

# **(Why) Did the Health Insurance Marketplaces Fail?**

*Antonia Rollwage*

In 2010, the ACA was signed into law and required states to establish and operate health insurance marketplaces for individuals without access to governmental payment programs or employer sponsored health insurance. Currently, the media is flooded with increasing premiums and health insurance companies leaving the marketplace. This paper aims to analyze the performance of the marketplace in terms of (1) enrollment, (2) risk pooling, (3) navigation, (4) financial performance and (5) affordability. The analysis showed initial technological problems inhibited a smooth launch of the marketplaces and led to skewed risk pools. Enrollment numbers are mediocre, reaching only 20 percent of the market's target population. Individuals lacking health literacy face a challenging market environment, leading to a significant number of enrollees who do not know their exact insurance plan coverage and cost-sharing requirements. In the first two years, the financial performance of the insurance market was poor, but as more data on enrollees was obtained and used for premium calculations the performance of insurance companies slowly started to improve. Despite the positive trend, insurers decided to leave the marketplace. However, to offer profitability and maintain insurer participation, a continuing stabilization of the market is needed. Individuals and families, especially, report trouble in affording care, financial insecurities, and postponement of care. The establishment of the marketplaces helped to increase insurance coverage, but also introduced new challenges hindering the marketplace to reach its full potential. Interventions are needed for the marketplace to become more successful.

## **Contents**

1	Introduction .....	50
2	The Health Insurance Marketplace .....	50
3	Challenges and Problems .....	53
3.1	Enrollment.....	53
3.2	Risk Pooling.....	53
3.3	Navigation.....	54
3.4	Financial Performance .....	56
3.5	Affordability .....	58
4	Discussion .....	61
5	Conclusion.....	63
	References.....	64

## 1 Introduction

In March 2010, President Obama signed the Patient Protection and Affordable Care Act (PPACA), also referred to as Affordable Care Act (ACA) into law (Lammert, 2017, p. 66). The ACA required the establishment of health insurance marketplaces, where individuals without access to governmental payment programs and employer sponsored health insurance can access information and buy health plans subject to common rules regarding coverage, pricing, funding and subsidies (Kaiser Family Foundation, 2010, p. 1). According to a Gallup survey in 2013, 22 percent of the Americans named the ACA as the greatest achievement of the Obama administration. Unfortunately, the law was not implemented as smoothly as expected. Four years later in 2017, 36 percent of the population named the ACA (also called “Obamacare”) “the biggest mistake”: Major problems occurred during implementation, partially some with long-term consequences (Brady, 2015, p. 649; Lammert, 2017, p. 66).

Seven years after passing the ACA, health reform is on the agenda again. Currently, the US media is flooded with news about health reform including failures of Obamacare and reform plans of the new administration. Major topics of conflict include the increasing prices of premiums, health insurers leaving the marketplace, and, consequently, less health insurance options for consumers (Murphy, 2017). Aetna, the third-largest health insurer in the US, just announced it will be leaving the marketplaces in all states due to a loss of USD 450 million in 2016 and the future uncertainty about the exchanges in 2018 (Goldstein, 2017).

This paper aims to evaluate the performance of the health insurance marketplaces under the ACA to assess whether the establishment of the marketplaces was successful or failed. After an introduction of the marketplace, the performance by the means of (1) enrollment, (2) risk pooling, (3) navigation, (4) financial performance, and (5) affordability will be examined. Based on the analysis, the paper discusses the major challenges the marketplace faces and concludes with key findings.

## 2 The Health Insurance Marketplace

### *The ACA*

The ACA introduced several changes to the American health care landscape. It (1) mandates that all individuals need to have health insurance coverage by 2014, (2) requires employers with 50 or more full time employees to provide health insurance coverage meeting defined minimum requirements, (3) requires states to establish insurance marketplaces as a place where individuals and small employers can buy health insurance and (4) requires states to expand their Medicaid program to individuals under the age of 65 with an income up to 133 percent of the Federal Poverty Level (FPL) (Brady, 2015, pp. 631-633).

### *The Marketplace*

The health insurance marketplace, also known as the *exchange* or *non-group market*, was established by the ACA to provide a platform on state-level where individuals and small businesses without access to governmental insurance programs or employer-sponsored health insurance can compare and purchase health insurance plans starting on October 1, 2013. All health insurance plans offered must meet federal and state coverage requirements regarding coverage minimums or price regulations. The marketplace also offers help connecting individuals and families to financial assistance by allowing consumers to access tax credits or obtain coverage through governmental payment programs. Despite these requirements, flexibility was given to the states to allow a variety of substantially different marketplace designs (Kaiser Family Foundation, 2010, pp. 1-4; Robert Wood Johnson Foundation, 2013, p. 1).

