

Medical cost trend: Behind the numbers 2025





Heart of the matter

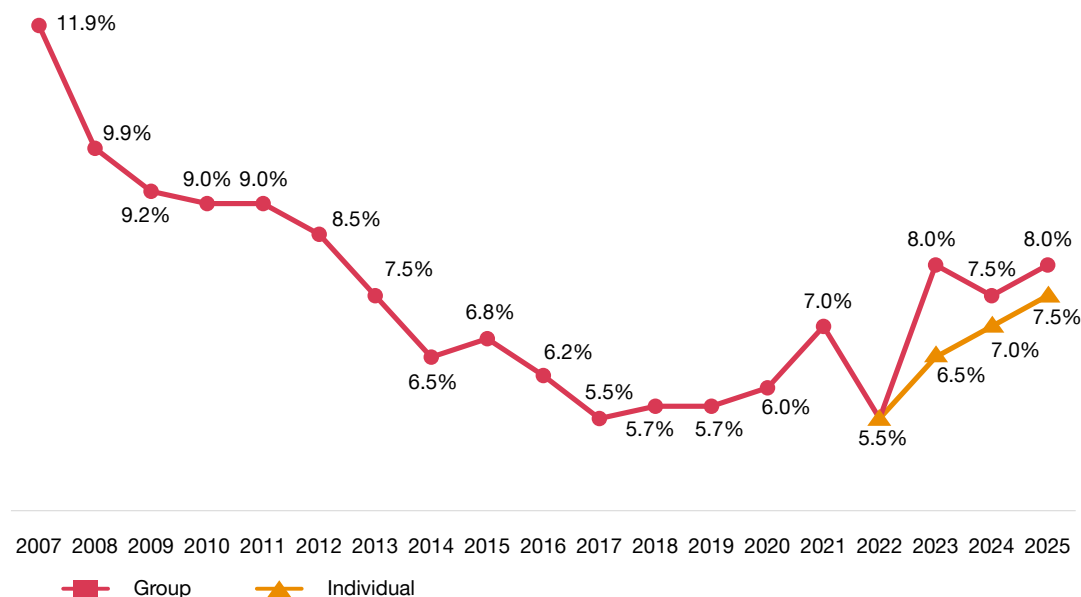
Commercial health care spending is estimated to grow 8.0% and 7.5% between 2024 and 2025, its highest level in 13 years, for Group and Individual markets, respectively. This near-record high is driven by continued inflationary pressures, prescription drug spending, and behavioral health utilization without new meaningful deflators.

The same inflationary pressure the healthcare industry has felt since 2022 is expected to persist into 2025, as providers look to pass their rising operational expenses to health plans. The utilization of Glucagon-like Peptide-1 (GLP-1) drugs is on a rising trajectory and can materially impact overall medical costs. Innovation in prescription drugs for chronic conditions and increasing use of behavioral health services are likely driving further cost inflation. Meanwhile, new deflators are not enough to offset these forces. Growing adoption of biosimilars may provide some relief, while many health plans are looking inward to find opportunities across business operations to generate additional savings. Other trends that health plans are keeping an eye on include CMS price transparency, implementation of generative AI, the No Surprises Act and the Inflation Reduction Act.

The 2023 and 2024 medical cost trends are also restated to be higher than previously reported based on the input of health plans we surveyed and their trend experience. This unfavorable development reflects higher than expected utilization of GLP-1 drugs for both diabetes and weight management as well as higher acuity inpatient and outpatient utilization. Inpatient and outpatient utilization were driven by demand from deferred care since the pandemic, which was met by newly created inpatient and outpatient capacity given the shift in sites of care towards outpatient, professional, ambulatory care settings.

PwC's Health Research Institute (HRI) surveyed and interviewed actuaries at more than 20 US health plans to generate an estimate of medical cost trend for the coming year. These plans cover more than 100 million employer-sponsored members and 10 million Affordable Care Act (ACA) marketplace members. Today's medical cost trend signals urgency to various healthcare players to rethink their organizational strategies to more effectively manage the total cost of care.

Figure 1. PwC Health Research Institute medical cost trends, 2009-2025
HRI projects medical cost trend to be 8.0% for Group and 7.5% for Individual in 2025, up from 7.5% and 7.0% in 2024



Source: PwC analysis

Note: 2023 and 2024 trends were restated to be higher than previously reported. This unfavorable development reflects higher than expected utilization of GLP-1 drugs for both diabetes and weight management as well as higher acuity inpatient and outpatient utilization.

Inflators

Inflation and its ramifications across the healthcare landscape are the main factors driving spending in 2025.

- **Inflationary impact on healthcare providers.** With health care inflation outpacing national inflation levels, driven primarily by rising costs of hospital related services, hospitals are expected to pass on impact to health plans in contract negotiations. Given stringent regulations on government-based fee schedules, private Commercial contracts are expected to most heavily feel the burden.
- **New launches and growth in prescription drugs for chronic conditions, including GLP-1, CNS, and more.** Biopharmaceutical innovation is yielding new treatments for obesity and neurological conditions, such as Alzheimer's disease and schizophrenia, as well as cellular gene therapies for rare diseases. Expected high utilization on top of high unit cost of these drugs put inflationary pressure on medical costs.
- **Continuous rise of behavioral health.** Rising utilization and unit cost of behavioral health services, exasperated by limited supply and reimbursement challenges, are expected to materialize as higher costs for health plans as providers look for higher reimbursement rates.

Note: Recent reports of increases in outpatient utilization among Medicare plans was not commented on during the research period for this report.

Deflators

New trends in the biosimilar market can bring some relief, but the overpowering inflationary forces demand health plans look inward for additional savings opportunities.

- **Biosimilars coming to market.** The launch and adoption of biosimilars have been generating savings. The new private-label biosimilar model this year may mark a turning point in the market where the potential of biosimilar savings can be more fully realized.
- **Reassessing total cost of care management: A holistic approach to affordability.** Traditionally, health plans address challenges to affordability with a siloed and modular approach. Recently, a more mature approach is emerging: it is holistic and enterprise-wide, establishes a dedicated function, and analyzes multiple interconnected components that determine premium costs.

Trends to watch

In addition to the inflators and deflators summarized in this report, there were several other factors reported by health plans as being considerations for trend development, but were not thought to be a significant trend bender as an inflator or deflator.

- **CMS price transparency.** The Centers for Medicare and Medicaid Services (CMS) price transparency data presents a valuable asset for contract negotiation, but first providers and health plans need to overcome challenges in transforming and analyzing data.

- **Implementation of generative AI.** None of the health plans we surveyed explicitly factored in the impact of GenAI in estimating the 2024-25 medical cost trend; however, GenAI and artificial intelligence broadly are expected to play a significant role in making healthcare more affordable as payers and providers leverage GenAI across different areas of the value chain.
- **Medicaid redetermination.** The net impact of Medicaid redetermination could be an inflator or deflator as redetermination ends, and most plans we surveyed indicated the impact to be neutral or low on the 2025 medical cost trend.
- **No Surprises Act.** The No Surprises Act of 2022 may have an impact on in-network and out-of-network rates, most notably for care provided by emergency rooms, radiology, anesthesia and pathology.
- **Implications of Inflation Reduction Act.** The expected higher initial drug prices stemming from the Inflation Reduction Act of 2022 can serve as an inflator in the Commercial market where negotiated maximum prices don't exist.

The scope of this analysis includes both small and large group (Group) and ACA marketplace (Individual) plans.

The Individual market has seen significant growth, from 12 million people enrolled in 2021 to 21.5 million in 2024.¹ In addition to Individual market-focused plans, major health plans in the Group market also offer plans in the Individual marketplace, where competition has intensified in recent years. The impact of major factors driving medical costs resonates across both markets.

This report does not focus on trends in Medicare and Medicaid.

What is medical cost trend?

Medical cost trend is defined as the projected percentage increase in the cost to treat patients from one year to the next, assuming benefits remain the same. While medical cost trends can be defined in several ways, this report estimates the projected increase in per capita costs of medical services and prescription medications that affect insurers' Group and Individual plans. Insurance companies use the projection to calculate health plan premiums for the coming year. For example, a 5.0% trend means that a plan that costs \$10,000 per member this year would cost \$10,500 next year. The medical cost trend, or growth rate, is influenced primarily by:

- Changes in the price of medical products and services and prescription medications, known as unit cost inflation.
- Changes in the number or intensity of services used or changes in per capita utilization.



Inflator:

Inflationary impact on healthcare providers

As hospitals continue to face operational pressures, health plans will feel the pass-through impact in ongoing contract negotiations

While recent years following the pandemic saw significant inflation across all industries, healthcare expenditures lagged behind inflation in overall household expenditures from 2021 through 3Q'23. In 4Q'23, healthcare inflation pulled ahead as the industry saw impacts of ongoing contract renegotiations. Figure 2 illustrates the continuous increase in the year-over-year healthcare expenditure index, with this rise in both utilization and unit costs starting in the third quarter of 2021 and persisting until a high of nearly 3.0% in the first quarter of 2024. Within health expenditures, the hospital and related services index has seen a significant uptick in the most recent two quarters, hitting a more than 7-year high of 6.3% growth in 4Q'23 relative to 4Q'22. On the other hand, the household expenditure index has decreased to nearly 2.5% after hitting a high of 6.5% in the second quarter of 2022. Generally, health expenditure inflation continues to lag behind hospital wage inflation.

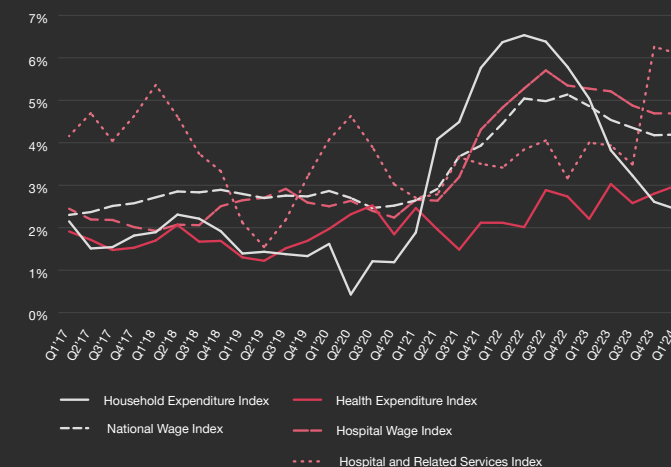
Despite these ongoing inflationary pressures, industry margins for hospital systems have bounced back with 1Q'24 margins at 4.7% relative to the low of -0.6% in 2022 following the pandemic, driven by increased revenue due to a combination of higher utilization and favorable shifts in payer mix (Figure 3). While the overall industry is rebounding, some of the largest systems experienced negative margins as recently as year-end 2023, as providers struggle with ongoing operational difficulties. Hospitals have identified workforce shortages, inflationary pressures (labor and supply costs), and shifts in utilization patterns (e.g., number of visits and sites of service)² as key operational pressures driving margin trends.

