Integrating Individual and Small Group Health Insurance Markets to Reduce Premiums and Administrative Costs

11%-16% of Government Spending on Individual Market Premium Subsidies (0.11%-0.17% of Total Health Spending)

Published: September 2026

Author: Michael J. Dickstein, New York University

Issue Summary: In 2024, the individual and small group health insurance markets covered approximately 32 million Americans. While the Affordable Care Act stipulated that officials regulate the two markets similarly, in most states insurers price and sell plans separately in each product segment. Both markets have their own inefficiencies and idiosyncrasies.

Adverse selection, which occurs when sicker enrollees choose more generous plans, tends to be more prevalent in the individual market. The small group market, by contrast, carries higher administrative costs, including broker fees; small group insurer markups have also typically exceeded those in the individual market in the years since the Affordable Care Act's passage. Combining the two markets through CHOICE Arrangements (formerly ICHRAs)—accounts through which employers fund tax-free individual market coverage for their employees—offers a possible way to lower premiums and government spending while reducing some of the administrative costs associated with small group coverage.

Policy Recommendation: Policymakers could build on existing federal CHOICE Arrangement policy to expand small firm employees' access to the individual market. We evaluate two approaches. First, federal and state lawmakers could strengthen incentives for voluntary CHOICE Arrangement adoption. Second, Congress could authorize state demonstrations of mandatory CHOICE Arrangement enrollment—under which small employers would fund individual market coverage in place of a group plan and require employee participation—and test the effects of this change on premiums, enrollment, and subsidy costs before any broader application. We predict the effects will depend importantly on the competitiveness of premium-setting and the degree of adverse selection in a state's insurance markets.

Potential Savings: Using data on health insurance in Oregon from 2014–2016, we find that integrating healthier small group enrollees into the individual market would reduce premiums and federal subsidies. If it became mandatory for small group employers who offer insurance to use CHOICE Arrangements to enroll their workers in plans on the individual market, gross premiums for the most adversely selected individual market plans (gold tier) would fall about 60%, and small group

enrollees' premiums would fall roughly 36 to 40% across tiers. Federal spending on premium subsidies would fall by 22%, and implicit tax expenditures associated with small group coverage would fall by 30%. In our sample in Oregon, small group enrollees also benefit, in aggregate, because participating in the individual market allows them to access plans with smaller markups. The size—and, for small group enrollees, the direction—of the effect does depend on local insurer competition, the relative enrollment in the two market segments, and the average health spending in the two pools. Savings are greatest in settings in which the status quo small group market is less competitive than the individual market and its enrollees are healthier. In recent years, the relative competitiveness of the two markets has varied both over time and across states. Subsidy changes also matter for these predictions. The expiration at the end of 2025 of the enhanced premium subsidies, which Congress created under the American Rescue Plan Act of 2021, shifted more of the financial burden of premiums onto individual market households, particularly those with incomes above four times the federal poverty level (KFF 2026a). These now-unsubsidized consumers would benefit directly from the premium reductions generated by a lower-cost small group population entering the individual market pool.

Related Literature and Evidence:

Dickstein, Michael J., Kate Ho, and Nathaniel Mark. 2024. "Market Segmentation and Competition in Health Insurance." *Journal of Political Economy* 132 (1): 96–147.

Background

In 2024, approximately 32 million Americans received health insurance coverage in either the individual market (22.3 million) or the small group market (9.9 million) (KFF 2026b, 2026c). Most individual market enrollees rely on federal subsidies, which cost the federal government $116.6 billion in 2024 (KFF 2024; CMS 2026a).

The Affordable Care Act (ACA) regulates the small group and individual markets similarly. Insurers in both product segments must offer coverage on a guaranteed-issue basis, meaning they cannot deny coverage based on an applicant's health status. Plans must also cover the same ten essential health benefits and fall within standardized metal tiers that cover 60 to 90 percent of expected costs. However, the law allows insurers to price and sell plans separately in each market.

In the individual market, households shop among a menu of plans through a marketplace, also called an exchange, or through a broker. If the sickest enrollees choose the most generous plans, premiums for those plans rise. Higher premiums may then lead healthier enrollees to choose less generous coverage to reduce their costs—a dynamic known as "adverse selection."

