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2025 INDIVIDUAL MARKET RISK POOL CONSIDERATIONS

This whitepaper provides a preliminary view into how the individual market risk pool is shifting in 2025 following the Medicaid redetermination period in 2023-2024, sizable historical market growth, and other recent enrollment dynamics. **Early results point to a notable increase in market risk for 2025, with demographic normalized relative risk[1] rising over 8.3% and 8.0% when comparing 2023 and 2024 to 2025 for the January-April period.** These increases appear to be concentrated primarily in federally facilitated exchange (FFE) states that have not expanded Medicaid, which shows an increase of 11.6% comparing January-April 2023 to 2025. While several factors likely contribute to the observed trend, the limited scope of four months of emerging data makes it difficult to isolate true morbidity changes from other drivers. We anticipate results could materialize differently through the remainder of 2025 and will continue to monitor. Please see Implications and Key Limitations sections below for a discussion on potential drivers of these increases and the associated caveats.

2025 represents a unique year for the individual market. Enhanced premium tax credits are still in effect and were proven to be a major driver in Exchanges reaching record high totals for the 2025 Open Enrollment Period (OEP).[2] Additionally, the wave of Medicaid redeterminations, following three years of Medicaid's continuous coverage requirements, resulted in a significant inflow of enrollments into the individual market, many of them occurring outside of the OEP. The redetermination process ended in 2024. A previous Wakely paper analyzed the impact of Medicaid redeterminations on individual market morbidity in 2023 and 2024[3]. That paper found that market relative risk had increased when comparing the full year 2023 to 2024, with the likely cause being the newly enrolled population, whether from Medicaid, other coverage, or previously uninsured through a special enrollment period. It's important to note that in recent years many states have seen both increases to relative risk alongside enrollment growth. This combination is a new phenomenon in the individual market as in earlier years as the market grew in size, relative risk decreased due to new members being healthier than the existing market risk pool.

[1] The market risk is measured as the HHS-HCC risk adjustment model plan liability risk score (PLRS) divided by the CMS risk adjustment formula actuarial value (AV) and average rating factor (ARF). The PLRS calculation removes the 1.12 induced utilization factor applied to Silver 87% and Silver 94% cost-share reduction (CSR) variants to adjust for changes in CSR mix. Changes due to mix in geography were not accounted for in the normalization of PLRS changes. All years were calculated based on the 2025 risk adjustment model. **Normalized relative risk = PLRS / (AV * ARF).**

[2] https://www.cms.gov/newsroom/press-releases/over-24-million-consumers-selected-affordable-health-coverage-aca-Exchange-2025

[3] https://www.wakely.com/blog/medicaid-redetermination-impacts-on-the-individual-market-2025-revision/

The influx of new enrollees in recent years, combined with ongoing market churn, raises important questions about emerging risk patterns in 2025. To explore this, Wakely analyzed individual market risk score experience between 2023 and 2025 data to assess how relative risk and enrollment has changed in 2025 relative to previous years. These findings have meaningful implications for 2025 performance, 2026 pricing, and future market dynamics.

Methods and Data

The analysis relied on data from Wakely's National Risk Adjustment Reporting (WNRAR) project from 2023, 2024, and 2025, using data from January-April for all years and full year 2023 to 2024 as the comparison points. Wakely receives summarized data from participating ACA compliant individual market plans. The reporting of the data is voluntary and not comprehensive of all issuers and may not be 100 percent participation in a given state. While the data is not representative of the entire market, the WNRAR project collected data from over 75 carriers in 36 states and represents nearly 80% of ACA compliant enrollment for the individual market. Risk scores, normalized for particular demographic changes, were used as a proxy for relative risk shifts by measuring the changes that occurred in 2025 relative to changes in 2024 and 2023.

The data includes monthly enrollment data, including information on the month of initial enrollment. To measure the relative level of health of the new enrollees, we relied on risk score coefficients from the 2025 Health and Human Services Hierarchical Condition Categories (HHS-HCC) risk-adjustment model. We examined the cumulative change in enrollment and risk scores between 2023 to 2025 using data from January through April and years 2023 to 2024 using a full year of incurred data, paid through April of the subsequent years.

