Found

The Affordable Care Act (ACA) exchanges have become an increasingly expensive, heavily subsidized insurance market. Premiums have risen much faster than those for employer-sponsored insurance (ESI), deductibles are substantially higher, and provider networks are considerably more restrictive. Federal taxpayers have absorbed nearly all the premium increases for subsidized enrollees. Despite enormous subsidies, the exchanges fell far short of their original enrollment expectations until Congress expanded subsidies during the pandemic. Those expanded subsidies contributed to a surge in improper and phantom enrollment by making coverage free for millions of people.

Why This Matters

The ACA was intended to create a competitive and affordable individual health insurance market. Instead, it has produced a market characterized by high premiums, limited provider access, and overwhelming dependence on taxpayer subsidies. The growing disparity between ACA subsidies and the tax benefits for employer coverage creates incentives for workers to move to exchange coverage and for employers to stop offering insurance, potentially shifting additional costs to federal taxpayers. Moreover, fully subsidized plans have weakened an important safeguard against unauthorized and fictitious enrollment. Rising enrollment figures from 2022 through 2025 included millions of improper and phantom enrollees — many of whom have been removed over the past year.

Key Findings

- **The ACA caused individual-market premiums to soar.** Premiums increased sharply when the ACA's major insurance regulations took effect in 2014 and have continued rising much faster than employer coverage premiums. From 2014 to 2026, benchmark premiums for a 50-year-old increased 129 percent, compared with 63 percent for ESI premiums and 39 percent for overall inflation.
- **ACA coverage provides less financial protection and more limited provider access than typical employer coverage.** The combined premium

and deductible for an ACA benchmark silver plan was approximately equal to that for ESI in 2014 but substantially higher by 2026. In 2023, 83 percent of individual-market enrollees had closed-network plans, compared with 18 percent of ESI enrollees.

- **Taxpayers bear nearly all the increase in subsidized premiums.** For a 50-year-old at 200 percent of the federal poverty level, taxpayers will finance approximately \$10,000 of a \$12,000 benchmark premium in 2027, absorbing more than 90 percent of the premium increase since 2014.
- **The exchanges are overwhelmingly taxpayer-financed.** Federal subsidies accounted for approximately 77 percent of premium revenue in HealthCare.gov states before the pandemic, increasing to 86 percent in 2025.
- **ACA subsidies increasingly favor exchange coverage over employer coverage.** For many lower-and middle-income households, the ACA subsidy is substantially greater than the tax benefit for ESI, creating incentives to shift coverage away from employers.
- **Exchange enrollment surged only after Congress expanded subsidies.** Enrollment was less than half of CBO’s original projection in 2016 and remained far below expectations for years. Enrollment increased substantially after the COVID-era subsidy expansions, which made coverage fully subsidized for millions and contributed to widespread improper and phantom enrollment.
- **Evidence of improper and phantom enrollment is substantial.** In 2026, 56 percent of HealthCare.gov plan selections reported incomes between 100 and 150 percent of the federal poverty level. In 13 states, enrollment in this category was more than twice the estimated eligible population, exceeding three times that population in several states. After both the 2025 and 2026 open enrollment periods, there were more than 6 million improperly enrolled individuals. The share of individual-market enrollees without medical claims increased from 19 percent in 2021 to 35 percent in 2024 — while the rate of zero-claim enrollment in the unsubsidized small group market remained at roughly 20 percent. The Trump administration has taken action to remove phantom enrollees, and states with higher zero-claim rates have generally experienced larger subsequent enrollment declines.

INTRODUCTION

Two years ago, Paragon released *The Falsehoods of Obamacare*, which documented how the Affordable Care Act (ACA) increased health care costs and federal deficits, caused people to lose their plans and doctors, and failed to improve health outcomes.¹ One of the ACA's central promises was that it would create a competitive, robust individual health insurance market. The reality has been quite different. ACA plans generally have high premiums, large deductibles, and narrow provider networks, and the market depends on far more federal subsidies than originally anticipated. The structure of the ACA encourages higher premiums.

As the 2027 open enrollment period approaches, this paper uses a series of figures to illustrate the current state of the ACA exchanges and the developments that brought the market to this point. The figures tell a troubling story: premiums have continued to rise quickly; taxpayers bear an ever-growing share of the cost; and expanded subsidies have contributed to widespread improper and phantom enrollment. Recent enrollment changes also provide evidence of how much the market has been distorted by zero-premium coverage.

Exchange Enrollment Fell Far Short of Expectations Until Subsidies Expanded

The ACA exchanges attracted far fewer enrollees than originally expected. In 2013, the Congressional Budget Office (CBO) projected that average exchange enrollment would reach 22 million in 2016 and approximately 24 million by 2023. As Figure 1 shows, actual enrollment was just 10 million in 2016 and remained near that level until Congress expanded the premium subsidies during the COVID pandemic.

The exchanges proved far less attractive to consumers than anticipated, with high premiums, large deductibles, and restrictive provider networks. Enrollment increased substantially only after Congress expanded premium subsidies during the pandemic, making coverage free for millions of people. As discussed later in this paper, much of the subsequent enrollment growth coincided with widespread improper and phantom enrollment.

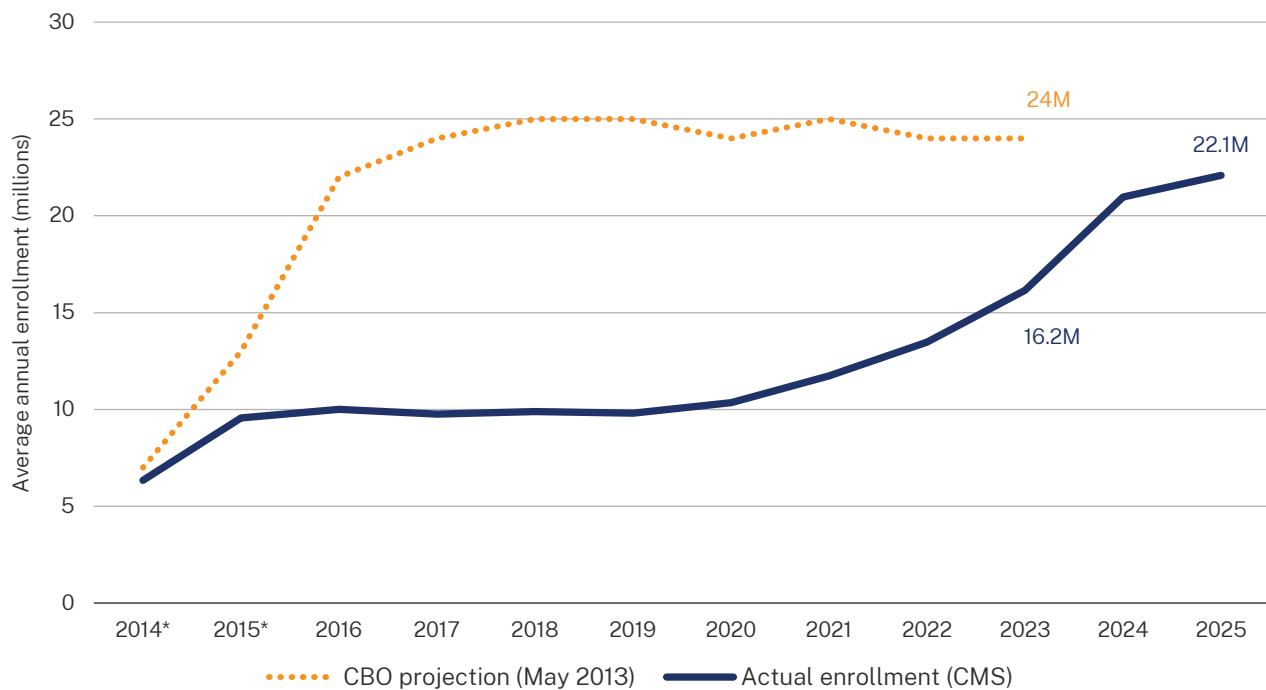
Rising Premiums, Rising Taxpayer Subsidies

Figure 2 compares benchmark premiums in 2014 and 2027 by state, sorted by the size of the 2027 premium. The benchmark plan is the second-lowest-cost silver plan available on the exchange, and its premium largely determines federal subsidies. Nationally, the benchmark premium has increased by 163 percent from 2014 to 2027. Premium growth has varied widely

¹ Brian Blase, Casey Mulligan, and Phil Kerpen, "The Falsehoods of Obamacare: A Dozen Broken Promises, Seven Million Canceled Plans, and Hundreds of Billions in Debt," Paragon Health Institute, October 2024, <https://paragoninstitute.org/private-health/the-falsehoods-of-obamacare-a-dozen-broken-promises-seven-million-canceled-plans-and-hundreds-of-billion-in-debt/>.



Figure 1: ACA Exchange Enrollment Fell Far Short of Initial Projections Until Subsidies Expanded



SOURCES: Congressional Budget Office, “Effects of the Affordable Care Act on Health Insurance Coverage, May 2013 Baseline,” Table 3; and Centers for Medicare & Medicaid Services effectuated enrollment data (annual file as of April 21, 2026; 2014–2015 quarterly snapshots).

