Marketplace Premiums in 2025

Insurer and Provider Concentration Contributes to Wide Variation in Rates

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June 2025

The nongroup Marketplaces set up under the Affordable Care Act (ACA) have become an important source of health insurance for Americans. More than 24 million people selected coverage for 2025, most of them taking advantage of tax credits to make coverage more affordable. Premiums in the Marketplace vary by state and area; although premiums are high in some places, they have grown at about the same rate as health spending overall since 2014, when ACA Marketplace coverage started. Since 2019, premiums have grown at a slower rate than overall spending. A policy of provider rate caps (or a public option) could lower premiums further, especially in states and areas with low competition and higher spending.

Critics of the Affordable Care Act (ACA) have argued that Marketplace premiums are unaffordable.[1] An analysis by the Peterson Center on Healthcare and KFF estimated that the median Marketplace premium would increase by 7 percent in 2025.[2] (This paper uses actual 2025 benchmark premiums rather than this projection). Most of this sizable increase is due to growth in health care prices. The authors of that analysis cited the introduction of weight loss and other specialty drugs as one factor driving the increase in health insurance premiums. In our previous work, we found that premiums have been well contained in competitive markets, though significantly less so in markets with less insurer or hospital market competition (Holahan, O'Brien, and Wengle 2024). Another reason that premiums are largely well-contained is the high deductibles associated with silver and bronze plans, which often make care under ACA plans unaffordable (Holahan, Simpson, and Wengle 2025).

In this paper, we update the previous analysis of Marketplace premiums (Holahan, O'Brien, and Wengle 2024). We report premium increases for 2025 and compare them to previous-year increases, showing the variation in benchmark premiums across states and rating areas in the United States. We then present the results of a regression analysis that identified factors correlated with variation in benchmark premiums. Detailed data on five high-cost and five low-cost markets illustrate how competition and other factors affect Marketplace premiums. Finally, we suggest strategies for targeting either a public option or a capped rate strategy to help contain premiums in high-cost areas.

Premium Increases in 2025

Table 1 shows that the average Marketplace benchmark premium rose from $473 in 2024 to $500 in 2025, an increase of 5.8 percent.[3] This followed an increase of 4.2 percent from 2023 to 2024. In previous years, annual premium increases were relatively flat, with average national growth of −0.7 percent between 2019 and 2023. In general, Marketplace premiums have been well contained. For example, in previous research, we showed that employer-sponsored insurance premiums exceeded Marketplace premiums by 23 percent in the small-group market and 15 percent in the large-group market, after accounting for differences in actuarial value, age, and the inclusion of cost-sharing subsidies for low-income individuals in premiums (Holahan and Wengle 2024).

TABLE 1

Average Monthly Benchmark Premium for a 40-Year-Old Nonsmoker and Average Annual Change, by State, 2019–25

	Monthly Benchmark Premium				Average Annual Change		
	2019	2023	2024	2025	2019–23	2023–24	2024–25
US average	**$468**	**$454**	**$473**	**$500**	**−0.7%**	**4.2%**	**5.8%**
Vermont*	$517	$841	$950	$1,277	14.3%	12.9%	34.4%
Alaska	$714	$760	$886	$1,050	1.7%	16.5%	18.6%
West Virginia	$585	$835	$854	$920	9.4%	2.3%	7.8%
Wyoming	$860	$802	$818	$868	−1.5%	1.9%	6.1%
New York*	$572	$621	$731	$789	2.1%	17.6%	7.9%
Connecticut	$472	$623	$657	$690	7.5%	5.4%	4.9%
Nebraska	$825	$545	$568	$592	−9.6%	4.2%	4.2%
DC	$393	$428	$532	$578	2.4%	24.2%	8.6%
South Dakota	$526	$591	$571	$575	3.0%	−3.3%	0.7%
Maine	$530	$458	$516	$550	−3.3%	12.8%	6.6%
Montana	$553	$468	$499	$546	−3.9%	6.8%	9.3%
Utah	$540	$468	$499	$544	−3.4%	6.7%	8.9%
Delaware	$685	$549	$533	$534	−4.9%	−3.0%	0.2%
Alabama	$544	$562	$557	$532	0.9%	−1.0%	−4.5%
New Mexico	$366	$449	$477	$520	5.7%	6.0%	9.1%
Louisiana	$461	$552	$553	$518	4.8%	0.2%	−6.2%
Tennessee	$545	$474	$502	$517	−3.3%	6.0%	3.0%
Florida	$485	$474	$491	$516	−0.6%	3.8%	5.0%
California	$447	$427	$465	$509	−1.1%	8.7%	9.5%
Kansas	$527	$465	$482	$506	−3.0%	3.7%	5.0%
Georgia	$457	$402	$453	$500	−2.8%	12.7%	10.3%
Oregon	$433	$454	$480	$499	1.2%	5.7%	3.9%
North Carolina	$609	$503	$491	$499	−4.5%	−2.3%	1.4%
Hawaii	$503	$471	$470	$494	−1.5%	−0.4%	5.3%
Pennsylvania	$458	$450	$463	$492	−0.3%	2.7%	6.3%

