
# Targeting Highly Concentrated Insurer and Provider Markets for Rate Regulation

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*March 2024*

**It has been well documented that the cost of health care in the United States is high compared with other advanced nations (Gunja, Gumas, and Williams 2023; Simpson and Holahan 2024). Much evidence suggests that a major reason is differences in health care prices.[1] Some argue that controlling provider payment rates may be necessary, particularly for hospitals and some physician specialties. Rate control could be either through a public option or caps on payment rates (Simpson and Holahan 2021a, b, c, d). To some extent, the high prices stem from insurers' inability to exercise leverage over providers in payment rate negotiations, as many providers have considerable market power and, thus, considerable power in negotiating rates (Papanicolas, Woskie, and Jha 2018). Sometimes, high prices reflect inadequate incentives, that is, insurers do not need to negotiate aggressively because they have no competitors and can pass on higher rates with higher premiums.**

Despite the merits of public options or caps on payment rates, policymakers could face strong political opposition from providers and insurers and those with ideological opposition to government regulation. Rather than advocate broad-based policies, it may be more palatable to focus rate-setting options on the areas most obviously in need of regulation—areas with little insurer competition, high levels of hospital concentration, or high premiums regardless of reason.

In this report, we present considerable data that identify rating areas with high premiums in the nongroup market and examine what makes them different. We provide results of a regression analysis that identifies factors correlated with high and low premiums and show that high premiums are related

to markets having a limited number of insurers and high levels of hospital concentration. We then identify seven approaches to identifying target areas based on measures of insurer and hospital concentration and levels of premiums. In general, these targeted markets are most often in small urban markets that are not big enough to have competitive insurer and hospital markets. Several targeted markets are in rural areas for the same reasons, but these are a smaller share of the population. Fewer large urban markets are targeted, but many people can be affected when they are targeted. In the discussion, we address the question of targeted versus broad-based policies. There are clear advantages of targeting because the policy is focused on those areas with the most serious insurer or hospital concentration or cost problems. Broad-based policies would still have the largest effects in the targeted areas but would also have some effects in almost all markets.

## Data and Methods

We provide insurer and premium participation data from Healthcare.gov for 32 states and 19 state-based Marketplace websites. We collect data at the rating area level for more than 503 rating areas to calculate state average benchmark premiums and growth rates from 2023 to 2024. We also show previously published data from 2019 to 2023 for comparison. By weighting by rating area population, we provide state averages of the benchmark premiums, that is, the second-lowest-cost silver plan premium in the rating area.

We use the benchmark premium because it is used to calculate federal premium tax credits, and insurers are under competitive pressure to be one of the two lowest-priced silver plans. In tables showing the numbers and types of insurers that participate, we use the lowest premium offered by that insurer. Therefore, the benchmark premium, the second-lowest-cost silver premium, applies to only one insurer.

We also estimate a linear regression model with robust standard errors to explain variations in benchmark premiums. We include market-level factors such as the number and types of participating insurers and a measure of hospital concentration. We compute the Herfindahl-Hirschman Index (HHI) at the rating area level using annual survey data from the American Hospital Association. We also control for whether the state had a Medicaid expansion by 2024, whether the state had a reinsurance policy, whether the state had a state-based Marketplace, the area wage index, census region, and whether the state uses community rating (i.e., New York and Vermont). Finally, we controlled for whether the rating area was urban or rural.

## Premiums by State and Region

Benchmark nongroup premiums at the state and rating area levels are shown in tables 1 and 2. Table 1 shows that premium growth over the last five years has been relatively modest, averaging 0.2 percent per year, with a jump of 4.2 percent in 2024 after four years of declines on average. By comparison, the forecasted consumer price index growth for 2024 is 2.5 percent, and the predicted 2024 gross domestic product growth is 3.5 percent. Average annual growth is considerably below increases in the consumer

price index (4.1 percent from 2019 to 2024), gross domestic product (5.6 percent from 2019 to 2024), or employer-sponsored insurance premiums (2.9 percent for individuals from 2019 to 2022).[2]

But although Marketplaces have controlled premium growth overall, premiums are relatively high in several states. Table 1 provides data on benchmark premiums, the second-lowest-cost silver plan offered in a rating area, for a 40-year-old nonsmoker.[3] Premiums would be higher for older people and lower for younger people, except in Vermont and New York, where community rating keeps premiums the same for all ages. The high premiums in New York and Vermont reflect a somewhat older population and, therefore, are not comparable to other states and are not discussed below.

In 2024, the average national benchmark premium is $473, which masks considerable variation among states. The highest premiums are in Alaska ($886), West Virginia ($854), and Wyoming ($818). Premiums in Alabama, Connecticut, Louisiana, Nebraska, and South Dakota are also relatively high, with monthly premiums over $550. On the other hand, several states have monthly premiums of less than $400—Arizona, Maryland, Michigan, Minnesota, Nevada, New Hampshire, and Virginia.