NOTE: CBO projection is individually purchased exchange enrollment from CBO’s May 2013 baseline, measured as average enrollment over the year; the baseline ended in 2023. Actual enrollment is CMS’s average monthly effectuated (paid) enrollment. Expanded premium tax credits took effect in 2021. *CMS did not publish full-year averages for 2014 or 2015; 2014 is effectuated enrollment in December 2014, and 2015 is the average of CMS’s four quarter-end counts.

across the country, ranging from 64 percent in New Hampshire to 352 percent in West Virginia. Geographic disparities have also widened: the standard deviation of state benchmark premiums increased from \$55 in 2014 to a projected \$190 in 2027, while the coefficient of variation rose from 19.9 percent to 25.7 percent.²

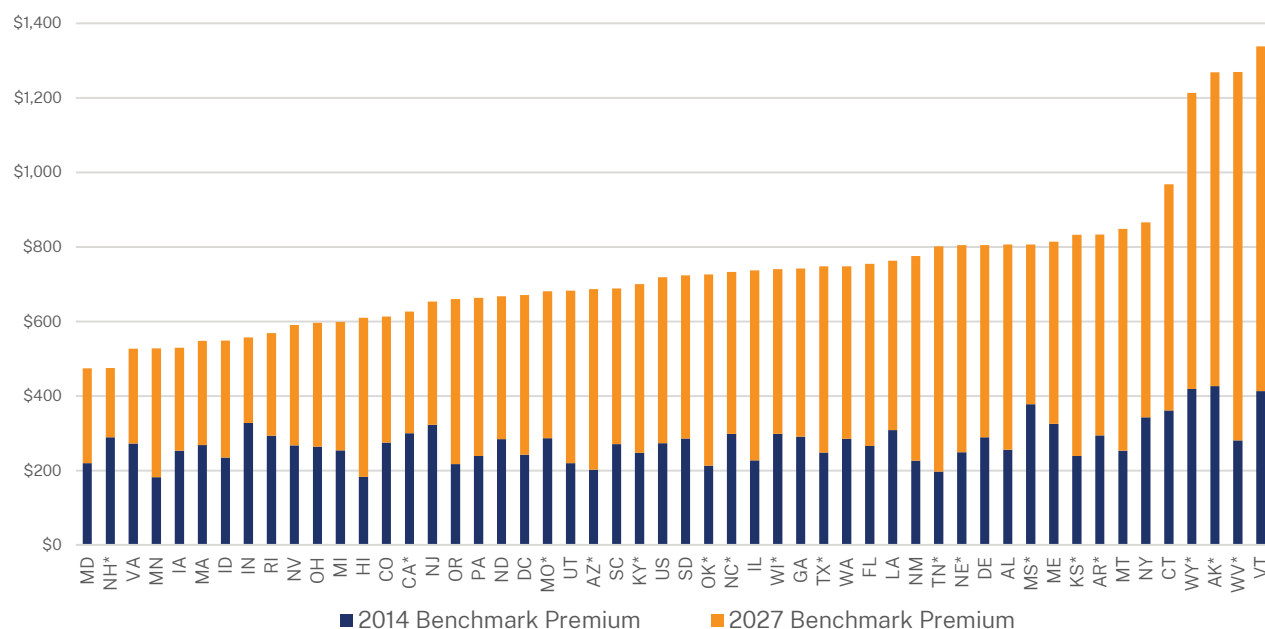
Since benchmark premiums vary so dramatically across the country, so do subsidies. The contrast between neighboring states New Hampshire and Vermont makes this clear. Federal taxpayers are bearing a much greater cost for exchange enrollees in Vermont — largely because Vermont does not permit insurers to charge younger enrollees lower premiums than older enrollees, which significantly raises overall premiums.

² The standard deviation measures how much benchmark premiums typically differ from the average benchmark premium across states. The coefficient of variation is the standard deviation divided by that average, expressed as a percentage. Because the coefficient of variation is a unitless measure that captures dispersion in the data relative to the average premium, it is useful for comparing how widely premiums vary across states in years when premium levels differ substantially.



Figure 2: ACA Benchmark Premiums Increased 163% Nationally from 2014 to 2027

Premium increases range from 64% in New Hampshire to 352% in West Virginia



SOURCES: KFF, "Marketplace Average Monthly Benchmark Premiums" for a 40 year old; Louise Norris, "Health insurance premium increases for 2027: proposed rates by state," [healthinsurance.org](https://www.healthinsurance.org); KFF, "How Much and Why ACA Marketplace Premiums Are Going Up in 2027."

NOTE: Figures for 2014–2026 are KFF estimates of premiums. Figures for 2027 are calculations applying each state's average 2027 individual-market rate change to its 2026 benchmark premium, so realized 2027 benchmark premiums will differ. States marked with an asterisk had preliminary 2027 rates still awaiting regulator approval as of October 23, 2026 (approved rates are shown for 33 of the 50 states and DC). The United States figure applies KFF's 15 percent median proposed increase across 276 insurers and is also not final.

Of the people who selected a plan during the 2026 open enrollment period, 87 percent were subsidized through premium tax credits.³ Figure 3 shows an essential feature of the ACA — the subsidy caps the amount of money that enrollees have to pay for their coverage. The subsidies are structured so that the benchmark premium cannot exceed a certain amount of household income, with higher subsidies for lower-income enrollees.

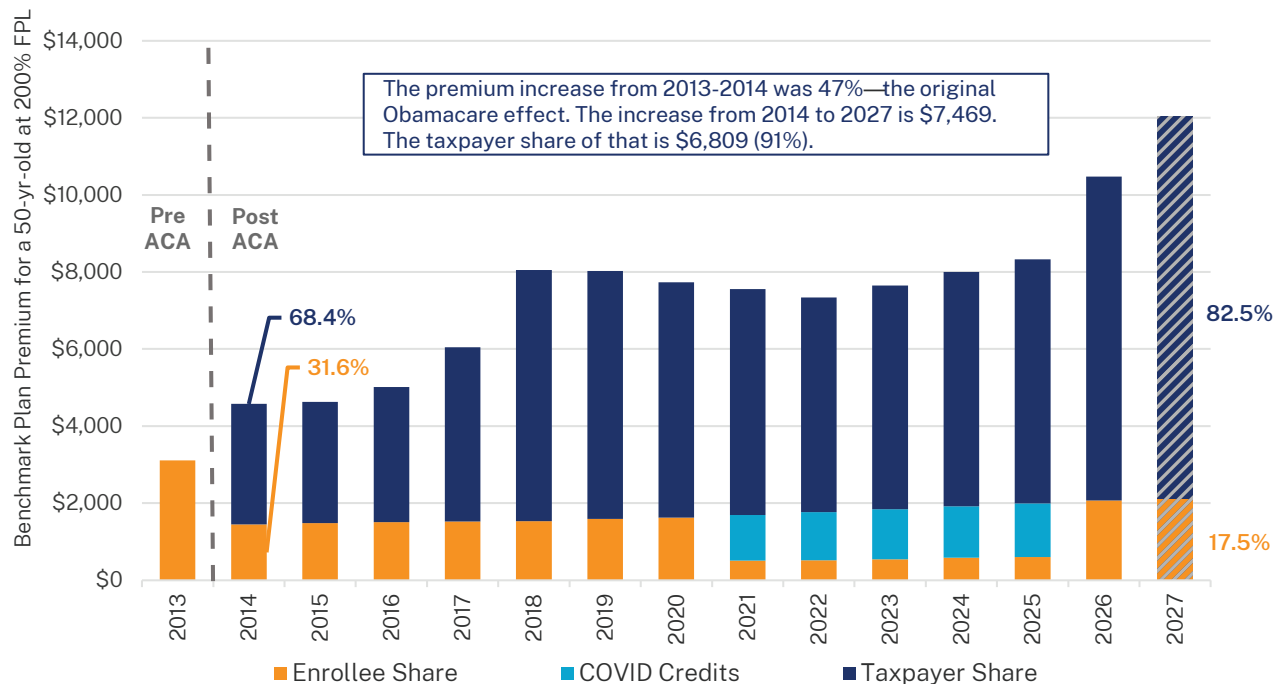
Figure 3 shows the enrollee and taxpayer share of the benchmark premium for a 50-year-old enrollee at 200 percent of the federal poverty level (FPL) — about the average age and income for a single ACA plan enrollee. The enrollee's share (the orange bar) has barely changed because taxpayers have absorbed more than 90 percent of the premium increase since 2014. In 2027, this enrollee will receive about a \$10,000 subsidy for a \$12,000 plan. The enrollee's share of the premium has fallen from 31.6 percent to 17.5 percent while the taxpayer share of the premium has risen from 68.4 percent to 82.5 percent in 13 years.

³ Matt McGough et al., "What We Know So Far About 2026 ACA Marketplace Enrollment, Premiums, and Deductibles," KFF, May 19, 2026, <https://www.kff.org/affordable-care-act/what-we-know-so-far-about-2026-aca-marketplace-enrollment-premiums-and-deductibles/>.



Figure 3: Taxpayers Pay for Almost the Entire Increase in Obamacare Premiums

Next year, the premium for a 50-yr-old enrollee will likely exceed \$12,000 — with taxpayers covering nearly \$10,000 of that cost



SOURCES: Authors' calculations using KFF Health Insurance Marketplace Calculator data and ASPE Data Point, "Individual Market Premium Changes: 2013–2017," U.S. Department of Health and Human Services; Peterson-KFF Health System Tracker, "How much and why ACA Marketplace premiums are going up in 2027."

NOTE: 2027 is a projection that applies a 15% premium increase to the 2026 benchmark premium, reflecting the Peterson-KFF Health System Tracker's analysis of preliminary 2027 ACA Marketplace rate filings.

Figure 4 shows the growing share of ACA insurers' premium revenue financed by federal taxpayers in states using HealthCare.gov. Before the pandemic, taxpayers already financed approximately 77 percent of premium revenue. By 2025, that share had increased to more than 86 percent. The analysis focuses on HealthCare.gov states because CMS does not publish comparable premium data for states operating their own exchanges.

