ACA Unified Rate Review Template (URRT) Market Trends Over Time

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Overview

In recent years, there have been substantial external forces that have impacted the individual and small group Affordable Care Act (ACA) markets. These forces have ranged from the COVID-19 pandemic to policy changes increasing individual market premium subsidies, developing new pathways for ICHRAs (individual coverage HRAs), large inflationary pressures, Medicaid re-determination, and more. How have issuers adapted their participation and pricing to this changing landscape and, consequently, impacted market size and dynamics? To answer this question, we examined the CMS required Unified Rate Review Template (URRT) which includes a breakdown on plan rate changes, financial reporting, and the various components of premiums. The URRT allows us to explore variations in retention, risk adjustment, premiums, and claim costs by plan.

The intent of this brief is to share trends on the financial health of markets and issuers over time, how issuer participation, market size, and plan offerings have evolved, the driver of revenue changes due to these external forces, and what those trends could mean for future years.

How have issuers adapted their participation and pricing to this changing landscape, and consequently, impacted market size and dynamics?

Methodology

The URRT is an individual and small group federal rate filing requirement used by CMS to ensure compliance with ACA rating rules. It illustrates pricing development for the projection period (pricing year) starting with base period experience, whether from a manual or issuer experience source. Data is presented at the HIOS ID[1] and plan-level for all ACA market issuers offering coverage within the pricing year[2]. This analysis focused on the years 2019 to 2024 (or the last six years) to review recent trends.

Individuals should use caution while drawing inferences from plan-level URRT data, as an issuer may report certain assumptions differently from actual expectations such as profit, administrative expenses, or risk adjustment transfers per member per month (PMPM), for example, an equal PMPM across all plans when in reality the PMPMs vary. Further, the URRT instructions can leave some room for

[1] "HIOS ID" refers to the 5-digit identifier assigned to each issuer in each state and market.

[2] This includes all issuers and plans regardless of Exchange status.

interpretation and do not advise specifically on the reporting or bucketing of particular impacts i.e., where to include COVID-19 impacts, which may affect comparisons for trends and other projection factors. Additionally, the URRT does not show regional variation in experience or plan-level offerings.

Below, the first question we examine is how medical loss ratios[3] have changed over recent years and the potential drivers of the varying financials.

Trends in Loss Ratios and Their Drivers

Historical Loss Ratios

In the four years span from 2019 through 2022, emerging loss ratios were, on average, 81.8% in the individual market and 83.2% in the small group market.[4] Loss ratios in both markets were higher in years 2021 and 2022 than both 2019 and 2020. In the individual market, the higher loss ratios in 2021 were driven by premium rate increases being insufficient – there was a 10.6% increase in claim costs whereas the premium PMPM increased only 0.5%.[5] In the small group market, claim costs increased by 11.8%, however the loss ratio deterioration was slightly offset by a premium change of 4.2%. Loss ratios improved slightly in 2022 relative to 2021 in both markets as issuers sought to correct their claim cost losses with premium increases.

It is important to note that there is typically a two-year lag between experience and a rate correction, assuming rational pricing. As shown in Table 1, individual market premiums increased in 2023 and 2024, after years of lower rate increases and worsening experience. Individual market premiums decreased on average in 2024 following a slight improvement in 2022 loss ratios.

Table 1 - Individual Experience Year Loss Ratios and Pricing Year Premium Rate Increases

Pricing Year	2021	2022	2023	2024
Experience Year Loss Ratio[6] (Pricing Year minus 2)	76.6%	79.1%	87.0%	83.7%
Premium Rate Increase (Pricing Year)[7]	1.5%	3.8%	6.8%	6.0%

[3] Medical loss ratio = (claim costs + risk adjustment) / premium

[4] Note the definition of medical loss ratio in this context is different from the Federal medical loss ratio rebate calculation (Federal medical loss ratios are generally higher due to the formula removing taxes and fees, and accounting for quality initiative expenses).

[5] "Claims" in this context is referring to the sum of claims and risk adjustment transfers. In theory, the market average risk adjustment transfer should be $0. However, due to market exits, there may be a lack of experience reported leading to a slight payable or receivable on average.