TABLE 1

**Average Benchmark Premium for a 40-Year-Old Nonsmoker and Percent Change from 2019 to 2024, by State**

*From Highest 2024 Premium to Lowest*

| | Benchmark Premium ($) | | | Percent Change (%) | | |
|---|---|---|---|---|---|---|
| | 2019 | 2023 | 2024 | Average annual, 2019–23 | 2023–24 | Average annual, 2019–24 |
| US average | 468 | 454 | 473 | −0.7 | 4.2 | 0.2 |
| Vermont[a] | 517 | 841 | 950 | 14.3 | 12.9 | 14.0 |
| Alaska | 714 | 760 | 886 | 1.7 | 16.5 | 4.7 |
| West Virginia | 585 | 835 | 854 | 9.4 | 2.3 | 8.0 |
| Wyoming | 860 | 802 | 818 | −1.5 | 1.9 | −0.8 |
| Connecticut | 472 | 623 | 657 | 7.5 | 5.4 | 7.1 |
| New York[a] | 572 | 621 | 622 | 2.1 | 0.1 | 1.7 |
| South Dakota | 526 | 591 | 571 | 3.0 | −3.3 | 1.7 |
| Nebraska | 825 | 545 | 568 | −9.6 | 4.2 | −6.9 |
| Alabama | 544 | 562 | 557 | 0.9 | −1.0 | 0.5 |
| Louisiana | 461 | 552 | 553 | 4.8 | 0.2 | 3.8 |
| Delaware | 685 | 549 | 533 | −4.9 | −3.0 | −4.5 |
| DC | 393 | 428 | 532 | 2.4 | 24.2 | 6.7 |
| Maine | 530 | 458 | 516 | −3.3 | 12.8 | −0.1 |
| Missouri | 490 | 476 | 502 | −0.6 | 5.5 | 0.6 |
| Tennessee | 545 | 474 | 502 | −3.3 | 6.0 | −1.4 |
| Montana | 553 | 468 | 499 | −3.9 | 6.8 | −1.8 |
| Utah | 540 | 468 | 499 | −3.4 | 6.7 | −1.4 |
| South Carolina | 557 | 498 | 499 | −2.4 | 0.2 | −1.9 |
| Florida | 485 | 474 | 491 | −0.6 | 3.8 | 0.3 |
| North Carolina | 609 | 503 | 491 | −4.5 | −2.3 | −4.1 |
| Oklahoma | 661 | 469 | 486 | −7.9 | 3.7 | −5.6 |
| Mississippi | 522 | 468 | 486 | −2.6 | 3.8 | −1.3 |
| Kansas | 527 | 465 | 482 | −3.0 | 3.7 | −1.7 |
| Oregon | 433 | 454 | 480 | 1.2 | 5.7 | 2.1 |

| | Benchmark Premium ($) | | | Percent Change (%) | | |
|---|---|---|---|---|---|---|
| | 2019 | 2023 | 2024 | Average annual, 2019–23 | 2023–24 | Average annual, 2019–24 |
| New Mexico | 366 | 449 | 477 | 5.7 | 6.0 | 5.7 |
| Texas | 419 | 455 | 475 | 2.1 | 4.4 | 2.6 |
| New Jersey | 348 | 453 | 474 | 7.0 | 4.6 | 6.5 |
| Illinois | 473 | 453 | 472 | −0.9 | 4.0 | 0.1 |
| Hawaii | 503 | 471 | 470 | −1.5 | −0.4 | −1.3 |
| California | 447 | 427 | 465 | −1.1 | 8.7 | 0.9 |
| Wisconsin | 519 | 445 | 464 | −3.6 | 4.1 | −2.0 |
| Pennsylvania | 458 | 450 | 463 | −0.3 | 2.7 | 0.3 |
| Georgia | 457 | 402 | 453 | −2.8 | 12.7 | 0.3 |
| Iowa | 731 | 469 | 445 | −9.7 | −5.0 | −8.7 |
| Colorado | 496 | 351 | 440 | −7.7 | 25.2 | −1.1 |
| North Dakota | 396 | 421 | 438 | 2.8 | 4.1 | 3.1 |
| Kentucky | 432 | 426 | 437 | −0.1 | 2.6 | 0.4 |
| Ohio | 366 | 412 | 432 | 3.1 | 5.0 | 3.5 |
| Arkansas | 380 | 416 | 427 | 2.4 | 2.8 | 2.5 |
| Massachusetts | 330 | 415 | 425 | 5.9 | 2.4 | 5.2 |
| Idaho | 485 | 419 | 417 | −3.4 | −0.6 | −2.8 |
| Washington | 380 | 386 | 403 | 0.4 | 4.4 | 1.2 |
| Rhode Island | 336 | 379 | 400 | 3.1 | 5.5 | 3.6 |
| Indiana | 338 | 395 | 400 | 4.2 | 1.3 | 3.6 |
| Arizona | 463 | 400 | 398 | −3.5 | −0.3 | −2.8 |
| Nevada | 413 | 388 | 391 | −1.4 | 0.7 | −1.0 |
| Michigan | 373 | 353 | 373 | −1.3 | 5.5 | 0.1 |
| Virginia | 557 | 367 | 372 | −9.7 | 1.4 | −7.5 |
| Maryland | 419 | 333 | 346 | −5.4 | 3.8 | −3.6 |
| Minnesota | 333 | 331 | 343 | −0.1 | 3.5 | 0.7 |
| New Hampshire | 402 | 323 | 335 | −5.0 | 3.9 | −3.2 |

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

**Notes:** State average is average of second-lowest silver premium offered in each rating area weighted by rating area population size.

[a] Premiums for Vermont and New York, which have community rating, are not strictly comparable to other states.

Table 2 provides similar information for the highest-cost rating areas. In general, these rating areas are in many of the same states with high premiums, as shown in table 1. Table 2 shows that premiums are as high as $966 in Huntington, West Virginia; $907 in rural Alaska; and $900 in Charleston, West Virginia. Several of the highest-cost rating areas are in West Virginia. Most rating areas in Wyoming and Alaska are affected as well. However, there are other high-rating areas, such as rural Florida and rural Illinois, and small cities, such as Rapid City, South Dakota, and Bridgeport, Connecticut. It is striking how many rural rating areas have extremely high premiums (see table 3). This illustrates the challenge of any public option or capped rate policy because provider availability must be protected in less-populated areas.

