



# No let up in sight: 2026 medical cost trend set to grow at 8.5%

**Is your playbook ready?**

**Medical cost trend: Behind the numbers 2026**



# Heart of the matter

The US healthcare system is heading into another year of powerful inflationary forces exerting pressure with few deflationary forces in sight. Commercial payers in 2026 will be asked to continue paying the ballooning bill for medical services and prescription drugs. Meanwhile, federal policy decisions and legislation are likely to reduce federal funding for medical care, particularly spending on Medicaid and Affordable Care Act subsidies over the next 10 years, with an expected impact on medical cost trend in the future.

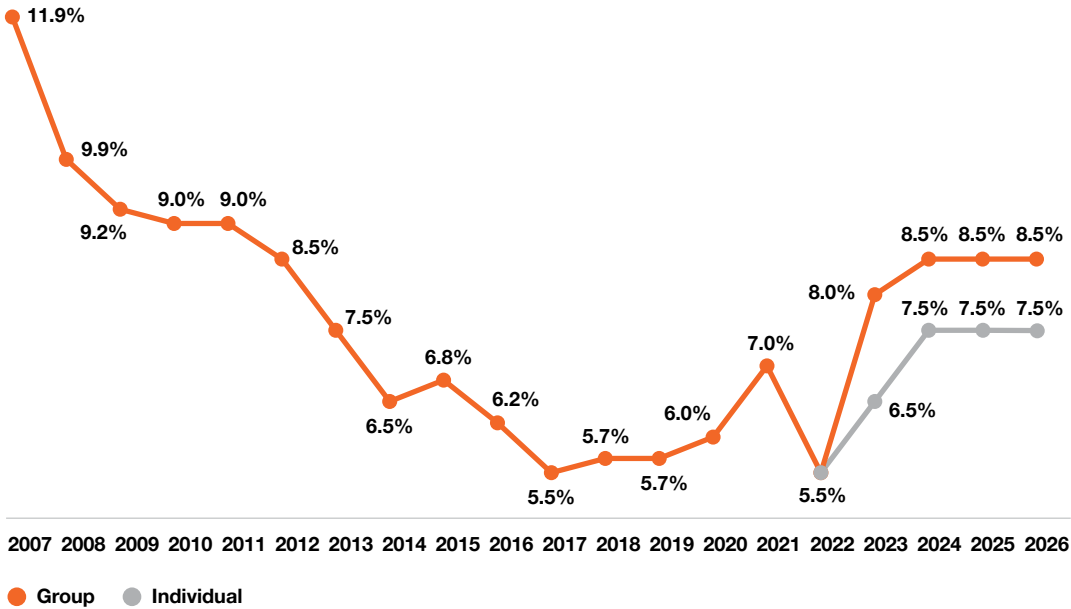
PwC’s health researchers surveyed and interviewed actuaries at 24 US health plans to generate an estimate of medical cost trend for the coming year. These plans cover more than 125 million employer-sponsored members and 12 million Affordable Care Act (ACA) marketplace members.

For the fourth year, health plan actuaries told us they anticipate medical cost trends for the Group and Individual markets to remain elevated. Based on their input, we’re projecting the Group medical cost trend to remain at 8.5% in 2026 (the same level as 2025) and for the Individual market to remain at 7.5% (the same level as 2025). The pharmacy cost trend was 2.5 points higher than the medical trend, reinforcing the urgency of managing pharma care. We’re also restating Group and Individual trends for 2024 and 2025, as all are higher than previously projected.

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Rising costs are one of the driving forces that make healthcare transformation inevitable.

Figure 1: PwC medical cost trends, 2007-2026

PwC projects medical cost trend to be 8.5% for Group and 7.5% for Individual in 2026, in line with 8.5% and 7.5% in 2025



Source: PwC analysis

This trend is without the expiration of the American Rescue Plan; more details appear in the regulatory section below.

The 2024 and 2025 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 physician administered drugs—particularly for oncology, GLP-1 drugs, and behavioral health services since the second half of 2024, continuing into 2025.

Leaders should read the 2026 medical cost trend as a signal of the future, pointing to a need for deeper, structural changes in how healthcare is used and what it costs. We've outlined actions to take now under each cost inflator and deflator to help improve cost trend pressure in the short-term. Notably, health plans should pick up the pace in managing the cost of care to bring medical cost trend to a sustainable level.

Longer term, bold reinvention will mean the reallocation of healthcare spending to create a patient-centric ecosystem anchored by care that's preventive, personalized and predictive with flexible sites of care built around the patient. In the future, payers will become health architects—personalizing coverage, steering care and managing increasing provider costs in real time while providers focus on health outcomes, leveraging AI to improve efficiency and creating connections across the ecosystem.

### **The pressure's on**

Claims costs continue to rise as hospitals and health systems shoulder heavier operating outlays and find innovative ways to collect additional revenue. Behavioral health spending is climbing dramatically. Spending on drugs is also increasing, in part due to the popularity of GLP-1s and launches of new drugs.

Countering the cost inflators are two deflators that could have modest effects next year. Biosimilars continue to nibble at the margins of the spending on biologics. Commercial plans are experiencing some success in managing the total cost of care. Still, in 2026, medical cost trend is once again hovering at rates reminiscent of 15 years ago.

### **Bracing for shrinking federal spending on healthcare**

Medical cost trend pressures are playing out against a backdrop of changes in federal health policy and regulation that could lead to significant declines in federal spending. The Congressional Budget Office (CBO) estimates there will be 12 million fewer people insured in 2034 than would otherwise be covered under H.R.1, also known as the “One Big Beautiful Bill Act” (OBBBA) signed into law by President Trump in July 2025. While the impact of many of these policy changes likely won't be fully felt until after 2026, stakeholders from hospitals to drug companies may take action sooner to brace for shrinking federal spending on healthcare.

### **Act now and use your pressure relief valves**

High costs aren't going away. What now? The use of AI, innovative health plans offering consumers greater choice and affordability, and more transparency in government health plans could become important deflators in coming years. In the meantime, to stay ahead of escalating medical costs, payers should tighten utilization management (UM) and payment integrity. Rising inpatient admissions and case severity are boosting provider revenue—but health plans are absorbing the cost. Stronger controls and smarter use of data, including claims analysis, rate benchmarking and scenario modeling are essential to inform provider negotiations and prevent budget overruns.

Drug spending is another pressure point—and it's only intensifying. Health plan executives should rethink their pharmacy benefit strategy. That means auditing existing pharmacy partners and exploring transparent, innovative models from Pharmacy Benefit Managers (PBMs) and Pharmacy Benefit Administrators (PBAs.)

Tighter oversight of GLP-1s—enhanced prior authorization, value-based contracts, and integrated wraparound services like nutrition counseling and digital coaching—can help plans manage both cost and outcomes. Agility is key: Health plan executives should monitor the drug pipeline, model impact scenarios and adapt policies to stay ahead of trends.

Emerging therapies like gene and cell treatments pose concentrated financial risk. Payers should be proactive—developing reimbursement models like outcomes-based rebates, milestone payments and carve-out partnerships to manage exposure.

At the same time, biosimilars represent a powerful lever to offset drug costs. Plans should remove barriers to adoption by streamlining approvals, enabling fair reimbursement and supporting changes in providers. Transparent rebate negotiations with PBMs will be crucial to realizing these savings.

Cost containment can't be just an initiative—it has to be an operating principle. Health plans should embed AI into UM, pre-payment audits and care coordination to boost efficiency and impact. It's time to cut underperforming care programs and prioritize digital-first interventions that engage members without bloating overhead. Foundational investments in data infrastructure can help sharpen analytics and power more effective fraud, waste and abuse detection.

Payers should partner with employers. Employers should be intentional about setting clear trend targets and holding vendors accountable—especially related to GLP-1 oversight, behavioral health integration and pharmacy cost controls. Larger employer groups, in particular, can push the envelope with benefit innovations like mental health out-of-network parity to improve outcomes and satisfaction.

**The scope of this analysis includes 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 24.3 million in 2025.<sup>1</sup> 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 cost trend 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.



By leveraging predictive analytics, health plans can identify trends in claims data to address potential cost drivers early.



## Regulatory changes

### **\$1 trillion dollar turn in federal healthcare spending adds pressure on costs**

President Trump and Congress are reducing federal spending on Medicaid and ACA marketplace plans, changes that could have long-term consequences for the US health industry. The CBO's analysis of H.R.1 tallied a \$1 trillion reduction in federal healthcare spending between 2025 and 2034.<sup>2</sup> Many of the consequences of H.R.1 and other policy decisions loom on the horizon; in 2026, these policy shifts are likely to have modest inflationary effects on medical cost trend for Group and Individual plans (Figure 2).

Three policies, in particular, may impact commercial plans in 2026. In 2021, Congress made subsidies for ACA plans more generous and expanded cost-sharing assistance to Americans earning higher incomes. As affordability increased, so did plan enrollees; between 2021 and 2025, the number of Americans covered by the Individual market rose from 12 million to 24.3 million. Congress appears poised to allow those changes to expire at the end of 2025. For many Americans, plans that were affordable this year may be significantly

less so next year. A second key policy change in H.R. 1 requires states to make work, community service, education or participation in a work program a condition of receiving Medicaid for some enrollees by the end of 2026. The CBO estimated these policies could reduce federal spending on Medicaid by more than \$325 billion between 2025 and 2034, which could prompt providers to compensate by seeking higher rates from commercial payers. If enacted, the third change – proposed tariffs on pharmaceutical imports – could drive up drug prices and worsen shortages.<sup>3</sup> All of these shifts could add additional upward pressure on medical cost trend for Group and Individual plans in 2026.

Other changes, including additional and tighter requirements for Americans seeking to establish and maintain Medicaid coverage, are slated to go into effect in 2026 and beyond. Many of these policies likely will reduce federal and state funding of Medicaid. Hospitals and health systems, along with other stakeholders such as pharmaceutical companies, may try to compensate by seeking greater rates from commercial plans and other strategies.



Figure 2. Potential regulatory changes and impact on medical cost trend 2025-6

| Regulatory change                                          | Overview                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Current status                                                                                                                                 | Potential impact to medical cost trend                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | LOB                | Impact & size                                                                                           |
|------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------|---------------------------------------------------------------------------------------------------------|
| <b>Expiration of ACA enhanced subsidies</b>                | In 2021, the American Rescue Plan (“ARP”) provided an increased amount of ACA subsidy in the form of premium tax credits (“PTC”) and expanded subsidy eligibility above 400 percent of the federal poverty level (“FPL”). Such enhanced subsidy was later extended to the end of 2025 by the Inflation Reduction Act (“IRA”). <sup>4</sup>                                                                                                                                                            | With no intervention, the enhanced subsidies will expire at the end of 2025.                                                                   | Enhanced subsidies have significantly reduced premiums for subsidized consumers, with price-sensitive consumers <sup>5</sup> earning 100–150% of the FPL eligible for \$0 premium enhanced Silver plans due to full subsidies based on the benchmark second-lowest-cost Silver plan. The expiration of enhanced subsidies will lead to a material enrollment drop, reversing previous gains in Individual marketplace enrollment, especially for non-Medicaid-expansion states. Risk pools will deteriorate, consequently, as enrollees willing to pay that higher premium will be sicker. A preliminary analysis of 2026 rate filings combined with input from participants in our report indicates that health plans are adding 4% to 6% of rate action to specifically compensate for subsidy expiration in Medicaid expansion states, with non-expansion states incorporating additional morbidity trend as high as 8% to 12%. <sup>6</sup>                                                                                                                                                                                                             | Individual         | Inflator, High<br>   |
| <b>Increased / new tariffs on imported pharmaceuticals</b> | In 2025, the Trump administration implemented a broad set of new tariffs under the International Emergency Economic Powers Act (IEEPA). While the IEEPA tariffs applied to certain medical equipment, including devices, many pharmaceutical products and ingredients have been largely exempted. However, a Section 232 investigation on the pharmaceutical products and ingredients was initiated on April 1; the results of which are forthcoming and due no later than 270 days after initiation. | New tariffs on certain medical products are in effect but pharmaceuticals are largely unimpacted pending the outcome of the 232 investigation. | The value of US imports of pharmaceuticals and medical products has risen sharply over the past decade. Few drugs are made entirely in the US; the same is true of many medical equipment categories. New tariffs could drive up prices, squeezing industry stakeholders from consumers to providers to health plans to pharmaceutical and life sciences companies. Tariffs could also exacerbate shortages that plague the US health industry. For these reasons, tariffs are likely to be inflators of trend though the magnitude of their impact will depend on the rate of the new tariffs and the categories of products affected.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Individual & Group | Inflator, Medium<br> |
| <b>Medicaid community engagement requirements</b>          | H.R. 1 requires that able-bodied adults aged 19 to 64 without dependents must complete 80 hours per month of work, education, or volunteering to maintain Medicaid eligibility. Exemptions apply to seniors, pregnant individuals, caregivers, and those with disabilities. <sup>7</sup>                                                                                                                                                                                                              | For the most part, states are required to enact the provisions by Dec. 31, 2026.                                                               | The number of individuals who lose Medicaid eligibility due to not meeting the new community engagement requirements provision and switch to Individual or Group plans is expected to be small: on the Individual side, individuals non-compliant with the work requirement provision are unlikely to have household income equal or above 100% FPL and thus would be ineligible for PTC (applicable to Medicaid expansion states only); on the Group side, these individuals by definition are not eligible for employer-sponsored health coverage. In addition, the new community engagement requirements are not expected to increase employment, based on both CBO projection and Arkansas experience. <sup>8</sup> Meanwhile, there may be a selection effect in which higher risk individuals who lose Medicaid coverage would be more likely to seek other forms of coverage. Aside from its impact on Medicaid enrollment, the new policy could lead to an increase in uncompensated care sought by the uninsured, thus pressuring hospitals to seek higher rates in contract negotiation and driving increases in medical cost trend. <sup>9</sup> | Individual & Group | Inflator, Low<br>   |