[6] Experience Loss Ratios refer to the loss ratios in the year of the experienced used for pricing. There is typically a two-year lag between experience and pricing. For example, the individual experience loss ratio of 76.6% is the base loss ratio used to price premiums in 2021, which is from issuer experience in 2019.

[7] The premium rate increases presented in Table 1 represent the population mix at the time of rate filing, whereas the premium increases in the proceeding paragraphs include population mix differences year over year.

Table 2 - Small Group Experience Year Loss Ratios and Pricing Year Premium Rate Increases

Pricing Year	2021	2022	2023	2024
Experience Year Loss Ratio (Pricing Year minus 2)	82.4%	80.1%	85.9%	84.6%
Premium Rate Increase (Pricing Year)	3.4%	5.2%	4.7%	7.0%

Metal-level loss ratios by market are presented in Table 3. From 2019 to 2022, platinum was consistently the worst-performing metal in both the individual and small group markets. Silver, bronze, and gold fluctuate in performance year over year.

One potential driver of the gold plans performing worse in the individual market in later years is due to policy changes and tightening of regulation across states through pricing factor mandates. The impacts have caused an increase in migration of members from lower metal level plans (silver and bronze) to gold plans over time. This was partially a result of the introduction of higher premium subsidies (beginning in 2021 through the American Rescue Plan Act), states limiting the induced demand curve factors to lessen the premium gap between silver and gold, as well as a number of states implementing requirements for higher cost-share reduction loads (further increasing silver premiums). Relative to a market average premium increase of 19.3% from 2021 through 2024, gold premiums have reduced comparatively over that period, increasing only 13.2% on average.

Table 3 - Individual Metal-Level Experience Year Loss Ratios

Metal	2019	2020	2021	2022
Silver	76.8%	81.0%	88.0%	84.7%
Gold	78.6%	68.2%	93.3%	91.7%
Bronze	73.3%	78.0%	80.9%	75.6%
Platinum	102.1%	103.5%	113.2%	117.2%
All	76.6%	79.1%	87.0%	83.7%

Table 4 – Small Group Metal-Level Experience Year Loss Ratios

Metal	2019	2020	2021	2022
Silver	79.0%	76.7%	81.8%	80.8%
Gold	83.4%	81.3%	87.7%	85.6%
Bronze	76.0%	75.7%	82.5%	79.4%
Platinum	89.4%	85.4%	90.5%	90.2%
All	82.4%	80.1%	85.9%	84.6%

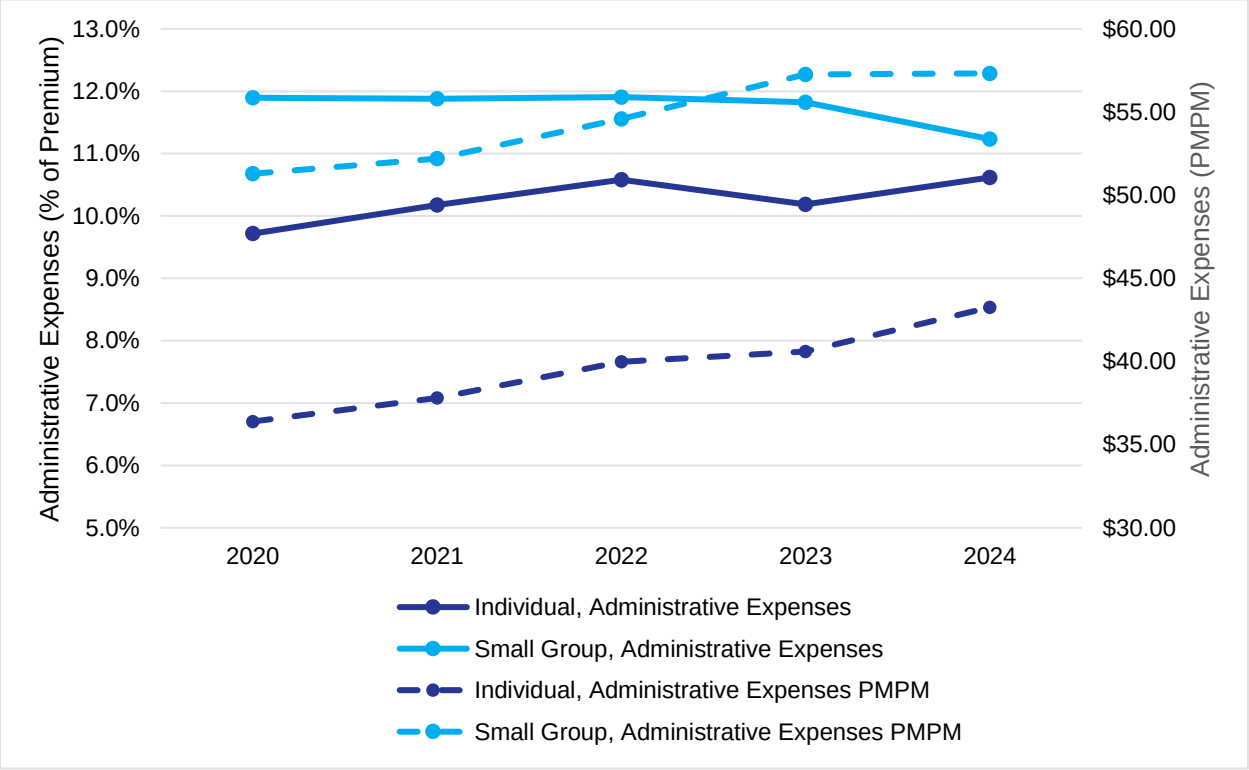
A key question surrounding medical loss ratios is what factors led to their changes. We examine some of the potential drivers in premium and loss ratios in the following sections.