As providers look to combat inflationary struggles and further improve margins, they are turning to contract negotiations with

health plans, primarily private insurance contracts, to offset rising costs. Given constraints under required budget neutrality, rate increases on government-sponsored insurance remain well below cost trends. The final 2024 Medicare provider rates are a modest increase relative to contract year 2023 (0.4%). Medicaid rates, while contracted at the state level, are usually tied to a fraction of Medicare rates (approximately 72% across all services³) with rate changes closely following Medicare. Despite historical studies indicating no evidence of cost shifting between government and private insurance, most recent results from the RAND study indicate a growing spread of Medicare versus Commercial fees. Nationally, Commercial rates were at 253% of Medicare rates in 2022, up from 246% in 2020⁵, suggesting providers continue to balance their costs across all lines of business through private contracts. Based on the 2023 payer mix⁶ for hospital revenue and the assumed Medicare rate increase, hospitals need an 11.5% increase on Commercial rates to match the 6% to 7% increase observed in year-over-year expenses, with certain major hospital systems requiring significantly higher rate increases on Commercial rates to match recent increases in operating expenses.

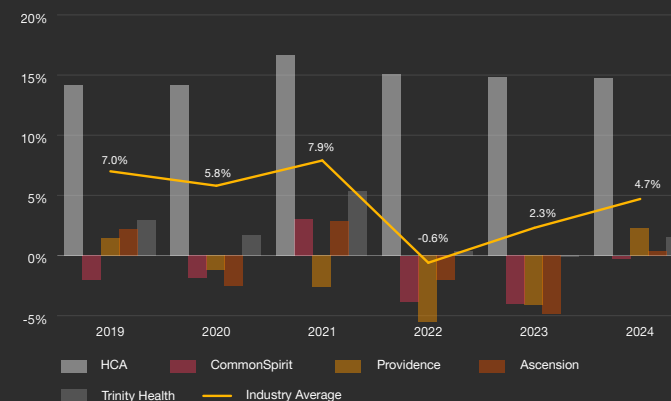
Seventy percent of health plans identified inflationary impacts on providers as one of two top drivers of increases to medical costs. Accordingly, health plans can expect continued pressures on contract negotiations as providers look to rebound on financial performance and make up for flat reimbursement on Medicare and Medicaid rates. Payers' ability to manage rate increases in coming contract renewals will be a key indicator of who is left with the burden of rising medical cost trend.

Figure 2. Expenditure and Wage Indices year-over-year growth 2017 – Q1'2024



Source: Bureau of Economic Analysis Personal Consumption Expenditure, Bureau of Labor Statistics Consumer Price Index, PwC analysis

Figure 3. Hospital system operating margins 2019 – YTD-2024



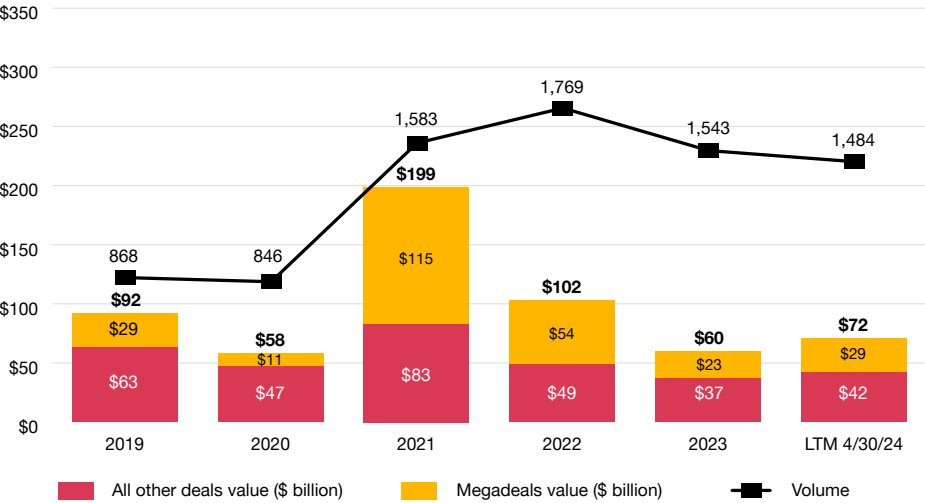
Source: Publicly available hospital financials, Strata, PwC analysis
Note: Hospital systems are ranked by 2023 revenue

Hospital, private equity and other physician consolidation, though decelerating, continues to amplify inflationary pressures

While it was another strong year in health services deals with volumes well above pre-pandemic levels, 2023 nevertheless saw a 13% decline in volume from 2022 levels. The sector continued to be impacted by headwinds, such as higher-for-longer interest rates and increased federal and state regulatory concerns, driving a slowdown in the broader deals market (Figure 4)⁷. Further, the industry has observed fewer private equity backed deals with a shift in specialties that experience high growth rate (e.g., laboratory / imaging and primary care) as shown in Figure 5.

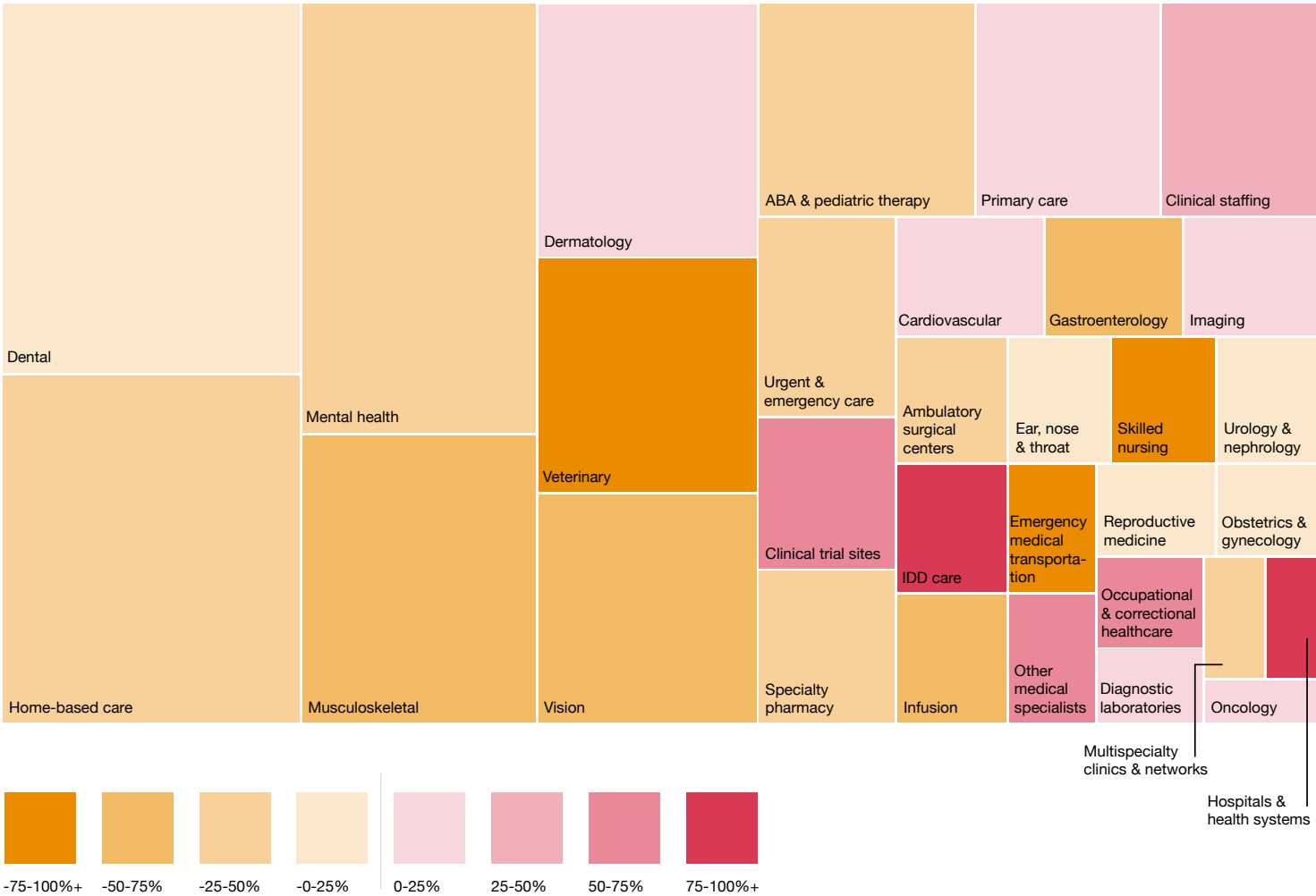
Despite the evolving deals landscape, when surveyed, more health plans regarded hospital, private equity and other physician consolidation as among the top three inflators this year (50%) as compared to the prior year (20%), likely a manifestation of the lasting impact of consolidation on contract negotiation as existing contracts come up for renewal over time. A 2022 review of studies⁸ indicates that actual impact varies widely by types of consolidation as well as context of the consolidation within the same type. So far, the strongest evidence exists for correlation between horizontal and cross-market hospital consolidation and higher prices. While data on the impacts to healthcare costs of this heightened deals activity is still emerging, preliminary studies are quantifying price increases in the range of 12% to 21%⁹. To better evaluate the effect of consolidation on medical cost trends, health plans should consider future deal trends at a more detailed level, by segment as well as local markets, specific to the plan.

Figure 4. Health services deal value (\$ billions) and volume, 2019-LTM 4/30/24



Source: LevinPro HC, Levin Associates, 2024, April, levinassociates.com
LTM 4/30/24 refers to the period from May 1, 2023 through April 30, 2024. Megadeals are those valued at \$5 billion or greater. Totals may appear not to sum due to rounding.

Figure 5. PE-backed healthcare services platforms by segment as of December 31, 2023, US and Canada



Source: Pitchbook Q4 2023 Healthcare Services Report
Note: Size represents the number of PE-backed platforms

Implications

Health plans and payviders:

Health plans will likely encounter greater unit cost increase pressure from providers, which can play out for several years. Health plans should continue to rethink their strategies that deliver greater affordability. Value-based care, targeted care management, versatile in-house data analytics and harnessing the power of AI technology can help plans aggressively counteract the forces of inflation.

Providers:

The ongoing cost pressures require providers to solve for systemic workforce shortages that continue to strain operations and be creative in leveraging new technology to automate processes and implement efficiencies (e.g., billing, scheduling, electronic record management). In the long term, the squeeze of likely CMS constrained reimbursement can require more orchestrated efforts to optimize margin.

Employers:

As employers feel the impact of inflationary healthcare spending on premiums, they are expected to maintain current employee cost sharing in an attempt to retain key talent and manage affordability. Employers are leveraging plan design (e.g., steer members to lower-cost providers, navigation solutions, virtual health) and network strategies (narrow, high-performing, tiered networks, centers of excellence) to control costs.



Inflator:

New launches and growth in prescription drugs for chronic conditions, including GLP-1, CNS, and more

Pharmaceutical companies have successfully invested in innovation or therapies for many chronic conditions, which, while delivering improved health for many consumers, creates sustained inflationary pressure on medical cost trends in coming years. Specifically, biopharmaceutical innovation is yielding new treatments for obesity and neurological conditions, such as Alzheimer's disease and schizophrenia, as well as cellular gene therapies for rare diseases. The drugs listed in Figure 6, which have just come to market or will launch soon, are expected to have significantly greater impact on conditions relative to drugs already on the market. Therefore, higher utilization rates are expected for these drugs on top of known high unit cost which is likely to drive up medical costs in the near future.

