ASPE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION | OFFICE OF HEALTH POLICY

ISSUE BRIEF

October 1, 2024

HP-2024-19

HealthCare.gov Plan Selections by Race and Ethnicity, 2015-2024

During the 2024 Open Enrollment Period, nearly 5 million Latinos and 3 million Black Americans made plan selections in HealthCare.gov, with overall plan selections roughly tripling for both populations since 2020.

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KEY POINTS

- In 2024, over 21 million people made plan selections in the Affordable Care Act (ACA) Marketplaces, including 16.4 million in the Federally Facilitated Marketplace, HealthCare.gov.
- Plan selections increased for all racial and ethnic populations; the gains were especially large for Latino and Black consumers.
- The number of Latino consumers selecting plans increased by 185 percent and the number of Black consumers increased by 204 percent between 2020 and 2024.
- In 2024, Latino consumers represent 29.4 percent and Black consumers represent 16.3 percent of all consumers selecting plans in HealthCare.gov.
- Other racial and ethnic groups also experienced large gains in plan selections between 2020 and 2024. The number of American Indian/Alaska Natives (AI/AN) selecting coverage through HealthCare.gov more than doubled. The number of Asian-American, Native Hawaiian, and Pacific Islander (AANHPI) enrollees increased by 22 percent.
- Silver plans with cost-sharing reductions (CSRs) remain the most frequently selected plans overall, representing over half of all plan selections by AANHPI, Black, and Latino consumers. In contrast, more than half of AI/AN individuals continue to select bronze plans in 2024, though this share has decreased by 12.4 percentage points between 2021 and 2024.
- After enhanced premium tax credits went into effect in 2021, the share of individuals selecting a bronze plan decreased across all racial and ethnic groups between 2021 and 2024, while the share of individuals selecting a silver plan with CSRs increased across most racial and ethnic groups over the same period.

OVERVIEW

Since they were established in 2014, the Affordable Care Act (ACA) Marketplaces have been an important source of affordable private health insurance coverage for Americans.[1] The ACA provided for income-based subsidies in the form of Advance Payments of the Premium Tax Credit (APTC), which were initially made available to consumers with household incomes between 100 and 400 percent of the Federal Poverty Level (FPL) who did not have an offer of affordable employer-sponsored insurance and were not eligible for a government program like Medicaid or Medicare. The amount of APTC a household is eligible to receive is calculated based on the difference between the second lowest-cost silver plan in the individual's market and the consumer's expected contribution, which is based on their income.

The Biden-Harris Administration has built on the ACA in order to increase access to affordable health coverage and improve health equity. The American Rescue Plan Act of 2021 (ARP) increased the value of Marketplace APTC for consumers already eligible and expanded eligibility to consumers with incomes above 400 percent of the FPL. The Inflation Reduction Act of 2022 (IRA) extended these enhanced subsidies through 2025. Enhanced APTC improved the affordability of Marketplace coverage for consumers of all income levels.[2,3,4] In 2021, the Biden-Harris Administration established a Special Enrollment Period (SEP) beginning February 15 through August 15 to allow people who lost coverage because of the COVID-19 pandemic to enroll in Marketplace plans outside of the annual Open Enrollment Period (OEP).[5] A subsequent SEP for those losing Medicaid or Children's Health Insurance Program (CHIP) coverage due to the end of the Medicaid continuous enrollment condition was established, which is available to qualified individuals and their families from March 31, 2023 to November 30, 2024. The 2021 SEP for applicants who are eligible for an APTC with household incomes no greater than 150 percent of the FPL was recently made permanently available through the Department of Health and Human Services' 2025 Notice of Benefit and Payment Parameters.[6]

The Administration also made important efforts to increase awareness of the Marketplaces and facilitate enrollment. In 2022 and again in 2023 and 2024, the Administration invested roughly $99 million in grants to support Navigator programs.[7,8] Through "Weeks of Action," the Department of Health and Human Services partnered with national organizations to increase Marketplace enrollment among specific communities, such as the Black, Latino, and AI/AN populations.[9] This targeted approach reflects the Administration's twin goals of increasing access to affordable health coverage and improving health equity.[10,11]

Together, these policies led to a dramatic increase in Marketplace coverage. In 2024, 21.4 million people made Federally Facilitated Marketplace (HealthCare.gov) and State-Based Marketplace plan selections, an increase of 30 percent relative to 2023 and over 80 percent relative to 2020. A previous ASPE Issue Brief analyzing data from HealthCare.gov examined how plan selections among different racial and ethnic groups grew between 2015 and 2023.[12] That study found that while over time plan selections have increased for all groups, in recent years the growth has been especially pronounced among non-White consumers, with plan selections among Latino and Black consumers roughly doubling between 2020 and 2023.

This Issue Brief updates that analysis to include HealthCare.gov plan selection data for 2024. A fundamental challenge with the analysis is that while information on race and ethnicity is collected on in the Marketplace application, the provision of this information by consumers is voluntary. In 2024, data on race and ethnicity was missing for more than half of all individuals who made selections on HealthCare.gov. As in the previous brief, we address this data limitation using a validated imputation technique.

METHODS

This analysis uses HealthCare.gov data in plan selections made during OEPs from 2015 to 2024, obtained from the Centers for Medicare & Medicaid Services' (CMS) Center for Consumer Information and Insurance Oversight (CCIIO). See Appendix Figure 1 for a full list of HealthCare.gov states by year.

We impute the missing data using the modified Bayesian Improved First Name Surname Geocoding (mBIFSG) method, which was developed by RAND. This approach has been validated and is described in more detail elsewhere.[13,14,15,16]