Small employers, by contrast, typically offer only one or two broker-recommended plans to their workers and generally cover approximately two-thirds of premiums using pre-tax dollars (Claxton et al. 2015; AHRQ 2016). Administrative costs tend to be higher in the small group market—broker fees per member run roughly double those in the individual market—likely due to brokers' more intensive involvement in selecting plan options for employers. And because brokers intermediate most sales, plans may face less direct competition on premiums, supporting higher markups (Li et al. 2026). The ACA's employer shared responsibility penalties apply only to firms with 50 or more full-time-equivalent employees; among smaller firms, which face no penalty for not offering coverage, only a third offered health insurance to their employees in 2024 (KFF 2026d).

Combining the two markets would likely benefit households and lower spending. First, it would help alleviate adverse selection in the individual market by introducing healthier small group households into the pool (though the overall gain depends on how the two populations' health needs, incomes, and preferences compare). Second, it would allow small group households to escape the higher insurer markups (the gap between premiums and medical costs) in their segment. Although relative markups between the small group and individual market have fluctuated over time, the average small group markup has varied between 20 and 25% of medical costs from 2014 to 2024 nationally, while the individual market markup averaged around 10 to 15%, apart from a spike between 2018 and 2020, when it exceeded the small group level.[1]

CHOICE Arrangements, formerly known as Individual Coverage Health Reimbursement Arrangements (ICHRAs), were introduced by federal regulation in 2019 and effective in 2020.[2] These arrangements offer a way to pool coverage across the two markets. Through a CHOICE Arrangement, an employer funds a tax-exempt account that employees use to purchase individual coverage, rather than enrolling them in an employer-selected group plan. If widely adopted, CHOICE Arrangements could eliminate the employer's role in plan choice and—depending on the conditions of insurance markets in a given area—benefit both individual and small group households while lowering taxpayer costs.

Evidence Base

We examine spending and premiums in Oregon's small group and individual markets, using detailed 2014–2016 data on enrollment, premiums, health spending, and plan characteristics. We then predict the effects of pooling the two markets through CHOICE Arrangements. The key insight is that the gains from integration do not depend only on small group enrollees being healthier: because small group households have stronger preferences for comprehensive coverage, their entry can reduce adverse selection even when their health spending is similar to that of individual market enrollees.

The Small Group Market Carries Higher Markups Despite Healthier Enrollees

Holding plan generosity fixed, small group enrollees in Oregon spent 26 percent less on covered services than individual market enrollees yet faced about 7 percent higher gross premiums. After accounting for subsidies, insurer markups were higher in the small group market. We also found that small group markups exceeded individual market markups in 36 states in 2017. Administrative costs explain part of the gap, with broker fees averaging $19.01 per member per month in the small group market versus $10.09 in the individual market in Oregon in 2016 (KFF 2016).

The Individual Market Suffers from Adverse Selection

Generous gold-tier plans in the individual market, which cover 80 percent of expected health costs, appear highly adversely selected. In Oregon, only 14 percent of insured households chose gold-tier plans and incurred an average of $811 per month in covered spending—costs that feed into higher gold-tier premiums and deter healthier enrollees.

The small group market differed sharply: 36 percent of enrollees chose gold plans, while covered spending averaged just $439 per month. This suggests far less adverse selection in the small group market: these households prefer more comprehensive plans even when their health spending needs are equal to or below those in the individual market.[3]

The ACA's risk-related programs—risk adjustment, and the temporary risk corridor and reinsurance programs that ran through 2016—do not directly improve the health composition of the overall insurance pool. Instead, they mitigate the financial consequences of adverse selection and help stabilize the insurance market. Risk adjustment, in particular, reduces insurers' incentives to avoid high-risk enrollees. It redistributes the cost of existing enrollees among insurers: plans with healthier members pay in, and plans with sicker members receive payments. But this program by itself does not make the market-wide pool healthier, and its transfers occur within each market segment separately.

What Pooling Would Do

To predict the effects of pooling the two markets through CHOICE Arrangements, we used Oregon data to build a model of how households choose coverage and how insurers set prices.

Because Oregon's small group enrollees were healthier, spent less on health care, and preferred more generous plans, moving them into the individual market risk pool and requiring them to maintain coverage would weaken adverse selection in gold-tier plans: the gross premium for a gold plan in the individual market—standardized to a 40-year-old enrollee before subsidies—would fall from $685 per month in our model's baseline to $276, a roughly 60% reduction in the most adversely selected tier. On

average, households in the individual market would end up about $44 a month better off through lower premiums and coverage that better fits their needs. Likewise, because they escape higher markups and administrative costs, the average household insured through the small group market would be about $58 a month better off (table 1). For small group enrollees, shedding higher markups would lower gross premiums by 36 to 40% across all tiers.

