U.S. Health Insurance Sector View 2025

Elevated Earnings Risks And Health Policy Uncertainty

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S&P Global
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This report does not constitute a rating action

Contents

Key Takeaways

We revised our U.S. health insurance sector view to negative from stable. Key drivers include:

- The recent and projected strain in operating performance, predominantly in the Medicare Advantage (MA) and Medicaid segments, and in certain geographic markets;
- A rising share of negative rating outlooks (35% as of Jan. 29, 2025) based on company-specific earnings deterioration and criteria changes; and
- Higher legislative and regulatory risk, which could affect both health insurance and pharmacy-related segments.

Nevertheless, long-term sector fundamentals remain solid:

- The average financial strength rating of 'A/A-' among the rated companies reflects strong and stable competitive positions, supported by overall pricing flexibility, favorable long-term growth prospects, and high barriers to entry;
- Sound balance sheets, manageable leverage, and healthy operating cash flows also provide financial flexibility that supports overall credit quality; and
- Solid long-term sector fundamentals suggest that not all negative rating outlooks will result in downgrades in 2025-2026, particularly if operating performance stress is not sustained for an extended period.

U.S. Health Insurance

Negative sector view highlights

Operating performance stress will continue in 2025

We anticipate the health insurance sector will achieve overall revenue and earnings growth in 2025. However, several factors from 2024 will carry over to 2025, including negative Medicare Advantage rates, elevated medical utilization, and inadequate Medicaid rates related to higher acuity membership. Additionally, some not-for-profit and mutual companies will face earnings pressure in their commercial business due to geographic-specific competitive and medical cost risks.

The sector's operating performance stress may be temporary because companies can reprice products annually. However, regulatory restrictions and the sector's status as a "price taker" in Medicare and Medicaid will limit their repricing ability. Therefore, we expect the sector's earnings improvement will be incremental in 2025, forming part of a recovery from 2025 to 2027.

Negative bias in rating outlook trends

Seven of the 20 rated insurance groups (35%) have ratings with a negative outlook. The negative outlooks on Elevance Health Inc. and Centene Corp. reflect changes in our capital adequacy criteria (implemented in November 2023). The other negative outlooks are primarily among geographically-concentrated health insurers that face amplified sector-wide operating stress factors in their markets.

Legislative and regulatory pressure on multiple fronts

The sector's revenue growth in recent years has been bolstered by government-sponsored programs that have lowered the uninsured rate to record lows. We expect the new administration and Congress's legislative and regulatory agenda may consider proposals that would alter the sector's growth prospects. (cont.)

U.S. Health Insurance

Negative Sector View Highlights

Legislative and regulatory pressure on multiple fronts

(cont.) Our legislative and regulatory outlook is favorable for Medicare Advantage, but unfavorable for Medicaid, which is a target for budget cuts within the broader tax-cut extension discussion. Regarding the ACA exchanges, Congress's primary action may be inaction, by letting the enhanced ACA subsidies (in place since 2021) expire at the end of 2025. The rating implications, if any, of major Medicaid and ACA changes in 2025 (affecting future years) would depend on the scope and timing of the changes, as well as company-specific exposures, mitigation strategies, and key credit ratios.

Bipartisan pharmacy benefit management (PBM) reform legislation made its way into the year-end continuing resolution (CR) bill in 2024, before it was removed at the last minute. We believe there's momentum for some type of PBM reform legislation in 2025. Based on what we've seen, such reform would likely be a modestly negative, though manageable, event for ratings.

Factors supporting overall credit quality

Overall credit quality in the sector remains strong, with an average financial strength rating of 'A/A-', reflecting strong and stable competitive positions, supported by overall pricing flexibility, favorable long-term growth prospects, and high barriers to entry.

While the negative sector view reflects continued operating performance stress in 2025, the underlying stress factors should be temporary, as we expect improvement in Medicaid rates in 2025-2026 and in Medicare Advantage rates in 2026. However, we remain cautious on the timing and magnitude of the Medicaid rate updates, as well as Medicare Advantage cost trends.

Sound balance sheets, manageable leverage, and healthy operating cash flows providing financial flexibility also support overall credit quality. Not-for-profit and mutual health insurers maintain strong levels of capital adequacy based on regulatory measures and our capital model. Meanwhile, for-profit health insurers maintain adequate levels of capital adequacy, enhanced by their diversified earnings and unregulated cash flows.

U.S. Economic Forecast

Steady Growth, Significant Policy Uncertainty

The U.S. health insurance sector is generally resilient across economic cycles. We expect business conditions for the sector to be supported by solid U.S. GDP growth in 2025-2026.

The sector's commercial group segment (where about half of Americans get their health insurance coverage) should benefit from stable employment conditions. While the unemployment rate steadily rose in 2023-2024, it will remain fairly low in 2025-2026.

We expect medical cost inflation will continue to push up overall inflation because of higher unit costs and medical/drug utilization. Overall inflation will moderate in 2025-2026 but remain above the Fed's 2% target. Greater progress on inflation in 2025-2026 may eventually help insurers with their multi-year provider contracts.

The inflation situation will likely cause the Fed to be more cautious in reducing the federal funds rate. We expect a lower (but higher than previously expected) federal funds rate and 10-year Treasury yield in 2025-2026. Lower rates will present an investment earnings headwind for insurers, given that they predominantly invest in short- to medium-term fixed-income securities.

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S&P Global Ratings' U.S. economic forecast

Key indicator (annual average % change)	2019	2020	2021	2022	2023	2024f	2025f	2026f
Real GDP	2.3	-2.2	6.1	2.5	2.9	2.7	2.0	2.0
Core CPI	2.2	1.7	3.6	6.2	4.8	3.4	2.6	2.4
Core PCE (Q4/Q4)	1.4	1.5	4.9	5.2	3.2	2.9	2.3	2.0
Unemployment rate	3.7	8.1	5.4	3.7	3.6	4.0	4.2	4.2
10-year Treasury (%)	2.1	0.9	1.4	3.0	4.0	4.2	4.0	3.6
Federal funds rate (%)	2.2	0.4	0.1	1.7	5.0	5.1	3.9	3.4

Note: All percentages are annual averages, unless otherwise noted. Core CPI is consumer price index excluding energy and food components. Core PCE is personal consumption expenditures price index excluding energy and food. f—Forecast. Table above is from S&P Global Ratings' article "Economic Outlook U.S. Q1 2025: Steady Growth, Significant Policy Uncertainty" (published Nov. 26, 2024). Sources for the data in the table: Bureau of Economic Analysis, Bureau of Labor Statistics, The Federal Reserve, S&P Global Market Intelligence Global Link Model, and S&P Global Ratings Economics Forecast.

