American Academy of Actuaries

Issue Brief

Drivers of 2025 Health Insurance Premium Changes

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Key Points

- The impact of inflation on health insurance premiums appears within historical norms.
- Increasing prescription drug spending is leading to higher premiums.
- The risk pools are likely to be relatively stable, with risk pool changes having a minor effect on premiums.
- Premium changes will reflect local market dynamics with variations driven by insurer goals and state and local policies, rather than by nationwide considerations.

This document is intended to describe how premiums may change in the upcoming plan year. It is not intended to be used or relied on by actuaries or insurers for rate filings.

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Introduction

Every year, changes in the prices and utilization of health care services contribute to changes in health insurance premiums. The specific factors, however, can change from year to year. Inflation increases the input costs of health care goods and services, which in turn increases health care prices and premiums. For 2025, inflation's impact on premiums appears to be within historical norms. That said, prescription drug spending is increasing faster than medical spending and adding to premium growth. Higher expected drug spending is due to higher price growth as well as the increased demand for expensive weight-loss drugs in plans in which they are covered. Changes in the composition of the risk pool—that is, the mix of insurance enrollees who have high expected health care utilization versus the those who have low expected utilization—can also affect expected health care spending and premiums.

Although some enrollment factors might affect the risk pool in certain states—such as the continuing Medicaid redetermination process—the risk pools for 2025 are generally expected to be relatively stable, causing only minor changes in premiums. Premium changes will reflect local market dynamics and could vary materially by carrier and by area, as well as state-specific rules and policies. Looking ahead, a greater availability of genetic therapies (or other similarly expensive treatments), along with the currently scheduled expiration of enhanced premium tax credits at the end of 2025, could increase future premiums, potentially dramatically.

This issue brief by the American Academy of Actuaries' Individual and Small Group Markets Committee provides more details on the factors that are likely to drive premium changes in 2025 for plans operating in the individual and small group markets subject to Affordable Care Act (ACA) rules. Importantly, this brief focuses on changes in gross premiums rather than changes in premiums net of ACA premium subsidies.

Contributors to Medical Trend

Medical trend reflects changes in health care prices, utilization, and service intensity.

Inflation

After a couple of years of especially high increases in medical input costs—due to such factors as provider wages, technology enhancements, and increased real estate costs—inflation has returned to historical norms. Inflation assumptions could be somewhat higher for insurers with multiyear provider contracts that were recently—or will soon be—up for renewal, as the new rates would likely reflect not only current inflation, but also the higher inflation rates of recent years.

Increased prescription drug spending

Prescription drug spending is increasing faster than medical spending and adding to premium growth. Higher expected drug spending is due to higher price growth as well as the increased demand for expensive weight-loss drugs in plans in which they are covered. Glucagon-like peptide-1 agonist medications (GLP-1s) have traditionally been used to treat type 2 diabetes and morbid obesity, and these uses are usually covered by health insurance in the individual and small group markets. Demand for these drugs to treat general weight loss has increased considerably. However, these medications are typically subject to prior authorization, and weight-loss prescriptions are not typically covered in the ACA markets. GLP-1s hold some promise for positive long-term health outcomes, but continuous use may be required for weight loss and other benefits to be sustained. The

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high cost of GLP-1s and their long-term use, if covered, could push premiums higher in 2025, especially as obesity rates and pre-diabetic diagnoses rise, pushing more patients into the more clinical diagnoses where these medications are typically approved.

Over time, any potential positive health outcomes of these drugs—such as reduced blood pressure, cholesterol, heart disease, and diabetes—could lower other health care costs, offsetting to some extent the direct cost of these medications. Such reductions would not be incorporated into 2025 premiums, however, as they are longer term in nature and the insurer that pays for this coverage may not be the one that sees the benefits. Insurers that broaden eligibility for these treatments, either by choice or by mandate, would require more significant premium increases to address this immediate increase in upfront spending.

