Five forces. Few brakes. What 2027 means for healthcare costs

Medical cost trend: Behind the numbers 2027

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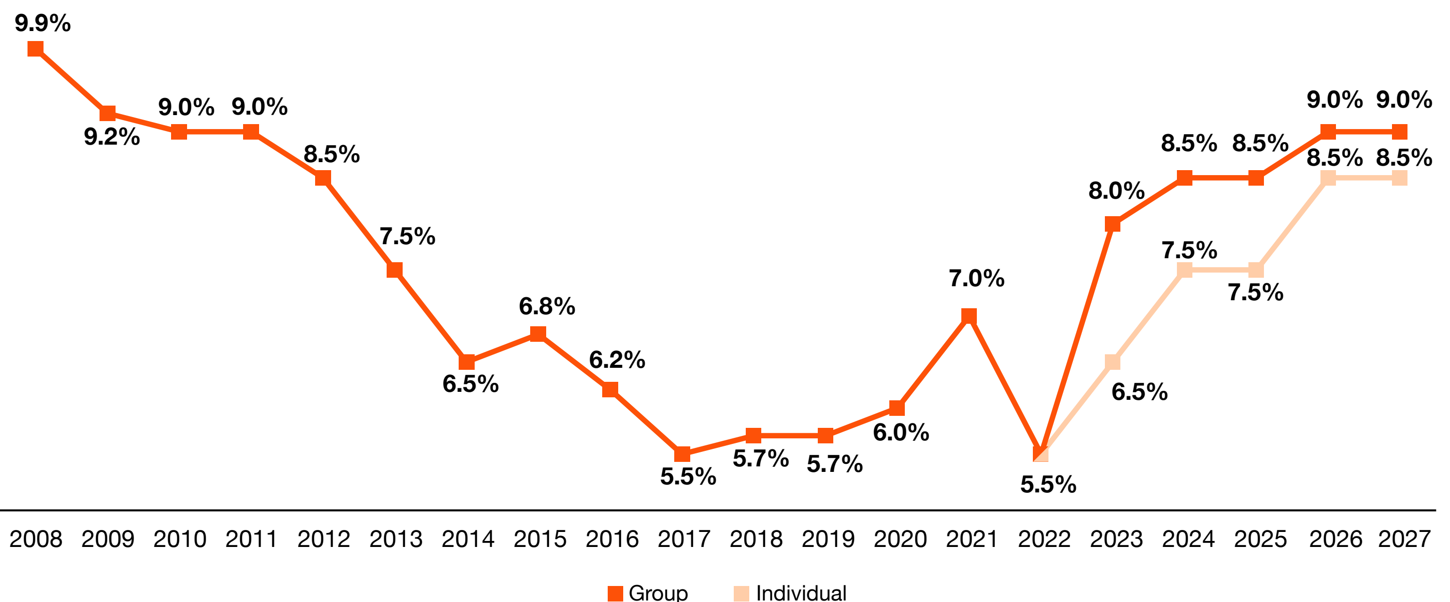
Heart of the matter

Five powerful inflators rise to the top in driving medical cost trend heading into 2027, with few meaningful deflators in sight. AI-enabled billing tools are helping providers capture more revenue per encounter. Reimbursement rates are increasingly driven by inflation and pressure from continued consolidation of providers and physicians. Pharmacy costs are increasing as higher cost specialty and GLP-1 therapies gain broader utilization. Behavioral health utilization continues to increase. The unintended consequences of the arbitration process of the No Surprises Act (NSA) are increasing out-of-network reimbursement costs.

Figure 1. PwC medical cost trends, 2008–2027

PwC projects medical cost trend to be 9.0% for Group and 8.5% for Individual in 2027, in line with restated 2026 trends



Source: PwC analysis

This trend does not take into account the impact of the expiration of enhanced subsidies in the Individual ACA market. More detail appears in the ACA Subsidy section below.

The 2026 medical cost trends restated higher than previously reported based on the input of health plans surveyed and their trend experience. This unfavorable development reflects higher-than-expected utilization, compounded by provider contract rates, coding intensity, and pharmacy costs remaining high since the second half of 2025 and continuing into 2026.

Counterweights to these inflators are insufficient to offset the pressure, but cost-of-care initiatives can have an impact. The question is whether payers and employers can engage with them quickly and precisely enough to make a material difference.

PwC's health researchers surveyed and interviewed actuaries at 27 US health plans to produce our estimate of medical cost trend for 2027, supplemented with additional sources of supporting external data to help understand the trend. The plans surveyed and interviewed cover more than 103 million employer-sponsored members and 8 million Individual Affordable Care Act (ACA) marketplace members. For the fifth consecutive year, plan actuaries expect elevated medical cost trends for the Group and Individual markets. Based on their input and our analysis, the Group medical cost trend is projected at 9.0% in 2027. The Individual market trend is projected at 8.5%. The study also supports a restatement of the Group and Individual trends up for 2026 from 8.5% and 7.5% to 9.0% and 8.5%, respectively.

Inflators

Five inflators are driving commercial medical cost trend for 2027:

1

AI-enabled documentation and coding tools allow providers to capture greater specificity and reimbursable severity without proportionate increases in care intensity.

2

Provider reimbursement pressure remains elevated due to inflationary pressure across provider underlying cost structures, reinforced by market consolidation limiting market alternatives.

3

Pharmacy trend continues to outpace overall medical trend, driven by advances in specialty drugs and expanding GLP-1 indications.

4

Behavioral health continues to outpace broader medical trend, with utilization surging 62% from 2018 to 2024.

5

The **No Surprises Act (NSA) Independent Dispute Resolution (IDR) arbitration process** has become a durable reimbursement inflator, with 2.6 million cases filed in 2025 and providers winning 88% of disputes.

Note: Inflators are ranked based on PwC's synthesis of health plan survey and interview responses, ordered by the greatest expected upward variance from historical medical cost trend.

Deflators

Historical deflators—biosimilars, generic drugs, and site-of-care optimization—remain active but are now embedded in the baseline. They are necessary to the current trend trajectory, not drivers of further improvement. What remains is what plans can directly control through cost-of-care initiatives.

1. **Payment integrity should remain the first line of defense.** Providers (and/or their vendors) are using AI-enabled documentation and coding tools to capture greater billing complexity, and plans are absorbing the cost. The response is to move payment review upstream, validating high-dollar claims before payment leaves the plan, tracking provider-level severity drift, and integrating contract terms, payment policy, and claims edits into a single accuracy engine. The goal is more accurate payment, not more denials.

2. **Utilization management should become more targeted, not simply more restrictive.** Retire low-yield prior authorization requirements. Instead, concentrate clinical review on the services where cost and variation are genuinely highest.

3. **Pharmacy management remains critical.** GLP-1s, specialty drugs, and medical-benefit therapies are contributing to pharmacy trend. Plans need class-specific governance, disciplined GLP-1 access policies by indication, accelerated biosimilar conversion where savings are real, and tighter alignment among pharmacy, utilization management, and site-of-care programs.

4. **Put network and reimbursement strategy to work.** Plans should use price transparency alongside their own claims experience to identify high-cost outliers, reset value-based contracts around specific cost drivers, and build steerage toward lower-cost sites of care.

5. **Use disciplined, event-driven care management.** Event-triggered, modifiable-risk interventions can bend trend. Plans should set explicit trend-deflation targets by lever, hold vendors to quantifiable outcomes, and stop funding programs that are unable to demonstrate avoided utilization or measurable savings.

The cost environment heading into 2027 is not a temporary spike. Inflators are structural, deflators are limited, and there is no more margin for passive management. Plans that move with precision, sequence their levers deliberately, and hold every program to demonstrated value targets can be better positioned to absorb what is coming. Those that do not are likely to find costs compounding faster than their ability to respond.

The scope of this analysis includes Group and Individual ACA marketplace plans

This analysis, including health plans surveyed and supporting research, is focused on small and large group (Group) and ACA marketplace (Individual) plans. The Individual market has recently seen a significant deterioration in morbidity due to expiration of premium subsidies, as discussed in more detail in the next section. 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.

Medical cost trend is primarily influenced by three core levers:

Price/unit cost

The amount paid for a given service, encounter, admission, or drug cost increase.

Units/utilization

More services, visits, prescriptions, or admissions are used on a per capita basis.

Mix/intensity

Spending shifts toward more expensive services, sites of care, drugs, or coded levels of severity.

Note: This report's medical cost trend estimates do not account for changes in population morbidity or enrollment mix. These factors can affect premiums and average claims cost, but they are distinct from the underlying cost of care trend.

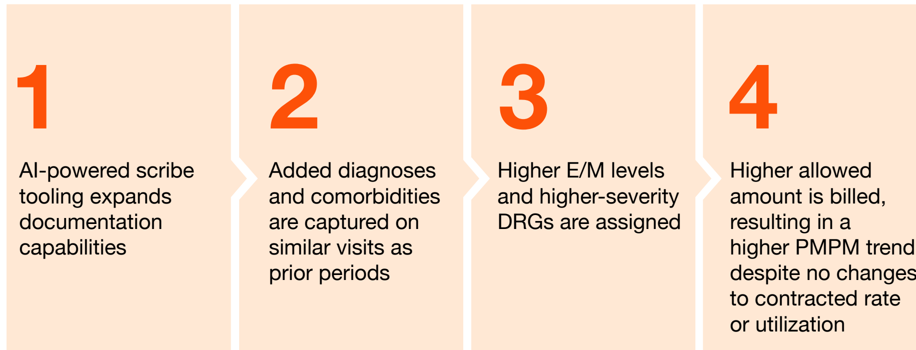
Price/unit cost | Units/utilization | **Mix/intensity**

Inflator 1: AI-enabled revenue optimization increases documentation and coding intensity

Revenue cycle management is emerging as a more meaningful contributor to medical cost trend as providers (and/or their vendors) expand the use of AI-enabled documentation and coding tools. The issue is not simply greater efficiency in note-taking. More complete, detailed documentation can increase the capture of billable complexity, support higher-severity coding, and raise reimbursement per encounter or admission under current payment models. As adoption broadens, the financial impact is emerging less through higher utilization and more through changes in coded severity, case mix, and paid amount per claim.

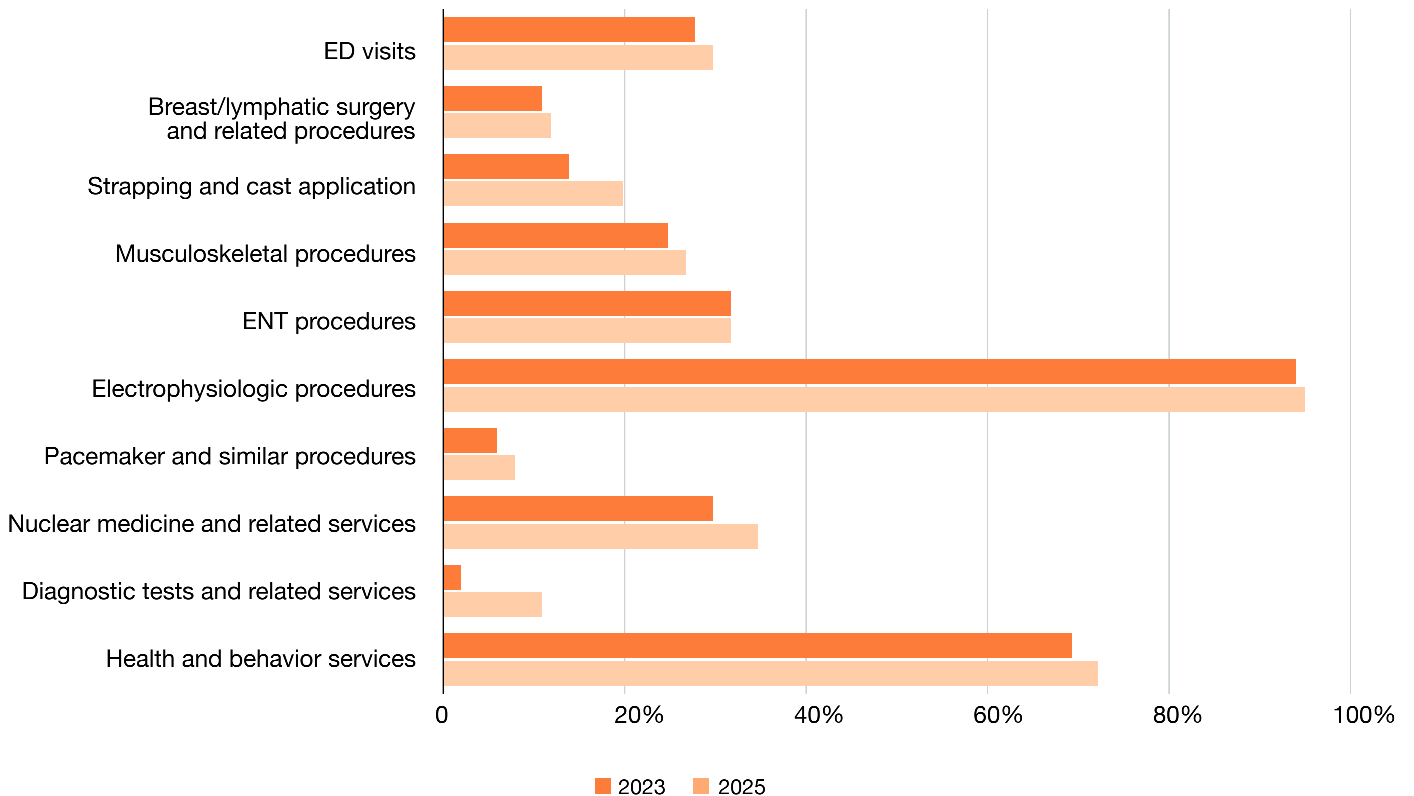
This dynamic is moving beyond isolated pilots. A recent survey of 43 health systems found that ambient notes for clinical documentation was the only AI use case with adoption activity reported across all respondents, with 53% reporting a high degree of success.[1] These tools expand both the volume and specificity of documentation available to support billing. In the outpatient setting, more complete documentation can support higher evaluation and management (E/M) coding and higher paid amounts per visit. In the inpatient setting, more complete capture of complications and comorbidities can shift admissions into higher-paying severity tiers. In both cases, reimbursement can rise as coded complexity increases, even when the underlying clinical work or treatment pattern does not increase proportionately.