	Monthly Benchmark Premium				Average Annual Change		
	2019	**2023**	**2024**	**2025**	**2019–23**	**2023–24**	**2024–25**
Missouri	$490	$476	$502	$488	−0.6%	5.5%	−2.8%
New Jersey	$348	$453	$474	$488	7.0%	4.6%	3.0%
Mississippi	$522	$468	$486	$486	−2.6%	3.8%	0.0%
Texas	$419	$455	$475	$485	2.1%	4.4%	2.2%
Wisconsin	$519	$445	$464	$484	−3.6%	4.1%	4.3%
North Dakota	$396	$421	$438	$480	2.8%	4.1%	9.4%
Illinois	$473	$453	$472	$476	−0.9%	4.0%	0.8%
South Carolina	$557	$498	$499	$474	−2.4%	0.2%	−4.9%
Oklahoma	$661	$469	$486	$470	−7.9%	3.7%	−3.3%
Colorado	$496	$351	$440	$460	−7.7%	25.2%	4.7%
Arkansas	$380	$416	$427	$458	2.4%	2.8%	7.1%
Massachusetts	$330	$415	$425	$449	5.9%	2.4%	5.7%
Kentucky	$432	$426	$437	$446	−0.1%	2.6%	2.1%
Ohio	$366	$412	$432	$439	3.1%	5.0%	1.5%
Idaho	$485	$419	$417	$437	−3.4%	−0.6%	4.8%
Washington	$380	$386	$403	$434	0.4%	4.4%	7.7%
Rhode Island	$336	$379	$400	$425	3.1%	5.5%	6.2%
Nevada	$413	$388	$391	$419	−1.4%	0.7%	7.1%
Iowa	$731	$469	$445	$410	−9.7%	−5.0%	−7.9%
Arizona	$463	$400	$398	$403	−3.5%	−0.3%	1.2%
Michigan	$373	$353	$373	$394	−1.3%	5.5%	5.8%
Indiana	$338	$395	$400	$383	4.2%	1.3%	−4.3%
Virginia	$557	$367	$372	$374	−9.7%	1.4%	0.3%
Maryland	$419	$333	$346	$365	−5.4%	3.8%	5.7%
Minnesota	$333	$331	$343	$361	−0.1%	3.5%	5.2%
New Hampshire	$402	$323	$335	$324	−5.0%	3.9%	−3.3%

Source: Urban Institute analysis of data from HealthCare.gov and relevant state-based Marketplace websites.
Note: The benchmark premium is the second-lowest silver premium in each rating area in the state. Average premiums are weighted by rating area population. * indicates premiums for Vermont and New York, which have community rating and therefore are not strictly comparable to other states.

The 4.2 and 5.8 percent increases in Marketplace premiums in 2024 and 2025, respectively, are comparable to the 5.2 percent increase in gross domestic product (GDP) in 2024.[4] In the same year, the consumer price index (CPI-U) increased by 2.9 percent, and national health expenditures (NHE) increased by an estimated 5.2 percent. In 2025, the CPI-U is projected to grow by 2.2 percent and NHE by 4.9 percent.[5] But in the years prior to 2024, GDP, NHE, and the CPI-U increased by substantially higher rates while Marketplace premiums were barely increasing.[6] So, the growth in premiums in 2024 and 2025 could signal that premiums are catching up with changes occurring elsewhere in the economy, particularly in the health sector.

Premium Variation across States

Table 1 shows considerable variation in monthly premiums across states. In 2025, the average monthly premium in the US was $500. Twenty-one states had premiums that were equal to or higher than the national average. Vermont, Alaska, West Virginia, Wyoming, New York, Connecticut, and Nebraska had the highest premiums. Premiums in Vermont and New York were among the highest, primarily because those states use community rating, in which premiums are based only on the average risk within a geographic area rather than the insured's age.[7] Premiums in other states increase with age, reflecting increasing health care spending as people age. For that reason, community-rated premiums are not strictly comparable to the other premiums shown in Table 1, which are based on a 40-year-old nonsmoker. In most states, the premium for a 40-year-old is about 43 percent of that for a 64-year-old. Community rating increases the premiums paid by relatively younger people, including 40-year-olds. The high premiums in Alaska, West Virginia, Wyoming, and Nebraska likely reflect the rural nature and sparse populations of these states.

At the other end of the spectrum, 30 states had premiums below the national average. New Hampshire, Minnesota, Maryland, Virginia, Indiana, Michigan, and Arizona had the lowest premiums. Their low premiums reflect many factors. As we show below, premiums are lower when a market has many competing insurers and less hospital concentration. Premiums are also lower in markets that offer plans that participate in Medicaid or have provider-sponsored plans. In general, the populations of these states are more urban.

Table 2 shows the rating areas with the highest benchmark premiums. The highest premiums were in the three rating areas of Alaska, where monthly premiums exceeded $1,000. Premiums were also between $900 and $1,000 in most areas of West Virginia, even in urbanized areas, such as Charleston and Morgantown. The rural parts of most states, such as Florida and Illinois, also had very high premiums. The three rating areas of Wyoming had premiums between $800 and $900.