Driver of Premium Increases: Administrative Expenses and Overall Retention

Changes in administrative expenses are one reason for changes in premium rates and consequently loss ratios. However, we found that as a percentage of premium, administrative costs have been rather stable between 2020 to 2024 in both the individual and small group markets, experiencing only 0.9% and 0.7% of variation, respectively. As shown in Table 5, the PMPM administrative expenses increased steadily at similar levels as premium trends. This indicates issuers are not accruing savings due to relatively smaller administrative expenses.

Retention, which includes not only administrative expenses but other non-claims factors like profit margin, taxes, and fees, showed a relative decrease as a percent of premium. Profit margins shrunk in 2024 compared to 2020 (3.0% down from 3.7%). Competitive pressures may have resulted in lower retention, which would put downward pressure on premium increases.

Table 5 - Market Average Administrative Expense Over Time



Driver of Loss Ratios: Claim Cost Trends

Increases in claim costs are another driver of premium increases. As shown in Tables 6 and 7, projected trends rose to an all-time high in 2024 (over the six-year span), primarily due to rising unit cost pressures. In small group, utilization increases also played a role in 2024 trend increases.

Table 6[8] - Individual Projected Market Trends by Trend Type

Component	2019	2020	2021	2022	2023	2024
Unit Cost Trend	2.5%	4.2%	3.3%	3.4%	3.3%	4.3%
Utilization Trend	1.0%	1.8%	2.3%	2.7%	1.9%	2.2%
Total Trend	3.6%	6.1%	5.8%	6.3%	5.2%	6.6%

Table 7 - Small Group Projected Market Trends by Trend Type

Component	2019	2020	2021	2022	2023	2024
Unit Cost Trend	3.8%	3.6%	3.3%	3.2%	3.4%	4.5%
Utilization Trend	2.2%	2.3%	2.5%	2.5%	1.7%	2.5%
Total Trend	6.1%	5.9%	5.8%	5.8%	5.2%	7.1%

Trend differences by medical and pharmacy are presented in Tables 8 and 9. For the individual market, 2024 medical and pharmacy trends are increasing at about the same rate (1.3% and 1.4%, respectively). For small group, 2024 pharmacy trends are increasing at a faster rate than medical (3.2% and 1.6%, respectively). Beginning in 2020, medical trends for individual and small group followed very similar patterns. Pharmacy trends for individual were higher than small group until 2024 when small group trends surpassed individual levels. Given the two-year nature of trends within the URRT, 2025 trends will include the period from 2023 to 2024 within them. This will likely cause 2025 reported trends, in the upcoming rate filing submission, to be high, regardless of the expected trend from 2024 to 2025.