Figure 6. Drugs to watch in 2024-5

Drug class / name	Description	Listed price	Trend to watch
GLP-1 (Glucagon-like Peptide-1) agonists	Various drugs treating type 2 diabetes, chronic weight management, decreased secondary cardiovascular events	\$11,000+ (annually, pre-rebates)	Surge in utilization since 2023; addition of second GLP-1 weight loss medications, new approved indication etc. can further drive utilization up
CNS (Central Nervous System)	Various drugs treating conditions, such as Alzheimer's, Parkinson's, MS, schizophrenia	\$20,000+ (annually, see Figure 9 below for more details)	Demand for effective medications has been largely unmet. Many of the new drugs mark breakthroughs after a long history of high rates of clinical trial failure.
Hemophilia B	Gene therapies BEQVEZ™ approved in 2024 following Hemgenix® approval in 2023	\$3.5 million (for a one-time intravenous infusion) ¹⁰	Costly but significantly reduces the need for clotting factor replacement therapy, which costs upward of \$600,000. ¹¹ Rare condition with estimated 6,000 patients in the US. ¹²
Sickle cell disease (SCD)	Gene therapies Casgevy® and Lyfgenia™ approved in December 2023	\$2.2 million (Casgevy®) \$3.1 million (Lyfgenia™) (for a one-time dose) ¹³	Costly but an alternative to lifetime transfusions and chelatin therapy which are estimated to cost \$5.4 million. ¹⁴ Estimated 100,000 patients in the US. ¹⁵
Fatty liver disease	Rezdiffra™ approved in March 2024	\$47,400 (annually, with daily oral intake) ¹⁶	First FDA-approved drug for nonalcoholic steatohepatitis (NASH). Estimated 5-20 million patients in the US. ¹⁷



Evolution of GLP-1 (Glucagon-like Peptide-1) agonist drugs in diabetes and obesity

GLP-1 agonists are a type of medication that mimics the effects of a hormone called glucagon-like peptide-1 (GLP-1), which helps to regulate blood sugar levels and promote weight loss. They first became a major cost inflator last year given a spike in utilization combined with high unit cost – recent list prices range upward of \$11,000 annually^{18,19}, though pharmacy benefit management (PBM) formulary rebates do lower actual net costs. A year of experience since our last report substantiated the inflationary impact, and health plans continue to regard GLP-1 as a key inflator for the coming years, with 90% ranking this factor as one of the top two inflators for 2024-5.

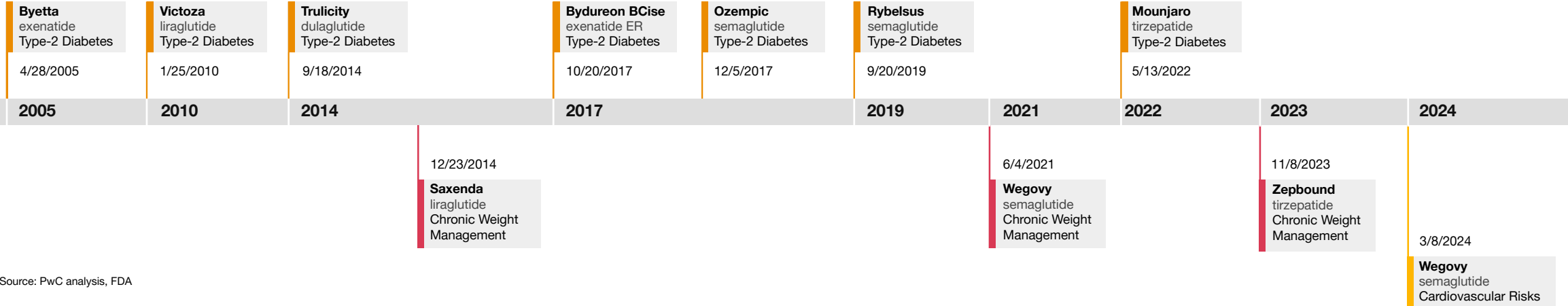
GLP-1 agonists were initially approved in 2005 for treating type 2 diabetes, with subsequent approvals for chronic weight management and risk reduction for major cardiovascular events (Figure 7). Following a surge in media coverage and with accumulating evidence of safety and efficacy^{20,21}, recent years saw a significant increase in utilization and demand for GLP-1 agonists

across many lines of business, including Individual and Group markets (Figure 8). Demand for GLP-1’s for weight management specifically has increased substantially, even leading some manufacturers to go directly to patients through new models and business relationships. The impact on medical cost trend can vary by health plans, depending on their choice on coverage for weight management (most plans covered GLP-1 agonists for type 2 diabetes). Surveys indicate that approximately 30% to 40% of employer-sponsored insurance plans currently also cover GLP-1 agonists for weight management²².

In the short to medium term, utilization of GLP-1 agonists is anticipated to continue to grow in both Individual and Group markets, driven by the following forces: expansion (studies are being conducted for a wide range of indications, including Parkinson’s disease, sleep apnea, addiction, etc.), the availability of Zepbound® as a second GLP-1 weight loss agent, and growing patient interest and acceptance²³. The ultimate market penetration

of GLP-1 agonists remains unknown at this point; nevertheless, a vast base population exists in the US. Among the 67.5 million adults aged 18-64 who were insured by private insurance in 2022, 32.3% were obese and 5.5% were diagnosed with diabetes (not mutually exclusive), according to a 2022 National Health Interview Survey²⁴. Each 10% of the 32.3% obese Commercial population taking GLP-1 agonists means a \$30 increase to medical cost per month.²⁵ The long-term savings generated by these drugs need more time to manifest and then be analyzed. However, as well reported, the benefits of managing weight – one of the key effects of GLP-1 agonists – include lowering the risks of type 2 diabetes, heart disease and stroke, all of which carry significant medical and economic costs²⁶.

Figure 7. Timeline of GLP-1 Agonist Approvals by Indication



Source: PwC analysis, FDA



Implications

Health plans and payviders:

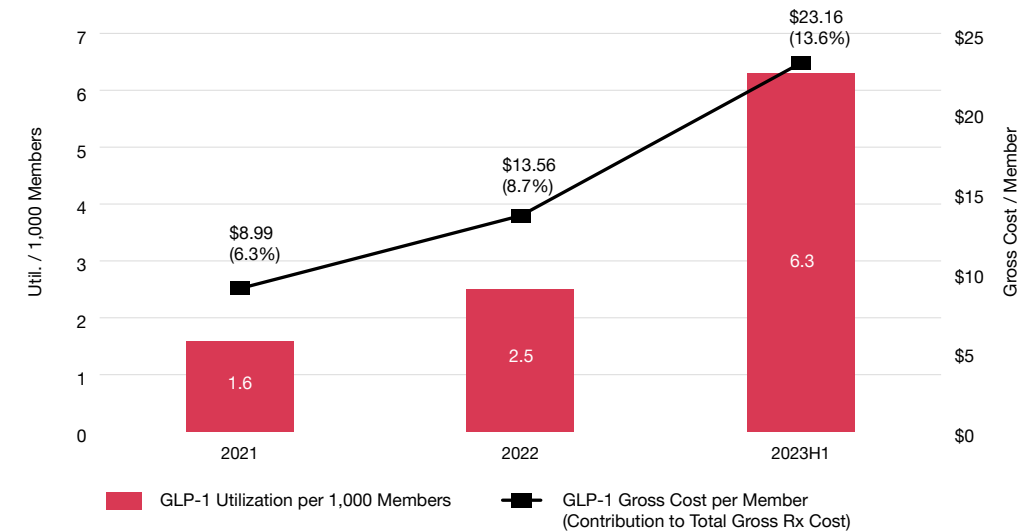
Most health plans offer coverage of GLP-1 agonists for type 2 diabetes. For weight management, GLP-1 agonists are not considered as “essential health benefits” under the Patient Protection and Affordable Care Act (“ACA”) and therefore not required to be covered by plan sponsors. Health plans should consider their broader weight management benefit strategies, expected costs based on their member demographics, potential cost savings (if quantifiable through analysis), and effects on member or employee satisfaction and well-being. Plans can manage the associated costs by confirming proper utilization (e.g., guard against off-label use, set BMI threshold and co-morbid conditions criteria, require participation in holistic weight management programs etc.) and increase the impact through accompanying patient engagement strategies (e.g., medication adherence limited fills to 30-day supplies, and lifestyle counseling, etc.). Lastly, health plans should closely monitor regulatory changes that might require coverage for GLP-1 agonists for obese members meeting certain criteria. For example, the California Obesity Treatment Parity Act (SB 839) has been introduced in the California legislature; if it becomes law, the bill will mandate holistic coverage for obesity treatment²⁷.

Pharmaceutical manufacturers:

GLP-1 agonists have launched a significant opportunity for the manufacturers already in market and have driven a wave of R&D investments and M&A as other manufacturers look to enter the space. R&D, M&A and Commercial investment in the arena will likely continue as manufacturers look to position and differentiate their assets to gain share, while managing pricing and gross-to-net impact. Manufacturers are also likely to continue innovating their commercial model to differentiate, work around market access barriers and provide a better overall patient and prescriber experience. The recent LillyDirect™ model is one such example. These models will likely spread to other applicable conditions and Pharma manufacturers (e.g. Pfizer’s recently announced model). Lastly, manufacturers are expected to continue evolving their products and pipelines to gain advantages in longer dosing cycles (e.g. daily, weekly, Q2W, Q4W, etc.), more convenient routes of administration (e.g. oral), and superior clinical, more positive side effects profile and health economics data.



Figure 8. 2021-2023H1 GLP-1 utilization, unit cost, and cost as percentage of total cost trend, as exemplified by the book of business of pharmacy benefit management (“PBM”) group serving more than 1.6 million Group plan members



Source: [Employer Health](#)

Central Nervous System medications coming to market

The continued development and approval of new Central Nervous System (“CNS”) drugs, which had an estimated global market size of \$128.3 billion in 2022²⁹, is likely to drive further increases in healthcare costs in upcoming years. CNS drugs are used to treat brain disorders, including Alzheimer’s disease, Parkinson’s disease, multiple sclerosis (MS), bipolar disorder, anxiety and schizophrenia. Historically, CNS drugs have had failure rates as high as 85% in Phase 2 and 3 clinical trials²⁹ with the failure rate for Alzheimer’s clinical trials hitting 99% in the past few decades.³⁰ However, recent advancements are introducing a wave of innovative drugs for conditions such as Alzheimer’s disease and schizophrenia. While the approval and introduction of innovative CNS drugs hold promise for improving patient outcomes, they also present challenges to managing healthcare costs, as these drugs come with high price tags and fill in the previously unmet demand and high unit cost.

Alzheimer’s disease has seen a notable development with the recent approval of one drug, lecanemab (Leqembi™), in 2023³¹, which is the first drug to slow the delay of cognitive decline associated with Alzheimer’s³². This marks a turning point in Alzheimer’s treatment after a long history of failed clinical trials³³. With nearly 7 million Americans impacted by Alzheimer’s³⁴ and an annual list price of \$26,500³⁵, Medicare expects to spend \$3.5 billion on coverage for this drug in 2025³⁶. In addition to the direct drug costs for lecanemab, there are associated costs for genetic testing, required brain scans, and other monitoring, bringing the total annual medical costs to above \$80,000³⁷. Another Alzheimer’s drug, donanemab (Kisunla™), was approved June 2024³⁸ and has been shown to slow the progression of the disease³⁹; it is also expected to have an annual price of \$26,500.⁴⁰ Besides Alzheimer’s, KarXT, developed for schizophrenia, works by activating muscarinic receptors unlike other schizophrenia-treating drugs. It is expected to be approved in Q3 2024⁴¹ with an estimated price of \$16,000 to \$20,000⁴². As developments in CNS drug research are made and additional CNS drugs are approved, a higher burden on the healthcare system is expected.