TABLE 2

The 20 Rating Areas with the Highest Monthly Benchmark Premiums

State	Rating Area Number	Rating Area Name	Monthly Benchmark Premium
Alaska	2	Rural Alaska	$1,076
Alaska	3	Rural Alaska	$1,048
Alaska	1	Anchorage, AK	$1,023
West Virginia	5	Huntington-Ashland, WV-KY-OH	$1,006
West Virginia	10	Parkersburg-Vienna, WV	$992
West Virginia	2	Charleston, WV	$937
West Virginia	3	Rural West Virginia	$937
West Virginia	4	Beckley, WV	$937
West Virginia	1	Rural West Virginia	$937
West Virginia	8	Morgantown, WV	$913
West Virginia	9	Morgantown, WV	$913
Florida	44	Rural Florida	$906
Illinois	13	Rural Illinois	$888
West Virginia	11	Wheeling, WV	$888
Florida	23	Rural Florida	$884
Wyoming	3	Rural Wyoming	$882
Wyoming	1	Casper, WY	$858
Wyoming	2	Cheyenne, WY	$821
West Virginia	6	Martinsburg, WV	$809
West Virginia	7	Keyser, WV	$809

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

Table 3 shows the rating areas with the lowest monthly premiums, all at or below $371. In general, these were in urban areas, such as Louisville, Kentucky; Detroit, Michigan; the Maryland and Virginia suburbs of Washington, DC; Philadelphia, Pennsylvania; Baltimore, Maryland; and Tucson and Phoenix, Arizona. Unlike in Table 2, several rural areas also had quite low premiums. These were in Maryland, Minnesota, Michigan, Indiana, Illinois, and Georgia. Premiums were the same in all areas of Maryland because the lowest-cost premiums were offered by Kaiser, which maintained the same prices across all markets in the state.

TABLE 3

The 20 Rating Areas with the Lowest Monthly Benchmark Premiums

State	Rating Area Number	Rating Area Name	Monthly Benchmark Premium
Indiana	16	Louisville/Jefferson County, KY-IN	$307
Minnesota	8	Rural Minnesota	$315
New Hampshire	1	Whole state of New Hampshire	$324
Michigan	2	Detroit-Warren-Dearborn, MI	$335
Michigan	5	Rural Michigan	$346
Virginia	10	Washington-Arlington-Alexandria, DC-VA-MD-WV	$357
Michigan	1	Rural Michigan	$360
Indiana	12	Columbus, IN	$361
Michigan	4	Rural Michigan	$362
Pennsylvania	8	Philadelphia-Camden-Wilmington, PA-NJ-DE-MD	$363
Indiana	15	Rural Indiana	$364
Arizona	6	Tucson, AZ	$365
Maryland	4	Rural Maryland	$365
Maryland	2	Rural Maryland	$365
Maryland	3	Washington-Arlington-Alexandria, DC-VA-MD-WV	$365
Maryland	1	Baltimore-Columbia-Towson, MD	$365
Illinois	4	Rural Illinois	$369
Virginia	9	Virginia Beach-Norfolk-Newport News, VA-NC	$369
Georgia	10	Rural Georgia	$370
Arizona	4	Phoenix-Mesa-Scottsdale, AZ	$371

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

Table 4 provides more detail on high-premium areas. Rating areas are divided into rural, small urban, and large urban areas. The table shows that premiums in rural and small urban areas tend to be higher than those in large urban areas, as we discuss later. Premiums in the most expensive 20 large urban areas ranged from $527 to $722. Large urban areas with the highest premiums include San Francisco, Sacramento, and San Jose, California; Hartford, Connecticut; Jacksonville, Orlando, and Miami, Florida; and the District of Columbia. Premiums in the top 20 small urban areas ranged from $691 to $1,023. The small urban areas with the highest premiums include Anchorage, Alaska; Huntington, Parkersburg, Charleston, and Morgantown, West Virginia; Casper and Cheyenne, Wyoming; Bridgeport, Connecticut; Rapid City, South Dakota; and St. George, Utah. Rural areas with the highest premiums were spread across the US, with prices in the highest 20 ranging from $659 to $1,076. The highest premiums in rural areas were in Alaska, West Virginia, Florida, and several other states.