TABLE 2

**Rating Areas with the 25 Highest Benchmark Premiums in 2024, by State**

*From Highest Premium to Lowest*

| State | Rating area number | Rating area name | Benchmark premium ($) |
|---|---|---|---|
| West Virginia | 5 | Huntington-Ashland, WV-KY-OH | 966 |
| Alaska | 2 | Rural AK (Northern) | 907 |
| West Virginia | 2 | Charleston, WV | 900 |
| West Virginia | 3 | Rural WV (Southwestern) | 900 |
| Alaska | 3 | Rural AK (Southern Peninsula) | 885 |
| West Virginia | 9 | Morgantown, WV | 876 |
| West Virginia | 10 | Parkersburg-Vienna, WV | 866 |
| Alaska | 1 | Anchorage, AK | 863 |
| West Virginia | 1 | Rural WV (Central) | 857 |
| Florida | 23 | Rural FL (Panhandle) | 844 |
| Illinois | 13 | Rural IL (Southern) | 838 |
| West Virginia | 8 | Morgantown, WV | 837 |
| Wyoming | 3 | Rural WY (All of WY besides Cheyenne & Casper) | 831 |
| Florida | 44 | Rural FL (Southern) | 817 |
| West Virginia | 4 | Beckley, WV | 815 |
| Wyoming | 1 | Casper, WY | 808 |
| West Virginia | 6 | Rural WV (Eastern Panhandle) | 777 |
| Wyoming | 2 | Cheyenne, WY | 773 |
| West Virginia | 11 | Rural WV (Northern Panhandle) | 764 |
| Florida | 21 | Rural FL (Southern) | 759 |
| West Virginia | 7 | Rural WV (Eastern Panhandle) | 756 |
| Illinois | 9 | Rural IL (Eastern) | 736 |
| Florida | 24 | Rural FL (Central) | 726 |
| South Dakota | 1 | Rapid City, SD | 725 |
| Connecticut | 1 | Bridgeport-Stamford-Norwalk, CT | 710 |

**Source:** Urban Institute analysis of data from Healthcare.gov and relevant state-based Marketplace websites.
**Notes:** Rating area name is based on metropolitan statistical area. New York and Vermont are excluded because premiums are community-rated.

In table 3, we show the results of a multivariate regression analysis of correlates of benchmark premiums at the rating area level. We regress benchmark premiums against the number of insurers participating in the rating area, the type of insurer participating (e.g., Blue Cross Blue Shield, national commercial insurer, provider-sponsored insurer), the hospital system HHI measure of market concentration, the area wage index, and other factors.

We found that the number of insurers participating in the rating area was negatively correlated with benchmark premiums. Compared with rating areas that had five or more insurers, areas with one insurer had premiums $216 higher, and areas with two insurers had premiums $133 higher. Rating areas with three and four insurers had premiums lower than these but still higher than areas with five or more.

Type of insurer was also a highly significant factor. Rating areas with a Medicaid insurer had premiums $42 per month lower than areas without a Medicaid insurer. Rating areas with national plans

had higher premiums than those without a national plan. Conversely, those with provider-sponsored plans had somewhat lower premiums than those without provider-sponsored plans.

TABLE 3

**Regression Coefficients Associated with a Benchmark Premium in 2024**

| | Benchmark premium ($) |
|---|---|
| **Number of insurers participating in 2024** | |
| One | 215.9*** |
| Two | 132.9*** |
| Three | 47.16*** |
| Four | 32.12*** |
| **Type of insurer participating in 2024** | |
| Blue Cross Blue Shield | 16.81 |
| Medicaid | −41.81*** |
| National | 16.70** |
| Provider | −17.26** |
| Regional/Co-op | 4.791 |
| **Other factors** | |
| Hospital system HHI | 0.00583*** |
| Area wage index | 77.65** |
| Medicaid expansion status | −8.927 |
| Community rated | 124.7*** |
| Reinsurance 2024 | −39.28*** |
| State-based Marketplace in 2024 | −103.9*** |
| Urban area | −24.14** |
| **Census region** | |
| South | 28.88** |
| Northeast | 113.4*** |
| West | 84.46*** |
| Constant | 400.6*** |
| *N* | 503 |
| *R*-squared | 0.442 |

**Source:** Urban Institute analysis of data from Healthcare.gov and relevant state-based Marketplace websites.
**Notes:** HHI is the hospital system Herfindahl-Hirschman Index. The benchmark premiums are taken from each rating area. Robust standard errors were used.
** $p < 0.05$; *** $p < 0.01$.

The hospital system HHI coefficient was positive and statistically significant, suggesting that the more concentrated the hospital market, the higher the average rating area premiums. The rating area's area wage index was also positively correlated with premiums. Rating areas in states that adopted reinsurance policies and in states with their own Marketplace had lower premiums, whereas rating areas in states with community rating (New York and Vermont) had higher premiums, largely because their premiums reflect a somewhat older population. Compared with the Midwest, all other regions had higher premiums.

We also controlled for whether the rating area was urban or rural (see appendix A for details of how we define rurality). The coefficient was negative and statistically significant, indicating that rural areas had higher premiums, all else being equal. The significance held even after we controlled for the number

of insurers and hospital concentration, each of which is related to the level of rural premiums and other variables included in the regression. Thus, the urban-rural variable reflects the impact of being in a rural area over and above the effects of insurer and hospital concentration on rural area premiums.

Tables 4 and 5 clearly illustrate the difference between highly competitive urban markets and smaller city and rural markets with fewer insurers and higher premiums. Based on our previous work, the rating areas selected represent markets in large urban and small cities or rural areas.