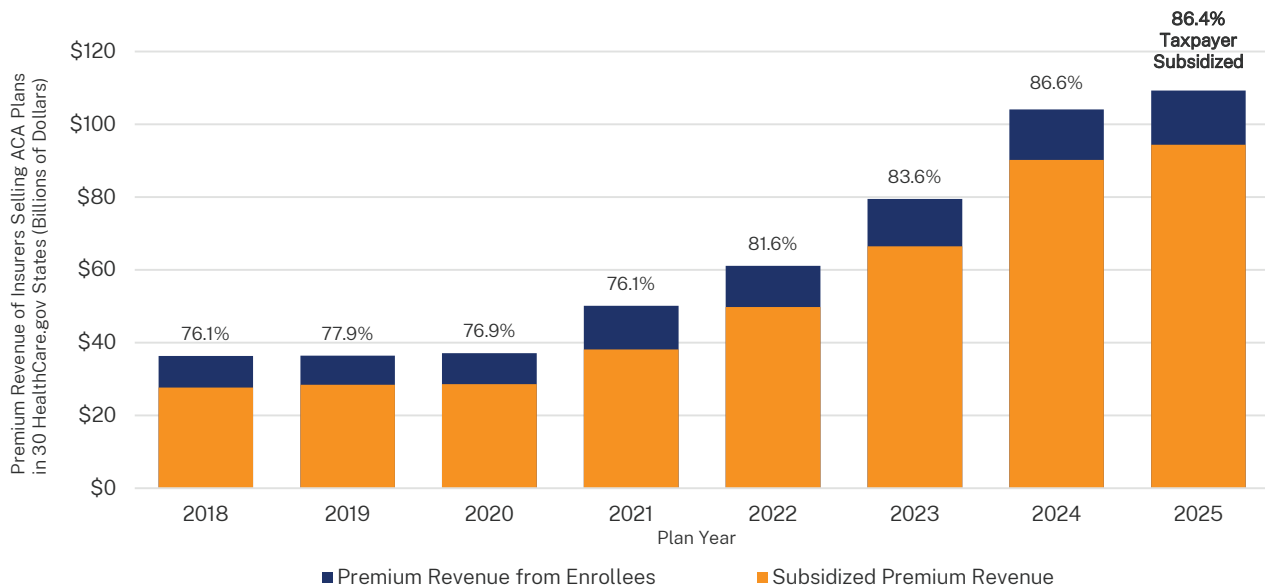
In 2021, as a pandemic relief measure, Congress increased the subsidies and extended them to people in households with income above 400 percent of the FPL. Congress set those enhanced subsidies to expire after 2025. The enhanced subsidies are displayed in Figure 3 as the light blue bar and represent a shift in the financial burden from the enrollee to the federal taxpayer.

The ACA organizes health insurance marketplace plans into four metal categories based on actuarial value (AV) — bronze (60 percent AV), silver (70 percent AV), gold (80 percent AV), and



Figure 4: Federal Taxpayers Financed 86% of ACA Insurers' Premium Revenue in 2025

The share of ACA premiums subsidized by the government was nearly ten percentage points higher than pre-COVID



SOURCE: CMS Open Enrollment Period Public Use Files 2018 -2025 and CMS Issuer-Level Enrollment Data 2018 -2025

NOTE: Data represents only the 30 states that use HealthCare.gov to administer ACA benefits. Oregon is the only state in our analysis to use HealthCare.gov, then start a Basic Health Program (BHP) later. Oregon, started its BHP on July 1, 2024. Therefore, we removed observations from Oregon for the 2024 plan year. Other states that operate BHPs include New York and Minnesota, but they never used the HealthCare.gov platform to administer benefits during our analysis window. Thus, they were excluded from our analysis. We estimated revenues based on average premiums before and after APTCs and actual member months reported in the issuer-level data. Alaska and Wyoming were excluded due to missing PUF data.

platinum (90 percent AV). AV is the average percentage of covered medical costs paid by the plan. Higher AV plans generally have lower deductibles and cost-sharing requirements. Lower-income enrollees who choose silver plans qualify for an additional benefit that raises the actuarial value of the plan by lowering plan deductibles and copayments. Figures 5 and 6 show how much more heavily subsidized the market is in 2027 than it was in 2014. Figure 5 shows the percentage of the national average bronze plan premium covered by the subsidy for single enrollees of four ages at various income levels. Figure 6 shows the percentage of the national average benchmark silver plan premium covered by the subsidy. Nearly half of exchange enrollees report incomes below 150 percent of FPL, and more than two-thirds report incomes below 200 percent of FPL. As the figures illustrate, these enrollees generally qualify for fully subsidized bronze plans and subsidies covering most of the cost of benchmark silver plans.



Figure 5: Subsidies Covered a Growing Portion of Bronze Plan Premiums from 2014 to 2027

Most ACA enrollees qualify for a fully subsidized bronze plan in 2027

Bronze Plan, 2014

Percentages Reflect the Share of Premium Paid for by Taxpayers

	Premium for a Single Adult	100%	150%	200%	250%	300%	350%	400%
21 yr old	\$1,945	100%	96%	57%	13%	0%	0%	0%
40 yr old	\$2,486	100%	100%	73%	39%	0%	0%	0%
50 yr old	\$3,474	100%	100%	90%	65%	37%	22%	6%
64 yr old	\$5,836	100%	100%	100%	92%	76%	66%	57%

Bronze Plan, 2027

	Premium for a Single Adult	100%	150%	200%	250%	300%	350%	400%
21 yr old	\$4,924	100%	100%	93%	67%	38%	21%	4%
40 yr old	\$6,292	100%	100%	100%	82%	59%	46%	33%
50 yr old	\$8,794	100%	100%	100%	98%	81%	72%	63%
64 yr old	\$14,771	100%	100%	100%	100%	100%	98%	93%

SOURCE: Authors' calculations based on KFF's Health Insurance Marketplace Calculator (2026 premiums, U.S. average) and KFF's 2014 Health Insurance Marketplace Calculator (2014 premiums, U.S. average), IRS Rev. Proc. 2026-26, the ACA's 2014 applicable-percentage table, and KFF's analysis of preliminary 2027 rate filings.

NOTE: Darker cells mean taxpayers cover a larger share of the premium; 100% means the enrollee pays no premium. Incomes are annual household income for a single adult. Premium Cost is the full annual premium before the tax credit. 2014 uses the statutory applicable-percentage table (2.0%–9.5% of income, ACA §36B(b)(3)(A)) and income measured against the 2013 federal poverty guideline (\$11,490), the guideline that governed 2014 coverage. 2027 applies a 15% premium increase to 2026 premiums, with required contributions set by the 2027 applicable-percentage table (2.15%–10.22% of income) and income measured against the 2026 federal poverty guideline (\$15,960).

ACA Subsidies Increasingly Favor Exchange Coverage Over ESI

The ACA also provides much larger federal subsidies to many low-and middle-income people who obtain coverage through the exchanges than the tax benefits available to those with employer-sponsored insurance (ESI). Employer-paid health insurance premiums are generally excluded from federal income and payroll taxes.

Figure 7 updates a figure from a November 2025 Paragon policy brief by Brian Blase and John R. Graham, comparing the value of the tax exclusion for employer coverage with ACA



Figure 6: Subsidies Covered a Growing Portion of Benchmark Plan Premiums from 2014 to 2027
Most ACA enrollees qualify for a subsidy that covers more than 80 percent of the premium for a benchmark plan in 2027

Benchmark Plan, 2014

Percentages Reflect the Share of Premium Paid for by Taxpayers

	Premium for a Single Adult	100%	150%	200%	250%	300%	350%	400%
21 yr old	\$2,562	91%	73%	43%	10%	0%	0%	0%
40 yr old	\$3,274	93%	79%	56%	29%	0%	0%	0%
50 yr old	\$4,575	95%	85%	68%	49%	28%	16%	5%
64 yr old	\$7,685	97%	91%	81%	70%	57%	50%	43%

Benchmark Plan, 2027

	Premium for a Single Adult	100%	150%	200%	250%	300%	350%	400%
21 yr old	\$6,742	95%	85%	68%	49%	27%	15%	3%
40 yr old	\$8,617	96%	88%	75%	60%	43%	34%	24%
50 yr old	\$12,042	97%	91%	82%	71%	59%	53%	46%
64 yr old	\$20,227	98%	95%	89%	83%	76%	72%	68%

SOURCE: Authors' calculations based on KFF's Health Insurance Marketplace Calculator (2026 premiums, U.S. average) and KFF's 2014 Health Insurance Marketplace Calculator (2014 premiums, U.S. average), IRS Rev. Proc. 2026-26, the ACA's 2014 applicable-percentage table, and KFF's analysis of preliminary 2027 rate filings.

