U.S. GOVERNMENT ACCOUNTABILITY OFFICE

441 G St. N.W.
Washington, DC 20548

November 14, 2024

Congressional Committees

Private Health Insurance: Market Concentration Generally Increased from 2011 through 2022

Private health insurance is the most common source of health insurance coverage in the United States—covering approximately two-thirds of the United States population in 2022, according to the United States Census Bureau. The market for private health insurance in the United States historically has been concentrated, meaning a small number of issuers of insurance plans enrolled most of the people in a given market.[1] In our 2022 report on health insurance market concentration, we considered a market concentrated in a state if three or fewer issuers held at least 80 percent of the market share of enrollment among consumers.[2]

We found that each of the three types of health insurance markets were concentrated from 2011 through 2020—the large-group market (coverage offered by large employers), the small-group market (coverage offered by small employers), and the individual market (coverage primarily sold directly to individual consumers who lack access to group coverage).[3] Within the individual market, we reported a similar pattern in concentration starting in 2015 for those issuers participating in the individual insurance exchanges—marketplaces operated by either the state or federal government that were required to be established in each state by the Patient Protection and Affordable Care Act (PPACA).[4] Highly concentrated insurance markets may

[1]We use the term "issuer" when referring to the entities that are licensed by a state to engage in the business of health insurance in that specific state.

[2]See GAO, *Private Health Insurance: Markets Remained Concentrated through 2020, with Increases in the Individual and Small Group Markets,* GAO-23-105672 (Washington D.C.: November 7, 2022).

[3]Federal law defines a small employer as having an average of 1 to 50 employees during the preceding calendar year; however, states may apply this definition based on an average of 1 to 100 employees. See 42 U.S.C. §§ 300gg-91(e)(4),(7), 18024(b)(2)-(3).

[4]Pub. L. No. 111-148, § 1321, 124 Stat. 119, 186 (2010). Health insurance exchanges are markets that operate within each state's overall individual and small-group market where eligible individuals and small employers can compare and select among qualified insurance plans offered by participating issuers. In this report, the term "state" includes the District of Columbia. States may choose to operate their own exchanges, or this responsibility can be carried out by the federal government. In this report, we refer to exchanges in the individual health insurance market as individual exchanges.

indicate less competition, which may affect consumers' choices of issuers and the premiums they pay for insurance.

PPACA included a provision for us to conduct a study on competition and concentration in health insurance markets.[5] This report describes changes in the concentration of enrollment among issuers from 2011 through 2022 in each state's

- individual health insurance market, including the individual exchanges;
- small-group health insurance market; and
- large-group health insurance market.

To describe changes in concentration in the three health insurance markets in each state,[6] we analyzed Medical Loss Ratio (MLR) data that PPACA requires issuers to report annually to the Department of Health and Human Services' Centers for Medicare & Medicaid Services (CMS) for years 2011 through 2022.[7] At the time of our analysis 2022 data were the most recent data available across all the data sources used in this report. We previously used the same MLR data source to analyze concentration from 2011 through 2020.[8] We present this information alongside our updated analyses in this report.[9] Within the individual, small-group, and large-group markets in each of the 51 states, we determined the state-level market share for each

[5]Pub. L. No. 111-148, § 1322(i), 124 Stat. at 192. PPACA includes a provision for us to report to Congress biennially beginning in 2014. In addition to GAO-23-105672, our prior work in response to this mandate includes GAO, *Private Health Insurance: Concentration of Enrollees among Individual, Small Group, and Large Group Insurers from 2010 through 2013*, GAO-15-101R (Washington, D.C.: Dec. 1, 2014); *Private Health Insurance: In Most States and New Exchanges Enrollees Continued to be Concentrated among Few Issuers in 2014*, GAO-16-724 (Washington, D.C.: Sept. 6, 2016); *Private Health Insurance: Enrollment Remains Concentrated among Few Issuers, including in Exchanges*, GAO-19-306 (Washington, D.C.: Mar. 21, 2019); and GAO, *Private Health Insurance: Markets Remained Concentrated through 2018, with Increases in the Individual and Small Group Markets*, GAO-21-34 (Washington D.C.: Nov. 13, 2020).