Figure 2. How AI-enabled documentation can increase paid severity



Source: PwC analysis

Figure 3. Changes in portion of patient visits billed with high-acuity codes (non-exhaustive)



Sources: PurpleLab Claims Data (based on claims count), PwC analysis

Early evidence suggests these tools may already be affecting billed intensity. A recent study of ambient AI scribe adoption at University of California, San Francisco (UCSF) Health found use of the technology was associated with higher relative value units (RVUs) per encounter, higher RVUs per week, and modestly higher ambulatory encounter volume, with no measurable increase in claims denials (Figure 4).[2] These findings do not suggest that all higher-intensity coding is inappropriate, but they do indicate that AI-enabled documentation can increase billing intensity and provider revenue without a corresponding offset through denial activity.

Figure 4. Early evidence on AI scribe impact on billed intensity

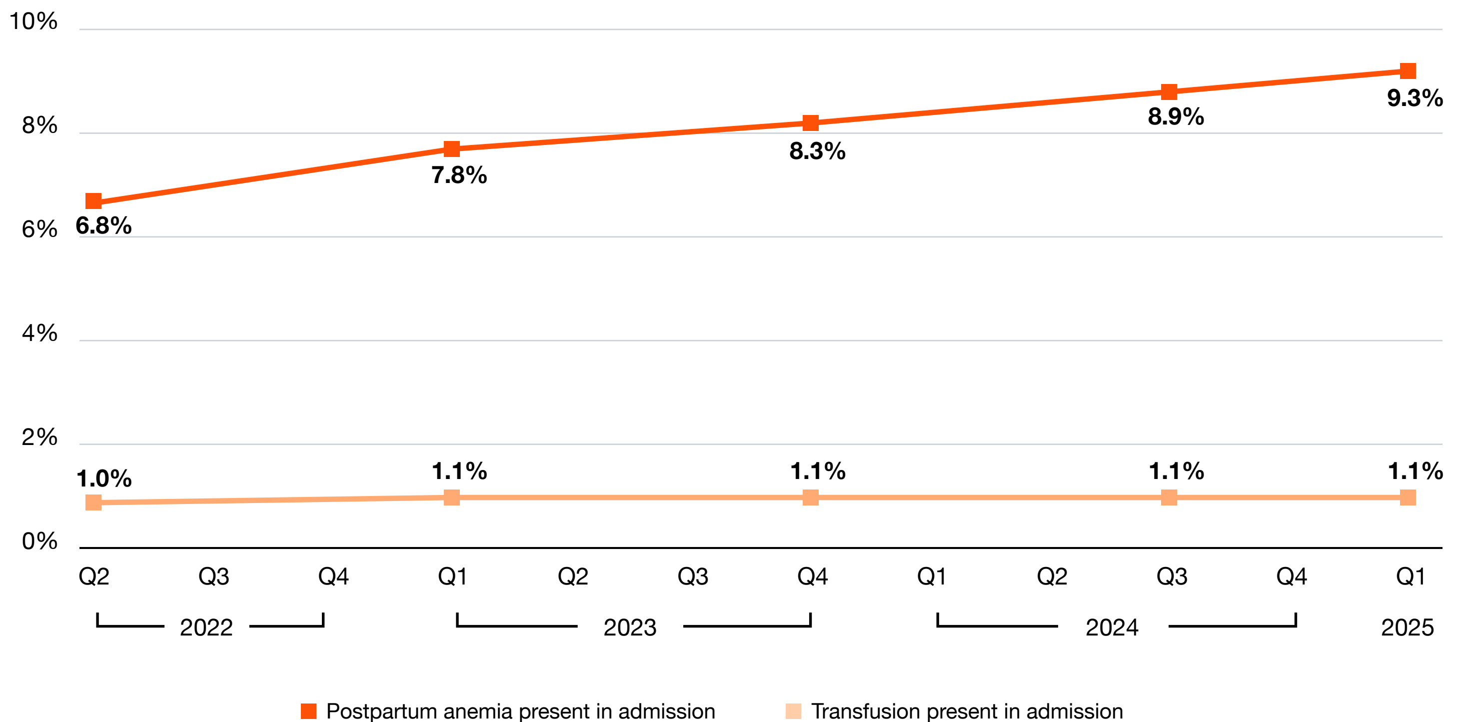
Metrics	Observed impact	Implication
Estimated annual revenue impact	~$3,044 per physician	Illustrates potential reimbursement effect at scale
RVUs per encounter	+0.04	Suggests higher billed intensity per visit
RVUs per week	+1.81	Indicates greater reimbursable output
Ambulatory encounters per week	+0.80	Suggests modest throughput increase
Claims with any denial	No measurable difference	Higher billed intensity did not appear to be offset by worse payment success

Note: Annual revenue impact based on 2025 Medicare payment rates

Source: JAMA Network, JAMA, Jan. 9, 2026

Commercial claims analyses point in a similar direction. A review of service dates from April 1, 2022, through March 31, 2025, found that 10% of hospitals drove a 13.1% increase in the proportion of inpatient admissions coded as complex. That concentration suggests changes in documentation and coding practices—rather than broad-based shifts in patient acuity alone—may be contributing materially to rising paid severity. A maternity example further illustrates the same dynamic. In certain hospitals, diagnosis rates of postpartum anemia increased from 4.0% to 12.3% over the study period, while transfusion rates only increased from 0.8% to 1.2%. The analysis estimated that coding intensity contributed $22 million in additional maternity spending, highlighting how documentation-driven severity shifts can increase reimbursement even when observable treatment intensity remains relatively stable.[3]

Figure 5. Changes in coding patterns for postpartum anemia and transfusions



Source: BHI and BCBSA, BCBS, March 2026

~70%

ranked AI-enabled documentation as a top-three inflator

53%

Recent survey found ambient notes for clinical documentation was the only AI use case with adoption activity reported across all respondents, with 53% of participants reporting a high degree of success

$22m

Coding intensity contributed $22 million in additional maternity spending in recent analysis

From a 2027 pricing perspective, this makes documentation intensity and severity capture an increasingly important trend driver. Nearly 70% of BTN survey participants ranked this as a top three inflator, and roughly 20% ranked it as the number one inflator for 2027. The concern is not that every increase in coded complexity is unwarranted. It is that providers now have tools that may make it easier and faster to increase reimbursable severity. In a market facing elevated provider price pressure, this creates another pathway outside of rate negotiations for medical costs to rise through case-mix shift and higher paid amounts before plans can fully distinguish documentation effects from true changes in patient complexity.

Implications

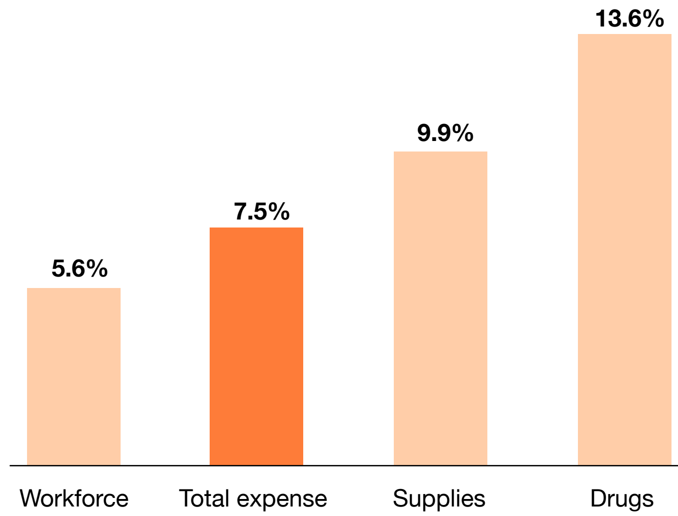
As the use of artificial intelligence-enabled documentation and coding tools increases, a growing share of cost trend may show up through higher coded severity, greater case-mix intensity, and increased paid amounts per claim rather than through higher volume or rates alone. That makes traditional utilization and unit-cost monitoring less sufficient on its own. Health plans should pair contracting discipline with coding-intensity surveillance, severity-shift monitoring, and payment integrity capabilities that can distinguish changes in documentation from true changes in patient complexity. For self-funded employers, the same dynamic can surface, increasing the need for employers to work with their administrative partners to help determine whether appropriate monitoring and payment integrity capabilities are in place. In a market where providers are becoming more sophisticated at increasing reimbursable severity, safeguarding against trend requires managing not just what care is delivered, but also how it is documented and coded. Over time, greater transparency and information exchange may increase scrutiny of the quality, value, necessity, and cost of services, while also shaping the coverage and spending decisions of plans, employers, and consumers.

Price/unit cost | Units/utilization | Mix/intensity

Inflator 2: Provider reimbursement pressure remains elevated

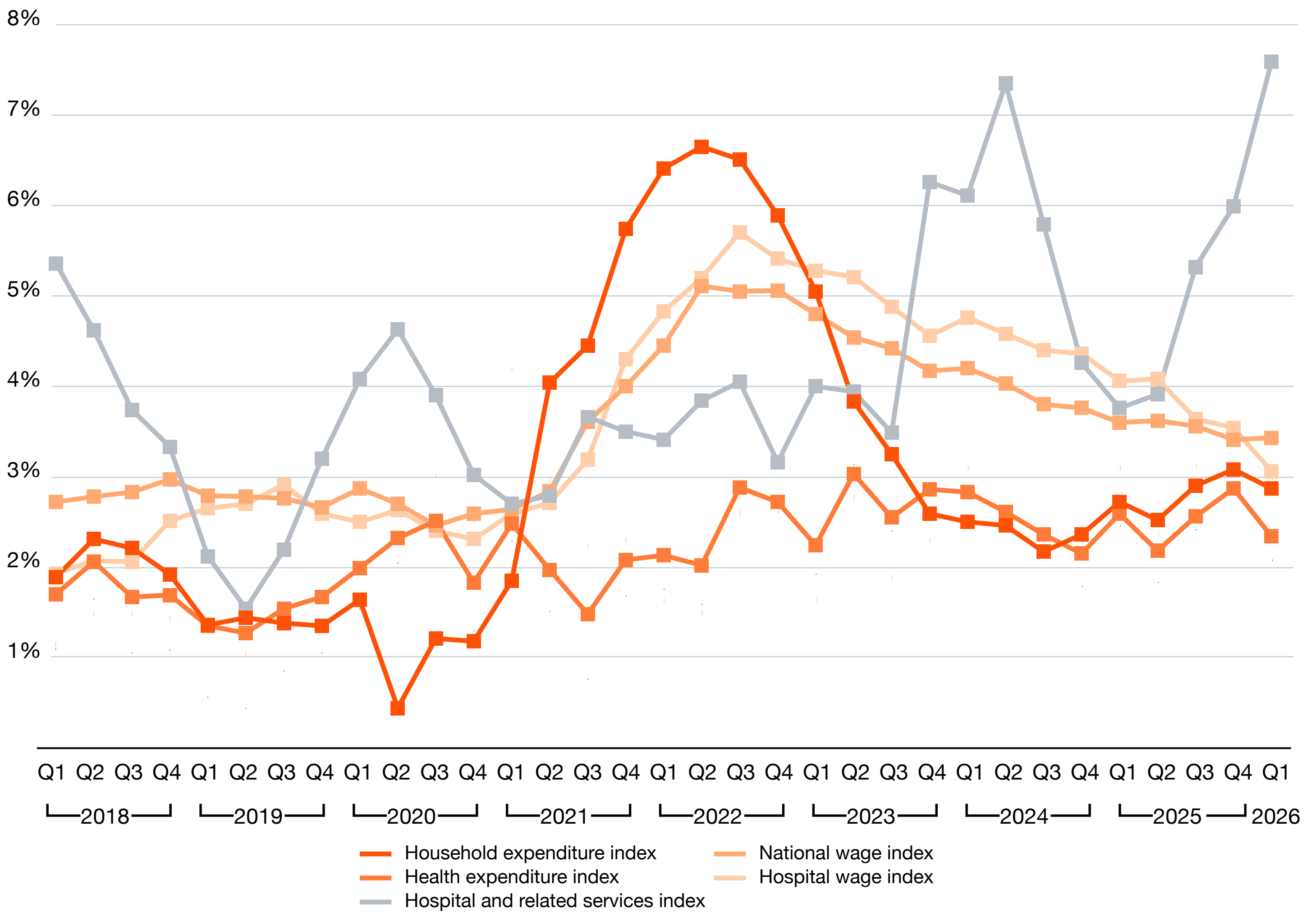
Provider price pressure remains a leading driver of commercial medical trend. Hospital margins last year recovered from their post-pandemic disruption as volumes stabilized and labor volatility eased, but provider cost structures did not return to pre-pandemic norms. Hospitals and health systems continue to face elevated labor expense, higher input costs for drugs and supplies, and persistent reimbursement shortfalls in public programs (Figure 6).[4] Broader inflation trends reinforce that pressure: Hospital and related services inflation spiked in early 2026 to post-pandemic highs, reaching 7.59% year over year in February. These inflationary pressures are exacerbated in the commercial market, where providers have more flexibility to negotiate rates than with government and public fee schedules. Provider contracting pressure remains a leading concern for 2027, with nearly 65% of BTN survey respondents ranking it among their top three inflators.