Table 4 shows premiums for five large cities. East Los Angeles,[4] Houston, Cleveland, and Philadelphia all have premiums below the national average, and Miami has premiums slightly above the national average. Each market includes several competitors. Generally, there is at least one Medicaid plan, as well as competing Blue Cross Blue Shield or Anthem plans that often offer products with more limited networks than their traditional plans.

TABLE 4

**Lowest Monthly Silver Premiums for a 40-Year-Old Nonsmoker in Selected Large Cities and Their States and Percent Change from 2019 to 2024, by Insurer**

| Insurer | Lowest Silver Premium ($) | | | Average annual percent change, 2019–24 (%) |
|---|---|---|---|---|
| | 2019 | 2023 | 2024 | |
| **East Los Angeles, CA** | | | | |
| Anthem | n/a | 335 | 374 | n/a |
| Blue Shield of California | 346 | 369 | 423 | 4.3 |
| Health Net[a] | 337 | 359 | 385 | 2.7 |
| Kaiser Permanente | 404 | 386 | 411 | 0.4 |
| L.A. Care Health Plan[a] | 338 | 317 | 336 | 0.0 |
| Molina Healthcare[a] | 391 | 387 | 410 | 1.1 |
| Oscar | 443 | 454 | n/a | n/a |
| **Percent change in lowest premium** | | | | 0.0 |
| **California average (all regions)** | 414 | 412 | 442 | 1.4 |
| **Houston, TX** | | | | |
| Aetna | n/a | 450 | 481 | n/a |
| Ambetter | 385 | 443 | 458 | 3.7 |
| Blue Cross and Blue Shield of Texas | 508 | 460 | 429 | −2.6 |
| Bright HealthCare | n/a | n/a | n/a | n/a |
| Community Health Choice[a] | 464 | 445 | 470 | 0.5 |
| Friday Health Plans | n/a | n/a | n/a | n/a |
| Imperial | n/a | n/a | 609 | n/a |
| Molina Healthcare[a] | 418 | 541 | 587 | 7.4 |
| Oscar Insurance Company | n/a | 506 | 526 | n/a |
| United Healthcare | n/a | 519 | 480 | n/a |
| **Percent change in lowest premium** | | | | **2.5** |
| **Texas average (all regions)** | **404** | **448** | **468** | **3.1** |

| Insurer | Lowest Silver Premium ($) 2019 | 2023 | 2024 | Average annual percent change, 2019–24 (%) |
|---|---|---|---|---|
| **Cleveland, OH** | | | | |
| Aetna | n/a | n/a | 460 | n/a |
| Ambetter from Buckeye Health Plan[a] | 323 | 430 | 468 | 8.0 |
| Anthem | n/a | 555 | 580 | n/a |
| CareSource[a] | 371 | 405 | 432 | 3.2 |
| Medical Mutual of Ohio | 360 | 446 | 491 | 6.6 |
| Molina Healthcare[a] | 366 | 381 | 398 | 2.1 |
| Oscar | 466 | 531 | 558 | 3.7 |
| United Healthcare | n/a | 400 | 444 | n/a |
| **Percent change in lowest premium** | | | | 4.5 |
| **Ohio average (all regions)** | 359 | 409 | 429 | 3.7 |
| **Philadelphia, PA** | | | | |
| Ambetter[a] | 465 | 395 | 365 | −4.6 |
| Cigna | n/a | 458 | 519 | n/a |
| Independence Blue Cross (Highmark) | 464 | 389 | 378 | −3.9 |
| Jefferson Health Plan | n/a | n/a | 362 | n/a |
| Oscar | n/a | 470 | 504 | n/a |
| **Percent change in lowest premium** | | | | −4.7 |
| **Pennsylvania average (all regions)** | 446 | 434 | 447 | 0.1 |
| **Miami, FL** | | | | |
| Aetna CVS Health | n/a | 467 | 493 | n/a |
| Ambetter[a] | 440 | 488 | 551 | 4.7 |
| AmeriHealth Caritas Next[a] | n/a | 481 | 490 | n/a |
| AvMed | n/a | 575 | 589 | n/a |
| Bright Health | n/a | n/a | n/a | n/a |
| Cigna | n/a | 488 | 611 | n/a |
| Florida Blue (Blue Cross Blue Shield of Florida) | 543 | 462 | 485 | −2.0 |
| Health Options | 458 | n/a | n/a | n/a |
| Molina Healthcare[a] | 568 | 476 | 495 | −2.6 |
| Oscar | n/a | 470 | 496 | n/a |
| United Healthcare | n/a | 493 | 513 | n/a |
| **Percent change in lowest premium** | | | | 2.0 |
| **Florida average (all regions)** | 468 | 470 | 488 | 0.9 |

**Source:** Urban Institute analysis of data from Healthcare.gov and relevant state-based Marketplace websites.
**Notes:** n/a = not applicable (insurer was not participating in the Marketplace). Insurers were instructed to load the cost of cost-sharing reductions into silver Marketplace premiums only. The lowest-cost premiums are shaded. The percent change in the lowest-cost premium is the average of the yearly change in the lowest-cost silver premium.
[a]Medicaid plan.

Specific key findings in table 4 include the following:

- East Los Angeles has six plans in 2024. The lowest-cost silver premium is $336, less than the statewide average of $442. The growth in premiums from 2019 and 2024 is also below the

statewide average. There are three Medicaid plans—L.A. Care, Molina, and Health Net—and a fairly competitive plan offered by Anthem.