[6]Federal requirements may affect market concentration and competition among health issuers and differ for health insurance coverage in the individual, small-group, and large-group markets. For example, PPACA required that issuers offer coverage to all individuals regardless of health status, and it limited the ability of issuers to deny coverage or charge higher premiums to individuals and small groups based on health risks or certain other factors. Therefore, we analyze these markets separately in this report.

[7]PPACA required that all issuers report Medical Loss Ratio data to CMS, which include the percent of premiums the issuers spent on their enrollees' medical claims and quality initiatives, known as their medical loss ratio. These data also include enrollment data that can be used to calculate the market share for fully insured health plans. The Medical Loss Ratio data include state-level enrollment data and are publicly available on the CMS website. These data do not include information for self-funded health plans, where small and large employers set aside funds to pay for employee health care rather than pay premiums to an issuer to do so, and this report does not include information on self-funded health plans. Almost two-thirds of workers with health insurance coverage through their employers were enrolled in self-funded health plans in 2022.

[8]GAO-23-105672

[9]We present previously reported information from 2011 through 2020 in this report unless our updated analysis resulted in data points that did not match exactly. In those limited instances, we present the more current data points based on our updated analysis.

issuer by calculating the ratio of the enrollment for each issuer in a state to the total enrollment in that state.[10]

To analyze changes in concentration in the individual exchanges, we used data obtained from CMS or states for 2015 through 2022.[11] For states that used a federally facilitated exchange, we analyzed summary-level enrollment data from CMS's data warehouse—the Multidimensional Insurance Data Analytics System—for 2015 through 2022.[12] For states that operated their own exchange, we analyzed enrollment data that we received for a previous report from the individual states for 2015 through 2017 and summary-level enrollment data from CMS's PPACA Risk Adjustment Program for 2018 through 2022.[13] Where applicable, we present previously reported information on the exchanges alongside our updated analyses in this report.[14]

For each state's overall markets and exchange, we counted issuers as participating in a market if they had enrollment in that market. We did not count issuers that offered coverage in a market but did not have any enrollment. Because there can be multiple issuers within a market that share a single parent company, we aggregated such issuers to the parent-company level. If

[10]We measured enrollment by calculating covered life-years for each issuer in a state, which measure the average number of lives insured, including dependents, on a pre-specified day of each month of the 12 months in the reporting year. Rather than a point-in-time measurement, this measure accounts for changes in enrollment that occur throughout the year. Our analysis includes the 50 states and the District of Columbia.

[11]The individual exchanges were required to be established in each state by PPACA in 2014, and our analysis of the individual exchanges begins in 2015 due to the availability of more complete data starting that year. We also measured enrollment in the individual exchanges by calculating covered life-years for each issuer. This measure is calculated as the average number of lives insured each month in the reporting year. Rather than a point-in-time measurement, this measure accounts for changes in enrollment that occur throughout the year.

[12]States that operate their own exchanges can use a federally facilitated exchange for certain functions, such as enrollment. For this report, states that use federal infrastructure (i.e., Healthcare.gov) to operate their exchanges, even if the states retain plan management functions, are classified as "federally facilitated exchanges."

[13]Officials from CMS told us issuers submit at least 90 percent of their enrollment data annually to its PPACA Risk Adjustment Program, which CMS can access at the insurance plan summary level.

[14]In our most recent report in response to this mandate, we used the Multidimensional Insurance Data Analytics System (MIDAS) and PPACA Risk Adjustment data to analyze concentration in the individual exchanges from 2018 through 2020. In another prior report, GAO-19-306, we reported data on state-based exchanges that we received from the individual states for 2015 through 2017. For this report, we used these MIDAS, PPACA Risk Adjustment, and state-provided state-based exchange data to analyze individual market concentration from 2015 through 2022.

there was no parent company, we analyzed the data by the individual issuers.[15] We did this to more fully account for the portion of the market held by each parent company. We calculated the combined enrollment for the three largest issuers in each market and the market share of the single largest issuer in each market.[16] We considered states' overall markets or exchanges to be concentrated if three or fewer issuers held at least 80 percent of the market share of enrollment. While states may have multiple local markets with differing concentrations of enrollees among health issuers, the data we used to measure concentration were generally limited to enrollment at the state level, with the exception of our individual exchange enrollment data. For the individual exchanges, we present measures of concentration by aggregating local market data to the state level.[17] For all other markets, we present state-wide issuer market share.