Implications

Health plans and payviders:

As more CNS drugs are approved, health plans will likely face increasing pressure to cover these new treatments, which typically come with high price tags and increasingly complex monitoring programs. Many members who were previously unable to get approved for other drugs, did not have success with existing medications, or are newly diagnosed will likely expect coverage for these drug options. Consequently, health plans should make critical decisions about formulary inclusion and whether to implement stringent utilization management techniques. While the current utilization of these drugs is relatively low, the approval and launch of more effective drugs is likely to lead to increased utilization. However, despite the initial financial burden, health plans may see a decrease in long-term medical costs as patient outcomes improve. Enhanced efficacy of these new CNS drugs could result in better disease management, fewer hospitalizations, and reduced need for extensive medical interventions, ultimately balancing out the higher upfront costs.

Pharmaceutical manufacturers:

New mechanisms of action and advances in drug targets are turning neurological conditions into opportunities for research, development and commercial potential. Successfully launching and commercializing forthcoming drugs for key conditions, including Alzheimer’s disease, Parkinson’s disease, epilepsy and schizophrenia will likely take significant effort across sales and marketing, pricing and market access, patient services, medical affairs, and several other areas. Identifying patients for treatment, supporting those patients and their providers from initiation to adherence, demonstrating real world value over current standards of care, and differentiating from competitors can be keys to success in each area.

Figure 9. CNS drugs to watch 2024-5

Drug	Use	FDA Approval Year	Annual List Price ⁴³
Lecanemab	Alzheimer’s	2023	\$26,500 ⁴⁴
Donanemab	Alzheimer’s	2024	\$26,500 ⁴⁵
KarXT	Schizophrenia	Awaiting FDA Approval	Health-benefit price benchmark (HBPB) calculated to be \$16,000-20,000 per year ⁴⁶
Ansofaxine	Depression	Awaiting FDA Approval	Not available



Inflator:

Continuous rise of behavioral health

Utilization of behavioral health (BH) and mental health or substance abuse (MH or SA) services experienced a significant and sustained uptick in the years following the COVID-19 pandemic, coupled with a steady increase in per claim costs (Figure 10a), leading to higher overall costs. While historical PMPMs for these services were too low to be considered an inflator to overall medical costs, spending on mental health has increased more than 50% since the pandemic, driven by a nearly 40% rise of in-person behavioral health utilization.⁴⁷ With this rise in utilization and unit costs rise, BH services are accounting for a greater percentage of overall medical spending each year following the pandemic (Figure 10b). BH services were listed as a top three inflator by 30% of health plans surveyed.

Further, the availability and supply of BH services have not kept pace with the surging demand as hospitals are underfunded and understaffed, resulting in a supply-demand imbalance (Figure 11) that exacerbates the strain brought on by utilization trends. The demand for BH workers has been intensified by competition among providers and is projected to grow at an even faster rate than the projected year-over-year decrease in supply for BH workers. The market size for BH is expected to increase 53% from 2023 to 2033 (Figure 12), widening the gap between demand and supply in the mental health space⁴⁸. This shortage also raises concerns about the accessibility and quality of care, including specialized services such as applied behavior analysis (ABA). Inflated medical costs are expected as the health industry looks to address insufficient resources, limited access to providers and inadequate funding for MH or SA services.

Reimbursement challenges have compounded the lack of sufficient supply and pose a significant barrier to addressing the rising costs of BH services. Historically, these challenges have presented themselves in the form of gaps in reimbursement rates between both BH versus physical health services, and in-network versus out-of-network care, leading to underfunding and limited access to care. Reimbursement rates for office visits with medical or surgical clinicians were about 22% higher than they were for behavioral health clinicians. The gap between in-network and out-of-network mental health care is a significant issue, as patients are 3.5 times more likely to receive BH services in an out-of-network setting than they were for clinicians. For psychiatrists and psychologists, patients were even more likely to go out of network—at 8.9 times and 10.6 times, respectively⁴⁹. Providers struggle to cover the costs of delivering BH services, as payment amounts for inpatient and outpatient BH services fall well below costs, with the average payment amounts being 34.3% and 31.7% below costs, respectively⁵⁰. With the rising demand for these services, hospitals are expected to require higher reimbursement rates to effectively deliver care and manage financial pressure, resulting in unit cost increases for health plans as providers look to renegotiate rates.

Figure 10a. Behavioral health unit cost trend 2018-YTD 9/30/2023

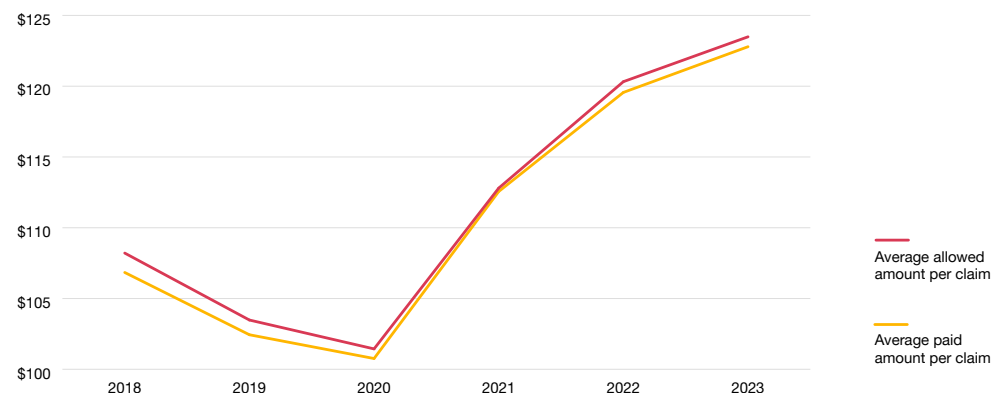
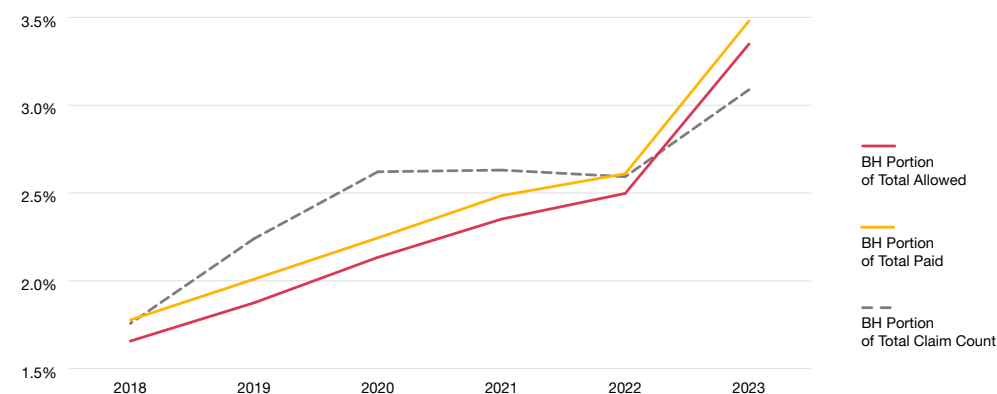


Figure 10b. Percentage of behavioral health total claims and claim counts among all medical claims 2018 – YTD 9/30/2023



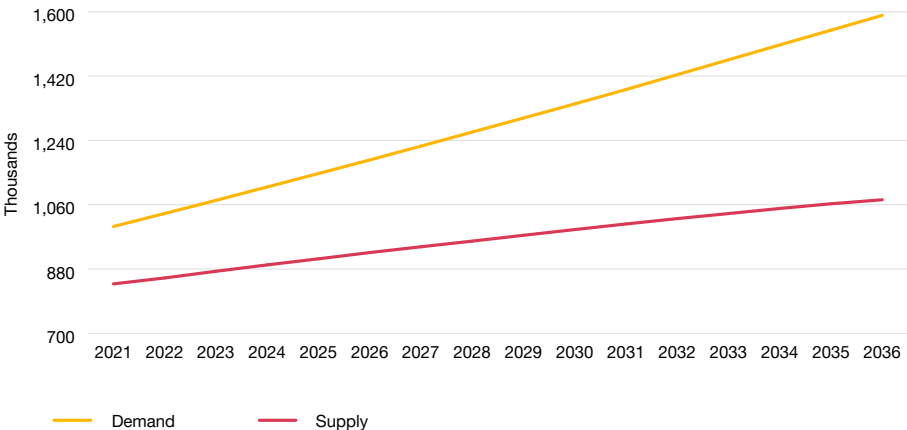
Source: CareJourney, "Commercial Market Intelligence – Provider Procedure Cost Variation Analysis" Dataset from 2018 – Q3 2023; PwC analysis

*Dataset consists of 17 million lives as of 2022 for US Mid-Level Commercial and National Carriers

**Methodology: Dataset contains claims by HCPCS codes; BH specific codes were identified using a join of multiple BH HCPCS mappings found in our research, with [ihs.gov](#) contributing most of the codes.

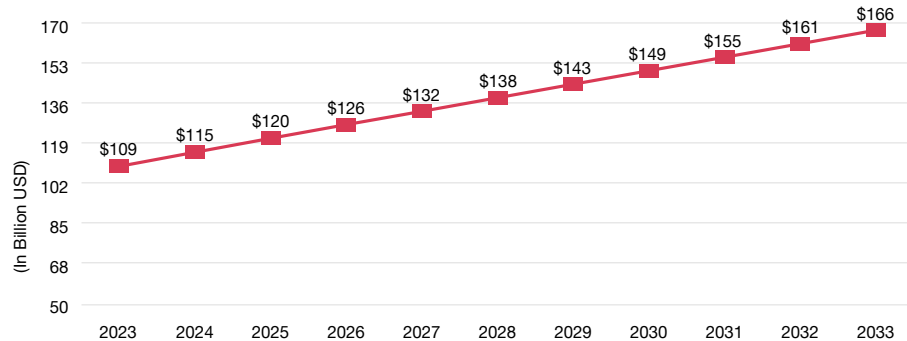


Figure 11. Projected supply and demand of healthcare workers from 2021 through 2036



Source: [Health Resources & Services Administration](#)

Figure 12. Behavioral health market size in the U.S. from 2024 to 2033



Source: [Precedence Research](#)

Implications

Health plans and payviders:

Health plans will likely face the challenge of striking a balance between adequately covering BH services and managing medical costs. The high demand for MH or SA treatments requires careful strategizing, especially considering the forefront issue of reimbursement with providers. Health plans may need to explore innovative solutions, such as condition-specific value-based payment models that incentivize quality outcomes and efficient resource utilization in behavioral health services. Additionally, they could invest in relationships with providers to establish collaborative care models that integrate physical and mental health services, promoting holistic and cost-effective care.

