



How Do Marketplace Premiums Compare with Premiums in the Large- and Small-Group Markets?

John Holahan and Erik Wengle

July 2024

The Affordable Care Act (ACA) has been criticized on many grounds, including the high cost of premiums available in the Marketplace, despite limited evidence that premiums are high (Holahan, O'Brien, and Wengle 2024). Full Marketplace premiums are important even though many people receive subsidies; they pay a percentage of income for the benchmark silver premium plan. Government tax subsidies pay the difference. Although subsidized households are protected, the federal government is not; federal payments will vary with the size of premiums, as will premiums for unsubsidized households. Thus, the full premium determines the government cost and the full cost for individuals not eligible for subsidies. Full premiums determine the benchmark to which subsidies are tied, and individuals pay the full marginal cost of higher-than-benchmark premiums. Premium tax credits only limit individuals' premiums to a percent of income for the benchmark plan. They must pay more for more expensive plans. Insurers thus face considerable incentives to keep premiums low to compete for market share. In this brief, we address whether this competition results in lower premiums in the Marketplace compared with large-group and small-group premiums and explore whether the incentives in the Marketplace result in more efficient outcomes than seen in the commercial market.

We compare average Marketplace benchmark premiums before applicable ACA tax credits with premiums in the large and small employer markets. In a previous paper, we compared Marketplace

premiums with premiums in the employer market for 2016 (Blumberg, Holahan, and Wengle 2016). We adjusted for the fact that employer-sponsored plans typically had actuarial values (AV) greater than 70 percent. In addition, utilization of services by enrollees in employer-sponsored insurance (ESI) tends to be higher than for nongroup enrollees, primarily because of lower cost-sharing levels. The population in employer-sponsored plans also tends to be younger than those enrolling in Marketplace plans. After adjusting for these factors, we found that Marketplace premiums were about 10 percent below premiums for ESI on average. Average Marketplace premiums were lower in 39 of 50 states. We now update these results for 2022 data and disaggregate the small- and large-group markets. Making similar adjustments for comparability, we find that average silver Marketplace premiums are now, on average, 23 percent below premiums in the small-group market and 15 percent below premiums in the large-group market.

Below, we describe the data sources used in this paper and the various adjustments made.

Data and Methods

We measure single (worker-only) employer premiums using the state averages provided in the Medical Expenditure Panel Survey Insurance Component published data tables for 2022 for employer sizes below 50 employees (small-group estimates) and over 50 employees (large-group estimates).¹ We use these premiums as a comparison with Marketplace nongroup premiums for our analysis. We compare average silver premiums to ESI to compare an average to another average. Our measure of nongroup premiums relies, at its core, on the average silver premium for single coverage in each rating area of the country. We choose silver because the majority of Marketplace enrollees have selected silver plans (Holahan, Wengle, and O'Brien, 2023); thus, with the adjustments we discuss below, it seems the most appropriate for comparisons to ESI premiums.

We obtain 2022 Marketplace nongroup premiums for a single 50-year-old in each ACA rating area from the RWJF HIX Compare dataset. We then calculate the premium for a 40-year-old using the federal default age curve and relevant state-specific curves where appropriate. State silver premium averages are computed as population-weighted averages of every silver plan in each rating area within that state. Consistent with the March 2022 Current Population Survey (and Urban Institute's coverage edits), we compute the average nongroup Marketplace silver premium for single coverage, using state-specific premium age curves and assuming the age distribution of enrollees is identical to that for adult (18 and older) ESI enrollees (workers and adult dependents) nationwide. This adjustment to an ESI-consistent age distribution increases Marketplace premiums by an average of 5.6 percent for states using the federal age curve, with smaller adjustments for states with non-standard age curves. This is an increase relative to 2016 because Marketplace enrollees became younger and the ESI population somewhat older (Holahan et al. 2017).²