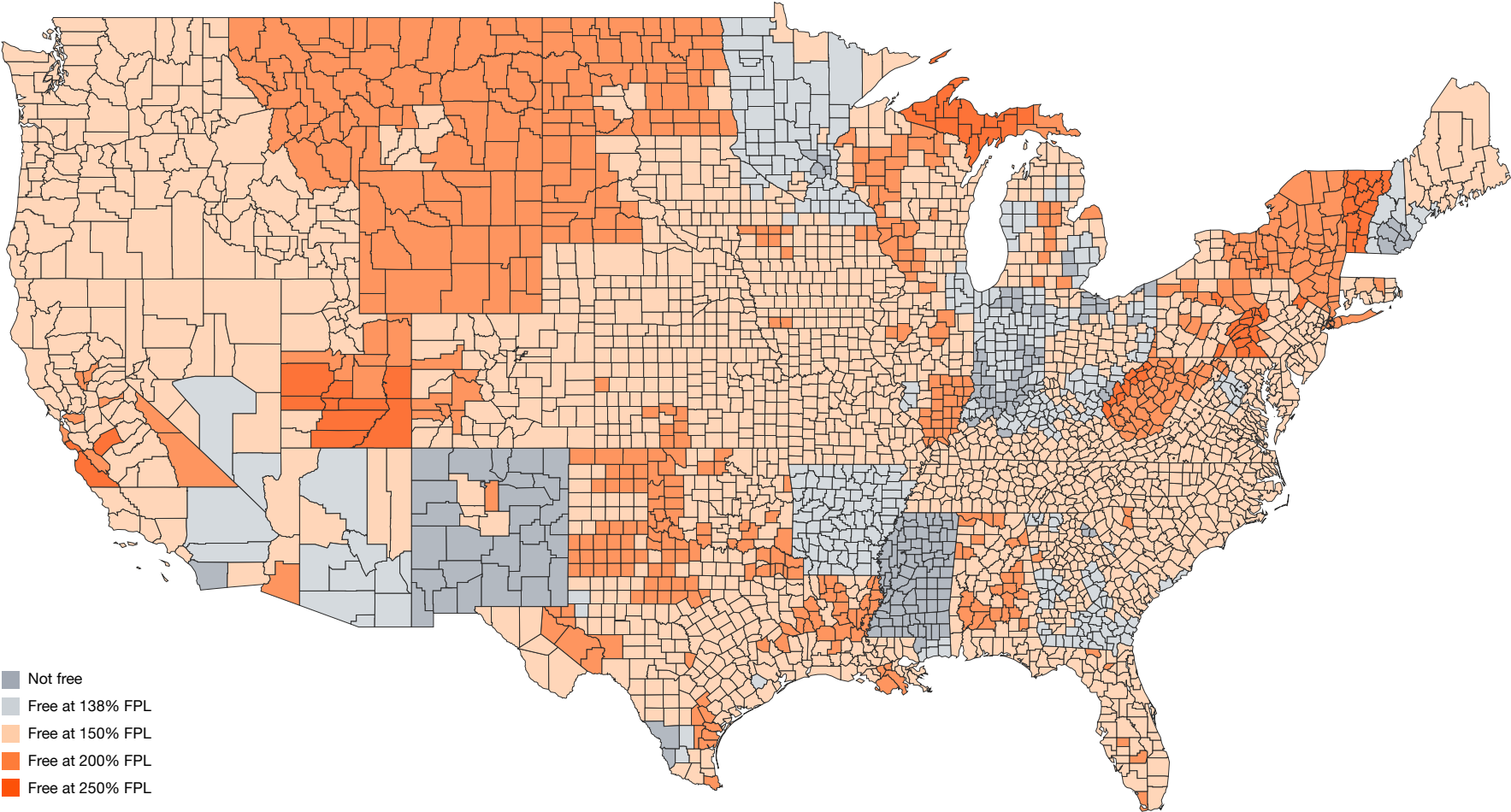


**How could consumers respond to the expiration of enhanced ACA subsidies?**

If enhanced ACA subsidies expire, consumers earning 100-150% of the federal poverty level (FPL)—previously eligible for \$0 premium Silver plans—could see annual premiums rise to between \$312 and \$935, depending on income. During the 2025 open enrollment period (OEP), consumers in the 100-150% FPL range account for nearly half of enrollment.<sup>10</sup> If enhanced subsidies expire, we could expect healthier and more engaged consumers in this lower-income cohort—who are not expecting material healthcare spending and who are familiar with shopping on the marketplace—to switch to Bronze plans as available. Meanwhile, those consumers in the lower-income cohort who do not have access to a free Bronze plan or who passively relied on auto-reenrollment and are unaware of the policy changes may do nothing again in the 2026 open enrollment period, thus missing payment and losing coverage. The map illustrates the availability of \$0 premium Bronze plans based on 2025 market data (Figure 3).

We could expect that higher-risk consumers who anticipate incurring substantial healthcare costs would be more likely to pay increased premiums and stay in Silver plans for the cost-sharing reductions. The expiration of enhanced subsidies could lead to a shift in plans, and more importantly, overall market risk pool deterioration, as higher-risk consumers stay and healthier consumers leave, putting pressure on the Individual market medical cost trend.

**Figure 3. Free Bronze availability by county and FPL level assuming no enhanced subsidy, and continued silver loading**



Source: 2025 CMS Qualified Health Plan Landscape Files, PwC Analysis

# Top 4 medical cost inflators

Hospital costs, hospital revenue cycle management, prescription drugs led by GLP-1 agonists, and spending on behavioral healthcare are driving medical cost trend in 2026 with little relief in sight.

## Providers are shouldering elevated prices for most everything from wages to hospital gowns.

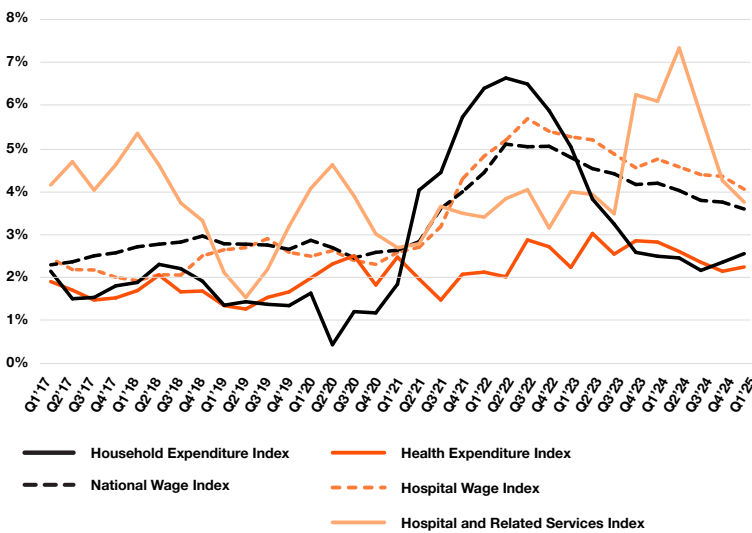
Seventy-three percent of health plan executives we interviewed identified inflationary impact on providers and/or provider consolidation as a top three driver of rising claim costs. Plans' ability to maintain competitive and deep networks while arguing modest increases on rate schedules will determine who carries the burden of consistent inflationary trends in the next contract cycle.

After surpassing household inflation in 3Q'23, the healthcare expenditure index continued to outpace household inflation in 2024 (Figure 4). The hospital index also exceeded household inflation in 2Q'23, peaking at 7.3% in 2Q'24 before declining. Similarly, the hospital wage index has outpaced the national wage index since 2021. While some stabilization occurred in late 2024, elevated healthcare and hospital expenditure and wage indices indicate that hospital systems remain burdened by rising operational costs due to ongoing labor shortages, wage increases and overall inflation in costs of supplies and goods. Inflation is expected to remain high due to labor, regulatory and supply chain pressures, offering little expected operational relief for hospitals in the foreseeable future.

Most recent hospital financials tell the same story. Systems are seeing margin relief relative to pandemic lows, yet earnings have not returned to pre-pandemic levels. As indicated in Figure 5, 2024 hospital system year-end operating margins landed at 2.10%, still well below the 7.00% margins seen in 2019. Early indicators signal 2025 may continue this downward trend with 1Q'25 margins ebbing further. While major hospital systems have reported increasing revenues in the wake of higher utilization and favorable shifts in payer mix, ongoing pressures from high inflation and escalating wage indices continue to challenge margin recovery.

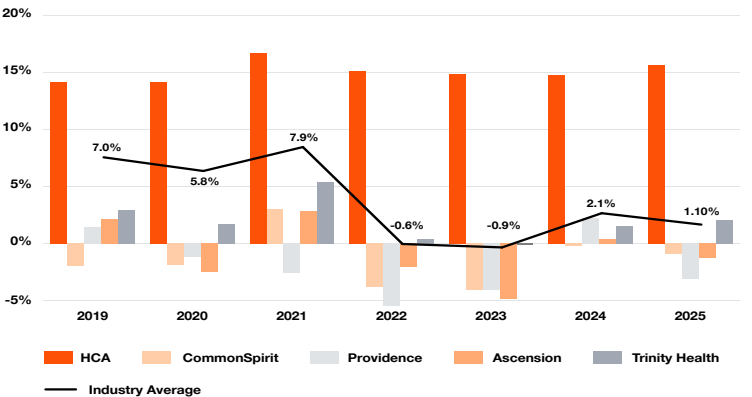
With constant inflationary pressure on expenses, providers are seeking rate schedule increases, specifically in private insurance contracts, in the coming contract negotiation cycles. The expiration of the temporary increase in Medicare payment rates for calendar year 2024 generated a 2.83% decrease<sup>11</sup> in the Medicare physician fee schedule. With Medicaid rate schedules following Medicare, dampened Medicare and Medicaid fees have produced additional financial strain for providers. A nearly 14% increase (based on 2024 payer mix<sup>12</sup>) in commercial rates is required to cover the 6-7% trend in operating expenses. Hospitals will need to make significant adjustments in their commercial contracts to match the rise in costs, especially as public reimbursement rates remain stagnant or even fall and the number of uninsured patients rises as the H.R. 1 policy changes go into effect.

Figure 4. Expenditure and wage indices year-over-year growth 2017 – Q1'2025



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

Figure 5. Hospital system operating margins 2019 – YTD-2025



Source: Publicly available hospital financials, Strata, PwC analysis

Note: Hospital systems are ranked by 2024 revenue



In the broader healthcare sector, health services deals are busier than at pre-pandemic levels, though the volume and value of deals have decreased since the highs observed in 2021. Certain provider-based deals, particularly those involving physician medical groups and hospitals, have seen an uptick in value. Figure 6 illustrates the fluctuations in deal volume and value across the industry, with a noticeable variation in activity. Consolidation among providers continues to fortify their negotiating power. Health plans can expect continued challenges in managing these cost increases in upcoming contract renewals.

Act now

In the coming years, health plans should revamp their contracting strategy and approach to combat rising unit cost pressure from provider contracts. Value-based contracting and alternative payment models can partially shift the impact of rising costs back to providers. Plans should consider incorporating more comprehensive and data-enabled analytics, such as claims analysis, to inform alternative payment models (APM) designs, reimbursement rate benchmarking and rate change impact analysis to support their provider negotiation and contracting processes.



Figure 6. Health services deal volume, value, and growth by target subsector (LTM 11/15/24)

| Volume<br>LTM 11/15/24 |                          | Value (\$ billions) LTM 11/15/24 | Growth<br>(LTM 11/15/24 vs 2023) |       |
|------------------------|--------------------------|----------------------------------|----------------------------------|-------|
|                        |                          |                                  | Volume                           | Value |
| 93                     | Pharma services*         | \$22.2                           | (12%)                            | 75%   |
| 466                    | Physician medical groups | \$11.7                           | (13%)                            | 431%  |
| 67                     | Hospitals                | \$11.0                           | (13%)                            | 34%   |
| 113                    | Labs, MRI & dialysis     | \$9.5                            | (10%)                            | (29%) |
| 404                    | Other**                  | \$6.1                            | 2%                               | (70%) |
| 25                     | Managed care             | \$4.8                            | (19%)                            | 340%  |
| 97                     | Home health & hospice    | \$3.0                            | (2%)                             | (40%) |
| 67                     | Behavioral care          | \$0.4                            | (19%)                            | 324%  |
| 41                     | Rehabilitation           | \$0.2                            | (20%)                            | 146%  |
| 1,373                  |                          | \$68.8                           | (9%)                             | 10%   |

Source: LevinPro HC, Levin Associates, 2025, May, levinassociates.com

\*Pharma services include contract development, manufacturing organizations, contract research organizations, and clinical trial sites. Value decline driven by Q1-24 Catalent acquisition by Novo Handlings (\$16.5B).

\*\*Other services include a broad range of companies such as ambulatory surgery centers, home infusion services companies, retail healthcare, and medical office buildings. Value increase driven by Q1-25 Walgreens Boots Alliance acquisition by Sycamore Partners (\$17.9B).

Providers rev up revenue cycle management to bolster bottom line

In response to financial pressures following the pandemic, healthcare providers—particularly large hospital systems—have focused on enhancing revenue cycle management (RCM) to maximize revenue capture. RCM is essential for timely and accurate payments for services rendered, given the complexity of how money flows through the US healthcare system. The COVID-19 pandemic exacerbated RCM challenges by disrupting patient volumes, increasing care complexity, and placing financial strain on providers and patients. Hospitals faced rising operational costs, staffing shortages and delayed reimbursements, adding significant pressure to revenue cycle functions.

