Health insurance premiums: comparing ACA exchange rates to the employer-based market

At a glance

In 2014, the premiums for health plans offered on new state exchanges under the Affordable Care Act (ACA) are comparable to—and in some cases lower than—those being offered by employers with similar levels of coverage. The data suggest the new exchanges are competitive with the current insurance market and may open doors for employers as they contemplate future benefits strategies.

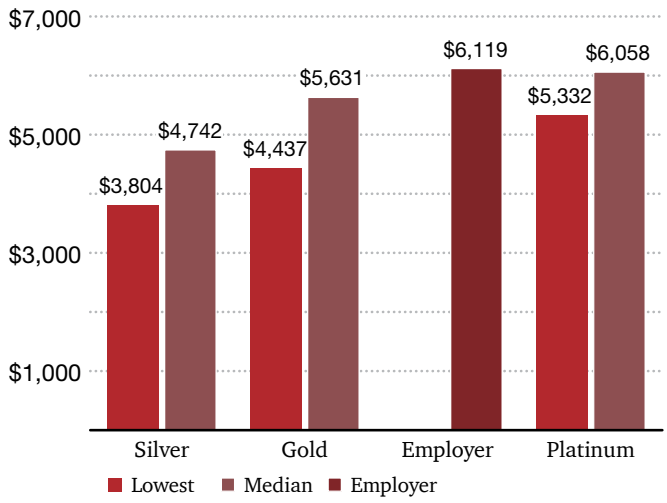
More than 156 million Americans receive health insurance through the workforce today, making employer-based coverage the foundation of the nation's $2.8 trillion health system.[1,2] But the employer-sponsored market is in flux as businesses evaluate myriad options, including private exchanges or even the ACA's public exchanges, which may be open to large employers in 2017.

In a recent survey, insurance company executives told PwC's Health Research Institute (HRI) that they expect price to be a primary influencer for consumers.[3] Given that, HRI undertook a premium analysis comparing the employer-based market with the median and lowest-cost exchange plan premiums.[4]

Premium comparison by metal level

Under the ACA, consumers shopping on the 51 new state exchanges may choose from four levels of plans, named bronze, silver, gold, and platinum, which pay 60%, 70%, 80% or 90% of healthcare costs respectively, known as the actuarial value. The actuarial value includes costs such as deductibles and other types of cost sharing. Employer-sponsored health plans pay about 85% of healthcare costs with the remainder paid by the employee. In other words, the average employer-based plan falls between the gold (80%) and platinum (90%) levels created under the 2010 law. (See Figure 1)

Figure 1. Comparison of exchange premiums with average employer premiums



Source: HRI calculations based on published exchange premiums and the average premium for single worker with employer coverage from the Kaiser Family Foundation (2013). Single worker premium for 2013 was increased by 4% to account for 2013–2014 premium growth.

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This year's exchange premiums range from a low of $95 for a 27-year-old to a high of $936 for a 50-year-old.[5] No two health plans are exactly the same—even if they have the same actuarial value. Many of this year's exchange plans have narrow provider networks, while employer-based coverage often includes financial incentives and penalties for wellness activities.

Across the board, at every level, average exchange premiums are lower than this year's average premiums for employer-sponsored coverage. The average median premium for gold plans is 8% lower than the national average employer premium. When examining the average of the lowest premiums for gold plans the gap is 27%. Premiums for platinum plans are naturally higher—the average lowest premium is 13% below the average employer plan, while the average median premium is 1% lower.

Aggregate premium comparison

HRI analyzed the average premium costs for a working population nationally in the public exchanges, and calculated that the median 2014 premium for a plan with coverage similar to that of the average employer-sponsored plan was $5,844. The typical actuarial value of an employer sponsored plans falls between the Gold and Platinum exchange plans. (See Figure 2) By comparison, the average employer premium for a single worker was $6,119, a difference of about $275, or 4%.[6] The premiums do not include subsidies.

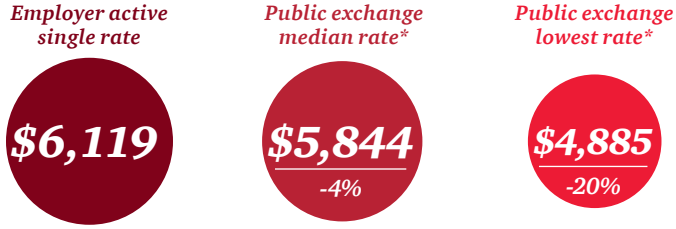
The difference between premiums in exchange plans and employer-based coverage depends on which plan a consumer chooses. If an individual chooses the lowest priced plan in each state, the average exchange premium would be $4,885, or 20% lower than the average premium for comparable employer-sponsored coverage.[7]

Additional factors influencing premium analysis

There are a number of factors that influence this analysis:

Figure 2. Comparison of 2014 premiums: Employer-based plans compared to public exchange plans

HRI calculated national average premium for the working population



*Average of Gold and Platinum rates (comparable to an average actuarial value of 85% for employer provided plans) pre-subsidy. Source: HRI calculations based on published exchange premiums and the average premium for single worker with employer-sponsored coverage from the Kaiser Family Foundation (2013). NOTE: HRI increased the Kaiser single worker premium for 2013 by 4% to account for 2013-2014 premium growth. Exchange premiums were age adjusted to match the age distribution of workers with employer coverage.