- Houston has eight plans in 2024, including two Medicaid plans, Ambetter and Molina. Blue Cross Blue Shield of Texas offers the lowest-priced plan in the Houston market. The lowest-cost silver premium in Houston is below the average lowest-cost silver premium in the state. Increases in silver premiums are somewhat below the statewide average
- Cleveland has eight plans. Three are Medicaid plans, Ambetter, CareSource, and Molina. Molina has the lowest-cost plan in the region. The benchmark premium is below the average for the state.
- Philadelphia has five plans. The lowest cost is offered by a new entrant, Jefferson Health Plan. Jefferson premiums are followed closely by Ambetter, a Medicaid plan, and by Independence Blue Cross. Premiums offered by three of the five insurers are lower than the statewide average benchmark. Premiums fell over the five-year period.
- Miami has nine competing plans, with Blue Cross Blue Shield the lowest-cost plan in the market. Additionally, there are two Medicaid plans, Ambetter and Molina. AmeriHealth is the second-lowest-cost plan in the market. Several other plans have similar premiums. The benchmark premium is about equal to the average for the state. Premium increases are somewhat higher than the statewide average.

Table 5 illustrates how different the less-competitive markets are. Each market has two or three insurers and high HHIs (over 5,000, indicating an uncompetitive market). Only three markets have a Medicaid plan. All have fairly high premiums that are higher than the statewide average, with two exceptions: Tuscaloosa, Alabama, and Cheyenne, Wyoming.

TABLE 5

**Lowest Monthly Silver Premiums for a 40-Year-Old Nonsmoker in Selected High-Cost Markets, and Percent Change from 2019 to 2024, by Insurer**

| Insurer | Lowest Silver Premium ($) | | | Average annual percent change, 2019–24 (%) |
|---|---|---|---|---|
| | 2019 | 2023 | 2024 | |
| **Yuma, AZ (Urban)** | | | | |
| BannerAetna | n/a | 659 | 687 | n/a |
| Blue Cross and Blue Shield of Arizona | 691 | 700 | 665 | −0.6 |
| **Percent change in lowest premium** | | | | **−0.7** |
| **Arizona average (all regions)** | **447** | **394** | **363** | **−4.0** |
| **Tuscaloosa, AL (Urban)** | | | | |
| Blue Cross and Blue Shield of Alabama | 478 | 522 | 543 | 2.6 |
| United Healthcare | n/a | n/a | 510 | n/a |
| **Percent change in lowest premium** | | | | **1.4** |
| **Alabama average (all regions)** | **504** | **551** | **556** | **2.0** |
| **St. George, UT (Urban)** | | | | |
| Molina Healthcare[a] | 764 | 687 | 652 | −2.2 |
| Select Health | 582 | 569 | 690 | 3.9 |
| University of Utah Health Plans | 732 | 759 | 816 | 2.2 |
| **Percent change in lowest premium** | | | | **2.5** |
| **Utah average (all regions)** | **509** | **457** | **496** | **−0.3** |
| **Indiana Cincinnati Suburbs (Rural)** | | | | |
| Ambetter from MHS[a] | 239 | 381 | 420 | 12.1 |
| CareSource[a] | 344 | 432 | 425 | 4.4 |
| **Percent change in lowest premium** | | | | 12.1 |
| **Ohio average (all regions)** | 333 | 391 | 393 | 3.5 |
| **Charleston, WV (Urban)** | | | | |
| CareSource[a] | 611 | 849 | 910 | 8.3 |
| Highmark Blue Cross Blue Shield | 713 | 869 | 890 | 4.7 |
| **Percent change in lowest premium** | | | | 7.8 |
| **West Virginia average (all regions)** | 562 | 828 | 847 | 8.7 |
| **Cheyenne, WY (Urban)** | | | | |
| Blue Cross Blue Shield of Wyoming | 790 | 849 | 772 | 0.0 |
| Mountain Health CO-OP | n/a | 801 | 846 | n/a |
| **Percent change in lowest premium** | | | | −0.2 |
| **Wyoming average (all regions)** | 853 | 801 | 817 | −0.7 |
| **Lynchburg, VA (Urban)** | | | | |
| HealthKeepers | 570 | 431 | 419 | −5.9 |
| Optima Health Plan (Sentara) | n/a | 403 | 407 | n/a |
| Piedmont Community HealthCare | 641 | 369 | n/a | n/a |
| **Percent change in lowest premium** | | | | −6.1 |
| **Virginia average (all regions)** | 526 | 348 | 372 | −6.3 |

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

**Notes:** n/a = not applicable (insurer was not participating in the Marketplace). Insurers were instructed to load the cost of cost-sharing reductions into silver Marketplace premiums only. The lowest-cost premiums are shaded. The percent change in the lowest-cost premium is the average of the yearly change in the lowest-cost silver premium.

[a]Medicaid plan.

Specific key findings in table 5 include the following:

- Yuma, Arizona, has two plans: Aetna and Blue Cross Blue Shield. Premiums are well above the state's average benchmark premium.
- Tuscaloosa, Alabama, has two plans—Blue Cross Blue Shield of Alabama, long the largest insurer in the state, and recent entry United Healthcare. Premiums in Tuscaloosa are below the statewide average.
- St. George, Utah, has three competing plans, all of which have premiums well above the statewide average. Even Molina Healthcare, a Medicaid plan and the lowest-cost plan in the market, has a fairly high premium.
- The Indiana suburbs of Cincinnati are their own rating area. The market has two Medicaid plans, Ambetter and Care Source, but both have premiums above the statewide average.
- Charleston, West Virginia, has two plans: Highmark Blue Cross Blue Shield and CareSource, a Medicaid plan. Both have premiums above the state average benchmark.
- Cheyenne, Wyoming, has Mountain Health CO-OP and Blue Cross Blue Shield of Wyoming, which are the major plans in the state. Blue Cross premiums in Cheyenne are below the statewide average.
- Lynchburg, Virginia, has two plans—HealthKeepers, a limited network plan offered by Anthem, and Optima Health, a provider-sponsored insurance. Both insurers have premiums above the statewide average. In 2023, Piedmont Community HealthCare offered a significantly lower-cost plan but no longer participates in the market.