Gene therapy

The interest in and availability of new gene therapies is growing rapidly, and the costs for these treatments can be in the millions of dollars. They aren't typically covered by plans in individual and small group markets, however. As a result, such therapies are unlikely to affect premiums in 2025 unless coverage for such treatments is state-mandated. In the future, however, if coverage for such treatments becomes more widely available, premiums would likely increase dramatically, potentially offset in part by any state reinsurance programs or other risk mitigation mechanisms.

Adult dental coverage

New rules issued in 2024 will allow states to begin including routine non-pediatric dental coverage as an essential health benefit (EHB). Because any such requirements cannot take effect until 2027, however, this change will not affect 2025 premiums. For 2027 and beyond, any premium changes due to the addition of adult dental coverage will depend on state decisions on whether dental coverage will be included in the EHB requirements, how that coverage differs from what is currently offered, and the specific parameters regarding that coverage (e.g., the services covered, cost-sharing requirements, etc.).

COVID-19

Four years after the onset of the COVID-19 pandemic, the cost and utilization of COVID-19 treatments and tests is better understood, and the effects of COVID-19 on health care costs are both more predictable and have become part of the underlying claims data used to project 2025 claims. Issuers may no longer need to build in separate adjustment factors for COVID-19, and COVID-19 is unlikely to contribute to premium changes for 2025 and beyond.

No Surprises Act

The No Surprises Act protects plan members from balance billing in most common situations where unexpected balance bills have historically occurred (i.e., where patients have used emergency care at in-network facilities, non-emergency care from out-of-network providers at in-network facilities, and air ambulance services). Over time, the law was expected to reduce health inflation. However, its effects on provider network development and on prices are not yet clear, especially considering recent legal challenges to the law's independent dispute resolution provisions, and the law is not expected to significantly affect 2025 premiums.

Risk Pool Composition Factors

Premiums reflect the composition of the risk pool—the overall level of health care utilization—which is largely driven by the share of the risk pool that is lower cost (healthier) versus the share that is higher cost (sicker). One key element of risk pool composition assumptions is enrollment rates. Higher enrollment rates typically result in a healthier risk pool, as individuals who opt to forgo coverage are likely healthier than those obtaining coverage. Changes in premiums will reflect expected changes in the risk profiles of the enrollee population, as well as any changes in insurer assumptions based on whether experience to date differs from that assumed in 2024 premiums.

Individual enrollment has grown considerably over the past few years. As of February 2024, 20.5 million individuals enrolled in individual market coverage, up 31% from 2023, and up 83% from 2021.[1] This growth, has been attributed to numerous factors such as enhanced premium subsidies, Medicaid eligibility redeterminations, enrollment mandates in certain states, and increased enrollment outreach and assistance. These factors have generally improved the overall risk pool in the individual market, which has put downward pressure on premiums.

Although some factors may have small effects on the risk pool composition in 2025, no major risk-pool-related changes on premiums are expected.

1 *Health Coverage Under the Affordable Care Act: Current Enrollment Trends and State Estimates*, Assistant Secretary for Planning and Evaluation; Office of Health Policy issue brief; March 22, 2024.

Medicaid eligibility redeterminations

During the COVID-19 public health emergency, states received extra Medicaid funding if they met certain requirements, including no involuntary termination of beneficiary coverage. In April 2023, states were permitted to begin re-evaluating member eligibility and terminating those who were deemed ineligible. Individuals deemed ineligible could gain coverage through the individual market, the employer group market, other public coverage, or become uninsured. Most Medicaid eligibility redeterminations are likely to be completed in 2024. This redetermination population is assumed to have lower health costs than other Medicaid enrollment populations, but the cost relationship for these enrollees relative to the individual market is less certain. The shift of prior Medicaid enrollees to the individual market could somewhat improve the individual market risk pool, but the effects can vary widely by state and carrier, and the effects on 2025 premiums will likely be small.