Under this model, government spending would also fall. Lower individual market premiums would reduce federal spending on advance premium tax credits (APTCs) by about 22% (roughly $15 per household per month). Because employer-funded premiums are tax-exempt, lower small group premiums would mean the government loses less tax revenue—about $37 per household per month.

A voluntary approach—extending CHOICE Arrangements without a coverage mandate—would produce somewhat smaller federal subsidy savings (about 15%), similar small group tax savings, and smaller but still positive gains for individual market households (about $28 per month). But it would lead many small group households, disproportionately the healthier ones, to drop coverage.[4] Because our model assumes all small employers participate, these figures likely represent an upper bound on the effects of a purely voluntary expansion, in which employers also choose whether to adopt CHOICE Arrangements.

Table 1. Predicted effects of integration via CHOICE Arrangements (Oregon, 2016)

Change per household per month	Individual market	Small group market
Gross premium	-60% (for gold tier); -8% to -11% for bronze and silver tiers	-36% to -40% (across all tiers)
Consumer surplus, or how much better off a household is (change from baseline)	+$44	+$58
Government spending (change from baseline)	-$15 (-22%)	-$37 (-30%)

Note. Predicted effects of integrating the small group and individual markets through employer-funded CHOICE Arrangements with sustained coverage; Oregon, 2016. Negative government spending figures denote savings. Premiums and surplus are standardized as described in the source study.

Who Benefits from Pooling—and By How Much?

Even if insurers in the individual market charged a markup of 25 percent above costs—approximately the highest level consistent with federal medical loss ratio rules—households buying individual plans would still gain about $18 a month, and premiums for gold-level plans would stay below their pre-pooling level at any allowed insurer markup. The benefits also do not require small group members to be much healthier: they tend to choose comprehensive coverage at every health level, so adding them to the pool eases adverse selection even when they are just as sick. Individual market households come out behind only if small group members' health costs run more than 30 percent above their own.

Small group enrollees also benefit from pooling in markets where their group coverage costs more and carries higher markups than individual market plans, as was the case in Oregon. Where the small group market is already competitively priced, however, pooling might raise their premiums and lead some to drop coverage. The benefits are also unevenly distributed: the sickest households in the individual market gain the most, while sicker and higher-income members in small group households gain the least. Three factors explain the smaller gains for these enrollees: pooling gives up the platinum-level plans the individual market does not offer; it decouples workers' premiums from the health of their own workgroup, which had benefited sicker workers in healthy groups; and the comprehensive plans these households prefer tend to be more adversely selected in the individual market. If insurers respond to pooling with higher markups, these same households can even lose from the change.

Policy Recommendation

Below we offer two approaches to pooling the individual and small group markets that our model evaluated.

Approach 1: Encourage Voluntary Adoption of CHOICE Arrangements

One incremental approach would encourage voluntary CHOICE Arrangement use while keeping the traditional small group market. Employers could continue to offer group coverage or instead give workers a fixed sum to buy individual market plans, which offers workers more flexibility and a wider choice of plans than most employers offer.

To this end, Indiana and Mississippi enacted tax incentives for small employers adopting CHOICE Arrangements in 2024 and 2026, respectively. Nine other states (Arizona, Connecticut, Georgia, Illinois, New Hampshire, Ohio, Pennsylvania, Texas, and Wisconsin) have considered similar legislation as of mid-2026.

Small group households benefit the most when small group premiums involve larger markups and when the pool of individual market households is relatively closer in health spending needs. The main risk from voluntary expansions is selection: if employers with sicker workforces are the first to adopt CHOICE Arrangements to reduce their benefits costs, it leaves healthier employees in the small group pool and limits the improvement in the individual market pool. Affordability, administrative complexity, and uncertainty about individual market coverage may also slow adoption. So voluntary participation alone may not do much to combine the two markets, and would lower premiums and federal spending by less than a broader shift would.

Approach 2: Mandate Enrollment through CHOICE Arrangements

A more far-reaching approach would require small employers that offer coverage to replace their group plans with CHOICE Arrangement funding for individual market coverage, keeping their already-insured workers enrolled rather than letting them drop out. Early evidence suggests this requirement approximates current practice: among employers that replaced group plans with CHOICE Arrangements, employee participation was essentially unchanged (Niver and Coates 2023). Broad, uniform participation would create the largest, most stable pool and offer the greatest potential to lower individual market premiums and federal spending on subsidies (Fleitas et al. 2021; Hall and McCue 2021).