To address these issues, many healthcare organizations have turned to advanced automation technologies and analytics. These tools have streamlined processes such as insurance eligibility verification, diagnosis coding, claims scrubbing and proactive denial management. Hospitals also have outsourced billing operations and improved patient financial engagement to manage their revenue cycles more efficiently. These improvements have accelerated internal processes, reduced errors and maximized revenue capture. As a result, many systems have been able to treat more patients, capture revenue for newer high-cost procedures, and identify opportunities to further boost revenue.

Recent financial results from major hospital systems highlight the impact of these enhanced RCM strategies. Inpatient admissions in the first quarter of 2025 are up over the prior year for several large systems. The same is true of revenue per admission (Figure 8). While revenue per admission is influenced by factors like payer mix and rate increases, hospital systems cited higher patient acuity and case mix severity as key drivers of recent revenue growth.<sup>13</sup> This shift is further evidenced by the rising proportion of emergency room admissions coded as level 4 or 5, which increased from 58% in January 2023 to 63% in April 2025.<sup>14</sup> While RCM improvements benefit providers financially, health plans face the burden of rising costs due to increased severity and utilization.

Act now

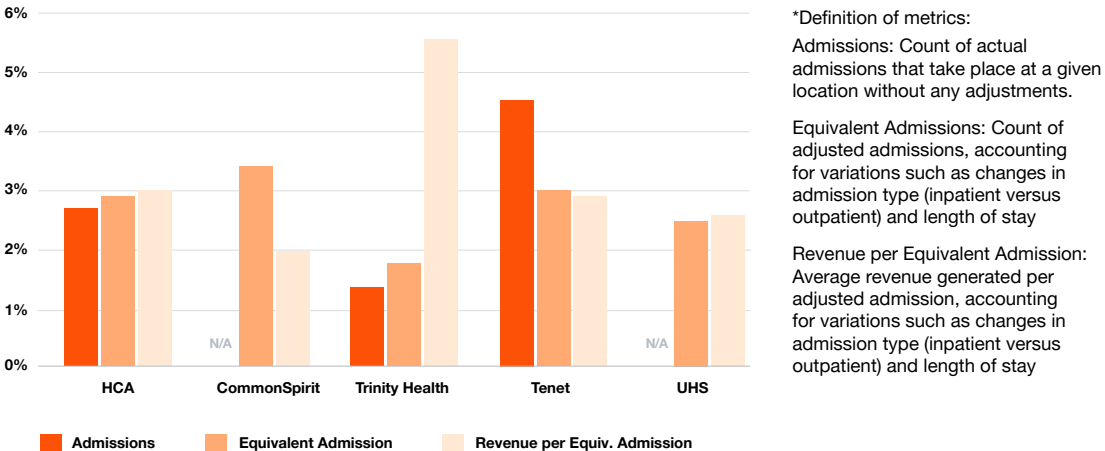
To mitigate the impact of rising medical costs due to enhanced RCM strategies, health plans should strengthen payment integrity and UM programs. By leveraging predictive analytics, health plans can identify trends in claims data, such as higher acuity cases or increased inpatient admissions, to address potential cost drivers early. Collaborating with providers on clear contract terms and employing fraud detection tools will help improve billing accuracy, preventing overpayments and upcoding. Additionally, focusing on robust UM can ensure that only medically necessary services are reimbursed, limiting unnecessary cost escalation.

Figure 7: The provider revenue cycle



Source: PwC analysis

Figure 8: 1Q'25 same-facility admissions and revenue versus prior period



Source: Publicly available hospital financials

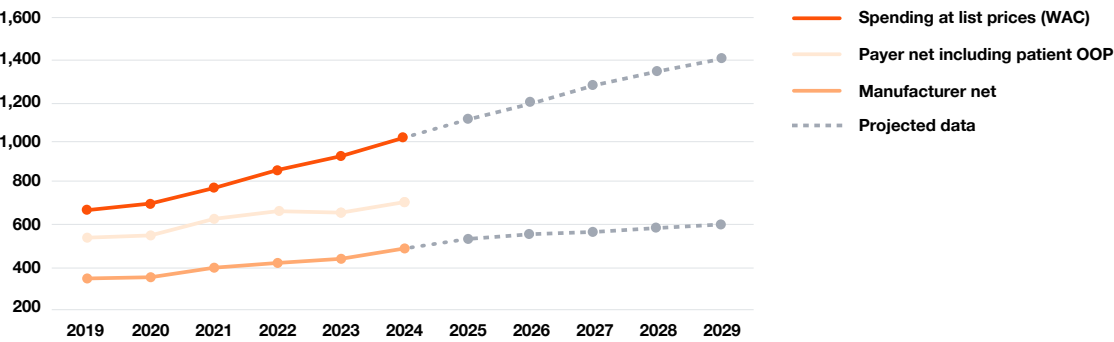
**A wave of new therapeutics—not only GLP-1 agonists—are hitting the market**

Investment in pharmaceutical research and development continues to grow dramatically.<sup>15</sup> These efforts are yielding a wave of breakthrough therapies that span prevalent chronic illnesses and rare genetic disorders. Many of these drugs, while significantly improving the quality of life and health of individuals, in some cases are also creating new classes of chronic and life-long disease treatment that will likely lead to persistent effects on medical cost inflation.

Drug spending in the US grew by \$50 billion from \$437 billion to \$487 billion (11.4%) in 2024 at net manufacturer prices, up from \$20 billion of growth (4.9%) in 2023 (Figure 9).<sup>16</sup> The 2024 increase was driven by a subset of 31 products, each with more than \$500 million in growth, and which increased sales by \$50 billion in aggregate, offset by the loss of exclusivity impact. From the therapeutic area perspective, oncology, immunology, obesity, diabetes and cardiovascular led the growth, totaling \$37 billion. (Figure 10).

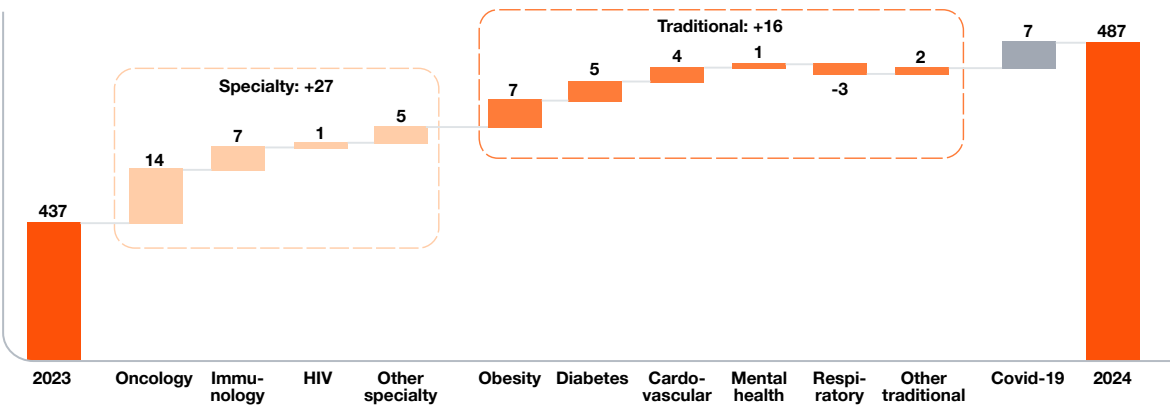


**Figure 9. Prescription drug spending 2019-2029 (\$ in billions)**



Source: IQVIA Institute

**Figure 10. Therapy area drivers of spending growth at estimated net manufacturer prices, 2024, \$ in billions**



Source: IQVIA Institute

Impact of GLP-1s

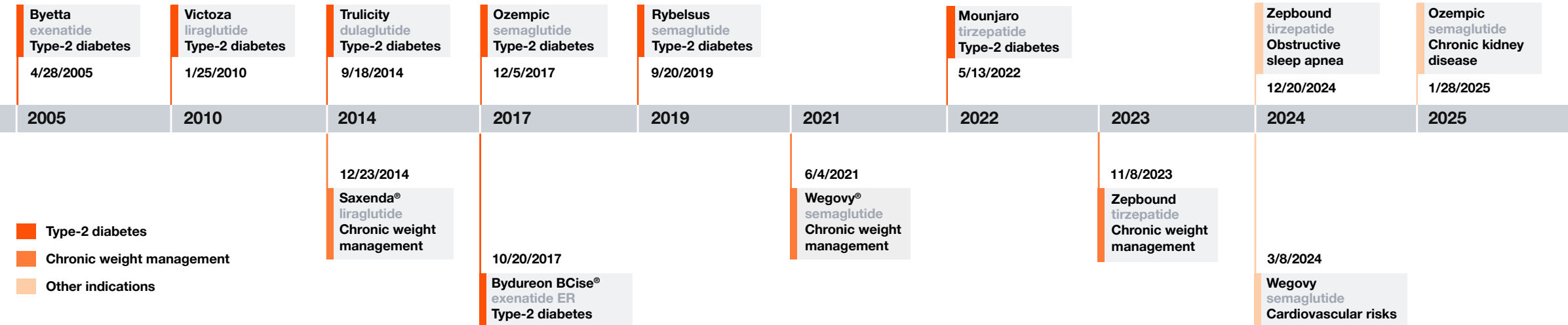
GLP-1s are medications that mimic the effects of a hormone called glucagon-like peptide-1 (GLP-1), which helps to regulate blood sugar levels and can promote weight loss. The surge in interest and uptake of these therapies—particularly since 2023—shows no signs of slowing. For the third consecutive year, a coupling of increased utilization and persistently high unit costs has positioned GLP-1s as a major medical cost inflator. In fact, 41% of health plans surveyed identified GLP-1s as one of the top two cost drivers for 2025-6.

GLP-1s were initially approved for treating type 2 diabetes; recent innovations have brought greater efficacy, more convenient weekly and oral dosing options and expanded FDA approvals for conditions including chronic weight management and more (Figure 11). While unit cost is stabilizing as GLP-1 tirzepatide and semaglutide shortages were resolved by early 2025,<sup>17</sup> health plans we interviewed consistently reported double-digit utilization trends. To manage costs and achieve better treatment outcomes, many health plans are tightening restrictions such as clinical criteria and step therapies

for GLP-1 weight management use starting in 2025.<sup>18</sup> Overall, health plans generally expect a half to one percent impact from GLP-1 utilization on their 2026 medical cost trend per our surveys and interviews.

Despite short-term medical cost inflation stemming from GLP-1 agonists, the hope is that savings await in the longer-term future as GLP-1s, along with other behavioral modification resources (e.g. exercise, diet/nutrition and other programs) make patients healthier and prevent costly medical events. There is little doubt about the clinical effectiveness of GLP-1s,<sup>19</sup> but their cost effectiveness hinges on effectively navigating several barriers. First, studies find that while tirzepatide and semaglutide offered substantial long-term health benefits, they are far from cost-effective at current net prices.<sup>20</sup> Meanwhile, adherence is poor. A recent study found that only 47.1% of commercially insured study members did not have a 60-day gap in therapy at 180 days, which is reduced to 28.9% at one year, and 14.8% at two years.<sup>21</sup> Addressing the affordability of GLP-1s (increased competition, supply chain improvements), promoting drug adherence (member support and engagement), and encouraging sustained lifestyle changes will be integral to realizing long-term health benefits without incurring a heavy financial burden on the healthcare system and society at large.

Figure 11. Timeline of GLP-1 agonist approvals by indication



Source: PwC analysis

Act now

Overall, health plans and employers should continue to evaluate strategies and partners to optimize their pharmacy benefits, with innovative and transparent models available both from PBMs and the growing PBA segment. A wide range of technologies and AI-enabled solutions are emerging to improve efficiency, reduce waste and improve costs.

Plans should closely consider their policies on covering GLP-1s for weight loss. Most survey participants indicated they are not covering GLP-1 medications for those purposes, except for administrative services only (ASO) customers who request coverage. Plans that continue to cover these medications, outside of states where coverage is mandated, may face selection issues. As demand remains high, health plans should remain vigilant on eligibility requirements, as well as fraud, waste and abuse, as members seeking access to these medications may pose further costs due to over-utilization. For plans offering weight loss coverage, it will be important to sustain the health benefits of these drugs through tighter integration of GLP-1 coverage with wraparound services like nutritional counseling, exercise, behavioral coaching and digital weight management tools for patients. Health plans should prepare for pipeline monitoring, scenario modeling and policy adaptability to anticipate utilization increases and budget impact.

Looking ahead, the therapeutic pipeline is robust with potential new therapies and expanded indications (Figure 12a and 12b).

Figure 12a. New GLP-1 indications in the pipeline with patient volumes

| Proposed indications                                                | US patients estimates                         |
|---------------------------------------------------------------------|-----------------------------------------------|
| Non-alcoholic fatty liver disease (MASH)                            | 22 million                                    |
| Neurodegenerative diseases (e.g., Alzheimer’s, Parkinson’s)         | 600+ different disorders affecting 50 million |
| Polycystic ovary syndrome (PCOS)                                    | 5–6 million women with PCOS                   |
| Prevent onset of type 2 diabetes in high-risk individuals           | 97 million at high-risk                       |
| Gastrointestinal disorders (e.g., IBS and IBD)                      | 60–70 million                                 |
| Psychiatric disorders (e.g., mood disorders and cognitive function) | 59 million                                    |
| Reducing or eliminating drinking, smoking, and gambling             | 55 million                                    |
| Obesity-associated cancers (13 types)                               | 800,000/year                                  |

Source: OptumRx



It will be important for health plans to integrate GLP-1s with nutritional counseling, exercise, behavioral counseling and digital tools.