## Approaches to Targeting High-Cost Areas

Identifying areas with few insurers or highly concentrated hospital markets would generally target markets with high premiums. Alternatively, one could simply target those rating areas with the highest premiums, regardless of reason. We discuss seven alternative approaches that could be used for targeting.

1. Rating areas with one or two insurers, an indicator of little insurer competition.
2. Rating areas with less than five insurers—our analysis has shown that areas with five or more insurers are highly competitive and have the lowest premiums.
3. Rating areas with substantial hospital concentration, defined as having an HHI of greater than 5,000.

4. Rating areas with even more substantial hospital concentration, defined as areas with an HHI of greater than 2,500.
5. Rating areas that have either one or two insurers or a health system HHI above 5,000.
6. Rating areas with the highest benchmark premiums, defined as being in the top 25 percent.
7. Rating areas with the highest benchmark premiums, defined as being in the top 50 percent.

These approaches allow us a range of ways of targeting high-cost areas. The problem with the number of insurers is that targeting could change depending on insurer entry or exit. Hospital concentration is less likely to change from year to year but is not as strong of a predictor of high premiums. The highest benchmark premiums are also subject to change but are a useful starting point.

Table 6 shows the number of rating regions and the size of the population residing in these areas that would be affected. The top row shows the number of targeted rating regions that are in rural, small urban, or large urban areas. It also shows the share of the population in each of these areas. We define large urban areas as the top 50 metropolitan areas in the US in terms of population; the remaining urban areas are grouped as small urban. This roughly divides the urban population in half. Overall, 11.6 percent of the population is in rural areas, 42.7 percent in small urban areas, and 45.7 percent in large urban areas. As we will show, each of the targeting criteria would disproportionately affect rural areas, somewhat disproportionately affect small urban areas, and have less effect on larger urban areas than their share of the population. But because the number of people living in large urban areas is so large, several of these criteria have a big effect on at least some large metropolitan areas.

TABLE 6

**Number of Rating Regions and Size of Population Affected by Alternative Policies**

| | Number of rating regions | | | | Population | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | All | Rural | Small Urban | Large Urban | Total | | Share of Population Affected by Criteria | Rural | | Small Urban | | Large Urban | |
| | (N) | (%) | (%) | (%) | (N in millions) | (%) | (%) | (N in millions) | (%) | (N in millions) | (%) | (N in millions) | (%) |
| **All Rating Areas (no targeting)** | 503 | 31.2% | 50.7% | 18.1% | 331.9 | 100.0% | (100.0%) | 38.4 | 11.6% | 141.7 | 42.7% | 151.8 | 45.7% |
| Targeted Rating Areas | | | | | | | | | | | | | |
| **1 or 2 insurers** | 87 | 42.5% | 49.4% | 8.0% | 32.2 | 100.0% | (9.7%) | 7.3 | 22.6% | 17.1 | 53.0% | 7.9 | 24.5% |
| **< 5 insurers** | 322 | 39.1% | 50.6% | 10.2% | 126.0 | 100.0% | (38.0%) | 28.9 | 22.9% | 66.6 | 52.8% | 30.5 | 24.2% |
| **High HHI >5,000** | 58 | 24.1% | 69.0% | 6.9% | 11.4 | 100.0% | (3.4%) | 2.1 | 18.3% | 8.2 | 71.9% | 1.1 | 9.8% |
| **High HHI >2,500** | 210 | 27.6% | 64.8% | 7.6% | 69.8 | 100.0% | (21.0%) | 10.2 | 14.6% | 49.6 | 71.1% | 10.0 | 14.3% |
| **1 or 2 insurers** or **high HHI >5,000** | 124 | 38.7% | 54.0% | 7.3% | 39.7 | 100.0% | (12.0%) | 9.6 | 24.1% | 22.0 | 55.6% | 8.1 | 20.3% |
| **Benchmark Premium in 75th percentile** | 126 | 39.7% | 50.0% | 10.3% | 58.9 | 100.0% | (17.8%) | 13.2 | 22.5% | 25.6 | 43.5% | 20.1 | 34.0% |
| **Benchmark Premium in 50th percentile** | 252 | 36.1% | 50.8% | 13.1% | 118.9 | 100.0% | (35.8%) | 21.0 | 17.6% | 58.5 | 49.2% | 39.4 | 33.1% |

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

**Notes:** HHI is the hospital Herfindahl-Hirschman Index. A rating area is considered rural if the majority of residents live in a rural county as defined by "Health Insurance Marketplace Rating Areas," University of Iowa Center for Rural Health Policy Analysis, https://rupri.public-health.uiowa.edu/publications/policybriefs/2014/premiums/.

***One or two insurers.*** Targeting areas with one or two insurers would affect 87 rating regions and include rating areas with about 32 million, or 10 percent, of the US population. Most of the affected rating regions are small urban or rural areas. In terms of population affected, 53.0 percent are in small urban areas, 22.6 percent are in rural areas, and 24.5 percent are in large urban areas. While a large percentage of rural rating areas would be affected, they account for only 22.3 percent of the population living in areas affected by the policy. This option would affect much of Alaska, Arkansas, Connecticut, Louisiana, West Virginia, Wyoming, and parts of Alabama, California, Colorado, Florida, South Dakota, and Virginia.