We analyzed enrollment data from all of our sources as they were reported by issuers to CMS or states. We did not otherwise independently verify the accuracy or completeness of the information with the issuers. We assessed the reliability of the data in several ways, including reviewing relevant data manuals and other documentation and performing electronic tests of the data to identify any outliers or anomalies. We determined that the data were sufficiently reliable for the purposes of our reporting objectives.

We conducted this performance audit from November 2023 through November 2024 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

The majority of private health insurance is provided through small group (for small employers) or large group (for large employers) plans. Small and large employers may offer fully insured group plans (by purchasing coverage from an issuer) or self-funded group plans (by setting aside

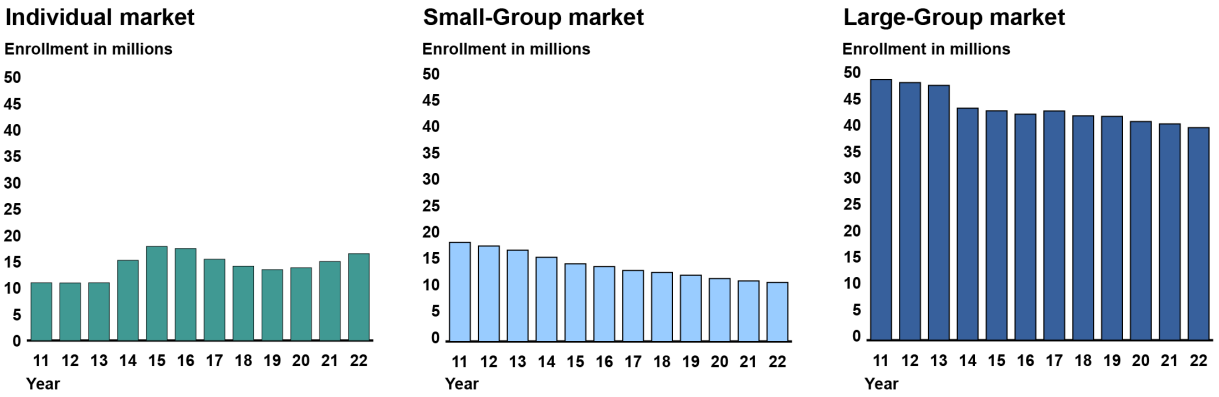
[15]Specifically, we considered issuers to have the same parent company if, in their Medical Loss Ratio data, they reported having the same National Association of Insurance Commissioners holding group identifier, the same National Association of Insurance Commissioners company identifier, or the same Health Insurance Oversight System company identifier.

[16]In cases where there are fewer than three issuers in a state's market, we still refer to this measure as the three largest issuers. Two states and 28 states in the small-group markets and individual exchanges, respectively, did not have at least three issuers. In those markets we calculated the enrollment for one or two issuers instead of three.

[17]A recent analysis of health issuer concentration found that, in 38 states, the largest issuer in the state overall was also the largest issuer in at least three-quarters of the local markets studied in that state. That analysis used 2022 data on enrollment in fully and self-insured plans by metropolitan statistical areas, which include a county or counties associated with a city or urbanized area that has a population of at least 50,000. See American Medical Association, *Competition in Health Insurance: A Comprehensive Study of U.S. Markets*, 2023 Update (Chicago, Ill.: 2023).

funds to pay for employee health care).[18] Many consumers also purchase coverage directly from an issuer through the individual market.[19] Figure 1 shows the total enrollment reported by issuers to CMS in the individual and fully insured small-group and large-group markets.

Figure 1: Enrollment Reported by Issuers to CMS by Health Insurance Market, 2011 through 2022



Source: GAO analysis of data from the Centers for Medicare & Medicaid Services. | GAO-25-107194

Notes: We calculated the size of each market from 2011 through 2022 using covered life-years, which measure the average number of lives insured, including dependents, during the reporting year. Covered life-years were reported by issuers to the Department of Health and Human Services' Centers for Medicare & Medicaid Services (CMS). This is one of several ways to measure health insurance enrollment, so it may differ from other measures of market size. An employer offering coverage in the small-group market can have an average of 1 to 50 employees as per federal law; however, states are permitted to include in this definition up to an average of 100 employees. Small and large employers may offer fully insured group plans (by purchasing coverage from an issuer) or self-funded group plans (by setting aside funds to pay for employee health care). Most small employers purchase fully insured plans, while most large employers self-fund at least some of their employee health benefits. For the small-group and large-group markets, enrollment data is from fully insured plans only. The individual market includes enrollment in the individual exchanges.