Figure 6. Hospital expense growth in 2025



Source: AHA, Costs of Caring, March 2026

Figure 7. Expenditure and wage indices, YoY growth

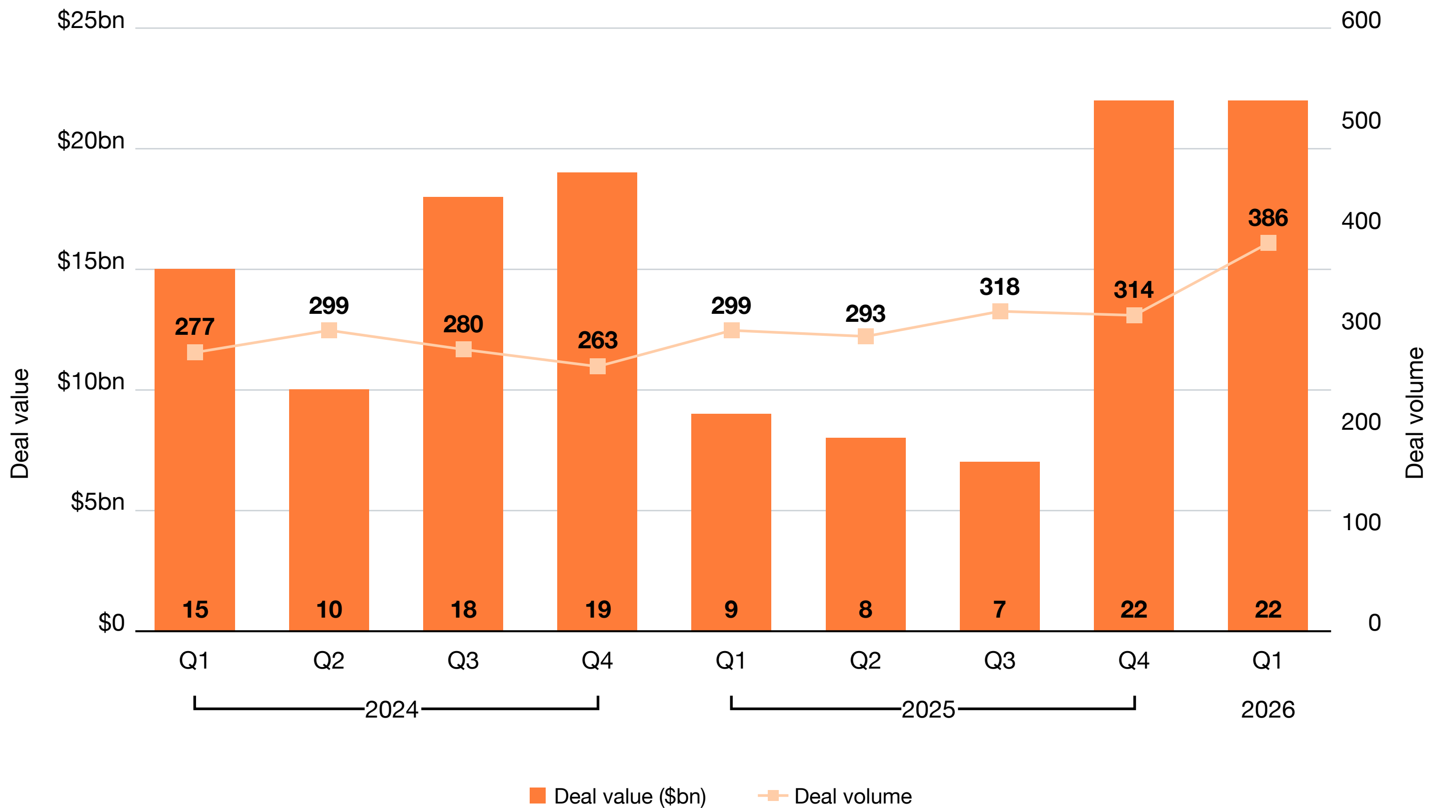


Source: Bureau of Economic Analysis Personal Consumption Expenditure, Bureau of Labor Statistics Consumer Price Index, PwC analysis

Ongoing inflationary pressures, scale economics, and a better understanding of negotiating levers continue to point providers to continued consolidation, pursuing operating and investment scale, capital access, and operating efficiencies through affiliation or sale. Stronger negotiating leverage with payers remains a clear strategic rationale. The American Medical Association reported that among independent physicians who sold their practices in the last 10 years, 70.8% cited inadequate payment rates as an important or very important reason for sale.[5]

Recent Government Accountability Office analysis underscores how widespread this shift has become: At least 47% of physicians were employed by or affiliated with hospital systems in 2024, up from less than 30% in 2012. The same report found that private equity[6] represented about 6.5% of physicians nationally in 2024, with higher shares in certain specialties and geographic markets. Consolidation is not just a response to financial strain; it is also a strategic lever for improving reimbursement position.

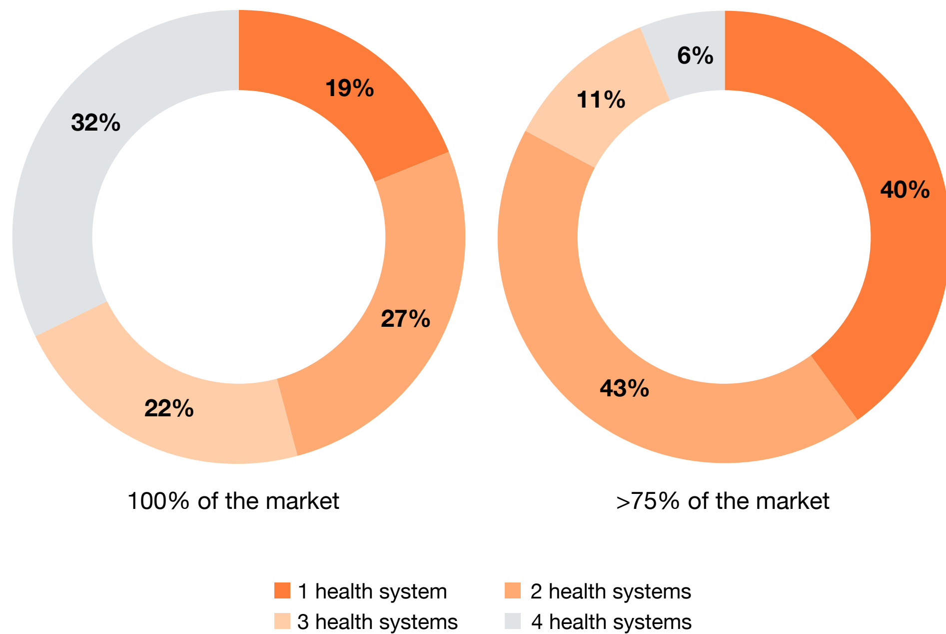
Figure 8. Health services deal value and volume[7]



Source: LevinPro HC, Levin Associates, May 2026, levinassociates.com

This dynamic is most visible in concentrated hospital markets with limited alternatives. KFF reported that 97% of metropolitan areas had highly concentrated inpatient hospital markets in 2024, and that one or two health systems controlled the inpatient market in 47% of metropolitan areas. In more than four of five metropolitan areas, one or two systems controlled more than 75% of the inpatient market.[8] The GAO's findings also suggest consolidation has meaningful price effects: Hospital-physician consolidation was associated with a 17% increase in commercial office visit prices and 3% to 5% increases in inpatient hospital prices.[9] In markets like these, providers are often better positioned to secure multi-year agreements with rate increases.

Figure 9. Number of hospital systems that control a given share of a Metropolitan Statistical Area (MSA) market



Source: KFF

~65%

Nearly 65% of BTN survey respondents rank price pressure among their top three inflators

17%

Hospital-physician consolidation was associated with a 17% increase in commercial office visits

70.8%

of physicians cited inadequate payment rates as an important or very important reason for sale in a recent survey

Price pressure is also increasingly reinforced by provider-side revenue optimization. More complete documentation, greater code specificity, and fewer denials can raise paid amounts over time, enabling greater reimbursement through contract performance as well as contract repricing. Price transparency adds another dimension by giving providers more visibility into peer reimbursement levels and stronger support for benchmarking rate demands in negotiation. Taken together, negotiated rate pressure and revenue optimization are becoming increasingly intertwined, with both contributing to higher realized cost trend.

Implications

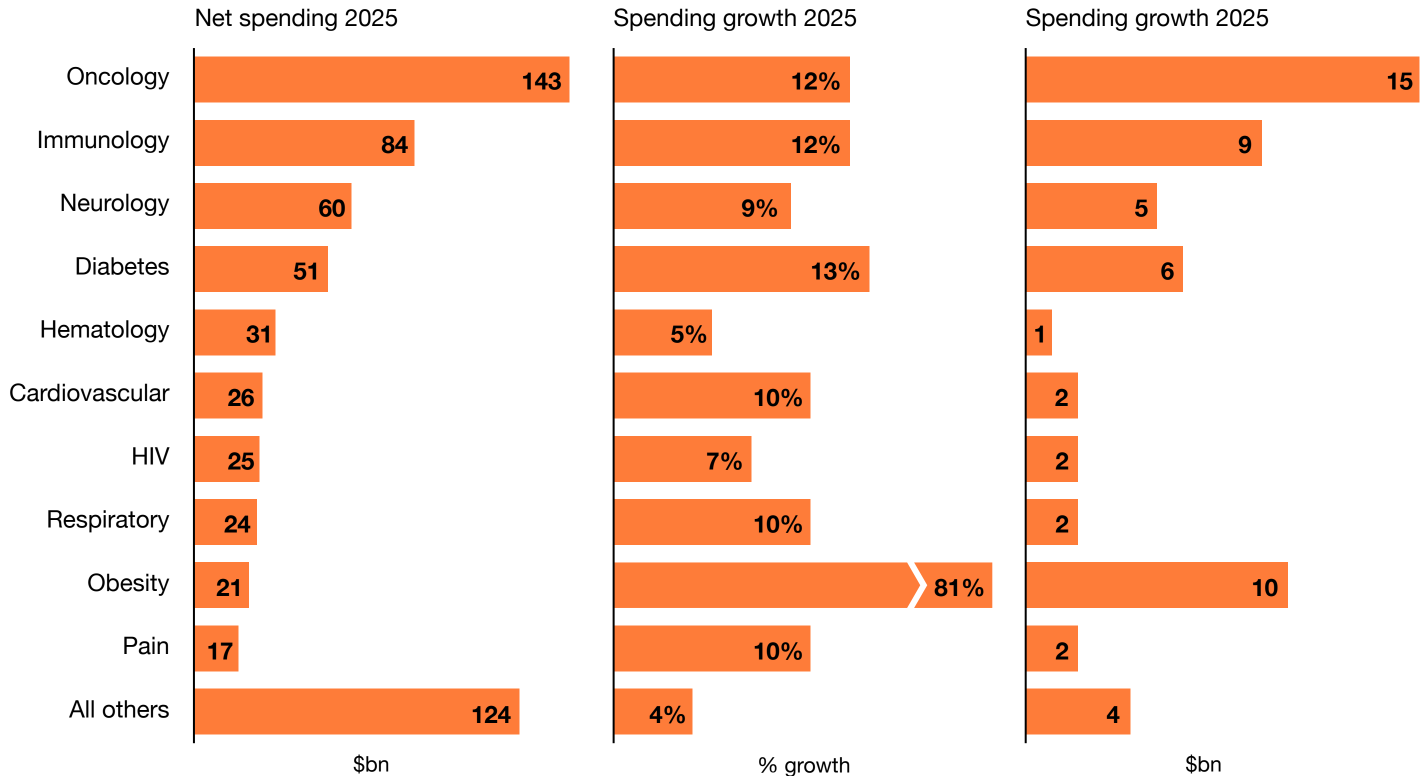
Elevated hospital cost structures, concentrated markets, and provider-side revenue optimization are contributing to higher realized reimbursement. For health plans, durable rate assumptions will require disciplined contracting, stronger visibility into contract performance, and targeted protections against reimbursement drift once contracts are in place. In some markets, that may also mean greater willingness to use out-of-network pressure, narrow network exclusion, or less preferential benefit design and steerage for providers that do not meet expectations set forth in negotiations. For large self-funded employers, the same dynamics can show up through higher renewals, narrower network value, and greater affordability pressure in markets with limited provider alternatives, reinforcing unit cost as a critical decision point in evaluating carrier performance, network strategy, and long-term affordability. Safeguarding against provider trend now requires managing both negotiated rates and realized yield.

Price/unit cost | Units/utilization | **Mix/intensity**

Inflator 3: Pharmacy pressure remains broad, durable, and high cost

Pharmacy remains one of the clearest sources of medical cost pressure, with trend increasingly concentrated in a small number of high-impact categories. More than 85% of survey participants cited a 2027 pharmacy cost trend that was outpacing overall medical trend. Higher-cost specialty and physician-administered drugs continue to drive structural spend growth, while GLP-1s remain a visible and expanding source of utilization pressure. At the same time, growing uncertainty around pharmacy benefit manager (PBM) transformation and pricing transparency is adding another layer of complexity to pharmacy trend management, even if its direct effect on underlying cost trend remains less clear.