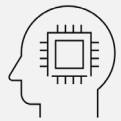
Long-term Sector Fundamentals Remain Solid

Favorable growth prospects and earnings stabilizers, balanced by policy and medical cost risks

Long-term sector strengths

Favorable growth: The resilient U.S. economy, growing population, and public policy moves that have lowered the uninsured rate

Pricing flexibility: The ability to reprice many products, or have rates adjusted annually, based on anticipated medical cost inflation



Improving tech and data analytics (including AI): Both factors should aid pricing and underwriting, member experiences, and operating efficiency

Value-based care: Insurers are well-positioned to promote new payment structures with providers to lower costs and raise quality

High barriers to entry: Due to regulatory and capital requirements, actuarial expertise, and provider networks

Long-term sector risks

Persistent legislative and regulatory risks: Federal and state budgetary issues, as well as social risks will keep the sector under persistent pressure

Government pricing and compliance risks: Affect premium rates, benefit and network requirements, marketing rules, and earnings

Unsustainable medical/drug cost inflation: Hurts product affordability, leads to political risk, and causes periodic earnings surprises

Rising consumer expectations: Will require greater product innovation and tech investments

Disruption risks: Especially from nontraditional competitors, as well as new competitive risks, as health insurers diversify into new lines

Sector View: Key Factors In 2025

Growing negative bias in rating actions
Operating performance stress in 2025
Legislative and regulatory pressure on multiple fronts

Rating And Outlook Distribution

The U.S. health insurance sector is highly rated, but with a growing portion of negative outlooks

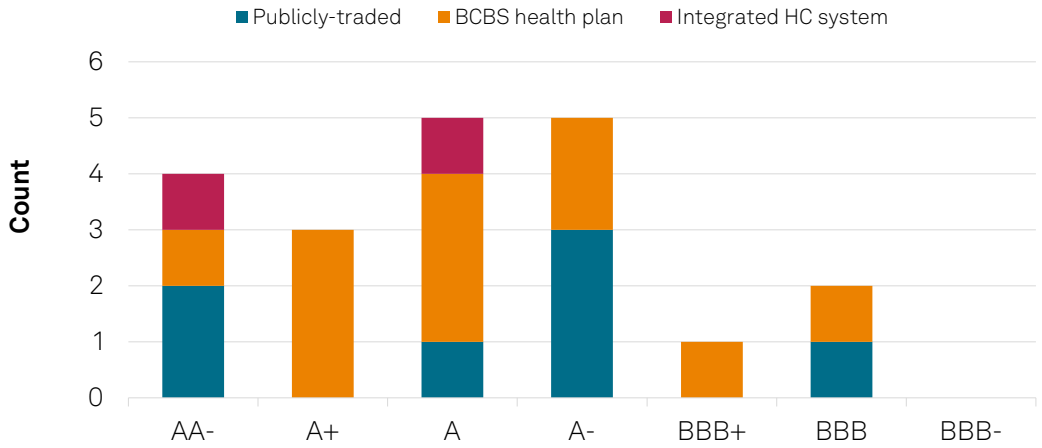
We have ratings on 20 insurance groups:

- Seven publicly traded companies
- 11 privately owned Blue Cross & Blue Shield (BCBS) health plans
- Two integrated health care delivery systems (Kaiser Permanente and HealthPartners).

Revisions to negative outlooks in 2024 were largely based on:

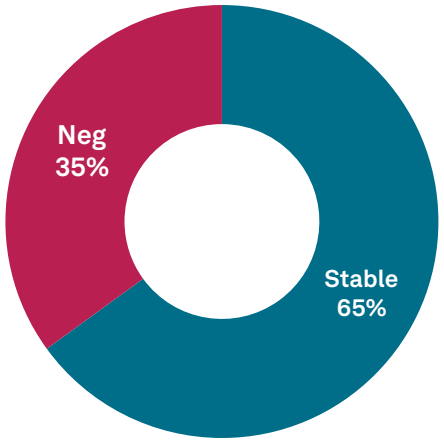
- Implementation of the capital adequacy criteria (released in November 2023)
- Operating performance deterioration
- M&A-related integration/execution and capital/earnings risks

Average financial strength rating (FSR) of 'A/A-'



Data as of Jan. 27, 2025. Note: FSR distribution includes one indicative rating where the holding company is rated but the insurance entities are unrated. Source: S&P Global Ratings.

Rating outlooks



Data as of Jan. 27, 2025. Source: S&P Global Ratings.

Growing Negative Bias In Recent Rating Actions

- There were no rating changes in 2023. The five upgrades in 2020-2022 were driven by acquisitions (by a larger, higher rated entity) and capital improvement, while the two downgrades in the same period were driven by weakened operating performance and capital deterioration.
- In 2024 through January 2025, we **raised our rating on Molina Healthcare Inc.** based on reduced financial leverage, and we **lowered our rating on Humana Inc.** due to the revised capital adequacy criteria. We **revised our outlooks to negative on Centene Corp. and Elevance Health Inc.** due to the revised capital adequacy criteria. We also **revised our outlooks to negative on Aetna Inc., BCBSNC, HealthPartners, and Horizon BCBS** on weakened operating performance, as well as on **Health Care Service Corp.** due to its pending acquisition of Cigna's Medicare business.

Positive versus negative rating actions

Data as of Jan. 27, 2025. Note: Negative count on y-axis represents a negative rating action. Source: S&P Global Ratings.

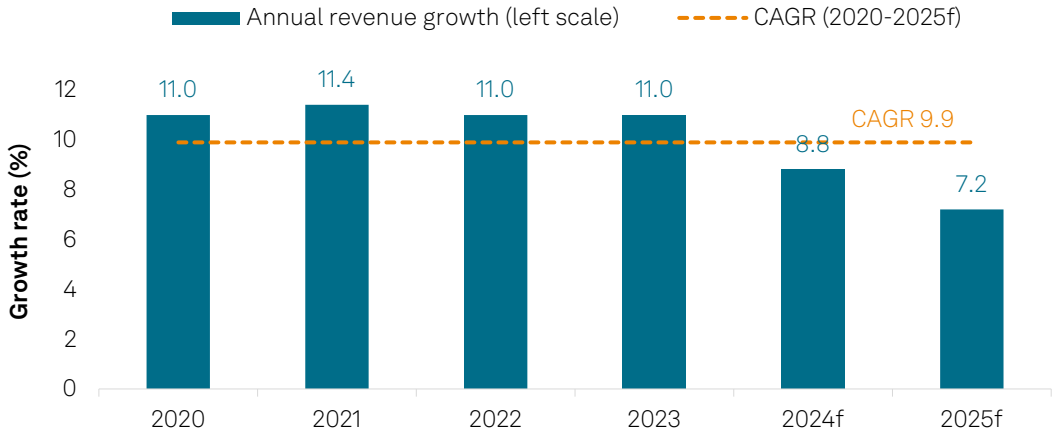
Operating Performance: Sector Revenue And Earnings Trends

Steady revenue growth in 2025, with earnings still vulnerable to Medicare and Medicaid risks

- **Strong sector revenue growth in recent years** driven by premium rate increases, membership growth in the commercial and MA segments, health care services growth, and acquisitions, slightly offset by membership losses from Medicaid redeterminations (in 2023-2024), and divestitures.
- **Healthy revenue growth expected in 2025** based on similar trends, though with stable Medicaid membership, and upside from acquisitions.

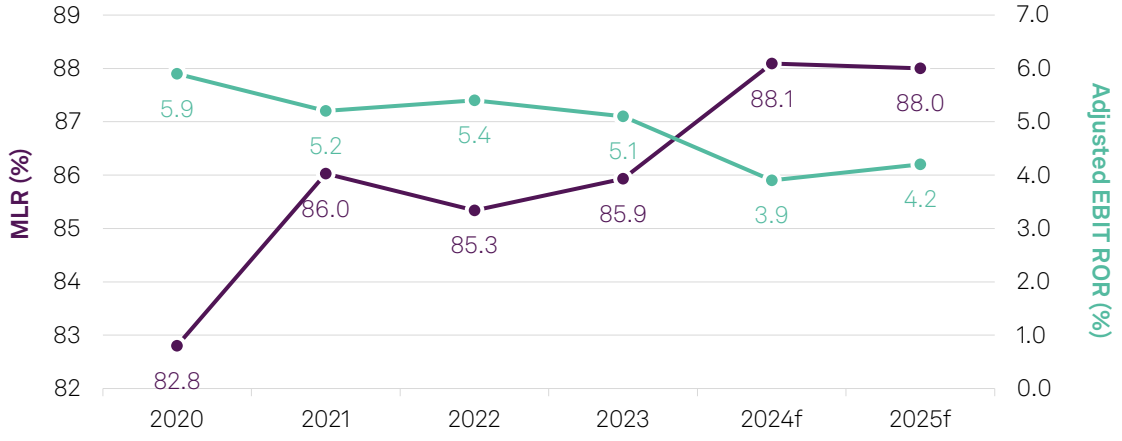
- **Sector earnings hurt by the rising medical loss ratio (MLR) in recent years** based on membership growth in higher MLR segments (MA and Medicaid). MLR pressure was driven by higher-than-expected utilization in MA in 2023-2024, the MA rate cut for 2024, and rising Medicaid acuity in 2024.
- **In 2025, the sector's MLR and margins could improve incrementally.** Another year of weak MA rates, Medicare Part D product changes, and recovering Medicaid rates leave the sector vulnerable to higher utilization.

