LOCKTON | PEOPLE SOLUTIONS

LOCKTON PEOPLE SOLUTIONS MARKET UPDATE

Health plan cost pressures continue in 2025

Q1 2025

INTRODUCTION

Lockton's People Solutions Market Update offers comprehensive quarterly insights on the U.S. health insurance market and industry dynamics impacting cost management, employee wellbeing, and benefits strategies. In this edition, we explore key factors shaping the year ahead, including historically high medical and pharmacy cost trends and heightening fiduciary responsibilities.

Contributors

SHANNON DEMAREE, ASA, MAAA, FCA	EVP, People Solutions Resource Group Practice Leader
JON ACKER, ASA, MAAA	SVP, Data Science Practice Leader
SHEALYNN BUCK, MD	SVP, Chief Medical Officer
ROSHI FISHER, MBA, MPH	VP, Director of Clinical Practice Operations
RACHEL HARGROVE, MBA-HCM	VP, Clinical Consulting and Complex Claims Practice Leader
TODD HLASNEY, CEBS, FPA, GBA	SVP, Precision Health Practice
SCOTT KLEIN	SVP, Consulting Director
ROBERT KORDELLA, RPH	Chief Clinical Officer, Pharmacy Analytics
BETH LATCHANA, JD	SVP, Director of Compliance Consulting
SHELLY LEWIS, FSA, MAAA	VP, Director of Actuarial Analytics
ROB McGEE	VP, Integrated Absence Solutions
JULAYNA MEYER, RPH, MBA	SVP, Pharmacy Practice
TRACY PEREZ, CEBS	SVP, Director of Collaborative Consulting
AMY PIZZEY	VP, Complex Claims Specialty Practice
TAMMY QUINN	SVP, Director of Data Analytics
KEVIN SEELMAN	EVP, Practice Leader
LAKSHMI SESHADRI, MD	VP, Executive Medical Director

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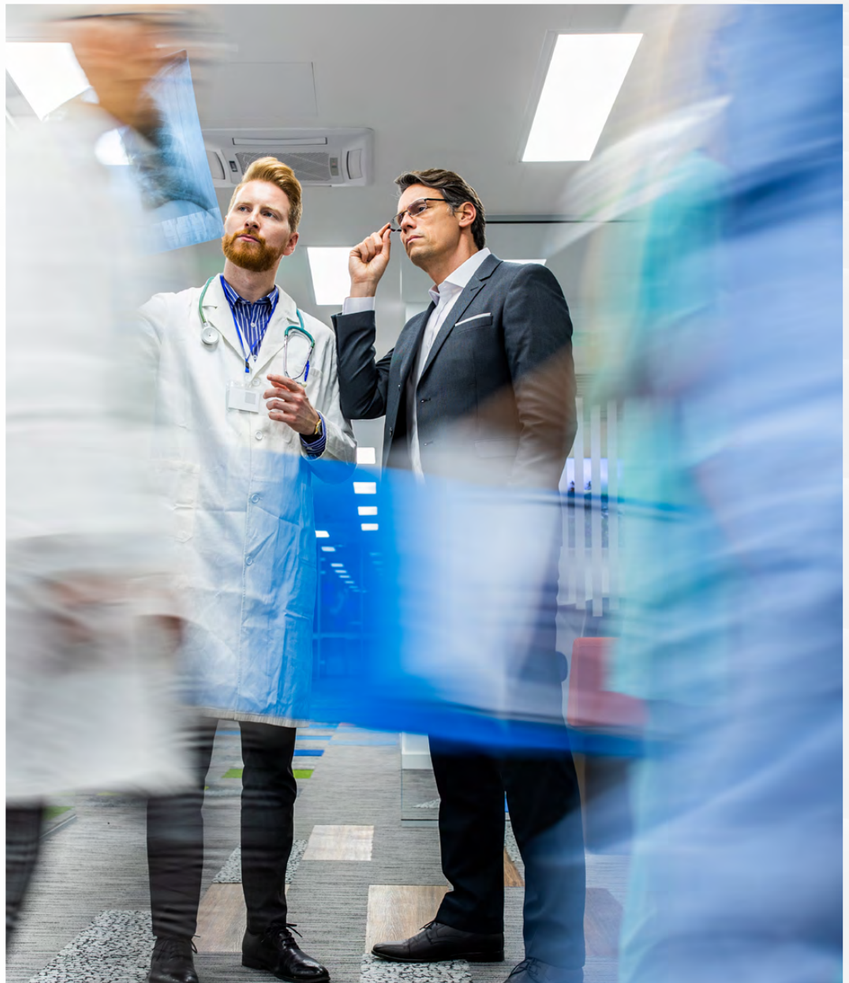