TABLE 4

The 20 Rating Areas with the Highest Monthly Benchmark Premiums by Rural, Small Urban, and Large Urban Areas

Rural Areas			Small Urban Areas			Large Urban Areas		
Rating area	Rating area name	Monthly benchmark premium	Rating area	Rating area name	Monthly benchmark premium	Rating area	Rating area name	Monthly benchmark premium
AK-2	Rural Alaska	$1,076	AK-1	Anchorage, AK	$1,023	CA-8	San Francisco, CA	$722
AK-3	Rural Alaska	$1,048	WV-5	Huntington, WV-KY-OH	$1,006	CA-5	San Francisco, CA	$702
WV-1	Rural West Virginia	$937	WV-10	Parkersburg, WV	$992	CT-7	Hartford, CT	$687
WV-4	Beckley, WV	$937	WV-2	Charleston, WV	$937	CT-4	Hartford, CT	$687
WV-3	Rural West Virginia	$937	WV-8	Morgantown, WV	$913	CA-4	San Francisco, CA	$667
WV-9	Morgantown, WV	$913	WV-11	Wheeling, WV	$888	GA-4	Atlanta, GA	$646
FL-44	Rural Florida	$906	WY-1	Casper, WY	$858	CA-6	San Francisco, CA	$641
IL-13	Rural Illinois	$888	WY-2	Cheyenne, WY	$821	CT-2	Hartford, CT	$636
FL-23	Rural Florida	$884	WV-6	Martinsburg, WV	$809	FL-45	Jacksonville, FL	$601
WY-3	Rural Wyoming	$882	WV-7	Keyser, WV	$809	CA-3	Sacramento, CA	$601
UT-6	Provo, UT	$765	IL-9	Champaign, IL	$765	DC-1	All of DC	$578
FL-24	Rural Florida	$753	IL-8	Bloomington, IL	$764	CA-7	San Jose, CA	$572
MI-16	Rural Michigan	$749	CT-1	Bridgeport, CT	$744	FL-2	Jacksonville, FL	$563
FL-21	Rural Florida	$743	CA-9	Salinas, CA	$744	IL-11	St. Louis, MO-IL	$550
PA-6	Rural Pennsylvania	$717	SD-1	Rapid City, SD	$738	AL-3	Birmingham, AL	$549
NE-4	Rural Nebraska	$705	FL-63	Lake Butler, FL	$719	FL-58	Jacksonville, FL	$544
CA-1	Rural California	$695	FL-33	Mayo, FL	$719	WI-3	Minneapolis, MN-WI	$542
CT-3	Rural Connecticut	$687	PA-7	Reading, PA	$708	FL-57	Orlando, FL	$530
NV-4	Rural Nevada	$667	UT-5	St. George, UT	$698	GA-3	Atlanta, GA	$528
CO-9	Rural Colorado	$659	PA-9	Harrisburg, PA	$691	FL-50	Miami, FL	$527

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

Explaining Variation in Marketplace Premiums across Rating Areas

Table 5 shows the results of a multivariate regression analysis of the factors correlated with benchmark premiums at the rating area level. We regressed benchmark premiums against the number of insurers participating in the rating area in 2025, the types of insurers participating (e.g., Blue Cross Blue Shield, national commercial insurers, provider-sponsored), a measure of hospital concentration, the area wage index, and other factors. We found that the number of insurers participating was highly significant. Compared with rating areas with five or more insurers, those with only one or two insurers had higher premiums by more than $204. Markets with three and four insurers also had higher premiums than those in more competitive areas.

TABLE 5

Regression Coefficients Associated with Monthly Benchmark Premium in 2025

	Monthly Benchmark Premium, 2025
Types of insurers participating in 2025	
Blue Cross Blue Shield	−5.837
Medicaid	−39.48**
National	28.68***
Provider	−22.49**
Regional/co-op	39.07***
Number of insurers participating in 2025	
One or two	204.3***
Three	58.08***
Four	26.54**
Other factors	
Hospital system Herfindahl-Hirschman Index	0.00434^
Teaching hospital share	38.55^
Area wage index	95.76**
Medicaid expansion status, 2025	−72.12***
Community rated	264.1***
Reinsurance, 2025	−56.58***
State-based Marketplace, 2025	19.28
Small urban area	29.78***
Rural area	61.30***
Census region	
South	3.250
Northeast	14.37
West	63.64***
Constant	367.7***
N	503
R^2	0.427

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

Notes: The benchmark premiums are taken from each rating area. Robust standard errors were used. ** $p < 0.05$; *** $p < 0.01$. For the hospital Herfindahl-Hirschman Index variable, $p = 0.119$; and for the teaching variable, $p = 0.114$ as indicated by ^.

The type of insurer was also highly significant. Medicaid plans—that is, plans in Medicaid that also participate in the exchange—and provider-sponsored plans were both associated with lower Marketplace premiums. Medicaid plans often have narrow networks of providers that have already agreed to accept Medicaid rates. Provider-sponsored plans can have lower premiums, presumably because they control their own provider payment rates. National and local/regional plans have somewhat higher premiums, often because of their broader provider networks.

We used the Herfindahl-Hirschman Index (HHI) at the rating area level to measure hospital concentration. The results showed that it was not quite statistically significantly related to premiums ($p = 0.119$)—the more concentration, the higher the premiums. Many of the areas with high HHIs were located in small urban and rural areas. Large urban areas have many hospitals and less concentration. But these areas often have teaching hospitals, which have substantial market power. Insurers generally believe they must have these hospitals in their networks and therefore are willing to pay higher payment rates. We found that the teaching hospital variable was not significant ($p = 0.114$), possibly because of the high correlation between several other variables in the regression.