The marketplaces can be run by state governments, the federal government (by default if the state government defers its responsibility to the federal level), or a combination of both known as *state partnership exchange* (Robert Wood Johnson Foundation, 2013, p. 1). The responsibilities for implementation of the marketplaces included core functions such as (1) eligibility and enrollment, (2) plan management, (3) consumer assistance (4), outreach and education, and (5) fiscal management (Kaiser Family Foundation, 2010, p. 2).

### *Funding*

To promote the establishment of marketplaces by states, the federal government provided appropriations and more than four billion USD in grants for marketplace planning and facilitation (Robert Wood Johnson Foundation, 2013, p. 2; Hellander, 2015, p. 720). States were able to choose between operating two separate marketplaces for individuals and small businesses or combining both target groups into one marketplace. It was also possible to create multistate/regional marketplaces or several marketplaces within one state to account for regional differences as long as the marketplace operated for a specific region (Health Policy Brief, 2013, p. 2; Kaiser Family Foundation, 2010, p. 1).

Governmental funding for the establishment of the marketplaces was only provided for the duration of one year starting in January 2014. Afterwards, marketplaces needed to prove that they are self-sustaining. In 2015, many of the state-run marketplaces ran at deficit and still relied on leftover funding. To achieve self-sustainability, the marketplaces could charge user fees to participating health insurance companies or pursue other alternatives to generate funding (Kaiser Family Foundation, 2010, p. 1; Hellander, 2015, p. 720).

### *Eligibility and Coverage*

Individuals, including U.S. citizens and legal immigrants, qualify for the marketplaces if they are not eligible for governmental payment programs and have no access to employer-sponsored health insurance. Health plans are *not allowed to discriminate* against individuals on the grounds of age, disability, or expected length of life. Previously, these aspects were considered in the design of benefit packages or reimbursement schemes to benefit health insurers. (Kaiser Family Foundation, 2010, pp. 1, 3).

According to the ACA, all health insurance plans offered must cover at least the *essential health benefits*:

- Ambulatory patient services
- Chronic disease management
- Emergency services
- Hospitalization
- Laboratory services
- Maternity and newborn care
- Mental health benefits and substance abuse disorder services
- Pediatric services including oral and vision care
- Prescription drugs
- Preventive and wellness services
- Rehabilitative and habilitative services and devices

Further, states can require additional benefits be covered by plans (Kaiser Family Foundation, 2010, p. 3). In practice, more than half of the health plans purchased on the marketplace use higher standards than required by the law (Collins and Garber, 2013, p. 1). To make the comparison of different plans easier, all insurance plans are offered with four coverage levels depending on how much the insurer pays:

- *Bronze*: Benefits equal 60 percent of the actuarial value
- *Silver*: Benefits equal 70 percent of the actuarial value
- *Gold*: Benefits equal 80 percent of the actuarial value
- *Platinum*: Benefits equal 90 percent of the actuarial value

All insurances must offer at least one silver and one gold plan on each marketplace where the insurance operates (Kaiser Family Foundation, 2010, p. 3).

### **3 Challenges and Problems**

#### **3.1 Enrollment**

Before the launch date of the marketplace, one of the immediate challenges for all 50 states was ensuring that all eligible individuals could enroll in a timely manner and that recipients of subsidies de facto enroll in health plans (Collins and Garber, 2013, p. 1). However, one of the biggest difficulties the ACA has faced was the initial rollout of the federal website *healthcare.gov*, which was dysfunctional for several weeks due to failures affecting the consumer's interface as well as the back-end of the website. In advance, enrollees were promised that buying health insurance coverage would be as easy as shopping on Amazon.com, a website many Americans were familiar with. Based on the 30,000 simultaneous users at the launch of the marketplace, government officials expected the typical website traffic to be between 50,000 and 60,000 simultaneous visitors. The actual number of 250,000 simultaneous users exceeded these planned numbers, though, and led to several glitches, error messages, and long waits. During this timeframe, the sign up option for health insurance had even been rendered unusable. In the first few days, the website was visited more than eight million times (Brady, 2015, p. 638).

Although technological problems were resolved by making additional servers available and updating the software, critics of the Obama administration still disapproved and sentiment that the federal government was not competent enough to administer the marketplaces remained (Hall, 2014, pp. 1,036-1,037; Brady, 2015, p. 639). Thousands of Americans discovered that the website made mistakes by denying coverage, enrolling individuals in the wrong insurance program, and incorrectly calculating their subsidies. To address these problems, more than 20,000 Americans filed appeals with the government, a process that was complicated by a non-existent complaint system for the marketplaces. Until the technological challenges were resolved, some enrollees had to pay more or were left without coverage at all (Brady, 2015, p. 639). Nevertheless, more than twelve million individuals were enrolled through the marketplace by 2017. Comparing this number to potential marketplace population, enrollees only make up to 40 percent of the target population (Kaiser Family Foundation, 2016; Kaiser Family Foundation, 2017a).