Q1 2025 highlights

Due to high increases in healthcare costs and recent lawsuits directed toward employer plans, plan sponsors face growing pressure to manage their plan costs effectively. While there is a spectrum of strategies available to alleviate and manage cost pressures in today's market, balancing the needs and expectations of the workforce with the cost of benefits will remain a critical consideration for employers throughout 2025.

Healthcare cost **trends remain high**, but the rate of **increase is stabilizing**.

Unsustainable medical and pharmacy trend increases, alongside **litigation**, have shined a spotlight on **plan sponsor fiduciary responsibilities**.

Will employers look to **more progressive strategies** to **mitigate costs?**

CURRENT MARKET LANDSCAPE

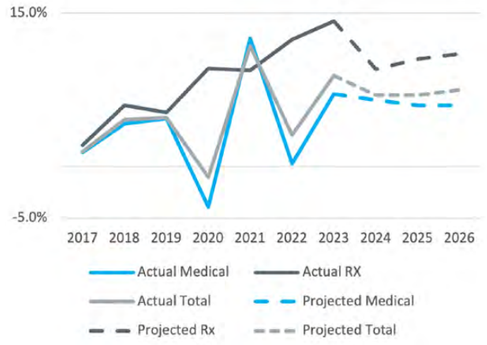
3 key insights

Healthcare cost trends remain high, but the pace of increase is stabilizing.

After a shock year of healthcare cost trends in 2023, when medical and pharmacy trend rate reached 10.2%, the rate of increase now appears to be stabilizing. Healthcare trends are still expected to remain high, with projections for 2025 ranging from 6%-8% and projections for 2026 ranging from 6.5%-7.5%.

Source: Infolock®.

MEDICAL & PHARMACY TREND: PAST & PROJECTED RATES



Lawsuits directed toward employer plans continue to shine a spotlight on fiduciary duties to prudently manage cost, including these two high-profile cases:

The now procedurally dismissed suit against Johnson & Johnson for breach of fiduciary duties and mismanagement of group health plan

The class action suit against Wells Fargo alleging fiduciary breach and mismanagement of prescription drug plan

Stay updated with the latest alerts, insights, and legislative guidance on Lockton's ERISA Compliance Consulting page.

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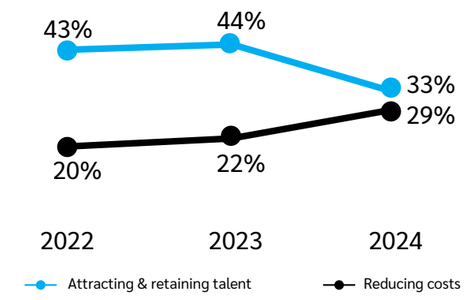
Focus on costs is expected to keep growing.

After years of prioritizing employee support during the pandemic and adapting to changing expectations, employers are now shifting their focus to cost management. In 2024, attracting and retaining talent was the top priority for 33% of employers when making benefits decisions, while 29% ranked cost reduction as their primary factor. We predict that cost reduction will surpass talent considerations in 2025, with a greater percentage of employers making it their top focus.

Source: 2024 Lockton National Benefits Survey.