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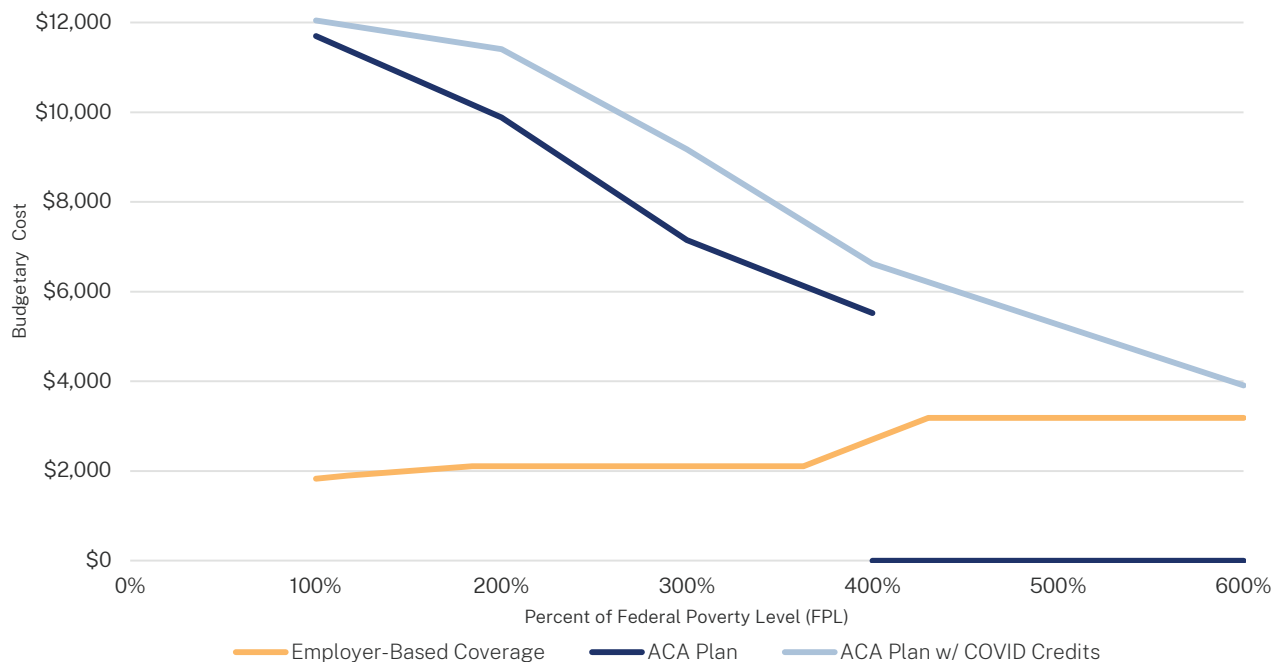
premium tax credits at different income levels in 2027.⁴ For example, a 50-year-old earning \$47,880 would receive a federal tax benefit of approximately \$2,109 for employer coverage that year, compared with an ACA premium tax credit of \$7,151 under the original subsidy structure. If the COVID-19 enhanced subsidies were restored, the ACA benefit would be \$9,171. This disparity creates a powerful incentive for lower-and middle-income workers to seek jobs that do not offer employer coverage and that come with higher wages as a

⁴ Brian Blase and John R. Graham, "Problems with ACA Subsidies Compounded by COVID Credits: Unfair to Americans with Employer-Based Insurance, Punish Work, and Incentivize Employers to Drop Coverage," Paragon Health Institute, November 2025, <https://paragoninstitute.org/private-health/problems-with-aca-subsidies-compounded-by-covid-credits-unfair-to-americans-with-employer-based-insurance-punish-work-and-incentivize-employers-to-drop-coverage/>.



Figure 7: ACA Subsidies Exceed the Tax Benefit for Employer Coverage at Many Income Levels

Budgetary cost of ACA subsidies with and without COVID credits for a 50-year-old compared to employer-based coverage (2027)



SOURCE: KFF 2026 Employer Health Benefits Survey with 2027 premiums increasing 9.5 percent. ACA premiums will increase 15 percent from 2026, per KFF estimate.

compensating differential. It also creates incentives for employers to discontinue coverage, shifting more workers into federally subsidized plans and increasing federal spending.

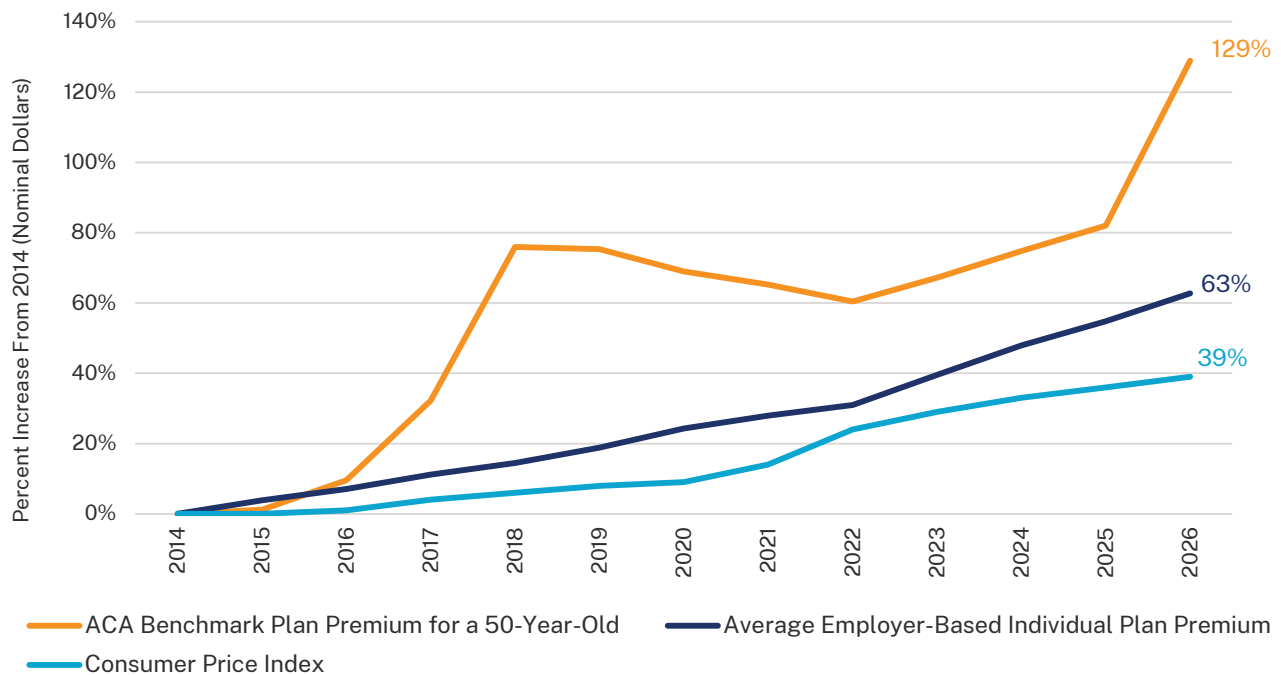
ACA Premiums Have Risen More Than Twice as Fast as ESI Premiums

ACA premiums have increased more than twice as fast as ESI premiums since 2014. As Figure 8 shows, benchmark premiums for a 50-year-old ACA enrollee increased 129 percent from 2014 to 2026, compared with 63 percent for average ESI premiums and 39 percent for overall inflation. These figures measure the full premium, including the amounts paid by taxpayers and enrollees. The much faster growth in ACA premiums suggests that the law’s regulatory and subsidy structures have contributed to higher premium growth than in the employer market.

A particularly large increase in premiums occurred in 2018, driven by “silver loading” — the practice of inflating ACA silver plan premiums to cover insurers’ cost-sharing reduction (CSR)



Figure 8: Obamacare Plan Premiums Have Increased 2x Faster Than Employer-Based Plan Premiums Since 2014



SOURCES: KFF, Health Insurance Marketplace Calculator (2014–2026); KFF, Employer Health Benefits Survey (2013–2026); Federal Reserve Bank of Minneapolis, Consumer Price Index (1913–2026).

NOTE: A 50-year-old is used for the ACA line since that is the typical age of an ACA enrollee.

obligations after a court ruled that the Obama administration’s CSR payments were unlawful.⁵ After the federal government halted CSR payments in 2017, insurers still had to offer CSR plans to eligible enrollees. To recoup these costs, insurers increased premiums on silver plans, which are used to calculate benchmark premiums and determine premium tax credits (PTCs). Insurers overshot those premium increases in 2018 — which is a large reason for the decline during the next few years.

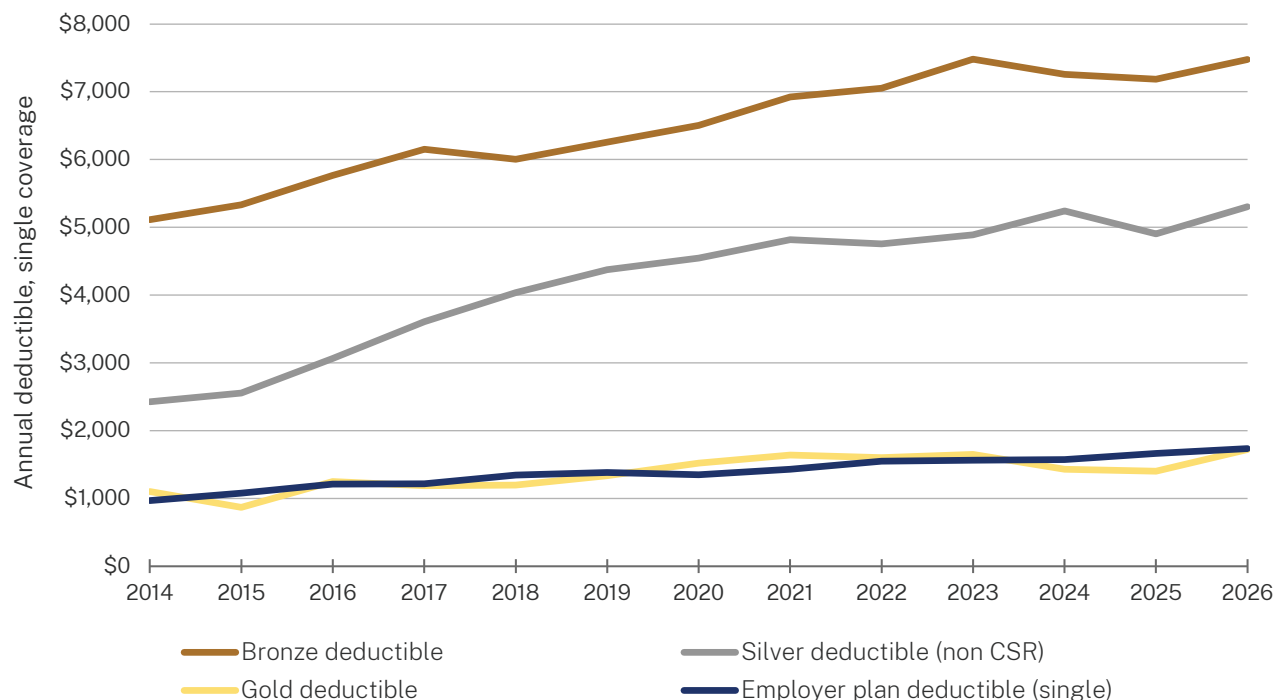
High Deductibles and Narrow Networks

Figure 9 shows that ACA bronze and standard silver plans have substantially higher deductibles than ESI. In 2026, the average bronze plan deductible was approximately \$7,500, while the average standard silver plan deductible exceeded \$5,000. By comparison, the 2026 average deductible for employer coverage was about \$1,700, roughly the same as the average ACA gold plan deductible. These differences are particularly important for enrollees who do not qualify for cost-sharing reductions, as they may face thousands of dollars in out-of-pocket costs before their insurance covers many services. Thus, even with substantial federal