Several factors can affect concentration in health insurance markets. Increased market concentration has often been the result of consolidation—mergers and acquisitions—among existing issuers. However, concentration can also increase if existing issuers leave the market, reducing the number of issuers from which consumers can purchase coverage. Similarly, concentration can increase if larger issuers gain market share from smaller issuers. In addition, concentration can persist because it can be difficult for new issuers to enter the market. For example, new issuers that do not have large numbers of enrollees may have greater challenges negotiating discounts with health care providers, especially if health care providers are

[18]Most small employers purchase fully insured plans, while most large employers self-fund at least some of their employee health benefits. Approximately 65 percent of covered workers were in a self-funded plan in 2022, with 82 percent and 20 percent of covered workers in large employers and small employers, respectively, enrolled in self-funded plans. See Kaiser Family Foundation, *Employer Health Benefits 2022 Annual Survey* (San Francisco, Calif.: October, 2022).

[19]While all consumers can purchase coverage directly from an issuer through the individual market, consumers offered health insurance through their employer (or their spouse's) may prefer such coverage for a number of reasons, including that employers typically pay a portion of the insurance premium.

themselves consolidated.[20] This may encourage issuers to consolidate in order to attain enough enrollees to gain bargaining power, further facilitating concentration by reducing the overall number of issuers.

Concentration can also decrease if new issuers enter the market. Researchers have hypothesized that issuers may enter a market as enrollment in that market increases.[21] For example, overall enrollment in the individual exchanges increased during the COVID-19 pandemic, and issuers entered the individual exchanges during this same period.[22]

Concentration in health insurance markets can have several effects on consumers. For example, research studies have found strong evidence that concentration in health insurance markets is associated with higher consumer premiums.[23] Although some studies find that concentration can result in reduced costs for issuers (e.g., from lower administrative expenses) and lower prices paid by issuers to providers for medical care, these savings may not be passed on to consumers as lower premiums.[24] Higher premiums may result in decreased consumer access to affordable health insurance, although studies do not clearly establish the effect of concentration on consumer access.

Concentration in the Individual, Small-Group, and Large-Group Health Insurance Markets Generally Increased from 2011 through 2022

[20]There are two types of consolidation. Horizontal consolidation refers to the integration of the same types of organizations; for example, between two hospitals or two physician groups. Vertical consolidation is the integration of different types of organizations that may offer related services. In health care, for example, vertical consolidation could occur between entities offering related patient care services, such as hospitals with physician groups.

[21]In addition to enrollment increases, issuers may enter a market for other reasons. See David M. Anderson and Kevin N. Griffith, "Increasing Insurance Choices in the Affordable Care Act Marketplaces, 2018–21," *Health Affairs*, vol. 40, no. 11 (2021).

[22]Researchers hypothesized that a number of factors caused individual exchange enrollment changes during the pandemic. One example is the American Rescue Plan Act of 2021 (Act), which in March 2021 offered increased subsidies in the form of premium tax credits to eligible individuals who purchased coverage in the individual exchanges for 2021 and 2022. Specifically, the Act both temporarily increased credit amounts for eligible individuals and families and made the premium tax credits available to those with incomes at and above 400 percent of the federal poverty level. As a result, these temporary subsidies lowered the cost of health insurance for many consumers. See Pub. L. No. 117-2, § 9661, 135 Stat. 4, 182-183. The Inflation Reduction Act of 2022 extended these provisions through the end of tax year 2025. See Pub. L. No. 117-169, § 12001, 136 Stat. 1818, 1905.

[23]In 2022, the Department of Health and Human Services' Office of the Assistant Secretary for Planning and Evaluation conducted a literature review that examined trends and effects of concentration in health care markets, including health insurance markets. See RAND Health Care, *Environmental Scan on Consolidation Trends and Impacts in Health Care Markets*, a report prepared at the request of the Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation (August 2022), 52.