Strong sector growth from organic growth and M&A



Note: Sector revenue (includes investment/other income) is based on aggregate data for The Cigna Group, Centene Corp., CVS Health Group, Elevance Health Inc., Humana Inc., Molina Healthcare Inc. and UnitedHealth Group Inc. f--Forecast. Source: Company filings and presentations, S&P Capital IQ, and S&P Global Ratings.

Rising MLR is dampening operating margins



Note: Sector MLR and ROR based on the average of The Cigna Group, Centene Corp., CVS Health (HCB Segment), Elevance Health Inc., Humana Inc., Molina Healthcare Inc., and UnitedHealth Group Inc. f--S&P Global Ratings' forecast. Source: Company filings and presentations, S&P Capital IQ, and S&P Global Ratings.

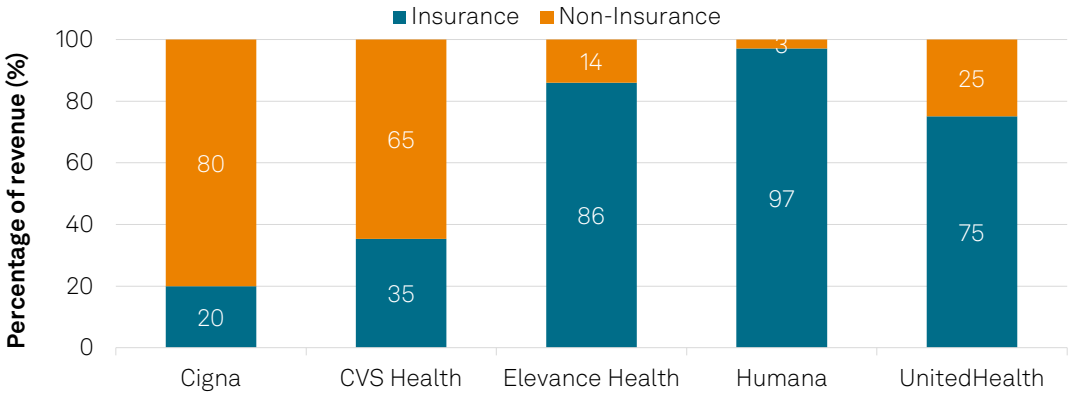
Operating Performance: Diversification From Noninsurance Business

Noninsurance earnings have helped offset weaker insurance results, though they have some correlated risks

- **The sector continues to diversify outside of health insurance into noninsurance areas such as care delivery, pharmacy services, home health, and health care IT.**
- This is an insourcing strategy, as well as a growth strategy, reliant on external clients, that expands a company's long-term revenue and earnings opportunities in less regulated businesses.

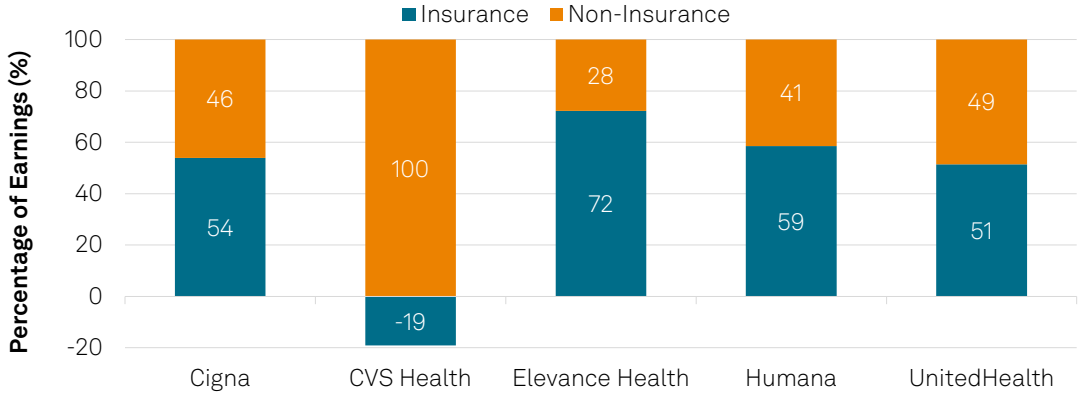
- **Noninsurance assets provide a partial earnings hedge, as higher medical and drug utilization, which dampen health insurance earnings, can bolster certain care delivery and pharmacy-related earnings.**
- That said, noninsurance businesses can pose correlated risks. For example, earnings for senior-focused primary care providers have been hurt by the new MA risk model (v28) and higher utilization. Separately, the cyberattack on UnitedHealth's Change Healthcare in 2024 took a toll on both the noninsurance and insurance businesses.

Revenue: insurance versus noninsurance



As of Q3 2024 YTD. Note: Revenue excludes investment/other income, corporate/other segments and intersegment revenue. Noninsurance segments include Evernorth (Cigna), CVS Health Services and Pharmacy/Consumer Wellness (CVS Health), Carelon (Elevance Health), CenterWell (Humana), and Optum (UnitedHealth). Source: Company filings, S&P Capital IQ, and S&P Global Ratings.

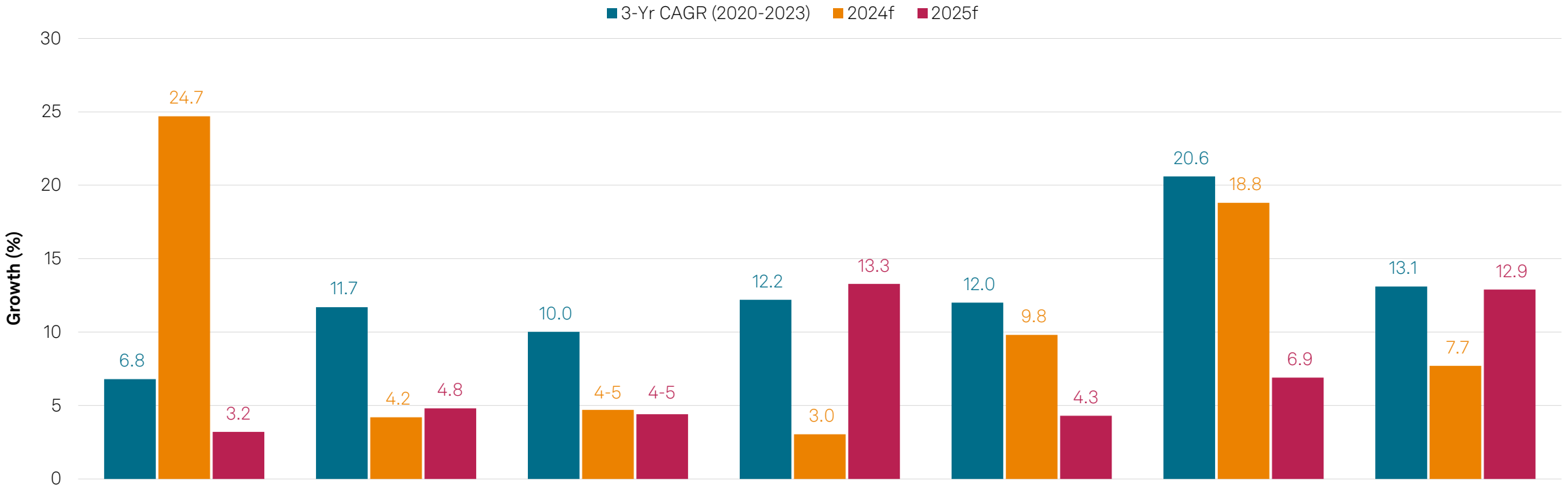
Operating earnings: insurance versus noninsurance