Figure 12b. GLP-1 pipeline by indication and route of administration (non-exhaustive)

| Route of administration                                                          | Drug name                               | Manufacturer                   | Proposed indication                                                                                                      | Clinical trial phase                                                                                                                                                 |
|----------------------------------------------------------------------------------|-----------------------------------------|--------------------------------|--------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>New oral GLP-1s</b> .....                                                     |                                         |                                |                                                                                                                          |                                                                                                                                                                      |
| Oral                                                                             | Orforglipron                            | Eli Lilly                      | Obesity<br>Type 2 Diabetes<br>Osteoarthritis + Obesity                                                                   | Phase 3 - results expected Jul 2027<br>Phase 3 - results expected Aug 2025<br>Phase 3 - results expected Dec 2026                                                    |
|                                                                                  | Semaglutide                             | Novo Nordisk                   | Obesity<br>CVD and/or CKD + Obesity<br>Alzheimer's disease                                                               | Phase 3 complete - Pending FDA review, expected Q42025<br>Phase 3 complete - Expected to file for regulatory approval in 2025<br>Phase 3 - results expected Oct 2026 |
|                                                                                  | Aleniglipron                            | Structure Therapeutics         | Obesity                                                                                                                  | Phase 2 - results expected Nov 2025                                                                                                                                  |
|                                                                                  | VK2735                                  | Viking Therapeutics            | Obesity                                                                                                                  | Phase 2 - results expected Nov 2025                                                                                                                                  |
| <b>New Indications for existing GLP-1s</b> .....                                 |                                         |                                |                                                                                                                          |                                                                                                                                                                      |
| Subcutaneous injection                                                           | Tirzepatide                             | Eli Lilly                      | Type 1 Diabetes + Obesity<br>Psoriasis + Obesity<br>Psoriatic Arthritis + Obesity                                        | Phase 3 - results expected Apr 2027<br>Phase 4 - results expected Sep 2026<br>Phase 4 - results expected Dec 2026                                                    |
|                                                                                  | Semaglutide                             | Novo Nordisk                   | MASH (Metabolic steatohepatitis)<br>Liver cirrhosis                                                                      | Phase 3 complete - Pending FDA review, expected Q42025<br>Phase 2 - results expected Jan 2026                                                                        |
| <b>New subcutaneous injection GLP-1s with existing and new indications</b> ..... |                                         |                                |                                                                                                                          |                                                                                                                                                                      |
| Subcutaneous injection                                                           | "MariTide<br>(maridebart cafraglutide)" | Amgen                          | Obesity<br>Type 2 Diabetes + Obesity                                                                                     | Phase 3 complete - Pending FDA review, expected Q42025<br>Phase 3 complete - Expected to file for regulatory approval in 2025<br>Phase 3 - results expected Oct 2026 |
|                                                                                  | Retatrutide                             | Eli Lilly                      | Obesity<br>Knee Osteoarthritis + Obesity<br>CVD and/or CKD + Obesity<br>Type 2 Diabetes                                  | Phase 2 - results expected Nov 2025                                                                                                                                  |
|                                                                                  | Survodutide                             | Zealand & Boehringer Ingelheim | Obesity<br>Type 2 Diabetes + Obesity<br>NASH (Non-Alcoholic<br>Steatohepatitis) + Obesity<br>NASH/MASH + Liver cirrhosis | Phase 3 - results expected Feb 2026<br>Phase 3 - results expected Apr 2026<br>Phase 3 - results expected Nov 2025<br>Phase 3 - results expected Jun 2029             |

Source: PwC analysis

### Cellular, gene, RNA therapies and other drugs to watch

Cellular, gene, and RNA therapies (CGTs) are at the forefront of pharmaceutical innovations, delivering first-in-class treatments for a growing number of rare, genetic and previously untreatable diseases. While participants generally did not cite these therapies as a cost driver to date, there is concern that they will begin to exert inflationary pressure on medical cost trends as an increasing number of drugs enter the market and more members progress through the approval process.

In addition to their high list prices driven by complex and resource-intensive manufacturing processes (Figure 13), the total cost of cellular, gene, and RNA therapies is compounded by specialized administration requirements, such as cryopreserved handling and inpatient infusions, and long-term monitoring obligations. So far, providers are using these therapies sparingly due to safety concerns, uncertain long-term benefits, prescriber caution and payer hesitancy. But physicians and systems could adopt these therapies more widely as clinical evidence matures, real-world outcomes become more predictable and payment models evolve to better align cost with demonstrated value over time.

Figure 13. Drugs to watch in 2025-6 (non-exhaustive)

| Drug name           | Indication                                                            | Drug class       | FDA approval date                                                                                  | Drug list price*                                                                              | Implications for medical cost trend                                                                                                                                                                                                                                                                                    |
|---------------------|-----------------------------------------------------------------------|------------------|----------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| CASGEVY<br>LYFGENIA | Sickle cell disease (SCD) with recurrent vaso-occlusive crises (VOCs) | Gene therapy     | Dec 2023 <sup>22</sup>                                                                             | \$2.2/3.1 million (CASGEVY/LYFGENIA for a one-time infusion                                   | Costly one-time treatment, but could free patients from severe VOCs with very high associated medical costs. <sup>23</sup> It is estimated that among 100,000 people in the US affected by SCD, around 16,000 patients may be eligible for the gene therapies. <sup>24</sup>                                           |
| AMTAGVI             | Unresectable or metastatic melanoma                                   | Cellular therapy | Feb 2024 <sup>25</sup>                                                                             | \$515,000 for a one-time infusion <sup>26</sup>                                               | Around 6,300 patients per year in the US will require second-line therapy and be eligible for the cellular therapy. <sup>27</sup>                                                                                                                                                                                      |
| Lenmeldy            | Children with Metachromatic leukodystrophy (MLD)                      | Gene therapy     | March 2024 <sup>28</sup>                                                                           | \$4.25 million for a one-time infusion                                                        | The most expensive drug approved by the FDA to date. It is estimated that 40 children are born with MLD each year. <sup>29</sup>                                                                                                                                                                                       |
| ELEVIDYS            | Duchenne muscular dystrophy (DMD)                                     | Gene therapy     | Jun 2024 for expanded indication <sup>30</sup>                                                     | \$3.2 million for a one-time infusion                                                         | The indication expansion increased the target population from 3% to 90% of DMD patients—around 13,000 in the US. <sup>31</sup> In 2025, a second death in a patient being treated with Elevidys prompted its maker to take actions to address the setback and questions around safety.                                 |
| Qfitlia             | Hemophilia A and B                                                    | RNA therapy      | Mar 2025 <sup>32</sup>                                                                             | \$642,000 annually for subcutaneous injections <sup>33</sup>                                  | Costly but significantly reduces the need for clotting factor replacement therapy, which costs upward of \$600,000. <sup>34</sup> More convenient dosing compared to competitor drugs. It is estimated that Qfitlia™ could benefit up to one million people around the world, 12 years of age and older. <sup>35</sup> |
| LEQEMBI             | Alzheimer's Disease (AD)                                              | Biologic         | Originally approved in Jun 2023, new maintenance dosing regimen approved in Jan 2025 <sup>36</sup> | \$26,500 annually for biweekly intravenous infusions <sup>37</sup>                            | It is estimated that 1.4 million patients in the US are eligible for AD treatment that targets beta-amyloid. <sup>38</sup> A small portion of the eligible population could be under age 65, thus affecting the costs in the Individual and Group markets.                                                             |
| Kisunla             |                                                                       |                  | Jul 2024 <sup>39</sup>                                                                             | \$32,000 annually for monthly intravenous infusions <sup>40</sup>                             |                                                                                                                                                                                                                                                                                                                        |
| ANDEMBRY            | Hereditary angioedema (HAE)                                           | Biologic         | Jun 2025 <sup>41</sup>                                                                             | TBD (a competing drug, Orladeyo, is listed at approximately \$500,000 per year) <sup>42</sup> | It is estimated that around 6,000 people in the US live with HAE. <sup>43</sup> The drug offers a first-in-class mechanism that works to prevent swelling attacks in advance of the existing treatments. <sup>44</sup>                                                                                                 |

\*Drug list price does not include additional treatment costs such as chemotherapy, hospital stays, etc.

Source: PwC analysis



Other emerging drugs outside of CGTs—especially those for chronic conditions or rare diseases—also have the potential to significantly influence medical cost trend. Expensive orphan drugs can have an outsized financial impact, particularly for smaller employers, where even a single case may lead to substantial financial risk. In addition, newly approved and pipeline treatments for other chronic conditions—central nervous system (CNS) disorders for example—address broad patient populations and may drive high utilization. Innovation in oncology through new mechanisms of action (e.g. bispecific and trispecific antibodies, antibody drug conjugates) and improved delivery mechanisms is continuing to drive both clinical outcomes and health plan costs.

#### **Act now**

Many health plans we interviewed expressed concerns over the financial risk posed by coverage of CGTs. Traditional reinsurance for these claims is costly and may provide no relief as reinsurance carriers often exclude payments for CGT-eligible conditions. To manage the financial risk, health plans should explore innovative solutions like predictive models within the underwriting process to identify potential claimants and strategic reimbursement models including outcomes-based rebates, milestone-based payments and carve-out partnerships. Targeted care management confirming that members who need these treatments are receiving them at appropriate service locations at a reasonable cost can also mitigate cost impact.

Behavioral health claims are soaring

The rising cost of behavioral health (BH) services continues to be a significant inflator of overall medical expenses. Utilization of behavioral health services rose 44.6% from January 2023 to December 2024, (Figure 14), with a nearly 80% rise in behavioral health claims for inpatient services between January 2023 and December 2024. Utilization is trending upwards across most condition categories; developmental, anxiety and depressive disorders are seeing the largest increases (Figure 15). Health plan executives also cited the popularity of telehealth visits and virtual care for mental health as a driver of utilization.

This increasing demand is straining the industry, which suffers from an imbalance in the supply of providers and expanding demand. A recent survey reported that 58%<sup>45</sup> of executives claim payer rate reductions and minimal rate increases have become significant financial pressures. Third-party aggregators and provider consolidation are further driving up negotiated rates. Reimbursement issues are compounded by staffing shortages, with 31% of executives citing workforce constraints as a major challenge. Low reimbursement rates, especially for specialized services, make it difficult for providers to offer competitive salaries, exacerbating the workforce shortage. The system is under considerable strain as rising costs and workforce gaps create barriers to sustaining service quality and access.

Looking ahead, health plans can expect continued utilization and unit cost pressure, with a third of respondents listing behavioral health as a top three cost driver, and plans anticipating an increasing 10–20% trend on behavioral health in the coming year. With demand continuing to grow and financial pressures mounting, the behavioral health sector faces an uphill battle to maintain access and quality of care in the years to come.

Act now

The rising cost of behavioral health will place continued pressure on health plans to balance appropriate and holistic coverage of mental health-related conditions while also incorporating new strategies to maintain cost trends. Collaborating with providers to develop strategic models including condition-based alternative payment models, such as a capitation model, or collaborative care models, can help plans control the cost burden. Plans can also partner with third-party solutions like employee assistance programs to offer customers holistic coverage while limiting their share of the cost trend.

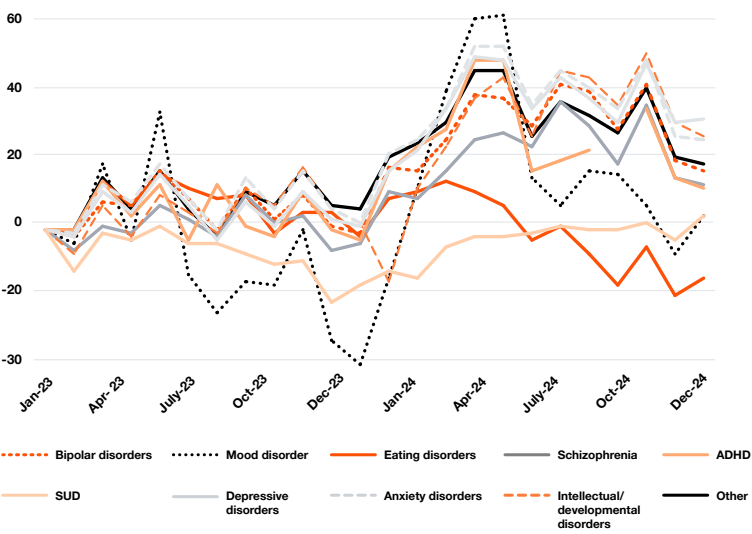
Figure 14: Percent change in total behavioral health claims (vs. January 2023)



Source: PurpleLab Claims Data \*Based on claims count

\*\*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 15: Percent change in outpatient behavioral health claims by condition (vs. January 2023)



Source: PurpleLab Claims Data \*Based on claims count

\*\*Methodology: Dataset contains claims with HCPCS and ICD-10 diagnosis codes; BH claims were identified using a join of multiple BH HCPCS mappings found in our research, with ihs.gov contributing most of the codes. Resulting BH claims mapped to condition type based on primary diagnosis code.



## Top 2 medical cost deflators

Biosimilars and cost containment tools are making progress, but not fast enough.

### Biosimilars gain some ground

The shift toward biologic drugs is one of the biggest contributors to higher drug spending. In 2023, biologics accounted for nearly half of all national prescription drug spending.<sup>46</sup> The accelerating launch and adoption of biosimilars in recent years continue to keep trend in check, and for the third year, is regarded by health plans as the top deflator for the upcoming year.

