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Changes in Marketplace Premiums and Insurer Participation, 2022–2023

Summary of Findings

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In the report "Changes in Marketplace Premiums and Insurer Participation, 2022–2023," we use regression analysis to explain the variation and the growth in benchmark premiums between 2022 and 2023. We then looked at changes at insurer participation in 43 rating regions in 28 states. Finally, we examined detailed data on insurers participating in each rating region, focusing on changes in premiums and insurer participation at the local level.

Following years of premium reductions, analysts speculated that Marketplace premiums would increase in 2023, largely because of inflation and uncertainty over the extension of enhanced tax credits from ARPA (the American Rescue Plan Act).[1] We found that in 2023, Marketplace benchmark premiums increased nationally by an average of 3.4 percent. This followed average annual premium reductions of 2.2 percent between 2019 and 2022.

The main reasons for the 2023 increase in premiums appear to be the strong economy and related inflationary pressures. The unemployment rate has averaged less than 4.0 percent in 2022 (3.7 percent in October 2022)[2], and real gross domestic product increased by 2.9 percent in the third quarter of 2022.[3] Perhaps more important, the consumer price index increased by 7.7 percent in the 12 months ending in October 2022 and is expected to increase by 3.1 percent in 2023.[4] It is impossible to know how insurers account for the high rate of inflation in 2022, both overall and for medical care, and the expectation of lower inflation in 2023. But insurers need to consider underlying economic conditions as well as the competitive pressures they face.

The uncertainty over whether ARPA premium subsidies would be extended or made permanent further complicated insurers' decisionmaking. Extending the subsidies, as in the Inflation Reduction Act,

increases the likelihood that healthy people would choose to buy coverage previously deemed unaffordable. A healthier risk pool should lead to lower premiums.

Another factor affecting insurers' decisionmaking is the anticipated end of the continuous Medicaid coverage instituted during the COVID-19 public health emergency, perhaps in mid-2023. The effect on the risk pool is uncertain. In general, people losing Medicaid are expected to be relatively healthy. Many of these people are employed and will enroll in employer-sponsored coverage. However, some will enroll in Marketplace coverage (Buettgens and Green 2022).

Finally, the number of insurers in the marketplace has again increased. Competition should dampen benchmark premium increases because insurers that want to maintain market share cannot risk setting premiums too high.

About US Health Reform—Monitoring and Impact

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Changes in State Average Benchmark Premiums

Table 1 shows state average monthly benchmark premiums for 2023 and changes from 2022 to 2023, as well as the same information for 2019 to 2022. The 2023 national average benchmark premium was $453 per month for a 40-year-old nonsmoker. Benchmark premiums are important because they are the second lowest cost silver premium and Affordable Care Act premium subsidies are tied to them. Furthermore, people tend to enroll in the lowest-cost options (Holahan, Elmendorf, and Wengle 2020).

Many states with high benchmarks have fewer insurers competing, while those with low premiums are in highly competitive insurance markets or have a Medicaid insurer (that was formerly a Medicaid-only insurer) participating. The latter typically offer narrow network products at lower premiums. The table also shows 12 states with monthly benchmarks above $500: Alabama, Alaska, Connecticut, Delaware, Louisiana, Nebraska, New York, North Carolina, South Dakota, Vermont, West Virginia, and Wyoming. (New York and Vermont have community rating, therefore, premiums for a 40-year-old are not strictly comparable with states that use age rating.) Many of the other states have one or two insurers in most rating regions and higher concentrations of hospitals. Conversely, 10 states had premiums below $400: Colorado, Indiana, Maryland, Michigan, Minnesota, Nevada, New Hampshire,

Rhode Island, Virginia, and Washington. Most of these have robust competition among insurers, a Medicaid insurer, or both.