As of 3Q 2024 YTD. Note: Reported operating earnings exclude investment/other income and corporate/other segments. Cigna's segment earnings are reported before eliminations unlike peers. Noninsurance segments include Evernorth (Cigna), CVS Health Services and Pharmacy/Consumer Wellness (CVS Health), Carelon (Elevance Health), CenterWell (Humana), and Optum (UnitedHealth). CVS Health's insurance segment (HCB) reported a net operating loss for 3Q'24 YTD. Source: Company filings, S&P Capital IQ, S&P Global Ratings.

Operating Performance: Revenue Growth By Company

Revenue growth variation in 2024-2025 due to business mix, client shifts, and M&As



The Cigna Group
2025: Slower revenue growth based on modest commercial segment growth, and lower Evernorth growth after large Centene PBM win in 2024

Centene Corp.
2025: Medicaid organic growth with improving rates, and higher Medicare Part D membership, offset by MA membership losses

CVS Health Corp.
2025: MA membership decline of 5%-10%, ACA membership decline

Elevance Health Inc.
2025: Carelon exceeding long-term target growth range, MA membership growth of 7%-9% will outpace the overall market average

Humana Inc.
2025: MA membership decline of 200,000 – 300,000

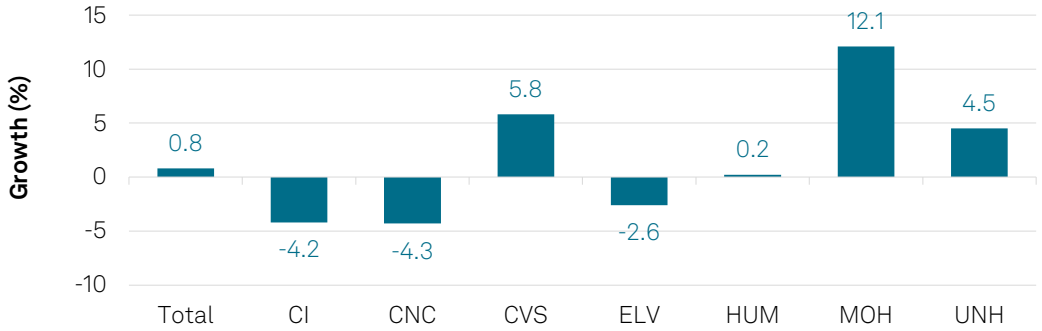
Molina Healthcare Inc.
2025: Medicaid contract wins plus recently completed acquisitions, ACA growth

UnitedHealth Group Inc.
2025: Diversified growth at both UHC and Optum

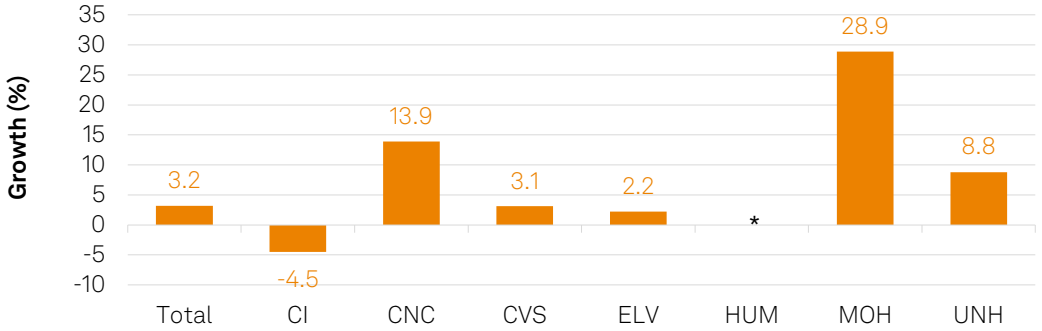
Note: 2024 actual used for Elevance Health, and UnitedHealth. f--forecast. Source: Company filings and presentations, S&P Capital IQ, and S&P Global Ratings.

Medical Membership: Medicare Advantage Gains, Medicaid Losses In 2024

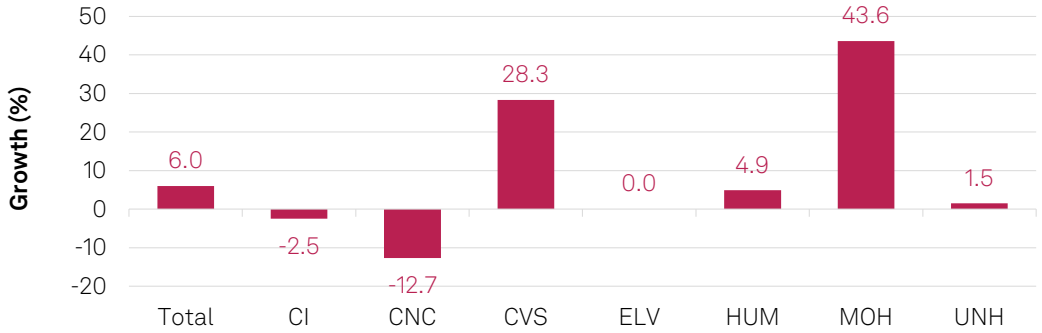
Total membership growth (Q3 2024 versus year-end 2023)



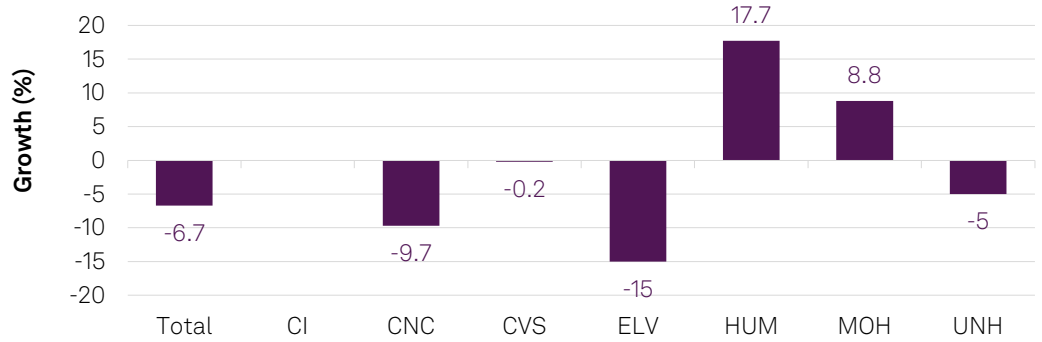
Commercial group/individual growth (Q3 2024 versus year-end 2023)



MA growth (Q3 2024 versus year-end 2023)