The area wage index was significant, indicating, not unsurprisingly, that areas with higher wages have higher premiums. States that had expanded their Medicaid program had lower premiums because the lowest income group—those earning between 100 and 133 percent of the federal poverty level—would be covered under Medicaid rather than the Marketplaces. Since health status is usually inversely related to income, these results reflect the healthier Marketplace-insured populations in expansion states. The use of community rating in New York and Vermont was associated with substantially higher premiums for 40-year-olds, by $264; as noted earlier, the community-rated premiums at age 40 reflect the costs of a somewhat older population. States with reinsurance had lower premiums, as reinsurance policies absorb some of the risk, reducing the need for insurers to incorporate that risk into their premiums. The existence of a state-based Marketplace was not significantly related to premiums. Rating areas in the West had higher premiums than other regions. After controlling for all of these factors, urban areas still had lower premiums than rural areas.

Low- and High-Cost Rating Areas

LOW-COST MARKETS

Table 6 presents premium data from several areas with 2025 premiums below the national average. Several common features are apparent, but there are also some exceptions. Premiums tended to be low in markets that had several competitors as well as one or more plans that began as Medicaid managed care plans. Blue Cross and commercial plans frequently offer narrower network products that are more competitive. But other commercial plans have relatively high premiums, perhaps because they offer broader networks. In competitive markets, premiums are frequently below the average for the state as well as the nation. (Note that we used the lowest-premium insurer in each area, not the benchmark, because of the difficulty of identifying the second-lowest-cost plan if it was offered by the same insurer as the lowest-cost plan.)

TABLE 6

Lowest Silver Monthly Premiums for a 40-Year-Old and Percentage Change from 2019 to 2024, by Insurer in Selected Low-Cost Markets

	Lowest Silver Monthly Premium				Percentage Change		
Insurer	**2019**	**2023**	**2024**	**2025**	**2023–24**	**2024–25**	**Average annual change, 2019–25**
East Los Angeles, California (rating area 15)							
Anthem	N/A	$335	$374	$422	11.5%	12.9%	N/A
Blue Shield of California	$346	$369	$423	$457	14.7%	8.2%	5.0%
Health Net^	$337	$359	$385	$407	7.3%	5.9%	3.3%
Kaiser Permanente	$404	$386	$411	$434	6.3%	5.7%	1.3%
LA Care Health Plan^	$338	$317	$336	$354	6.0%	5.3%	0.9%
Molina Healthcare^	$391	$387	$410	$436	5.8%	6.3%	1.9%
Oscar	$443	$454	N/A	N/A	N/A	N/A	N/A
Percentage change in lowest option available					6.0%	5.3%	0.9%
California average (all areas)	$414	$412	$442	$472	7.2%	6.9%	2.3%
Houston, Texas							
Aetna	N/A	$450	$481	$512	6.9%	6.3%	N/A
Ambetter^	$385	$443	$458	$427	3.4%	-6.7%	2.0%
Blue Cross and Blue Shield of Texas	$508	$460	$429	$450	-6.7%	4.8%	-1.4%
Bright HealthCare	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Community Health Choice^	$464	$445	$470	$456	5.7%	-3.0%	0.0%
Friday Health Plans	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Imperial	N/A	N/A	$609	$508	N/A	N/A	N/A
Molina Healthcare^	$418	$541	$587	$627	8.5%	6.8%	7.3%
Oscar	N/A	$506	$526	$521	3.8%	-0.9%	N/A
United HealthCare	N/A	$519	$480	$543	-7.5%	13.1%	N/A
Wellpoint	N/A	N/A	N/A	$582	N/A	N/A	N/A
Percentage change in lowest option available					-3.1%	-0.4%	2.0%
Texas average (all areas)	$404	$448	$468	$478	4.5%	2.2%	2.9%
Cleveland, Ohio							
Aetna	N/A	N/A	$460	$520	N/A	12.9%	N/A
Ambetter from Buckeye Health Plan^	$323	$430	$468	$440	8.8%	-5.9%	5.7%
Anthem	N/A	$555	$580	$467	4.6%	-19.5%	N/A
Antidote	N/A	N/A	N/A	$511	N/A	N/A	N/A
CareSource^	$371	$405	$432	$440	6.7%	1.7%	2.9%
Medical Mutual of Ohio	$360	$446	$491	$419	10.1%	-14.6%	3.1%
Molina Healthcare^	$366	$381	$398	$402	4.4%	1.0%	1.9%
Oscar	$466	$531	$558	$604	5.0%	8.2%	4.5%
UnitedHealthcare	N/A	$400	$444	$485	11.1%	9.1%	N/A