***Less than five insurers.*** As we have shown, rating areas with five or more insurers are highly competitive and have the lowest premiums. Targeting areas with less than five insurers would affect those areas shown to have higher premiums. This policy would affect 322 rating regions; these regions have 126 million people. Of these regions, about half are in small urban areas and about half the population that is affected are in these areas. A large share, 39.1 percent, of rural areas would be affected, and 22.9 percent of the population affected by this policy are in rural areas. The large urban areas targeted by this policy would account for 10 percent of the rating regions and 24.5 percent of the population affected, over 30.5 million people.

***High HHI—greater than 5,000.*** This policy would target rating regions with very high levels of hospital concentration. Table 6 shows that 58 areas with 11 million people would be affected. Of these, about 69.0 percent of the rating regions would be in small urban areas, and about 72 percent of the population affected live in smaller urban areas. Large urban areas account for only 6.9 percent of the rating regions affected and 10 percent of the affected population. About 24 percent of rural areas would be affected, but only 3 percent of the population. This option would affect much of Alabama, Connecticut, North Dakota, Virginia, West Virginia, Wyoming, and parts of several other states.

***High HHI—greater than 2,500.*** This would expand targeting to areas meeting the FCC definition of high concentration levels. With this criteria, 210 rating areas with 70 million people would be affected. About 65 percent of the rating regions affected would be in small urban areas and over 70 percent of the population. Another 27.6 percent rating regions would be in rural areas (only 15 percent of the population). Only 7.6 percent of areas that are affected are larger urban areas, but these account for 14.3 percent of the population or about 10 million people.

***One or two insurers or high HHI—greater than 5,000.*** This criteria would target areas meeting criteria of either insurer or hospital concentration. We find 124 areas would be affected. Of these, 54 percent are in smaller urban areas. Another 38.7 percent of the rating regions affected are rural. Over half the population that is affected is in small urban areas. Another 20.3 percent, or 8.1 million people, are in large urban areas. These areas are in the states mentioned above and are largely a mix of small cities and rural areas.

***Benchmark premium in the top 25 percent.*** This criteria would affect 126 rating regions; these regions have 59 million people. Of these, half are small urban, about 40 percent are rural, and another 10 percent are large urban areas. The large urban areas account for 20 million people or about 34

percent of the population. Smaller urban areas account for 25.6 million people or 43.5 percent of the population.

***Benchmark Premium in the top 50 percent.*** This criteria would target the highest-cost regions and 252 rating regions would be affected. These regions have 119 million people. About half the affected regions are in smaller urban areas, 36.1 percent in rural areas, and 13.1 percent in large urban areas. About half of the population in affected regions is in smaller urban areas, and about a third is in large metropolitan areas. Rural areas account for 36.1 percent of the affected rating regions, but these account for less than 20 percent of the impacted populations.

# Discussion

We show in this report that there are several ways of targeting rate regulation to areas with less competitive insurance or hospital markets and those that simply have high premiums. Introducing a public option into these areas would mean another competing insurer with payment rates set at Medicare plus a multiple in addition to Medicare's adjustments for teaching, geography, and rural areas. A public option would be attractive to beneficiaries who want a lower-cost option but with access to a large number of providers. We assume that the public option would require providers in Medicare and Medicaid to participate.

Capping provider payment rates at the same levels in the targeted areas would have similar effects. Provider payment rates would be reduced for all payers without the need to introduce a new insurance plan. This rate-regulation method should bring down the premiums of not just a single public option plan but all plans offered by all insurers. Capping rates may make participation more attractive to additional insurers that do not have the market share to bargain with providers. Again, rates would be set at Medicare plus a multiple plus various adjustments that are currently incorporated in Medicare.

We also show that most of the effects of the targeted options would be in small cities, which could be problematic as they are less likely to attract many insurers and have fewer hospitals. Rural areas would also be often targeted for the same reasons, but these account for smaller shares of the population. Fewer large urban areas are affected because there are more insurers and more competitive hospital markets, but those that are affected have large populations. Disproportionately targeting small cities and rural areas could be problematic. The more far-reaching of the targeting approaches we proposed may have fewer problems in this regard, but of course, they are less targeted. As we have shown elsewhere, reducing premium levels through these policies not only provides savings to the government but also to households and employers (Simpson and Holahan 2024). Such targeting could be seen as arbitrary and could affect some markets in a state but not others, including neighboring rating areas. Furthermore, although rating areas are clear boundaries that insurers must use to determine participation and price in the individual market, they do not correspond with the boundaries in which providers and hospitals participate. Individuals living in targeted markets could be users of health care in neighboring rating areas that would not be affected by these policies.

Additionally, a targeting policy would not affect problems that exist in areas that are not targeted. For example, some areas could have lower premiums because some insurers offer plans with narrow networks of providers willing to accept low rates. Higher-cost, broader network plans may only be affordable for those with higher incomes. A public option or capping rates may make lower-cost options available, even in markets not meeting our targeting thresholds.

A broad-based approach to regulating premiums does have advantages. Introducing a public option nationwide (without targeting high-cost areas) would have the most significant effects on areas affected by targeting. But a public option would still be a choice in areas that would not otherwise be affected; for example, areas that would be exempt under a targeting policy would experience some cost-reducing effects. Capping rates everywhere would also have its primary effects on the targeted areas, but all providers would be affected; providers that negotiated payment rates above the level of Medicare plus a multiple would have rates reduced regardless of whether they are in the targeted areas or elsewhere. The policy would have the same effect of having the largest effects on the areas that would otherwise be affected under a targeting policy.