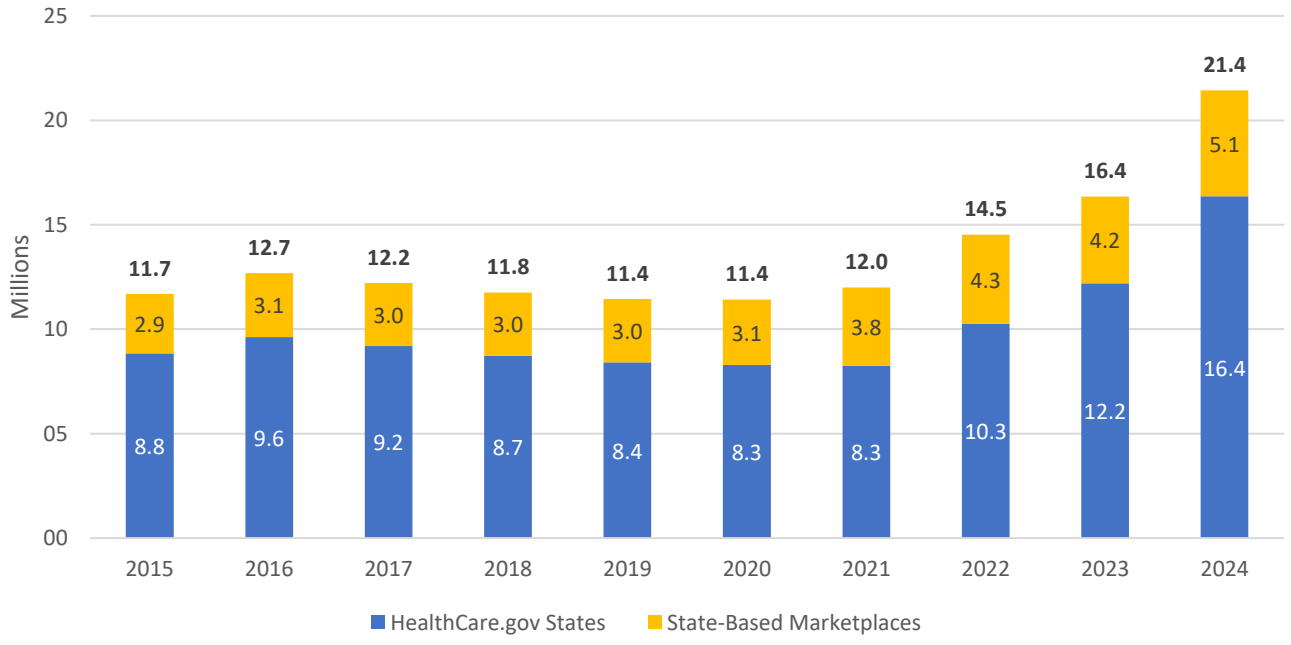
The discriminatory power of the imputation method can be assessed using C-statistics, which essentially measures how well the imputation results predict for observations where race and ethnicity are observed in self-reported data. C-statistics range from 0.5 (no better than chance) to 1.0 (perfect prediction). Values above 0.7 are generally considered "acceptable" and values above 0.9 are considered "excellent."[17] In our data, the mBIFSG method produces C-statistics above 0.9 for all groups except AI/AN (0.64) and Multiracial (0.69). Thus, while we have confidence in our results for Latino, Black, AANHPI, and White individuals, the results for AI/AN and Multiracial individuals should be interpreted cautiously.

RESULTS

Trends in Open Enrollment Plan Selections

Figure 1 plots trends in total Marketplace and HealthCare.gov plan selections from 2015 to 2024. In 2024, total Open Enrollment plan selections in HealthCare.gov states reached a record high of 16.4 million. The 34 percent growth between 2023 and 2024 for HealthCare.gov plan selections was the greatest year-to-year percentage increase in plan selections since 2015.

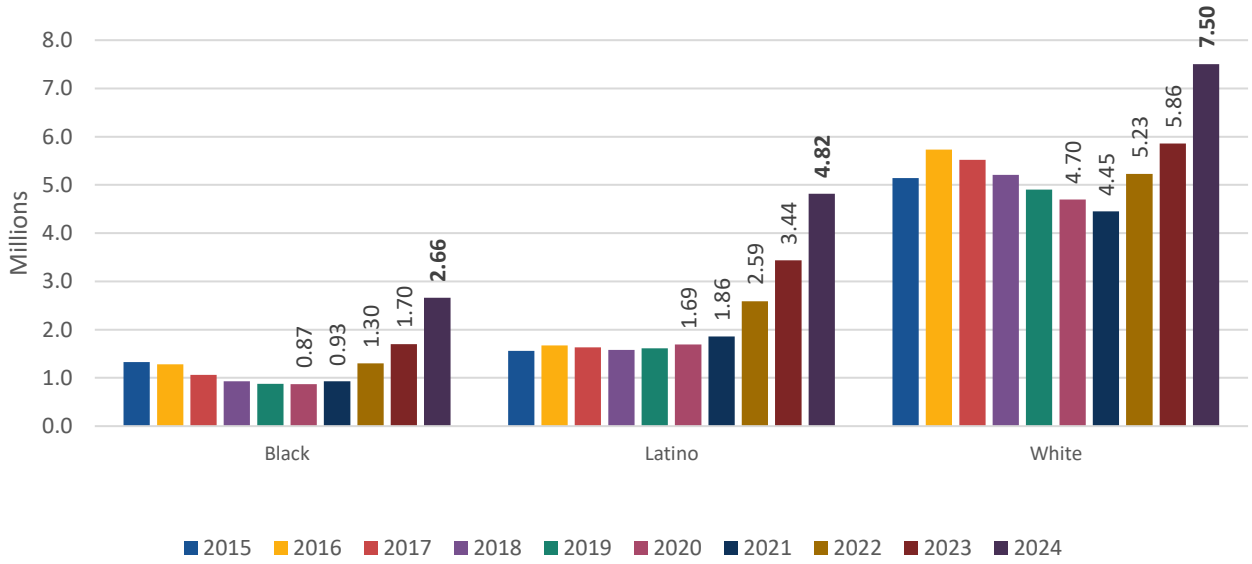
Figure 1. Number of HealthCare.gov and State-Based Marketplaces Open Enrollment Plan Selections, 2015-2024



Notes: From analysis by ASPE and RAND of HealthCare.gov data Open Enrollment Periods, 2015-2024 and analysis by the Kaiser Family Foundation of Open Enrollment Period Public Use Files. Data labels are in units of millions.

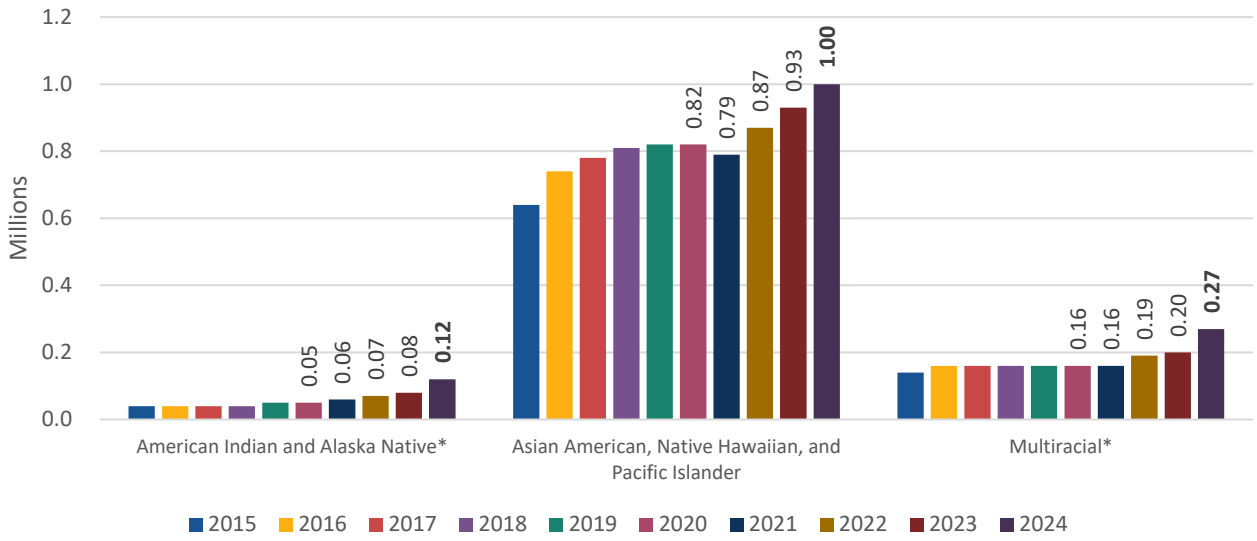
Figures 2a and 2b show total estimated HealthCare.gov enrollment from 2015 to 2024 by race and ethnicity. The exact numbers underlying the graphs are presented in Appendix Table 2. Between 2023 and 2024, plan selections grew most among White consumers (1.6 million from 5.9 million to 7.5 million) followed by Latino (1.4 million from 3.4 million to 4.8 million) and Black consumers (just under 1 million from 1.7 million to 2.7 million). Relative to 2023, these changes represented an increase of 28.1 percent for White consumers, 40.1 percent for Latino consumers, and 56.4 percent for Black consumers. Plan selections among AI/AN individuals increased by 41.3 percent between 2023 and 2024, though from a low base (roughly 82,000). AANHPI consumers had the lowest growth both in terms of absolute numbers (an increase of roughly 71,000) and percent change (7.6 percent).