Enhanced premium subsidies

The enhanced premium subsidies provided through the American Rescue Plan Act (ARPA) and extended through 2025 by the Inflation Reduction Act (IRA) should help to maintain or increase enrollment in the individual market. These enhanced subsidies have given individuals with incomes below 150% of the federal poverty level (FPL) access to zero-premium silver plans. Even before the enhanced subsidies were enacted, many individuals with incomes somewhat higher than 150% of FPL had access to free or low-premium bronze and gold plans from increased subsidies resulting from cost-sharing reduction (CSR) premium loads.[2] The enhanced premium subsidies expanded on this dynamic, as subsidies became more generous for those who already received them and increased the number of individuals eligible for subsidies. Such premium reductions increase enrollment even among healthy individuals, thereby improving the risk pool composition. Claims experience for 2022, which was used as a basis to project 2024 claims and premiums, reflected both of these policies. Therefore, the risk pool improvements were likely already incorporated into 2024 premiums. To the extent that insurers expect additional improvement due to enhanced premium subsidies, especially in combination with Medicaid redeterminations, additional decreases in 2025 premiums could result.

If the enhanced premiums are allowed to expire at the end of 2025, premiums in 2026 would be expected to increase. Reduced subsidies would be expected to lower enrollment, especially among healthy individuals, thereby worsening the risk pool.

2 In October 2017, the federal government ceased reimbursing issuers for cost-sharing reduction costs. Despite the lack of federal funding, health insurers are still required by law to continue providing silver-plan variants with lower cost-sharing for CSR-eligible enrollees. Beginning in 2018, issuers in nearly all states increased their premiums (a practice referred to as CSR loading) to cover the costs associated with providing CSRs to eligible enrollees. Currently, most states allow or require insurers to increase the premiums only for silver plans, often specifically only on-exchange silver plans.

Contraction of short-term, limited duration (STLD) plans

Short-term, limited duration plans are not required to comply with ACA issue, premium rating, and benefit requirements. These plans can vary rates by health status and offer fewer benefits at lower costs, which can make the plans more attractive to healthy individuals than to those who have pre-existing health conditions. Trump-era rules broadened access to STLD plans, allowing individuals to be enrolled in such plans for up to three years. To reflect the possibility of STLD plans taking healthy members away from the individual market risk pool, insurers may have responded by increasing premiums. Regulations implemented for 2025 reverse the Trump-era regulations, limiting STLD plan coverage to four months. To the extent that individuals who were getting coverage enroll in short-term limited duration plans enroll in individual market coverage, it could improve the market risk pool and slightly lower 2025 premiums.

Extension of coverage availability to DACA recipients

Beginning with 2025 open enrollment, Deferred Action for Childhood Arrivals (DACA) recipients will have access to ACA individual market coverage and subsidies. According to the Centers for Medicare and Medicaid Services, as many as 100,000 previously uninsured DACA recipients would be eligible to enroll in a marketplace plan or a basic health plan.[3] Although the impact could vary geographically, this expansion will likely have minimal effects on premiums because the number of potential DACA enrollees is small relative to the size of the individual market.

Shifts in employer funding arrangements

Small employers are facing increased pressure regarding their health care costs and continue to explore alternative funding arrangements. Shifting to other arrangements can affect the risk pool compositions of both the small group and individual markets.

Individual Coverage Health Reimbursement Arrangement (ICHRAs) and Qualified Small Employer HRAs (QSEHRAs). ICHRAs and QSEHRAs allow employers to fund employees' selection of a locally available individual market plan. Although adoption to date has been slow, particularly for ICHRAs, the recent expansion of available private market administration tools may facilitate greater take-up of this option. Growth in these plans has the potential to reduce participation in small group ACA plans. The expectation is that employers with high-cost workers and dependents may be more likely to shift to ICHRAs than employers with lower-cost members. For small employers, this is most likely in states where individual coverage is less expensive than available small group single risk pool options, and could reduce average costs and premiums for remaining

3 "HHS Final Rule Clarifying the Eligibility of Deferred Action for Childhood Arrivals (DACA) Recipients and Certain Other Noncitizens"; Centers for Medicare and Medicaid Services Newsroom; May 3, 2024.

members in the small group market. The movement of higher-cost people from small group coverage to the individual market could in turn worsen the individual market risk pool. Nevertheless, because the number of those migrating coverage to the individual market is likely to be small compared to the number of current individual market enrollees, the impact on premiums is expected to be negligible.