We classified states into three distinct categories: federally facilitated exchange (FFE) states that had expanded Medicaid, FFE states that had not expanded Medicaid, and state-based exchanges (SBEs)[4], to determine if the type of Exchange or if the state expanding Medicaid influenced results. We expect that the types of people currently enrolled and those newly entering the individual market may differ based on whether the Medicaid program included expansion enrollees. Furthermore, we would expect the impact to be different in FFE and SBE states since their operational processes and outreach efforts may differ. Using these three cohorts, we analyzed the change in enrollment, shifts in enrollment by metal level, and resulting relative risk score changes to best understand 2025 dynamics.

One difficulty in isolating how 2025 risk scores have changed from the prior year is that the first quarter of 2024 is potentially anomalous for several reasons. Most notably, some issuers experienced notable claim processing and payment issues in 2024 due to a cyber-attack. The impact of the cyber-attack was present in the April 2024 risk scores, which likely caused risk scores to be artificially deflated in comparison to April 2023 and 2025. In reviewing claimant ratios, April 2024 was 3.8% lower relative to April 2023 and April 2025 was 2.2% higher than April 2024, in total. These impacts varied greatly by state

[4] All SBMs operate in states that have expanded Medicaid.

and cohort. For example, April 2024 claimant ratios were 7.4% lower than April 2023 in FFE Medicaid expansion states compared to SBE states which were only 0.5% lower.

Another factor that could affect comparing 2025 risk scores to 2024 is that the ratio of members staying with the same issuer from 2024 to 2025 has increased in 2025 relative to prior years. While this pattern varies significantly by issuer and market, in aggregate, it may influence continuity of care and coding patterns as issuers are able to better capture diagnoses on retained members compared to new members. Finally, given Medicaid redeterminations were still occurring after April 2024 in certain states, and other special enrollment period (SEP) activity, comparing April 2024 to April 2025, would not capture enrollment growth and residual morbidity shifts from May through December 2024. As a result, while Wakely compared April 2025 relative risk scores to both April 2024 and April 2023, readers should be aware of potential caveats to those findings.

Findings

Enrollment

Tables 1A and 1B below show the enrollment (member month) percent changes comparing 2025 (based on January through April data for both years) to 2024 and 2023, by metal level and state cohort.

Table 1A. 2025 January to April Compared to 2024 Relative Enrollment Changes[5]

Metal	SBE	FFE Expanded	FFE Not Expanded	Total
Platinum	-4.5%	10.9%	-2.5%	-3.6%
Gold	2.0%	21.1%	4.4%	5.0%
Silver	15.3%	18.4%	9.3%	12.3%
Bronze	0.6%	3.7%	6.6%	4.1%
Total	8.2%	12.3%	7.8%	8.6%

Table 1B. 2025 January to April Compared to 2023 Relative Enrollment Changes[6]

Metal	SBE	FFE Expanded	FFE Not Expanded	Total
Platinum	-14.4%	12.3%	-2.8%	-12.1%
Gold	13.1%	50.2%	104.3%	55.1%
Silver	32.7%	68.0%	46.9%	44.7%
Bronze	5.7%	52.6%	41.3%	30.4%
Total	19.3%	59.4%	51.6%	40.7%

[5] Source: author's calculations

[6] Source: author's calculations

As can be seen in the previous tables, while enrollment increased across the board, it grew significantly more in FFE states compared to SBE states. There was also a more dramatic increase in FFE Medicaid expansion states from April 2024 to 2025. Note that there is considerable variability in the growth of each state and the averages displayed in the tables above are not representative of actual changes in each state.

Within FFE states, enrollment patterns differed based on Medicaid expansion status as non-Medicaid expansion states grew significantly more in Gold metal levels. We believe this is likely a function of high Silver premiums in relation to Gold (where Gold plans can be cheaper than Silver) allowing for lower income members to purchase a Gold plan at little to zero cost. SBE states saw the highest growth in Silver metal level plans throughout both 2023 and 2024.

As we consider how 2025 may fluctuate throughout the remaining months, it's important to keep in mind that there can be sizable differences in membership reported through initial enrollments and effectuation, and this is likely to change year over year. The drivers can be due to Exchange operational practices, percent of members who are auto enrolled, and general carrier market competitiveness changes. Nonetheless, Wakely has observed differences (and lower growth) compared to CMS' Open Enrollment Report[7], which is based on plan selections rather effectuated enrollment.