Figure 2a. Number of HealthCare.gov Marketplace Open Enrollment Plan Selections by Race and Ethnicity (Black, Latino, and White), 2015-2024



Notes: From analysis by ASPE and RAND of HealthCare.gov data Open Enrollment Periods, 2015-2024. These numbers only include HealthCare.gov Marketplace plan selections, and do not include plan selections of State-Based Marketplaces.

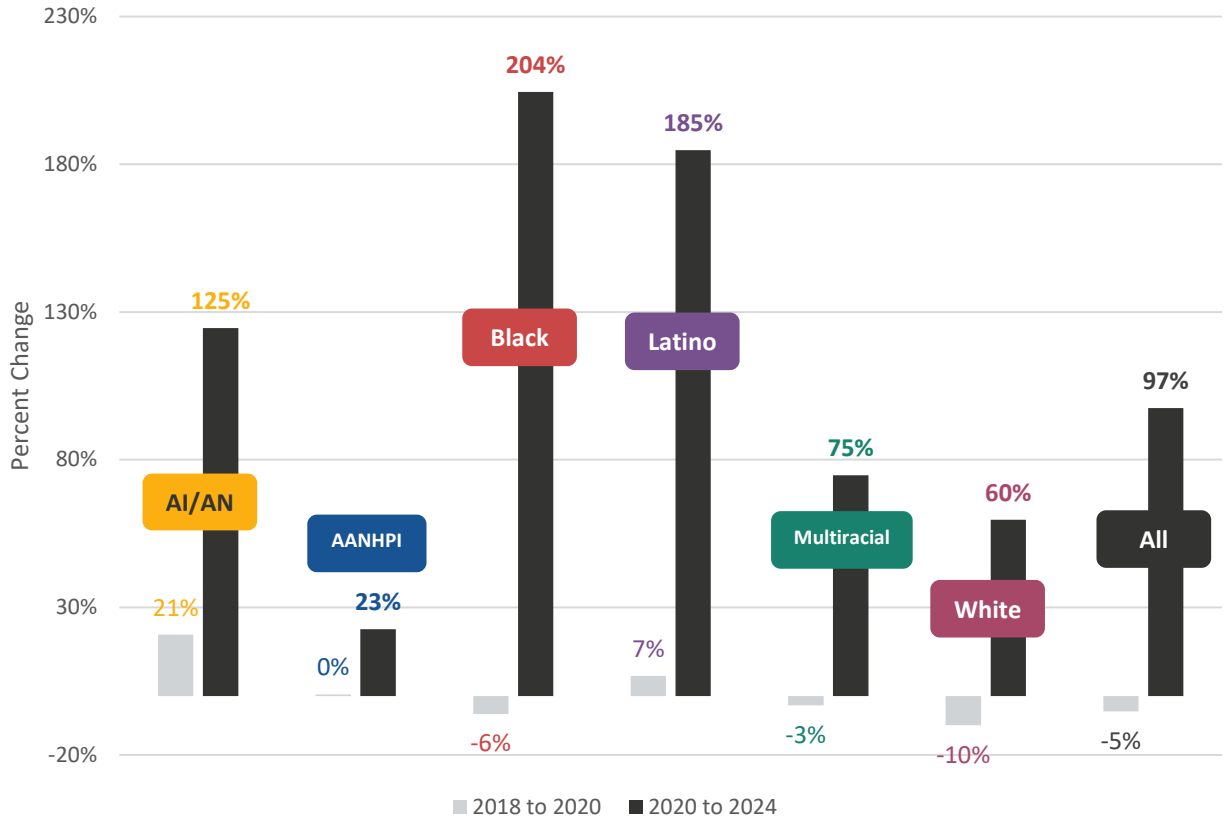
Figure 2b. Number of HealthCare.gov Marketplace Open Enrollment Plan Selections by Race and Ethnicity (AI/AN, AANHPI, and Multiracial), 2015-2024



Notes: From analysis by ASPE and RAND of HealthCare.gov data Open Enrollment Periods, 2015-2024. These numbers only include HealthCare.gov Marketplace plan selections, and do not include plan selections of State-Based Marketplaces.

To provide a better sense of longer-term trends, Figure 3 shows the percent change in HealthCare.gov plan selections by race and ethnicity over two recent periods: 2018 to 2020 (light gray bars) and 2020 to 2024 (black bars). Between 2018 and 2020, total HealthCare.gov plan selections fell by 5 percent, with three of the six subgroups experiencing a decline. In contrast, total plan selections roughly doubled, and all six groups experienced double-digit growth between 2020 and 2024. Combined Latino and Black plan selections roughly tripled between 2020 and 2024. Estimated plan selections among AI/AN consumers more than doubled over this period, though as noted above the imputation method is less accurate for this group than for others. In percentage terms, AAHNPI consumers had the lowest growth rate, at 23 percent.

