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UPDATED: 2025 INDIVIDUAL MARKET RISK POOL CONSIDERATIONS

Executive Summary

This white paper reviews the emerging 2025 individual market risk pool and how relative risk compares with 2024 and historical years. Results indicate an **overall increase in normalized relative risk[1] in 2025 from 2024.** This pattern is observed both in the initial analysis[2] using data from January to April and in the latest update incorporating data from January to July 2025. Although the early-year data comparison may have been influenced by potential noise—both due to limited data and anomalous effects[3] in 2024—the recent data from January to July 2025 consistently show significant and comparable increases in relative risk this year versus 2024.

Key Findings

- We continued to see a dramatic **increase in overall relative risk of 6.8 percent**[4] from 2024 to 2025.
- Federally facilitated exchange (FFE) states that expanded Medicaid saw relative risk increases, year over year, of 9.2 percent, whereas FFE states that did not expand Medicaid increased 8.6 percent. States with state-based exchanges (SBEs) saw lower than average increases of 2.6 percent.
- **Claimant ratios also increased for most states from 2024 to 2025**, equal to 2.2 percent overall. Claimant ratios generally have declined in the enhanced premium tax credit (ePTC) environment; the increase in 2025, however, represents a departure from those patterns**.** Similar to relative risk scores, FFE states claimant ratios increased more than SBE states, on average.
- Nationally, we found the following:
    - State relative risk score increases strongly correlated with lower increases in the percentage of enrollees with net premiums of less than $10.

[1] Market risk is measured as the HHS-HCC (Health and Human Services-Hierarchical Condition Category) risk-adjustment model plan liability risk score (PLRS) divided by the Centers for Medicare & Medicaid Services (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 percent and Silver 94 percent cost-sharing reduction (CSR) variants to adjust for changes in CSR mix. Changes resulting from 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] Wakely. 2025 Individual Market Risk Pool Considerations. 2025. Available at: https://www.wakely.com/blog/2025-individual-market-risk-pool-considerations/.

[3] It is likely that the Change Health cyberattack suppressed risk scores in the first quarter of 2023.

[4] 6.8 percent represents the member month weighted average; the straight average of states analyzed was equal to 6.6 percent.

- States that experienced lower rates of effectuation from enrolled members reported during open enrollment period (OEP) data as well as percentage of members auto enrolled during OEP were correlated with higher relative risk increases and vice versa.

Although important limitations and caveats apply to these findings, the consistent indication of elevated risk scores suggests that 2025 is likely to see worsening morbidity, meaning potentially higher claim costs, compared with 2024 despite ongoing growth in market enrollment. Industry carriers also report similar trends,[5] as evidenced by the final 2026 average premium rate increases of 26 percent,[6] the highest since 2018.

The following sections describe these findings in more detail, including the methodology used in the analysis, additional key findings, their implications, and the limitations of the analysis.

Methods and Data

The analysis relied on data from the Wakely National Risk Adjustment Reporting (WNRAR) project in 2024 and 2025, using data from January–July as comparison points. The WNRAR project provides Wakely with summarized data from participating Affordable Care Act (ACA)-compliant individual market plans. Data reporting is voluntary and, thus, exclusive of some issuers in a given state. Though the data are not representative of the entire market, the WNRAR project collected data from over 75 carriers in 36 states and represents nearly 80 percent 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 those in 2024.

The data include monthly enrollment information. 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 2024 and 2025 using data from January through July.

We classified states into three distinct categories—federally facilitated exchange (FFE) states that had expanded Medicaid, FFE states that did not expand Medicaid, and state-based exchanges (SBEs)[7]—to determine whether the type of exchange or state Medicaid expansion influenced results. We expected that the types of current enrollees and those newly entering the individual market would differ based on whether the Medicaid program included expansion enrollees. Furthermore, we anticipated that the impact would vary between FFE and SBE states because their operational processes and outreach efforts may

[5] Ortaliza J, McGough M, Vu K, et al. Marketplace Premiums Are Going Up in 2026. *Peterson-KFF Health System Tracker*. August 6, 2025. Available at: https://www.healthsystemtracker.org/brief/how-much-and-why-aca-marketplace-premiums-are-going-up-in-2026/#Overall%202026%20proposed%20rate%20change%20among%20ACA%20Marketplace%20plans,%20by%20insurer.

[6] Cox C. ACA Insurers Are Raising Premiums by an Estimated 26%, but Most Enrollees Could See Sharper Increases in What They Pay. *QuickTakes*. KFF. October 28, 2024. Available at: https://www.kff.org/quick-take/aca-insurers-are-raising-premiums-by-an-estimated-26-but-most-enrollees-could-see-sharper-increases-in-what-they-pay/.

[7] All SBEs operate in states that have expanded Medicaid. Exchange status was based on year 2023.

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.