We then adjust this 2022 nongroup single-premium measure upward to account for ESI having lower cost-sharing requirements (i.e., higher AV), on average, than a silver plan (70 percent AV). According to an analysis of 2021 data, large employer plans had an average AV of 83 percent (Fronstin

et al. 2021). Therefore, we multiply each nongroup premium measure in our study by 1.186 ($83 \div 70$) to consider that nongroup premiums can be expected to be lower than employer premiums because they have a lower AV on average.). For the small group comparison, we multiply each nongroup premium by a state-specific average AV ($X/70$) or ($X/80$) as published by the Centers for Medicare & Medicaid Services.³

We make an additional upward adjustment in our nongroup premium measure to consider that those with higher AV insurance plans tend to use more health care services. The Centers for Medicare & Medicaid Services produced induced-demand adjustment factors for the ACA's risk adjustment methodology; we use their relative adjustment factors for gold- (80 percent AV) and silver-level coverage to compute this adjustment. The centers' adjustment factors are 1.08 for gold coverage and 1.03 for silver coverage, and, as such, we adjust our nongroup premium measure by 1.0485 ($1.08 \div 1.03$) to approximate the utilization difference between average employer coverage and nongroup silver coverage (Pope et al. 2014).

We reduce our nongroup comparison premium by 19 percent on average to adjust for the cost-sharing reductions incorporated into the silver Marketplace premiums (Levitt, Cox, and Claxton 2017). We apply an adjustment of 21 percent to states that have not expanded Medicaid and 15 percent for states that have expanded Medicaid, consistent with Kaiser Family Foundation estimates.⁴ This adjustment is necessary because ESI is not required to subsidize cost sharing. This adjustment allows us to approximate nongroup premiums if there were no cost-sharing reductions. The 19 percent is an approximation. There are several reasons why actual state adjustments would differ. At least three states (New Mexico, Texas, and Pennsylvania) have specific rules about how much silver premiums should be increased. There are also differences because the share of Marketplace enrollees in each income group affects the amount that silver premiums would have to be increased for an insurer to afford to provide the cost-sharing reductions. If a state has more people in the lowest income groups, cost-sharing subsidies are greater; thus, silver loading would be greater and vice versa.⁵ If a state has a Basic Health Program, most individuals would be in higher income groups, and thus, the increase in premiums because of silver loading would be less. If a state had not expanded Medicaid, there would be more enrollees in the lowest income group that received the most generous cost-sharing subsidies, and thus, the impact on premiums of silver loading would be greater.