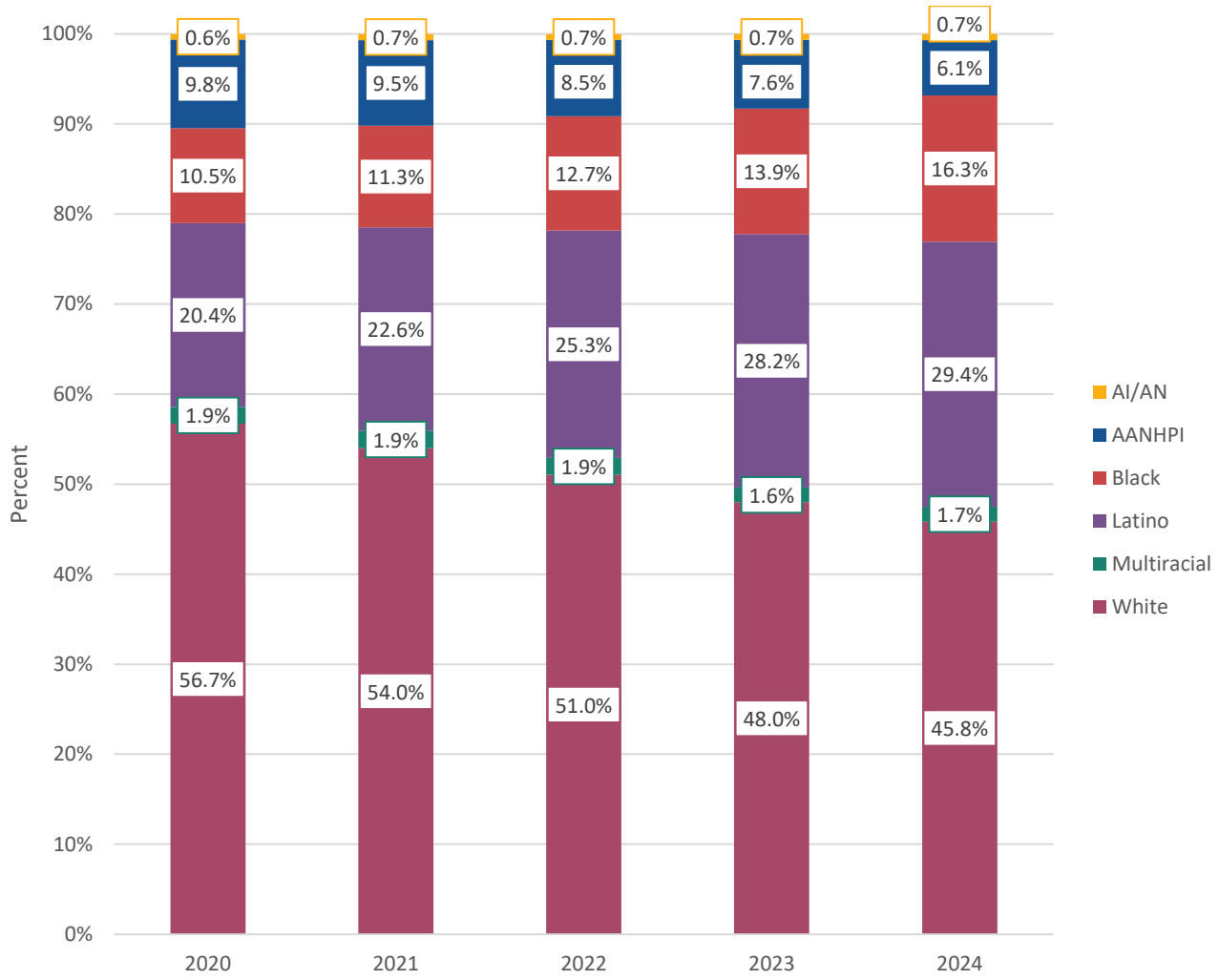
Figure 3. Growth in HealthCare.gov Marketplace Open Enrollment Plan Selections by Race and Ethnicity, 2018 to 2020 and 2020 to 2024



Notes: From analysis by ASPE and RAND of HealthCare.gov data Open Enrollment Periods from 2018 through 2024 (years are collapsed for 2018 through 2020, and 2020 through 2024). These numbers only include HealthCare.gov Marketplace plan selections, and do not include plan selections of State-Based Marketplaces.

The differential growth rates shown in Figure 3 led to a change in the composition of plan selections. Figure 4 presents the distribution of plan selections by race and ethnicity from 2020 to 2024. Latino consumers' share of plan selections increased by 9 percentage points, from 20.4 percent in 2020 to 29.4 percent in 2024. As a point of reference, Latinos made up 21.3 percent of the non-elderly adult population in 2022.[18] Black consumers' share of plan selections increased by nearly 6 percentage points, from 10.5 to 16.3 percent. By comparison, 12.3 percent of the non-elderly adult population is Black. The share of plan selections by White and AANHPI populations decreased 10.9 and 3.7 percentage points, respectively, between 2020 and 2024. In 2024, the AANHPI share of plan selections was 6.1 percent, down 3.7 percentage points from 9.8 percent in 2020. In 2024, the White share of plan selections is smaller than their share of the non-elderly adult population (45.8 percent compared to 54.3 percent) while the AANHPI share of plan selections is similar to their share of the non-elderly adult population (6.1 percent).

Figure 4. Distribution of HealthCare.gov Marketplace Open Enrollment Plan Selections by Race and Ethnicity, 2020-2024



Notes: From analysis by ASPE and RAND of HealthCare.gov data Open Enrollment Periods from 2018 through 2024. These numbers only include HealthCare.gov Marketplace plan selections, and do not include plan selections of State-Based Marketplaces.

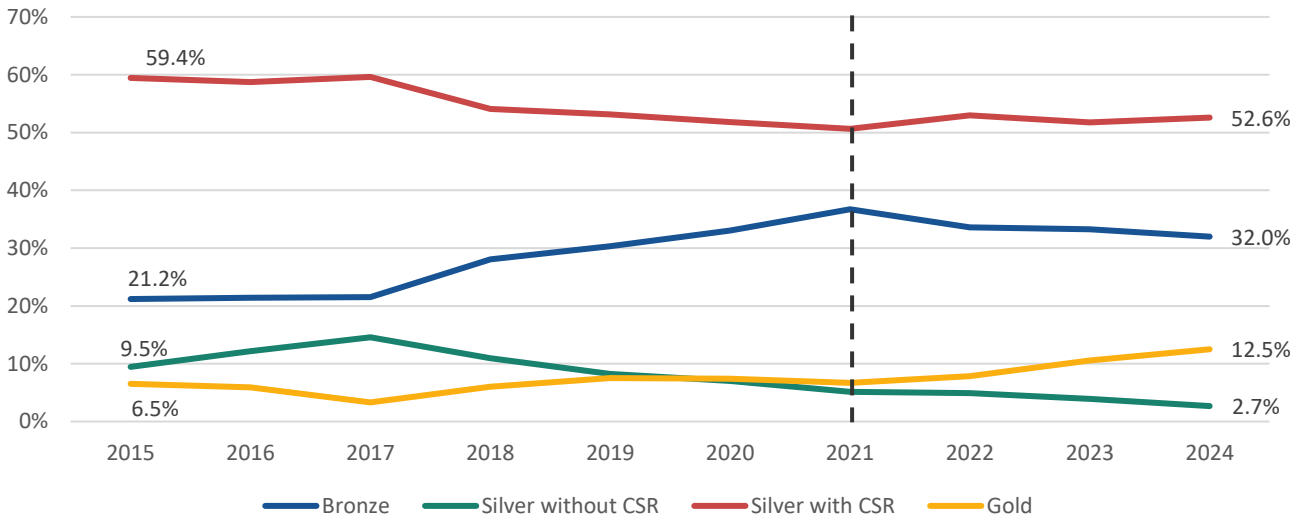
Trends in Open Enrollment Plan Selection by Plan Characteristics