The launch of private-label strategies marked a pivotal moment in biosimilar adoption in 2024, as we reported in this report last year. Data shows that the adoption rate of Humira biosimilars went up from 3% to 28% from January to November 2024 (Figure 16). Starting in 2025, the three largest PBMs are all moving away from Humira and including only biosimilars (at least one private-label) in their standard formulary.<sup>47</sup> The reality for many health plans that do not work with these three PBMs is more nuanced. Our interviews found that the economic value of biosimilars varies widely across the market, with some plans staying with biologics, which come with rebates that match or beat biosimilar pricing, and others switching to biosimilars, which generate savings. Portfolio rebate arrangement, ASO rebate sharing, and regulatory restrictions (e.g., ACA formulary change restriction) are examples of other factors that influence a health plan's choice.

In 2025, the launch of biosimilars for Stelara, another blockbuster biologic treating autoimmune conditions, is much anticipated as more biosimilars come to market. Stelara generated \$6 billion in US sales in 2024—making it the second highest-selling biologic, behind only Humira, among all biologics with biosimilars launched or expected through 2029 (Figure 17). To date, seven Stelara biosimilars have received FDA approval, launching with Wholesale Acquisition Cost (WAC) list prices more than 80% lower than the reference product.<sup>48</sup> A similar private-label dynamic seen with Humira biosimilars is emerging as well, with two of the three largest pharmacy benefit managers (PBMs) having either launched or announced plans to launch private-labeled versions.<sup>49</sup> These developments are expected to exert meaningful downward pressure on specialty drug spending and help moderate medical cost trend in the near term.





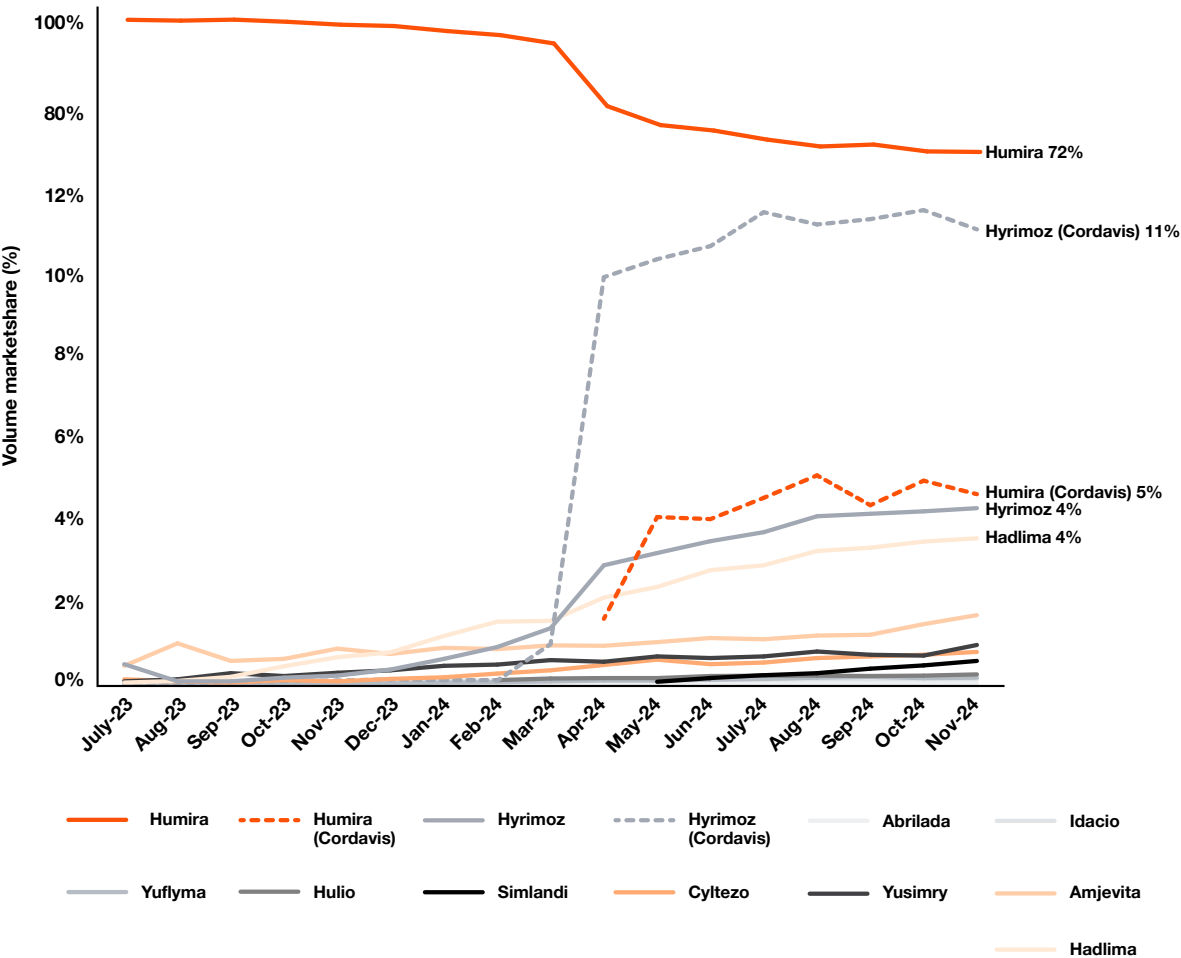
There is still a long road ahead. Over the next decade (2025-34), 118 biologics are expected to lose patent protection, but only 12 of them have biosimilars in development as of September 2024.<sup>50</sup> Biosimilar development has been concentrated on high-sales biologics (\$500M or more annual US sales) with near-term expiration. Challenges such as regulatory and legal complexities, slow market adoption, high investment costs and rebate walls need to be overcome through collaboration among stakeholders to ensure a sustainable biosimilar market in the long run.

Act now

Health plans can play a critical role in supporting providers and accelerating biosimilar adoption through measures like streamlining prior authorization, reimbursing fairly for biosimilars and supporting the infrastructure to change drugs. Meanwhile, in response to the adoption of lower list prices and lower rebate drugs such as biosimilars, PBMs are leveraging tactics like rebate credit and exclusivity deals to mitigate the impact on their revenue.<sup>51</sup> Health plans should proactively work with PBMs to fully understand rebate terms and push for more transparent rebate economics.

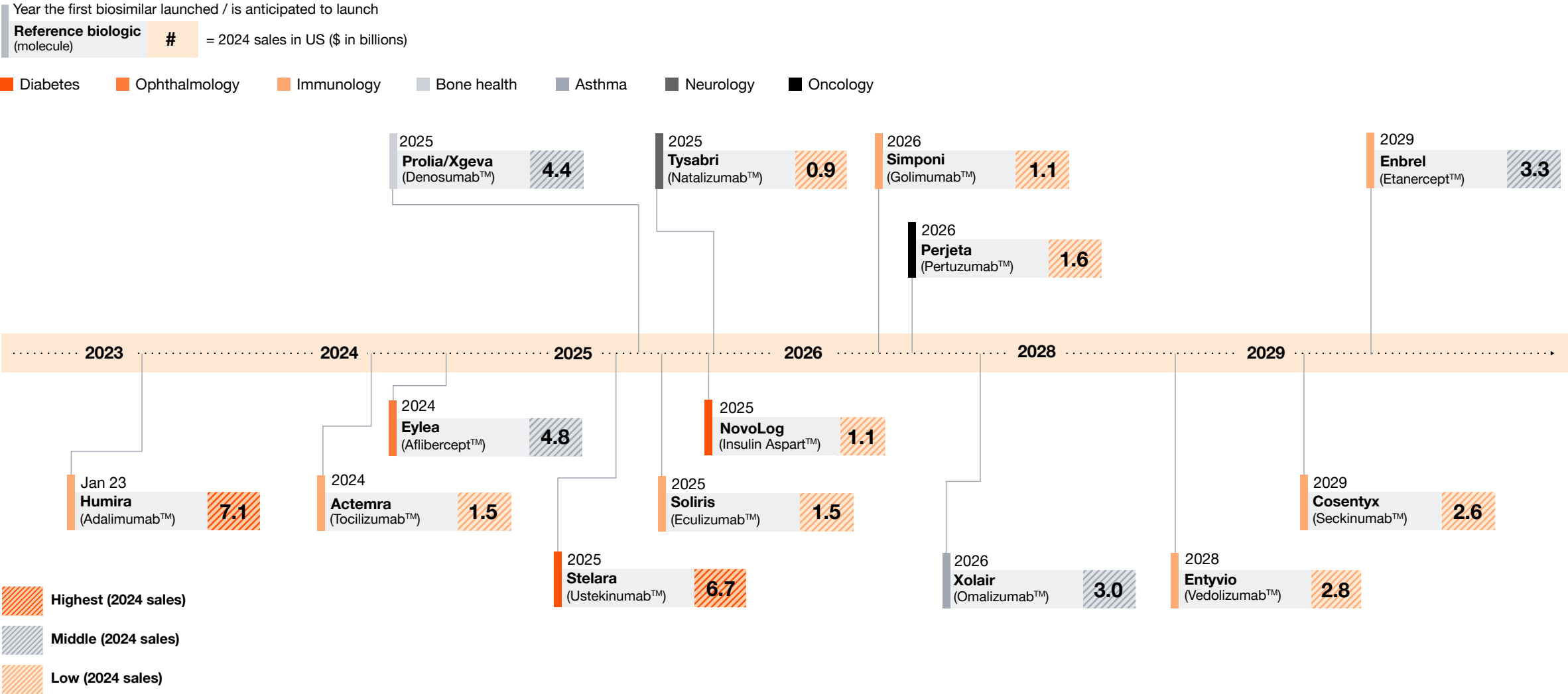


Figure 16. Adalimumab volume market share Jul-23 to Nov-24



Source: Samsung Bioepis

Figure 17. Historical and anticipated future biosimilar launches 2023-29



Source: Cardinal Health, PwC analysis

**Health plans are having (modest) success managing the total cost of care. They need to pick up the pace, seriously and relentlessly.**

This year, more than 75% of the health plans we surveyed ranked “managing total cost of care” as among the top 3 deflators, up from 60% last year. In response to persistent inflationary pressures and growing demands for affordability, health plans are evolving their strategies by complementing administrative tools with a stronger focus on medical management levers, including UM, quality/care management, claims integrity, Rx management and network design (Figure 18).

Utilization management is under renewed scrutiny due to regulatory shifts, media coverage and pressure to reduce provider burden. Payers are adopting AI-driven real-time prior authorization (PA) for low-risk services, removing PA for codes with >95% approval rates, and implementing gold carding to exempt high-performing providers—helping to reduce delays that exacerbate downstream utilization and cost.<sup>52</sup> The Centers for Medicare and Medicaid Services’ (CMS) 2024 rule mandates interoperability application programming interfaces (APIs) for prior authorization in public programs to streamline workflows through real-time data exchange. While not required for commercial or individual markets, many plans are expected to adopt similar technology, which could mitigate costly delays in care.<sup>53</sup>

Care management programs are facing increased scrutiny due to inconsistent ROI and scalability. While targeted interventions for high-risk members can reduce costs by 2-5%, many plans struggle with low engagement and high staffing costs.<sup>54</sup> Plans should prioritize care models that are operationally efficient, highly targeted, and engagement-driven to drive down cost trend. Integrated behavioral health programs with digital triage and coaching are gaining traction,

particularly in employer-sponsored plans focused on absenteeism and productivity.<sup>55</sup> Scaling back ineffective programs can improve the cost of care by reallocating resources to higher-impact strategies.

One of the most urgent pressure points is pharmacy spending—driven by member demand for GLP-1 medications for diabetes and weight management. Instead of relying solely on restrictive PA or exclusions, leading plans are adopting cross-functional GLP-1 strategies that align traditional UM and formulary controls (e.g., step therapy, indication-based coverage) with proactive care management requirements. These may include proof of enrollment and compliance with a structured diet and exercise program, medication adherence monitoring and clinical appropriateness reviews—all designed to ensure clinical outcomes are achieved in line with spending.<sup>56</sup> Moreover, employer groups—especially smaller groups that are vulnerable to a small number of high-cost members—are increasingly carving out or pairing traditional PBM reviews with secondary reviews and capabilities (e.g., for specialty drugs) to ensure appropriate clinical management.<sup>57</sup>

On the claims integrity front, forward-leaning plans are shifting from retrospective “pay-and-chase” models to real-time anomaly detection. AI tools now flag unbundling, improper coding and ineligible billing before payment is issued, enabling plans to reduce overpayment of claims while minimizing abrasion for compliant providers. Recent analysis suggests anywhere from ~\$50 to \$150+ per member per month (PMPM) in claims cost reductions through GenAI-enabled claims and payment integrity analytics, supplementing traditional fraud/waste/abuse solutions.<sup>58</sup>

Additionally, some payers are testing nontraditional strategies: reducing or eliminating cost differentials between in-network and out-of-network (OON) mental health providers to increase access; auto-enrolling members in care management or digital coaching after events like high-cost drug initiation or new diagnoses; and