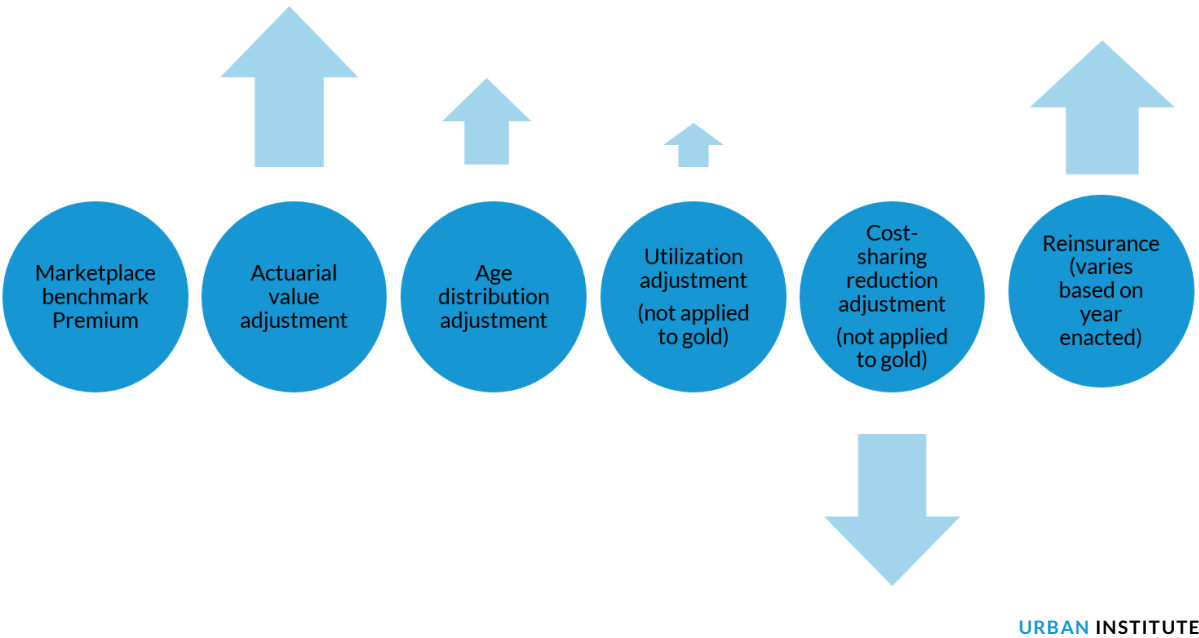
As stated above, we use data from a Kaiser study that estimated the national average impact on silver premiums would be 19 percent; increases would be 15 percent in states that expanded Medicaid and 21 percent in states that had not expanded. The study was based on 2016 data. Since the number of states that have expanded Medicaid has increased, we use only the 15 percent and 21 percent. No more recent estimates by state exist, but we believe our estimates will likely be low in most states. A more recent paper by Matthew Fiedler from the Brookings Institution estimated that the increase would be 24 percent without adjusting for the increased utilization because of expanded premium subsidies and 28 percent without an adjustment (Fiedler 2021).

Finally, we add in an adjustment to account for state reinsurance waivers, which artificially lower premiums. To create this adjustment, we use state-specific factors varying based on the initial year of

implementation consistent with the results found in Oyeka and Wehby’s analysis on the effects of state reinsurance programs on Marketplace premiums (Oyeka and Wehby 2023).

Figure 1 below illustrates the directionality and relative importance of the various adjustments.

FIGURE 1
Effective Adjustments to Make Marketplace Premiums Comparable to ESI (Approximate Magnitudes of Adjustments)



Source: Authors’ analysis.
Notes: ESI = employer-sponsored insurance.

Results

The key result from this analysis is that the difference between Marketplace and ESI premiums was even larger in 2022 than in 2016 since employer premiums have continued to grow faster than those in the nongroup market. For example, the decrease in Marketplace premiums of -2.2 percent between 2019 and 2022 compares with the increase in employer-sponsored plans of 2.9 percent for the same period (Holahan, O’Brien, and Wengle 2024). This difference is continuing. In 2024, Marketplace premium increases averaged 2.4 percent, while premiums for ESI are estimated to have increased in 2024 by 6.6 percent by Mercer (before benefit cuts), 7.0 percent by PricewaterhouseCoopers, and 7.7 percent for federal employees plans.⁶

The results are shown in table 1. We found that when the adjustments described above are made, Marketplace premiums are, on average, 23 percent below premiums in the small-group market and 15 percent below premiums in the large-group market. These differences hold in almost all states. The

exceptions are Alabama, Alaska, Louisiana, Nebraska, New York, Oklahoma, Oregon, South Dakota, Vermont, West Virginia, and Wyoming. New York and Vermont Marketplace premiums are high because the state uses community rating and the average Marketplace age is over 40. The other states tend to have fewer insurers participating and less competitive Marketplaces, resulting in higher Marketplace premiums.

The differences between observed and our adjusted premiums are greater in the small-group than in the large-group markets. Small-group and large-group premiums, as reported, are about the same nationally despite the fact that small-group plans typically have a lower AV. In some states, small-group premiums are less than large-group premiums because of the lower AV. In others, the reverse is true because of various inefficiencies in the small-group market, such as higher administrative costs and less ability to negotiate provider payment rates. When we adjust Marketplace premiums to reflect differences between those premiums and observed ESI premiums, the AV adjustment is typically smaller. This results in a greater difference between the average adjusted Marketplace premium and the actual ESI premium (in most states) in the small- than in the large-group market.