We also examined plan selections by metal tier and receipt of cost-sharing reductions (CSRs), which help lower cost-sharing requirements for enrollees. For many eligible individuals, CSRs increase the attractiveness of silver plans relative to other types of plans as they have the effect of increasing plans' actuarial value.[19] Marketplace enrollees with incomes from 100 to 250 percent of the FPL (and some individuals with income below 100 percent of the FPL who are ineligible for Medicaid or CHIP due to their immigration status) are generally eligible for CSRs. AI/AN enrollees who are members of federally recognized tribes or Alaska Native Claims Settlement Act (ANCSA) Corporation shareholders and earn an income between 100 and 300 percent of the FPL, however, do not have to pay in-network cost-sharing on *any* Marketplace plan in any metal tier except for catastrophic plans.[20]

Figure 5 displays the annual share of total plan selections for bronze, silver with CSRs, silver without CSRs, and gold plans between 2015 and 2024. Over the full period, HealthCare.gov consumers most frequently selected silver plans with CSRs. In 2024, 52.6 percent did so, which is down nearly 7 percentage points relative to 2015,

but slightly above the percentage in 2021 (50.6 percent.). Bronze plans are the next most commonly selected category. The share of consumers selecting a bronze plan increased by 15.5 percentage points between 2015 and 2021 before decreasing by 4.7 percentage points between 2021 and 2024. Between 2021 and 2024, the share of consumers selecting a gold plan increased by 5.8 percentage points.

Figure 5. HealthCare.gov Marketplace Open Enrollment Plan Selections by Metal Tier for All Consumers, 2015-2024

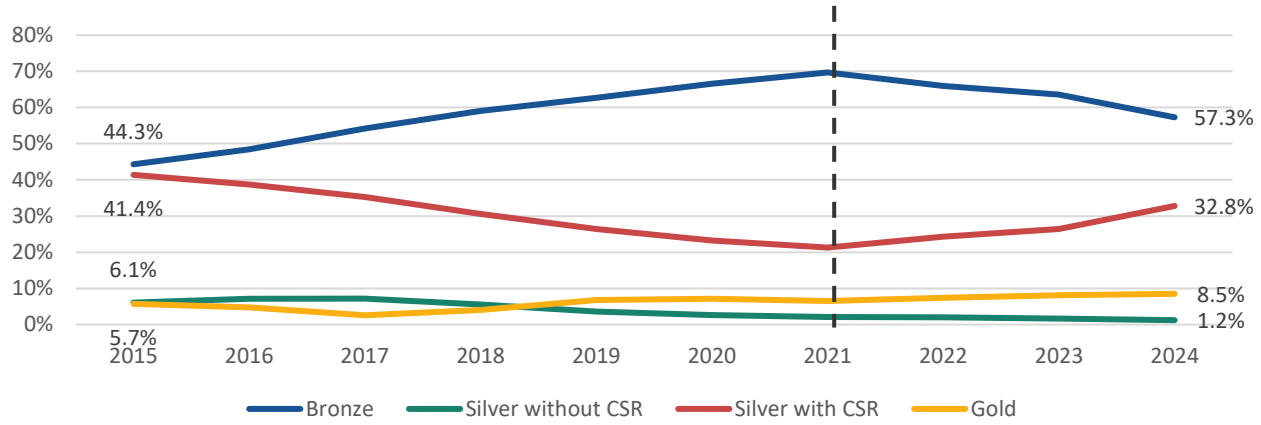


Notes: From analysis by ASPE and RAND of HealthCare.gov data Open Enrollment Periods, 2015-2024. Dashed line indicates enactment of enhanced premium tax credits from the ARP. These numbers only include HealthCare.gov Marketplace plan selections, and do not include plan selections of State-Based Marketplaces.

Figures 6-11 present the same results separately by race and ethnicity. The plan selection patterns for AI/AN consumers stand out relative to the other groups because they face no cost-sharing in any non-catastrophic plan, including bronze plans, which normally have high deductibles. Figure 6 shows that in 2015 the percentage of AI/AN consumers selecting bronze plans was slightly higher than the percentage selecting silver plans with CSRs (44.3 vs. 41.4 percent). Between 2015 and 2021, plan selections shifted from silver plans with CSR to bronze plans. This trend reversed after 2021, though in 2024 AI/AN consumers are still more likely to be in bronze plans (57.3 vs. 32.8 percent).

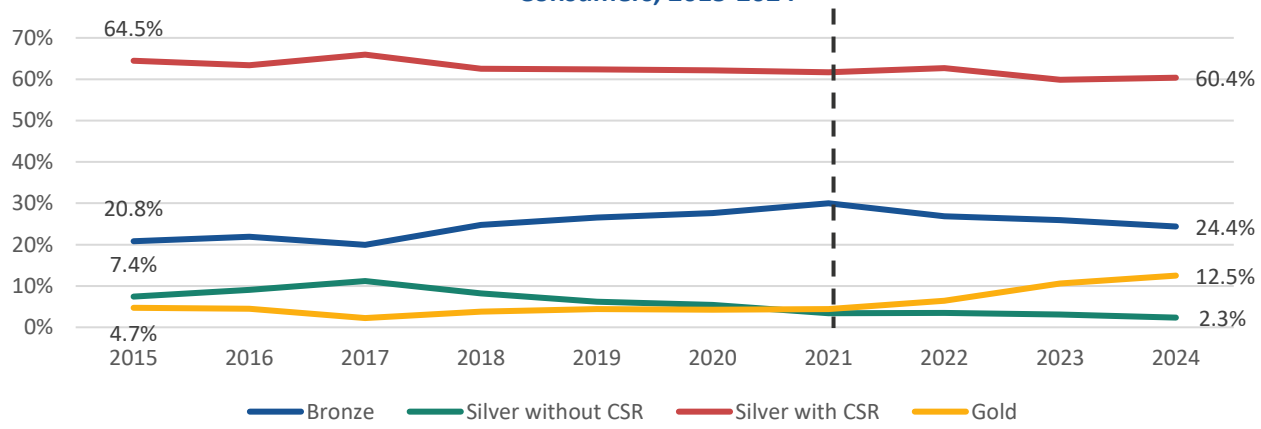
Silver plans with CSRs are the most commonly selected plans for other racial and ethnic groups, though the percentage selecting such plans varies considerably. In 2024, the percentage ranged from 43.7 percent for White consumers to 64 percent for Latinos. For all groups, selections of bronze plans increased from 2015 to 2021 and then decreased from 2021 to 2024. Since 2021, selections of gold plans increased for all groups, though it remains relatively low. In 2024, roughly 9 percent of Black consumers and between 12 and 14 percent of White, Latino, and AAHNPI consumers selected gold plans. For all groups, silver plans without CSRs were the least commonly selected options in 2024.