⁵ *U.S. House of Representatives v. Burwell*, 185 F. Supp. 3d 165 (D.D.C. 2016).



**Figure 9: Bronze and Silver Deductibles
Far Exceed Job-Based Coverage**



SOURCE: KFF, Deductibles in ACA Marketplace Plans, and KFF Employer Health Benefits Survey 2026 (Figure 7.9). Silver excludes cost-sharing reductions. Employer figures are average general annual deductibles for single coverage among all covered workers, including workers with no deductible. Nominal dollars. All 2026 figures are published data.

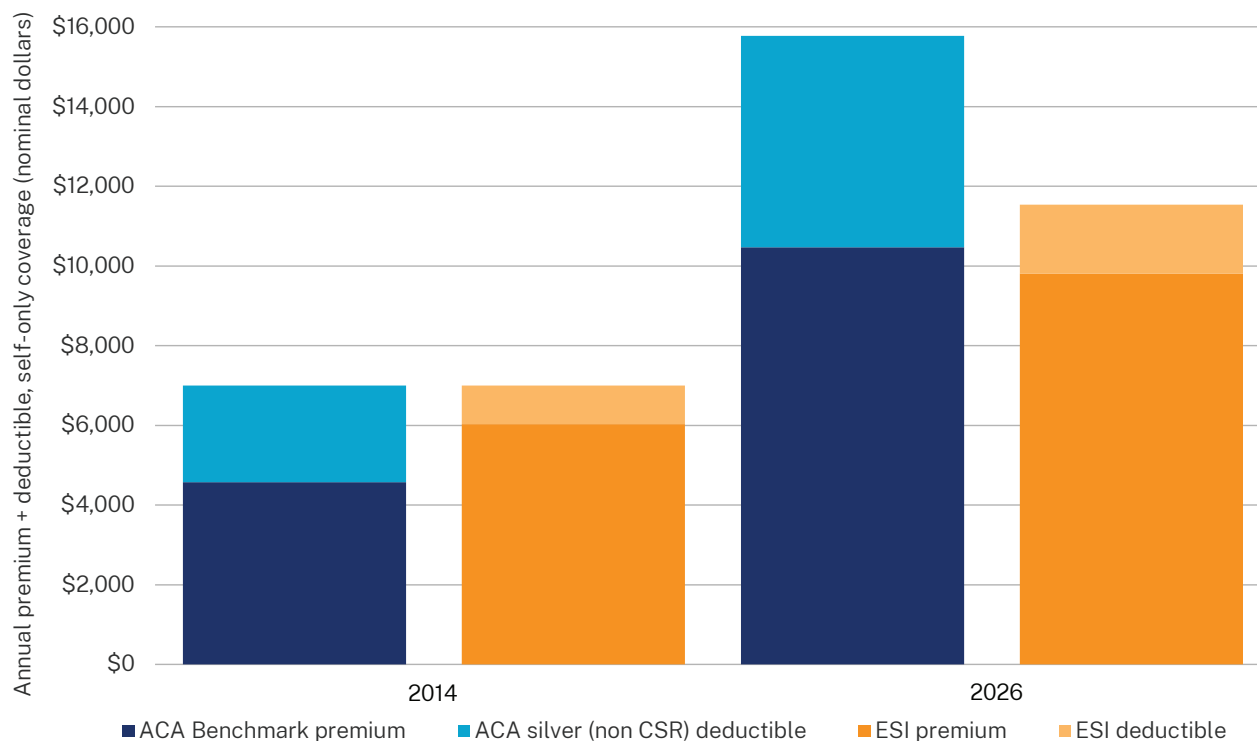
premium subsidies, many ACA plans provide significantly less financial protection than typical employer coverage.

The combination of rising premiums and high deductibles is a measure of the individual's financial exposure. As Figure 10 shows, by 2026, the combined premium and deductible was much higher for ACA plans than employer plans. In 2014, the combined annual benchmark premium and standard silver deductible for a 50-year-old ACA enrollee was approximately \$7,000, roughly equal to the combined premium and deductible for ESI. By 2026, the ACA combined amount had increased to nearly \$16,000, compared with approximately \$11,500 for ESI. Thus, the combined premium and deductible for ACA coverage increased by nearly twice as much in dollar terms as the corresponding amount for ESI. Although enrollees do not necessarily incur their full deductibles, the comparison illustrates the much greater potential financial exposure associated with ACA coverage, even before accounting for its narrower provider networks.

The differences between individual-market and ESI coverage extend beyond premiums and deductibles to patients' choice of providers and access to care. Individual-market coverage



Figure 10: Marketplace Enrollees Face Higher Combined Premium and Deductible Than Workers With Job-Based Coverage



SOURCES: KFF, Health Insurance Marketplace Calculator; KFF, Deductibles in ACA Marketplace Plans; and KFF, Employer Health Benefits Survey, 2026 Annual Survey.

NOTE: Self-only coverage, nominal dollars. Marketplace premium is the benchmark (second-lowest-cost silver) plan for a 50-year-old. Marketplace deductible is the average for standard silver plans without cost-sharing reductions. Employer figures are single coverage; the deductible is averaged across all covered workers, including those in plans with no deductible. Both bars show the full cost of coverage before premium tax credits or employer contributions.

generally provides substantially less access to out-of-network care and narrower provider networks than ESI plans. Figure 11, from a September 2024 Paragon study by Daniel Cruz and Greg Fann, shows that 83 percent of individual-market enrollees were in closed-network HMO or EPO plans in 2023, compared with just 18 percent of people with ESI coverage.⁶ A study published in *JAMA Network Open* independently found that large-group ESI plans included an average of 57 percent of local primary care physicians, compared with just 36 percent for ACA marketplace plans.⁷ A 2024 KFF analysis found that marketplace enrollees had access to only 40 percent of local physicians, on average.⁸ KFF also found that

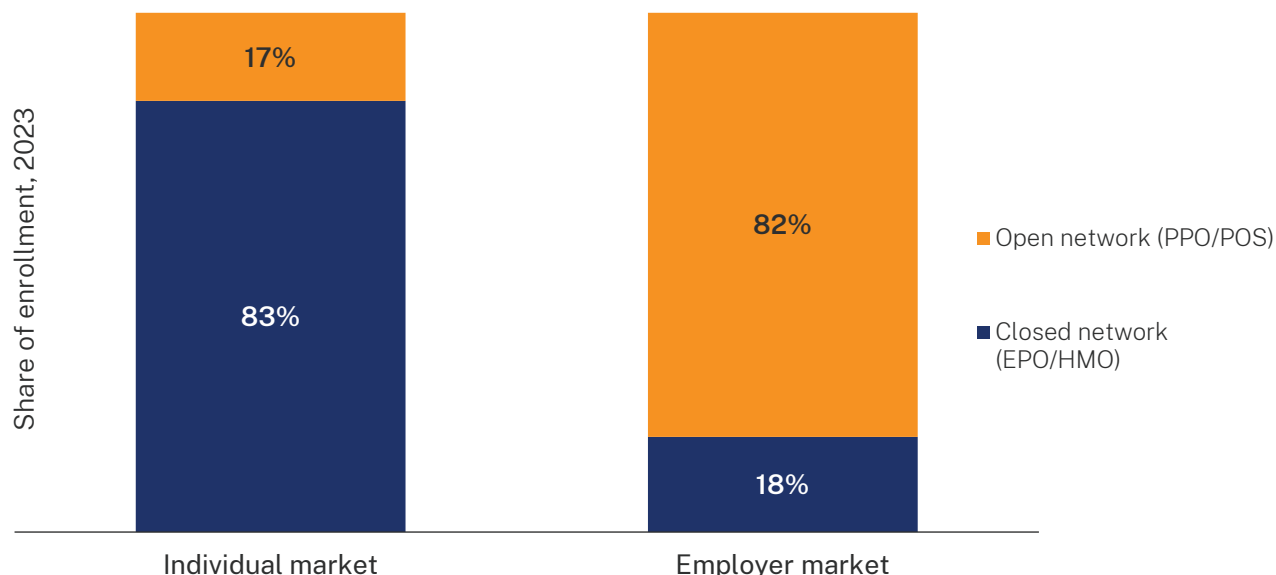
6 Daniel Cruz and Greg Fann, “It’s Not Just the Prices: ACA Plans Have Declined in Quality Over the Past Decade,” Paragon Health Institute, September 2024, <https://paragoninstitute.org/private-health/its-not-just-the-prices-aca-plans-have-declined-in-quality-over-the-past-decade/>.