Providers:

Providers should continue to address the complex needs of patients with behavioral health conditions while also managing the financial impact on their practices. This includes investing in specialized training and resources to effectively diagnose, treat and manage behavioral health conditions, as well as exploring creative approaches that move away from traditional therapy models. Providers may need to explore alternative payment models, such as bundled payments or capitated arrangements, to better manage the financial risks associated with behavioral health services. Collaborating with health plans and payviders to establish clear reimbursement policies and confirm adequate payment rates for behavioral health services is crucial for sustaining quality care delivery.

Employers:

To continue to manage access to behavioral health services and their rising costs, employers should reevaluate employee assistance programs (EAPs) and behavioral health resources. Market innovation continues to occur across traditional, payer-led and next-gen solutions to proactively support the mental health of the workforce, potentially reducing the need for more intensive and costly interventions later on. Collaborating with health plans and behavioral health providers to advocate for holistic and affordable coverage is essential for the overall well-being of employees and the financial sustainability of employers.



Deflator:

Biosimilars coming to market

The Food and Drug Administration (FDA) defines⁵¹ biosimilars as a biological product that is “highly similar” to and has “no clinically meaningful differences” from an existing FDA-approved reference product. Similar to last year, the adoption of biosimilars continues to be regarded by health plans as the top deflator this year.

As of June 2024, there are 53 biosimilars approvals by FDA⁵² and approximately 40 launched. The introduction of biosimilars drives down the overall molecule costs per unit (i.e., includes originator and biosimilars) between 18% and 50% per unit as of December 2022⁵³. Two industry reports estimate increased savings generated by biosimilars over time as shown in Figure 13; specifically, savings in 2022 are estimated to be \$9.4 billion or \$13.2 billion in the US (about 1.5% or 2% of total drug spending)^{54, 55, 56}.

A highly anticipated event in the biosimilar market last year was the arrival of the first biosimilars to a major specialty drug — adalimumab biosimilars to Humira®. In 2023, the sales from this blockbuster drug totaled more than \$12 billion in the US. Nine adalimumab biosimilars were launched since January 2023 (Figure 14). Many companies have chosen a dual-pricing strategy for their adalimumab biosimilars, either launching their product at two wholesale acquisition costs (WACs) or launching branded and unbranded versions at two different price points, many with lower WAC being more than 80% cheaper than that of Humira® (Figure 15). Despite such attractive pricing, adalimumab biosimilars saw slow adoption, taking only 4% market share as of Q1 2024 (Figure 16a), reflecting price competitiveness of Humira® through higher rebates, costs of switching to biosimilars, and other factors⁵⁷. The average sale prices of adalimumab reference and biosimilars are hard to ascertain, given the lack of public data, but the 35% drop in US sales of Humira® from 2022 to 2023 – likely mostly driven by larger rebates – is a telltale sign.⁵⁸

Figure 13a. Estimated biosimilar savings 2013-2027

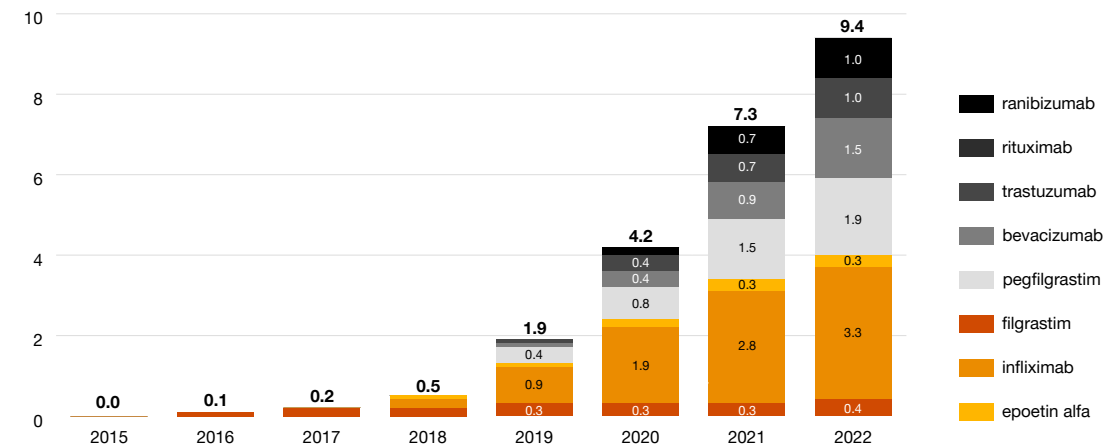
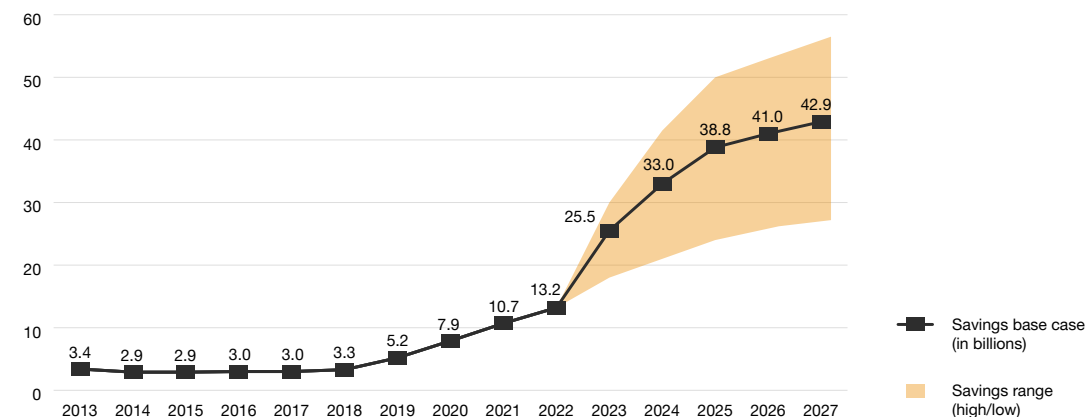


Figure 13b. Estimated biosimilar savings 2013-2027



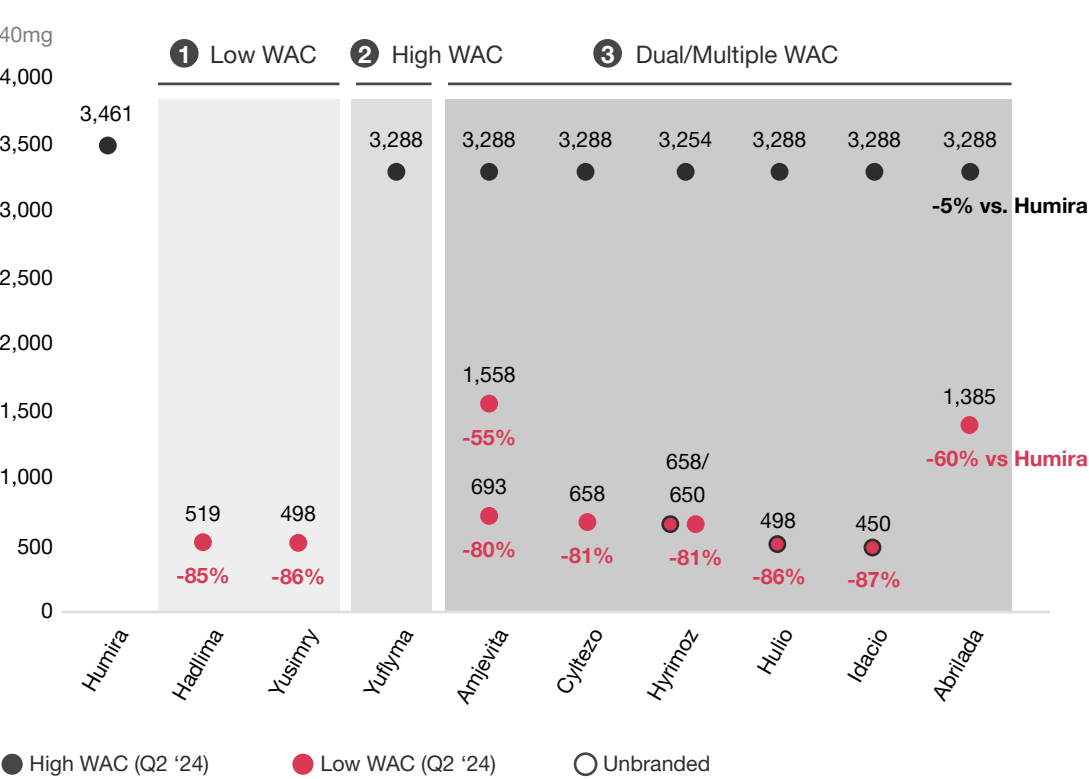
Source a. Association for Accessible Medicines b. IQVIA Institute for Human Data Science

Figure 14. Adalimumab biosimilars approval and launch timeline

Brand	Company	FDA Approval	Launch Date	Interchangeability Designation?	High/Low-Concentration?	Citrate-Free?
Amjevita™	Amgen	September 2016; approval for high-concentration version expected in 2024	Launched; high-concentration version expected in 2024	No	Low; high-concentration version in phase 3 trials	Yes
Cyltezo®	Boehringer Ingelheim	August 2017	Launched in July 2023	No	Low	Yes
Hadima™	Organon/Samsung Bioepis	July 2019	Launched in July 2023	No; Application for interchangeability is under review	Both	No for low-concentration; Yes for high-concentration
Hulio®	Mylan/Viatris/Biocon/Fujifilm Kyowa Kirin	July 2020	Launched in July 2023	No	Low	Yes
Yusimry™	Coherus BioSciences	December 2021	Launched in July 2023	No	Low	Yes
Abrilada™	Pfizer	November 2019	November 2023	Yes	Low	Yes
Hyrimoz®	Sandoz/Novartis	October 2018	Launched in July 2023	No	Both	No for low-concentration; Yes for high-concentration
Idacio®	Fresenius Kabi	December 2022	Launched in July 2023	No	Low	Yes
Yuflyma®	Celltrion	May 2023	Launched in July 2023	Filed application to conduct trial investigating interchangeability	High	Yes
Simlandi®	Alvotech/Teva Pharmaceuticals	February 2024	2024 expected	Yes	High	Yes

Source: Center for Biosimilars; FDA Biosimilar Product Information.

Figure 15. Adalimumab biosimilar wholesale acquisition cost (WAC) as of Q2 2024



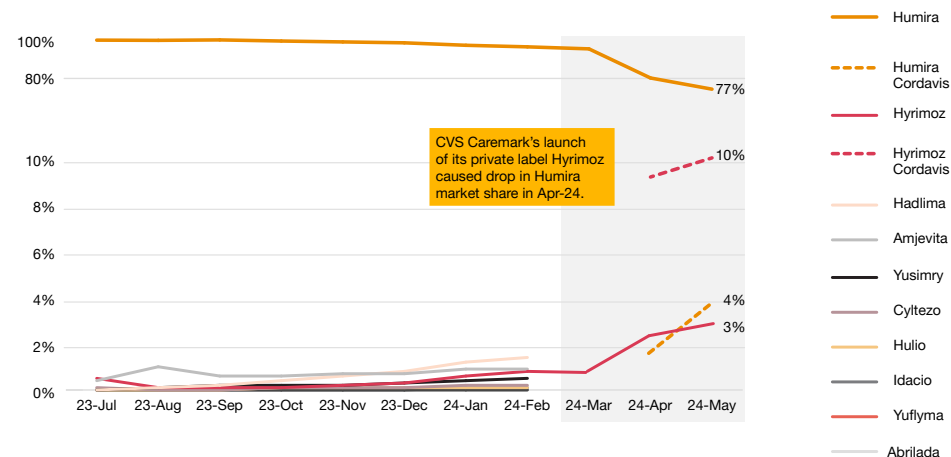
Source: Samsung Bioepis

The recent launch of private-label Humira® biosimilars by newly created or repurposed companies owned by major vertically integrated health services companies is changing the market. On April 1, CVS Caremark (PBM of CVS Health) removed Humira® from its national commercial template formularies; Hyrimoz®, a biosimilar private labeled by Cordavis, a wholly owned subsidiary of CVS Health, took its place⁵⁹. The effect is notable: the number of new prescriptions written for Humira® biosimilars surged to 36% from just 5% during the first week of April (Figure 16b)⁶⁰. Subsequently, Evernorth / Express Scripts (PBM of Cigna) announced the launch of its private-label biosimilars under Quallent Pharmaceuticals in June⁶¹. These models have already shown significant ability to rapidly move share from the innovator to biosimilar(s) within CVS, and we expect similar results in future models across the industry.