Table 8[9] – Individual Projected Market Trends by Category of Service

Component	2019	2020	2021	2022	2023	2024
Medical Trend	2.7%	5.3%	5.4%	5.7%	4.6%	5.9%
Rx Trend	8.9%	9.2%	7.3%	8.4%	7.9%	9.3%
Total Trend	3.6%	6.1%	5.8%	6.3%	5.2%	6.6%

Table 9 – Small Group Projected Market Trends by Category of Service

Component	2019	2020	2021	2022	2023	2024
Medical Trend	5.7%	5.6%	5.6%	5.4%	4.8%	6.3%
Rx Trend	8.0%	7.3%	7.0%	7.3%	7.2%	10.4%
Total Trend	6.1%	5.9%	5.8%	5.8%	5.2%	7.1%

[8] Reported trends represent the annualized two-year trends reported on Worksheet 1 of the filed-year URRT. For example, the 2024 individual trend of 6.6% is calculated as the annualized trend from issuers reported 2022 to 2024 trends on Worksheet 1 of the 2024 URRT.

[9] Reported trends represent the annualized two-year trends reported on Worksheet 1 of the filed-year URRT. For example, the 2024 individual trend of 6.6% is calculated as the annualized trend from issuers reported 2022 to 2024 trends on Worksheet 1 of the 2024 URRT.

While the URRT does not allow for an examination of trends absent of mix differences, projected trends suggest that inflation was anticipated to have a significant impact on 2024 experience. One caveat to this conclusion is how issuers included COVID-19 impacts within trends i.e., was COVID-19 reported under trend factors or within other projection factors such as morbidity.

Given these changes in loss ratios, profits, and claim costs, how did issuers respond in terms of their level of participation?

Trends in Issuer Participation

The rate of issuer entrants and exits between 2019 and 2024 was very different in the individual market compared to the small group market. Table 6 reports the number of HIOS IDs who exited, entered, and remained in the market in each year. Individual HIOS ID count is at an all-time high in 2024, whereas small group is at its lowest since 2019.[10]

While the number of HIOS ID exits suggest there is significant market churn, most of these exits are attributable to Bright Health (Bright) and Friday Health Plan (Friday), which exited several states in 2023 and 2024, respectively, due to solvency concerns. 15 of the 28 individual market exits in 2023 were attributed to Bright HIOS IDs, and 7 of the 21 individual market exits in 2024 were attributed to Friday. In 2023, excluding Bright, there was a net gain of 24 HIOS IDs and a net gain of 11 new HIOS IDs in 2024 excluding Friday. Additionally, Bright and Friday both exited the small group market in 6 states in 2023, and Friday exited one more in 2024.

Table 10 - HIOS ID Turnover by Market and Year

Market	Metric	2019	2020	2021	2022	2023	2024
Individual	New Entrants	19	30	24	57	37	25
Individual	Exits	-18	-8	-4	-9	-28	-21
Individual	Continuing	257	268	294	309	338	354
Individual	Total HIOS ID in Year	276	298	318	366	375	379
Small Group	New Entrants	14	8	20	20	9	5
Small Group	Exits	-23	-25	-20	-12	-29	-50
Small Group	Continuing	485	474	462	470	461	420
Small Group	Total HIOS ID in Year	499	482	482	490	470	425

New entrants continue to flood to the individual market spiking competition and putting downward pressure on premium increases, which also aligns with high membership increases within the market. Conversely, the above data suggests the small group market faces more consolidation and exits than individual, which may be driven by an uptick in small group alternatives such as ICHRAs and level-funded plans. Since 2019, more than half a million lives have left the small group market. It is possible that this

[10] Note that certain companies may offer multiple HIOS IDs within a state and market.

is resulting in the remaining risk pool being adversely impacted leading to greater pressure on claims cost, premium, and loss ratios.