EMPLOYERS' MOST IMPORTANT FACTOR IN MAKING BENEFIT DECISIONS



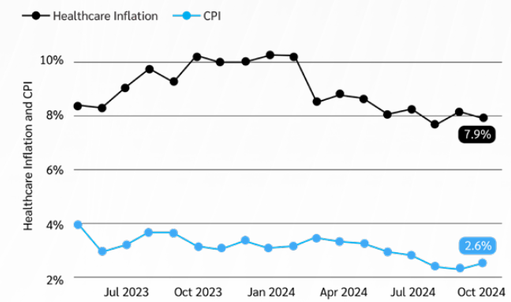
01

High healthcare costs expected through 2026

After spiking in 2023, healthcare trends began stabilizing in 2024, dropping by nearly 2% and showing signs of increasing at a lower rate. However, healthcare costs remain higher than other company expenses and will continue to consume a larger portion of the budget.

Despite remaining high, the stabilization provides some breathing room that will allow for better alignment of strategic benefits decisions with organizational goals in long-term planning.

HEALTHCARE INFLATION VS. CPI



Source: Lockton 2024 Market Experience Review, Infolock and data from the Bureau of Labor Statistics through October 2024.

$1K-$25K claimants	31% of trend
$25K-$300K claimants	52% of trend
$300K+ claimants	17% of trend

Source: Lockton's 2024 Market Experience Review, Infolock data paid through October 2024.

TREND DRIVERS ARE MULTIFACETED

Today's health plan costs are varied, driven by inflation, higher unit costs, and increased utilization across outpatient surgery, mental health and substance use treatment, and specialty medications.

According to Lockton's proprietary population health platform, Infolock, claims data through October 2024 reveals that high-cost claimants exceeding $300,000 accounted for 17% of healthcare trend, while the largest contributor to trend comes from mid-cost claimants between $25,000 and $300,000, accounting for 52% of trend.

With the average stop loss deductible being $300,000, according to Lockton's book of business for Jan. 1, 2025, renewals, the vast majority of trend falls to the cost the plan is funding.

Cost per unit has trended higher than utilization, particularly for pharmacy, where the average price per brand-name drug increased by $125 year-over-year, while increases in utilization were small. The price increase can be attributed to several factors, including new brand-name drugs entering the market, new indications for existing drugs, patent protections limiting competition, and growing use of specialty drugs.

What options are available to lower specialty drug spend?

- Narrow specialty networks
- Maximize copay cards from manufacturers
- Carve-out specialty drug management
- More restrictive utilization management criteria

Speak to a Lockton consultant about specialty drug options

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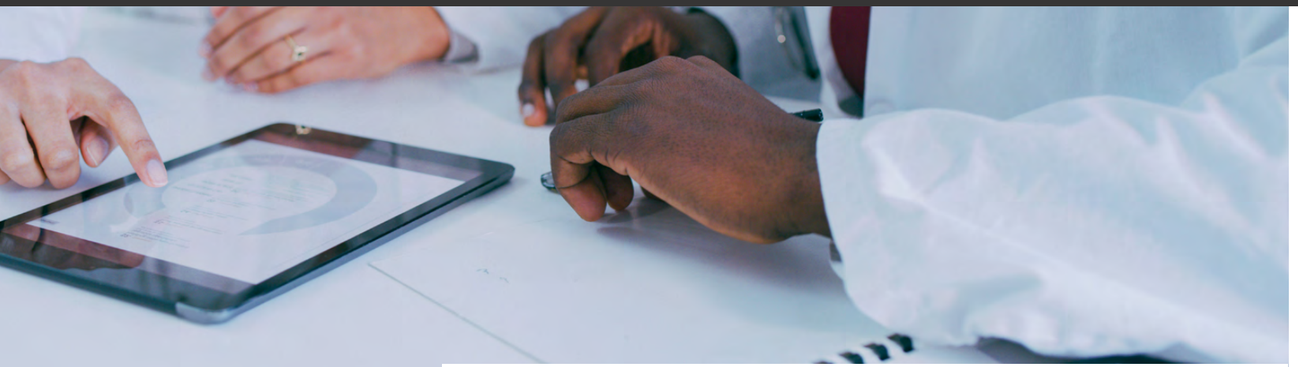
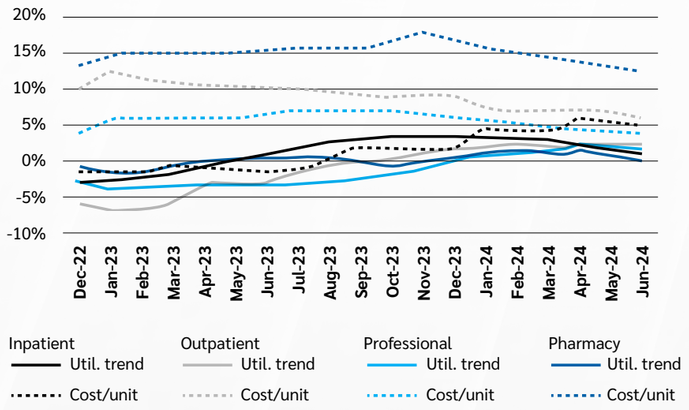