7 John A. Graves et al., “Breadth and Exclusivity of Hospital and Physician Networks in US Insurance Markets,” *JAMA Network Open* 3, no. 12 (December 2020): e2029419, <https://doi.org/10.1001/jamanetworkopen.2020.29419>.

8 Matthew Rae et al., “How Narrow or Broad Are ACA Marketplace Physician Networks?,” KFF, August 26, 2024, <https://www.kff.org/private-insurance/how-narrow-or-broad-are-aca-marketplace-physician-networks/>.



Figure 11: 83% of Individual-Market Enrollees Have Closed-Network Plans, Versus 18% of ESI Enrollees



SOURCES: Daniel Cruz and Greg Fann, “It’s Not Just the Prices: ACA Plans Have Declined in Quality Over the Past Decade,” Paragon Health Institute, September 2024, Table 2 and authors’ calculations using CMS Unified Rate Review public use files; Gary Claxton et al., “Employer Health Benefits: 2023 Annual Survey,” KFF, October 2023, Figure 5.1.

NOTE: Closed-network plans (HMOs and EPOs) generally do not cover non-emergency out-of-network care; open-network plans (PPOs and POS plans) do. Employer shares exclude high-deductible plans with a savings option, which the KFF survey treats as a separate plan type regardless of network structure. The 2014 individual market split is derived from the stated 50 percent PPO/POS share.

marketplace enrollees were more likely than those with ESI coverage to report that a needed doctor or hospital was not covered by their plan (20 percent versus 13 percent).⁹

The Surge in Improper and Phantom Enrollment

Table 1 compares open enrollment plan selections with average monthly effectuated enrollment from 2014 through 2026. It shows how the gap between these measures has changed over time. The 2026 average reflects only January and February enrollment. Before the COVID-era subsidy boosts, average monthly effectuated ACA exchange enrollment was approximately 18 percent below open enrollment plan selections from 2014 through 2019, reflecting normal attrition as individuals transitioned to other coverage or chose not to pay their share of premiums. Average monthly effectuated enrollment refers to the average number of enrollees with effectuated coverage during the period measured, including those who paid their monthly premium or had no premium obligation because subsidies covered the full premium.



Table 1: Pre-COVID ACA Enrollment Attrition Was Much Higher Than During the COVID Subsidy Boost Era
From 2014–2019, average monthly effectuated enrollment was 18% below open enrollment period plan selections, compared with an average of 4% below in 2021–2025

Year	OEP Plan Selections (millions)	Avg Monthly Effectuated (millions)	% Change from OEP to Avg Monthly Effectuated Enrollment
2014*	8.0	6.3	-21%
2015*	11.7	9.6	-18%
2016	12.7	10.0	-21%
2017	12.2	9.8	-20%
2018	11.8	9.9	-16%
2019	11.4	9.8	-14%
2020	11.4	10.3	-9%
2021	12.0	11.7	-2%
2022	14.5	13.5	-7%
2023	16.4	16.2	-1%
2024	21.4	21.0	-2%
2025	24.3	22.1	-9%
2026†	23.1	19.7	-15%

SOURCES: CMS Health Insurance Exchanges Open Enrollment Reports; CMS annual, monthly and quarterly effectuated enrollment data.

NOTE: OEP = open enrollment period plan selections. Figures are in millions; percentages use unrounded counts. *2014 includes December enrollment only; 2015 uses the mean of March, June, September and December snapshots. 2016–2025 use full-year monthly averages. †2026 uses the January–February average (CMS data as of May 5, 2026), not a full-year result. Annual averages include special enrollment and do not measure retention of the original OEP cohort. The headline averages are unweighted annual percentage differences for 2014–2019 and 2021–2025.

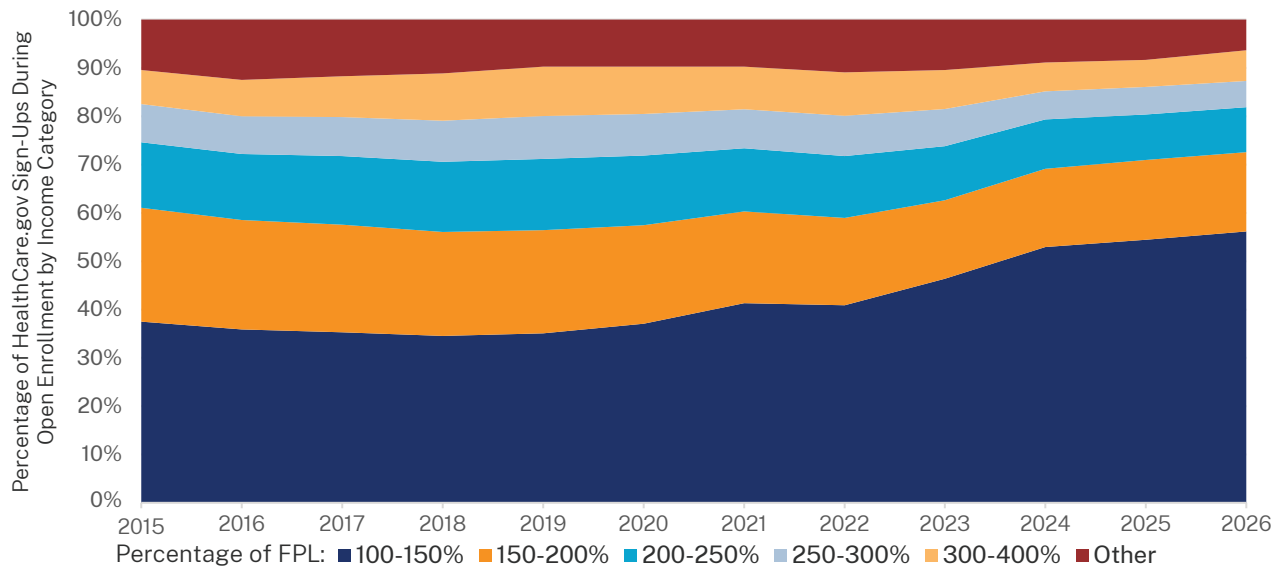
Through February 2026, average monthly effectuated enrollment was 15 percent below open enrollment selections, compared with a 9 percent gap for 2025.¹⁰ Although the 2026 data are preliminary and cover only the first two months of the year, the widening gap suggests that enrollment patterns may be moving back toward their pre-COVID levels as enhanced subsidies expire and CMS strengthens program-integrity enforcement.

HealthCare.gov enrollment has become increasingly concentrated among people reporting incomes between 100 and 150 percent of FPL, with reported enrollment far exceeding the subsidy-eligible population in this income range in many states. During the COVID enhanced subsidy period, these enrollees qualified for fully subsidized silver plans with a 94 percent actuarial value. Enrollment in this category surged from fewer than 5 million in 2023 to nearly 9 million in 2026, accounting for 56 percent of all HealthCare.gov plan selections. Figure 12

10 Centers for Medicare & Medicaid Services, “Health Insurance Exchanges 2026 Open Enrollment Report,” March 27, 2026, <https://www.cms.gov/files/document/health-insurance-exchanges-2026-open-enrollment-report.pdf>.



Figure 12: More Than Half of HealthCare.gov Sign-Ups Reported Income Between 100% and 150% FPL in 2026



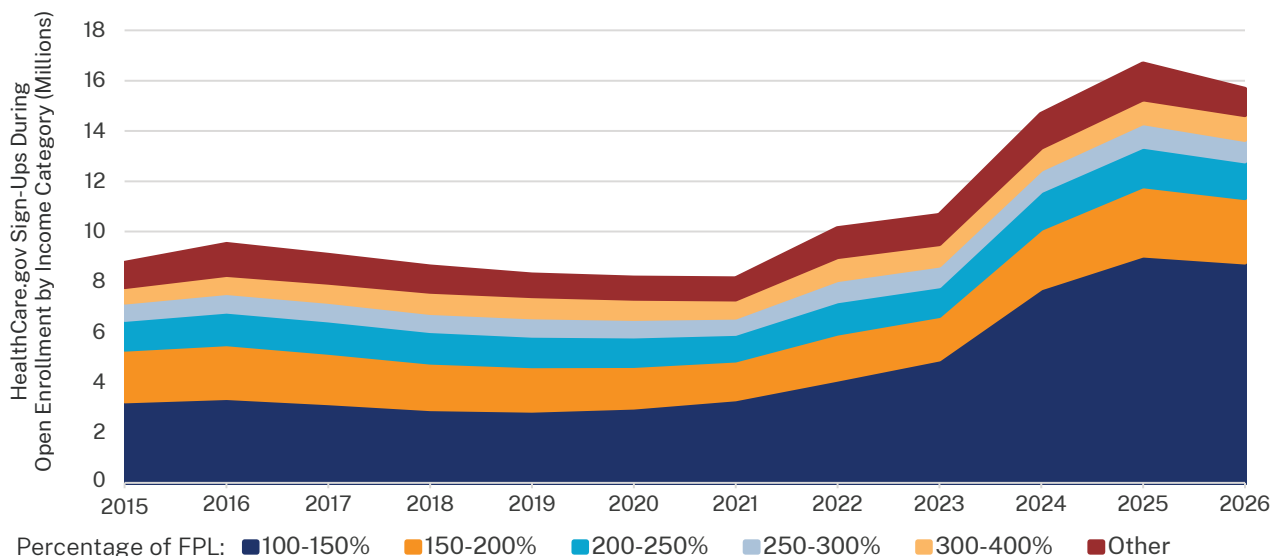
SOURCE: CMS Open Enrollment Period Public Use Files (2015-2026).