For clarity, here are some examples from the data. In Arizona, observed ESI premiums are about the same for large- and small-group markets, but the AV adjustment for small-group premiums we use is less. Thus, the difference between our estimates and actual ESI premiums is 35 percent in the small-group market and 21 percent in the large-group market. In Georgia, observed small-group ESI premiums are higher than large-group premiums, but the AV adjustment is much less. Thus, the difference between the adjusted Marketplace premiums and the observed ESI premiums is 57 percent in the small-group market and 33 percent in the large-group market. In New Hampshire, observed small-group premiums are considerably larger than large-group premiums, but the adjusted Marketplace premium is smaller in the small-group market, reflecting lower AV. Thus, the difference between the adjusted Marketplace premium and the observed premium is 91 percent in the small-group market and 52 percent in the large-group market.

TABLE 1

Adjusted Benchmark Marketplace Premiums Compared with Large-Group and Small-Group ESI, 2022

	ESI total premium over 50 employees	Benchmark Marketplace adjusted for age, AV, and CSR	Percent difference (silver)	ESI total premium under 50 employees	Benchmark Marketplace adjusted for age, AV, and CSR	Percent difference (silver)
United States	\$7,607	\$6,634	15%	\$7,513	\$6,098	23%
Alabama	\$6,652	\$7,383	-10%	\$7,340	\$6,902	6%
Alaska	\$8,441	\$13,579	-38%	\$9,424	\$12,041	-22%
Arizona	\$7,227	\$5,951	21%	\$7,140	\$5,299	35%
Arkansas	\$6,809	\$5,607	21%	\$7,124	\$5,317	34%
California	\$7,453	\$6,406	16%	\$7,921	\$6,020	32%
Colorado	\$7,207	\$6,192	16%	\$6,457	\$5,513	17%
Connecticut	\$8,272	\$7,675	8%	\$8,072	\$6,833	18%
Delaware	\$8,280	\$5,620	47%	\$7,739	\$5,512	40%