Inpatient cost per unit is trending higher than in previous years, primarily due to inflation driving up the cost of medical supplies, increased labor costs stemming from staffing challenges, and the adoption of new technologies.

Although no single condition is significantly driving the trend, diabetes-related spending has surged due to GLP-1s and SGLT2s. GLP-1 drugs, like Ozempic and Wegovy, mimic and amplify a hormone that the body produces naturally to lower glucose, slow the digestion of food, and increase and prolong the sense of fullness after eating. SGLT2s, like Jardiance, work by increasing glucose elimination through the kidneys. Inflammatory diseases and neoplasms are also large contributors.

LOCKTON BOOK OF BUSINESS —
ALLOWED COST PER UNIT VS. UTILIZATION TRENDS



Source: Lockton's book of business, rolling 12 months incurred with two months runout.

GLP-1s: TO COVER OR NOT TO COVER?

Employers are under pressure to cover GLP-1s for weight loss but should carefully evaluate the budget impact and cost management strategies. A successful program should combine intensive lifestyle intervention with a strong medication management program.

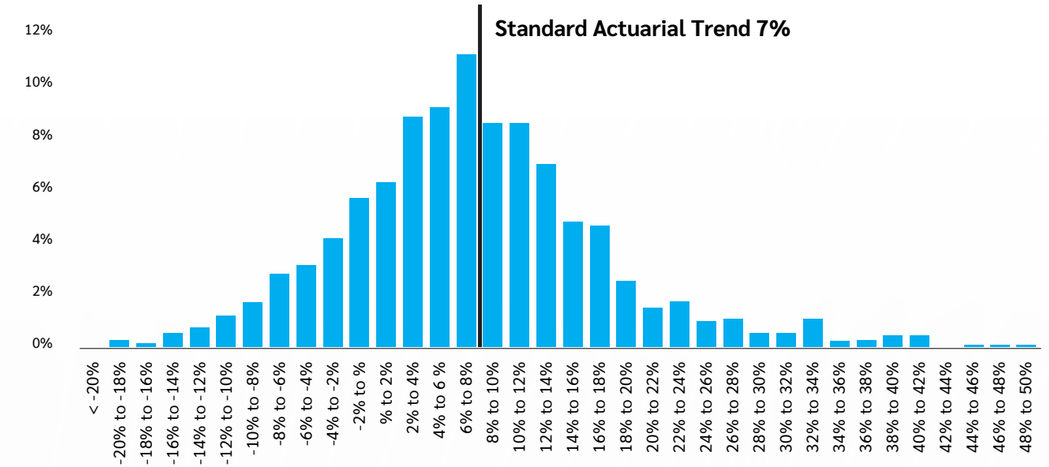
Leverage a Lockton clinical expert to better understand GLP-1 coverage considerations.