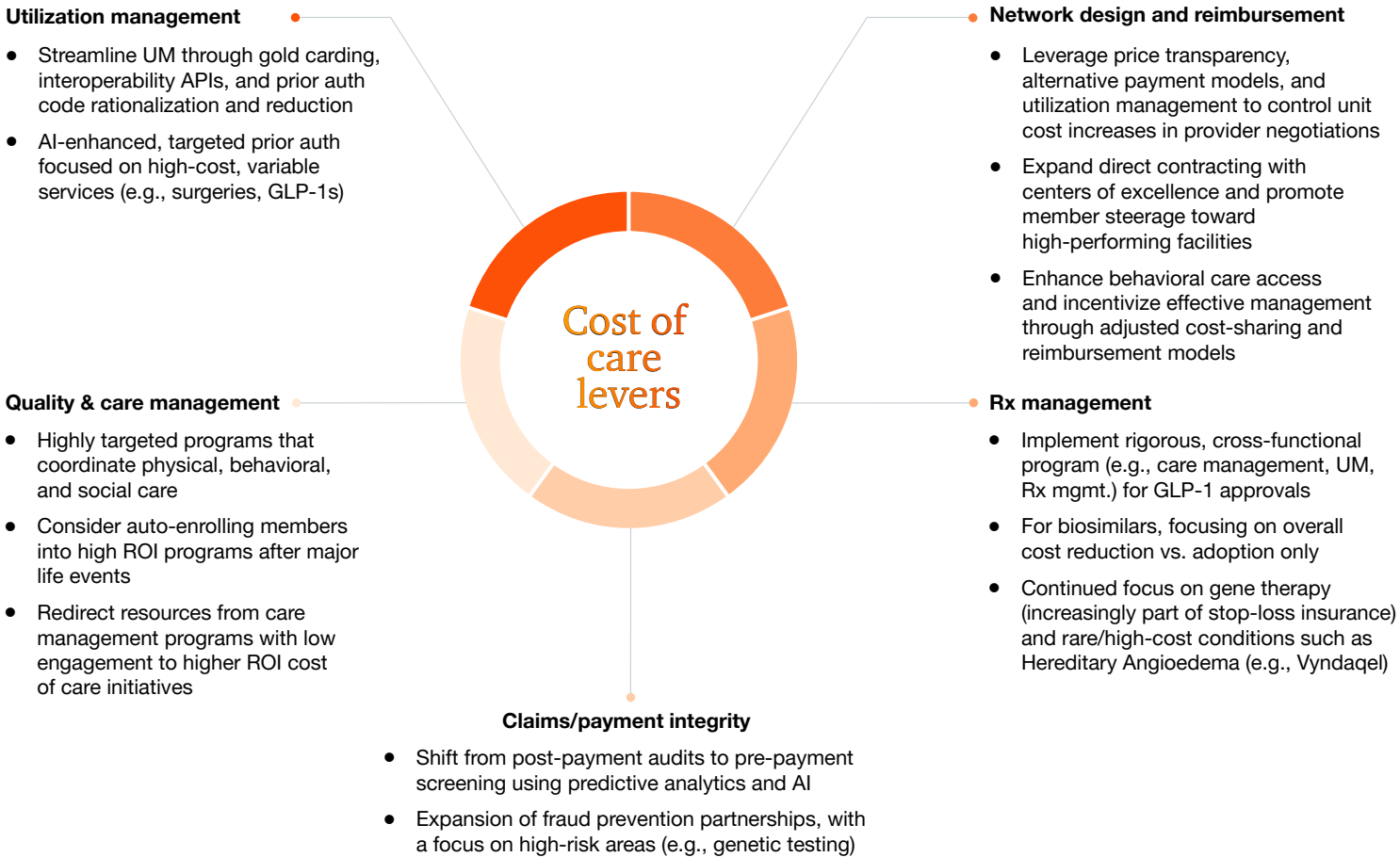
offering real-time cost-sharing incentives for choosing high-efficiency clinicians, all while preserving open network structures.<sup>59</sup> Health plans are also leveraging enhanced provider contracting strategies to mitigate unit cost increases such as use of price transparency data, modeling alternative payment models / value-based contracts and use of UM metrics as a lever in negotiations. But this should not detract from focusing on operational excellence.

**Act now**

Health plans should match cost containment goals with operational excellence, pulling all the levers to manage total cost of care. Simplifying UM, automating and enhancing (through AI) pre-payment audits and tightly integrating pharmacy and care management are essential. Plans should phase out low-performing care management programs and prioritize digital-first interventions that can engage populations with minimal overhead. Investing in foundational data exchange platforms can support higher quality cost of care analytics and sharpen increasing scrutiny on fraud, waste and abuse. Employers should be intentional about setting trend targets and pushing plans and vendors for clarity and performance metrics around GLP-1 oversight, behavioral health integration, and pharmacy cost drivers. Larger groups can push the envelope on benefit innovations like mental health, out-of-network cost-sharing parity and real-time steerage, which can improve both outcomes and employee satisfaction.



Figure 18: Levers to manage cost of care



Source: PwC analysis



## Trends to watch

### **The implementation of AI in healthcare delivery system could lead to inflationary pressure in the short term**

AI is revolutionizing healthcare. Across the ecosystem, AI has shown promise, with the potential to alleviate clinician burnout, improve healthcare outcomes, and lower the ever-growing healthcare spending in the US.<sup>60</sup> This section focuses on AI implementation in healthcare delivery systems and explores its implication on medical cost trend, pointing to potential inflationary pressures *in the short term*.

AI enablement, such as ambient scribes and AI-driven diagnostic support (Figure 19), are generally expected to increase provider productivity, which, in turn, should produce lower prices and savings. Healthcare economics, however, is more complicated. While alternative payment models (APMs) are gaining traction, most commercial healthcare payments are still fee-for-service (“FFS”).<sup>61</sup> Reimbursed per services rendered, FFS providers are using additional capacity from AI implementation to see more patients. Moreover, providers are, with few exceptions, not yet directly reimbursed by payers for the use of AI tools and thus need to absorb the cost through additional revenue. Further, unit cost is unlikely to go down immediately with improved labor efficiency given the typically multiyear nature of provider contracts, in the same way it didn’t go up immediately in response to inflation in 2022. In all, health plans may face inflationary pressure in this period of increased utilization prior to experiencing unit cost relief following labor productivity gain.

More diagnoses or overdiagnoses from AI algorithms could be another cost-inflator. AI is adept at identifying patterns and analyzing more massive and comprehensive healthcare data than ever before. AI algorithms are expected to assist physicians in diagnosing conditions earlier, faster and more accurately. This can lead to more diagnoses being made and thus more treatments and spending. AI algorithms are not exempt from the problem of overdiagnosis, either; experience in traditional screenings shows that there can be diagnoses that are correct but provide little to no health benefit for the patient, adding more costs to the healthcare system.<sup>62</sup>

Despite these short-term inflationary pressures, AI is embedded in the future of healthcare, with far-reaching potential to improve care quality and address affordability. For instance, AI-driven tools could alleviate clinician burnout by automating routine tasks, allowing healthcare professionals to focus on patient care. Beyond clinical settings, health plans are deploying AI to streamline claims processing, enhance care management and personalize member engagement, leading to more proactive and cost-effective care strategies. Additionally, AI-enabled platforms for molecular modeling and target prediction are accelerating drug discovery and lowering development costs.

To realize the full benefits of AI, stakeholders should collaborate to address challenges like data privacy, algorithmic bias and the need for robust regulatory frameworks.





Figure 19. Sample AI solution areas and implications for medical cost trend

| AI solution area               | Description                                                                                                                                                                                                               | Implications for medical cost trend                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Position on technology adoption curve <sup>63</sup>                                                         |
|--------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|
| Ambient scribe intelligence    | Combines speech recognition, natural language processing, and large language models (LLMs) to record, transcribe, summarize, and ultimately organize patient-provider conversations into a structured note. <sup>64</sup> | The use of ambient scribes could reduce clerical burdens on physicians, facilitating more personal and meaningful patient interactions and freeing up capacity for additional encounters. Various studies indicate an increase in encounter volume after the adoption of human or AI-empowered scribes; <sup>65</sup> which generates short-term cost pressure before unit price comes down.                                                                                                                                                                                | Scaling and adapting<br> |
| Diagnostic support             | Uses AI algorithms such as LLMs to analyze clinical data and provide real-time, evidence-based recommendations to support healthcare providers in diagnosing patients.                                                    | A multitude of studies have been showing promise for AI-driven diagnostic support across specialties, <sup>66</sup> improving diagnostic accuracy and ultimately healthcare outcome. Nevertheless, the clinical benefits may come with more healthcare spending. Taking early disease detection as an example: early detection does not necessarily lower cost for each diagnosed individual; <sup>67</sup> additionally, AI-empowered detection could lead to overdiagnosis and thus cost burden, just as many studies on traditional screenings have shown. <sup>68</sup> | Piloting<br>             |
| Clinical workflow optimization | Analyzes real-time staffing data, patient volume, provider preference, and institutional rules to predict care demands and generate optimized shift assignments.                                                          | Across settings—from hospitals to long-term care and operating rooms—AI enables faster, more accurate scheduling that reduces overtime, improves staff satisfaction, and maximizes resource utilization. Several real-world examples point to increases in provider productivity <sup>69</sup> and, therefore, short-term cost pressure.                                                                                                                                                                                                                                    | Piloting<br>             |
| Revenue cycle management (RCM) | Leverages AI and automated workflows to streamline RCM tasks like automated coding, claim scrubbing, denial management, and predictive analytics, enhancing accuracy, efficiency, and resource allocation.                | The power of AI has been harnessed by many hospitals and health systems, leading to operational efficiency and better financial outcomes. <sup>70</sup> The reduction in prior-authorization denials and enhanced coding accuracy put cost pressures on health plans.                                                                                                                                                                                                                                                                                                       | Scaling and adapting<br> |

Source: PwC analysis

## ICHRAs offer choice and cost options

Individual Coverage Health Reimbursement Arrangements (ICHRA), first made available in plan year 2020, let employers replace an employer-sponsored group medical and drug plan with a defined, tax-free allowance that employees use to buy any ACA-compliant individual-market plan. On one hand, this alternative allows employers a more predictable year-over-year cash flow related to coverage cost and provides employees greater flexibility to choose plans that best align with their healthcare needs. Conversely, ICHRA create additional administrative burden for employers such as compliance requirements, coordination with Marketplace eligibility, and employee training, and place additional work on employees to shop, compare and manage their own coverage options.

While early adoption was modest, momentum has built as medical inflation erodes traditional group affordability. The HRA Council's 2024-2025 Growth Trends report shows ICHRA uptake jumped nearly 35 percent<sup>71</sup> from 2023 to 2025, with small employers with fewer than 50 employees making up nearly 90 percent<sup>72</sup> of enrollment. ICHRA have been slow to penetrate the existing group segment, with 84%<sup>73</sup> of enrolled groups previously not offering health coverage at all. In 2022, the CBO estimated that approximately two million<sup>74</sup> people would enroll in an ICHRA rather than group coverage by 2032.

With opportunity for continued double-digit annual growth in ICHRA sponsorship, there is potential for impact across the ACA Individual and Small Group markets. As ICHRA attract younger, subsidy-eligible workers into the individual risk pool (two-thirds of covered lives are under 45<sup>75</sup>), the lower-risk may deflate cost trend in this market. Alternatively, if ICHRA are able to pull members from the group pool, a shift of lower-risk groups could put some upward pressure on cost trends in the Small Group market. The expiration of American Rescue Plan subsidies, however, could likely serve as a headwind to expected ICHRA growth in the coming years. Premium increases in the ACA Individual market due to subsidy expiration will further drive premium differentials between the Individual and Small Group markets.



## Health plans experiment with next-gen consumer-directed plans

Consumers want more transparency in pricing and coverage. High-value plans such as UHC Surest, Gravie Comfort, Aetna SimplePay Health, BCBS Coupe, and Curative have emerged as the next generation of consumer-directed health plans. These plans eliminate traditional deductibles and coinsurance, replacing them with fixed copays for all services. Members are encouraged to use price-shopping tools to find high-value care and make cost-conscious decisions. Plan designs are often coupled with high-performing networks to contain costs and steer members toward more cost-effective care options. Employers and consumers may increasingly find models that provide clear pricing attractive, along with the potential for improved health outcomes through better care management.

Given the relatively recent emergence of these plans, limited data is available on whether they are able to meaningfully lower the cost of medical expenses. Health plans offering these plan designs expect the transparent pricing to increase preventive and low-cost services in the near term, reducing unnecessary and high-cost procedures and lowering the prevalence of chronic illness down the road.. An initial review of Surest's book of business performance indicates 11%<sup>76</sup> lower total cost per member per month, with significant savings from fewer emergency room visits and hospital admissions.

Looking ahead, the demand for these health plans is expected to increase as consumers and employers seek more predictable and transparent pricing, potentially encouraging other insurers to offer similar products. With traditional health insurance models often criticized for their complexity and high out-of-pocket costs, these next gen consumer-directed plans offer a compelling alternative. While there is potential for the focus on price transparency and preventive care to mitigate cost trends, the full impact will likely take several years to materialize.