	ESI total premium over 50 employees	Benchmark Marketplace adjusted for age, AV, and CSR	Percent difference (silver)	ESI total premium under 50 employees	Benchmark Marketplace adjusted for age, AV, and CSR	Percent difference (silver)
District of Columbia	\$8,820	\$8,747	1%	\$7,865	\$8,156	-4%
Florida	\$7,661	\$6,690	15%	\$6,818	\$6,206	10%
Georgia	\$7,289	\$5,478	33%	\$7,801	\$4,976	57%
Hawaii	\$7,190	\$6,510	10%	\$7,789	\$6,957	12%
Idaho	\$7,585	\$6,718	13%	\$6,503	\$5,981	9%
Illinois	\$7,415	\$6,343	17%	\$8,098	\$6,075	33%
Indiana	\$7,680	\$5,826	32%	\$7,053	\$5,229	35%
Iowa	\$7,565	\$6,638	14%	\$6,865	\$5,726	20%
Kansas	\$7,035	\$6,527	8%	\$6,286	\$6,032	4%
Kentucky	\$7,024	\$6,253	12%	\$6,779	\$5,756	18%
Louisiana	\$7,471	\$8,702	-14%	\$7,277	\$8,115	-10%
Maine	\$8,128	\$7,200	13%	\$7,553	\$6,151	23%
Maryland	\$8,076	\$5,860	38%	\$7,591	\$5,302	43%
Massachusetts	\$7,894	\$6,145	28%	\$8,903	\$5,686	57%
Michigan	\$7,268	\$5,543	31%	\$7,313	\$5,303	38%
Minnesota	\$7,624	\$6,523	17%	\$7,045	\$5,871	20%
Mississippi	\$6,938	\$6,004	16%	\$5,986	\$5,591	7%
Missouri	\$7,787	\$6,698	16%	\$7,471	\$6,077	23%
Montana	\$7,957	\$7,855	1%	\$7,309	\$6,880	6%
Nebraska	\$7,681	\$8,844	-13%	\$7,139	\$7,736	-8%
Nevada	\$6,930	\$5,885	18%	\$6,384	\$5,382	19%
New Hampshire	\$7,839	\$5,163	52%	\$8,829	\$4,615	91%
New Jersey	\$8,394	\$8,234	2%	\$7,290	\$7,490	-3%
New Mexico	\$7,880	\$5,997	31%	\$7,499	\$5,621	33%
New York	\$8,939	\$9,600	-7%	\$8,924	\$8,871	1%
North Carolina	\$7,769	\$7,339	6%	\$7,674	\$6,632	16%
North Dakota	\$7,976	\$7,473	7%	\$7,464	\$7,365	1%
Ohio	\$7,761	\$6,243	24%	\$7,656	\$5,649	36%
Oklahoma	\$6,871	\$7,095	-3%	\$6,312	\$6,642	-5%
Oregon	\$7,150	\$8,848	-19%	\$6,911	\$8,219	-16%
Pennsylvania	\$8,107	\$7,014	16%	\$8,062	\$6,583	22%
Rhode Island	\$8,194	\$6,334	29%	\$8,286	\$6,334	31%
South Carolina	\$7,154	\$6,334	13%	\$7,932	\$5,640	41%
South Dakota	\$7,761	\$7,845	-1%	\$7,304	\$6,512	12%
Tennessee	\$7,274	\$6,331	15%	\$6,668	\$5,622	19%
Texas	\$7,373	\$6,220	19%	\$7,244	\$5,628	29%
Utah	\$6,804	\$6,548	4%	\$6,430	\$5,854	10%
Vermont	\$8,582	\$9,654	-11%	\$7,761	\$8,863	-12%
Virginia	\$7,634	\$6,610	15%	\$7,860	\$6,243	26%
Washington	\$7,331	\$5,905	24%	\$6,647	\$5,464	22%
West Virginia	\$7,887	\$11,076	-29%	\$9,013	\$10,102	-11%
Wisconsin	\$7,745	\$7,469	4%	\$7,379	\$6,911	7%
Wyoming	\$7,555	\$9,546	-21%	\$8,871	\$8,569	4%

Source: MEPS-IC and authors' analysis.

Notes: ESI = employer-sponsored insurance; AV = actuarial value; CSR = cost-sharing reduction.

Discussion

Why are Marketplace premiums lower than premiums in employer-sponsored plans? The differences should not be because of the factors we have adjusted for: differences in AV of plans, the impact of cost sharing on utilization, and age, though these adjustments could be imperfect. There could be unmeasured health status differences, but this would be an unlikely cause because the higher-income working population should typically be in better health than those with lower incomes. We also used average Marketplace premiums. Enrollees tend to gravitate to plans with premiums at or near the benchmark, i.e., the second-lowest-cost silver plan (Holahan et al. 2023). Thus, if anything, our comparisons should be understating differences.

The more likely explanation for Marketplace premiums being lower is the substantially higher payment rates and breadth of provider networks in commercial markets than in Marketplaces, Medicare, and Medicaid. Considerable research has shown the magnitude of these differences. Previous Urban Institute research has shown that provider payment rates in the more competitive Marketplaces approximate those in Medicare (Blumberg et al. 2020). Lower premiums on the Marketplace could also increase the appeal of individual coverage Health Reimbursement Arrangements, which permit employers to make tax-excluded payments for employees' coverage in the individual market.⁷ This has been a growing segment of the individual market, with some estimates as high as 3.1 million enrollees by the end of 2023 (Avalere Health 2022).