LEARN MORE ⟶

TREND PROJECTIONS

We project medical and pharmacy trends to increase 7% on average for 2025 and 7.5% on average for 2026, assuming the plan does not cover GLP-1s for weight loss. Trend increases will vary depending on factors such as group size, location, risk profile, and other variables.

HEALTHCARE TREND VARIABILITY



Source: Lockton's 2024 Market Experience Review, Infolock data paid through September 2024.

Emerging trends to watch

- Biosimilars will bring relief for expensive specialty drugs like Humira, but an extensive list of new drugs could offset any savings.
- Cancer diagnoses have seen an 11% YoY increase in self-funded employer plan spend.
- Discussions around gene therapy drugs continue, but their utilization currently remains low.
- Mental health continues to be a priority, and support for more complex mental health conditions and focus on substance misuse or abuse is increasing.
- More pressure on retail pharmacies and pharmacy closures are expected in 2025 and could increase costs.
- Pressure is increasing on employer plans to cover GLP-1s for anti-obesity, while other FDA-approved indications for these medications expand.
- Prevalence of cardiovascular treatment and musculoskeletal therapy treatment is increasing.

02

Increasing focus on fiduciary duties

ADDRESSING HEALTHCARE COST CHALLENGES ISN'T JUST A FINANCIAL CONCERN, BUT AN IMPORTANT FIDUCIARY OBLIGATION.

Employers are facing a brighter spotlight on fiduciary governance and must work to actively demonstrate that health benefit plan costs are reasonable and aligned with the best interests of participants.

New transparency requirements under the Consolidated Appropriations Act amplify this scrutiny and reinforce employers' responsibility to make informed decisions in their plans' cost management. This is because under ERISA, plan sponsors have a legal obligation to ensure that all benefit plan arrangements — medical, pharmacy, and beyond — are cost-effective and provide clear value.

Fiduciary responsibility can exist whether a plan sponsor designates a fiduciary or not. To address this, employers can choose one of two paths.

Read "The importance of an ERISA health & welfare plan fiduciary" to learn about your options. ⟶

READ MORE

In 2025's elevated cost market, the risk of litigation underscores the need for fiduciary oversight, especially regarding pharmacy benefits.

High-profile examples from the past year include the Johnson & Johnson class-action lawsuit for allegedly not ensuring reasonable plan costs and failing to exercise prudence when selecting a pharmacy benefit manager (PBM), and the litigation facing Wells Fargo for breaching similar duties related to their health plans.

Although two of the fiduciary duty claims against Johnson & Johnson were dismissed, this was based on procedural litigation rules and stopped short of weighing in on ERISA fiduciary breach allegations, so employers should still prioritize a proper fiduciary governance plan.

More legal activity is expected in 2025, as states continually introduce hundreds of bills on PBM regulation every year, and we could see litigation expanding beyond pharmacy.

PBM COST ACCOUNTABILITY

A key concern raised in recent litigation is the need for effective evaluation and oversight of PBMs to ensure fiduciary compliance.

With pharmacy benefits accounting for 30% of total health plan costs, addressing high costs with responsible PBM oversight is a legal obligation for plan sponsors. However, managing the complexities of the PBM industry is challenging due to its concentration and vertical integration.

The top three PBMs control over 80% of the market, creating obstacles for plan sponsors seeking transparency and value. Because of this market dominance, securing cost efficiency aligned with fiduciary responsibilities requires thorough assessments and competitive evaluations of service providers to ensure effectiveness and value.

How can employers make practical PBM decisions? Transparency and competition.

01 **Work with independent experts:** Partners without ties to PBMs who aren't operating with predetermined agreements help ensure unbiased evaluations and will focus on the best solution rather than recommending their own product.

02 **Conduct evaluations:** Assess PBMs thoroughly for cost and value with RFPs and market checks. Lockton believes healthy competition also provides opportunities for cost savings.