NOTE: Oregon is excluded because it runs a Basic Health Program. The shaded areas represent percentages of the federal poverty level (FPL). The "Other" category includes people with income below 100% FPL, those above 400% FPL, and those with uncertain income. We classify states based on the exchange status (i.e., Healthcare.gov or SBE) that they had each year; a small number of states have changed their exchange status, so the composition of the Healthcare.gov and SBE groups varies over time.



Figure 13: HealthCare.gov Enrollment Became Even More Concentrated at 100–150% FPL in 2026

Reported 100–150% FPL sign-ups far exceeded the number of people with that income

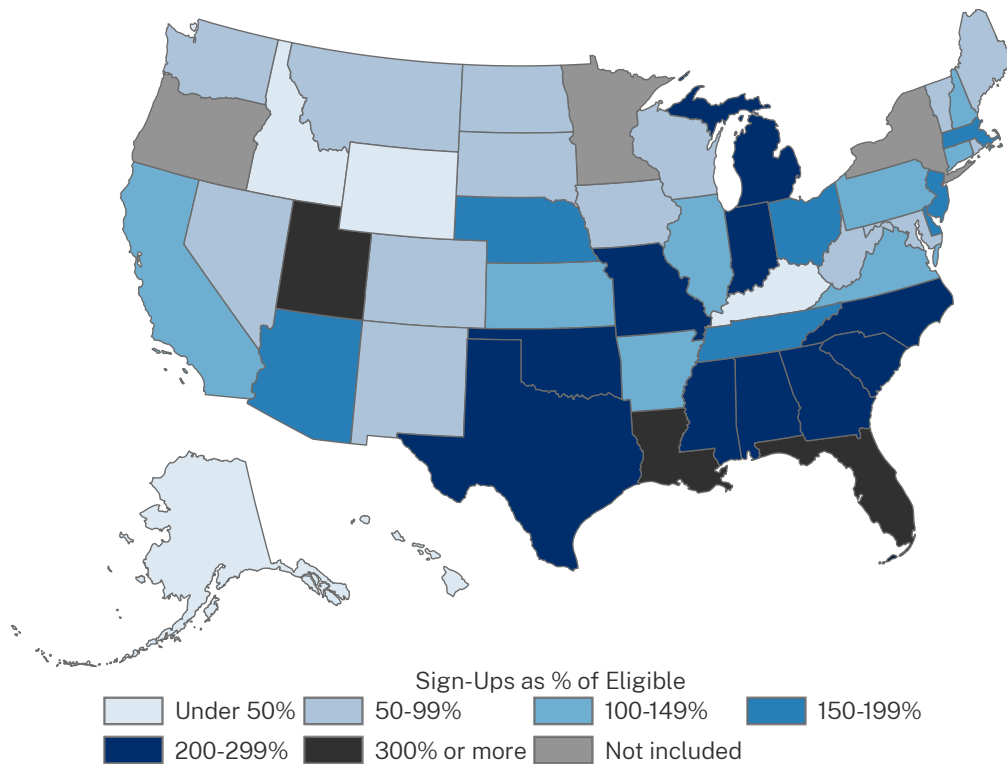


SOURCE: CMS Marketplace Open Enrollment Period Public Use Files, 2015-2026.

NOTE: Oregon is excluded because it operates a Basic Health Program. Shaded areas represent income categories as a percentage of the federal poverty level (FPL). The "Other" category includes enrollees with income below 100% FPL, above 400% FPL, or unknown income. States are classified based on exchange status in each year, so the composition of HealthCare.gov and SBE groups changes over time.



Figure 14: Exchange Sign-Ups as a Percent of Eligible 100-150% FPL ACA Enrollees (2026)



SOURCES: CMS Marketplace Open Enrollment Period PUFs; Census ACS 1-Year PUMS and population estimates.

NOTE: State ratios are rounded to the nearest whole percentage point. DC, MN, NY, and OR are excluded. Ratio = 2026 exchange sign-ups / estimated eligible enrollees ages 19-64 at 100-150% fpl.

shows the percentage of enrollment by FPL grouping from 2015 to 2026, and Figure 13 shows total enrollment by FPL grouping.

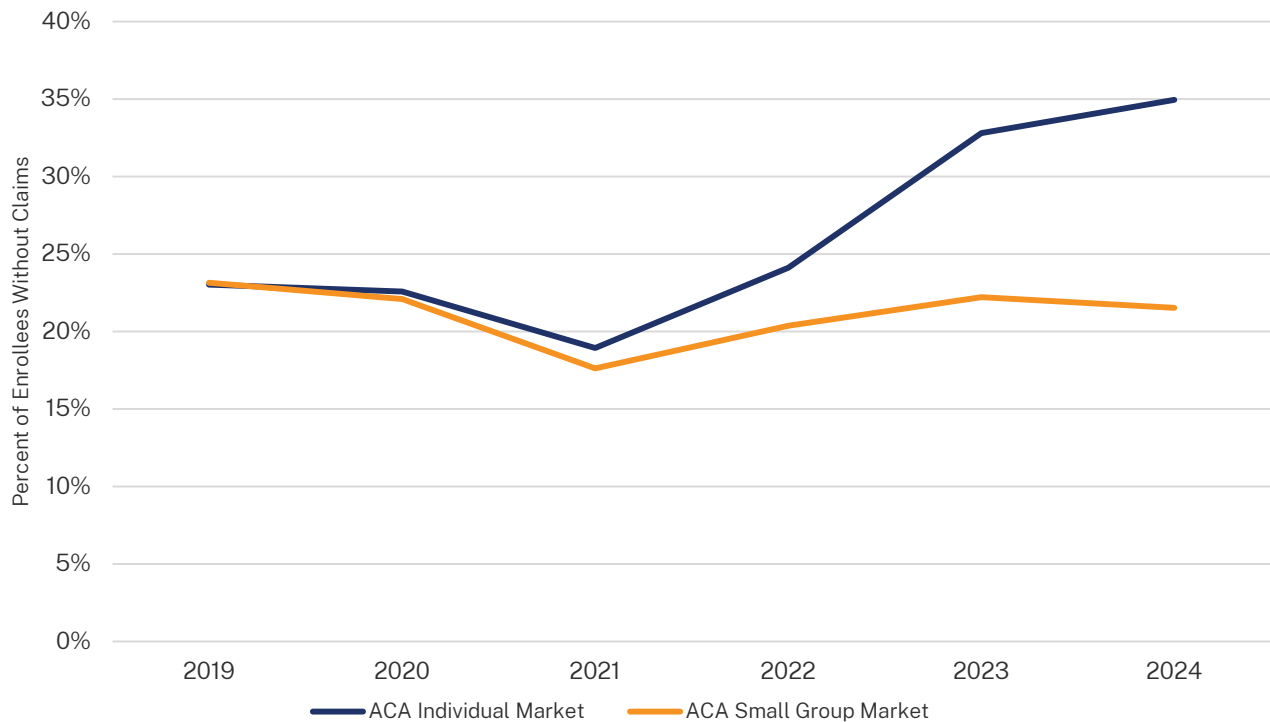
The number of people signing up in this income category far exceeds the number of Americans who actually have incomes in that range — strong evidence of widespread improper enrollment.¹¹ Zero-premium plans are central to the problem. When coverage requires no premium payment from the enrollee, brokers can enroll people without their knowledge, and fictitious enrollees can remain on the rolls. People who are unaware they have coverage, or who do not even exist, cannot pay premiums themselves. Fully subsidized plans eliminate that natural check on enrollment while allowing insurers to continue collecting federal subsidies.

Figure 14 shows that the apparent improper exchange enrollment is heavily concentrated in the Sun Belt. In 13 states, the number of people signing up for exchange coverage in 2026

¹¹ Brian Blase et al., “The Greater Obamacare Enrollment Fraud,” Paragon Health Institute, June 2025, <https://paragoninstitute.org/private-health/the-greater-obamacare-enrollment-fraud/>; Brian Blase and Drew Gonshorowski, “The Great Obamacare Enrollment Fraud,” Paragon Health Institute, June 2024, <https://paragoninstitute.org/private-health/the-great-obamacare-enrollment-fraud/>.



Figure 15: Share of Individual-Market Enrollees Without Medical Claims Rose Sharply After COVID-Era Subsidy Expansion



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

who reported incomes between 100 and 150 percent of the FPL was more than twice the estimated number of people eligible for exchange subsidies in that income range. In several states, including Florida, Louisiana, and Utah, reported enrollment exceeded three times the estimated eligible population.