TABLE 1

State Average Benchmark Premium for a 40-Year-Old Nonsmoker and Percent Change, 2019–23

	Benchmark Premium ($)			Average Annual Change (%)	
	2019	2022	2023	2019–22	2022–23
US average	**$468**	**$438**	**$453**	**–2.2**	**3.4**
Alabama	$544	$591	$562	2.8	–4.9
Alaska	$714	$717	$760	0.2	6.0
Arizona	$463	$381	$400	–6.2	4.8
Arkansas	$380	$387	$416	0.7	7.4
California	$447	$418	$427	–2.2	2.3
Colorado	$496	$351	$351	–10.3	0.0
Connecticut	$472	$577	$623	7.3	8.0
DC	$393	$387	$428	–0.4	10.7
Delaware	$685	$548	$549	–6.6	0.1
Florida	$485	$458	$474	–1.9	3.5
Georgia	$457	$386	$402	–5.2	4.3
Hawaii	$503	$487	$471	–1.0	–3.1
Idaho	$485	$454	$419	–2.0	–7.7
Illinois	$473	$415	$453	–4.3	9.4
Indiana	$338	$399	$395	6.0	–1.2
Iowa	$731	$454	$469	–13.9	3.1
Kansas	$527	$453	$465	–4.9	2.7
Kentucky	$432	$405	$424	–1.9	4.6
Louisiana	$461	$511	$552	3.7	7.9
Maine	$530	$426	$458	–6.9	7.4
Maryland	$419	$326	$333	–8.0	2.2
Massachusetts	$330	$400	$415	6.6	3.6
Michigan	$373	$333	$353	–3.7	6.1
Minnesota	$333	$319	$331	–1.3	3.8
Mississippi	$522	$449	$468	–4.9	4.2
Missouri	$490	$447	$476	–3.0	6.5
Montana	$553	$479	$468	–4.4	–2.4
Nebraska	$825	$575	$545	–11.1	–5.3
Nevada	$413	$386	$388	–2.1	0.7
New Hampshire	$402	$309	$323	–8.2	4.6
New Jersey	$348	$422	$415	6.9	–1.7
New Mexico	$366	$393	$449	2.7	14.5
New York	$572	$604	$621	1.8	2.9
North Carolina	$609	$493	$503	–6.7	2.1
North Dakota	$396	$437	$421	4.9	–3.6
Ohio	$366	$372	$412	0.5	10.6
Oklahoma	$661	$452	$469	–11.8	3.7
Oregon	$433	$441	$454	0.6	3.1
Pennsylvania	$458	$444	$450	–0.9	1.4
Rhode Island	$336	$360	$379	2.4	5.3
South Carolina	$557	$446	$498	–7.1	11.7
South Dakota	$526	$571	$591	2.9	3.3

	Benchmark Premium ($)			Average Annual Change (%)	
	2019	2022	2023	2019–22	2022–23
Tennessee	$545	$444	$474	−6.6	6.6
Texas	$419	$417	$455	−0.1	9.0
Utah	$540	$452	$468	−5.6	3.4
Vermont	$517	$749	$738	15.0	−1.5
Virginia	$557	$450	$367	−6.9	−18.4
Washington	$380	$389	$386	0.8	−0.8
West Virginia	$585	$766	$835	9.5	9.1
Wisconsin	$519	$417	$445	−7.0	6.8
Wyoming	$860	$759	$802	−3.9	5.7

Source: Urban Institute analysis of data from Healthcare.gov and relevant state-based Marketplace websites.
Notes: State average is the average of the second-lowest silver premium offered in each rating region. Prices are weighted by rating region population size.