[24]Studies have also found that the extent to which issuers can negotiate lower prices with providers partly depends on concentration among providers. For example, providers in concentrated provider markets may negotiate higher prices from issuers.

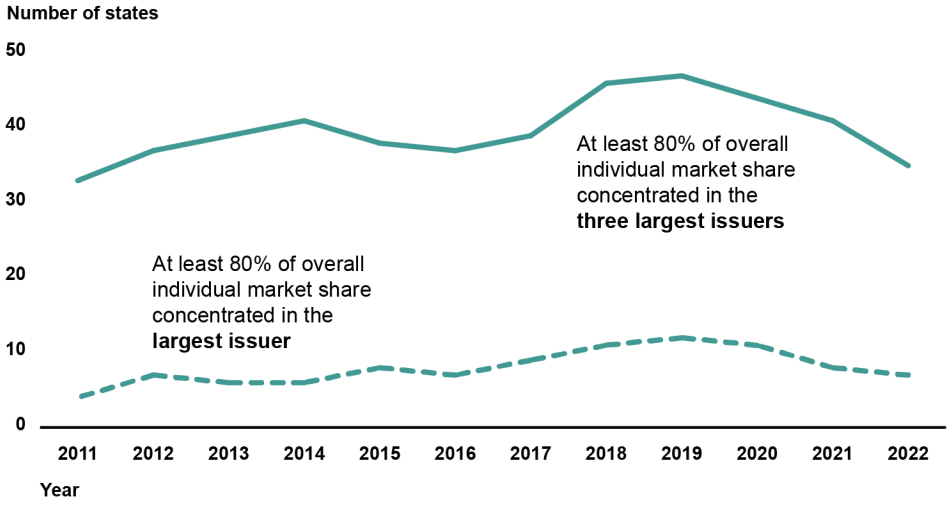
Overall Individual Health Insurance Market Concentration Increased from 2011 through 2022, Peaking in 2019

In 2022, 16.5 million consumers on average were enrolled in insurance plans in the overall individual market, and 13.5 million of these consumers on average were enrolled in plans through the individual exchanges. Our analysis of CMS data shows that enrollment in the overall individual health insurance market—including the individual exchanges—became more concentrated from 2011 through 2022. Specifically, the market became more concentrated from 2011 through 2019, then slightly less concentrated through 2022. Concentration is affected by a number of factors, as noted earlier. For example, health insurance markets can become less concentrated if new issuers enter the market and the market share of existing issuers decreases.

Three largest issuers. The number of states where at least 80 percent of enrollment in private health insurance was concentrated among the three largest issuers increased from 33 states to 47 states from 2011 through 2019. However, enrollment became less concentrated from 2020 through 2022, when the number decreased to 35 states.

Single issuer. Further, the number of states where at least 80 percent of enrollment was concentrated in a single issuer increased from 2011 through 2022, from four states to seven states. This number peaked at 12 states in 2019 (see fig. 2 and enclosure for summary statistics by year).[25]

Figure 2: Concentration in the Overall Individual Market, 2011 through 2022



Source: GAO analysis of data from the Centers for Medicare & Medicaid Services. | GAO-25-107194

Notes: This figure includes the 50 states and the District of Columbia. We use the term "issuer" when referring to the entities that are licensed by a state to engage in the business of health insurance in that specific state. Where multiple issuers in a state shared a parent company, we aggregated the individual issuers to the parent company level. We calculated market share using covered life-

[25]For this information at the state level and by market, see the interactive graphic at http://www.gao.gov/products/GAO-25-107194.

years, which measure the average number of lives insured, including dependents, during the reporting year. All states had at least three issuers in their individual markets during this time period.

Additional state-level information on health insurance market concentration can be viewed online at http://www.gao.gov/products/GAO-25-107194.

Number of issuers. In addition, the number of issuers participating in the individual health insurance market decreased from 2011 to 2022. Specifically, the median number of issuers decreased from 30 in 2011 to 10 in 2022 (see enclosure for statistics by year).

The Individual Exchanges Became More Concentrated from 2015 through 2020 and Generally Less Concentrated from 2021 through 2022

CMS and state-provided data show that enrollment in the individual exchanges became more concentrated from 2015 through 2020 and then generally less so.[26]

Three largest issuers. The number of states where at least 80 percent of enrollment was concentrated among the three largest issuers increased from 47 states to all 51 states from 2015 through 2020. Enrollment became generally less concentrated from 2021 through 2022, with this number decreasing to 47 states.