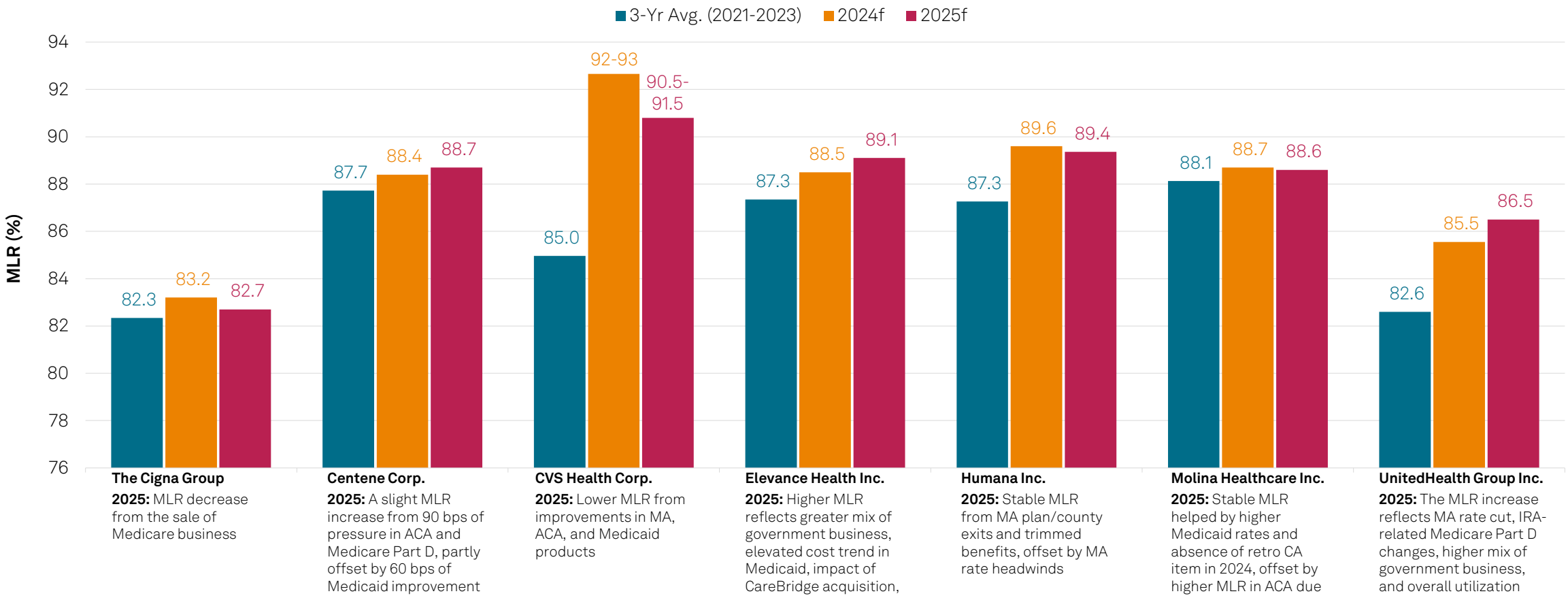
Medicaid growth (Q3 2024 versus year-end 2023)



Note: Elevance Health membership excludes BlueCard. Total—Aggregate data for peers. Humana is exiting the commercial group business in 2024 so its growth rate is shown as "*". CI--The Cigna Group, CNC--Centene Corp., CVS--CVS Health Corp., ELV--Elevance Health Inc., HUM--Humana Inc., MOH--Molina Healthcare Inc., UNH--UnitedHealth Group Inc. Source: Company filings and presentations, S&P Capital IQ, and S&P Global Ratings.

Higher MLRs In 2024-2025 Than In Prior Years

If MLR improves in 2025, it's likely to be incremental with key segments still below target margins



The Cigna Group
2025: MLR decrease from the sale of Medicare business

Centene Corp.
2025: A slight MLR increase from 90 bps of pressure in ACA and Medicare Part D, partly offset by 60 bps of Medicaid improvement

CVS Health Corp.
2025: Lower MLR from improvements in MA, ACA, and Medicaid products

Elevance Health Inc.
2025: Higher MLR reflects greater mix of government business, elevated cost trend in Medicaid, impact of CareBridge acquisition, and IRA related Medicare Part D changes

Humana Inc.
2025: Stable MLR from MA plan/county exits and trimmed benefits, offset by MA rate headwinds

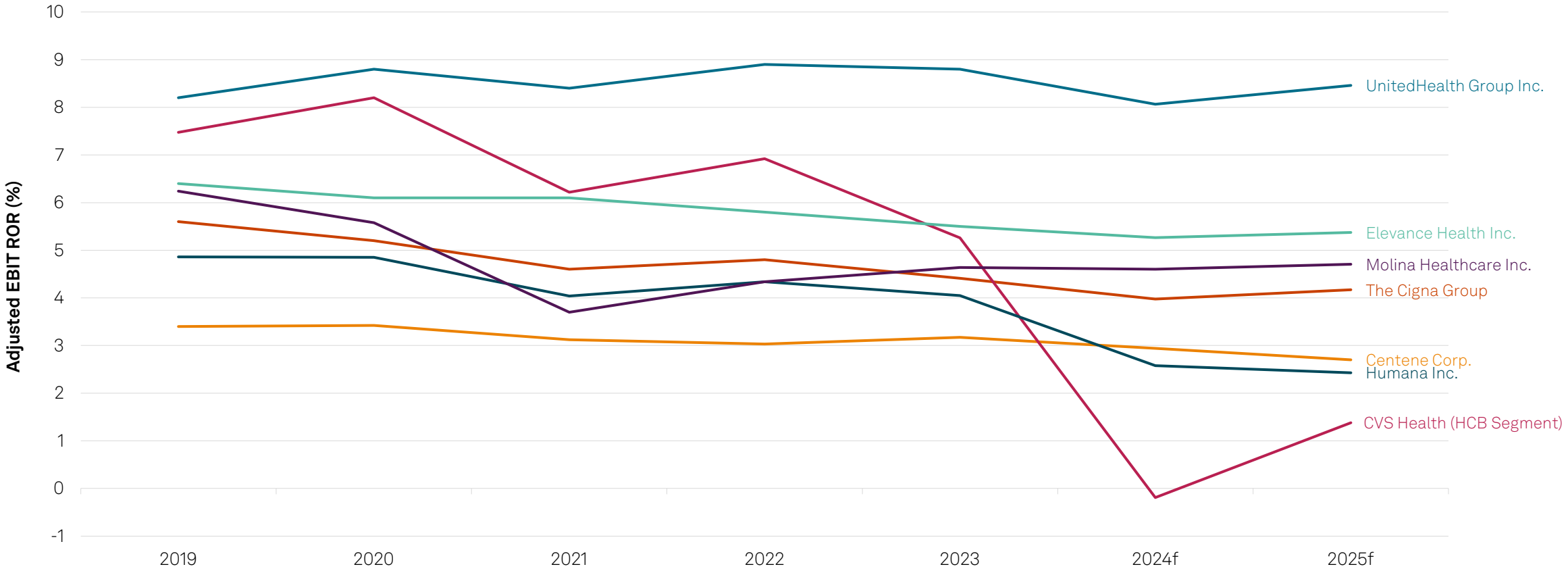
Molina Healthcare Inc.
2025: Stable MLR helped by higher Medicaid rates and absence of retro CA item in 2024, offset by higher MLR in ACA due to growth strategy

UnitedHealth Group Inc.
2025: The MLR increase reflects MA rate cut, IRA-related Medicare Part D changes, higher mix of government business, and overall utilization

Note: 2024 actual used for Elevance Health and UnitedHealth. Source: Company filings and presentations, S&P Capital IQ, S&P Global Ratings.

Operating Performance: Operating Margins By Company

Adjusted EBIT return on revenue is expected to be stable to slightly up in 2025



Note: Adjusted operating income used for CVS Health (HCB Segment). Source: Company filings and presentations, S&P Capital IQ, and S&P Global Ratings.