03 **Ensure fees are reasonable:** Plan sponsors should have a full understanding of PBM contracts and monitor costs, including administrative fees, dispensing fees, and utilization of rebates.

Review your pharmacy benefit plan options with a Lockton expert. ⟶

GET STARTED

Insurance lines market insights

STOP LOSS

Stop loss is on the rise

More employers are moving to self-funded plans, which is increasing the carriers' total risk pool. Even on an individual employer basis, exposure is increasing due to first-dollar trend pushing more claims over the stop loss deductible, causing the amount in excess of the deductible to increase and leading to a hardening of the market, which will result in higher stop loss premium increases and less flexibility in underwriting.

Over the past 10 years, Lockton's Infolock data shows that the excess amount over $250,000 has increased 12% annually, with 10.6% of the excess due to the number of claims and 1.3% due to the severity of claim.

This increase in severity is misleading. It's skewed by lower-cost claims just exceeding the stop loss deductible but doesn't show the steeper climb of million-dollar claims, which have seen a 15.3% annual increase over the last 10 years.

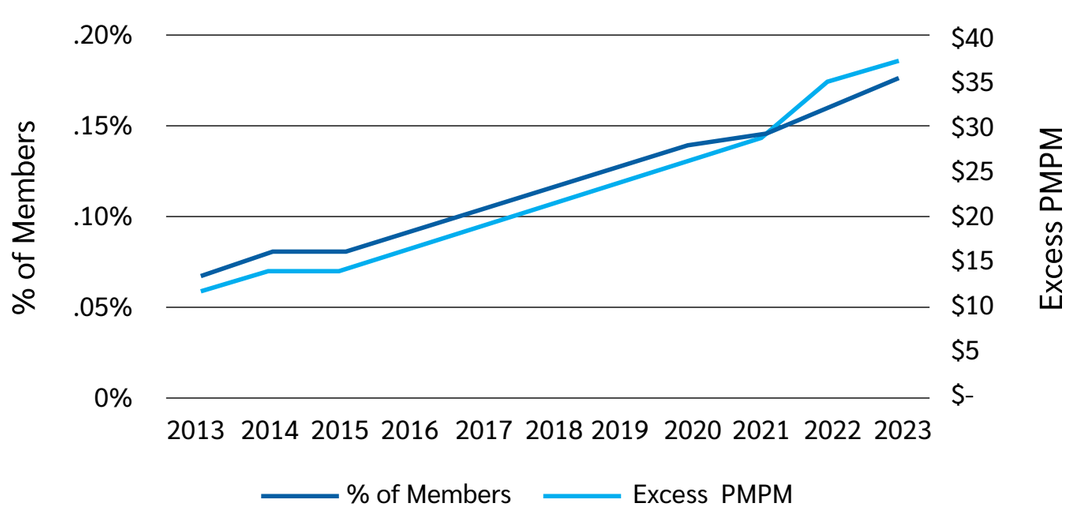
While it's not a surprise that specialty pharmacy is a large contributor to the severity of claims, the prevalence of cancer, catastrophic diagnoses for young children, and heart disease continues to be of significant concern, as the prevalence and severity is at an all-time high. Advancements in cell and gene therapy treatments keep stop loss carriers up at night but have historically only applied to rare conditions and represent a very small portion of catastrophic claims.

To help alleviate the impact of stop loss premium increases, employers need to mitigate large claims risk before it exceeds the specific deductible, as well as manage risk once it becomes a stop loss claim. This requires a close watch of claimants to ensure patients are directed to appropriate care and to reduce waste in the billing process.

Contact Lockton to learn more. ⟶

CONTACT US

NUMBER OF CLAIMS EXCEEDING DEDUCTIBLE DRIVE MAJORITY OF STOP LOSS TREND



Source: Infolock.

Number of claims exceeding $250,000 annualized 10-year trend = 10.6%

Stop loss PMPM claim cost annualized 10-year trend = 12%

FULLY INSURED

Premium increases for fully insured plans

For January 2025 renewals, Lockton's fully insured clients saw premium increases that were higher than self-funded clients' premium equivalent increases. This gap diminished after negotiations with carriers, but the final renewal increase remained slightly higher than self-funded.