#### **3.2 Risk Pooling**

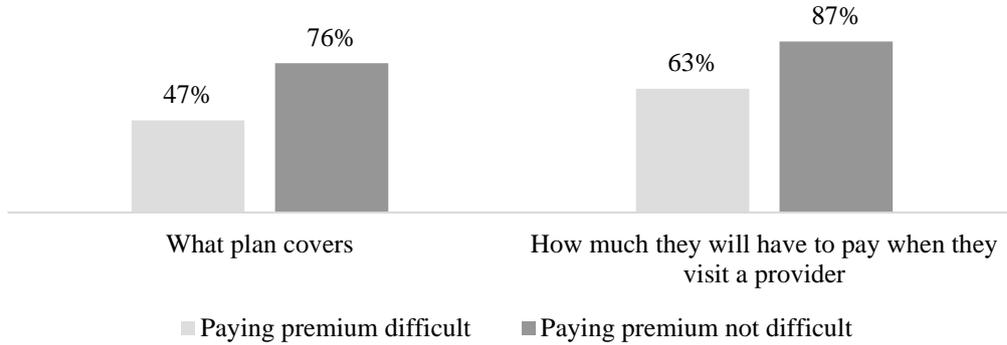
The more severe concern, however, was that the complicated enrollment affected the type of enrolling individuals. Sick and older people were more motivated to fight their way through the marketplace to get coverage for preexisting conditions, leading to unbalanced risk pools (Hall, 2014, pp. 1,038-1,039). There were also concerns about spillover effects into the subsequent year (Hall, 2014, p. 1,054). For the marketplace to work

successfully, individuals of all types – healthy and sick, young and old – must sign up to ensure a balanced risk pool. Although the marketplace is not a system offering universal health care, the system works in the same way: The healthy and young use less resources than they pay into the system, offsetting the cost of the old and sick. Because of the non-discrimination requirement in the ACA, health insurance companies cannot turn down sick or older individuals. Further, the insurer is not allowed to discriminate by age when setting premiums, making health insurers reliant on young people to sign up to cover the expenses of older, sicker individuals. If expenses cannot be covered, it could lead to a *death spiral*: Insurance companies being forced to increase premiums, making health insurance for *low-risk individuals* too expensive and leaving the marketplace more attractive. The remaining group is then more expensive than the calculated premium, leading to another premium increase and people leaving the insurance pool until the market eventually collapses. Therefore, the penalty for individuals without insurance coverage is essential to force young people to enroll and balance the risk pools (Brady, 2015, p. 639). The penalty was gradually increased from USD 95 in 2014, where only 27 percent of the enrollees were between the ages 18 and 34, to USD 695 or 2.5 percent of household income in 2016 (whichever is greater) (Brady, 2015, pp. 641-642).

### 3.3 Navigation

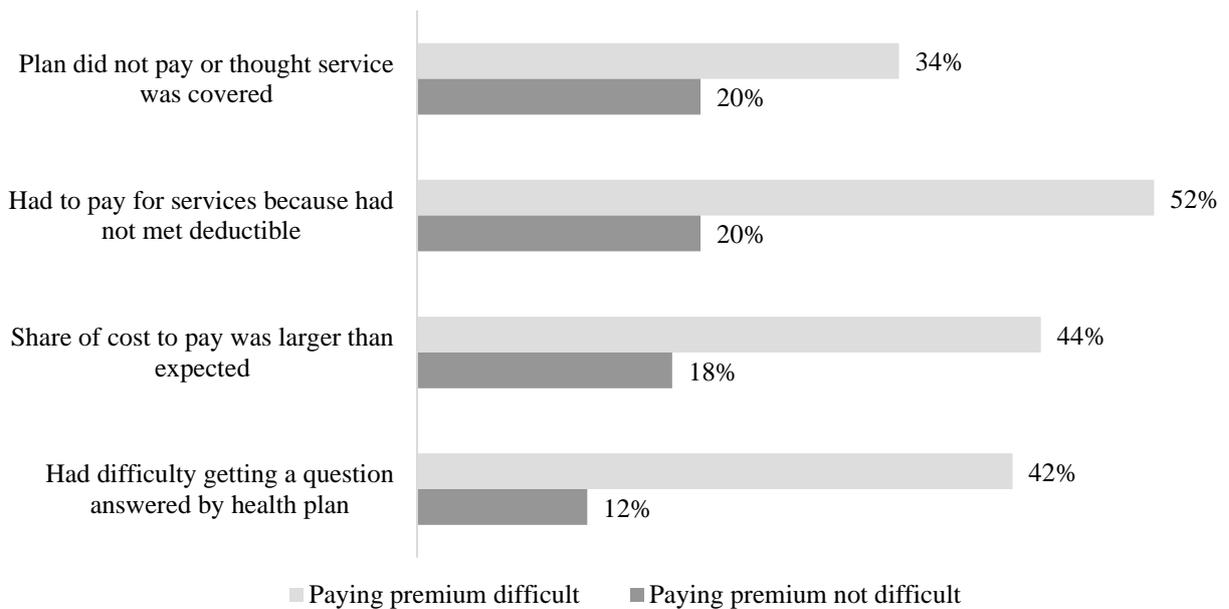
Looking at problems consumers face with their health plans, there is growing evidence that a lack of health literacy makes navigation on the marketplace more challenging. Health illiterate individuals do not fully understand the coverage and cost-sharing provisions of their health plans. Enrollees who report problems affording health care are reported to have lower levels of health literacy and were more likely to not understand what their health plans covered (see Figure 1). The group reporting “paying premium was difficult” was also not more likely to be uninsured before the ACA was introduced. This suggests the complexity of the available health plans leads to great confusion, especially for those experiencing trouble affording their coverage (see Figure 2) (Tolbert and Young, pp. 5-6).