Figure 6. HealthCare.gov Marketplace Open Enrollment Plan Selections by Metal Tier for AI/AN Consumers, 2015-2024



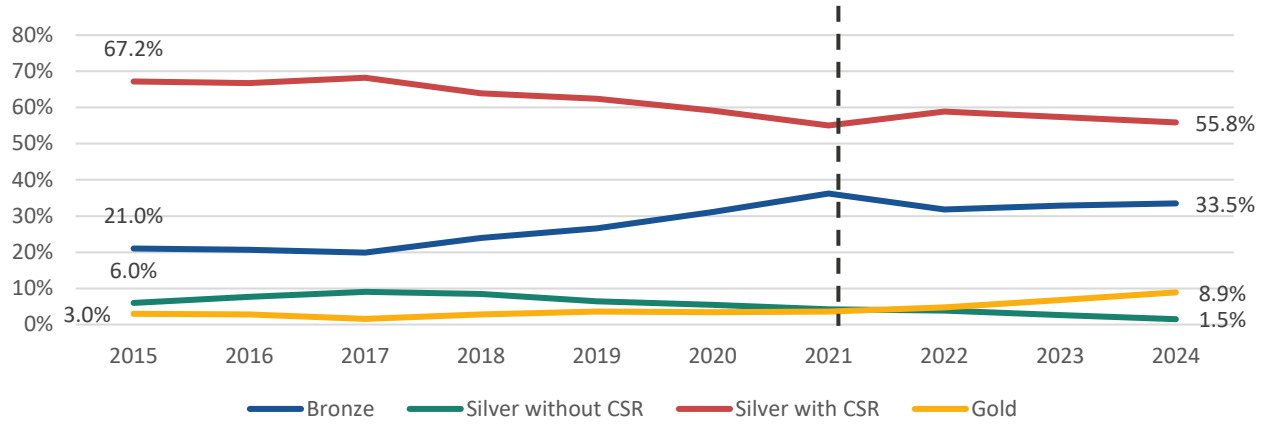
Notes: From analysis by ASPE and RAND of HealthCare.gov data Open Enrollment Periods, 2015-2024. Dashed line indicates enactment of enhanced premium tax credits from the ARP. These numbers only include HealthCare.gov Marketplace plan selections, and do not include plan selections of State-Based Marketplaces.

Figure 7. HealthCare.gov Marketplace Open Enrollment Plan Selections by Metal Tier for AANHPI Consumers, 2015-2024



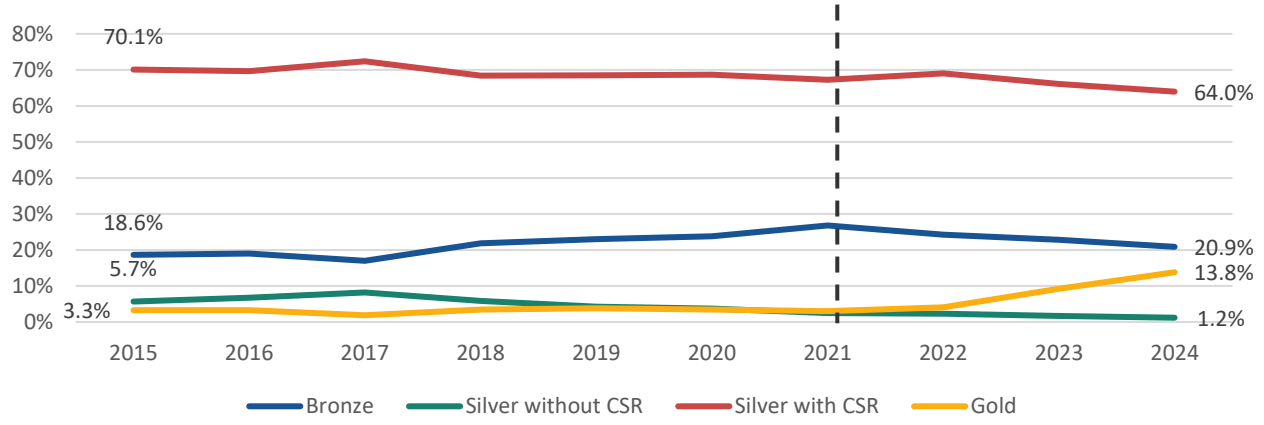
Notes: From analysis by ASPE and RAND of HealthCare.gov data Open Enrollment Periods, 2015-2024. Dashed line indicates enactment of enhanced premium tax credits from the ARP. These numbers only include HealthCare.gov Marketplace plan selections, and do not include plan selections of State-Based Marketplaces.

Figure 8. HealthCare.gov Marketplace Open Enrollment Plan Selections by Metal Tier for Black Consumers, 2015-2024



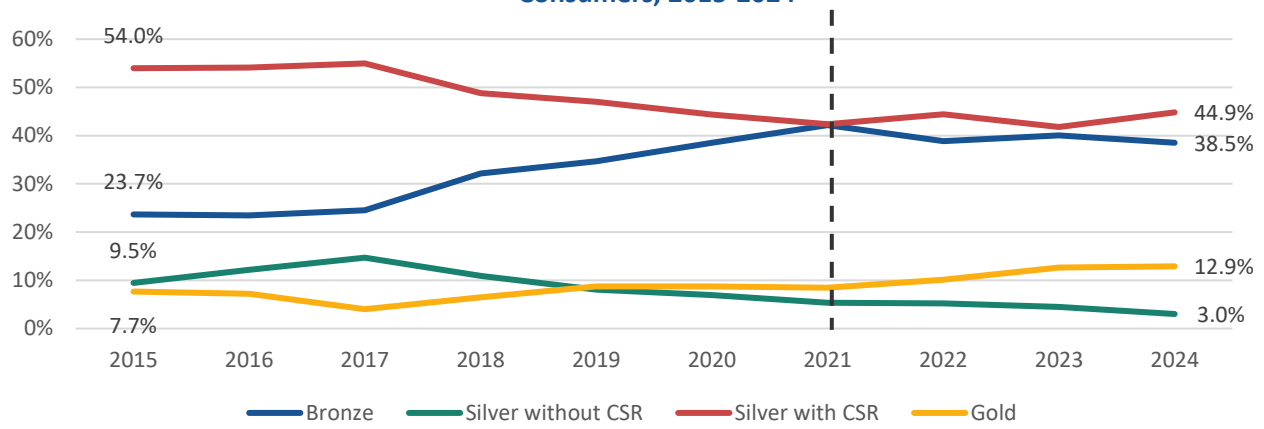
Notes: From analysis by ASPE and RAND of HealthCare.gov data Open Enrollment Periods, 2015-2024. Dashed line indicates enactment of enhanced premium tax credits from the ARP. These numbers only include HealthCare.gov Marketplace plan selections, and do not include plan selections of State-Based Marketplaces.