- *Differences between employer-based health insurance and exchange plans.* Many of the exchange plans have narrower provider networks with more limited choices of doctors and hospitals. However, employer interest in narrow networks and direct contracting with high performance networks is increasing. Under the ACA, cost sharing options for exchange plans are limited within each metal level, covered services are set by "essential health benefits" regulations, and administrative expenses are constrained at 20% by medical loss ratio requirements. Of the remaining tools, limited networks can be effective in reducing premium costs.[8]
- *Availability of federal subsidies.* About 85% of individual exchange participants are projected to qualify for premium subsidies. These subsidies are available for those earning between 100% and 400% of the federal poverty level (FPL).[9] On average, an individual at 138% FPL, or annual income of $15,856, is eligible for a subsidy between $2,013 and $7,083 per year depending on age.[10]

  The subsidies are based on the premium for the second lowest priced silver plan available. In addition, enrollees below 250% FPL, or about $28,725, receive cost sharing subsidies if they purchase silver plans. The cost sharing subsidies help reduce out of pocket costs, giving beneficiaries more generous benefits that are similar to employer-based coverage without having to purchase a gold or platinum plan.
- *Changes in coverage generally available in the individual marketplace.* HRI's analysis is based on survey data of employer-sponsored premiums of 156 million people in 2013. The analysis compares the premiums paid by employers for single worker coverage to premiums paid for similar coverage in the state exchanges. Prior to the ACA, individual insurance coverage was more limited than employer insurance, and, on average, comparable to bronze plans purchased on the ACA's exchanges. Some of the sticker shock noted among enrollees in the new exchanges is due to more comprehensive insurance coverage in the exchange plans. More than half the people in the individual market had coverage below the bronze level of 60%, the lowest level in the exchanges.[11]
- *Future fluctuations in public exchange rates.* Health plans are competing in the public exchanges under a new set of underwriting rules which provide some protections against financial risk. As a result of this uncertainty, the first-year exchange rates vary significantly. It may take several years for this new market to reach equilibrium.

Conclusion

In 2014 health insurance plans offered on the ACA's 51 new exchanges are on average, comparable to, or lower priced than, similar employer-based plans. In addition, most exchange shoppers have a wider variety of plans than the typical employer-based offering. The tradeoff may come in provider choice.

It remains to be seen whether these patterns will continue over time. As insurers gain more experience with exchange consumers, and temporary risk sharing and risk corridors are removed, premiums could change substantially in the public exchanges. However, if pricing dynamics in the public exchanges are sustained over time, this may provide an opportunity for employers to reexamine new approaches to providing health insurance coverage for their workers.

Premium price influencers

Many factors influence premium prices. Much of the conversation around exchanges has centered on the effects of narrow or more limited provider networks on reducing prices. When insurers contract with less expensive hospitals and doctors they can reduce premiums, but the trade-off is more limited consumer choice. Typically, employer plans have broader networks and greater consumer choice.

According to the HRI analysis, there are ten major influencers of premium price which include: guaranteed issue, competition, pricing band limits, low income subsidies, insured pool changes, new products, minimum essential benefits, medical cost trend, state management, and changes in network design. Further analysis of these ten premium influencers can be found in HRI's *Open for Business*.

What this means for your business

Employers

Employers may be surprised that exchange premiums in 2014 are comparable to employer premiums and in some states significantly lower than employer-based premiums. The comparison data may make public exchanges an attractive alternative for employers in the future. Employers contemplating future limits to their healthcare spending could face less resistance if employees are given a wider range of options at different price points via an exchange.

Providers

Providers are watching to see if lower-cost, narrow-network plans draw large numbers on the new exchanges. Growth in narrow networks could lead to changes in strategy by major medical centers. The higher cost medical centers that have historically refused to negotiate for inclusion in some plans may need to rethink that strategy and pursue ways to lower costs. Since such a large share of provider costs are fixed, the payments from plans that have low reimbursement rates might still improve hospital margins, if the new revenues cover more than variable costs.