Figure 1: Understanding of health insurance among nonelderly adults with marketplace coverage, by affordability of premium



Source: Author's own presentation, data from Tolbert and Young, 2016, p.1.

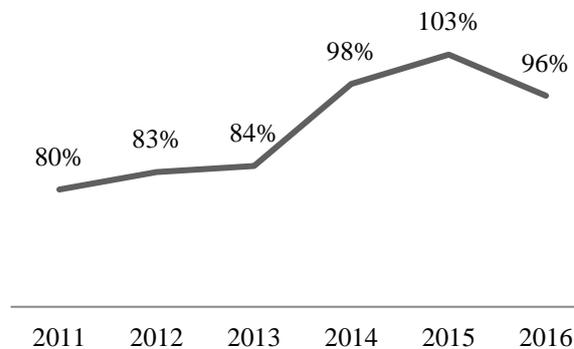
Figure 2: Problems with health plans among nonelderly adults with marketplace coverage, by affordability of premium



Source: Author's own presentation, data from Tolbert and Young, 2016, p.1.

### 3.4 Financial Performance

Figure 3: Average medical loss ratio by year



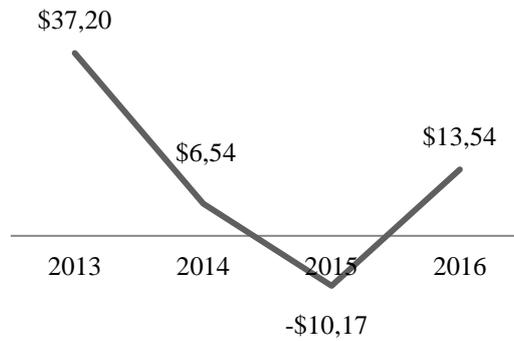
Source: Author's own presentation, data from Cox, Levitt and Claxton, 2017.

An analysis by the Kaiser Family Foundation found that the performance of key insurers operating on the marketplaces declined after opening the marketplaces but had stabilized in 2016. The study included two indicators for financial performance: the *average medical loss ratio* (the share of health premium paid out as claims) and the *average gross margin per member per month*. Since implementation of the ACA, the insurers remained profitable at all times, although performance worsened as changes accompanying the ACA came into effect in 2014 and 2015. Medical loss ratios should usually not exceed 85-90 percent for an organization to remain profitable. Nevertheless, after the ACA became effective the average medical loss ratio grew past this percentage and even up to 103 percent (see Figure 3). In 2014, the transition of the insurance market came with several changes and insurance companies had little experience in pricing the plans for the new population. On average, insurers set the premiums too low and they were not able to cover the cost of the plans. This mispricing was likely due to a smaller share of young and healthy enrollees than initially expected. Other factors, including competitors who strategically underpriced their plans and the retention of ACA non-compliant plans, increased the mispricing effect. In 2015, claims still outgrew premiums leading to an increase of medical loss ratios to an average of 103 percent. During the same year, premiums remained stable due to an ongoing lack of information and pricing knowledge on behalf of insurers, and ongoing competition for issuing the lowest-cost plan (Cox, Levitt and Claxton, 2017).

In addition to higher medical loss ratios, average gross margins per member fell with the transition to the marketplace from USD 37.20 in 2013 to USD -10.17 in 2015 (see Figure 4). Although gross margins are a great indicator of performance, a positive margin does not automatically translate into a higher profitability since they do not take

administrative expenses into account. Despite the medical loss ratio decreasing per individual, the total premium income is higher compared to pre-ACA conditions due to a higher total number of enrollees (Cox, Levitt and Claxton, 2017).

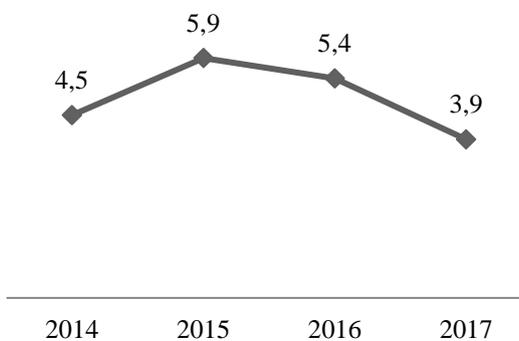
Figure 4: Average gross margins per member per month



Source: Author's own presentation, data from Cox, Levitt and Claxton, 2017.