Insurer	Lowest Silver Monthly Premium 2019	2023	2024	2025	Percentage Change 2023–24	2024–25	Average annual change, 2019–25
Percentage change in lowest option available					4.4%	1.0%	3.9%
Ohio average (all areas)	$359	$409	$429	$435	4.9%	1.5%	3.3%
Philadelphia, Pennsylvania							
Ambetter^	$465	$395	$365	$349	-7.7%	-4.4%	-4.5%
Cigna	N/A	$458	$519	N/A	13.4%	N/A	N/A
Independence Blue Cross (Highmark)	$464	$389	$378	$400	-2.7%	5.8%	-2.3%
Jefferson Health Plan^	N/A	N/A	$362	$380	N/A	5.0%	N/A
Oscar	N/A	$470	$504	$516	7.3%	2.4%	N/A
Percentage change in lowest option available					-6.9%	-3.7%	-4.5%
Pennsylvania average (all areas)	$446	$434	$447	$472	3.1%	5.4%	1.0%
Phoenix, Arizona							
Ambetter from Arizona Complete Health^	N/A	$364	$385	$371	5.7%	-3.5%	N/A
Antidote Health Plan of AZ	N/A	N/A	N/A	$429	N/A	N/A	N/A
Banner Health and Aetna	N/A	$359	$364	$405	1.3%	11.3%	N/A
Blue Cross Blue Shield of Arizona	N/A	$420	$332	$344	-20.9%	3.5%	N/A
Bright HealthCare	$427	N/A	N/A	N/A	N/A	N/A	N/A
Cigna	$426	$459	$455	$480	-1.0%	5.6%	2.1%
Health Net^	$415	N/A	N/A	N/A	N/A	N/A	N/A
Imperial Insurance Companies, Inc.	N/A	$469	$425	$387	-9.3%	-9.1%	N/A
Medica	N/A	$471	$534	N/A	13.3%	N/A	N/A
Oscar	$479	$389	$386	$386	-0.7%	0.1%	-3.1%
UnitedHealthcare	N/A	$385	$388	$389	0.8%	0.2%	N/A
Percentage change in lowest option available					-7.5%	3.5%	-2.9%
Arizona average (all areas)	$447	$394	$363	$375	-7.9%	3.3%	-2.8%

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). Shaded values reflect the lowest available silver premium in the region each year. Insurers are instructed to load the cost of cost-sharing reductions into silver Marketplace premiums only. ^ denotes a Medicaid plan.

East Los Angeles, California (premiums were similar in West Los Angeles). This market had six competitors for 2025, three of which were Medicaid plans. The lowest-cost plan was offered by LA Care Health Plan with a premium of $354, well below the national average of $500 and the statewide average of $472. Several other insurers, both commercial and Medicaid, also had fairly low premiums. Kaiser Permanente is often a strong competitor in markets where it participates, and this was the case in Los Angeles.

Houston, Texas. The 2025 Marketplace premiums in Houston were well below both the national and statewide averages. Houston had nine competing insurers, three of which were Medicaid plans. One Medicaid plan, Ambetter, had the lowest-cost silver plan, followed closely by Blue Cross and Blue Shield of Texas. The increase from 2024 to 2025 was also below the statewide average. Several commercial plans participated in Houston, but they typically had premiums well above the lowest premium (e.g., UnitedHealthcare, Wellpoint, Oscar, and Aetna).

Cleveland, Ohio. Premiums for 2025 in this market were below the national average, and the benchmark premium was below the statewide average. Cleveland had nine competing plans, including three Medicaid plans. The large commercial plans that participated—Aetna, Oscar, and UnitedHealthcare—had relatively high premiums. Molina had the lowest-cost plan. In addition to Molina, the lowest-cost plans tended to be Medicaid plans.

Philadelphia, Pennsylvania. The 2025 lowest premium in Philadelphia was $349 (Ambetter), well below the average for the state and the nation. There were four plans participating in Philadelphia. Thus, the driving force in this area was not the large number of competitors but rather competition from Medicaid plans (e.g., Ambetter and Jefferson Health Plan). Independence Blue Cross, the major insurer in the Philadelphia market, also offered a relatively low premium.

Phoenix, Arizona. Blue Cross Blue Shield of Arizona had a relatively low premium at $344 in 2025, which was below the statewide average and national average. There were eight insurers in Phoenix but only one Medicaid plan, Ambetter. Premiums offered by several other insurers were only slightly above that of Blue Cross Blue Shield.

HIGH-COST MARKETS

Table 7 shows data on five higher-cost markets. These markets differ in several ways. Two are urban markets in rural states. Others are located in urban areas that have high costs for a variety of reasons, including high cost of living, a dominant insurer, and concentrated hospital markets.