We used regression analysis to determine the association between various factors and both the levels of and the changes in benchmark premiums between 2022 and 2023 (table 2). The results showed that 2023 benchmark premiums were lower if a Medicaid plan (formerly Medicaid-only insurers such as Molina, CareSource, and Centene subsidiaries Ambetter, Coordinated Care, Fidelis Care, Health Net, and Meridian) participated in the Marketplace. Similarly, participation by Kaiser Permanente or a provider-sponsored insurer (such as the University of Pittsburgh Medical Center, Boston Medical Center, US Health and Life, SelectHealth, and Geisinger) was associated with lower benchmark premiums. Medicaid and provider-sponsored insurers were either attracted to low-cost markets or effectively lower benchmark premiums, perhaps because they often have narrower networks and lower provider payment rates. The latter seems more plausible. We also found that in response to a competing Medicaid insurer, other insurers have negotiated more favorable provider payment rates or narrowed their own networks (Wengle et al. 2020).

TABLE 2

Regression Coefficients Associated with Benchmark Premium, 2023, and Percent Change in Benchmark Premium Costs, 2022–23, in Rating Region

	Benchmark premium, 2023 ($)	Change in benchmark premium, 2022–23 (%)
Type of insurer participating in 2023		
Blue Cross Blue Shield	46.82*	0.173
Medicaid	−50.49***	−0.501
National	−5.543	−3.159***
Kaiser Permanente	−31.43**	−4.946***
Provider (excluding Kaiser)	−26.69***	−1.832**
Local/Regional	6.41	0.329
Number of insurers participating in 2023		
One	127.7***	−1.708
Two	119.3***	0.724
Three	11.2	−1.930*

	Benchmark premium, 2023 ($)	Change in benchmark premium, 2022–23 (%)
Four	14.1	0.148
Other factors		
Hospital system Herfindahl-Hirschman Index	0.00114	−3.64e-06
Area wage index	31.40*	1.350
Medicaid expansion status	−12.74	−2.426***
Community rated	126.7***	−3.794
Reinsurance 2023	−60.29***	−4.319***
State-based Marketplace in 2023	−32.52***	−1.976**
Urban area	−25.41***	−1.636**
Average monthly unemployment, May 2021–October 2021		1.514***
Increase in number of insurers, 2022–23		−2.768***
2022 benchmark premium		−0.031***
Constant	**473.3*** **	**17.24*** **
N	**503**	**476**
***R*-squared**	**0.465**	**0.324**

Source: Urban Institute analysis of data from Healthcare.gov and relevant state-based Marketplace websites.
Notes: The benchmark premium and the percentage change in benchmark premium are taken from each rating region. Texas is excluded from the change regression. Robust standard errors were used.
*$p < 0.10$; **$p < 0.05$; ***$p < 0.01$.

The number of insurers participating in 2023 also mattered. If only one insurer was in the market, premiums were higher by $128 relative to a market with five or more insurers. The presence of two insurers was associated with benchmark premiums being higher by $119. The area wage index was positively associated with premiums. Availability of a reinsurance plan or a state-based marketplace was associated with lower benchmark premiums in a rating region. Being in a Medicaid expansion state was not significantly related to premium costs. Urban rating areas had lower premiums by about $25, all else being equal.

We found that hospital concentration was not significant. There is a high correlation between hospital and insurer concentration: greater degrees of hospital concentration have no additional measurable effect on marketplace premiums above insurer concentration. For example, our simple regression of the Herfindahl-Hirschman index of market concentration (HHI) for hospitals against the number of insurers found that the HHI is 1,842 points higher in markets with one or two insurers relative to markets with five or more insurers (not shown).[5]

We next looked at changes in benchmark premiums between 2022 and 2023. We used the average monthly unemployment rate from May 2021 to October 2021 as a proxy for the effect of COVID-19 on premiums because the pandemic led to higher unemployment rates. We found higher unemployment in 2021 was, in fact, associated with higher premiums in 2023. The number of insurers participating was not found to be related to the increase in premiums. We did find that the presence of national insurers, Kaiser Permanente, or provider-sponsored insurers was associated with smaller premium increases.

An increase in the number of insurers in a rating region between 2022 and 2023 was negatively related to the change in premiums. That is, as more insurers entered the market, premium growth decreased. We also found that rating regions in states that had expanded Medicaid, reinsurance policies, and state-based marketplaces had smaller premium increases.