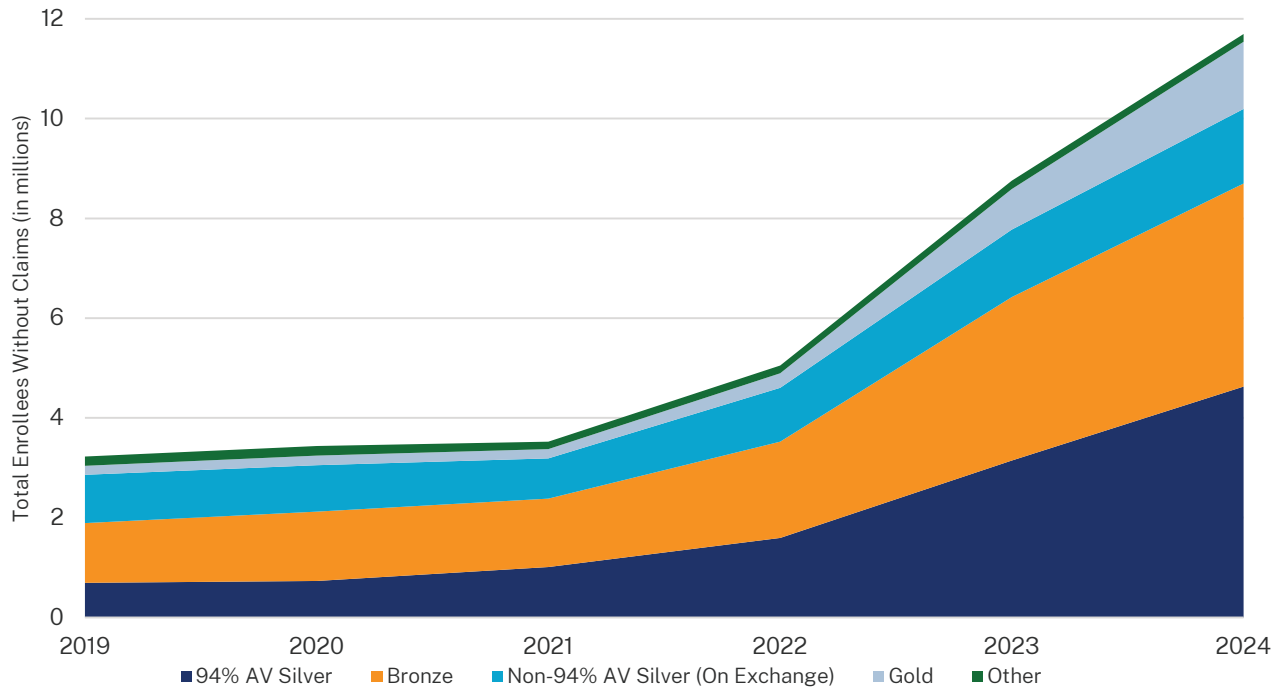
Zero-Claim Enrollment and the Evidence of Phantom Coverage

In August 2025, CMS released data on individual-market enrollees who had no medical claims from 2019 through 2024.¹² While a well-functioning health insurance market would be expected to include enrollees with no medical claims in any given year, the ACA individual market exhibits unusually elevated numbers of zero-claim enrollees. As Figure 15 shows, the percentage of enrollees without claims was nearly identical in the ACA individual and small-group markets from 2019 through 2021, before the enhanced subsidies were available during open enrollment (they were enacted in March 2021, after that year’s open enrollment period).

¹² Centers for Medicare & Medicaid Services, “Enrollees Without Claims 2019–2024,” August 8, 2025, <https://www.cms.gov/marketplace/resources/forms-reports-other>.



Figure 16: Surge in Individual Market Enrollees Without Claims Driven by 94% AV Silver Plan and Bronze Plan Enrollees



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

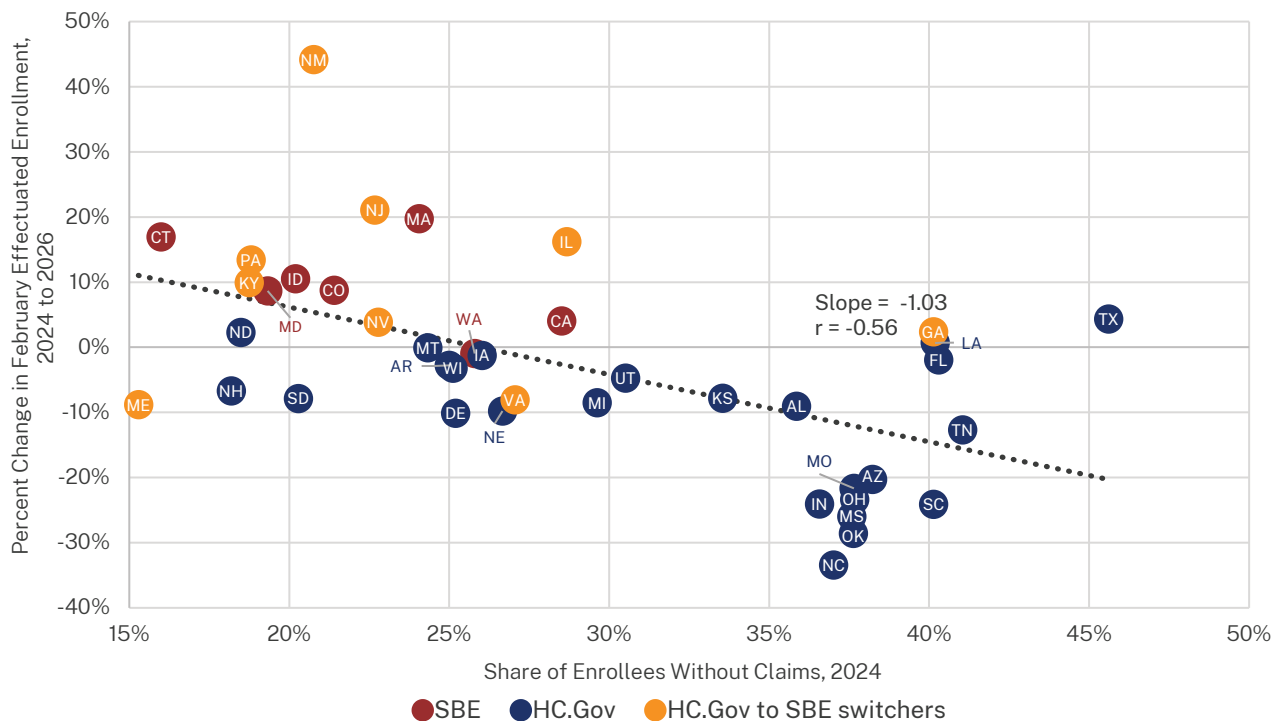
NOTE: Other consists of enrollees with catastrophic plans, platinum plans, and off-exchange silver plans. CMS reports enrollees as anyone with coverage during the year.

After the enhanced subsidies took effect, the trends diverged sharply. The share of individual-market enrollees without claims rose from 19 percent in 2021 to 35 percent in 2024, while the small-group market remained relatively stable at approximately 20 to 22 percent. This divergence coincided with the proliferation of fully subsidized plans and provides strong evidence of growing phantom enrollment — people enrolled without their knowledge or fictitious individuals.

Figure 16 shows that the number of individual-market enrollees without medical claims surged from approximately 3.5 million in 2021 to 11.7 million in 2024. Much of this increase occurred in 94 percent actuarial value silver plans, which were available with zero premiums to people reporting incomes between 100 and 150 percent of FPL, and bronze plans, almost all of which were also available with zero premiums for lower-income enrollees. These plans accounted for the vast majority of the increase in zero-claim enrollment. The CMS figures count anyone enrolled for any period during the year, rather than average monthly enrollment, and some individuals may be counted more than once if they switched plans. Zero-premium



Figure 17: States with More Zero-Claim Enrollees Experienced Much Sharper Two-Year Enrollment Declines



SOURCES: CMS, 2019-2024 Enrollees Without Claims by State Market Metal Level; CMS, Health Insurance Exchanges Monthly Effectuated Enrollment.

NOTE: HC.Gov to SBE switcher states are states that moved from HealthCare.gov to a state-based exchange since the start of the ACA. This group includes GA, IL, KY, ME, NV, NJ, NM, PA, and VA. Some states are omitted due to lack of data.

coverage allows unauthorized or fictitious enrollments to persist because people who are unaware of their coverage — or do not exist — cannot make premium payments themselves.

As Figure 17 shows, states with higher shares of individual-market enrollees who had no medical claims in 2024 generally experienced larger declines in effectuated enrollment between February 2024 and February 2026. The correlation was -0.56 , and the fitted regression slope was approximately -1.03 , indicating that each percentage-point increase in the zero-claim rate was associated with approximately a one-percentage-point greater decline in effectuated enrollment. States such as North Carolina, South Carolina, and Oklahoma, where zero-claim rates approached or exceeded 40 percent, experienced enrollment declines of roughly 25 to 35 percent. This pattern is consistent with the expiration of enhanced subsidies and program-integrity measures having a greater effect in states with more improper or phantom enrollment. Although the correlation does not establish causation, the relationship between unusually high zero-claim rates and subsequent enrollment declines provides additional evidence that the earlier enrollment surge included substantial improper and phantom enrollment.

CONCLUSION

The ACA exchanges have become an extraordinarily subsidized market characterized by rapidly rising premiums, high deductibles, narrow provider networks, and significant improper enrollment. The exchanges attracted far fewer enrollees than originally projected, and enrollment increased substantially only after Congress expanded subsidies during the pandemic. Those enhanced subsidies also created incentives for unauthorized and fictitious enrollments by making coverage free for millions of people. The unusually high concentration of enrollees reporting incomes between 100 and 150 percent of the FPL, the surge in enrollees without medical claims, and the relationship between zero-claim rates and subsequent enrollment declines all point to serious program-integrity problems.

The overall level of subsidization is particularly striking. In 2025, federal taxpayers financed 86 percent of premium revenue collected by insurers in HealthCare.gov states, up from roughly 77 percent before the pandemic. Even after the enhanced subsidies expired, most enrollees remain eligible for subsidies that cover the overwhelming share of their premiums. Meanwhile, ACA premiums have increased much faster than those for employer coverage, even as ACA plans generally have higher deductibles and narrower provider networks. The ACA exchanges increasingly resemble a government-financed coverage program rather than a competitive insurance market in which consumers bear a meaningful share of the cost. As the 2027 open enrollment period begins, policymakers should focus not simply on how many people enroll, but on whether coverage provides value, whether subsidies are properly targeted, and whether taxpayers are financing coverage for real and legally eligible people.