Figure 9. HealthCare.gov Marketplace Open Enrollment Plan Selections by Metal Tier for Latino Consumers, 2015-2024



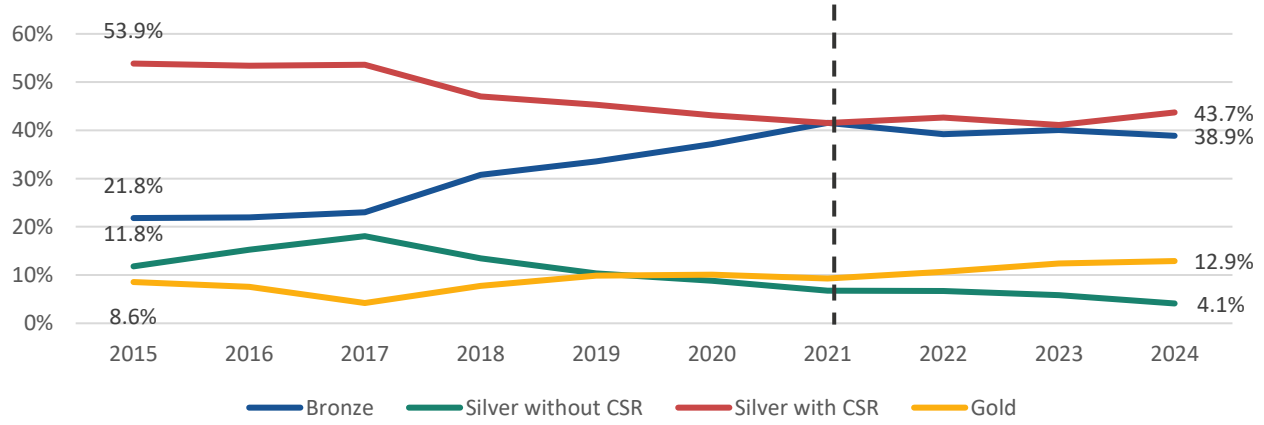
Notes: From analysis by ASPE and RAND of HealthCare.gov data Open Enrollment Periods, 2015-2024. Dashed line indicates enactment of enhanced premium tax credits from the ARP. Imputation estimates for the Latino category resulted in a C-statistic greater than 0.9 (excellent). These numbers only include HealthCare.gov Marketplace plan selections, and do not include plan selections of State-Based Marketplaces.

Figure 10. HealthCare.gov Marketplace Open Enrollment Plan Selections by Metal Tier for Multiracial Consumers, 2015-2024



Notes: From analysis by ASPE and RAND of HealthCare.gov data Open Enrollment Periods, 2015-2024. Dashed line indicates enactment of enhanced premium tax credits from the ARP. These numbers only include HealthCare.gov Marketplace plan selections, and do not include plan selections of State-Based Marketplaces.

Figure 11. HealthCare.gov Marketplace Open Enrollment Plan Selections by Metal Tier for White Consumers, 2015-2024



Notes: From analysis by ASPE and RAND of HealthCare.gov data Open Enrollment Periods, 2015-2024. Dashed line indicates enactment of enhanced premium tax credits from the ARP. These numbers only include HealthCare.gov Marketplace plan selections, and do not include plan selections of State-Based Marketplaces.

CONCLUSION

Since 2014, the Marketplaces established by the ACA have been an important source of health coverage for Americans who do not qualify for Medicaid or Medicare and do not have an affordable offer of employer-sponsored health insurance. After stagnating for several years, Marketplace plan selections have grown dramatically since 2020, increasing from 11.4 million to 21.4 million in 2024. According to a recent analysis by the U.S. Department of the Treasury, roughly 50 million Americans have held Marketplace coverage at some point since the inception of the ACA.[21]

It is important to not only track aggregate plan selections, but to understand how plan selection trends vary across different demographic groups. One challenge with such an analysis is that while information on race and ethnicity is collected on the Marketplace application, this information is not reported by a large fraction of consumers. In this Issue Brief, we apply a validated imputation method to administrative data from HealthCare.gov to overcome this data limitation and report trends in plan selections by race and ethnicity.

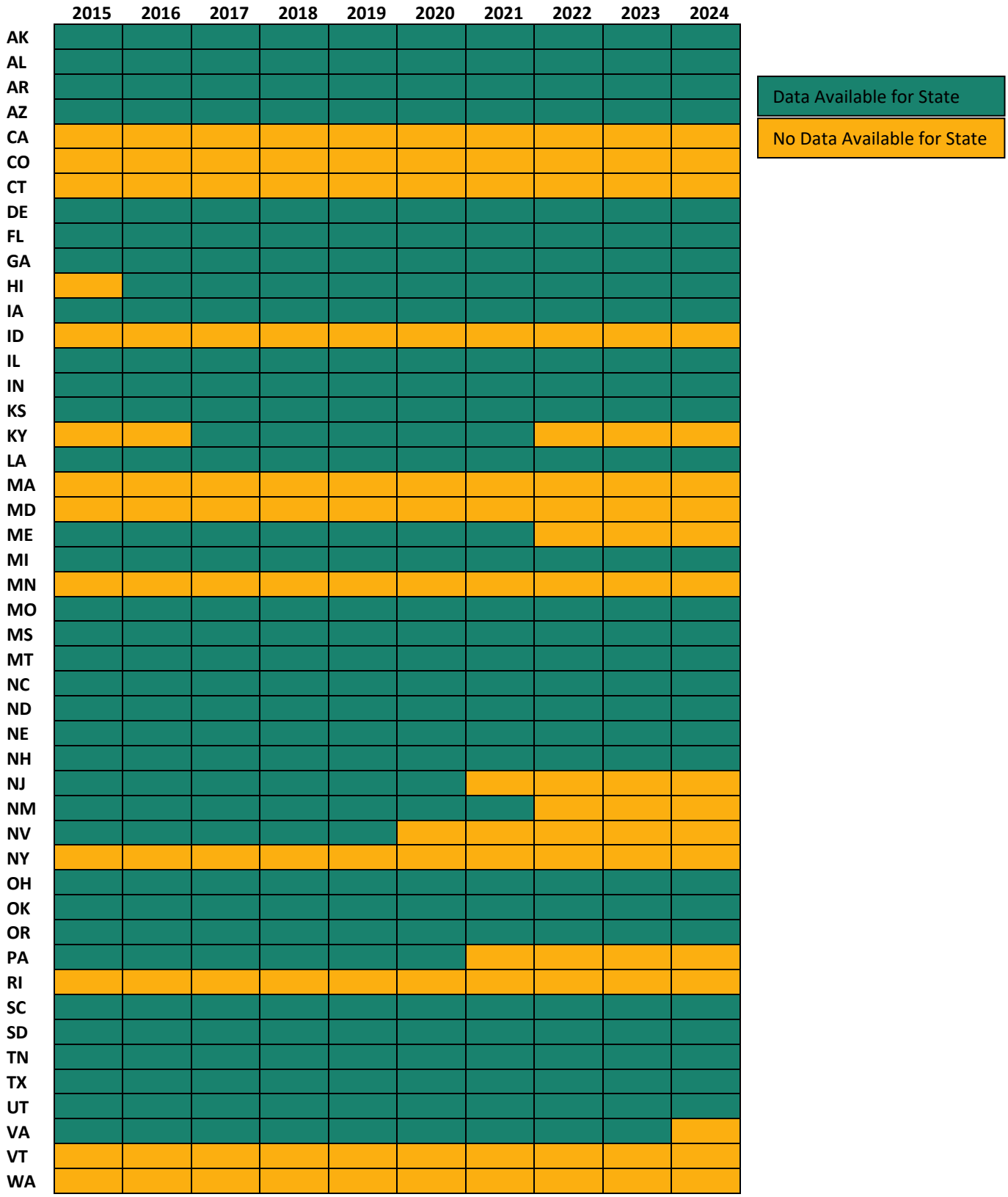
We find that while all racial and ethnic groups experienced sizeable increases in HealthCare.gov plan selections since 2020, growth was especially strong for certain groups. Between 2020 and 2024, plan selections increased by over 200 percent among Black consumers and by 185 percent among Latinos. As a result, Black and Latino Americans are overrepresented among HealthCare.gov consumers relative to their share of the non-elderly population. We estimate that plan selections among AI/AN consumers more than doubled, though because our imputation method is less predictive for this group, these results should be interpreted with caution. Importantly, after imputation, the Black and Latino share of total HealthCare.gov plan selections is higher than the shares observed in the self-reported data. This difference suggests how imputation of race and ethnicity may improve the ability of researchers to analyze coverage disparities and the ability of policy makers to design strategies to address these disparities.