In 2016, the third operating year of the marketplace, insurance companies were finally able to analyze more meaningful data to set more reasonable premium rates. For the first time, the premiums grew faster than cost claims leading to decreasing market loss ratios. Medical loss ratios fell by 7 percent to 96 percent but remained higher than the 2013 level of 80 percent. If insurers want to return to pre-ACA margins, the conditions still need to improve to include steady marketplace enrollment with premium increases and no substantial increase in claims. For the ACA's success it is essential that the marketplace remains stable and maintains the willingness of insurers to participate on the marketplace. Insurers will only be interested if long-term profitability is not at risk (Cox, Levitt and Claxton, 2017; Kaiser Family Foundation, 2017b).

Figure 5: Average number of insurers participating on the marketplace



Source: Author's own presentation, data from Cox, Long, Semanskee, et al., 2016.

Due to the retained losses of insurance plans operating on the marketplace, health insurance companies like UnitedHealth and Aetna announced their decision to leave some local markets or the ACA marketplace completely. In 2017, the average number of insurers participating on the marketplace will be 3.9 (see Figure 5), ranging from one insurer in five states and 15 insurers in Wisconsin. Per state, the number of available health insurers is decreasing with 21 percent of states having only one health insurer in 2017 compared to 2 percent of states having only one available insurer in 2016 (see Figure 6) (Cox, Long, Semanskee et al., 2016). On a county level, those numbers look more alarming: The number of counties with just one marketplace insurer is likely to increase from 225 counties in 2016 to 974 in 2017 due to the exit of UnitedHealth, which was formerly the second largest insurer in rural areas (Cox and Semanskee, 2016).

Figure 6: Insurer participation and choice of enrollees

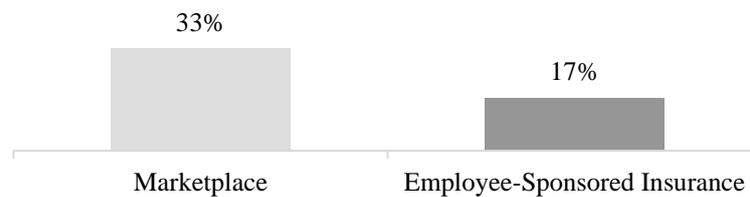


Source: Author's own presentation, data from Cox, Long, Semanskee, et al., 2016.

### 3.5 Affordability

Although subsidies are available to lower costs of private health insurance plans for individuals, 25 percent of the population have trouble affording premiums, deductibles and out-of-pocket costs when they receive health care services. Focusing on premiums only, a third of the marketplace enrollees find affording their premium *somewhat difficult* or *very difficult* compared to 17 percent of enrollees in an employer-sponsored health insurance (see Figure 7). These findings are consistent with other reports indicating that 36 percent of marketplace enrollees with a deductible are dissatisfied compared to 17 percent of employer-sponsored insurance enrollees (Tolbert and Young, 2016, p. 1).

Figure 7: Difficulty affording health insurance premiums among nonelderly adults, by insurance coverage

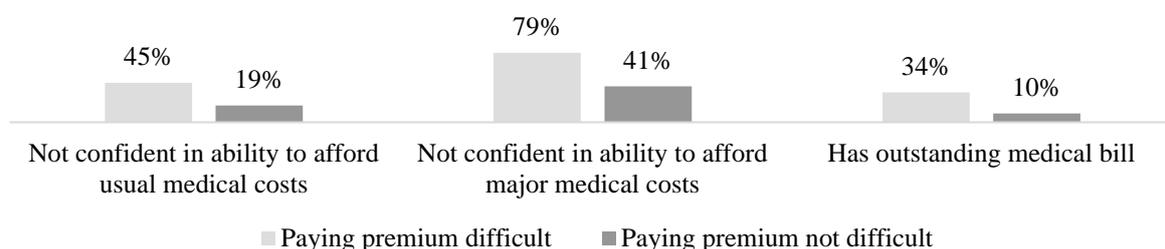


Source: Author's own presentation, data from Tolbert and Young, 2016, p. 1.

Comparing both population groups, with and without difficulties in affording coverage, both groups shared similar characteristics regarding income, age, and health status. The only difference is the group with difficulties was more likely to have dependent children (49 percent versus 16 percent) (Tolbert and Young, 2016, p. 2). Available subsidies for health insurance are based on the family's income rather than on a percentage of the health plan's cost. Thus, families do not pay more for coverage than childless individuals because they chose a family plan. Rather, families face higher household expenses due to additional cost for housing, food, or education which can stress the family budget, especially for lower income families. This can lead to trade-offs between paying for health insurance or household essentials (Tolbert and Young, 2016, pp. 2-3).