Health insurers determine an employer plan's renewal based on a combination of experience rating and manual rating. The smaller the group size, the more weight placed on manual rating. The larger the group size, the more reliance on experience rating.*

Claims experience rating	Manual rating
Based on the group's experience, adjusted for the impact of new changes in the risk. The experience could be a blend of multiple years, depending on credibility.	Based on the insurance company's expected rates for a similar demographic, geography, plan design, etc.

For the portion of the rate increase equation that's based on a plan's experience, influencers include historical experience of the plan, expected changes in risk, and projected trend. See more info on trend drivers such as pharmacy and inpatient cost on page 11 of this Market Update.

The other portion of the equation is the carrier's manual rating. To stabilize the P&L, a carrier may need to adjust their manual rating, based on current profitability of the book of business, while still adhering to the ACA Medical Loss Ratio (MLR). The ACA MLR requires health insurance companies to report the percentage of premium spend on medical care and quality improvements, and requires the carriers to refund customers if they don't meet minimum MLR standards.

They also look at projected changes in administrative and claim costs. Administrative costs are impacted by factors like inflation and technology investments.

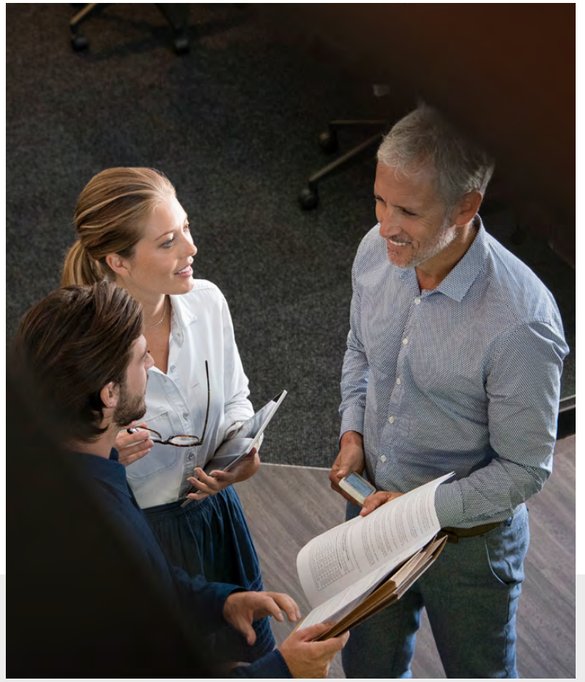
This impact to a carrier's manual rating could be broad across their entire manual rating or specific to an industry or region. For example, if a carrier's overall loss ratio is higher than expected for a certain industry, the carrier will adjust their manual rating, which increases rates above claim cost trend for that industry.

This rating methodology can cause wide fluctuations in the renewal increases that fully insured plans receive. We saw fully insured renewals ranging anywhere from a rate pass to as high as a 55% increase.

*Small groups with 50 or fewer employees are rated using a different community rating methodology, often using only ZIP codes, age, and gender data.

Why do fully insured plans have limited options to reduce the rate of increase?

- Limitation to pick from state-filed medical and pharmacy plans
- State-mandated coverage based on situs state
- Lack of flexibility around point solutions, networks, and navigation/advocacy programs
- Absence of crediting pharmacy rebates toward carrier underwriting



What options are available for fully insured plans?

Options for fully insured plans have varying degrees of cost savings and levels of employee disruption.