Additionally, we used Centers for Medicare & Medicaid Services (CMS) open enrollment period (OEP) data[8] to analyze other potential correlations between relative risk changes and the varying enrollment cohorts. These data may be useful indicators for future changes that may occur in the marketplace.

As noted in prior papers, there is no one-to-one correlation between relative risk changes and morbidity. The Change Healthcare cyberattack potentially continued to affect data quality and, therefore, July risk scores in 2024. In addition, WNRAR data showed that issuers experienced less membership churn in 2025 (i.e., issuers had fewer new people joining their plans, on average). Having a stable pool of individuals over multiple years may result in improved coding capture and, therefore, increased risk scores in 2025.

Findings

Enrollment

Table 1a compares the 2024 and 2025 enrollment (member month) changes (based on January–July data for both years) by metal level and state cohort. Tables 1b and 1c show the final metal distribution in July 2024 and July 2025, respectively, to understand the size of each metal level in each period.

Table 1a. July 2025 Compared to 2024 Enrollment Percentage Changes[9]

Metal	SBE	FFE Expanded	FFE Not Expanded	Total
Platinum	-3.9%	9.7%	-2.9%	-3.2%
Gold	1.6%	21.1%	2.5%	3.8%
Silver	15.3%	14.5%	8.3%	11.1%
Bronze	0.9%	2.4%	5.4%	3.4%
Total	8.3%	10.0%	6.6%	7.6%

[8] Centers for Medicare & Medicaid Services. 2025 Marketplace Open Enrollment Period Public Use Files. Last modified May 12, 2025. Available at: https://www.cms.gov/data-research/statistics-trends-reports/marketplace-products/2025-marketplace-open-enrollment-period-public-use-files.
[9] Author's calculations; percent differences are on a member month weighted basis.

Table 1b. July 2024 Metal Level Member Month Distribution

Metal	SBE	FFE Expanded	FFE Not Expanded	Total
Platinum	2.6%	0.3%	0.2%	1.0%
Gold	17.4%	8.6%	15.7%	15.2%
Silver	51.8%	49.1%	58.3%	54.9%
Bronze	28.2%	42.0%	25.7%	28.9%
Total	100.0%	100.0%	100.0%	100.0%

Table 1c. July 2025 Metal Level Member Month Distribution

Metal	SBE	FFE Expanded	FFE Not Expanded	Total
Platinum	2.3%	0.3%	0.2%	0.9%
Gold	16.3%	9.5%	15.1%	14.6%
Silver	55.1%	51.1%	59.2%	56.7%
Bronze	26.3%	39.2%	25.4%	27.8%
Total	100.0%	100.0%	100.0%	100.0%

Although enrollment increased across the board, it grew more pronounced in Medicaid expansion states. Note that there is considerable variability in the growth of each state, and the averages displayed in the Tables 1a through 1c are not representative of actual changes in each state.

Generally, Silver enrollment grew the most across the board in this timeframe, with 1.8 percent more enrollment distribution in 2025 than in 2024. Interestingly, Gold enrollment grew in FFE Medicaid expansion states, likely because of high Silver premiums in relation to Gold premiums (where Gold plans can be cheaper than Silver plans), allowing for lower-income members to purchase a Gold plan at little to zero cost. Bronze plans in FFE non-Medicaid expansion states also experienced significant growth.

Relative Risk

Next, we analyzed how the emerging individual market risk may be changing. We measured market risk using the calendar year (CY) 2025 HHS-HCC risk-adjustment model plan liability risk score (PLRS) and, in order to remove demographic shifts, we divided 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, our PLRS calculation removed the 1.12 increase factor applied to the Silver 87 percent and the Silver 94 percent cost share reduction (CSR) variants to adjust for CSR mix variation. Given that the market risks were compared across states, we made no adjustment for any risk changes resulting from mix in geographic cost areas. The formula for **Normalized Relative Risk=PLRS/(AV * ARF).**

Table 2 shows the normalized relative risk percent changes comparing 2025 with 2024 (based on January through July data for both years) by metal level and state cohort.

Table 2. July 2024 to July 2025 Normalized Relative Risk Score Changes[10]

Metal	SBE	FFE Expanded	FFE Not Expanded	Total
Platinum	-0.5%	1.3%	0.7%	-0.4%
Gold	4.4%	2.6%	11.2%	7.9%
Silver	2.7%	8.8%	8.4%	6.7%
Bronze	2.9%	9.5%	7.5%	6.8%
Total	2.5%	9.2%	8.6%	6.8%

Normalized relative risk scores increased between July 2024 and July 2025, although we found some notable differences by type of exchange, whether the state had expanded Medicaid, and metal level. FFE states had significantly larger risk score increases than SBE states. Within FFE states, Silver and Bronze plans experienced large increases closer to the average. For Gold plans, FFE non-Medicaid expansion states saw a much larger increase in plan relative risk when compared with FFE Medicaid expansion states, despite considerable enrollment growth. For SBEs, Gold plans saw the largest increase between 2024 and 2025. With the scheduled expiration of enhanced premium tax credits (ePTCs) in 2026, large shifts in metal level distribution could occur in 2026, which would likely alter overall profitability—an issue we will need to monitor. The shifts will differ by geographic region given varying competitive positioning changes from 2025 and relative position of the premium rates and metal level positioning.