Congress could authorize state demonstrations to test this approach. One key design choice worth exploring—though not one our model evaluates—would be a minimum employer contribution, set at a meaningful level and varied across sites. States could then measure how the policy affects premiums, enrollment, and federal subsidy costs. Again, the gains would be largest where the small group market carries higher markups and where small group enrollees are no sicker, and ideally healthier, than the individual market population; states with these characteristics would be natural demonstration sites.

Potential Savings

If CHOICE Arrangements were made mandatory, premiums would fall most where adverse selection was worst: gross premiums for gold-tier individual market plans would drop about 60% ($685 to $276 for a standardized 40-year-old), and small group enrollees' premiums would fall roughly 36 to 40% across all tiers. We estimate that individual market households would gain $44 per month, while small group households would gain $58 per month; these estimates include both the value of lower premiums and added choices. Government spending per individual market household would fall from $67 to $52 (about 22%) and per small group household from $124 to $87 (about 30%).

In other states, the effects on premiums and government spending would depend on how the two populations' health costs differ and how competitive each market is. To gauge the potential national scale of these effects, we perform a new extrapolation exercise, developed for this brief, that builds on the estimates in our published study. We first construct each state's baseline subsidy spending using public data from the Centers for Medicare & Medicaid Services (CMS) on the number of subsidized enrollees and the average subsidy amount in each state. We then use Medical Loss Ratio data from CMS filings to compute enrollment, insurer-level costs, and markups in both the individual and small group markets across all states. Anchoring to the estimates from Oregon, we scale each state's predicted subsidy savings by two adjustments, each measured relative to Oregon. The first captures the relative size of the entering pool: a state whose small group market is large relative to its individual market experiences a bigger improvement in the risk pool, and thus larger premium and subsidy declines, than a state whose small group market is comparatively small. The second captures the gap in health costs between the

two segments: savings are larger where small group enrollees are healthier relative to individual market enrollees. We do not scale savings one-for-one with this cost gap, however, because our Oregon model implies that pooling reduces adverse selection even when the two populations are equally healthy—small group households prefer comprehensive plans at every health level—so a portion of the predicted savings carries over regardless of a state's cost gap.[5] Since other states may differ from Oregon in ways our two adjustments do not capture, we view these figures as indicating the scale of savings rather than as precise state-level predictions.

We project savings in individual market premium subsidies of between $3.9 billion and $5.9 billion, depending on whether small group employees, once shifted to CHOICE Arrangements, may choose to forgo coverage or must remain enrolled. These dollar savings represent 11% to 16% of total APTC spending in 2017, or 0.11% to 0.17% of national health expenditures.[6] If we also include the reduction in small group tax expenditures, we predict savings of $8.0 billion to $10.2 billion, or 16% to 20% of the combined annual total of subsidies and tax expenditures. The combined savings equal 0.23% to 0.29% of national health expenditures.

Existing Policy Proposals

In the years since CHOICE Arrangements (then known as ICHRAs) took effect in 2020, policymakers have shown interest in a range of incremental reforms, distinct from the policies modeled above. Congress considered adding provisions to the 2025 budget reconciliation bill that would have encouraged small employers to adopt these arrangements, though they failed to pass the Senate. A subsequent House-passed bill, the Lower Health Care Premiums for All Americans Act (H.R. 6703), included provisions that would codify CHOICE Arrangements and allow employers to offer both a group plan and a CHOICE Arrangement. This bill is also still pending in the Senate.

A few jurisdictions have integrated the markets directly. Massachusetts merged its individual and small group markets into a single risk pool in 2007, and the District of Columbia likewise requires insurers to pool the two segments for rating purposes. Vermont, which had merged the two, separated them again in 2022, after enhanced federal subsidies reduced small group enrollees' need to help subsidize the individual market. Vermont's reversal shows that the gains from integration can depend on the design of federal subsidies.

Footnotes

1. The markups cited here reflect our own calculations from Medical Loss Ratio filings that insurers must submit to regulators broken out by state, market segment, and year (CMS 2026b). These calculations update the cross-state analysis in Dickstein, Ho, and Mark (2024), which covers 2014 to 2017.

2. The Centers for Medicare & Medicaid Services adopted the CHOICE Arrangement name as the federal terminology in September 2026. See https://www.cms.gov/marketplace/employer-initiatives.

3. Because employers also play a role in small group plan choices, we developed our measure of small group consumer demand using a set of small group enrollees whose employer dropped coverage. These households thus had to substitute to plans in the individual market.

4. Our welfare estimates assume households make rational choices; we do not model search frictions or choice mistakes (Handel and Kolstad 2015). The coverage mandate we model addresses one such mistake—the choice to remain uninsured.