Relative Risk

Next, we analyzed how the emerging individual market risk may be changing. We are measuring market risk using the CY2025 HHS-HCC risk adjustment model plan liability risk score (PLRS) and, in order to remove demographic shifts, we are dividing by the risk adjustment formula actuarial value (AV) and average rating factor (ARF) which account for shifts in members metal level selection and average age. Further, the PLRS calculation removed the 1.12 increase factor applied to Silver 87% and Silver 94% cost-share reduction (CSR) variants in order to adjust for CSR mix variation. Risk changes due to mix in geography were not adjusted for. The formula for **Normalized Relative Risk = PLRS / (AV * ARF).**

Tables 2A and 2B show the normalized relative risk percent changes comparing 2025 (based on January through April data for both years) to 2024 and 2023, by metal level and state cohort.

Table 2A. April 2024 to April 2025 Normalized Relative Risk Score Changes[8]

Metal	SBE	FFE Expanded	FFE Not Expanded	Total
Platinum	-3.6%	-0.5%	2.9%	-2.2%
Gold	3.8%	4.2%	11.3%	7.8%
Silver	2.6%	11.6%	11.7%	8.9%
Bronze	1.6%	10.9%	8.2%	7.0%
Total	2.0%	11.5%	10.8%	8.0%

[7] https://www.cms.gov/files/document/health-insurance-exchanges-2025-open-enrollment-report.pdf
[8] Source: author's calculations

Table 2B. April 2023 to April 2025 Normalized Relative Risk Score Changes[9]

Metal	SBE	FFE Expanded	FFE Not Expanded	Total
Platinum	2.1%	-3.4%	14.5%	5.3%
Gold	5.1%	2.4%	-2.1%	0.1%
Silver	4.6%	4.9%	15.3%	10.9%
Bronze	6.7%	6.6%	8.1%	8.3%
Total	4.3%	5.3%	11.6%	8.3%

Overall, normalized relative risk scores increased between April 2023 and 2024 to 2025 across all cohorts, although, there were differences by year, type of Exchange, and whether the state had expanded Medicaid. While FFE Medicaid expansion states saw the largest increase from April 2024 to 2025, from April 2023 to 2025 they experienced a lower relative risk change compared to non-Medicaid expansion states. In fact, when observing the two-year comparison, FFE Medicaid expansion relative risk score increase is closer to SBE rather than FFE non-Medicaid Expansion. Note that it is uncertain whether April 2024 was a fully accurate measure of risk, especially for FFE Expanded or if other drivers, such as the cyber attack, may be falsely deflating that data point.

SBE states saw increases in relative risk although lower across the board in both years compared to FFE states. It is interesting to analyze how relative risk changes moved across metal levels – from April 2023 to 2025 Bronze plans have the highest increase in SBE and FFE Medicaid expansion states; FFE non-Medicaid expansion states saw a dramatic increase localized in Silver metal levels. In fact, in those states Gold metal levels experienced a reduction in relative risk which may be correlated with the findings noted above in the enrollment increase driven by the Silver to Gold metal level sloping.

It is uncertain if lower relative risk scores in prior base years (2023 and 2024) are attributed to lower morbidity or other factors such as lower capture of risk scores given the significant increase in membership in 2024. Additionally, while relative risk scores show large increases in this analysis, risk scores for partial-year enrollment are likely understated. Therefore, actual relative risk differences may be higher than shown in our data or complete differently throughout the remaining months. **Please refer to the Limitations section below for a full listing of important considerations and caveats associated with the changes in relative risk scores and what may be contributing to the increases.**

Full Year 2023 to 2024 Enrollment and Relative Risk

Tables 3 and 4 below report on full year 2023 and 2024 enrollment and normalized relative risk changes whereas Tables 5 and 6 report on April 2023 and 2024 time frames to provide a comparison point of how the results shifted throughout the year. While we don't anticipate April 2025 to follow completion patterns of 2023 and 2024, it does illustrate the moving target and potential unknowns for future months.