Legislative And Regulatory Risks: ACA And Medicaid Could Be Targets

Sector revenue could take a hit if changes lead to a higher uninsured rate

- The new administration and Congress may consider legislative and regulatory changes that could affect major health coverage programs.
- Letting the enhanced ACA subsidies expire requires no action by Congress, whereas enacting sizable Medicaid cuts will be more difficult.

Enhanced ACA subsidies to expire

Enhanced ACA subsidies will expire at the end of 2025, unless Congress passes legislation to extend all (or part of) the subsidies. If the enhanced subsidies expire, ACA enrollment will fall by 20%-30% during 2026-2027 per CBO estimates.

Ahead of losing coverage, ACA members could "pull-forward" their utilization in H2 2025, leading to MLR pressure for the sector. Health insurers could face pricing risks in estimating enrollment losses, adverse selection, and risk pool changes for 2026.

The new administration has already issued executive orders that will defund ACA marketing and outreach efforts and could shorten the ACA enrollment period in certain states.

Possible Medicaid program changes

Medicaid is a target for federal budget cuts, as Congress attempts to extend the Tax Cuts and Jobs Act of 2017 via a budget reconciliation bill.

Proposals are likely to include reducing the FMAP for part (or all of) the Medicaid program, converting Medicaid to a block grant program, and setting per capita federal funding caps. These scenarios, while unlikely, could cause sizable enrollment losses.

HHS/CMS may promote work requirements in Medicaid, leading to moderate, or sizable, enrollment losses.

HHS/CMS could also tighten Medicaid enrollment processes and eligibility checks, causing incremental enrollment losses.

Medicare untouchable, for now

The new administration is unlikely to cut Medicare funding, per campaign promises.

New HHS/CMS leadership could take more of a pro-MA approach in terms of more favorable rates and regulations.

CMS will have a role in finalizing Medicare Advantage rates for 2026 in April 2025. It will have a greater role in the rates for 2027.

While unlikely, CMS could pause or retract the phase-in of the v28 risk coding model, which has put pressure on the sector's revenue. CMS may also tweak the Star Ratings methodology; recent changes have been generally negative for the sector.

Congress May Consider A Range Of Medicaid Changes

More details on three Medicaid proposals that Congress may consider in 2025

The sector covers ~75% of the 79.4 million Medicaid/CHIP enrollees. Medicaid expansion enrollees (~25% of all enrollees) are most at risk of losing coverage under possible changes. Adding work requirements to Medicaid is the most likely scenario (through legislation or regulation) and will have a manageable impact on the sector. Lowering the FMAP and block grants/per capita caps are meaningful changes that will be tougher to pass through legislation.

1. Add work requirements

In the first Trump Administration, CMS approved work requirements for Medicaid in 13 states. Only one state, Arkansas, implemented it (18,000 people lost coverage) before legal challenges stopped it.

A 2023 CBO study on a House bill estimated that adding work requirements could result in federal savings of $109 billion (2023-2033), with 1.5 million adults being affected and 40% (600,000) becoming uninsured.

2. Lower the FMAP

The federal government currently matches each state's Medicaid funding based on a FMAP with a min/max range of 50%-83%. The ACA law also provides a 90% FMAP for the Medicaid expansion population.

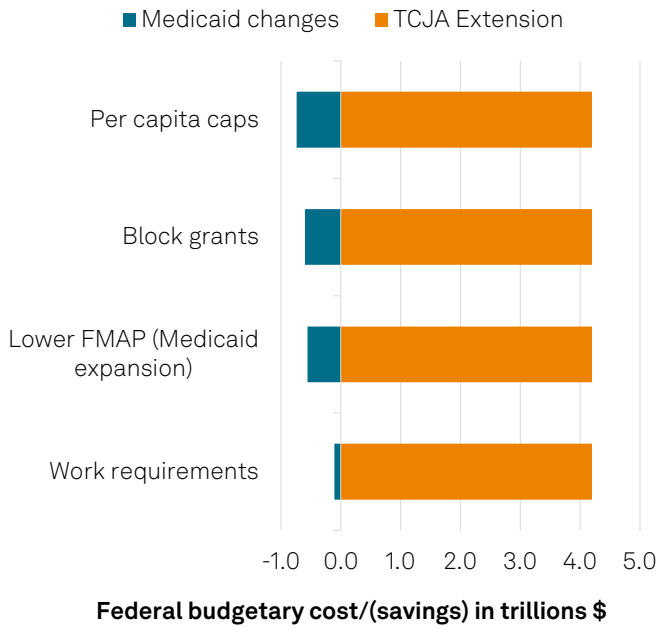
Proposals could lower the FMAP floor below 50%, and/or lower the FMAP for the Medicaid expansion population. The CBO estimated federal savings of $561 billion for the Medicaid expansion proposal in 2025-2034.

3. Convert to block grants or per capita caps

a. Under a block grant program, the federal government would set an annual max payment *per each state*, subject to an annual growth factor such as inflation. A 2024 CBO report estimated federal savings of $459 billion - $742 billion in 2025-2034.

b. Under a per capita cap, the federal government would set a max payment *per enrollee*, which would vary by enrollee type, subject to an annual growth factor such as inflation. A 2024 CBO report estimated federal savings of $588 billion - $893 billion in 2025-2034.

Est. Medicaid savings versus TCJA extension cost (10-year period)