**Pressed by CMS, payers and providers are sharing pricing data with some resulting market shifts**

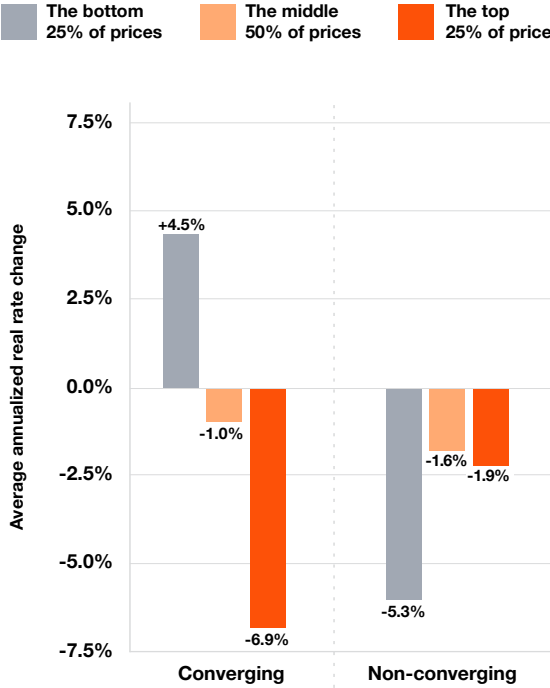
Starting in 2021, CMS required hospitals to publish clear, accessible pricing online, including a machine-readable file (MRF) listing gross charges, discounted cash prices, and payer-specific negotiated rates for all items and services. In July 2022, the rule was extended to health plans. CMS’s 2024 Outpatient Prospective Payment System (OPPS) rule, released in November 2023, further requires that hospitals present charge data in a standardized format and disclose additional fields such as charge methodology.<sup>77</sup>

A primary goal of price transparency rules is to lower healthcare costs through increased competition. Historically, the prices Individual and Group insurers paid to hospitals varied widely within and across states and could be as high as more than 300% of Medicare rates, as found by various studies.<sup>78</sup> In theory, the price transparency data could inform hospitals and payers in the contract negotiations, influencing the outcomes. Specifically, increased scrutiny of high-outlier prices is expected to lead to meaningful price reductions for those services.<sup>79</sup>

This is the third year that price transparency rules have been noted by health plans as a top trend to watch. We heard more stories of payers successfully leveraging price transparency data to influence contract negotiations during this year’s interviews as compared to last year. A new study published at the end of last year also testifies to the emerging impact of price transparency data on negotiated rates.<sup>80</sup> From December 2021 to June 2024, the majority of markets (83%) examined by the study experienced notable price convergence. The top-quartile rates decreased (-6.9%) and the bottom-quartile rates increased (+4.5%) (Figure 20). Outpatient services experienced greater price convergence as competition and shoppability are higher. Such convergence of prices toward a middle ground can be seen as an early sign of a maturing, more efficient market.

While the number of hospitals and payers complying with the rules and posting MRFs has grown in the last few years,<sup>81</sup> data quality continues to be a concern. The efforts required to aggregate and parse MRFs and the expertise required to untangle complex pricing data constitute other barriers, especially for smaller health plans and hospitals. Per an October 2024 Government Accountability Office (GAO) report, while CMS’s updated 2024 requirements and enforcement actions help enhance standardization and compliance, the completeness and accuracy of the price transparency data are currently not guaranteed.<sup>82</sup> Looking ahead, CMS should first assess if the data is sufficiently complete and accurate, and then, if deemed necessary, pursue additional enforcement, such as risk-based and random sampling, which would be cost-effective.

**Figure 20. Rate changes in converging vs. non-converging markets**



Notes: A market is defined as a service in a US metro in the study. The rate change is adjusted for inflation using the Hospital Services component of the Consumer Price Index (CPI).

Source: Turquoise Health



## About this research

Each year, PwC health researchers project the growth of employer medical costs in the coming year and identify 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 “inflaters” 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 2025. In April and May 2025, we surveyed and interviewed actuaries at 24 US health plans to generate an estimate of medical cost trend for the coming year. These plans cover more than 125 million employer-sponsored members and 12 million Affordable Care Act (ACA) marketplace members.

Participants were asked about their trend experience for 2023-24 and 2024-25, trend estimates for 2025-26, 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.





# Acknowledgements

Blue Cross and Blue Shield of Alabama  
Blue Cross and Blue Shield of Kansas  
Blue Cross and Blue Shield of Kansas City  
Blue Cross Blue Shield of Massachusetts  
Blue Cross Blue Shield of Michigan (BCBSM)  
Blue Cross Blue Shield of North Carolina  
Blue Cross Blue Shield of Rhode Island  
Blue Shield of California  
Cambia Health Solutions  
CareFirst BlueCross BlueShield  
CareSource  
CVS Health Corporation  
Elevance Health  
Excellus BlueCross BlueShield  
GuideWell  
Health Alliance Plan (HAP)  
Health Care Service Corporation (HCSC)  
Horizon Blue Cross Blue Shield of New Jersey  
Independence Blue Cross  
Kaiser Permanente  
Oscar Health  
The Cigna Group  
UnitedHealth Group  
Wellmark Blue Cross and Blue Shield

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# Endnotes

1. Centers for Medicare & Medicaid Services, "Health Insurance Exchanges 2025 Open Enrollment Report," accessed July 10, 2025. <https://www.cms.gov/files/document/health-insurance-exchanges-2025-open-enrollment-report.pdf>
2. Congressional Budget Office, "Estimated Budgetary Effects of an Amendment in the Nature of a Substitute to H.R. 1, the One Big Beautiful Bill Act, Relative to the Budget Enforcement Baseline for Consideration in the Senate," June 27, 2025. <https://www.cbo.gov/publication/61533>
3. Nathaniel Weixel, "Trump floats 200 percent tariffs on pharmaceutical imports 'very soon,' " The Hill, July 8, 2025. <https://thehill.com/homenews/administration/5390505-trump-200-percent-tariffs-pharma-imports/>
4. Congressional Research Service, "Enhanced Premium Tax Credit Expiration: Frequently Asked Questions," Dec. 4, 2024. <https://www.congress.gov/crs-product/R48290>
5. KFF, "Inflation Reduction Act Health Insurance Subsidies: What Is Their Impact and What Would Happen if They Expire?" July 26, 2024. <https://www.kff.org/affordable-care-act/issue-brief/inflation-reduction-act-health-insurance-subsidies-what-is-their-impact-and-what-would-happen-if-they-expire/>
6. ACA Signups, "2026 Rate Change Project," May 14, 2025. [https://acasignups.net/rate\\_changes/2026](https://acasignups.net/rate_changes/2026)
7. H.R. 1, 119th Congress, July 4, 2025. <https://www.congress.gov/bill/119th-congress/house-bill/1/text>
8. Elizabeth Hinton and Robin Rudowitz, "5 Key Facts About Medicaid Work Requirements," KFF, Feb. 18, 2025. <https://www.kff.org/medicaid/issue-brief/5-key-facts-about-medicaid-work-requirements/>  
Michael Karpman and Anuj Gangopadhyaya, "New Evidence Confirms Arkansas's Medicaid Work Requirement Did Not Boost Employment," Urban Institute, April 23, 2025. <https://www.urban.org/urban-wire/new-evidence-confirms-arkansas-medicaid-work-requirement-did-not-boost-employment>
9. Fredric Blavin and Michael Simpson, "State-Level Estimates of Health Care Spending and Uncompensated Care Changes Under the Reconciliation Bill and Expiration of Enhanced Subsidies," Urban Institute, June 13, 2025. <https://www.urban.org/research/publication/state-level-estimates-health-care-spending-and-uncompensated-care-changes>
10. CMS, "2025 Open Enrollment Report," (see footnote 1).
11. CMS, "Calendar Year 2025 Medicare Physician Fee Schedule Final Rule," Nov. 1, 2024. <https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2025-medicare-physician-fee-schedule-final-rule>
12. Publicly available hospital financials, year ending 2024.
13. Ibid.
14. Purple Labs claims data.
15. Citeline, "Pharma R&D 2025," <https://www.citeline.com/-/media/C28F0B5022334A4EAC9B0DDDE55F5737>
16. IQVIA Institute for Human Data Science, "Understanding the Use of Medicines in the US 2025," April 30, 2025. <https://www.iqvia.com/insights/the-iqvia-institute/reports-and-publications/reports/understanding-the-use-of-medicines-in-the-us-2025>
17. US Food and Drug Administration, "FDA clarifies policies for compounders as national GLP-1 supply begins to stabilize," April 28, 2025. <https://www.fda.gov/drugs/drug-safety-and-availability/fda-clarifies-policies-compounders-national-glp-1-supply-begins-stabilize>
18. AIS Health, "Current Market Access to GLP-1s — and What's Next," April 17, 2025. <https://aishealth.mmitnetwork.com/blogs/spotlight-on-market-access/current-market-access-to-glp-1s-and-what-s-next>
19. Grace Niewijk, "Research shows GLP-1 receptor agonist drugs are effective but come with complex concerns," University of Chicago Medicine, May 30, 2024. <https://www.uchicagomedicine.org/forefront/research-and-discoveries/articles/research-on-glp-1-drugs>
20. Rebecca Robbins, "How Much Should Weight Loss Drugs Cost?" The New York Times, March 14, 2025. <https://www.nytimes.com/2025/03/14/health/wegovy-zepbound-cost-weight-loss-drugs.html>  
Jennifer H. Hwang, Neda Laiteraopong and Elbert S. Huang, "Lifetime Health Effects and Cost-Effectiveness of Tirzepatide and Semaglutide in US Adults," JAMA Health Forum, March 14, 2025. <https://jamanetwork.com/journals/jama-health-forum/fullarticle/2831205> Institute for Clinical and Economic Review, "Medications for Obesity Management: Effectiveness and Value," Oct. 20, 2022. [https://icer.org/wp-content/uploads/2022/03/ICER\\_Obesity\\_Final\\_Evidence\\_Report\\_and\\_Meeting\\_Summary\\_102022.pdf](https://icer.org/wp-content/uploads/2022/03/ICER_Obesity_Final_Evidence_Report_and_Meeting_Summary_102022.pdf)
21. Patrick Gleason, Landon Marshall, Ben Urlick, Yang Qiu and R. Scott Leslie, "Year-Two Real-World Analysis of Glucagon-Like Peptide-1 Agonist (GLP-1) Obesity Treatment Adherence and Persistency," Prime Therapeutics, July 10, 2024. <https://www.primetherapeutics.com/documents/d/primetherapeutics/prime-mrx-glp-1-year-two-study-abstract-final-7-10>
22. FDA, "FDA Approves First Gene Therapies to Treat Patients with Sickle Cell Disease," Dec. 8, 2023. <https://www.fda.gov/news-events/press-announcements/fda-approves-first-gene-therapies-treat-patients-sickle-cell-disease>
23. ICER, "Report at a Glance: Sickle Cell Disease," August 2023. [https://icer.org/wp-content/uploads/2023/08/SCD\\_RAAG\\_AUG-2023.pdf](https://icer.org/wp-content/uploads/2023/08/SCD_RAAG_AUG-2023.pdf)
24. Ahmar U. Zaidi, et al, "A systematic literature review of frequency of vaso-occlusive crises in sickle cell disease," Orphanet Journal of Rare Diseases, Nov. 2, 2021. <https://ojrd.biomedcentral.com/articles/10.1186/s13023-021-02096-6#Sec1>  
Vertex, "Vertex and CRISPR Therapeutics Announce US FDA Approval of CASGEVY (exagamglogene autotemcel) for the Treatment of Sickle Cell Disease," Dec. 8, 2023. <https://investors.vrtx.com/news-releases/news-release-details/vertex-and-crispr-therapeutics-announce-us-fda-approval>
25. FDA, "FDA Approves First Cellular Therapy to Treat Patients With Unresectable or Metastatic Melanoma," Feb. 16, 2024. <https://www.fda.gov/news-events/press-announcements/fda-approves-first-cellular-therapy-treat-patients-unresectable-or-metastatic-melanoma>
26. Carmen Phillips, "First Cancer TIL Therapy Gets FDA Approval for Advanced Melanoma," National Cancer Institute, March 5, 2024. <https://www.cancer.gov/news-events/cancer-currents-blog/2024/fda-amtagvi-til-therapy-melanoma>
27. HM Insurance Group, "Pharmacy Focus: Amtagvi—A Novel Treatment for Metastatic Melanoma," accessed July 11, 2025. <https://www.hmig.com/content/dam/hmig/en/website/documents/pdf/v1/pharmacy-focus-amtagvi.pdf>
28. FDA, "FDA Approves First Gene Therapy for Children with Metachromatic Leukodystrophy," March 18, 2024. <https://www.fda.gov/news-events/press-announcements/fda-approves-first-gene-therapy-children-metachromatic-leukodystrophy>
29. Brenda Goodman, "A lifesaving therapy for children with a rare disease is now the world's most expensive drug, raising questions about access," CNN, March 20, 2024. <https://edition.cnn.com/2024/03/19/health/gene-therapy-orchard-mld>
30. FDA, "FDA Expands Approval of Gene Therapy for Patients with Duchenne Muscular Dystrophy," June 20, 2024. <https://www.fda.gov/news-events/press-announcements/fda-expands-approval-gene-therapy-patients-duchenne-muscular-dystrophy>
31. Greg Slabodkin, "Expanded Approval of Sarepta's Elevidys Is Progress, But More Needed for DMD Patients," BioSpace, June 21, 2024. <https://www.biospace.com/expanded-approval-of-sarepta-s-elevidys-is-progress-but-more-needed-for-dmd-patients>
32. FDA, "FDA Approves Novel Treatment for Hemophilia A or B, With or Without Factor Inhibitors," March 28, 2025. <https://www.fda.gov/news-events/press-announcements/fda-approves-novel-treatment-hemophilia-or-b-or-without-factor-inhibitors>
33. Jacob Bell, "FDA approves first-of-its-kind RNA drug for hemophilia," Biopharma Dive, March 28, 2025. <https://www.biopharmadive.com/news/sanofi-hemophilia-qfitilia-fitusiran-rna-fda-approval/743914/>
34. Tom Burke, Sohaib Asghar, Jamie O'Hara, Eileen K. Sawyer and Nanxin Li, "Clinical, humanistic, and economic burden of severe hemophilia B in the United States: Results from the CHES US and CHES US+ population surveys," Orphanet Journal of Rare Diseases, March 20, 2021. <https://pmc.ncbi.nlm.nih.gov/articles/PMC7981988/>
35. Alnylam, "FDA Approves Qfitilia (fitusiran), the First siRNA (RNAi Therapeutic) for the Treatment of Hemophilia A or B," March 28, 2025. <https://investors.alnylam.com/press-release?id=28901>
36. Eisai, "FDA Approves Leqembi (Lecanemab-IRMB) IV Maintenance Dosing for the Treatment of Early Alzheimer's Disease," Jan. 26, 2025. <https://media-us.eisai.com/2025-01-26-FDA-Approves-LEQEMBI-R-lecanemab-irmb-IV-Maintenance-Dosing-for-the-Treatment-of-Early-Alzheimers-Disease>
37. PR Newswire, "Eisai's Approach to US Pricing for Leqembi (Lecanemab), a Treatment for Early Alzheimer's Disease, Sets Forth Our Concept of 'Societal Value of Medicine' in Relation to 'Price of Medicine,'" Eisai, Jan. 6, 2023. <https://www.prnewswire.com/news-releases/eisais-approach-to-us-pricing-for-leqembi-lecanemab-a-treatment-for-early-alzheimers-disease-sets-forth-our-concept-of-societal-value-of-medicine-in-relation-to-price-of-medicine-301715694.html>
38. ICER, "Lecanemab for Early Alzheimer's Disease," April 17, 2023. [https://icer.org/wp-content/uploads/2023/04/ICER\\_Alzheimers-Disease\\_Final-Report\\_For-Publication\\_04172023.pdf](https://icer.org/wp-content/uploads/2023/04/ICER_Alzheimers-Disease_Final-Report_For-Publication_04172023.pdf)