TABLE 7

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

	Lowest Silver Monthly Premium				Percentage Change		
Insurer	2019	2023	2024	2025	2023–24	2024–25	Average annual change, 2019–25
Charleston, West Virginia (urban)							
CareSource^	$611	$849	$910	$956	7.1%	5.1%	7.8%
Highmark Blue Cross Blue Shield	$713	$869	$890	$926	2.4%	4.1%	4.6%
Percentage change in lowest option available					4.8%	4.1%	7.2%
West Virginia average (all areas)	$562	$828	$847	$910	2.3%	7.4%	8.5%
Cheyenne, Wyoming (urban)							
Blue Cross Blue Shield of Wyoming	$790	$849	$772	$809	-9.1%	4.7%	0.8%
Mountain Health CO-OP	N/A	$801	$846	$935	5.6%	10.6%	N/A
UnitedHealthcare	N/A	N/A	N/A	$904	N/A	N/A	N/A
Percentage change in lowest option available					-3.6%	4.7%	0.6%
Wyoming average (all areas)	$853	$801	$817	$855	1.9%	4.7%	0.2%
Birmingham, Alabama (urban)							
Ambetter from MHS^	N/A	N/A	$737	$553	N/A	-24.9%	N/A
Blue Cross and Blue Shield of Alabama	$525	$538	$569	$526	5.9%	-7.7%	0.1%
UnitedHealthcare	N/A	$671	$566	$562	-15.7%	-0.6%	N/A
Bright Health	$499	N/A	N/A	N/A	N/A	N/A	N/A
Percentage change in lowest option available					5.1%	-7.1%	1.1%
Alabama average (all areas)	$504	$551	$556	$521	0.9%	-6.3%	0.6%
Miami, Florida							
Aetna CVS Health	N/A	$467	$493	$558	5.5%	13.2%	N/A
Ambetter^	$440	$488	$551	$598	12.9%	8.4%	5.4%
AmeriHealth Caritas Next^	N/A	$481	$490	$515	1.8%	5.1%	N/A
AvMed	N/A	$575	$589	$648	2.5%	10.0%	N/A
Bright Health	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Cigna	N/A	$488	$611	$686	25.1%	12.3%	N/A
Florida Blue (Blue Cross Blue Shield of Florida)	$543	$462	$485	$515	5.0%	6.1%	-0.6%
Health Options	$458	N/A	N/A	N/A	N/A	N/A	N/A
Molina Healthcare^	$568	$476	$495	$523	3.9%	5.6%	-1.2%
Oscar	N/A	$470	$496	$521	5.5%	5.2%	N/A
UnitedHealthcare	N/A	$493	$513	$569	4.0%	11.1%	N/A
Wellpoint	N/A	N/A	N/A	$587	N/A	N/A	N/A
Percentage change in lowest option available					5.0%	6.1%	2.7%
Florida average (all areas)	$468	$470	$488	$513	3.8%	5.2%	1.6%

Insurer	Lowest Silver Monthly Premium 2019	2023	2024	2025	Percentage Change 2023–24	2024–25	Average annual change, 2019–25
San Francisco, California							
Anthem	N/A	$680	$759	$857	11.5%	12.9%	N/A
Blue Shield of California	$658	$610	$699	$722	14.7%	3.3%	1.9%
Chinese Community Health Plan	$575	$682	$715	$747	4.9%	4.4%	4.6%
Health Net^	$859	N/A	N/A	N/A	N/A	N/A	N/A
Kaiser Permanente	$546	$574	$621	$669	8.0%	7.8%	3.5%
Oscar	N/A	$721	N/A	N/A	N/A	N/A	N/A
Percentage change in lowest option available					8.0%	7.8%	3.5%
California average (all areas)	$414	$412	$442	$472	7.2%	6.9%	2.3%

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). Shaded values reflect the lowest available silver premium in the region each year. Insurers are instructed to load the cost of cost-sharing reductions into silver Marketplace premiums only. The San Francisco metropolitan area spans multiple rating areas. For this table, we used California rating area 8. ^ denotes a Medicaid plan.

Charleston, West Virginia. Charleston's 2025 premiums were among the highest in the nation, as were premiums in all areas of West Virginia. The lowest-cost plan in Charleston was $926, offered by Highmark Blue Cross Blue Shield. There was only one other competitor, CareSource, a Medicaid plan.

Cheyenne, Wyoming. Wyoming had some of the highest-cost plans in the United States in 2025, probably because of the state's small numbers of insurers and providers. The lowest premium, $809, was offered by Blue Cross Blue Shield of Wyoming. This premium was below the statewide average of $855. There were only two other competitors in the state.

Birmingham, Alabama. The lowest-premium plan in 2025 in this market was above the national average. Blue Cross and Blue Shield of Alabama has been the dominant insurer in the state for many years. It had the lowest premium at $526. Birmingham had only two competitors, both of which had higher premiums than Blue Cross and Blue Shield.

Miami, Florida. The 2025 premiums in Miami were slightly above the national average. Miami's characteristics would typically be associated with lower-cost premiums, with 10 competitors and three Medicaid plans. But Miami is known to be a high-cost market with some of the highest premiums, for example, in Medicare Advantage. The lowest-premium plan in Miami was $515, offered by AmeriHealth Caritas and Florida Blue. Several insurers had premiums similar to these carriers (e.g., Molina and Oscar), but several commercial plans had much higher premiums, well above the average for Florida.

San Francisco, California. The 2025 premiums in San Francisco were substantially higher than the statewide average and significantly higher than those observed in Los Angeles. The lowest-cost plan was offered by Kaiser Permanente. Several other plans, such as Anthem and Blue Shield of California, had much higher premiums. The lack of competition from multiple insurers could be a factor, but San Francisco is known to have a very high-cost hospital market.