Individuals with having trouble paying their premiums were also more likely to feel financially insecure than the population without trouble. Further, the insecurity over medical cost was not fully eased for the insured population with trouble affording their premiums, including usual and major medical cost. Medical debt was a major cause for personal bankruptcies (see Figure 8) (Tolbert and Young, pp. 3-4).

Figure 8: Financial insecurity over medical costs among nonelderly adults<sup>2</sup> with marketplace coverage, by affordability of coverage



Source: Author's own presentation, data from Tolbert and Young, 2016, p. 3.

People facing difficulties in paying for health care were also more likely to use health services and to have higher unmet health needs than those without difficulties in paying

<sup>2</sup> Includes adults aged 19-64.

for care (38 percent versus 19 percent). For families with already strained budgets, accessing care put another burden on families perceiving their insurance coverage as unaffordable (see Figure 9). Worryingly, individuals facing challenges in affording their premiums were also more likely to postpone care and cost was often mentioned as a factor (Tolbert and Young, 2016, pp. 4-5).

Figure 9: Unmet needs for care among nonelderly adults with marketplace coverage, by affordability of premium



Source: Author's own presentation, data from Tolbert and Young, 2016, p 4.

The initial premiums were based on the actuarial assumptions regarding age and health status mix of an unknown population (Hall, 2014, p. 1039). Due to the previously mentioned substantial losses of health insurances participating in the marketplace and the phasing out of the ACA's reinsurance program, insurance companies started to increase premiums. For the second-lowest priced silver plan, which serves as the benchmark plan for financial assistance, the premium for a 40-year-old non-smoker ranges from USD 299 in Cleveland, Ohio, to USD 904 in Anchorage, Alaska, before tax credits are taken into account. The largest increases in premiums were recognized in Phoenix, Arizona, with up to a 145 percent increase from USD 207 to USD 507 (Kaiser Family Foundation, 2016). The increase in premiums was one major issue publicly debated with critics and defenders citing negative and positive aspects of a system with subsidies: younger, healthier people pay more for their insurance than older, sicker population pays (Hall, 2014, pp. 1044-1045). On average, insurers participating on the marketplace raised premiums substantially by 22 percent from 2016 to 2017 (Cox, Levitt and Claxton, 2017). On the contrary, the premium projections of the Congressional Budget Office of the year 2009 show a different picture: The average nationwide premium for the benchmark plan for the year 2016 was USD 5,200 a year compared to an actual USD 4,583 or 12 percent lower than originally projected. Even if premiums rise by nine percent in 2017, the average premium still remains below the cost projections of the Congressional Budget Office. Potential explanations are intense competition, underpricing, and a slowdown in healthcare cost suggesting some reason for optimism (Levitt, Cox and Claxton, 2016).

## 4 Discussion

After analyzing the marketplace in the areas of enrollment, risk pooling, navigation, financial performance and affordability the reasons for the failure of the marketplace become more evident.

### *Enrollment*

Although the initial failure of the website *healthcare.gov* affected enrolling individuals, the problems have been resolved and the government has likely learned from its mistakes. More than twelve million individuals are enrolled in a marketplace plan as of 2017. Nevertheless, the share of the actual enrollees in relation to the marketplace potential was unfortunately only 40 percent in 2016, leading to a mediocre performance of the marketplace which was far from reaching its full potential.

### *Risk Pooling*

The automatic risk selection process which happened due to the failure of the website is the more severe problem because the risk pool was not as balanced as needed. Having more old and sick people in the risk pool risks starting the *death spiral*, which poses a substantial risk to health insurances due to repeated premium increases and individuals leaving the marketplace. Eventually, healthy individuals weigh the costs and benefits of paying for health insurance coverage versus paying the fine. The government should set incentives to ensure that as many people as possible enroll on the marketplace so the risk pools are large enough and balance the number of high- and low-risk individuals. This is essential to stabilize the market and make operations profitable for participating health insurance companies.

### *Navigation*

A lack of health literacy makes it harder for individuals to understand their coverage and the cost-sharing provision they receive. Individuals who report having trouble affording their premium were especially more likely to lack health literacy and not understand their health plans. Also, this population was less likely to know what they must pay in case they see a provider. This suggests the marketplace and its website *healthcare.gov* confuses individuals so that coverage and cost of health plans are not fully understood. *Healthcare.gov* offers many plans with various cost-sharing options so that comparing plans is not a simple task even for educated people. Since being covered by health insurance is not enough to improve health outcomes, the marketplace should improve its efforts to assist customers by presenting information as clearly as possible.

### *Financial Performance*

Due to an initial lack of knowledge of the future marketplace population and a lack of pricing skills, the financial performance of health insurers declined after entering the

marketplace. The average medical loss ratio, typically not higher than 85 percent, increased with a spike at 103 percent in 2015. A similar negative development could be seen with the average gross margins per member per month which declined to a low of a negative gross margin of -10.17 USD in 2015. After insurance companies gained more data and improved their pricing schemes, the average medical loss ratio started to decline and the average medical gross margin started to rise. To return to pre-ACA conditions in the perspective of health insurers, the positive trend needs to continue. Therefore, the stabilization of the marketplace is essential to maintain the participation of insurers.