Trends in Marketplace Type and Plan Offerings

Between 2019 and 2024, seven states converted from federally facilitated marketplaces (FFM) to state-based marketplaces (SBM). This increase happened alongside a CMS mandate stating that beginning in 2023, insurers in FFM states must offer standardized plans, with guidance that non-standardized plan offerings must be limited in 2024 and further restricted in 2025.[11] Table 11 shows the total and average number of plans per HIOS ID in each year in the individual market from 2019 to 2024 for FFM and SBM states.

Table 11 - Count of Individual Plan Offerings by Marketplace Type and Year

Market Type	Metric	2019	2020	2021	2022	2023	2024
FFM	Number of States[12]	39	38	36	33	33	32
SBM	Number of States	12	13	15	18	18	19
FFM	Number of HIOS IDs	190	204	194	226	236	225
SBM	Number of HIOS IDs	86	94	124	140	139	154
FFM	Total Plans Offered	3,748	4,486	4,956	6,776	7,770	6,289
SBM	Total Plans Offered	2,200	2,447	3,037	3,787	3,628	3,680
FFM	Average Plans per HIOS ID	19.7	22.0	25.5	30.0	32.9	28.0
SBM	Average Plans per HIOS ID	25.6	26.0	24.5	27.1	26.1	23.9
Both	Average QHPs per Enrollee[13]	N/A	39	61	108	114	100

Plan offerings per HIOS ID reached an all-time high for FFM states in 2023 and then decreased on average in 2024, in line with CMS guidance, with anticipation of this trend continuing. Despite CMS' guidance being non-applicable in SBM states, they also saw a similar decline in plan offerings in 2024. This may suggest that the plan offering pressure instituted in FFM states is spreading to SBM jurisdictions.

[11] Federal Register: Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2024

[12] This includes all fifty states and Washington DC.

[13] The Average Number of QHPs Available to Enrollees is reported by CMS in this document: https://www.cms.gov/files/document/2024-qhp-premiums-choice-report.pdf

Anticipated Impacts on 2025 and Beyond

Looking into 2025, it is likely that unit cost trends will continue to rise with inflationary pressures.[14] Administrative expenses are unlikely to present any savings for issuers as inflation continues to drive up premium rates. With individual market competition on the rise and consumer participation at new records, issuers will strive to find a competitive edge in their rates, creating further pressure on loss ratios.[15] However the continuation of this trend beyond 2025 may highly depend on the renewal of the enhanced subsidies, which are scheduled to sunset at the end of 2025. Conversely, as the small group market continues to decline, both in terms of participation and overall market size, the question regarding the sustainability of this market across various states could increase.

As FFM (and even some SBM) states more strictly enforce the non-standard plan restriction, issuers will have to be strategic about what plans and benefits will be most attractive to the consumers they serve. While the 2025 Draft Notice of Benefit Payment Parameters tightened the process and standards for states to SBM conversion, it is likely that states will continue to form their own marketplaces as they seek flexibility in offerings for consumers.[16] Further, the trend of pricing factor restriction in many states continues to make the individual market strategies more difficult. This puts an added importance on understanding how regulatory limitations in place may impact overall profitability and cross subsidization.

The combination of these two trends may be, for 2025, more issuer participation but fewer plan choices per issuer in the individual market. While trend pressures could push premiums up, competitive pressures may limit the size of the premium increases. Beyond 2025, political decision may trump up all these factors in determining the trajectory of the individual and small group markets.

Please contact Michelle Anderson at michelle.anderson@wakely.com, Michael Cohen at michael.cohen@wakely.com, or Jenna Stefan at jenna.stefan@wakely.com with any questions or to follow up on any of the concepts presented here.

[14] The trends presented in the 2025 URRT may be inflated relative to actuals as they will represent the annualized trends from 2023 to 2025, which is anticipated to be higher than the actual annual trend from 2024 to 2025.

[15] https://www.cms.gov/newsroom/fact-sheets/marketplace-2024-open-enrollment-period-report-national-snapshot-0

[16] https://www.shvs.org/the-proposed-2025-notice-of-benefit-and-payment-parameters-implications-for-states/

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Five decades. Wakely began in 1969 and eventually evolved into several successful divisions. In 1999, the actuarial arm became the current-day Wakely Consulting Group, LLC, which specializes in providing actuarial expertise in the healthcare industry. Today, there are few healthcare topics our actuaries cannot tackle.

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