Single issuer. Further, we found a similar pattern with an earlier peak in the number of states where at least 80 percent of enrollment was concentrated in a single issuer. Specifically, this number increased from nine states to 20 states from 2015 through 2018. The number then decreased to eight states by 2022.

Number of issuers. The median number of issuers participating in each state's individual exchange decreased from 2015 through 2018, from five issuers to two issuers (see enclosure for statistics by year). From 2019 through 2022, the median number of issuers increased to five.

Individual Exchange Enrollment Increased in Number and as a Proportion of the Overall Individual Market from 2015 through 2022

CMS data show enrollment through the individual health insurance exchanges—marketplaces created in 2014 where consumers can select among insurance plans sold by participating issuers—increased from approximately 9.0 million enrollees in 2015 to approximately 13.5 million enrollees in 2022, on average. Individual exchange enrollment also increased as a proportion of overall enrollment in the individual health insurance market in states, growing from 50 percent in 2015 to 82 percent in 2022.

Enrollment grew by nearly three-quarters of a million consumers on average from 2015 through 2019 and then grew by over three million on average from 2020 through 2022. This growth may have been a result of disruptions in the health insurance market caused by the COVID-19 pandemic. For example, researchers found that some consumers obtained coverage through a health insurance exchange upon losing access to employer-sponsored health insurance.

Source: GAO analysis of data from the Centers for Medicare & Medicaid Services (CMS). | GAO-25-107194

The Small-Group Health Insurance Market Became More Concentrated from 2011 through 2022

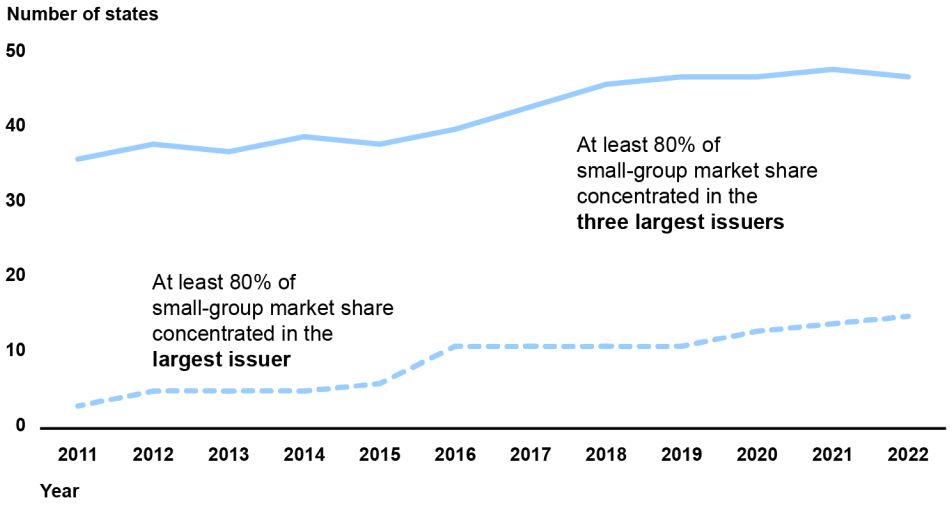
[26]As noted above, the individual exchanges were required to be established in each state by PPACA in 2014, and our analysis of the individual exchanges begins in 2015 due to the availability of more complete data starting that year.

In 2022, an average of over 11 million consumers were enrolled in insurance plans in the small-group health insurance market. Our analysis of CMS data shows that enrollment in the small-group health insurance market became more concentrated from 2011 through 2022.

Three largest issuers. The number of states where at least 80 percent of enrollment was concentrated among the three largest issuers increased from 2011 through 2022, from 36 states to 47 states. From 2019 through 2022, specifically, concentration generally remained steady, with three or fewer issuers holding at least 80 percent of the market in 47 or 48 states during this time.

Single issuer. The number of states where at least 80 percent of enrollment was concentrated in a single issuer increased from 2011 through 2022, from three states to 15 states (see fig. 3 and enclosure for statistics by year). From 2020 through 2022, enrollment concentrated in a single issuer increased at a slower rate, from 13 states to 15 states.