Other research by ASPE has shown that since the health insurance provisions of the ACA went into effect, disparities in coverage with respect to race and ethnicity have decreased.[22,23,24,25] Although non-elderly Latino and Black adults are still substantially more likely to be uninsured than White and AAHNPI adults, the coverage gap is lower than before the ACA. The coverage gains realized in the past decade have coincided with improved access to care and health outcomes. The results presented in this Issue Brief highlight the importance of the ACA Marketplaces in achieving these improvements in health equity.

The greatest gains in Marketplace plan selections followed important policy changes. Starting in 2021, the eligibility of APTCs was expanded to higher income consumers, and the value of these subsidies was increased for households that were already eligible. The Biden-Harris Administration also increased investments in education and outreach. The analysis presented in this Issue Brief is descriptive and cannot speak directly to the causal effects of these policies.[26,27] The analysis presented in this Issue Brief suggests that communities of color would be disproportionately affected by these coverage losses, if the enhanced APTC is not extended.

APPENDIX

Appendix Figure 1. State Representation in Marketplace Race and Ethnicity Data by Year, 2015-2024



WI										
WV										
WY										

Notes: HealthCare.gov states examined include both Federally Facilitated Marketplaces and State-Based Marketplaces that use the HealthCare.gov platform, including: Alabama, Alaska, Arizona, Arkansas, Delaware, Florida, Georgia, Hawaii (added in 2016), Illinois, Indiana, Iowa, Kansas, Kentucky (added in 2017 and removed in 2022), Louisiana, Maine (removed in 2022), Michigan, Mississippi, Missouri, Montana, Nebraska, Nevada (removed in 2020), New Hampshire, New Jersey (removed in 2021), New Mexico (removed in 2022), North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania (removed in 2021), South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia (removed in 2023), West Virginia, Wisconsin, and Wyoming. Data was available for some plan selections in certain states that were not HealthCare.gov states at the time, including: California (2015-2017), Colorado (2015-2021), Connecticut (2015-2016), DC (2016), Hawaii (2015-2016), Idaho (2015-2021), Kentucky (2015-2016), Maryland (2015-2021), Massachusetts (2015-2021), Minnesota (2015-2021), New York (2015-2018, 2020), Pennsylvania (2021), Rhode Island (2015), and Washington (2015-2017).

Appendix Figure 2. Combined Self-Reported and Modified BIFSG-Imputed Results for Non-Reporters, 2015-2024[a]

Race and Ethnicity	AI/AN		AANHPI		Black		Latino		Multiracial		White		All	
	N	***%***	***N***	***%***	***N***	***%***	***N***	***%***	***N***	***%***	***N***	***%***	***N***	***%***
All Years	473,531	0.6	7,188,425	8.6	10,288,953	12.3	17,629,469	21.0	1,484,720	1.8	46,747,183	55.8	83,814,223	100.0
2015	38,088	0.4	638,513	7.2	1,328,643	15.0	1,555,091	17.6	136,625	1.5	5,140,261	58.2	8,837,454	100.0
2016	42,996	0.4	736,596	7.7	1,280,152	13.3	1,670,595	17.4	161,161	1.7	5,733,257	59.6	9,625,010	100.0
2017	43,354	0.5	783,920	8.5	1,060,322	11.5	1,627,361	17.7	164,926	1.8	5,521,115	60.0	9,201,198	100.0
2018	42,860	0.5	811,746	9.3	930,404	10.6	1,583,919	18.1	160,368	1.8	5,213,926	59.6	8,743,373	100.0
2019	47,304	0.6	820,381	9.8	882,570	10.5	1,609,002	19.1	156,204	1.9	4,895,427	58.2	8,411,039	100.0
2020	51,734	0.6	815,443	9.8	873,405	10.5	1,691,488	20.4	155,294	1.9	4,698,530	56.7	8,286,070	100.0
2021	56,635	0.7	785,380	9.5	929,726	11.3	1,864,605	22.6	159,450	1.9	4,454,769	54.0	8,250,833	100.0
2022	68,367	0.7	867,423	8.5	1,303,192	12.7	2,590,613	25.3	192,040	1.9	5,233,486	51.0	10,255,632	100.0
2023	82,193	0.7	929,023	7.6	1,700,539	13.9	3,436,795	28.2	198,652	1.6	5,856,412	48.0	12,203,614	100.0
2024	116,176	0.7	1,000,002	6.1	2,659,205	16.3	4,816,535	29.4	271,307	1.7	7,499,893	45.8	16,363,118	100.0

Abbreviations: mBIFSG, modified Bayesian Improved First Name Surname Geocoding; AANHPI, Asian American, Native Hawaiian, and Pacific Islander; AI/AN, American Indian and Alaska Native.

[a] Data are from 2015-2024 Open Enrollment Periods for states using HealthCare.gov. The mBIFSG method was used to impute race and ethnicity. Probability-based results used each consumer's mBIFSG-generated probabilities for race and ethnicity categories.

REFERENCES

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SUGGESTED CITATION
Warrier A, Lee A, Peters C, De Lew N, Buchmueller T. HealthCare.gov Plan Selections by Race and Ethnicity, 2015-2024. (Issue Brief No. HP-2024-19). Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. October 2024.
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ACKNOWLEDGMENTS
ASPE would like to acknowledge the analysis and data collection and development were conducted in collaboration with CCIIO, RAND, and former ASPE intern Lucy Chen.

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