Figure 10. Medicine spending and growth at estimated net manufacturer prices by therapy area



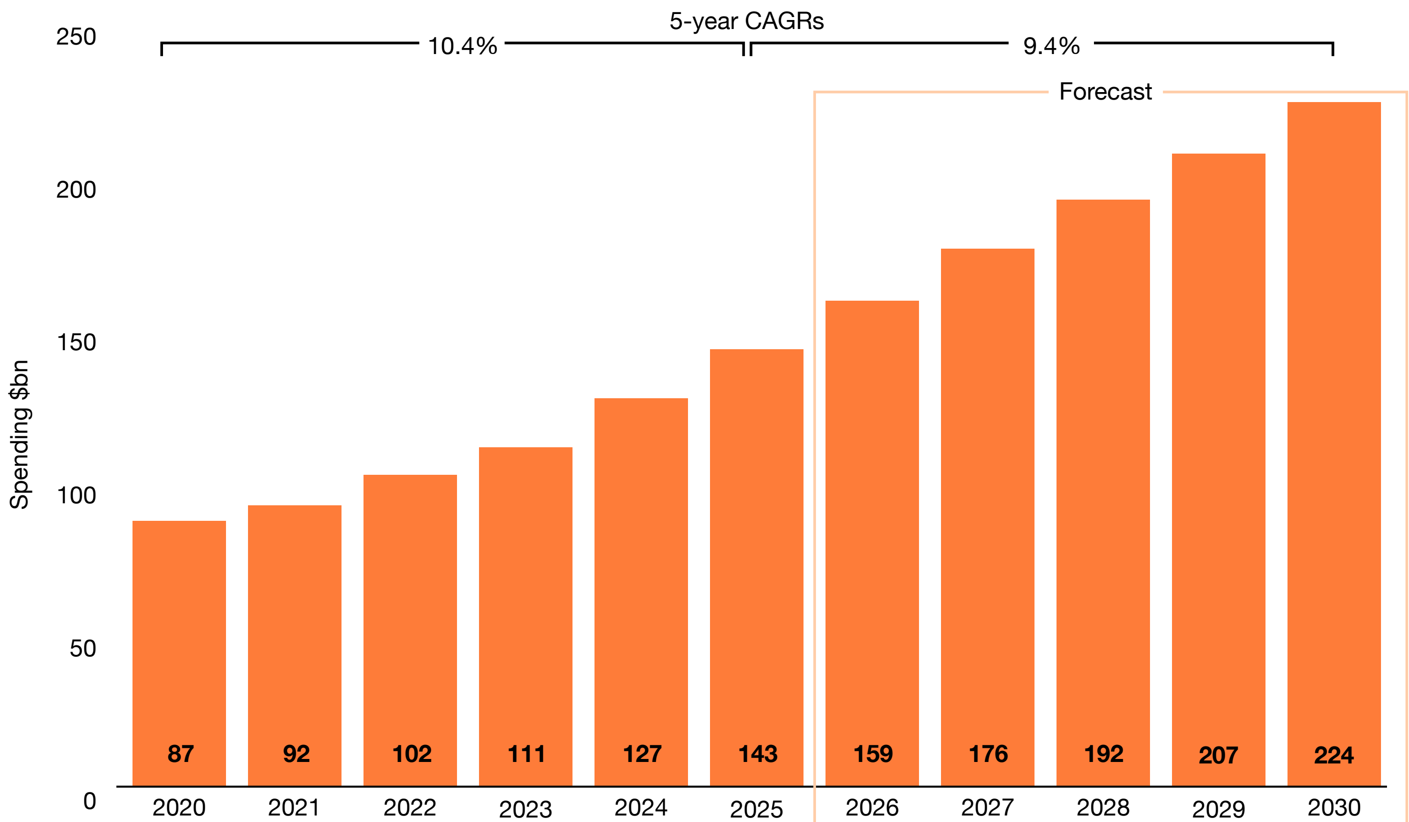
Source: IQVIA, US Medicine Use Trends, April 28, 2026

High-cost specialty and physician-administered drugs remain the structural core of pharmacy trend

The foundation of pharmacy trend remains specialty drug spend, particularly in categories that are high cost, administered under the medical benefit, or difficult to manage through traditional formulary tools. Oncology is the clearest example. IQVIA reported that US spending on cancer medicines reached $143 billion in 2025.[10] That growth is being driven by antibody-drug conjugates, bispecific antibodies, radioligand therapies, and other premium-priced treatments that continue to raise the cost of care.

The challenge extends beyond oncology. Clinically administered and infused specialty drugs often sit under the medical benefit, interact with provider reimbursement, and are harder to control through conventional pharmacy management. At the same time, the innovation mix remains heavily skewed toward high-cost therapy areas. Protected brand therapies across oncology, immunology, and neurology drove nearly 70% of spending growth over $500m in 2025.[11] Meanwhile, oncology spending is expected to increase by nearly 60% by 2030.[12] For 2027, that means specialty pressure is likely to remain the structural backbone of pharmacy trend, particularly in categories where substitutes and management options for high-cost therapies are limited.

Figure 11. Oncology spending and growth at estimated net manufacturer prices



Source: IQVIA, US Medicine Use Trends, April 28, 2026

GLP-1s continue to expand through broader indications and new oral options

GLP-1 pressure has extended beyond obesity treatment. While many commercial plans have tightened coverage for obesity-indicated use, the category continues to expand through broader clinical adoption, new indications, and product innovation. The cost issue is no longer just current injectable utilization, but category expansion across a widening set of conditions and members. The FDA has now approved GLP-1s for cardiovascular disease, metabolic dysfunction-associated steatohepatitis (MASH), chronic kidney disease, and obstructive sleep apnea[13]—conditions that collectively affect tens of millions of commercially insured lives, with additional indications still emerging. Emerging approvals have translated to a significant increase in utilization, with 3.5 million prescriptions filled in December 2025,[14] two times the number filled in December 2024. The promise of lower costs as a result of healthier patients has not yet been seen in industry data, and represents another tension point about investing in preventive treatments where the impact may not be felt for many years.

Figure 12. GLP-1 pipeline by indication (non-exhaustive)

Route of administration	Drug name (brand)	Manufacturer	Indications & earliest potential approval date
New oral GLP-1s			
Oral	**Orforglipron (Foundayo)**	Eli Lilly	• Obesity—FDA approved • T2DM—earliest approval 2026 • OSA + Obesity—earliest approval 2027 • HTN + Obesity—earliest approval 2028
Oral	**Semaglutide 25mg (Ozempic/ Wegovy oral)**	Novo Nordisk	• Obesity or Overweight—FDA approved • CVD + Obesity—FDA approved • T2DM—FDA decision Q4 2026
New indications for existing GLP-1s			
Subcutaneous Injection	**Tirzepatide (Mounjaro/ Zepbound)**	Eli Lilly	• T2DM—FDA approved (ages ≥10 years) • T2DM + CVD—FDA decision mid-2026 • Obesity or Overweight—FDA approved • OSA + Obesity—FDA approved • T1DM + Obesity—earliest approval 2028
Subcutaneous Injection	**Semaglutide (Ozempic/ Wegovy SC)**	Novo Nordisk	• T2DM—FDA approved • T2DM + CVD—FDA approved • Diabetic Nephropathy—FDA approved • Obesity or Overweight—FDA approved (ages ≥12 years) • Obesity + CVD—FDA approved • MASH—FDA approved
New subcutaneous GLP-1s with existing and new indications			
Subcutaneous Injection	**VK2735**	Viking Therapeutics	• Obesity or Overweight—earliest approval 2028
Subcutaneous Injection	**Survodutide**	Zealand Pharma & Boehringer Ingelheim	• Obesity or Overweight—earliest approval 2027 • Obesity + CVD—earliest approval 2027 • MASH + Obesity—earliest approval 2027

Source: Prime Therapeutics, Prime Therapeutics GLP-1 pipeline table

>85%

More than 85% of survey participants cited a 2027 pharmacy cost trend that was outpacing overall medical trend

50%

US spending on cancer medicines reached $143 billion in 2025, growing 50% since 2020

2x

3.5m GLP-1 prescriptions filled in Dec ’25, nearly two times Dec ’24

Oral formulations add a new layer of pressure. In April 2026, the Food and Drug Administration approved Foundayo (orforglipron) for chronic weight management in adults with obesity or overweight and at least one weight-related comorbidity, marking the first oral GLP-1 approved for weight loss.[15] Oral options may lower some of the initiation and adherence friction associated with injectable therapies and could broaden uptake beyond the population already managed under existing prior authorization frameworks. For payers, that makes GLP-1 trend more durable: Even where obesity carveouts or tighter utilization management are in place today, broader indications and easier-to-use formulations may continue to expand category exposure.

Implications

Sustained specialty pressure and an expanding GLP-1 category—both of which continue to broaden exposure to high-cost therapies—continue to drive pharmacy trend. For health plans, that means managing pharmacy trend will likely require more than traditional formulary controls, particularly as more high-cost therapies enter categories with limited substitutes and broader eligible populations. Growing uncertainty around PBM transformation, transparency, and pricing reform adds another layer of complexity: Some of these changes may improve visibility into pharmacy economics, but their effect on underlying medical cost trend will likely depend on whether they materially alter net drug costs, formulary incentives, and specialty drug management, rather than simply redistributing savings within the supply chain. For self-funded employers, the same dynamics can translate into higher budget pressure and more difficult tradeoffs around benefit design, coverage strategy, PBM contracting, and workforce affordability.

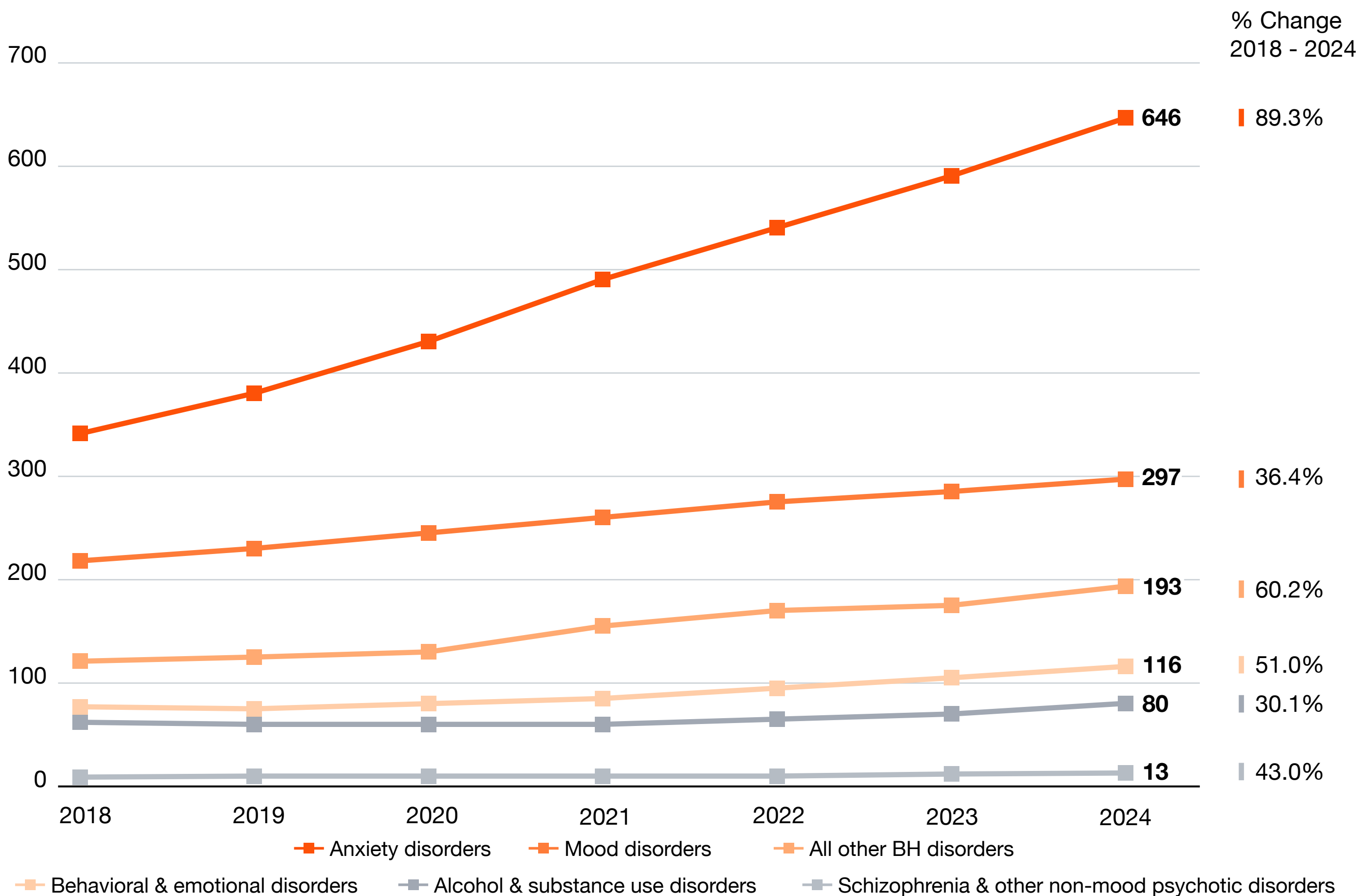
Price/unit cost | **Units/utilization** | Mix/intensity

Inflator 4: Behavioral health continues to outpace broader medical trend

Behavioral health remains an important medical cost inflator for 2027. While it is not the largest driver of overall medical trend, its sustained utilization growth and expanding share of care delivery have made it a material source of trend pressure over time. Unlike many other medical cost categories, where trend is driven primarily by price and unit cost, behavioral health growth has been fueled more directly by rising utilization. Recent *Health Affairs* journal analysis found that US spending on mental health and substance use disorder treatment reached $267 billion in 2021, and that utilization rather than price growth drove increased spending over time.[16] Trilliant Health's 2026 Behavioral Health Report found that behavioral health visit rates increased 62.6% from 2018 to 2024, underscoring how demand has continued to build across the market.[17]

This growth is both significant and expansive across the behavioral health spectrum. Trilliant found that behavioral health visit rates increased from 828 to 1,346 visits per 1,000 people between 2018 and 2024.[18] The increase spanned anxiety disorders, mood disorders, autism spectrum disorders, substance use disorders, and other behavioral health needs. Prescription demand has risen alongside visit growth, with stimulant use up 53.3% and antipsychotic use up 45.4% over the same period.