5. We set the savings in Massachusetts, Vermont, and DC from our calculation to zero, since these jurisdictions had already combined the small group and individual market segments in 2017, our baseline year. To keep the extrapolation within the range of market conditions our model examines, we cap each state's adjustment at twice the Oregon-relative value and set the savings floor at zero in states where small group enrollees are substantially costlier than individual market enrollees, as in New York. We choose 2017 because it is the last year in which premiums and subsidy amounts were unaffected by the federal defunding of cost-sharing reductions in late 2017; insurers responded by raising benchmark premiums, and thus APTCs, beginning with 2018 plan year rates.

6. Using 2019 data, we calculate savings of $4.5 billion to $6.7 billion. Relative to 2017, these savings are larger in dollars but represent a smaller share (8.6% to 12.9%) of APTC spending, due to the post-2017 increase in benchmark premiums.

References

AHRQ (Agency for Healthcare Research and Quality). 2016. "Medical Expenditure Panel Survey: Insurance Component: Table I.A.2.d, Percent of Private-Sector Establishments That Offer Health Insurance That Offer Two or More Health Insurance Plans, by Firm Size." Rockville, MD: AHRQ. https://meps.ahrq.gov/data_stats/summ_tables/insr/national/series_1/2016/tia2d.htm

Claxton, Gary, Matthew Rae, Michelle Long, Nirmita Panchal, and Anthony Damico. 2015. "Employer Health Benefits: 2015 Annual Survey." Menlo Park, CA: Kaiser Family Foundation.

CMS. 2026a. "National Health Expenditure Data: Historical." Centers for Medicare & Medicaid Services. https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/historical

CMS. 2026b. "Medical Loss Ratio Data." Centers for Medicare & Medicaid Services. https://www.cms.gov/marketplace/resources/data/medical-loss-ratio-data-systems-resources

Dickstein, Michael J., Kate Ho, and Nathaniel Mark. 2024. "Market Segmentation and Competition in Health Insurance." *Journal of Political Economy* 132 (1): 96–147.

Fleitas, Sebastián, Caitlyn Fleming, Gautam Gowrisankaran, and Anthony T. Lo Sasso. 2021. "Selection, Subsidies, and Welfare in Health Insurance: Employer-Sponsored Health Insurance versus the ACA Marketplaces." Working manuscript.

Hall, Mark A., and Michael J. McCue. 2021. "Expanding Consumer Health Insurance Options by Easing the Boundaries between Individual and Small-Group Markets." New York: The Commonwealth Fund.

Handel, Benjamin, and Jonathan Kolstad. 2015. "Health Insurance for 'Humans': Information Frictions, Plan Choice, and Consumer Welfare." *American Economic Review* 105 (8): 2449–2500.

KFF. 2016. "Broker Fees and Direct Sales by Health Insurance Market." https://www.kff.org/health-costs/state-indicator/health-insurance-broker-compensation/; Accessed July 2026.

KFF. 2024. "Inflation Reduction Act Health Insurance Subsidies: What is Their Impact and What Would Happen if They Expire?" https://www.kff.org/affordable-care-act/inflation-reduction-act-health-insurance-subsidies-what-is-their-impact-and-what-would-happen-if-they-expire/

KFF. 2026a. "What We Know So Far About 2026 ACA Marketplace Enrollment, Premiums, and Deductibles." https://www.kff.org/affordable-care-act/what-we-know-so-far-about-2026-aca-marketplace-enrollment-premiums-and-deductibles/

KFF. 2026b. "Market Share and Enrollment of Largest Three Insurers – Small Group Market." https://www.kff.org/state-health-policy-data/state-indicator/market-share-and-enrollment-of-largest-three-insurers-small-group-market/

KFF. 2026c. “Market Share and Enrollment of Largest Three Insurers – Individual Market.” https://www.kff.org/private-insurance/state-indicator/market-share-and-enrollment-of-largest-three-insurers-individual-market/

KFF. 2026d. “Percent of Private Sector Establishments That Offer Health Insurance to Employees, by Firm Size.” https://www.kff.org/state-health-policy-data/state-indicator/firms-offering-coverage-by-size/

Li, Anran, Tong Liu, Anthony Lo Sasso, and Nicholas Tilipman. 2026. “Going for Broker? Intermediation in Health Insurance Markets.” Working manuscript.

Niver, Erik, and Sarah Coates. 2023. “Early ICHRA Insights.” Seattle, WA: Milliman.