At least in the near term, ICHRA adoption among larger employers is likely to be slow. Nevertheless, the sheer number of employees who receive coverage through large employers means that even negligible adoption of ICHRAs by large employers could produce meaningful changes to the individual market single risk pool. Although employers that might be drawn to ICHRAs may have the least healthy enrollees, the relatively healthier risk profile of large employers means that the effects on the risk pool remain uncertain. Therefore, these funding arrangements are likely to have a negligible impact on 2025 premiums.

Shift to self-funding and other alternative plan funding arrangements. Cost pressures on small employers could result in a continued shift away from ACA-compliant fully insured plans to self-funded, level-funded (i.e., stop-loss coverage combined with an insurer-managed claims payment fund), multiple employer welfare arrangements (MEWAs) and association health plans (AHPs). Because these alternative plans are not required to comply with the single risk pool rating limitations, they can offer lower premiums for healthier groups. This flexibility may make them more attractive to employers with lower-cost employees, and further migration to alternative plans could cause a deterioration of the fully insured small group market risk pool and increase premiums. The propensity for employers to move to alternative funding arrangements can vary by industry and geographic area. Overall, the shift to self-funding and other arrangements by small employers will likely have only a nominal impact on 2025 premiums, though it appears to be driving the longer-term slow decline in enrollment in small group ACA-compliant fully insured plans.

Other Factors

State and local considerations

Premium rate changes can vary significantly by geographic area. Premium rates reflect state legislative and regulatory requirements, as well as local market conditions. Examples of state-related factors include Medicaid expansion status, presence/absence of a reinsurance program, state benefit mandates, utilization management restrictions, public option programs, and supplemental premium or cost-sharing subsidies.

Change Healthcare ransomware cyberattack hack

The February 2024 ransomware cyberattack on Change Healthcare, a major U.S. health care technology company, interfered with billing and care authorization portal activity nationwide for a significant portion of the insured population. The resulting delay in claims information may have made it more difficult for issuers to incorporate information from early 2024 claims activity into their initial 2025 premium rate filings. Federal regulators allowed more time for certain premium reporting and risk adjustment processes. These accommodations should limit the effect of the cyberattack on premium rates.

CSR load factor

Nationwide, the percentage of enrollees eligible for the most generous silver plan CSR variant increased from 37% in the 2023 open enrollment to 41% in 2024.[4] In states that permit silver CSR loads, issuers might increase the load (and thus silver plan premiums) to reflect a shift in the distribution of silver plan membership to higher CSR variants. This is likely to have a limited effect on gross premiums for plans located off the Exchange or situated on other "metal tiers," but any resulting increase in premium tax credits would reduce net premiums for many participants.

Summary

Rate setting in the ACA-compliant individual and small group markets is complex, and pricing actuaries consider a wide range of factors when determining rate levels. How 2025 premiums differ from those set in 2024 will be influenced by a variety of factors. In general, inflation and increased prescription drug prices and use will be the major factors in increasing medical trend. Several factors have the potential to change the composition of the risk pool, including Medicaid redeterminations, enhanced premium subsidies, and a shift in small employers pursuing alternative funding arrangements, but the individual market and small group market risk pools are likely to be relatively stable in 2025, with only minor effects on premiums. Premiums and premium changes will reflect local market dynamics that could vary materially by carrier and by area. In addition, state-based policies, such as decisions on Medicaid expansion, reinsurance programs, supplemental premium and cost-sharing availability, will affect premium changes.

4 *Health Insurance Marketplaces 2024 Open Enrollment Report*; Centers for Medicare and Medicaid Services; undated.