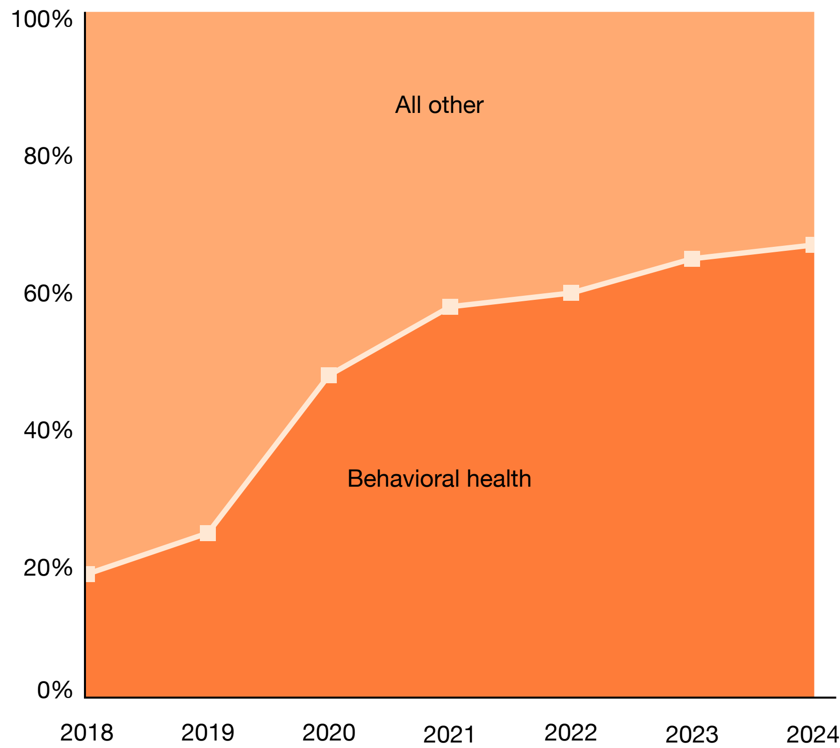
Figure 13. Rate of behavioral health visits per 1,000, by condition category



Source: Trilliant Health, Trilliant Health 2026 Behavioral Health Report

This pressure is also being shaped by how care is delivered. Behavioral health has become the dominant use case in telehealth, accounting for 65.6% of telehealth volume in 2024, up from 18.4% in 2018.[19] At the same time, plans continue to report rising intensity within professional behavioral health services, including longer sessions and higher-acuity visits, both of which carry higher unit costs. As a result, the trend is not just about more visits; it is also about more expensive visits and a delivery model that continues to expand access and utilization. Supply constraints also suggest that this pressure is unlikely to ease quickly. The HRSA notes that behavioral health access remains constrained by provider-level barriers, including limited scopes of practice, reimbursement challenges, and clinician burnout, all of which limit the system's ability to meet rising demand.[20]

Figure 14. Share of telehealth visits by behavioral health and all others



Source: Trilliant Health, Trilliant Health 2026 Behavioral Health Report

Behavioral health conditions are often associated with higher downstream spending across the rest of the healthcare system, including emergency department (ED) use and inpatient admissions when needs are not addressed early. More recent evidence points in the opposite direction when access improves. A 2025 *American Journal of Managed Care* study found that commercially insured members connected to timely outpatient behavioral health care were 35% less likely to have behavioral health-related emergency department visits and 43% less likely to have behavioral health-related inpatient admissions, with total medical cost savings of $27.63 per member per month.[21] More recent analysis of employer-sponsored populations also suggests that holistic behavioral health programs may reduce total medical spending, reinforcing the view that better behavioral health access and care navigation can lower broader medical costs, not just behavioral health-specific utilization.[22]

62.6%

Behavioral health visit rates increased 62.6% from 2018 to 2024

65.6%

Behavioral health has become the dominant use case in telehealth, accounting for 65.6% of telehealth volume in 2024, up from 18.4% in 2018

35%

Members connected to timely OP BH care were 35% less likely to have a BH-related ED visit

At the same time, the delivery landscape is becoming more expensive in select segments. Plans continue to report the most visible behavioral health trend on the professional side, but inpatient and residential behavioral health spending is also rising. That dynamic is increasingly complicated by the growing role of private equity in the facility space. A recent study of residential substance use treatment facilities found that mean daily rates at private-equity-owned facilities were 15.6% higher than at other for-profit facilities,[23] despite offering fewer services on average. As more expensive residential and inpatient models continue to expand in the commercial market, they may exacerbate behavioral health trend.

Implications

Unlike many other inflators, sustained utilization rather than unit cost and rising intensity is driving growth of behavioral health. For health plans, that makes behavioral health important not only as a direct source of professional and facility trend, but also as an area where access, site of care, and care management can influence broader medical costs. For large self-funded employers, the same dynamic extends beyond claims spend alone, with implications for absence, productivity, disability, and overall workforce health. It also reinforces the need to evaluate behavioral health vendors and point solutions not just on engagement, but also on their ability to improve access, redirect care to more efficient settings, and produce measurable impact on total cost of care. As a result, behavioral health is becoming one of the clearest areas where better access and more effective management can influence both medical trend and broader affordability.

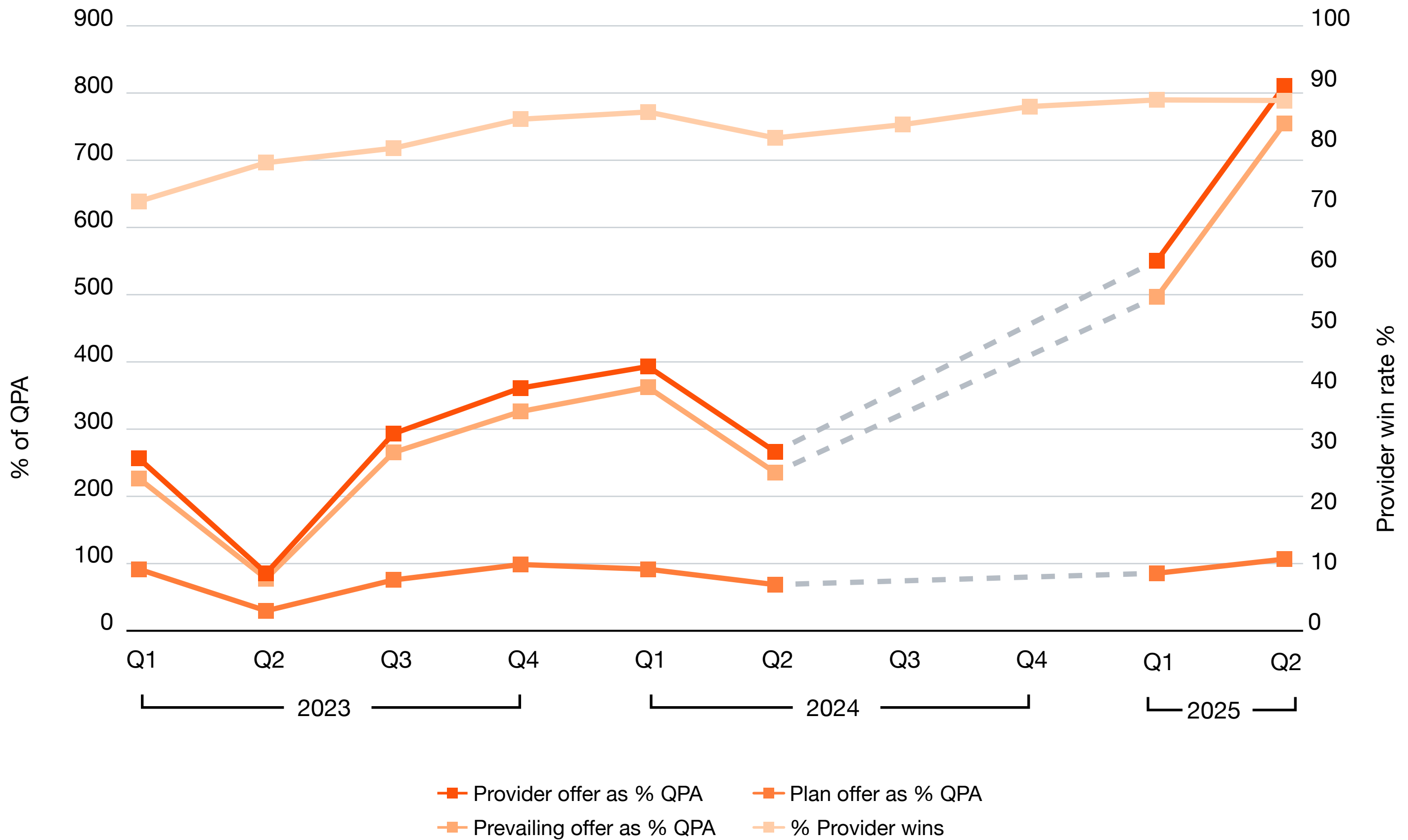
Price/unit cost | Units/utilization | Mix/intensity

Inflator 5: Provider-favorable IDR outcomes are sustaining out-of-network pressure

The NSA eliminated surprise billing for members with the positive intent of improving member protection from unexpected out-of-network bills. However, the payment dynamics emerging from the federal independent dispute resolution (IDR) process are increasing reimbursement pressure for commercial payers. The Congressional Budget Office (CBO) originally projected the IDR process would reduce insurer costs (and thus premiums paid by members) by 1% and reduce the federal deficit by $17 billion through 2030.[24]

In reality, IDR dispute volumes are exceeding initial estimates. Projections estimated roughly 17,000 disputes annually.[25] Instead, Georgetown's Center on Health Insurance Reforms (CHIR), citing Centers for Medicare & Medicaid Services (CMS) public use files, reported that approximately 3.4 million disputes were filed from 2022 through June 2025, with nearly 4.8 million filed through the end of 2025.[26] With IDR volumes remaining high, determinations have consistently favored providers. In the first half of 2025, providers prevailed in about 88% of payment determinations versus 12% for insurers. During the same period, certified IDR entities rendered nearly 1.1 million payment determinations.[27]

Figure 15. Payment levels emerging from independent dispute resolution

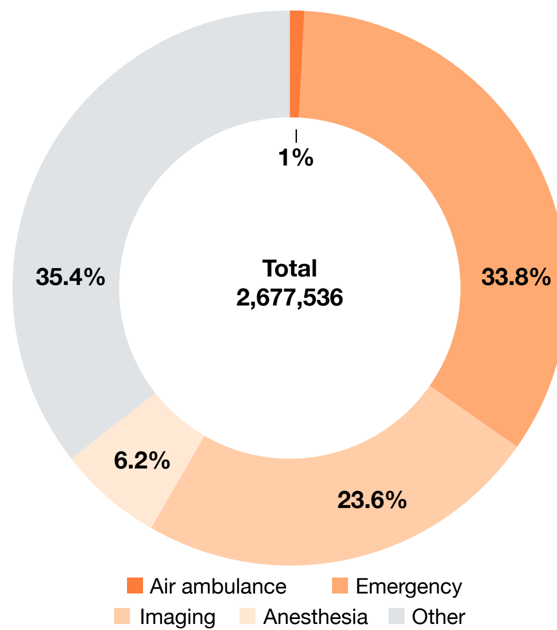


Sources: CMS publicly available data and PwC analysis

Emergency department and radiology services accounted for a large share of that activity. That concentration is significant because these services are among the categories most exposed to out-of-network reimbursement friction under the NSA, making provider-favorable outcomes in those areas especially relevant for commercial trend. The dispute activity in 2025 also remained highly concentrated among a small number of sophisticated provider organizations or their representatives. CHIR found dispute activity to be concentrated among a small number of provider organizations that initiated 99.9% of all disputes in the first half of 2025, and that four provider groups and provider representatives accounted for 56% of all disputes filed in the first half of 2025. The data suggests that IDR is a potentially durable channel for increasing reimbursement.