Figure 3: Concentration in the Small-Group Market, 2011 through 2022



Source: GAO analysis of data from the Centers for Medicare & Medicaid Services. | GAO-25-107194

Notes: This figure includes the 50 states and the District of Columbia. We use the term "issuer" when referring to the entities that are licensed by a state to engage in the business of health insurance in that specific state. Where multiple issuers in a state shared a parent company, we aggregated the individual issuers to the parent company level. We calculated market share using covered life-years, which measure the average number of lives insured, including dependents, during the reporting year. All states, except Vermont and Wyoming, had at least three issuers in their small-group markets during this time period.

Additional state-level information on health insurance market concentration can be viewed online at http://www.gao.gov/products/GAO-25-107194.

Number of issuers. As enrollment concentration increased, the number of issuers participating in the small-group health insurance market decreased, with the median number of issuers per state decreasing from 13 in 2011 to six in 2022 (see enclosure for statistics by year). From 2017 through 2022, however, the median number of issuers remained steady between five and six issuers.

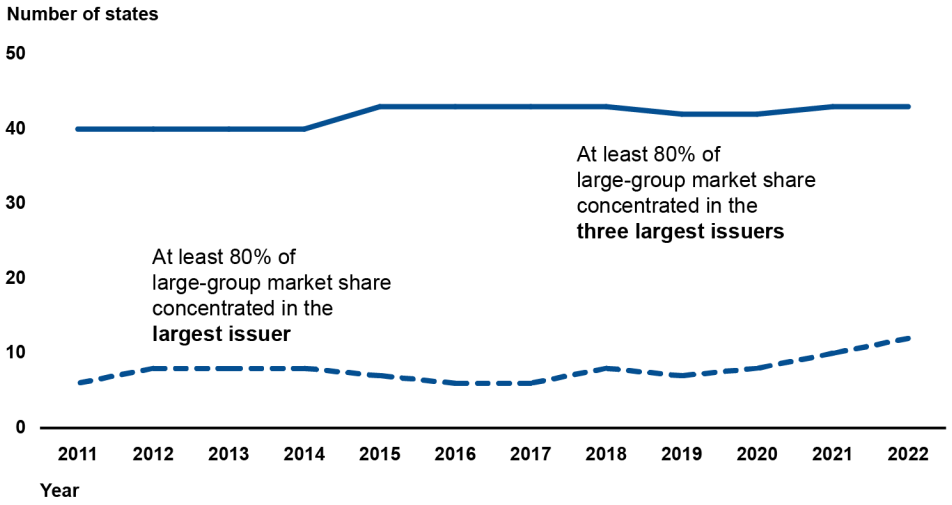
The Large-Group Health Insurance Market Remained Concentrated from 2011 through 2022

The large-group health insurance market is the largest of the three markets and had an average of over 40 million enrollees in 2022. CMS data show that concentration in the large-group health insurance market in all states remained generally steady, from 2011 through 2022, with only slight increases.

Three largest issuers. The number of states where at least 80 percent of enrollment was concentrated among the three largest issuers increased by three during this time, from 40 states to 43 states.

Single issuer. The number of states where at least 80 percent of enrollment was concentrated in a single issuer doubled from 2011 through 2022, from six to 12 (see fig. 4 and enclosure for statistics by year). This number remained generally steady, from six to eight from 2011 through 2020, but then increased from eight in 2020 to 12 in 2022.

Figure 4: Concentration in the Large-Group Market, 2011 through 2022



Source: GAO analysis of data from the Centers for Medicare & Medicaid Services. | GAO-25-107194

Notes: This figure includes the 50 states and the District of Columbia. We use the term "issuer" when referring to the entities that are licensed by a state to engage in the business of health insurance in that specific state. Where multiple issuers in a state shared a parent company, we aggregated the individual issuers to the parent company level. We calculated market share using covered life-years, which measure the average number of lives insured, including dependents, during the reporting year. All states had at least three issuers in their large-group markets during this time period.

Additional state-level information on health insurance market concentration can be viewed online at http://www.gao.gov/products/GAO-25-107194.