Historically, biosimilars uptake falls under two categories of “slow” and “fast” (Figure 17). A case study of oncology biosimilars (bevacizumab and trastuzumab have among the fastest uptake) shows that supportive clinical guidelines (National Holistic Cancer Network issued multiple guidelines around recommended use, safety, etc.) and new vendors supporting payers in streamlining pathways for biosimilar use (as it pertains to clinician decision, prior authorization, etc.) can encourage faster biosimilar adoption⁶². Interchangeability⁶³ and patient education are among many other factors that can affect the adoption speed. The success of Hyrimoz® points to another path: PBMs can effectively navigate members through formulary changes and may be able to reduce costs and improve economics through private-label biosimilars. This private label biosimilar model can be a strong force that speeds up biosimilar adoption.

Looking ahead, the biosimilar market will likely begin to get increasingly crowded. At least 10 additional molecules will face biosimilar competition for the first time in the next three years⁶⁴. Important to watch: the loss of exclusivity of two multi-billion-dollar drugs Stelara® and Eylea® later this year or early next year. One analysis performed in early 2023 projects total savings from biosimilars to range from \$125 billion to \$237 billion dollars for the five-year period from 2023 to 2027, with scenarios representing different biosimilar uptake rate and average-sales-price reduction assumptions (Figure 13)⁶⁵. The first success of private label biosimilars this year opens up a new range of possibilities.

Figure 16a. Adalimumab volume market share Jul-23 to May-24

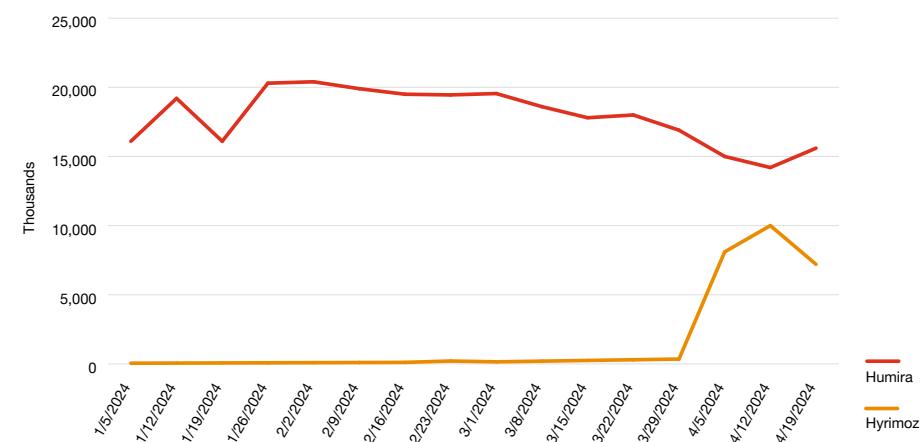


Source: Samsung Bioepis

*Selected data is shown for Mar-24 to May-24

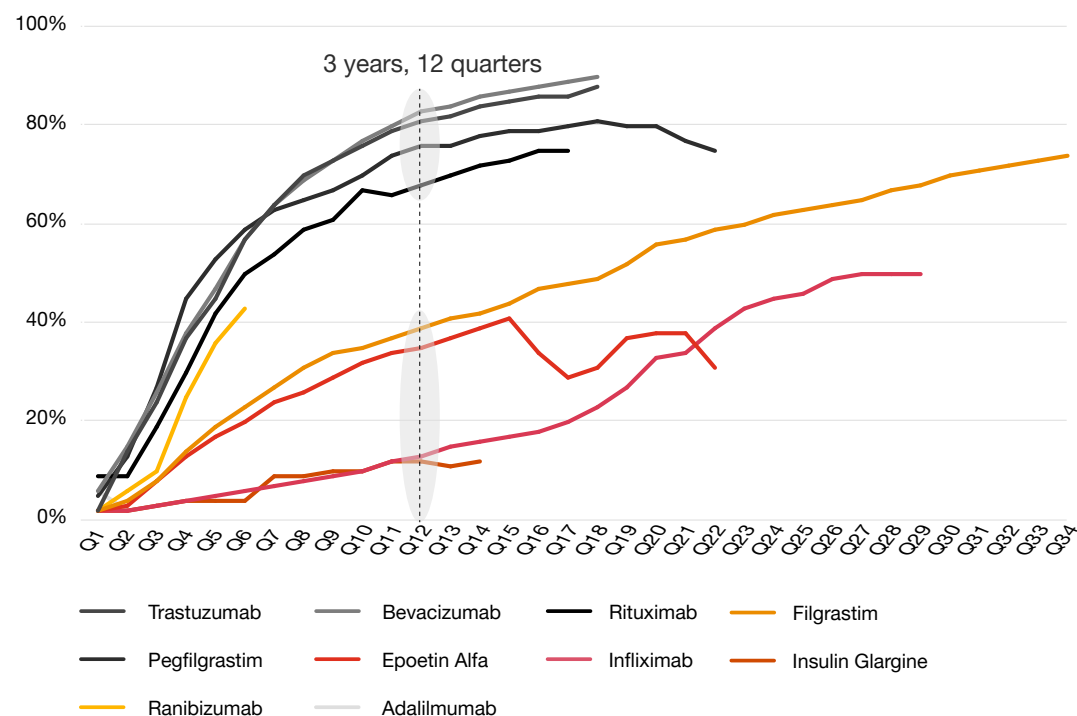
**Humira Cordavis represents co-branded Humira supplied to Cordavis.

Figure 16b. Adalimumab new prescriptions written Jan-24 to Apr-24



Source: Drug Channels

Figure 17. Biosimilar market share by post-launch quarters



Source: Samsung Bioepis



Implications

Health plans and payviders:

The launch of private-label biosimilars may mark a turning point in the market where the promise of biosimilar savings is realized through both price/rebate value and conversion to biosimilars. PBMs have already or are likely to introduce new terms to reduce the amount of rebates they are expected to pay to health plans when shifting formularies to lower-priced biosimilars to compensate for their own loss of rebates (for instance, CVS Caremark's "rebate credits"⁶⁶). Nevertheless, health plans should still expect to see net deflationary benefits by paying less for biosimilars. In addition to evaluating the cost savings, health plans seeking to promote exclusive/preferred biosimilars into formularies should consider a variety of other factors, such as how to convert existing reference biologic users, costs beyond drug acquisition such as provider and patient education and patient visits for transition, and pharmacovigilance.

Pharmaceutical manufacturers:

For companies with innovator drugs facing biosimilar competition, the biosimilar defense strategies that preserved share may be coming to an end as new models are introduced, including private-label strategies. For biosimilar manufacturers, the new private-label partnership opportunities combined with high and low WAC pricing approaches offer potential to capture a wide range of commercial and government business much closer to launch than previous biosimilar launches. The biosimilar market in 2025 and beyond promises to be a dynamic market. All manufacturers should monitor competitive events; consider drug, portfolio and pipeline implications; and evolve their strategies to better achieve brand and franchise goals.





Deflator:

Reassessing total cost of care management: A holistic approach to affordability

This year, 60% of the health plans we surveyed ranked “managing total cost of care” as among the top 3 deflators. In the face of unprecedented inflationary pressures and the lack of new deflators, a common theme during the interviews was plans’ refocused attention to total cost of care management and hope of more savings through improving existing initiatives or finding new opportunities while keeping or improving the quality of care. Meanwhile, as many acknowledged, beating the trend is hard as low-hanging fruit has been picked and effects of ongoing initiatives are likely to be baked into the baseline already. The challenge of managing total cost of care is inextricably linked to the broader challenge of affordability today, which the Affordable Care Act defines as the percentage of a member’s household income spent on healthcare expenses.

Health plans’ traditional approach to addressing affordability has not led to sustainable results, largely due to three reasons: 1) a siloed and modular approach centered on improving operations without addressing the underlying deficiencies in dependent functions; 2) greater focus on easy-to-address levers (e.g., administrative cost) and lesser focus on initiatives that are complex and need a longer time to realize savings (e.g., medical cost, care management, provider collaboration); 3) lack of a dedicated enterprise function to monitor, evaluate and implement agile initiatives to improve profitability (revenue and cost).

Recently, health plans’ efforts have matured to address the affordability challenge by employing a holistic enterprise-wide approach to analyze multiple interconnected components that determine premium costs, including medical expenses, risk revenue, operational expenses and margins. In addition to taking a holistic approach, health plans are establishing a dedicated function focused on creating the capabilities required to consistently improve affordability (Figure 18). This dedicated function in the form of an affordability command center champions the end-to-end affordability process by engaging the enterprise across six key stages – benchmarking, target setting, ideation, vetting and selection, execution, and performance management.

By executing this holistic approach through a dedicated function, health plans are striving to not only moderate medical costs trends but improve affordability by reducing over-utilization, improving efficiency of operations, and enhancing the effectiveness of medical management operations. While health plans have achieved varied results, a holistic approach to improving affordability can achieve 0.5% to 1.5% reduction in medical costs year over year^{67,68,69,70,71}.



Implications

Health plans and payviders:

In a race to provide more affordable products to members and achieve sustainable growth, health plans are focusing on reducing wasteful spending, leading to transformative changes in the marketplace (e.g., new PBM models⁷², integration of medical and pharmacy benefits, enhanced transparency and member navigation, etc.). Achieving sustainable impact on affordability also requires health plans to develop next generation capabilities across the six components of a dedicated affordability function, including investing in AI or machine learning to proactively identify wasteful spending and address operational inefficiencies. While national health plans have a long history in taking a disciplined approach to managing the total cost of care and continuously invest in improving their capabilities, medium / small sized plans and payviders often face significant investment challenges and are unable to keep up with national health plans. Smaller plans should look to external vendors or collaborative investments with other like-minded health plans to build competitive total cost of care management capabilities.