Applying targeting policies more broadly would still have the most effect in areas that we would target but also yield benefits elsewhere. Nonetheless, targeting is politically advantageous because fewer markets are affected, and those that are affected are at the heart of the cost problem. Thus, there is a clear political attraction to limiting the use of rate-setting policies in a targeted way.

# Appendix A. Insurer and Provider Participation and Rate Data by Rating Area

We used the following three variables to measure market competition:

1. ***Number of insurers as of 2024***. We used dummy variables for the number of insurers participating in a region, with five or more insurers as the omitted category. This variable ranged from 1 to 10, with a median value of 4.
2. ***Insurer type as of 2024***. We used dummy variables to indicate whether at least one insurer in the rating area was one of six types. We defined Blue Cross insurers as members of the Blue Cross Blue Shield Association. Consumer Operated and Oriented Plans, or CO-OPs, established under the Affordable Care Act (ACA), include nonprofit, member-controlled health insurance plans with ACA-compliant policies in the individual and small markets.[5] In 2021, three CO-OPs were present in five states. Medicaid insurers are those that offered Medicaid managed care plans before the creation of the Marketplaces in 2014. Regional insurers are commercial insurers that participate in a specific state or geographic region across several states. National insurers are commercial insurers that participate across the nation. Finally, provider-sponsored insurers are insurers directly associated with a hospital system.
3. ***Hospital concentration as of 2018***. We used a continuous variable to control for hospital concentration by computing HHI at the rating area level. We computed this HHI using annual

survey data from the American Hospital Association. Higher market concentration results in greater difficulty for insurers in negotiating lower provider payment rates, implying that a higher HHI, signifying greater concentration, should result in higher premiums, all else being equal. This variable ranged from 0 to 10,000, with a median value of 2,563.

We used the following seven variables that characterize state policies and additional controls:

1. ***State expansion of Medicaid by 2024***. This dummy variable equaled 1 if the rating area was in a state that expanded and implemented Medicaid eligibility under the ACA by 2024 for all residents with incomes up to 138 percent of the federal poverty level. As of the 2024 plan year, 40 states and the District of Columbia had expanded Medicaid.
2. ***Reinsurance***. This dummy variable equaled 1 if the state was one of 17 states that had a reinsurance program in 2024.
3. ***State-based Marketplace***. This dummy variable equaled 1 if the state was one of 19 states that ran its own Marketplace in 2024.
4. ***Area wage index***. We controlled for area wages because areas with higher labor costs were expected to have higher premiums, given that medical care is a labor-intensive good. We calculated this index at the rating area level for 2023. The index ranged from 0.66 to 1.89, and the median value was 0.89.
5. ***Urban area***. This dummy variable equaled 1 if the majority of rating area residents lived in counties classified as urban by the University of Iowa Center for Rural Health Policy Analysis.[6]
6. ***Community-rated***. Two states have community-rated Marketplace premiums: New York and Vermont.
7. ***Census region***. We used these dummy variables to control for geographic variation. The Midwest was the omitted category.

Rating area names were based on metropolitan statistical area. If no counties in the rating area are in an MSA, the rating region is referred to as a rural part of the state.

# Notes

[1] E. Wager, M. McGough, S. Rakshit, K. Amin, and C. Cox, "How Does Health Spending in the U.S. Compare to Other Countries?," Peterson-KFF Health System Tracker, January 23, 2024. Accessed February 8, 2024. https://www.healthsystemtracker.org/chart-collection/health-spending-u-s-compare-countries/.

[2] Urban Institute analysis of Bureau of Economic Analysis, National GDP and Personal Income, https://www.bea.gov/itable/national-gdp-and-personal-income; Congressional Budget Office, *CBO's Current View of the Economy from 2023 to 2025* (Washington, DC: CBO, 2023), https://www.cbo.gov/publication/59837; Bureau of Labor Statistics, Consumer Price Index Databases, https://www.bls.gov/cpi/data.htm; and Agency for Healthcare Research and Quality, Chartbook 27: Medical Expenditure Panel Survey Insurance Component 2022, https://meps.ahrq.gov/data_files/publications/cb27/cb27.shtml.

[3] State premiums are the average of rating area premiums weighted by the population of the rating area.

[4] Premiums in West Los Angeles are similar to those in East Los Angeles.

[5] "Consumer Operated and Oriented Plan (CO-OP)," healthinsurance.org, accessed March 22, 2024, https://www.healthinsurance.org/glossary/consumer-operated-and-oriented-plan/.

[6] "Health Insurance Marketplace Rating Areas," University of Iowa Center for Rural Health Policy Analysis, https://rupri.public-health.uiowa.edu/publications/policybriefs/2014/premiums/.

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Holahan has conducted significant work on Medicaid and Medicare reform, including analyses on the recent growth in Medicaid expenditures, the implications of block grants and swap proposals on states and the federal government, and how state decisions to expand Medicaid in the ACA affect federal and state spending. Recent work on Medicare includes a paper on reforms that could both

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# Acknowledgments

This report was supported by Arnold Ventures. We are grateful to them and to all our funders, who make it possible for Urban to advance its mission.

The views expressed are those of the authors and should not be attributed to the Urban Institute, its trustees, or its funders. Funders do not determine research findings or the insights and recommendations of Urban experts. Further information on the Urban Institute's funding principles is available at urban.org/fundingprinciples.

The authors are grateful to Michael Simpson and Fred Blavin for their helpful comments.


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