Changes in Insurer Participation

Table 3 shows changes in insurer participation across seven years. We examined 43 rating regions in 28 states. The rating regions tended to be large metropolitan areas, but some smaller markets and rural areas were represented as well. In our selected markets in 2023, the number of insurers grew slightly from 227 in 2022 to 232 in 2023. This was preceded by a large growth in the number of insurers between 2020 (185 insurers) and 2022 (227 insurers).

In 2023, three commercial carriers—Aetna, Cigna, and UnitedHealthcare—increased the number of markets in which they offered plans. UnitedHealthcare offered plans in 25 markets in 2023, compared with 3 markets in 2020. Similarly, Aetna increased its participation from 0 markets in 2020 to 12 markets in 2023. Cigna increased from 6 markets in 2020 to 12 markets in 2023. Oscar participated in only 3 markets in 2017 but had increased to 20 markets by 2023. The number of provider-sponsored plans (usually built around hospital systems) also increased, participating in 10 markets in 2020 but 25 in 2023. Blue Cross Blue Shield continued to be present in nearly every market in our sample (37 of 43 markets). Lastly, between 2017 and 2022, the number of markets where Bright Health offered coverage grew. However, by 2023, Bright Health no longer offered plans in any of our selected markets.

TABLE 3

Insurer Participation in Rating Regions among Select Study Regions, by Insurer, 2017–23

Insurer	2017	2018	2019	2020	2021	2022	2023
Aetna	2	0	0	0	0	8	12
Anthem	9	4	4	5	7	9	9
Blue Cross Blue Shield[a]	36	36	36	38	38	38	37
Bright Health	0	1	3	6	8	13	0
CareSource	4	4	4	5	5	5	5
Centene (Ambetter, Health Net, Fidelis Care, Coordinated Care)	20	21	22	24	28	30	30
Cigna	5	4	5	6	7	10	12
Humana	6	0	0	0	0	0	2
Kaiser Permanente	9	9	9	9	9	9	9
Molina Healthcare	12	10	10	10	10	11	12
Oscar	3	7	11	16	18	21	20
UnitedHealthcare	4	2	3	3	9	19	25
Provider	14	11	11	10	13	19	25
Other	29	27	29	29	33	35	34
Total	**153**	**136**	**147**	**161**	**185**	**227**	**232**

Source: Urban Institute analysis of data from Healthcare.gov and relevant state-based Marketplace websites.

[a] Blue Cross Blue Shield excludes Anthem.

In the full report, we provide detailed descriptions of 43 markets in 28 states, focusing on premiums for each insurer from 2019 through 2023. Several key findings emerged:

1. Medicaid insurers, led by Centene and its subsidiaries, as well as other Medicaid plans such as CareSource and Molina, are almost always among the lowest-cost plans offered in each market where such a plan participates.
2. Most of the urban markets have six or more insurers. The competition typically results in lower premiums.
3. In many of these urban markets, several insurers offer similar premiums. This is typical of mature markets in which information about health risk, provider payment rates, and ability to develop provider networks has stabilized.
4. A few markets, such as Boston, New York City, and Long Island, seem to be bifurcated. Some insurers offer narrow network products at low premiums and the rest offer broad network products at high premiums.
5. Many large commercial insurers, including Aetna, Cigna, and UnitedHealthcare, have entered more Marketplaces. In many cases, these insurers participated in the Marketplace previously but with high premiums. They are now reentering with more competitive premiums and likely narrower networks, although data on network breadth are not readily accessible.
6. Rural areas and smaller cities typically have two or three insurers. Yet, many seem to exhibit genuine competition despite having fewer competing insurers. In others, a Blue Cross Blue Shield plan dominates and premiums are high. Even if such markets offer an additional plan, provider relationships of the dominant plan seem to set the market, making it difficult for a competitor to negotiate lower payment rates and offer appreciably lower premiums.
7. Provider-sponsored insurers have increasingly entered the Marketplaces and have done so competitively, as seen in our regression results. In many cases these insurers are not the benchmark but are still affecting the benchmarks. Some larger provider-sponsored insurers have entered and expanded their presence around the country, including US Health and Life and SelectHealth.