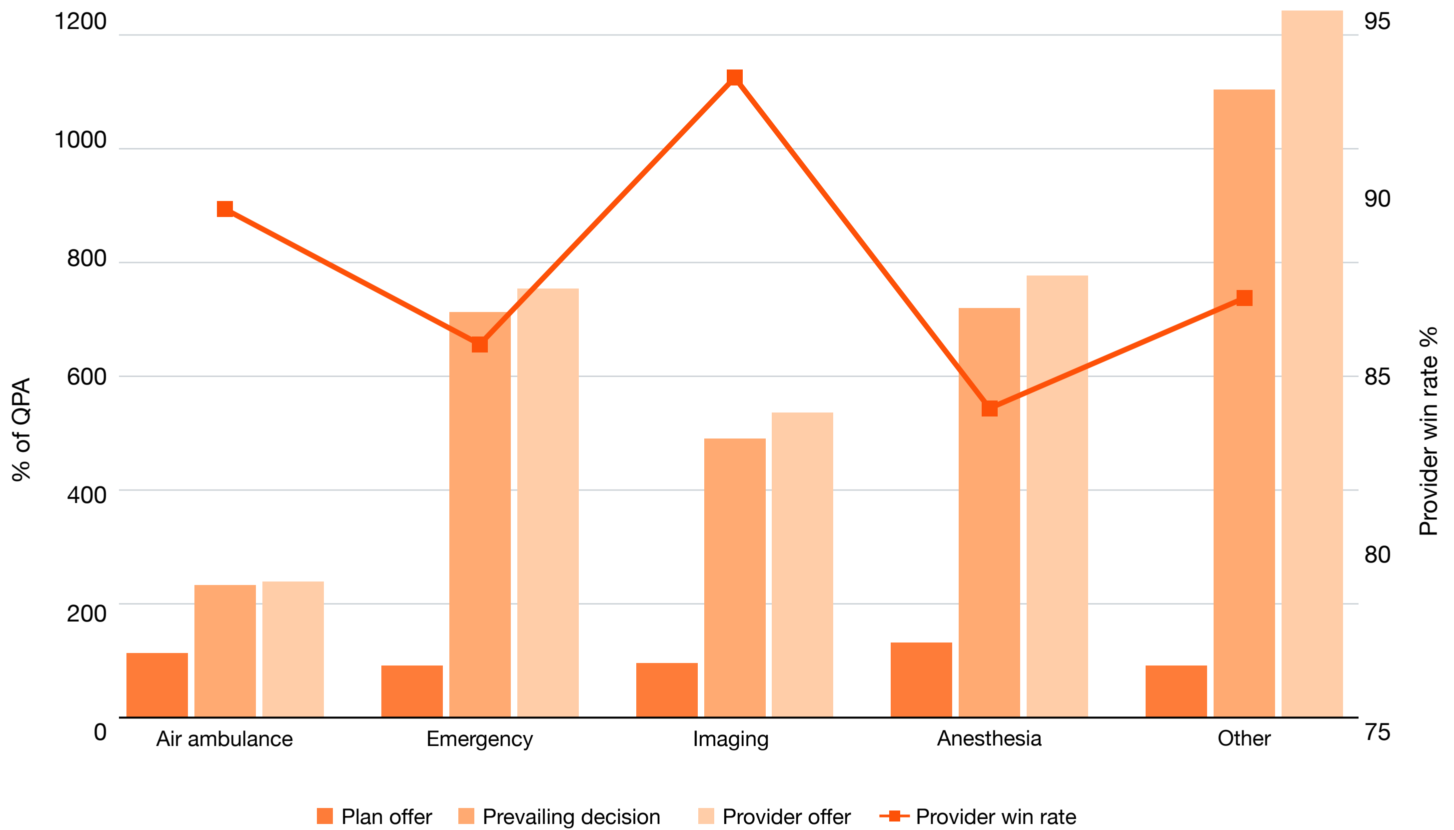
Recent analysis (see Figure 15) of resolutions suggests that payment levels emerging from IDR often remain above qualifying payment amounts (QPAs), the payer-calculated median in-network rate the NSA uses as its central payment benchmark. The inflationary impact of IDR is therefore not only a function of dispute volume, but also of the payment levels the process continues to validate in high-friction specialties.

Figure 16a. Dispute counts by service category



Sources: CMS publicly available data and PwC analysis

Figure 16b. Payment levels emerging from independent dispute resolution by service category



Sources: CMS publicly available data and PwC analysis

Litigation has not materially relieved the pressure on payers. CHIR's 2025 early-look analysis notes that payers have increasingly turned to the courts to confront high-volume IDR participants.[28] In addition, Georgetown's Health Care Litigation Tracker shows that cases have been filed against many of the entities responsible for the majority of disputes.[29] However, recent court decisions have narrowed that path. The O'Neill Institute's review of the first two court decisions in insurer lawsuits under the NSA found that federal district courts in California and Florida dismissed insurer suits against HaloMD and Radiology Partners in April 2026, concluding that the NSA and its incorporated arbitration-review standards sharply limit judicial second-guessing of IDR awards and related eligibility determinations.[30] As a result, health plans may have fewer practical options to challenge allegedly abusive dispute patterns after the fact, increasing the importance of eligibility-stage defenses and operational controls within the IDR process itself.

88%

Providers won 88% of payment determinations in the first half of 2025

56%

of disputes filed in 2025 were concentrated in four provider groups or representatives

1.1m

payment determinations rendered in the first half of 2025

Regulators have now moved to address some of the operational strain on the program, but the changes are more likely to improve process efficiency than materially alter the underlying reimbursement dynamic. In May 2026, **CMS announced** that the Departments of Health and Human Services, Labor, and Treasury finalized updates intended to streamline the federal IDR process, including lower administrative fees, broader batching flexibility, standardized communication requirements, a new centralized IDR Gateway, a payer registry, and new timelines for eligibility determinations. The final rule is also intended to reduce the volume of ineligible disputes entering arbitration by improving the exchange of information during open negotiation and requiring certified IDR entities to assess eligibility within five business days of selection. While these changes may reduce friction, processing delays, and administrative burden, they do not directly address the core cost concern for payers: provider-favorable award patterns and payment levels that continue to exceed payer benchmarks in high-friction specialties.

Implications

IDR is reinforcing higher paid amounts and elevated out-of-network settlement expectations in affected categories over time. For health plans, that means member protections under the NSA are not eliminating exposure to reimbursement inflation once disputes move into arbitration, particularly in markets with concentrated provider groups, limited steerage alternatives, or heavy reliance on emergency and facility-based specialties. For self-funded employers, the same dynamic can surface through higher claim volatility, greater stop-loss exposure, and less predictable out-of-network costs than policy changes alone can address. Managing that exposure will require close monitoring of dispute patterns and service-category concentration, stronger qualifying payment amount documentation, and more effective eligibility-stage defenses within the IDR process as arbitration outcomes continue to outpace payer benchmarks. Payers can also respond via more direct efforts to control out-of-network spend through reimbursement policies, contracting provisions, and network strategies that reduce reliance on nonparticipating providers in high-friction specialties and facility-based settings.

Deflator: Plans should prioritize cost-of-care levers based on realizable value and speed to impact

Plans have a wide range of tools to manage cost of care, but not all levers can bend trend at the same rate. In the near term, the highest-value opportunities are those that reduce avoidable leakage, prevent unnecessary utilization, or redirect care before costs become embedded in the baseline.

With few new external deflators emerging, plans are relying more heavily on internal levers to offset the pressures described here. Payment integrity and utilization management (UM) rise to the top because they can be deployed within the next plan year and measured more directly. Pharmacy management remains a high-value lever, but the focus should be on reducing exposure to the pharmacy trends already discussed rather than revisiting those inflators themselves. Network design and reimbursement may offer the largest structural opportunity, but savings often depend on contract cycles, market leverage, benefit design, and member steerage. Quality and care management remain important, but their impact is most reliable when programs target measurable, modifiable sources of avoidable cost.

Figure 17. Cost of care levers ranked by effectiveness

	Lever	Role in bending commercial trend	What plans should do now	What is changing
1	**Claims/payment integrity**	Fastest leakage-reduction lever	Shift from post-payment recovery to pre-payment accuracy. Prioritize high-dollar inpatient claims, DRG validation, clinical documentation review, duplicate billing, unbundling, modifier misuse, ED facility levels, COB and contract compliance.	Provider-side revenue optimization and documentation intensity are increasing the need for real-time payment accuracy.
2	**Utilization management**	Fastest utilization-control lever	Move from broad prior authorization to precision UM. Remove low-yield PA requirements, strengthen medical policy rigor, and focus review on high-cost, high-variation services.	UM is becoming more digital, transparent, and regulated. Plans will need faster decisions, better data exchange and stronger governance.
3	**Rx management**	High-value pharmacy and specialty drug lever	Focus on GLP-1 access governance, specialty drug management, medical-benefit drug site-of-care, biosimilar conversion and high-cost drug dose, and waste and quantity management.	Pharmacy trend is broadening across specialty, GLP-1s, and high-severity therapies, making Rx management a more important total-cost-of-care lever.
4	**Network design and reimbursement**	Largest structural lever, slower to realize	Use site-of-care strategy, high-performing networks, centers of excellence, price transparency, unit-cost analytics and reimbursement redesign to reset the cost baseline.	Price transparency data and employer demand for high-value networks are increasing pressure to convert pricing insight into contracting and steerage.
5	**Quality and care management**	Essential enabler, conditional deflator	Target modifiable risk rather than broad engagement. Prioritize behavioral health integration, oncology navigation, maternity/NICU risk, transitions of care and chronic condition escalation.	Plans and employers are scrutinizing point solutions and care management programs that cannot prove outcomes, avoided utilization, or savings.

Source: PwC analysis

Claims and payment integrity: from pay-and-chase to prospective payment accuracy

As described in Inflator 1, AI-enabled documentation and coding intensity are becoming more meaningful drivers of paid severity. In that environment, payment integrity becomes less about post-payment recovery and more about confirming the validity of high-risk claims before payment is released. Plans should respond by moving payment integrity upstream. Prioritize the following for pre-payment review: high-dollar inpatient claims, shifts in diagnosis-related groups (DRG), duplicate claims, unbundling, modifiers, genetic testing, durable medical equipment (DME), implant/device charges, and fast-growing gray-zone services. The goal is not more denials; it is more accurate payment before dollars leave the plan.

AI can reshape this space by helping plans identify billing anomalies, match claims to clinical evidence, summarize medical records, and route complex claims to the appropriate clinician for review. But AI should be used to triage and assess, not to make opaque payment decisions. Plans should pair AI-enabled analytics with clinician review, appeal tracking, provider abrasion monitoring, and model governance.

Lastly, payment integrity cannot be managed as a set of disconnected vendor recoveries. Plans should own the strategy, savings methodology, provider experience, and root-cause remediation, while using vendors for specialized review and analytics capacity. For some plans, that may mean bringing more policy, analytics, and vendor management in-house. For others, it may mean consolidating vendors and tightening performance governance.

Highest-yield actions

- Move high-dollar and high-variation claims into pre-pay clinical validation.
- Track provider-level severity drift, including DRG weight, complication and comorbidity capture, E/M levels, and ED facility coding.
- Integrate contract terms, payment policy, medical policy, and claims edits into one payment accuracy engine.
- Use AI to prioritize claims, detect anomalies, and summarize records, with clinician oversight for complex cases.
- Measure success based on net validated savings, appeal overturn rates, provider abrasion, claim cycle time, and sustained reduction of repeat billing issues.

Utilization management: from broad prior authorization to precision (UM)

Utilization management remains one of the fastest levers plans can pull, but the model is changing. The opportunity is not to add more prior authorization (PA). It is to reduce low-value administrative review while concentrating UM on services with the highest cost, variation, and avoidable utilization.

The regulatory and market directions are already pushing plans toward faster, more transparent UM. In 2025, health plans announced voluntary commitments to streamline, simplify, and reduce prior authorization across commercial, Medicare Advantage, managed Medicaid, and Marketplace coverage. A later AHIP/BCBSA update reported that participating plans had eliminated 11% of prior authorizations, representing 6.5 million fewer prior authorization requests.[31]

For plans, the next UM model should be smaller, faster and more targeted. Plans should remove or automate PA requirements with consistently high approval rates and low savings yield, and focus clinical review on high-cost, high-variation categories, such as high-cost imaging, elective musculoskeletal (MSK) procedures, and genetic testing.

AI can accelerate this shift. Plans can use AI to identify low-yield PA requirements, auto-approve low-risk requests, summarize clinical documentation, flag missing information, and route complex cases to the appropriate clinical reviewer. AI can also help identify provider and facility outliers where utilization patterns differ from peers. But AI should be used to facilitate faster approvals and better targeting—not to issue opaque medical necessity denials. Plans should maintain human clinical review for adverse determinations, audit trails, appeal monitoring, and model governance.

Highest-yield actions

- Rationalize the PA portfolio using approval rate, savings yield, overturn rate, provider abrasion, and administrative cost to identify where review generates the most value and where it does not.
- Remove or automate low-yield PA requirements to concentrate clinical review on high-cost, high-variation categories, such as advanced imaging, elective musculoskeletal procedures, and genetic testing.
- Strengthen medical policy rigor by confirming clinical criteria are evidence-based, regularly reviewed against current utilization patterns, and subject to structured physician oversight—with a tiered review process that routes criteria changes affecting medical necessity to committee-level approval.
- Pair UM decisions with active navigation to lower-cost, clinically appropriate sites of care or treatment alternatives.
- Digitize PA workflows and deploy AI-assisted triage with clear clinical governance, human review for adverse determinations, and audit mechanisms to enable accountability.

Pharmacy management: from formulary controls to class-specific governance

Pharmacy management remains a high-value commercial lever, but plans should focus on the categories where utilization is accelerating and action can be taken within the next benefit cycle: GLP-1s, specialty drugs, medical-benefit therapies, and high-cost drug waste.

GLP-1s should be the lead near-term action area. Large employers are increasingly covering GLP-1s for weight loss, but with growing concern over affordability. KFF found that 43% of firms with 5,000 or more workers covered GLP-1s for weight loss in 2025, up from 28% in 2024. Plans should respond with disciplined access, not blunt exclusion. That means separate coverage rules by indication, objective eligibility validation, reauthorization tied to adherence and clinical response, and integration with cardiometabolic, nutrition, and lifestyle support. The employer question is shifting from whether to cover GLP-1s to how to cover them sustainably.

Plans should also tighten management of medical-benefit drugs. Infused and injected therapies can create leakage when pharmacy, UM and network teams operate separately. Plans should align medical policy, J-code management, site-of-care rules, and provider-level analytics to redirect clinically appropriate administration to lower-cost settings and preferred products.

Highest-yield actions

- Build GLP-1 policies by indication, risk profile, clinical response, and continuation criteria.
- Manage specialty and medical-benefit drugs across pharmacy, UM, and site-of-care programs.
- Reduce high-cost drug waste through quantity limits, starter fills, dose optimization, and vial management where clinically appropriate.

Network design and reimbursement: from contracting to targeted unit-cost accountability

Network design and reimbursement remain the largest structural lever for commercial plans, but it takes longer to realize than claims integrity, utilization management, or pharmacy management. The near-term opportunity is not broad network redesign. It is targeted action on high-cost providers, high-variation service lines, and sites of care where plans can convert data into contract terms, benefit design, and steerage.

