BENAFICA × CBIZ PARTNER PLAYBOOK

ACA Market Overview

ICHRA Resource Library

1 How the Individual Market Is Priced

Individual health insurance is priced using standardized factors — not employer-specific risk or claims history.

What this means for employers:

- Pricing is not driven by an employer's claims experience.
- A single high-cost claimant does not impact overall rates.
- Rate changes are driven by broader market trends rather than individual group performance.

> Historically, the individual market has seen more moderate and stable rate increases — often in the range of ~5–6% year-over-year — compared to the variability commonly experienced in the group market.

2 Plan Availability and Carrier Landscape

In the individual market, employees typically have access to a wide range of carriers and plan designs.

This often includes:

- National carriers — Anthem, Blue Cross Blue Shield, UnitedHealthcare, Cigna, Kaiser Permanente
- Individual market specialists — Oscar, Ambetter/Centene, and others depending on the state

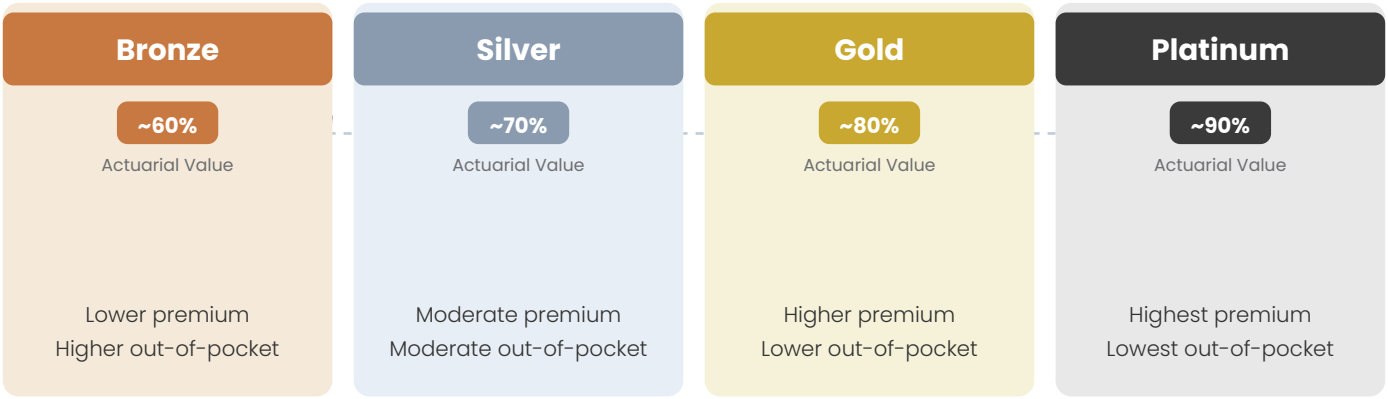
Each carrier may offer multiple plan designs, resulting in dozens of available options within a given area.

Plans vary by:

- Monthly premium
- Deductible
- Out-of-pocket maximum
- Cost-sharing structure (copays vs coinsurance)
- Network design

3 Understanding Plan Categories (Metal Levels)

Plans are grouped into four categories that reflect how total healthcare costs are shared between the plan and the member. All plans cover the same essential health benefits — the difference is how costs are distributed between premium and out-of-pocket exposure.



Plan category reflects cost structure, not quality of care or network access.

4 How Plan Structures Differ

Plan design differences are primarily driven by how costs are structured.

Bronze Plan

- Lower monthly premium
- Higher deductible
- Higher out-of-pocket exposure

Gold Plan

- Higher monthly premium
- Lower deductible
- Lower out-of-pocket exposure

These structures create different cost profiles depending on how frequently an employee uses care.

5 Understanding Silver Plans

Silver plans are often interpreted as a middle or balanced option. In practice, their role is more specific.

Benchmark for Affordability

Silver plans are commonly used as the reference point when determining affordability thresholds. Modeling often centers around a lowest-cost Silver plan, regardless of which plan an employee ultimately selects.

Pricing Can Be Distorted ("Silver Loading")

In many markets, Silver plan premiums are higher than expected relative to Bronze or Gold. This is due to how carriers price certain cost-sharing obligations into Silver plans.

What this means in practice:

- Gold plans may be closer in price to Silver than expected.
- Bronze plans may appear significantly less expensive.
- Silver pricing does not always represent the most efficient balance of premium and out-of-pocket cost.

Not Always the Best Fit

- Some employees may find Gold plans provide better value for their expected usage.
- Others may prioritize lower premiums and select Bronze.

> Plan selection should be based on expected utilization and cost preference — not defaulting to a middle-tier option.

6 What Employees Evaluate When Selecting Coverage

When reviewing plan options, employees typically focus on factors that drive decision-making more than plan category alone:

- Provider access — doctors, specialists, hospitals
- Monthly premium
- Deductible and out-of-pocket exposure
- Prescription coverage

Key Takeaways

- Individual plans are priced using standardized factors, not employer claims experience.
- Rate changes are driven by broader market trends and have historically been more stable than group renewals.
- Employees have access to a wide range of carriers and plan designs.
- Plan categories reflect cost structure, not quality.
- Silver plans are often used as a benchmark but are not always the most efficient option.
- Plan selection varies based on individual needs and expected utilization.