Despite the fact that the marketplace enrollees only make up a small part of the business insurers receive, the first insurance companies which decided to leave the marketplace decreased the choice of the consumer considerably. 21 percent of states have only one insurer left on the marketplace; bearing in mind that low competition is not beneficial for individuals in terms of price and quality, this number is alarming.

### *Affordability*

Due to incorrect initial premium projections, the financial performance of insurers declined. As insurers were able to recalculate premiums in the second year of the exchange, premiums increased significantly. From 2016 to 2017, premiums were again increased by an average of 22 percent, making this a major topic of critique in the media. Considering the premium projections of the CBO, the premium increase is put in a different perspective: The 2016 premium was lower than projected in 2009, deflating the arguments of critics.

The goal of health insurance is to make health care services affordable to the general population. Despite the substantial increase in the number of individuals with health insurance coverage, a third of the marketplace enrollees still face challenges in affording their insurance premiums, deductibles and out-of-pocket costs. This puts an especially large burden on families with children who have higher household expenditures in general, leading to families weighing their choices of paying for health insurance or household essentials because health care seems unaffordable. Further, enrollees who have trouble paying their premiums also felt more financially insecure and were more likely to have unmet health needs than the individuals without difficulty. Troublingly, individuals having issues affording care were also more likely to postpone care, likely due to cost. Although the *Affordable Care Act* was meant to increase access to care and make health services more affordable, many enrollees still struggle in paying for their care and perceive healthcare as still unaffordable. Since premiums increased rather than decreased, financial assistance programs might be a starting point to lift the financial burden.

## **5 Conclusion**

This paper aimed to evaluate the performance of the marketplace in terms of (1) enrollment, (2) risk pooling, (3) navigation, (4) financial performance, and (5) affordability to give a broad overview of the current challenges enrollees and insurers face. As the analysis showed, the initial problems of the marketplace such as technological challenges are resolved, but the marketplace still suffers from the aftermath in terms of a skewed risk pool composed of higher-risk individuals than intended. Since the outreach has been mediocre after 3 years of operation, it is essential to increase the enrollment rate to stabilize the market. Penalizing individuals without health insurance in a reasonable way is key for building up a balanced risk pool. Additionally, the navigation of the marketplace is complex. Achieving a balanced risk pool requires more assistance and a simpler presentation of information to assist individuals lacking health literacy so they can fully understand the coverage provisions and cost sharing requirements of marketplace plans. The initial financial performance of insurers operating on the market place was poor and reached the lowest point in 2015. Due to additional data used for price calculations, the financial situation of insurers has steadily improved and the market is stabilizing again. Nonetheless, the first insurers deciding to leave the marketplace in some or all states did so because of significant losses in 2016. Premiums increased again to make marketplace operations for insurance companies more profitable, but these higher rates also increased the financial burden on individuals. A third of marketplace enrollees, especially families with strained budgets, reported trouble in affording their insurance premiums, deductibles or out-of-pocket costs. Unfortunately, this leads to individuals suffering from financial insecurity and deciding to postpone care. Increasing the budget of financial assistance program could be one way to lift the financial burden off of individuals and making sure that everyone can afford to receive care.

Finally, the establishment of the marketplace was an approach which helped many people gain insurance coverage and did not fail entirely. Unfortunately, the implementation of the ACA has not happened as smooth as expected. Some challenges which occurred were only temporary – like the failure of website – but other problems still persist and hinder the marketplace. These issues prevent the marketplace from reaching its full potential and explain why its implementation was not successful. By examining the reasons for the failure of the marketplace, potential solutions have also come to light and may lead to future success of the marketplace.