It is important to note that these results reflect only partial year data, and final results for 2025 may vary, potentially significantly. **Please refer to the Key Limitations section for a full listing of important considerations and caveats associated with the changes in relative risk scores and what factors may be contributing to the increases.**

Claimant Ratios

Table 3 examines the changes in claimant ratio (percent of enrollees with claims) from July 2024 to July 2025 for each of the state cohorts.

Table 3. Changes in Claimant Ratios in July[11]

Variable	SBE	FFE Expanded	FFE Not Expanded	Total
Change in Claimant Ratio	1.0%	3.5%	2.4%	2.2%

We did see claimant ratios decrease between 2023 and 2024 in the WNRAR data, and public data have also shown a reduction in claimant ratios in historical years through 2024,[12] although there appears to be a change in patterns between 2024 and 2025 with claimant ratios increasing. Claimant

[10] Source: author's calculations

[11] Source: author's calculations

[12] National data from CMS has also point to an increase in percent of enrollees without claims between 2022 and 2024.

ratios generally have declined in the ePTC environment; **2025 represents a departure from prior patterns.** The increase is more pronounced in FFE states.

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

Implications

The above findings highlight several important conclusions. The first is that, despite enrollment increases, the individual market risk pool in 2025 appears to be deteriorating. Issuers expecting morbidity improvements given the large enrollment increases may not have appropriately rated for the 2025 experience, which might explain the larger than expected premium increases in 2026 even when controlling for premium increases due to expected policy changes.

Second, it is important to note the variation between states. Even within the reported cohorts of states, there is significant variation. For example, when examining risk score difference on a state-by-state basis, among SBEs, the 25th percentile of relative risk score changes was 0.7 percent while the 75th percent was 4.2 percent, compared with an average of 2.6 percent as shown in Table 2. Among FFE states that expanded Medicaid, the comparable range was between 7.4 percent and 10.9 percent, compared with an average of 9.2 percent.

Finally, while the lack of detailed enrollee level data makes it challenging to pinpoint the exact causes of the changes in risk scores, a few potential explanations warrant close monitoring, as they have implications for 2026 experience and 2027 pricing strategies. 2025 had a significantly higher percent of returning enrollees than in 2024. 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 with new members. Additionally, relative risk score increases at the state level highly correlate with decreases in the number of enrollees who have access to monthly premiums of less than $10 (i.e., more enrollees with free or lost-cost net premiums result in lower relative risk scores). At this time, enhanced premium tax credits are expected to expire in 2026, and the large net premium increases are expected to further drive up relative risk scores.

Key Limitations

Following are the key limitations in this analysis. Although the preliminary data do point to increased risk scores, given the limitations in the data, more information is needed as the exact changes and their drivers can be definitively identified.

- **Limited months of data**. The analysis was based on only seven months of data in both 2024 and 2025. With any analysis involving emerging experience, it is important to consider associated

caveats and the range of plausible outcomes with incomplete data as the annual completion will vary year over year. Furthermore, partial year risk scores may not fully account for morbidity.

- **Risk score to claims correlation**. The HHS-HCC risk-adjustment model offers an imperfect approximation of morbidity. Risk scores are calculated based on member-level enrollment and medical and pharmacy data. They are influenced by a variety of factors, including morbidity, claims volume, accuracy of coding and documentation, member engagement, data integrity, etc.
- **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 considered, 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 an inaccurate representation 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 influence member plan selections and the potential health status of individuals enrolling in the market in 2024 compared with 2025 enrollees. There is also potential variation in issuers' coding completeness such that members choosing different plans and therefore moving from one issuer to another may affect 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.
- **Data reliance.** The information used in this study included summarized data from health plans that were reviewed for reasonableness but not audited. Any deficient data submitted may impact the results, potentially significantly. Further, the data collected are dependent on issuer participation and, therefore, not fully representative of all issuers and markets.
- **Variability**. The conclusions will vary by state, and any additional data will influence results as well.

The authors also want to extend special thanks to Kayla Zimdars, Maris Hayes, and Zimo Han for their assistance with the analysis. Please contact Michelle Anderson at michelle.anderson@wakely.com, Michael Cohen at michael.cohen@wakely.com, or Chia Yi Chin at chiayi.chin@wakely.com with any questions or to follow up on any of the concepts presented here.

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