Providers:

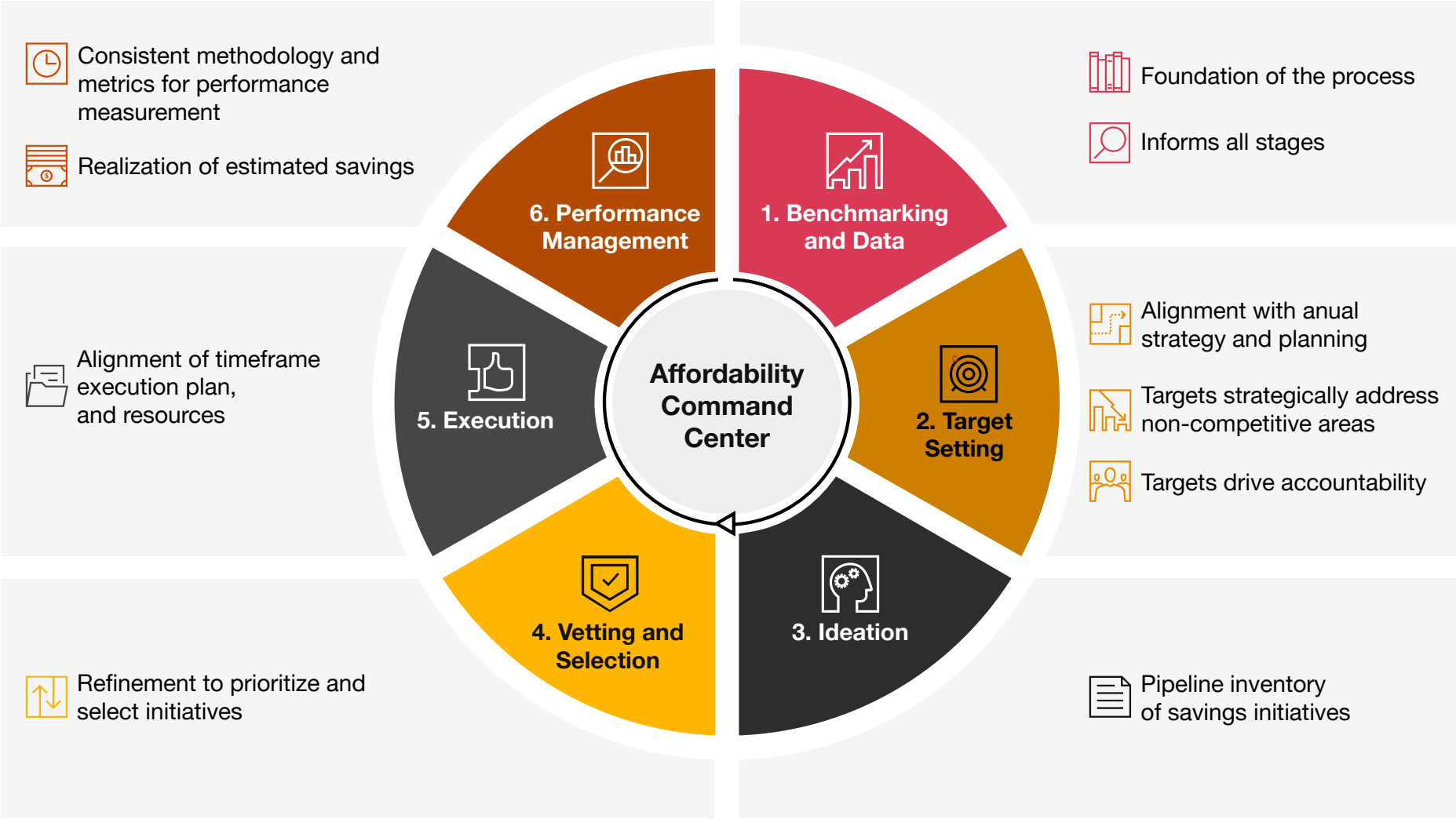
Providers have a critical role in educating members about making choices in obtaining healthcare services. Reducing unnecessary spending will likely require providers to adhere to evidence-based guidelines and understand the impact on economics from increased total cost of care management efforts. Providers can also continue to participate in value-based care arrangements that reward them for reducing wasteful spending.

Employers:

Employers are seeking more transparency and better reporting to understand the outcomes and effectiveness of their health plans’ cost of care management efforts. Additionally, employers’ demand to provide better value to their employees is incentivizing health plans to ensure demonstrated outcomes (e.g., independent validation⁷³) from their vendors.



Figure 18. Affordability Command Center



Trends to watch

Centers for Medicare and Medicaid Services (CMS) health plan and hospital price transparency rule

Starting in 2021, hospitals were required by CMS to provide clear, accessible pricing information online, including a holistic machine-readable file (MRF) listing gross charges, discounted cash prices and charges negotiated between the hospital and third-party payers for all the items and services provided. In July 2022, the rule was extended to include health plans as well.⁷⁴ CMS's 2024 Outpatient Prospective Payment System (OPPS), released in November, requires hospitals to display their charge information in a more standardized way, conforming to updated data specifications and to disclose additional fields, such as standard charge methodology.⁷⁵

In theory, the implementation of the Price Transparency Rule would expand visibility into unit prices and have wide and varied implications for all stakeholders, including hospitals and payers. On one hand, hospitals could analyze price transparency data to identify services where their charges are low relative to the market, or payers that are more generous in their reimbursements for competitor hospitals, and then demand greater price increases for these services or with these payers in future contract negotiations. On the other hand, payers could similarly leverage price transparency data to improve their contracted prices as related to high-cost services or hospitals.⁷⁶

In practical use, we start to see early signs of successful application, but several hurdles need to be overcome. Data accuracy and completeness is one concern: Aside from outright errors, MRFs might contain rate information on a limited set of codes (i.e., DRG, CPT, HCPCS etc.). Meanwhile, MRFs do not provide visibility into additional quality, administrative and risk payments on top of the base fee schedule. In addition, hefty data analytics efforts are needed to meaningfully put MRFs into use: Large datasets need to be first aggregated and transformed, and comparing different

charge methodologies (fee schedule, case rate, percent of total billed charges etc.) can itself be challenging. Ninety-five percent of the plans surveyed deemed the impact of the Price Transparency Rule on 2024-5 medical cost trend to be neutral or immaterial. Ninety-one percent of hospitals and more than 200 health plans published data as of December 2023, according to one analysis⁷⁷, and this wealth of data presents opportunities with appropriate analysis. For example, there are cases where health plans drive insights into their competitive unit cost position (how much they pay to hospitals compared to other payers) by identifying and analyzing the most comparable codes and then triangulating the results with other data, such as broker insights, and public premium data. There are also cases where health plans equip themselves with knowledge of how much rate increase the hospital under contract negotiation received in negotiations with other payers.

In the long run, if both data and capabilities to analyze data continue to mature, plans could see upward and downward pressures during contract negotiations (for example, price increases demanded by low-paid providers and price control on high-cost providers). More supervision from regulatory agencies, such as CMS' new rule and requirements specified in the 2024 OPPS, might facilitate the process.



Implementation of generative AI and other technological advancements

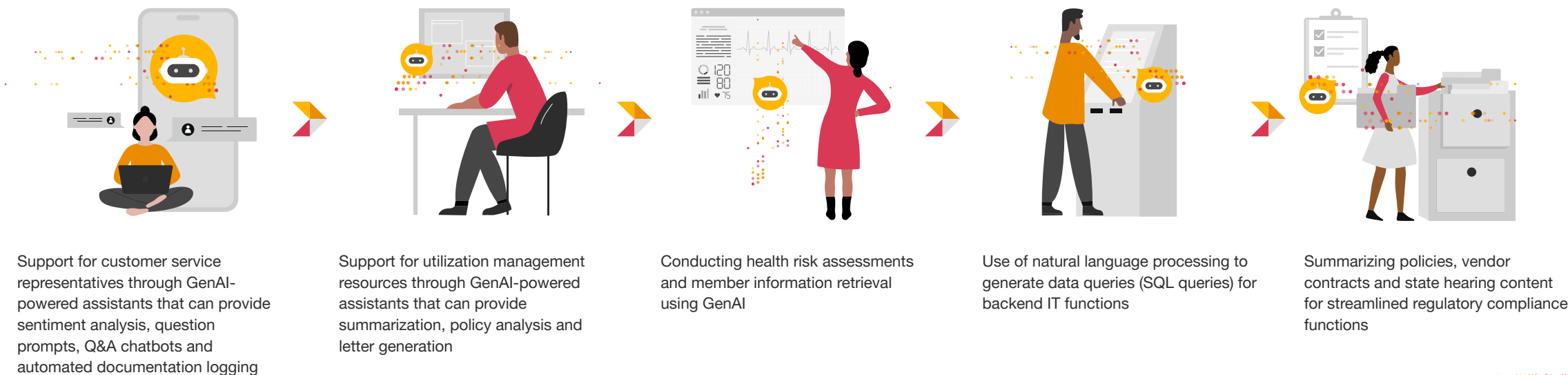
Payers and providers are leveraging GenAI across different areas of the value chain.⁷⁸ While many use cases help to improve administrative efficiency, opportunities for managing medical cost abound as well. For instance, payers can leverage GenAI to accelerate prior authorization with greater accuracy, thus delivering timely care. On the provider side, clinical decision support tools and diagnostics and treatment recommendations are among the top priorities.⁷⁹ None of the health plans PwC surveyed explicitly

factored in the impact of GenAI in estimating the 2024-25 medical cost trend; nevertheless, GenAI and artificial intelligence broadly are expected to play a large role in making healthcare more affordable.⁸⁰

Effective and scalable GenAI strategies require organizations to build out patterns that can be applied across core business processes and that focus on organizational readiness and repeatability.⁸¹ Meanwhile, payers and providers should navigate several critical considerations to manage risk and compliance. Trust and a focus on

data security should be the starting point – beyond GenAI systems, organizations should risk-assess network architecture, security policies, data governance, and more. Additionally, organizations should be prepared to focus on Responsible AI, implementing practices that can help preserve value and engender safety and trust, including reducing bias and enhancing transparency.

Figure 19. Illustration of GenAI use cases across the healthcare value chain (not exhaustive)



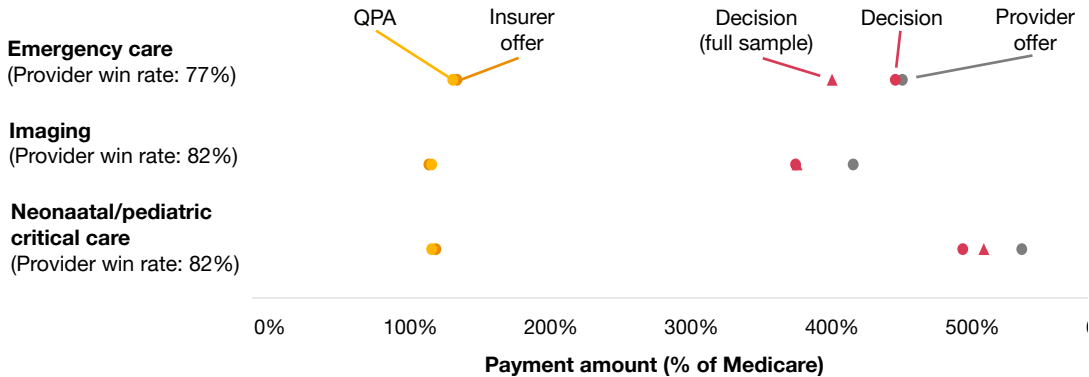
No Surprises Act

The federal No Surprises Act (NSA), which went into effect in 2022, protects patients with Individual and Group coverage from balance billing, commonly known as surprise billing, which refers to situations where an individual unexpectedly receives an out-of-network (OON) bill for the difference between what the provider charges for an item or service and what the individual's plan will pay. In general, under NSA, patients receiving OON services should not be billed for cost-sharing requirements greater than the requirements that would apply if the bill were in-network, unless the provider has obtained the patient's written consent to balance bill (only permitted for certain providers and services)⁸². Plans and providers should agree on the OON rate payable to the provider either within a 30-day open negotiation period or through the Federal independent dispute resolution (IDR) process⁸³.