# Endnotes

39. FDA, “FDA approves treatment for adults with Alzheimer’s disease,” July 2, 2024. <https://www.fda.gov/drugs/news-events-human-drugs/fda-approves-treatment-adults-alzheimers-disease>

40. Lilly, “Lilly’s Kisunla (donanemab-azbt) Approved by the FDA for the Treatment of Early Symptomatic Alzheimer’s Disease,” July 2, 2024. <https://investor.lilly.com/news-releases/news-release-details/lillys-kisunlatm-donanemab-azbt-approved-fda-treatment-early>

41. CSL, “US Food and Drug Administration Approves CSL’s Andembyr (garadacimab-gxii), the Only Prophylactic Hereditary Angioedema (HAE) Treatment Targeting Factor X11a With Once-Monthly Dosing for All Patients From the Start,” June 16, 2025. <https://newsroom.csl.com/2025-06-16-U-S-Food-and-Drug-Administration-Approves-CSLs-ANDEMBRY-R-garadacimab-gxii--the-Only-Prophylactic-Hereditary-Angioedema-HAE-Treatment-Targeting-Factor-X11a-with-Once-Monthly-Dosing-for-All-Patients-From-the-Start>

42. Optum Rx, “Optum Rx Report: Notable New Drugs,” Spring 2025. <https://business.optum.com/content/dam/noindex-resources/business/pdfs/guides/notable-new-drugs-spring-2025.pdf>

43. Discover HAE, “About HAE,” accessed July 11, 2025. <https://www.discoverhae.com/what-is-hereditary-angioedema>

44. Optum Rx, “Notable New Drugs,” (see footnote 42).

45. Robert Holly, “Behavioral Health Executives Sound Alarm on Reimbursement Woes, Share Slow Progress With Value-Based Care,” Behavioral Health Business, March 19, 2025. <https://bhbusiness.com/2025/03/19/behavioral-health-executives-sound-alarm-on-reimbursement-woes-share-slow-progress-with-value-based-care/>

46. IQVIA, “Biosimilars in the United States 2023-2027,” January 2023. <https://www.iqvia.com/-/media/iqvia/pdfs/institute-reports/biosimilars-in-the-united-states-2023-2027/iqvia-institute-biosimilars-in-the-united-states-2023-usl-orb3393.pdf>

47. Adam J. Fein, “The Big Three PBMs’ 2025 Formulary Exclusions: Humira, Stelara, Private Labels, and the Shaky Future for Pharmacy Biosimilars,” Drug Channels, Jan. 22, 2025. <https://www.drugchannels.net/2025/01/the-big-three-pbms-2025-formulary.html>

48. Samsung Bioepis, “Second Quarter 2025 Biosimilar Market Report,” April 24, 2025. <https://m.samsungbioepis.com/upload/attach/SB+Biosimilar+Markt+Report+Q2+2025.pdf>

49. Adam J. Fein, “The Big Three PBMs’ 2025 Formulary Exclusions,” (see footnote 47).

50. IQVIA, “Assessing the Biosimilar Void in the US,” Feb. 3, 2025. <https://www.iqvia.com/insights/the-iqvia-institute/reports-and-publications/reports/assessing-the-biosimilar-void-in-the-us>

51. Jason Wenzke, “Understanding Rebate Credit Values: When a Rebate Isn’t a Rebate,” Ringmaster, accessed July 11, 2025. <https://www.ringmastertech.com/blog-rx-understanding-rebate-credit-values/>

52. Tanya Albert Henry, “10 states have tackled prior authorization so far in 2024,” AMA, Aug. 19, 2024. <https://www.ama-assn.org/practice-management/prior-authorization/10-states-have-tackled-prior-authorization-so-far-2024>

Ani Turner, George Miller and Samantha Clark, “Impacts of Prior Authorization on Health Care Costs and Quality,” Altarum Center for Value in Health Care, November 2019. <https://www.nihcr.org/wp-content/uploads/Altarum-Prior-Authorization-Review-November-2019.pdf>

53. CMS, “CMS Finalizes Rule to Expand Access to Health Information and Improve the Prior Authorization Process,” Jan. 17, 2024. <https://www.cms.gov/newsroom/press-releases/cms-finalizes-rule-expand-access-health-information-and-improve-prior-authorization-process>

54. InfoMC. “How Risk-Bearing Entities Can Extract Value From Care Management Programs,” May 23, 2023. <https://www.infomc.com/extracting-value-from-care-management-programs/>

55. Matt Hawrilenko, et al, “Return on Investment of Enhanced Behavioral Health Services,” JAMA Network Open, Feb. 5, 2025. <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2829859>

56. Adam Siskand, et al, “3 health plan strategies for balancing cost and access with GLP-1s,” ZS, July 30, 2024. <https://www.zs.com/content/dam/pdfs/3-health-plan-strategies-for-balancing-cost-and-access-with-GLP-1s.pdf>

57. US-Rx Care, “An Education in Savings,” accessed July 11, 2025. <https://usrxcare.com/resources/#thought-leadership>

58. Andrew Borenstein, Vinod Swarna and Anuj Saxena, “AI tackles payment integrity as health plans face \$935B wake-up call,” ZS, Oct. 7, 2024. <https://www.zs.com/insights/ai-tackles-payment-integrity-for-health-plans>

Codexo, “Generative AI for Payment Integrity: The Vision and Promise to Improve Efficiencies & Costs,” accessed July 11, 2025. <https://www.codexo.com/generative-ai-for-payment-integrity-the-codexo-vision-and-promise/>

HL7 International, “Reducing Fraud and Improving Payment Integrity in Healthcare Through the Use of AI,” May 2025. [https://2167096.fs1.hubspotusercontent-na1.net/hubfs/2167096/HL7%20Reducing%20Fraud%20and%20Improving%20Payment%20Integrity%20in%20Healthcare%20Through%20the%20Use%20of%20AI\\_Final\\_5\\_7\\_25.pdf](https://2167096.fs1.hubspotusercontent-na1.net/hubfs/2167096/HL7%20Reducing%20Fraud%20and%20Improving%20Payment%20Integrity%20in%20Healthcare%20Through%20the%20Use%20of%20AI_Final_5_7_25.pdf)

59. Milliman Report, “Access Across America,” December 2023. <https://www.inseparable.us/AccessAcrossAmerica.pdf>

60. PwC, “You can help make healthcare more affordable through the power of AI,” March 4, 2025. <https://www.pwc.com/us/en/industries/health-industries/library/ai-healthcare-affordability.html>

61. Health Care Payment Learning & Action Network, “2024 Methodology and Results Report,” November 2024.

62. Cassandra Willyard, “AI can help screen for cancer—but there’s a catch,” MIT Technology Review, Sept. 15, 2023. <https://www.technologyreview.com/2023/09/15/1079499/ai-cancer-screening-overdiagnosis/>

63. Nikhil Sahni, George Stein, Rodney Zimmel and David M. Cutler, “The Potential Impact of Artificial Intelligence on Healthcare Spending,” National Bureau of Economic Research, October 2023. [https://www.nber.org/system/files/working\\_papers/w30857/w30857.pdf](https://www.nber.org/system/files/working_papers/w30857/w30857.pdf)

64. Peterson Health Technology Institute, “Adoption of Artificial Intelligence in Healthcare Delivery Systems: Early Applications and Impacts,” March 2025. <https://phti.org/wp-content/uploads/sites/3/2025/03/PHTI-Adoption-of-AI-in-Healthcare-Delivery-Systems-Early-Applications-Impacts.pdf>

65. Aaron A. Tierney, et al, “Ambient Artificial Intelligence Scribes to Alleviate the Burden of Clinical Documentation,” NEJM Catalyst, Feb. 21, 2024. <https://catalyst.nejm.org/doi/full/10.1056/CAT.23.0404>

Nate C. Apathy, A. Jay Holmgren and Dori A. Cross, “Physician HER Time and Visit Volume Following Adoption of Team-Based Documentation Support,” JAMA Internal Medicine, Aug. 26, 2024. <https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2822382>

Margaret Ziemann, Ciese Erikson and Maddie Krips, “The Use of Medical Scribes in Primary Care Settings,” Medical Care, October 2021. [https://journals.lww.com/ww-medicalcare/fulltext/2021/10001/the\\_use\\_of\\_medical\\_scribes\\_in\\_primary\\_care.9.aspx](https://journals.lww.com/ww-medicalcare/fulltext/2021/10001/the_use_of_medical_scribes_in_primary_care.9.aspx)

66. Hirotaka Takita, et al, “A systematic review and meta-analysis of diagnostic comparison between generative AI and physicians,” NPJ Digital Medicine, March 22, 2025. <https://www.nature.com/articles/s41746-025-01543-z>

67. Evans, et al, “Testing Treatments: Better Research for Better Care,” Pinter & Martin, 2011. <https://www.ncbi.nlm.nih.gov/books/NBK66205/>

68. Marcela Castro Ramos, et al, “Economic evaluations of colorectal cancer screening: A systematic review and quality assessment,” Clinics, April 25, 2023. <https://pmc.ncbi.nlm.nih.gov/articles/PMC10182269/>

69. Common Sense Systems Inc., “Revolutionizing Healthcare Operations with AI-Powered Patient Scheduling,” May 21, 2025. <https://common-sense.com/blog/2025/05/revolutionizing-healthcare-operations-with-ai-powered-patient-scheduling/index.html>

Shyft, “Healthcare AI Scheduling Success Stories: Implementation Case Studies,” accessed July 11, 2025. <https://www.myshyft.com/blog/healthcare-implementation-case-studies/>

70. American Hospital Association, “3 Ways AI Can Improve Revenue-Cycle Management,” accessed July 11, 2025. <https://www.aha.org/aha-center-health-innovation-market-scan/2024-06-04-3-ways-ai-can-improve-revenue-cycle-management>

71. HRA Council, “Growth Trends for ICHRA & QSEHRA, Vol. 4: 2024-2025,” accessed July 11, 2025. <https://www.hracouncil.org/report>

72. Ibid.

73. Ibid.

# Endnotes

- 74. CBO, "Federal Subsidies for Health Insurance Coverage for People Under 65: 2022-2032," accessed July 11, 2025. <https://www.cbo.gov/system/files/2022-06/57962-health-insurance-subsidies.pdf>
- 75. HRA Council, "Growth Trends," (see footnote 71).
- 76. Surest, "Addressing health care's biggest challenges," accessed July 11, 2025. <https://www.surest.com/resources/494710-23-ai-494722-all-all-b2b-impactplacemat-v2.pdf>
- 77. CMS, "Hospital Price Transparency Fact Sheet," Nov. 2, 2023. <https://www.cms.gov/newsroom/fact-sheets/hospital-price-transparency-fact-sheet>
- 78. Christopher M. Whaley, Rose Kerber, Daniel Wang, Aaron Kofner and Brian Briscoe, "Prices Paid to Hospitals by Private Health Plans," Rand, Dec. 10, 2024. [https://www.rand.org/pubs/research\\_reports/RRA1144-2-v2.html](https://www.rand.org/pubs/research_reports/RRA1144-2-v2.html)  
Calvin A. Ackley, "Regional Price Level Estimates for Medical Services in the United States," March 2025. <https://www.bea.gov/sites/default/files/papers/BEA-WP2025-3.pdf>
- 79. American Academy of Actuaries, "Implications of Hospital Price Transparency on Hospital Prices and Price Variation," March 2022. [https://www.actuary.org/wp-content/uploads/2022/03/HospPriceTranslB\\_3.22.pdf](https://www.actuary.org/wp-content/uploads/2022/03/HospPriceTranslB_3.22.pdf)  
US Government Accountability Office, "Health Care Transparency: CMS Needs More Information on Hospital Pricing Data Completeness and Accuracy," October 2024. <https://www.gao.gov/assets/gao-25-106995.pdf>
- 80. Forrest Xiao, "Is Price Transparency Helping?" Turquoise Health, 2024. [https://s3.uswest1.amazonaws.com/assets.turquoise.health/case\\_studies/Is+Price+Transparency+Helping+-+White+Paper+by+Turquoise+Health.pdf](https://s3.uswest1.amazonaws.com/assets.turquoise.health/case_studies/Is+Price+Transparency+Helping+-+White+Paper+by+Turquoise+Health.pdf)
- 81. Dave Muoio, "Hospital, payer price transparency compliance improves, but new requirements are kicking in this year," Fierce Healthcare, Jan. 4, 2024. <https://www.fiercehealthcare.com/regulatory/hospital-payer-price-transparency-compliance-improves-new-requirements-are-kicking-2024>
- 82. GAO, "Health Care Transparency," (see footnote 79).



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