Insurers

As the experience in the public exchanges matures, insurers may face increased demand from employers to replicate less costly plans offered on the public exchanges. In particular, insurers may need to focus some resources on creating higher performance and higher-quality provider networks to replace or supplement traditional wide access plans for all segments of the market. Private exchanges can be expected to apply similar cost pressures on insurers in order to further obtain the best value and grow market share.

Appendix: Methodology

The exchange premiums discussed in this report are based on premiums collected from the most populous county in each state, which are usually the premium rates that apply to the most populous metropolitan area in the state.[12] The premiums at the various metal levels—Bronze, Silver, Gold, and Platinum—were adjusted to reflect the national distribution of ages of workers with single worker coverage (and without Medicare or Medicaid coverage). Premiums for each metal level in each state were collected at various benchmarks—lowest, highest, and median. For Silver plans, the second lowest cost benchmark was also collected. For each metal level the various benchmarks were averaged across states using weights based on the number of workers with employer coverage (without Medicare and Medicaid coverage). The average premium is not sensitive to the weighting scheme. For example, the average premium is roughly the same if the state total population or the total number of workers is used as the weight instead of workers with coverage.

The overall statistic chosen to summarize the difference in premiums between the exchange and employer-sponsored plans—the average of the premiums for Gold and Platinum plans—is based on the average actuarial value of employer plans, which is about 85%, or the average of the actuarial value of Gold and Platinum plans.

The average premium for Platinum plans was based on the 37 states that offered Platinum plans. Average Gold and Silver premiums were based on a greater number of states. In addition, there are fewer Platinum plans, on average, than Silver and Gold plans in the states that offer one or more Platinum plans. The potential bias of having a different number of states was tested and found to be rather modest. For example, the average Silver premium (based on the median for each state) was $4,742, using all 51 states and DC, compared to $4,720 using only the 37 with Platinum plans, a difference of 0.4%. Similarly, the exclusion of the 14 states without Platinum plans changed the average Gold premiums by 0.3%.

1. Employee Benefit Research Institute, "Sources of health insurance and characteristics of the uninsured: Analysis of the March 2013 Current Population Survey," issue brief no. 390, September 2013.
2. Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group, "National Health Expenditures by Type of Expenditure and Program: Calendar Year 2012"
3. PwC Health Research Institute, "Open for business: Insurers prepare for new consumer market," 2013.
4. The average premium for exchange plans, as shown in Figure 1, is weighted by the number of workers with employer coverage in each state, that do not have Medicare or Medicaid coverage, as estimated from the 2013 Current Population Survey. The age of enrollees in exchanges is made comparable to those in employer plans by basing the average premium on the weighted average of premium by age with the weight for each age comparable to the number of workers with single worker coverage in each state, as estimated from the 2013 Current Population Survey. For example, if 3.5% of workers are 27 years old, then the premium for the median Gold plan for 27 year olds would be weighted by 3.5% in determining the weighted average of premiums for the Gold plan.
5. In Virginia, optional riders for services such as bariatric surgery boost premiums even higher to over $2400 for adults age 50. Data considers bronze, silver, gold, and platinum plans for the most populous county in each state. Catastrophic plans excluded. Sources: HRI 2013 exchange premium analysis based on premium data gathered in October/November of 2013, Healthcare.gov, Massachusetts Health Connector, MNsure.
6. Since consumers are expected to be searching for better values and enrolling in lower priced plans, the typical premium was assumed to be fall between the state averages for the median and lowest premium. The average employer premium for 2014 that was used, $6,119, is the average employer premium provided by Kaiser and adjusted for the 4% average premium rate increase.
7. Individual premium experiences vary much more than these averages. Premiums vary widely by state. For example, the second lowest price Silver Plan, the standard for calculating subsidy payments, ranges from $131 per month in Minnesota to $395 in Vermont, a factor of 3 to 1.
8. Limited networks include both PPOs and HMOs. HMOs have a dedicated provider network that manage care and reduce costs. PPOs are able to reduce costs through networks by limiting the network to providers that are willing to accept reduced rates set by the plan.
9. Congressional Budget Office, "CBO's May 2013 Estimate of the Effects of the Affordable Care Act on Health Insurance Coverage," May 2013.
10. Subsidies from the Kaiser Family Foundation Subsidy Calculator, accessed January 8, 2014.
11. Jon R. Gabel, Ryan Lore, Roland D. McDevitt, Jeremy D. Pickreign, Heidi Whitmore, Michael Slover and Ethan Levy-Forsythe, "More Than Half Of Individual Health Plans Offer Coverage That Falls Short Of What Can Be Sold Through Exchanges As Of 2014," Health Affairs, 31, no.6 (2012):1339-1348.
12. In Colorado, Denver County in the Denver MSA was substituted for the more populous county that surrounds the smaller MSA of Colorado Springs. In Maryland, Baltimore County was substituted for the more populous Montgomery County, which is part of the multistate MSA of Washington DC.

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