Marketplace plans have strong incentives to contain costs. Increasingly, more insurers are participating in Marketplace plans, increasing the effect of competition on premiums. The ACA ties premium subsidies to the benchmark premium or second-lowest-cost premium. Insurers have strong incentives to develop products with premiums at or close to the premium of the second-lowest-cost plan. Otherwise, individuals must pay the full marginal cost of higher premiums. Insurers keep Marketplace premiums low by aggressively negotiating payment rates with providers or establishing more narrow networks largely consisting of providers willing to accept lower payment rates. Marketplaces have successfully controlled costs because, compared with employer-sponsored plans, the intense competition results in lower provider payment rates than in the commercial market and, thus, lower premiums.

Notes

¹ Agency for Healthcare Research and Quality, Chartbook 27: Medical Expenditure Panel Survey Insurance Component, accessed May 31, 2024, https://meps.ahrq.gov/data_files/publications.

² "Current Population Survey (CPS)," Census.gov, accessed May 31, 2024, <https://www.census.gov/programs-surveys/cps.html>.

³ Centers for Medicare and Medicaid Services, "2022 Risk Adjustment Summary Tables," accessed June 24, 2024, <https://www.cms.gov/files/document/appendix-2022-benefit-year-risk-adjustment-summary-reporthhs-risk-adjustment-program-state-specific.xls>.

- ⁴ “Estimates: Average ACA Marketplace Premiums for Silver Plans Would Need to Increase by 19% to Compensate for Lack of Funding for Cost-Sharing Subsidies,” KFF, April 6, 2017, <https://www.kff.org/health-costs/press-release/estimates-average-aca-Marketplace-premiums-for-silver-plans-would-need-to-increase-by-19-to-compensate-for-lack-of-funding-for-cost-sharing-subsidies/>.
- ⁵ Silver loading is the term for instructing insurers to build the cost of the cost-sharing reductions into only the silver marketplace premiums, increasing the cost of silver plans and the value of the tax credit, which can be spent on other metal tiers.
- ⁶ “Health Benefit Cost Expected to Rise 5.4% in 2024, Mercer Survey Finds,” Mercer, September 7, 2023, <https://www.mercer.com/en-us/about/newsroom/health-benefit-cost-expected-to-rise-5-4-percent-in-2024/>; “Medical Cost Trend: Behind the Numbers 2024,” PwC, accessed May 31, 2024, <https://www.pwc.com/us/en/industries/health-industries/library/behind-the-numbers.html>; and Molly Weisner, “What’s Driving Rate Hikes for Federal Employee Health Premiums?,” *Federal Times*, November 21, 2023, <https://www.federaltimes.com/management/pay-benefits/health-care/2023/11/21/whats-driving-rate-hikes-for-federal-employee-health-premiums/>.
- ⁷ Maximizing the tax benefit from using an ICHRA generally requires using it to purchase individual market coverage outside the Marketplace. See “Health Reimbursement Arrangements and Other Account-Based Group Health Plans,” *Federal Register* 84 (119), June 20, 2019, <https://www.federalregister.gov/d/2019-12571/p-775>. This coverage is in the same risk pool as Marketplace coverage but is generally not subject to silver loading. See Fiedler 2021.