Examples include:

- Plan design changes (deductible, coinsurance, etc.)
- Eligibility changes, such as spousal carve-out
- High-performing networks, if available
- Navigation/advocacy to steer to higher-quality in-network provider, if available
- Medical Expense Reimbursement Plan
- Alternative funding, such as level-funding, reference-based pricing, or self-funding, perhaps through a stop loss captive
- Individual Coverage Health Reimbursement Arrangement

The life, disability, and leave market is favorable

2024 year-end results from IAS life, long-term disability (LTD), short-term disability (STD), and leave of absence (LOA) marketings yielded an average reduction of 5%, primarily on insured lines of coverage. Across administrative lines of coverage, i.e., leave of absence, self-insured short-term disability, and Americans with Disabilities Act Amendments Act (ADAAA), investments in technology, training, and wages have resulted in increases.

Overall, as fully insured premiums are materially larger than administrative fees, the market continues to be favorable, driven by continuation of advantageous interest rates and additional clarity following more volatile COVID-19 periods.

While marketing insured products across multiple carriers has resulted in favorable renewals, it isn't always required. Lockton has seen favorable results negotiating a renewal directly with the incumbent carrier. Given the complexity of implementing a new vendor, if an employer is satisfied with their current carrier, they may not need to market their plan.

Additional pricing considerations: State-mandated paid family and medical leave (PFML)

Insurance carriers have focused on growing the market share of private PFML programs to increase revenue and "stickiness" of broader lines of coverage. When numerous leave programs are outsourced, it's harder to implement a new vendor.

There has been an explosion of PFML legislation since New York Paid Family Leave went live in 2019, with 11 more states creating programs. 2026 will be a historic year, with four states (Delaware, Maine, Maryland, and Minnesota) all going live. We anticipate that carriers will continue to be aggressive in pushing the private approach.

Additional vendor considerations: Advancements in technology

Disability and leave vendors are making significant investments in technology to improve administration, increase automation, and enhance the employee and employer experience.

While traditional electronic data interchange continues to be the most prevalent approach to data sharing, insurance carriers are continuing to build connectivity with human resources (human resource information system the long term for HRIS) information system platforms through application programming interface (API). APIs are available for evidence of insurability (EOI), eligibility, leave status, billing, and plan design.

While many carriers have built or are working on integrations with Workday (and some expanding to ADP and UKG), experience levels with these solutions and offerings vary. Employers that have implemented an API with a vendor that is working well should carefully consider this when making decisions.

Beyond API, carriers are expanding communication capabilities with most major carriers and now offering either free-form texting or live chat features to handle basic customer service-related inquiries. Additionally, artificial intelligence is being deployed across numerous areas to improve efficiency and accuracy of triage, collection of medical, fraud detection and patterning, predictive analytics, and chatbots.

How can you evaluate if a private plan is the best option? Evaluate key factors, including:

01 **Claim volume:** It typically takes at least 500-1,000 employees to generate enough volume and impact enough claims/leaves to be worth the effort.

02 **Cost:** Projecting true impact is difficult when transitioning from unpaid FMLA to paid leave. Self-insured programs are generally not advised at the onset of a new program, and fully insured pricing is typically uncompetitive for industries with high utilization of leaves (retail, manufacturing, healthcare, etc.).

03 **Broader approach to outsourcing:** Private plans work best when leave is also outsourced, given many PFML leaves will run concurrently with FMLA and other company leaves of absence.

As 2025 continues, the combination of historically high health costs and heightened transparency expectations requires proactive health plan governance. By embracing a customized approach to plan management, employers can uphold their fiduciary duties, balance cost and experience, and optimize plan value.

ABOUT LOCKTON

What makes Lockton stand apart is also what makes us better: independence. Lockton's private ownership empowers its 12,500+ Associates doing business in over 150 countries to focus solely on clients' risk, insurance, and people needs. With expertise that reaches around the globe, Lockton delivers the deep understanding needed to accomplish remarkable results. For more information, visit Lockton.com.

ABOUT LOCKTON PEOPLE SOLUTIONS

Businesses can reach their full potential when their people do. That's why employers need solutions that help balance attracting and retaining talent, managing costs, and promoting employee wellbeing. Lockton helps provide solutions that make organizations more successful and people's lives better. For more information on employee experiences and engagement, total rewards and benefits, and measurement and management, visit Lockton People Solutions.

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