Price transparency is becoming more useful. Historically, hospital machine-readable files were difficult to operationalize because rates were inconsistent, incomplete, or expressed as formulas instead of comparable dollar amounts. CMS's CY 2026 hospital price transparency updates are designed to address these issues. Hospitals will be required to publish more comparable dollar-based allowed amounts—including median allowed amount and 10th and 90th percentile allowed amounts, in machine-readable files.[32] CMS says the changes are intended to improve transparency and comparability of hospital pricing information.

Plans need to combine transparency data with their own claims experience to identify where rates are materially above market and where members can realistically be steered. The first use cases should be narrow: imaging, labs, outpatient services, infusions, ambulatory procedures, elective MSK, maternity bundles, and other shoppable or high-volume outpatient services. These are the areas where plans can set renewal targets, cap rate escalators, carve out service lines, negotiate bundled rates, and move volume to lower-cost sites.

It is also a good idea to revisit value-based care (VBC) metrics. The problem is not that VBC is wrong; it is that too many commercial arrangements are too broad, too focused on upside, too disconnected from the cost drivers that move trend, and without sufficient incentive to support improved provider economics. VBC reimbursement models should target specific sources of avoidable cost: admissions, ED use, post-acute utilization, high-cost imaging, elective procedures, specialty referrals, site-of-care shifts, and avoidable complications.

Highest-yield actions

- Identify high-cost outlier providers and service lines using claims experience and transparency data and build out targeted contracting strategy.
- Expand high-performing networks, tiered networks, and centers of excellence.
- Stop expanding VBC contracts that do not produce net savings after incentive payments.
- Tie VBC to specific cost drivers: admissions, ED, post-acute care, specialty referrals, site of care, and avoidable complications.
- Pair site-of-care policies with benefit design and navigation so members can act on lower-cost options.

Quality and care management: from broad engagement to targeted, modifiable-risk intervention

Quality and care management should remain part of the cost-of-care toolkit, but plans should be selective about what they expect it to accomplish. Broad engagement programs are unreliable near-term trend deflators. The strongest programs target members whose risk is measurable, modifiable, and connected to a clear intervention.

Plans should prioritize event-triggered and condition-specific interventions, including repeat ED use, inpatient discharge risk, high-risk maternity or NICU risk, new cancer diagnoses, behavioral health comorbidity, and GLP-1 initiation. Members should be identified automatically from claims, authorizations, pharmacy events, lab values, or provider referrals, then matched to the right level of support.

Behavioral health should be integrated into this model rather than managed as a separate overlay. Recent employer-sponsored evidence suggests targeted behavioral health access can reduce medical cost when measured net of program cost. A 2025 JAMA Network Open study found that an enhanced behavioral health benefit was associated with $190 in reduced medical claims costs for every $100 invested, with larger savings among participants with higher medical costs.[33]

Plans should also raise the bar for vendor performance. Employers are focused on rising costs, complex employee needs, and vendor partnerships. Business Group on Health notes that employers are considering ending arrangements with underperforming partners as part of cost-cutting strategies.[34] Rather than evaluating care management vendors on outreach attempts, app downloads, or engagement rates, plans should look at avoided admissions, avoided ED visits, reduced readmissions, improved adherence, maternity/NICU outcomes, appropriate site of care, and total cost impact.

Highest-yield actions

- Auto-identify members after trigger events and segment them by modifiable risk, not merely total spend.
- Match intervention intensity to risk: digital-first for lower-risk members; nurse, pharmacist, social worker, or behavioral health clinician support for complex members.
- Embed behavioral health triage into oncology, maternity, chronic disease, pain, and GLP-1 programs.
- Integrate care management with UM and pharmacy so members affected by authorization or coverage policy receive appropriate navigation and support.
- Rationalize vendors and phase out programs that cannot show avoided utilization, improved outcomes, or measurable cost impact.

Implications

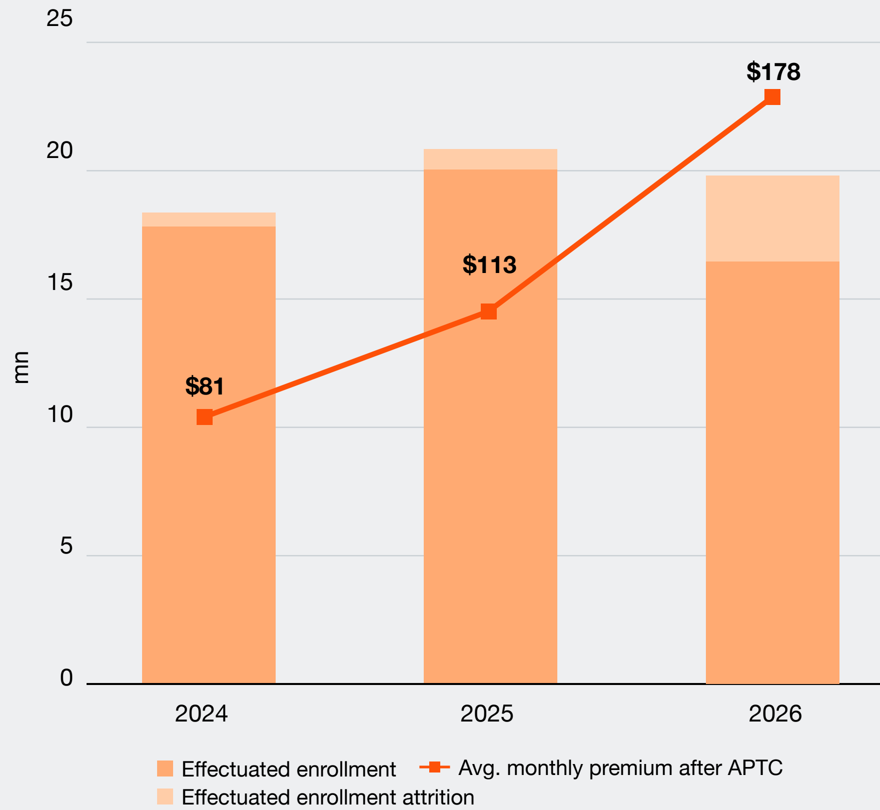
Improving claims and payment integrity and UM can create near-term savings by reducing leakage and avoidable utilization, while pharmacy management should focus on high-cost classes and medical-benefit therapies that can be governed within the next plan year. Network design and reimbursement remain the most important longer-term levers for resetting the cost baseline. Quality and care management are most effective when concentrated on areas where intervention can change utilization, outcomes, or adherence. For self-funded employers, the same framework applies, but with greater emphasis on aligning carriers, third-party administrators, PBMs, and point solutions around a smaller set of measurable affordability priorities.

Health plans should set trend-deflation targets by lever, align operational owners around shared savings goals, and stop funding programs that cannot demonstrate measurable value. Large employers can apply the same discipline by tying vendor oversight, carrier performance, and benefit strategy more directly to claims experience, trend reduction, and lowering total cost of care. In both cases, the more effective approach will be one that redirects resources away from low-performing interventions and toward the levers most likely to produce timely, measurable impact.

Individual ACA market subsidy expiration reshaped the 2026 market baseline

The expiration of the enhanced ACA premium subsidies changed the starting point for the 2026 Individual ACA market. After several years of strong enrollment growth and favorable affordability, the market entered 2026 with lower enrollment, higher member premium burden, and meaningful shifts in consumer plan selection. In 2025, CMS reported 24.3 million marketplace plan selections, with enrollment falling to 23.1 million in 2026, a 5% decline.[35] Early enrollment dynamics suggest the initial decline may understate the full impact on the market. In addition to weaker open enrollment results, attrition is expected to continue as some auto-renewed and auto-enrolled members fail to make premium payments. Early 2026 enrollment analysis indicates national enrollment has declined by roughly 17% through April, with states using the federal marketplace seeing disenrollment up to 21%.[36]

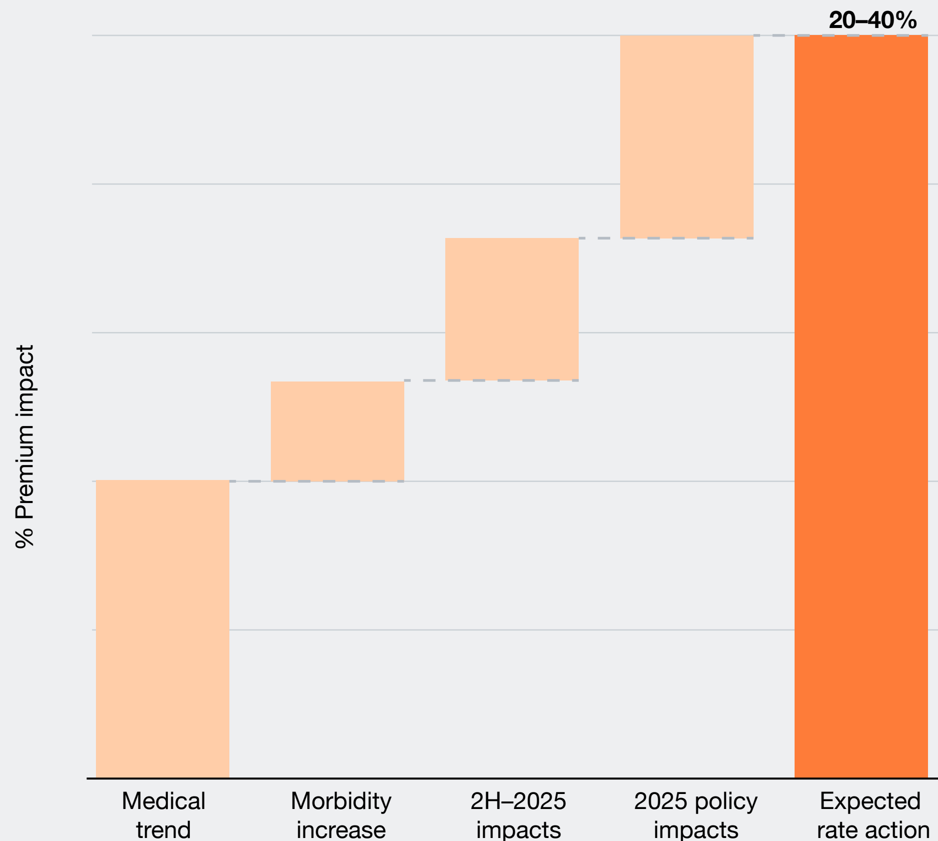
Figure 18. ACA marketplace enrollment and average monthly premium after APTC



Sources: CMS publicly available data and PwC analysis

This shift is a significant consideration for 2027 trend because it points to a change in market composition—not just a market contraction. Analysis of 2026 rate submissions indicate average annual premium rate action[37] roughly 26% from 2025 to 2026. That pricing reflects more than underlying medical cost trend alone, with early industry analysis indicating nationally 2.9% to 6.5% of morbidity increase adding to underlying medical cost trend and prior-year catchup. As shown in Figure 19, 2026 Individual ACA market rate actions can be viewed through both lenses: the underlying cost of care and the market reset that followed subsidy expiration.

Figure 19. Decomposing 2026 Individual ACA market rate increases

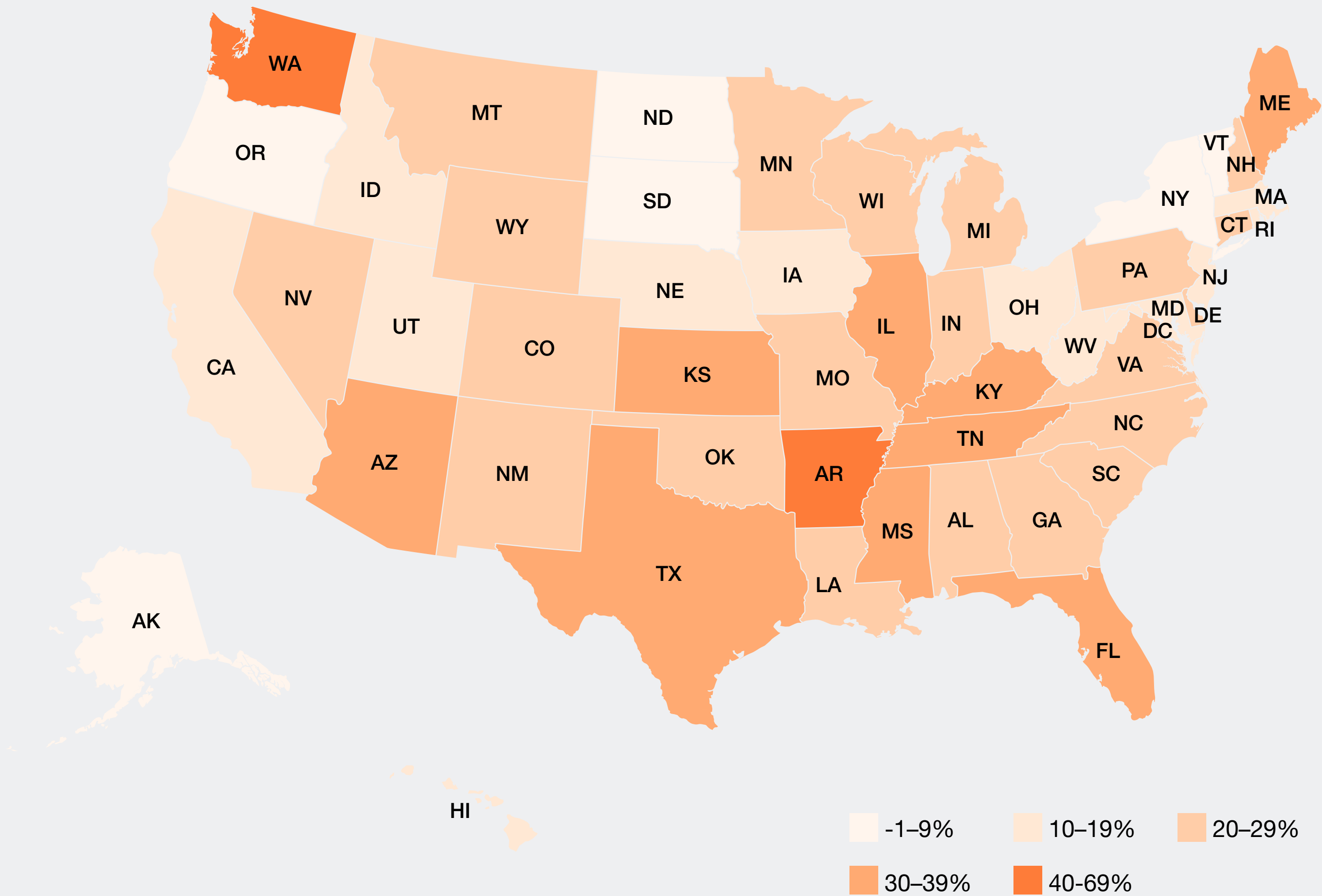


1. **Medical trend**: Underlying medical costs reflecting utilization, unit cost, and mix shifts
2. **Morbidity increases**: 2025 risk scores are up, driven by non-utilizer enrollment impacts, improved risk capture, and Medicaid redeterminations
3. **Second-half 2025 policy shifts**: CMS failure to reconcile and dual-coverage clean-ups suggest that the increase to morbidity in 2025 is not over
4. **eAPTC expiration + OBBBA**: The sunsetting of enhanced APTCs and OBBBA were expected to further deteriorate the Individual market's morbidity due to added pressure for healthier members to lapse their coverage

Sources: CMS publicly available data and PwC analysis

The impact was not uniform across all states. State subsidy wrap programs and other stabilization actions helped moderate disruption in some markets, while others experienced more pronounced deterioration in affordability and stability of the risk pool. As shown in Figure 20, issuer-reported pricing action varied meaningfully across states, underscoring that the effects of subsidy expiration were shaped not only by federal policy, but also by local market conditions, state protections, and market competitiveness.