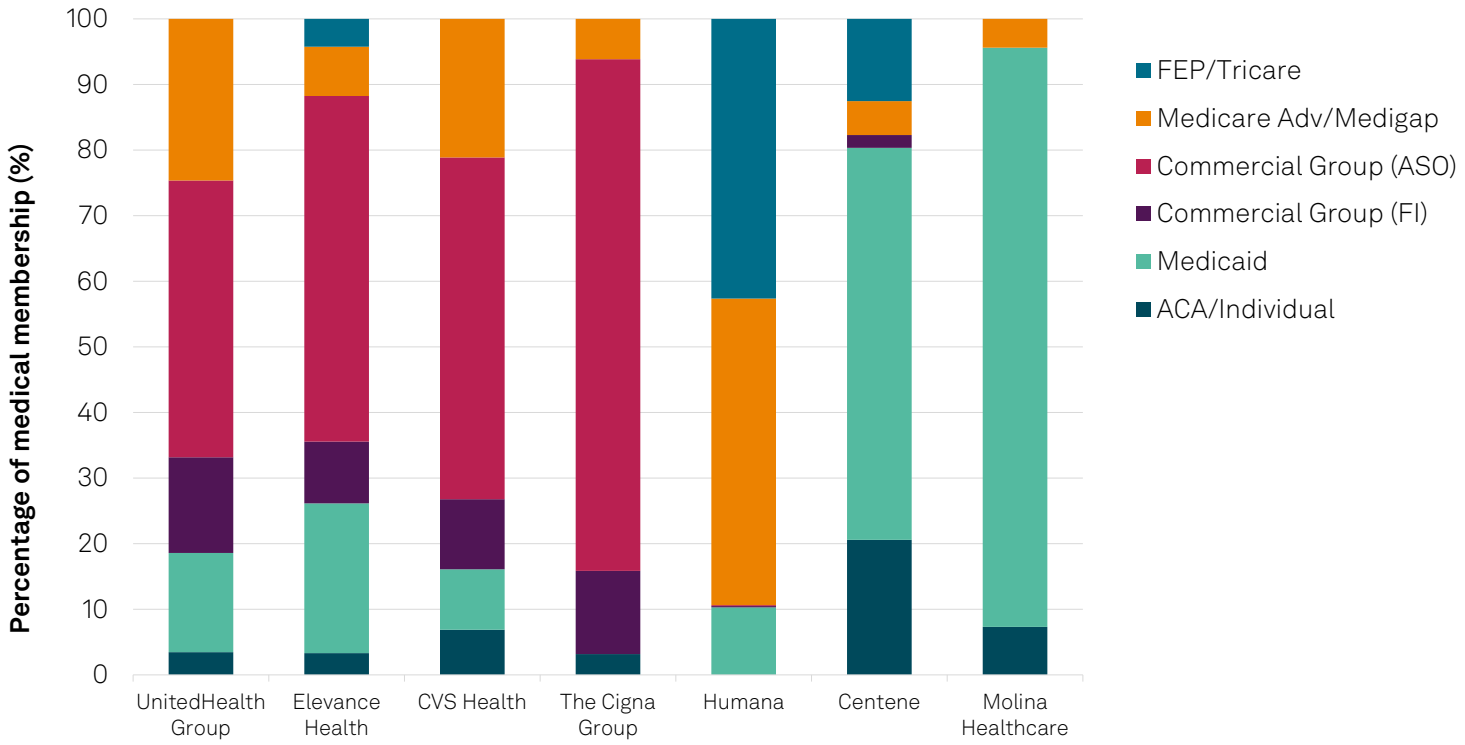


FMAP—Federal Medical Assistance Percentage. TCJA—Tax Cuts and Jobs Act of 2017. Note: Medicaid savings in chart are based on midpoint of CBO estimates. TCJA extension cost is based on U.S. Treasury analysis (January 2025). Source: CBO, KFF, U.S. Treasury, and S&P Global Ratings.

Federal Legislative And Regulatory Risks

Rating implications of ACA and Medicaid changes will depend on overall exposure and other factors

Medical membership Q3 2024: ACA and Medicaid exposures by company



FEP—Federal Employee Health Program. ASO—Administrative Services Only. FI—Fully Insured. ACA—Affordable Care Act Marketplace.
Source: Company filings, S&P Capital IQ, and S&P Global Ratings.

The expiration of the enhanced ACA subsidies would slow the ACA market's growth momentum. However, standard ACA subsidies will remain in place, and the ACA market could return to growth in the long term. In the past, some companies have completely exited the ACA market, though they were leaving behind unprofitable ACA businesses. The ACA business today can generate healthy pretax margins in the mid-single digits.

Significant cuts to federal Medicaid funding would likely take years to play out, which will give states (and the sector) time to prepare. Some states may be able to partly offset the federal funding cuts on their own. However, states would likely need to reduce enrollment and adjust products/benefits. Medicaid rate pressure is possible, but rates will still need to be actuarially sound.

The rating impact, if any, of the ACA and Medicaid changes would depend on company exposures, management's mitigation strategies, and the impact on key credit ratios. Capital adequacy could be pressured if excess capital is entirely deployed for shareholder returns, though lower premiums would also lower risk-based capital charges in our model.

Momentum For Long-Discussed PBM Legislation In 2025

Proposed PBM revenue and transparency changes should be manageable for the sector and ratings

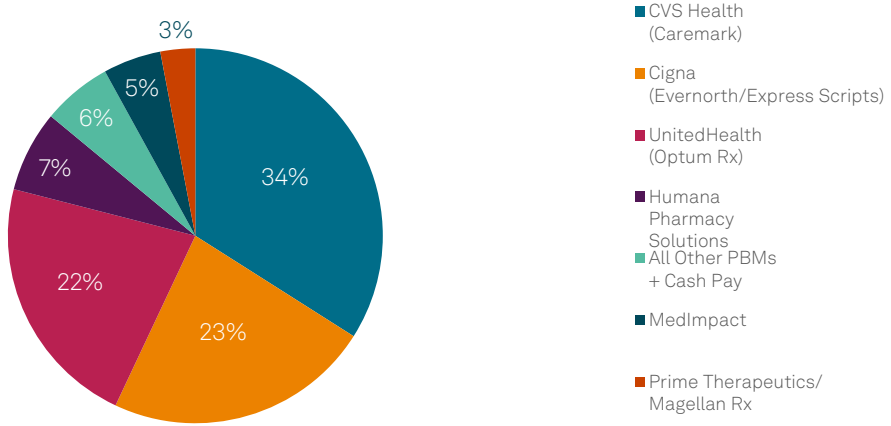
Bipartisan PBM legislation was included in the continuing resolution bill in 2024, but it was removed at the last minute. Key provisions were:

1. Removal of spread pricing and full pass-through of rebates in Medicaid (starting in 2027).
2. Delinking of drug prices from PBM compensation in Medicare Part D. PBMs would be prohibited from receiving income beyond "bona fide service fees", removing the linkage to Part D drug prices (starting in 2028).
3. Requirement to pass through 100% of rebates and discounts, excluding service fees, for employers or health plans regulated by ERISA (starting in 2028).

We believe there is momentum for transparency-oriented PBM legislation to pass in 2025 based on several factors:

1. President Trump's statement that "we're going to knock out the middleman".
2. The Federal Trade Commission's reports and lawsuits against the top three PBMs amplify the reform pressures.
3. PBM legislation could generate federal savings, which could be used in a budget reconciliation bill focused on extending tax cuts beyond 2025.

PBM Market Share



Data as of the end of 2023. Source: Drug Channels Institute and S&P Global Ratings.

There is less visible momentum for The PBM Act, introduced by Senators Warren and Hawley, which would prohibit the ownership of pharmacies (retail, specialty, mail-order) by groups with PBM or health insurance businesses.

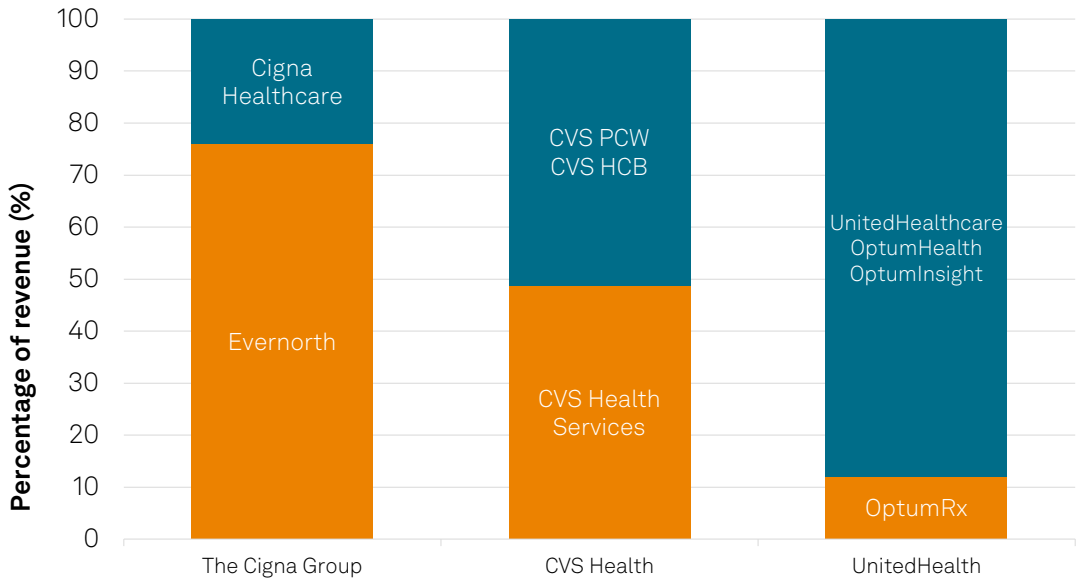
- This type of reform would affect CVS Health the most, though Cigna/Evernorth, UnitedHealth Group/OptumRx, and others would also be affected, given that they have mail-order and specialty pharmacies.
- Companies would have several years to divest businesses to comply with the law or face penalties.