We conclude that competition in most markets has kept premiums low and annual increases modest, resulting in lower costs for both households and the federal government. This is particularly true in urban markets with large number of competitors, including Medicaid and provider sponsored plans. Competition has been less robust in small cities and rural areas. Premiums have been kept low in part because insurers have developed narrow network plans with providers willing to accept lower payment rates. Narrow networks are not necessarily a problem. But the looming issue is whether the low premiums that have been achieved are also associated with provider networks that are in some ways inadequate. Exploring this issue is beyond the scope of this report.

One alternative often discussed is to introduce a public option plan into Marketplaces. This report offers some lessons on the likely impact of public option proposals. In markets that have relatively low

premiums because of competition or the presence of one or more Medicaid plans, a public option is likely to have little effect because most of the feasible savings are already captured. In many rural markets and some urban areas where there is little effective competition, a public option could, in principle, bring down benchmark premiums. But the public option is likely to face the same problems existing insurers face. That is, it is difficult to negotiate provider payment rates because the number of providers is limited. The risk of providers refusing to participate is great and the political power of these providers is considerable.

Notes

[1] "Marketplace Insurers Are Proposing 10% Premium Hikes for 2023 in 13 States and DC, though Many Enrollees Could Face Much Higher Increases If Congress Doesn't Extend Enhanced Tax Credits," news release, Kaiser Family Foundation, July 18, 2022, https://www.kff.org/health-reform/press-release/marketplace-insurers-are-proposing-10-premium-hikes-for-2023-in-13-states-and-dc-though-many-enrollees-could-face-much-higher-increases-if-congress-doesnt-extend-enhanced-tax-credits/; Robert King, "Why Insurers Are Weighing Double-Digit ACA Premium Hikes for 2023," *Fierce Healthcare* (blog), July 20, 2022, https://www.fiercehealthcare.com/payers/kaiser-family-foundation-insurers-so-far-raising-aca-premiums-2023-due-part-inflation; Victoria Bailey, "ACA Marketplace Premiums Projected to Increase by 10% in 2023," *Public Payers News* (blog), July 21, 2022, https://healthpayerintelligence.com/news/aca-marketplace-premiums-projected-to-increase-by-10-in-2023; Jared Ortaliza, Julia Lotan, Matthew McGough, Emma Wager, Krutika Amin, and Cynthia Cox, "An Early Look at What Is Driving Health Costs in 2023 ACA Markets," Peterson-KFF Health System Tracker, July 18, 2022, https://www.healthsystemtracker.org/brief/an-early-look-at-what-is-driving-health-costs-in-2023-aca-markets/.

[2] US Bureau of Labor Statistics, "The Employment Situation, November 2022," News Release USDL-22-2236, December 2, 2022, https://www.bls.gov/news.release/archives/empsit_12022022.htm.

[3] US Bureau of Labor Statistics, "Consumer Price Index Summary, October 2022," News Release USDL-22-2140, November 10, 2022, https://www.bls.gov/news.release/archives/cpi_11102022.htm; "Consumer Prices Up 7.7 Percent over Year Ended October 2022," *TED: The Economics Daily*, US Bureau of Labor Statistics, November 17, 2022, https://www.bls.gov/opub/ted/2022/consumer-prices-up-7-7-percent-over-year-ended-october-2022.htm.

[4] US Department of Commerce, Bureau of Economic Analysis, "Prices and Inflation," November 30, 2022.

[5] The HHI takes into account the relative size distribution of the firms in a market. It approaches zero when a market is occupied by a large number of firms of relatively equal size and reaches its maximum of 10,000 points when a market is controlled by a single firm.

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