References

- Avalere Health. 2022. *Impact of Individual Coverage Health Reimbursement Arrangements on Employees with Group Health Coverage*. Washington, DC: Avalere Health.
- Blumberg, Linda J., John Holahan, Stacey McMorro, and Michael Simpson. 2020. *Estimates of the Implications of Public Option and Capped Provider Payment Rate Reforms*. Washington, DC: Urban Institute.
- Blumberg, Linda J., John Holahan, and Erik Wengle. 2016. “Are Nongroup Marketplace Premiums Really High? Not in Comparison with Employer Insurance.” Washington, DC: Urban Institute.
- Fiedler, Matthew. 2021. “The Case for Replacing ‘Silver Loading.’” Washington, DC: Brookings Institution.
- Fronstin, Paul, Stuart Hagen, Olivia Hoppe, and Jake Spiegel. 2021. “The More Things Change, the More They Stay the Same: An Analysis of the Generosity of Employment-Based Health Insurance, 2013–2019.” Washington, DC: Employee Benefit Research Institute.
- Holahan, John, Linda J. Blumberg, Lisa Clemans-Cope, Stacey McMorro, and Erik Wengle. 2017. “The Evidence on Recent Health Care Spending Growth and the Impact of the Affordable Care Act.” Washington, DC: Urban Institute.
- Holahan, John, Claire O'Brien, and Erik Wengle. 2024. *Targeting Highly Concentrated Insurer and Provider Markets for Rate Regulation*. Washington, DC: Urban Institute.
- Holahan, John, Erik Wengle, and Claire O'Brien. 2023. “How Do People Make Choices among Marketplace Plans?.” Washington, DC: Urban Institute.
- Levitt, Larry, Cynthia Cox, and Gary Claxton. 2017. “The Effects of Ending the Affordable Care Act’s Cost-Sharing Reduction Payments.” Menlo Park, CA: KFF.
- Pope, Gregory C., Henry Bachofer, Andrew Pearlman, John Kautter, Elizabeth Hunter, Daniel Miller, and Patricia Keenan. 2014. “Risk Transfer Formula for Individual and Small Group Markets Under the Affordable Care Act.” *Medicare & Medicaid Research Review* 4 (3).
- Oyeka, Onyinye, and George L. Wehby. 2023. “Effects of State Reinsurance Programs on Health Insurance Exchange Premiums and Insurer Participation.” *Health Services Research* 2023 58 (5): 1077–1088. <https://doi.org/10.1111/1475-6773.14205>.

About the Authors

John Holahan is an Institute fellow in the Health Policy Center at the Urban Institute, where he previously served as center director for over 30 years. His recent work focuses on health reform, the uninsured, and health expenditure growth, developing proposals for health system reform, most recently in Massachusetts. He examines the coverage, costs, and economic impact of the Affordable Care Act (ACA), including the costs of Medicaid expansion and the macroeconomic effects of the law. Holahan has also analyzed the health status of Medicaid and exchange enrollees and the implications for costs and exchange premiums. He has written on competition in insurer and provider markets and implications for premiums and government subsidy costs as well as on the cost-containment provisions of the ACA.

Holahan has conducted significant work on Medicaid and Medicare reform, including analyses on the recent growth in Medicaid expenditures, implications of block grants and swap proposals on states and the federal government, and the effect of state decisions to expand Medicaid in the ACA on federal and state spending. Recent work on Medicare includes a paper on reforms that could both reduce budgetary impacts and improve the structure of the program. His work on the uninsured explores reasons for the growth in the uninsured over time and the effects of proposals to expand health insurance coverage on the number of uninsured and the cost to federal and state governments.

Erik Wengle is a former research analyst in the Health Policy Center using both quantitative and qualitative analysis in the monitoring of the Affordable Care Act Marketplaces and private health insurance. His research to date has focused primarily on the implementation of the Affordable Care Act and the outlook of the health insurance Marketplaces and health reform at large. Additionally, Wengle has written extensively on the competition and market dynamics of the health insurance Marketplaces and its interactions with private health insurance more broadly. He has analyzed various health reform proposals both actively under legislative construction and theoretical. Wengle graduated from the University of Maryland with a BS in environmental science and policy.

Acknowledgments

This brief was conducted with support from 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, Jason Levitis, and Cori Uccello for their insightful comments.



500 L'Enfant Plaza SW
Washington, DC 20024
www.urban.org

ABOUT THE URBAN INSTITUTE

The Urban Institute is a nonprofit research organization that provides data and evidence to help advance upward mobility and equity. We are a trusted source for changemakers who seek to strengthen decision making, create inclusive economic growth, and improve the well-being of families and communities. For more than 50 years, Urban has delivered facts that inspire solutions—and this remains our charge today.

Copyright © July 2024. Urban Institute. Permission is granted for reproduction of this file, with attribution to the Urban Institute.