Figure 20. State variation in 2026 Individual ACA rate action



Note: Premiums were analyzed using the second-lowest cost silver (benchmark) premium for a 40-year-old in each county and weighted by county plan selections, and may include premiums for non-Essential Health Benefits. In some state-based marketplaces, the premium data for some years are at the rating area level or zip level and are mapped to counties before weighting by county plan selections.

Source: KFF analysis of data from healthcare.gov, state rate review websites, state plan finder tools, and state provided data.

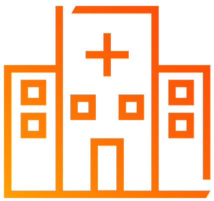
Taken together, the 2026 Individual ACA market reflects both a continuation of underlying medical cost pressure and a meaningful change in underlying population. While much of the morbidity shift appears to have been realized in 2026, residual effects are expected to persist into 2027 as enrollment attrition continues and the market resets. BTN medical cost trend estimates normalize for morbidity and population shifts to reflect the underlying cost of care trend rather than changes in the health status or composition of the covered population.

Trends to watch

Trend to Watch 1: Public program disruption may create commercial spillover

Policy and regulatory changes in Medicare, Medicaid, and the 340B program may increasingly, though indirectly, shape commercial trend. Financial pressure in public programs can intensify provider contracting demands, Medicare Advantage reforms may reset expectations for utilization management more broadly, and 340B-related incentives may continue to influence pharmaceutical spending and site-of-care economics.

Figure 21. Public program spillover



Public program financial pressure and commercial contracting

Pressure in Medicaid and the post-subsidy Individual ACA market is increasing financial strain for some providers, particularly hospitals with higher exposure to public program populations and uncompensated care. One early example is HCA, which said the expiration of enhanced ACA subsidies reduced first-quarter 2026 earnings by about $150 million.[38]

Potential impact to medical cost trend	Line of business	Impact/size
As hospitals absorb greater uncompensated care and public program reimbursement pressure, some may seek to offset margin compression through more aggressive commercial rate negotiations. The effect is likely to be most visible in markets with high Medicaid exposure, weaker hospital margins, or concentrated provider systems.	Group, Individual ACA	Inflator (medium-high)

Medicare Advantage UM reform

CMS is increasing oversight of Medicare Advantage UM. Beginning in 2026, all MA organizations are required to submit annual data on internal coverage criteria used to process PA for Medicare Part C services, including delegated arrangements.

Potential impact to medical cost trend	Line of business	Impact/size
Heightened scrutiny in MA may raise expectations for PA practices more broadly, particularly around transparency, clinical criteria, and turnaround times. This could narrow commercial payers' flexibility to manage utilization in select areas over time, especially high-cost outpatient services, and physician-administered drugs.	Group, Individual ACA , MA-to-Commercial spillover	Inflator (medium)

340B program expansion and reform risk

The 340B program continues to expand in scale and strategic importance, despite initial intentions to only provide safety-net providers with discounted outpatient drugs. The ACA and Medicaid expansion were a big factor in 340B expansion as the number of Medicaid enrollees increased, but the Disproportionate Share Hospital (DSH) threshold did not. The ACA also added eligibility to four new hospital types. Coupled with HRSA permitting unlimited contracted pharmacies, the program saw rapid growth. A 2025 CBO study reported that participating entities purchased $43.9 billion in 340B drugs in 2021, up from $6.6 billion in 2010.[39] Hospital outpatient departments and off-site clinics account for the largest share of participation, with disproportionate share hospitals and their off-site outpatient clinics representing 72% of hospital-based 340B facilities in 2021.

Potential impact to medical cost trend	Line of business	Impact/size
For commercial payers, 340B may contribute to higher pharmaceutical spending through hospital outpatient reimbursement, site-of-care migration, and greater exposure to physician-administered specialty drugs. Recent research found that new 340B participation was associated with higher spending on outpatient biologic oncology drugs for commercially insured patients.[40] Additionally, it is a structural incentive for hospital-physician consolidation, and research shows the share of hospitals with at least one off-site clinic has increased from 50% to 75%. The result may be overall higher cost of insurance.	Group, Individual ACA	Inflator (medium)

Sources: PwC Analysis

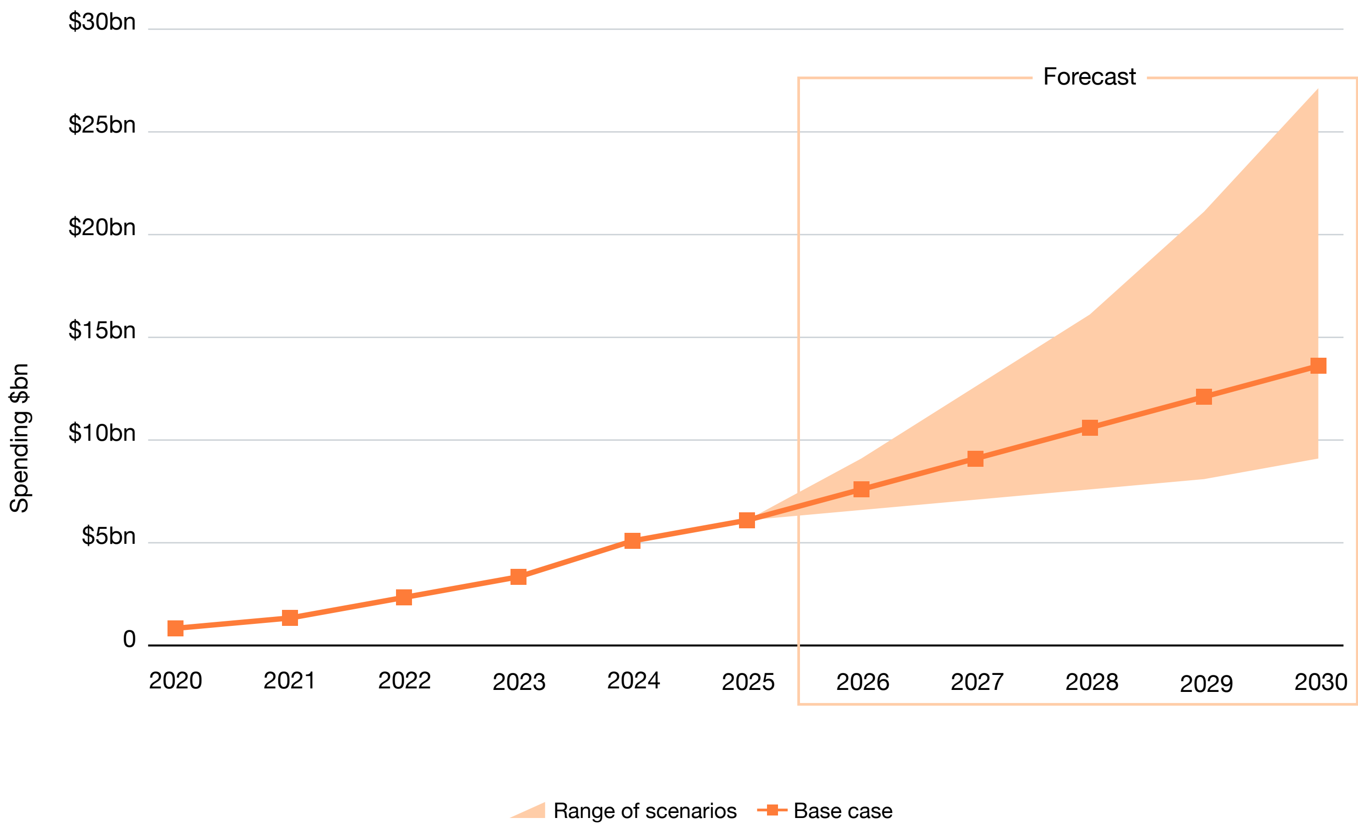
Trend to Watch 2: Cellular and gene therapies

Cell and gene therapy advancement remains a trend to watch. For most commercial plans and self-funded employers, current exposure is still relatively limited, and often concentrated in rare diseases and highly specialized populations. Even so, the category continues to warrant close attention because of its extreme pricing and the financial severity of even a small number of cases. The 10 most expensive drugs currently marketed in the US are all gene therapies, with several carrying one-time price tags above $2 million.[41] That makes cell and gene therapy a high-severity cost exposure that can materially affect claims experience once a case emerges.

What makes the category more strategically important over time is the possibility that these therapies could move into broader populations. Prime Therapeutics' 2026 pipeline outlook notes that while many cell and gene therapies remain focused on rare and orphan conditions, the pipeline increasingly includes new uses and potential expansion into more common diseases.[42] One recent example is Eli Lilly's VERVE-102, an in vivo gene-editing therapy targeting PCSK9. In early data released in May 2026, the therapy reduced LDL cholesterol by up to 62%, and Lilly said it is preparing to launch phase 2 testing.[43] While still early, programs like this suggest that cell and gene therapy could eventually extend beyond ultra-rare diseases into cardiometabolic conditions with meaningfully larger addressable populations.

For payers and employers, the key uncertainty is how quickly cell and gene therapy exposure could broaden. The increasing number of approved and emerging therapies will, by itself, create more opportunities for financial exposure over time, even if many products remain concentrated in rare diseases. The bigger strategic question is whether the category begins to move into more prevalent conditions, where one-time therapies would no longer represent episodic shock risk alone, but could become a significant source of pharmacy and medical spend. That makes cell and gene therapy an important trend to watch both for the steady expansion of approved therapies and for the possibility that the category extends into more mainstream commercial populations.

Figure 22. Cell and gene therapy spending



Source: IQVIA, US Medicine Use Trends, April 28, 2026

Final thoughts

The sustained elevation of commercial medical cost trend is reshaping how coverage is priced, funded, and managed across the private market. Plans are responding through pricing, product design, network strategy, and greater use of carveouts. Employers are taking a more active role in vendor oversight, benefit design, and funding decisions. Administrative services only (ASO) arrangements continue to grow in popularity, captive structures are gaining traction for managing catastrophic claim volatility, and individual coverage health reimbursement arrangements (ICHRAs) are expanding individual market participation for smaller and more distributed workforces. At the same time, a growing share of cost is being shifted directly to individuals through higher deductibles, increased cost sharing, and more limited coverage choices. As affordability erodes, the result is likely to be greater churn across coverage types, more movement toward alternative coverage strategies, and growing risk that individuals may be priced out of coverage altogether.

Whenever possible, in the interest of patient care, industry leaders should seek collaboration. Transparency, consumer education, and clarity on benefits and policy could improve patients' health and reduce the administrative burden across the health economy.

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 "inflators" and "deflators" to describe why and how the healthcare spending growth rate is affected. This forward-looking report is based on information available through June 2026. In April and May 2026, we surveyed and interviewed actuaries at 27 US health plans to generate an estimate of medical cost trend for the coming year. These plans cover more than 103 million employer-sponsored members and 8 million Individual Affordable Care Act (ACA) marketplace members.

We asked survey participants about their trend experience for 2024–25 and 2025–26, trend estimates for 2026–27, 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.

Acknowledgments

Blue Cross and Blue Shield of Rhode Island

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Blue Cross and Blue Shield of Massachusetts

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Blue Cross Blue Shield of Michigan (BCBSM)

Blue Shield of California

BlueCross BlueShield of Tennessee

Cambia Health Solutions

CareSource

CVS Health Corporation

Elevance Health

Excellus BlueCross BlueShield

Fallon Health

GuideWell

HCC Life

Health Alliance Plan (HAP)

Health Care Service Corporation (HCSC)

Highmark Inc.

Horizon Blue Cross Blue Shield of New Jersey

Independence Blue Cross

Kaiser Permanente

Mass General Brigham Health Plan

Medica

Medical Mutual of Ohio

The Cigna Group

UnitedHealth Group

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