[9] Source: author's calculations

Table 3. Full Year 2023 to Full Year 2024 Relative Enrollment Changes[10]

Metal	SBE	FFE Expanded	FFE Not Expanded
Platinum	-11.2%	1.4%	-1.1%
Gold	9.7%	23.7%	81.1%
Silver	16.8%	46.0%	31.9%
Bronze	4.8%	40.3%	25.4%
Total	10.9%	41.1%	35.8%

Table 4. Full Year 2023 to Full Year 2024 Normalized Relative Risk Score Changes[11]

Metal	SBE	FFE Expanded	FFE Not Expanded
Platinum	7.4%	0.2%	10.4%
Gold	3.5%	2.7%	-6.1%
Silver	1.8%	2.1%	5.3%
Bronze	5.4%	7.1%	2.6%
Total	2.9%	3.6%	3.4%

Table 5. April 2023 to April 2024 Relative Enrollment Changes[12]

Metal	SBE	FFE Expanded	FFE Not Expanded
Platinum	-10.4%	1.3%	-0.4%
Gold	10.8%	24.0%	95.6%
Silver	15.1%	41.9%	34.4%
Bronze	5.1%	47.2%	32.6%
Total	10.3%	41.9%	40.6%

Table 6. April 2023 to April 2024 Normalized Relative Risk Score Changes[13]

Metal	SBE	FFE Expanded	FFE Not Expanded
Platinum	5.9%	-2.9%	11.3%
Gold	1.3%	-1.7%	-12.0%
Silver	2.0%	-6.1%	3.2%
Bronze	5.0%	-3.9%	-0.1%
Total	2.3%	-5.6%	0.7%

[10] Source: author's calculations

[11] Source: author's calculations

[12] Source: author's calculations

[13] Source: author's calculations

As can been seen comparing full year 2023 to full year 2024 in Tables 3 and 4, patterns observed in the first part of the year can and will change over the course of the year. While enrollment growth in SBE and FFE Medicaid expansion states did not change much in total between April and full year, there was movement by metal level, particularly lower Bronze membership and higher Silver membership in FFE Medicaid expansion states compared to the full year. FFE non-Medicaid expansion states did show lower growth in the full year compared to April (35.8% compared to 40.6% in April), and lower Gold metal level membership relative to other plans.

When reviewing relative risk score differences, increases between 2.9% to 3.6% were experienced across all state cohorts throughout the full year. But, when comparing April 2023 to April 2024, SBE had increased 2.3%, FFE non-Medicaid expansion states by a marginal 0.7%, and FFE Medicaid expansion states actually showed a 5.6% reduction to relative risk in total. This shows, keeping in mind caveats with April 2024 data, that experience can dramatically shift throughout the year.

Overall, the results indicate that the emerging 2025 risk pool appears to exhibit higher risk scores than the 2024 prior year risk pool, although there are a number of caveats and considerations that may be contributing to the increases that may not directly related to morbidity or health status. Similar to findings during Medicaid re-determination periods, the typical pattern of larger enrollment increases leading to lower risk scores did not occur during this period.

Implications

The above findings highlight that relative risk scores have increased in 2025, especially for FFE non-Medicaid expansion. For this particular group of states, whether examining 2023 to 2025 or 2024 to 2025, the pattern holds that relative risk scores do dramatically increase. While normalized relative risk scores have increased on average between April 2024 to 2025, **we believe the shifts could be indicative of numerous factors** and we are continuing to analyze emerging data to further understand key drivers of the increases as it relates to true morbidity increases versus other factors. An initial review of coding intensity does suggest an increase in the number of members coded with more than two conditions.[14] It is likely that coding changes do not account for the full magnitude of relative risk score increases in aggregate, especially in FFE non-Medicaid expansion states, however individual state and issuer differences will diverge from the aggregate experience.

The resulting effects of morbidity and demographic shifts will have direct implications for CY2025 financial performance and future pricing, including the current CY2026 rate cycle, of individual market carriers. Each carrier has visibility only into their own morbidity data through claim cost expenditures and risk adjustment metrics. However, risk adjustment transfers for each carrier depend on how their morbidity trends compare to the overall market. Consequently, understanding the financial implications for any given carrier requires understanding both the carrier's experience as well as the average market experience. There can be significant unknowns related to market risk, enrollment size, and demographics depending on market growth and carrier churn.

[14] The additional detail is shared in Appendix A below.