Number of issuers. The number of issuers in each state's large-group market decreased as enrollment concentration remained generally unchanged. Specifically, the median number of issuers per state decreased from 12 issuers in 2011 to eight issuers during the time period from 2019 through 2022 (see enclosure for statistics by year).

Agency Comments

We provided a draft of this report to the Department of Health and Human Services for review and comment. The department did not have any comments on the report.

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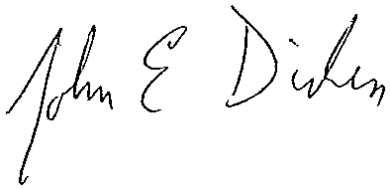
We sent copies of this report to the appropriate Congressional committees, the Secretary of Health and Human Services, and other interested parties. In addition, the report is available at no charge on the GAO website at http://www.gao.gov.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or dickenj@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are Pamela Dooley (Assistant Director), Fatima Sharif (Analyst-in-Charge), Joy Grossman, Robert Letzler, Theresa Osborne, Laurie Pachter, Daniel Ries, Ethiene Salgado-Rodriguez, Samantha Sloate, and Jennifer Whitworth.



John E. Dicken
Director, Health Care

Enclosure

List of Committees

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House of Representatives

Enclosure. Trends in Issuer Participation and Concentration in the Individual, Small-Group, and Large-Group Health Insurance Markets across States, 2011 through 2022

Table 1. Number of Issuers, Number of States Where Three Largest Issuers Held Most of the Market Share, Market Share of Three Largest Issuers, Number of States Where Single Issuer Held Most of the Market Share, and Market Share of Largest Issuer, by Health Insurance Market, 2011 through 2022

Year	Median number of issuers per state	Number of states where three largest issuers held at least 80 percent of market share	Median market share of three largest issuers (%)	Number of states where single largest issuer held at least 80 percent of market share	Median market share of single largest issuer (%)
Individual health insurance market					
2011	30	33	85	4	56
2012	26	37	87	7	54
2013	25	39	88	6	55
2014	21	41	88	6	56
2015	19	38	90	8	56
2016	16	37	91	7	54
2017	14	39	96	9	56
2018	12	46	98	11	59
2019	9	47	99	12	57
2020	10	44	97	11	57
2021	9	41	96	8	53
2022	10	35	91	7	50
Individual exchanges[a]					
2015	5	47	98	9	61
2016	4	48	98	9	60
2017	3	49	100	14	68
2018	2	50	100	20	74
2019	3	50	100	16	72
2020	3	51	100	15	67
2021	5	50	98	9	63
2022	5	47	96	8	58
Small-group health insurance market					
2011	13	36	87	3	50
2012	12	38	88	5	55
2013	12	37	88	5	59
2014	10	39	88	5	57
2015	9	38	89	6	55
2016	7	40	92	11	53
2017	6	43	92	11	57
2018	5	46	94	11	57
2019	6	47	97	11	58
2020	5	47	97	13	57

2021	6	48	97	14	58
2022	6	47	98	15	62
Large-group health insurance market					
2011	12	40	88	6	55
2012	11	40	89	8	60
2013	11	40	89	8	60
2014	10	40	90	8	59
2015	10	43	90	7	61
2016	9	43	90	6	58
2017	9	43	91	6	56
2018	9	43	92	8	58
2019	8	42	92	7	64
2020	8	42	92	8	64
2021	8	43	93	10	66
2022	8	43	93	12	62

Source: GAO analysis of data from the Centers for Medicare & Medicaid Services. | GAO-25-107194

Notes: This table includes the 50 states and the District of Columbia. Where multiple issuers in a state shared a parent company, we aggregated the individual issuers to the parent company level. We calculated market share using covered life-years, which measure the average number of lives insured, including dependents, during the reporting year. All states had at least three issuers in their individual and large-group markets during this time period. All states, except Vermont and Wyoming, had at least three issuers in their small-group markets during this time period.

[a]We refer to exchanges in the individual health insurance market as individual exchanges. For the individual exchanges, market share refers to the average market share across a state's rating areas—geographic areas established by states and used, in part, by issuers to set premium rates—weighted by the number of covered life-years in each rating area. Issuer counts in this table reflect the number of issuers, on average, across a state's rating areas, weighted by the number of covered life-years in each rating area. During this time period, multiple states did not have at least three issuers in their individual exchanges.

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