Summary and Discussion

In this paper, we have shown that there is widespread variation in premiums across rating areas in the ACA Marketplaces. Premiums are higher in areas where there are one or two insurers, where hospital markets are concentrated, and where teaching hospitals have a major presence. Medicaid plans and some commercial plans have been able to develop narrower network products with providers that are willing to accept lower rates and compete successfully, thereby keeping Marketplace premiums lower. The presence of few insurers means that one or two insurers have considerable ability to pass on higher premiums to consumers and, to a significant degree, to the federal government through premium tax credits. While it would seem that insurers with market power would be able to negotiate lower rates with providers, they typically do not because they simply do not have to.

Markets with high hospital concentration are often small urban and rural areas that have few hospitals. These hospitals thus have considerable market power over insurers. A different kind of market power exists in urban areas, where teaching hospitals account for a higher share of hospital admissions. These are often "must-have" hospitals that can negotiate substantial rates with insurers. Even though these markets have plenty of hospitals, insurers simply cannot afford to exclude teaching hospitals from their networks.

In another paper, Blavin and Holahan (2025) showed that the ratio of commercial payments to providers relative to Medicare rates was highest in markets with high HHIs, similar to what we observed for the Marketplace. The presence of teaching hospitals also resulted in higher ratios of commercial to Medicare rates. This analysis was based on data from a very large sample of insurers that provide coverage to many people in the employer market—thus, these problems go well beyond ACA Marketplaces.

We conclude that markets with high premiums usually do not have strong competition in nongroup or hospital markets. The most direct policy response to high premiums would be some form of price regulation. In the individual nongroup market, one alternative would be to introduce a public option in areas with few insurers. A public option paying multiple Medicare rates could also be introduced in areas with high hospital concentration and/or teaching hospitals. Since we do not fully understand why premiums are higher in some markets than others, a public option could be introduced in markets that have premiums above, say, the 75th percentile for three consecutive years.

An alternative to a public option would be to cap rates at a multiple of Medicare—say, Medicare plus 60 percent for hospitals and plus 15 percent for physicians and other providers. This would control the payment rates of providers that have considerable market power without threatening the market share of existing insurers. In the nongroup market, capped rates could be introduced in markets with one or two insurers, high hospital market power, or simply high premiums. The treatment of rural areas is more challenging. Having a public option or capped rates based on Medicare plus a percentage would build on the significant adjustments that Medicare makes to help rural facilities. But this approach would likely exclude most markets with large numbers of insurers, particularly those with Medicaid or national insurance plans that have developed narrower network products. Insurance premiums seem well contained in these markets, however, so it may be the best approach to reducing premiums in rural areas.

In the broader market that includes large and small employers as well as the nongroup market, a public option or capped rates could apply in markets with high hospital concentration or significant teaching hospital market share. A public option or capped rates could be employed everywhere but would likely be binding only in the more expensive markets. Or regulatory policies could be set nationally with exemptions for rural areas.

We conclude that Marketplace premiums are not "out of control" in most large markets but, in fact, are well contained compared with premiums in the employer-sponsored insurance market. While it is clear that premiums are indeed high in some markets, this is not a characteristic of the ACA but rather a reflection of conditions in these markets—namely, the lack of significant insurer or hospital competition.

Notes

1 Quoted in Glenn Kessler, "Did Obamacare 'Massively' Increase the Cost of Health Care?" *Washington Post*, May 13, 2024, https://www.washingtonpost.com/politics/2024/05/13/did-obamacare-massively-increase-cost-health-care/.

2 Weighted average premium in each state by insurer and across all metal tiers. See Jared Ortaliza, Matthew McGough, Anna Cord, and Cynthia Cox, "How Much and Why ACA Marketplace Premiums Are Going Up in 2025," Peterson-KFF Health System Tracker, August 2, 2024, https://www.healthsystemtracker.org/brief /how-much-and-why-aca-marketplace-premiums-are-going-up-in-2025.

3 The benchmark premium is the second-lowest silver premium in each rating area. Average premiums are weighted by rating area population. Figures are based on Urban Institute analysis of data from HealthCare.gov and relevant state-based Marketplace websites.

4 "Budget and Economic Data," Historical Data and Economic Projections, January 2025, Congressional Budget Office, accessed March 26, 2025, https://www.cbo.gov/data/budget-economic-data#11.

5 "Budget and Economic Data," Congressional Budget Office; and "NHE Historical and Projections—Data," Centers for Medicare & Medicaid Services, last modified September 10, 2024, https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/projected.

6 "Budget and Economic Data," Congressional Budget Office.

7 Based on projected Marketplace enrollment in 2025 and assuming no change in coverage or total premiums collected, we estimate that the 2025 benchmark premium for a 40-year-old nonsmoker would be $972 in Vermont and $613 in New York, if the default ACA age rating curve were used instead of community rating.

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Acknowledgments

This paper 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.

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