## References

- Brady, J. (2015), 'The Affordable Care Act: Creating Headaches instead of Healing Them', *University of Louisville Law Review*, no. 53, pp. 627–650.
- Collins, S. R. and Garber, T. (2013), 'State Health Insurance Exchanges: Progress and Challenges', *The Hastings Center Report*, vol. 43, no. 1, p. 1.
- Cox, C., Levitt, L. and Claxton, G. (2017), *Insurer Financial Performance in the Early Years of the Affordable Care Act*, Kaiser Family Foundation [Online]. Available at: <http://kff.org/private-insurance/issue-brief/insurer-financial-performance-in-the-early-years-of-the-affordable-care-act/> (Accessed May 27, 2017).
- Cox, C., Long, M., Semanskee, A., Kamal, R., Claxton, G. and Levitt, L. (2016), *2017 Premium Changes and Insurer Participation in the Affordable Care Act's Health Insurance Marketplaces*, Kaiser Family Foundation [Online]. Available at: <http://kff.org/health-reform/issue-brief/2017-premium-changes-and-insurer-participation-in-the-affordable-care-acts-health-insurance-marketplaces/> (Accessed May 28, 2017).
- Cox, C. and Semanskee, A. (2016), *Preliminary Data on Insurer Exits and Entrants in 2017 Affordable Care Act Marketplaces*, Kaiser Family Foundation [Online]. Available at: <http://kff.org/health-reform/issue-brief/preliminary-data-on-insurer-exits-and-entrants-in-2017-affordable-care-act-marketplaces/> (Accessed May 27, 2017).
- Goldstein, A. (2017), 'Aetna Exiting All ACA Insurance Marketplaces in 2018', *The Washington Post*, 10 May [Online]. Available at: [https://www.washingtonpost.com/national/health-science/aetna-exiting-all-aca-insurance-marketplaces-in-2018/2017/05/10/9dedbeea-35d4-11e7-b373-418f6849a004\\_story.html](https://www.washingtonpost.com/national/health-science/aetna-exiting-all-aca-insurance-marketplaces-in-2018/2017/05/10/9dedbeea-35d4-11e7-b373-418f6849a004_story.html) (Accessed May 31, 2017).
- Hall, M. A. (2014), 'Evaluating the Affordable Care Act: The Eye of the Beholder', *Houston Law Review*, no. 51, pp. 1029–1056.
- Hellander, I. (2015), 'The U.S. Health Care Crisis Five Years after Passage of the Affordable Care Act: A Data Snapshot', *International Journal of Health Services: Planning, Administration, Evaluation*, vol. 45, no. 4, pp. 706–728.
- Housten, A. J., Furtado, K., Kaphingst, K. A., Kebodeaux, C., McBride, T., Cusanno, B. and Politi, M. C. (2016), 'Stakeholders' Perceptions of Ways to Support Decisions about Health Insurance Marketplace Enrollment', *BMC Health Services Research*, vol. 16, no. 1, pp. 634–644.
- Kaiser Family Foundation (2010), *Explaining Health Care Reform: Questions about Health Insurance Exchanges*, Kaiser Family Foundation [Online]. Available at: <http://kff.org/health-costs/issue-brief/explaining-health-care-reform-questions-about-health-2> (Accessed May 21, 2017).

Kaiser Family Foundation (2016), *Marketplace Enrollment as a Share of the Potential Marketplace Population*, Kaiser Family Foundation [Online]. Available at: <http://kff.org/health-reform/state-indicator/marketplace-enrollment-as-a-share-of-the-potential-marketplace-population-2015/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> (Accessed June 02, 2017).

Kaiser Family Foundation (2017), *Analysis: Insurer Financial Indicators Show Signs of Stabilizing after Transition to ACA Marketplaces*, Kaiser Family Foundation [Online]. Available at: <http://kff.org/private-insurance/press-release/analysis-insurer-financial-indicators-show-signs-of-stabilizing-after-transition-to-aca-marketplaces/> (Accessed May 27, 2017).

Kaiser Family Foundation (2017), *Total Marketplace Enrollment*, Kaiser Family Foundation [Online]. Available at: <http://kff.org/health-reform/state-indicator/total-marketplace-enrollment/?currentTimeframe=0&-sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> (Accessed June 01, 2017).

Lammert, C. (2017), 'Ein historischer Erfolg: Obama und die Reform des Gesundheitssystems', *Zeitschrift für Außen- und Sicherheitspolitik*, vol. 10, Suppl 2, pp. 65–80.

Levitt, L., Cox, C. and Claxton, G. (2016), *How ACA Marketplace Premiums Measure Up to Expectations*, Kaiser Family Foundation [Online]. Available at: <http://kff.org/health-reform/perspective/how-aca-marketplace-premiums-measure-up-to-expectations/> (Accessed May 27, 2017).

Murphy, T. (2017), 'Insurers Continue to Hike Prices, Abandon ACA Markets', *The Washington Post*, 25 May [Online]. Available at: [https://www.washingtonpost.com/national/health-science/insurers-continue-to-hike-prices-abandon-aca-markets/2017/05/25/daf9564e-4157-11e7-b29f-f40ffced2-ddb\\_story.html?utm\\_term=.a1395bff345b](https://www.washingtonpost.com/national/health-science/insurers-continue-to-hike-prices-abandon-aca-markets/2017/05/25/daf9564e-4157-11e7-b29f-f40ffced2-ddb_story.html?utm_term=.a1395bff345b) (Accessed May 31, 2017).

Robert Wood Johnson Foundation (2013), 'Health Insurance Exchange and State Decisions', *Health Affairs - Health Policy Brief*.

Tolbert, J. and Young, K. (2016), *Paying for Health Coverage: The Challenge of Affording Health Insurance among Marketplace Enrollees*, Kaiser Family Foundation [Online]. Available at: <http://files.kff.org/attachment/issue-brief-paying-for-health-coverage-the-challenge-of-affording-health-insurance-among-marketplace-enrollees> (Accessed May 24, 2017).