The first annual report published by U.S. Department of Health and Human Services (HHS) in July 2023 provides a framework for understanding the multifaceted impact of NSA on the healthcare market⁸⁴. The primary impact is likely to be concentrated in certain specialties. Among emergency department services, radiology, anesthesia and pathology – the specialties most commonly associated with surprise billing– the OON percentage of claim lines for professional services in facility settings has been around 10% since 2022, according to an analysis of a large database of⁸⁵. Meanwhile, the impact may extend beyond OON to in-network rates through payer-provider negotiation dynamics that ultimately affect unit price. For example, providers who used to view OON billing as an attractive alternative to joining a plan's network may feel more pressure to join the network, given the modified expectation on OON payments because of NSA (deflationary). On the other hand, providers may believe the IDR process provides them with higher reimbursement than they would be able to negotiate themselves, thus they may be more willing to go out-of-network (inflationary).

The Congressional Budget Office (CBO) predicted NSA would reduce negotiated prices for all in-network care at enactment⁸⁶; meanwhile, early analysis is emerging with mixed findings regarding NSA's impact on in-network and OON costs. The same analysis of private healthcare claim records showed 2022-23 trends toward decline in percentage of OON claims as well as a convergence of OON unit cost towards in-network (both declining) among top CPT codes – supporting NSA's deflationary impact. On the other hand, the first CMS-released IDR data shows evidence potentially contradicting CBO's prediction⁸⁷. Specifically, one of CBO's hypotheses is that IDR decisions will lean closer to the qualifying payment amount (QPA), an insurer-specific median of contracted rates by service, insurance type and geography, but an analysis of CMS 2023 Q1-2 data indicates that IDR entities favored provider offers that were much higher than QPA (Figure 20). It is unclear whether the outcomes so far are representative of what typical providers could obtain in IDR (74% of the line items under analysis are associated with physicians affiliated with just four large firms) and how insurers' and providers' behaviors may change going forward (insurers may raise their offers in hopes of winning more often). The No Surprises Act has the potential to be a deflator or an inflator. Additional CMS data and the next HHS reports can provide more insights.

Figure 20. 2023 Q1-2 IDR median decisions, offers, and QPAs by type of service



Source: CMS Independent Dispute Resolution Reports, The Brookings Institution

Note: The above analysis includes only the line items that report all four relevant payment amounts (65% of all line items). These line items are deemed representative of the full data, as the median IDR of these line items are close to that of the full data.

Implication of Inflation Reduction Act

The Inflation Reduction Act (IRA) of 2022 brought about landmark changes to Medicare Part B and Part D drug pricing, allowing price negotiations and inflation rebates. Key provisions allow Health and Human Services (HHS) to negotiate prices of a certain number of drugs (varies by year) that have been on the market without competition and are a top expenditure drug by Medicare beneficiaries. Following negotiations, the future price of these drugs will be capped at the lower of the drug's previous average price in Medicare or 40% to 75% of the nonfederal average manufacturer price. The second key provision allows HHS to mandate that year-over-year price increases of these drugs must remain below CPI-adjusted price benchmarks; otherwise, manufacturers will be required to pay hefty fees. Figures 21a and b demonstrate the impact of this policy on net prices charged by manufacturers.

While the IRA provisions apply solely to Medicare, the effects of the policy are expected to ripple through the commercial markets. In the near term, the CBO⁸⁸ expects that manufacturers will set higher initial prices on new drugs to allow for slower price growth that falls within the inflation-adjusted benchmark set forth by HHS. Manufacturers can instead use rebates as a means to offer more competitive pricing and remain within negotiated Medicare prices. The higher initial prices, however, can serve as an inflator in the commercial market where negotiated maximum prices do not exist. In a survey conducted by Parexel International⁸⁹, all surveyed health plans noted that they expect IRA to impact their commercial plans in the form of higher launch prices for new drugs. Furthermore, respondents indicated that they would consider formulary and/or benefit redesigns coupled with increased utilization management to combat expected higher prices.

In the longer term, the CBO expects overall decrease in net drug prices across government and private coverage, as the regulation increases negotiation pressures on manufacturers and forces manufacturers to offset potentially higher prices with higher rebates. With lower-priced benchmarks in the Medicare segment, health plans can leverage this public information to pressure manufacturers into offering more competitive net prices in the commercial segment to remain on formularies.

Figure 21a: Prices Absent IRA Rebate Policy

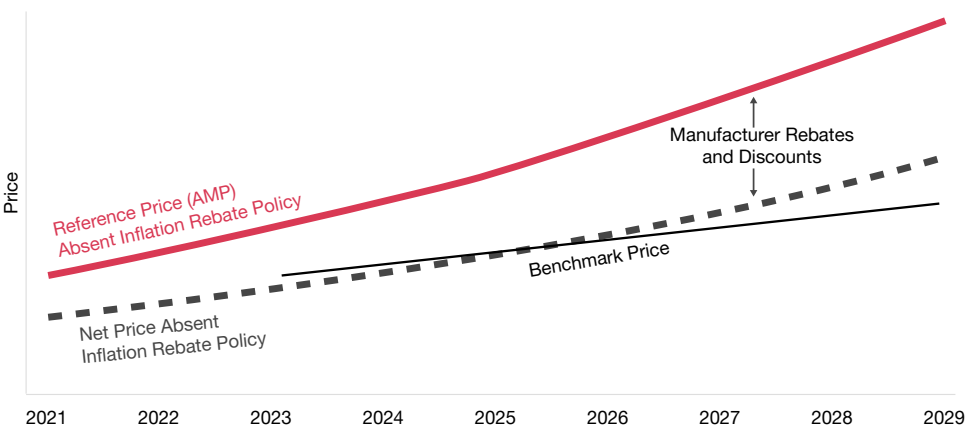
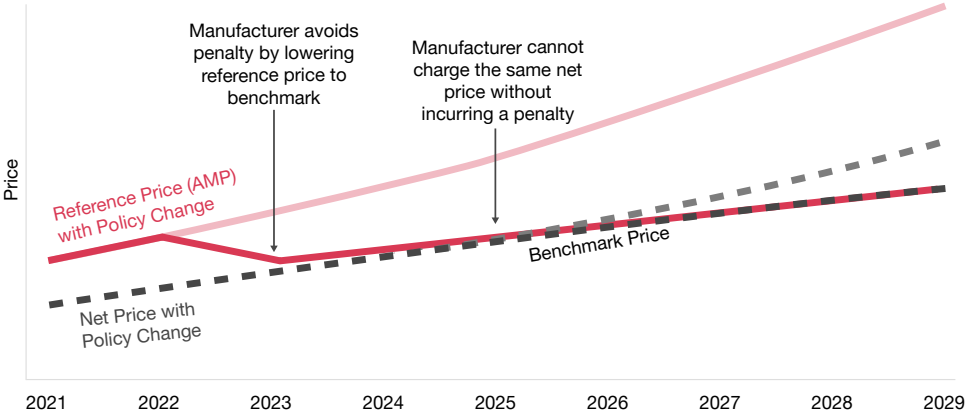


Figure 21b: Prices with IRA Rebate Policy



Source: Congressional Budget Office

Medicaid redetermination

Congress passed the Families First Coronavirus Response Act in 2020, which prohibits state Medicaid agencies from disenrolling people unless they specifically request it. The Kaiser Family Foundation reported that, as a result, enrollment in Medicaid and Children's Health Insurance Program (CHIP) peaked at 94.5 million in April 2023, a 23.1 million increase from February 2020⁹⁰. This continuous enrollment provision ended on March 31, 2023, after which states had 12 months to initiate redeterminations of Medicaid and CHIP eligibility for all enrollees and two additional months (14 months total) to complete all pending actions.

Following the end of the enrollment provision, nearly 22.4 million have been disenrolled with renewals outstanding for another 22.5 million members as of May 2024, far exceeding HHS's original projection of 15 million⁹¹ disenrolled. Of the nearly 22.4 million people disenrolled, however, 69% had coverage terminated for procedural reasons with these individuals likely still eligible for Medicaid or CHIP coverage.

The remaining nearly 7 million individuals no longer eligible for Medicaid or CHIP coverage are seeking coverage in the ACA Individual and employer-sponsored insurance (ESI) markets. HHS originally projected disenrollment of 8.2 million who would no longer be Medicaid or CHIP eligible with 3.6 million obtaining employer-sponsored insurance and 2.7 million qualifying for ACA premium tax credits (PTC), including 1.7 million who are also eligible for zero-premium Individual plans under the provisions of the ARP and IRA. Most recent ACA Marketplace data indicates nearly 4.7 million⁹² consumers have entered the Marketplace due to terminated Medicaid or CHIP coverage through February 2024.

As the majority of disenrollees who obtain ESI were expected to previously be double-covered by Medicaid or CHIP and ESI or to be returning to ESI following pandemic-related shifts in the job market, plans do not expect much impact to their small or large group risk pools. Consensus among health plans is that the impact of Medicaid redetermination is likely to be felt predominantly in the Individual market as enrollment continues to rise. Among the 2 million to 3 million disenrollees who become eligible for PTCs by the end of Medicaid disenrollment, not all of them will enroll in Individual plans, leading many health plans to expect a selection effect in which those who choose to enroll in Individual plans tend to have higher risk. Assessing the effects of adverse selection can be difficult, as plans are unable to precisely track which members were previously covered by Medicaid. Nevertheless, per the HHS projection, the Medicaid or CHIP disenrollees are much younger than the existing Individual market population and thus potentially lower risk. Further, slight relief to health plans may materialize through provider contracts, as hospitals experience favorable shift to payer mix (i.e., increased volume of Commercial revenue versus Medicaid revenue). Overall, the net impact of Medicaid redetermination could be an inflator or deflator as redetermination comes to an end, and 85% of surveyed plans indicated the impact to be neutral or low on the 2025 medical cost trend.



About this research

Each year, our Health Research Institute (HRI) projects the growth of employer medical costs in the coming year and identifies the leading trend drivers. Health insurance companies use the medical cost trend to help set premiums by estimating what this year's health plan will cost next year. In turn, employers use the information to make adjustments to benefit plan design to help offset health insurance cost increases. The report identifies and explains what it refers to as “inflators” and “deflators” to describe why and how the healthcare spending growth rate is affected. This forward-looking report is based on the information available through June 2024. HRI conducted more than 20 surveys and 10 interviews from April through May 2024 with health plan actuaries whose companies cover nearly 100 million employer-sponsored large and small group members and 10 million ACA marketplace members. Participants were asked about their trend experience for 2022-23 and 2023-24, trend estimates for 2024-25, and the factors driving those trends. Results from the surveys and interviews were aggregated using a weighted average approach based on the number of self-reported lives in the survey. Results for Group and Individual trends were not aggregated for any purposes or results during this process.



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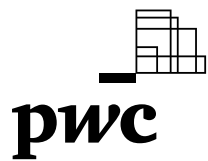


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