Overall, the findings highlight the importance of monitoring the morbidity trends for 2024 and 2025. If there is a true increase in total market morbidity, there should be consideration to account for cost increases from a premium perspective that would not be accounted for in the budget neutral risk adjustment program. As we monitor the 2025 experience going forward, it's important to note that market operational changes[15] and regulatory changes have caused and will continue to cause monthly enrollment attrition and claim cost spend to deviate year over year, making annual projections additionally difficult to estimate. Finally, it is important to note that policy changes such as the Program Integrity Rule or H.R.1 that have not yet gone into effect and will influence the final 2025 experience, as well as future years.

The following limitations should be noted.

Key Limitations

Listed below are key limitations in this analysis. While the preliminary data does point to increased risk scores, given the limitations in the data, more information is needed as the exact changes as well as drivers of those changes can be definitively identified.

- **Limited months of data**. The analysis was based on only four months of data in both years 2024 and 2025. With any analysis including emerging experience, those analyzing results should consider associated caveats and the range of plausible outcomes with incomplete data as the annual completion will vary year over year. Additionally, partial year risk scores may not fully account for morbidity and could be deflated.
- **Risk score to claims correlation**. The HHS-HCC risk adjustment model risk scores may not be a true approximation of morbidity. Risk scores are calculated based on member level enrollment, medical, and pharmacy data and are influenced by a variety of factors including morbidity, claims volume, coding documentation, member engagement, and data integrity.
- **Coding trend**. Members' risk scores are expected to increase yearly due to members' established care network, patient history, coding documentation, and other factors. The relative risk score increases were not normalized by coding trend which would not be reflective of a shift in morbidity.
- **Membership mix**. Not all membership mix changes were accounted for including any shift in geographic mix by region between 2024 and 2025. Additionally, the normalization of AV and ARF was based on the risk adjustment model factors which are not reflective of claim cost curves.
- **Market premium levels and pricing slopes.** Market premium changes in total or by issuer, the slope of metal levels, and the benchmark silver plan movement would have influence on member plan selections and potential health status of individuals enrolling in the market in 2024 compared to 2025. There is also potential variation in issuers' coding completeness such that members choosing different plans and therefore moving from one issuer to another may impact the risk scores contained in our results. Consequently, changes in benchmark silver status could influence both morbidity of the risk pool as well as coding completeness.

[15] For example, CMS' implementation of additional consent and compliance checks Exchange Consent and Compliance Webinar 09/19/24

- **Data reliance.** The data utilized in this study was summarized data from health plans that is reviewed for reasonableness but is not audited. If the submitted data is deficient, results will be impacted, potentially significantly. Additionally, the data collected is based on issuer participation and is not fully representative of all issuers and markets.
- **Variability**. The conclusions will vary by state and how additional data will influence results will also vary.

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Appendix A – Distribution of Coded Conditions in April 2023, April 2024 and April 2025

Given the increases shown in normalized relative risk, we reviewed the coding intensity for April 2023, April 2024, and April 2025 by examining the distribution of HCCs coded. In this analysis, we assume that RXCs are counted as an HCC as well.

Based on Table A1, overall coding patterns show significant increases across all markets from April 2024 to April 2025. The percent of members with at least 1 HCC increased when comparing April 2024 to April 2025 data. In Table A2 below, April 2025 results continue to show increases in members with at least 2 HCCs when compared to April 2023 results. However, we note that FFE Medicaid expansion states show a slight decrease in percentage of members with at least 1 HCC.

Table A1. April 2024 to April 2025 Distribution of HCC Changes[16]

HCCs	SBE	FFE Expanded	FFE Not Expanded
0 HCCs	-0.3%	-1.4%	-1.1%
1+ HCC	0.3%	1.4%	1.1%
2+ HCCs	0.2%	0.7%	0.6%
3+ HCCs	0.1%	0.3%	0.3%

Table A2. April 2023 to April 2025 Distribution of HCC Changes[17]

HCCs	SBE	FFE Expanded	FFE Not Expanded
0 HCCs	-0.6%	0.3%	-0.2%
1+ HCC	0.6%	-0.3%	0.2%
2+ HCCs	0.4%	0.1%	0.5%
3+ HCCs	0.2%	0.1%	0.3%

[16] Source: author's calculations

[17] Source: author's calculations

OUR STORY

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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