PBMs Are An Important, But Only One, Part Of Health Services Businesses

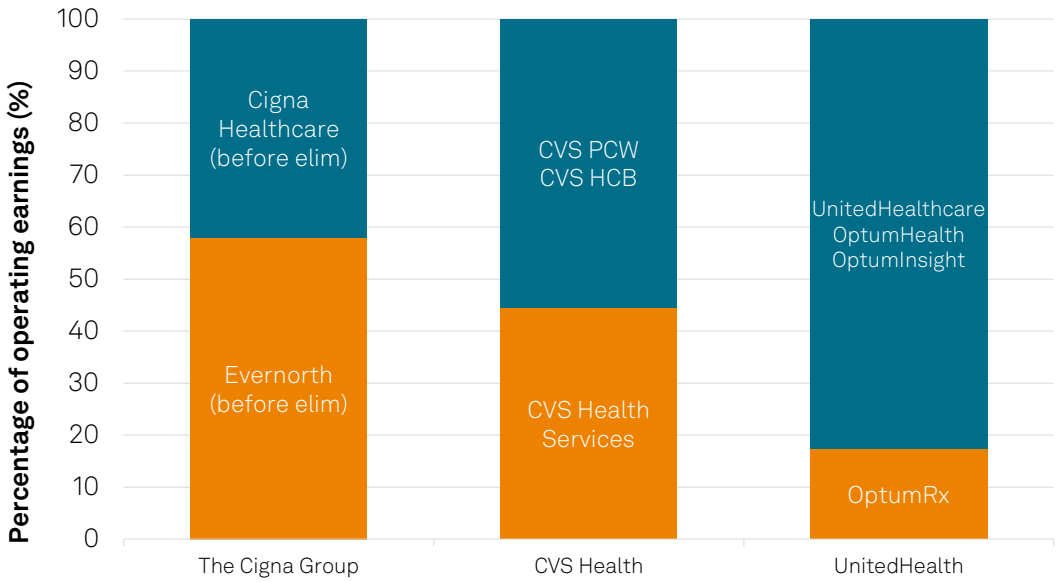
PBMs are housed within Cigna's Evernorth, CVS Health's Health Services, and UnitedHealth's OptumRx

The Big three PBMs likely contribute roughly half of their respective segment's earnings. Rebate and spread pricing-related earnings (the areas most at risk by legislation) likely make up a modest portion of total PBM earnings, as PBMs have been moving toward other fee-based earnings for some time.

Revenue mix by segment (2023)



Operating earnings mix by segment (2023)



Note: Cigna Evernorth includes PBM, specialty pharmacy, mail-order and care delivery services. CVS Health Services includes PBM, specialty pharmacy, mail-order, and care delivery services. CVS PCW—CVS Pharmacy & Consumer Wellness. CVS HCB—CVS Health Care Benefits. OptumRx includes PBM, specialty pharmacy, mail order, and other pharmacy services Revenue excludes corporate/other segments and intersegment revenue. Operating earnings excludes intersegment earnings except for Cigna/Evernorth. Source: Company filings and presentations, S&P Capital IQ, and S&P Global Ratings.

Potential Impact Of The PBM Legislation

PBMs will have time to adjust their business to the proposed changes

The PBM legislation, if it follows what we saw in the spending bill at the end of 2024, will likely be a modestly negative, though manageable, event for the sector.

- PBMs will have time to renegotiate contracts with clients and drug manufacturers to adjust their revenue structure and maintain some degree of operating margin stability.
- Removal of the spread pricing in Medicaid will have an incremental impact, as many state Medicaid agencies have already been moving in this direction.
- Commercial market reform relating to rebate pass-throughs may not necessarily make its way into legislation, if it's done through the budget reconciliation process.
- Transparency-related reporting requirements would add administrative work and compliance risk. Greater transparency could also increase competition among PBMs, as clients will have more information to compare PBMs.

Company commentary on PBM transparency and earnings

Cigna: "Approximately 20% of Evernorth's adjusted pre-tax earnings are comprised of PBM retained rebates and retail spread. This percentage has decreased over time as we continue to expand fee-based client relationships and as our Evernorth portfolio becomes more diverse and continues to grow" *(Q1 2023 earnings call).*

CVS Health: "So 75% of our adjudicated claims are on a fully transparent basis, which essentially means that 25% are those customers that have chosen to create a spread for simplicity and economic benefit. But ultimately, all of this actually generates, again, less than 20% of the operating income for the business, a significant change to what I would have said a decade ago and I would expect as we continue to evolve and adapt our model, it will be different in the next decade" *(CVS 2023 investor day).*

UnitedHealth: "Last year, our PBM passed through more than 98% of the rebate discounts. We're committed to fully phasing out those remaining arrangements, so that 100% of rebates will go to customers by 2028 at the latest" *(Q4 2024 earnings call).*

2025 Sector View

Capital And Earnings
Key Credit Metrics
Capital Deployment
M&A
Debt Maturity Schedule

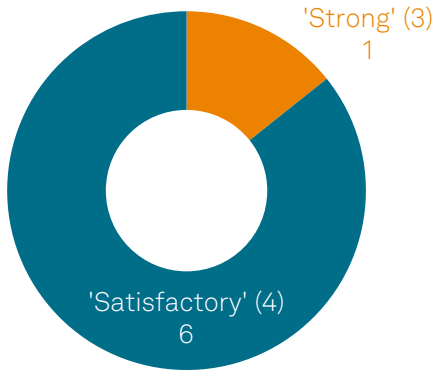
Capital And Earnings (C&E)

The ratings on U.S. health insurers reflect solid overall capitalization

Publicly traded companies maintain healthy levels of capital versus regulatory requirements. Risk-based capital (RBC) targets are 350%-550% (based on the authorized control level). We assess them as having satisfactory or strong C&E based on our capital model and other factors. These companies benefit from strong and diverse earnings, which can replenish capital, and from wide access to public debt and equity markets. Conversely, we believe the quality of their capital is weakened by significant holding company debt and a high amount of goodwill/intangibles.

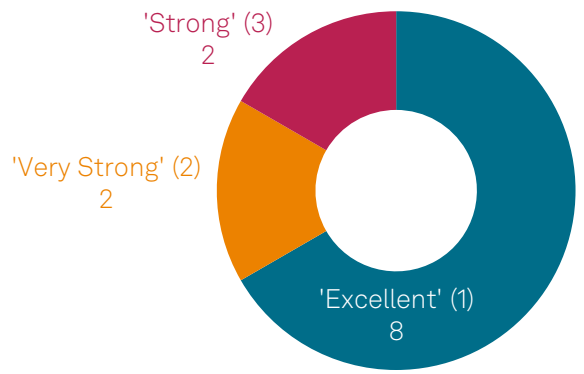
Privately owned companies, which primarily include not-for-profit and mutual BCBS health plans, have high C&E assessments. They generally maintain ample regulatory capital, with RBC targets of 500% - 1,000%, as well as high levels of capital redundancy based on our capital model. Most companies also have low to moderate levels of debt (<25% financial leverage). Conversely, many companies need to maintain high levels of capital because of modest earnings power, as well as business and geographic concentration risks.

S&P Global Ratings C&E assessments: Publicly traded companies



Data as of Jan. 27, 2025. Number of companies in each C&E category is reflected in the chart. C&E is ranked 1-8 from strongest to weakest: excellent (1) to vulnerable (8): Source: S&P Global Ratings.

S&P Global Ratings C&E assessments: Privately owned companies



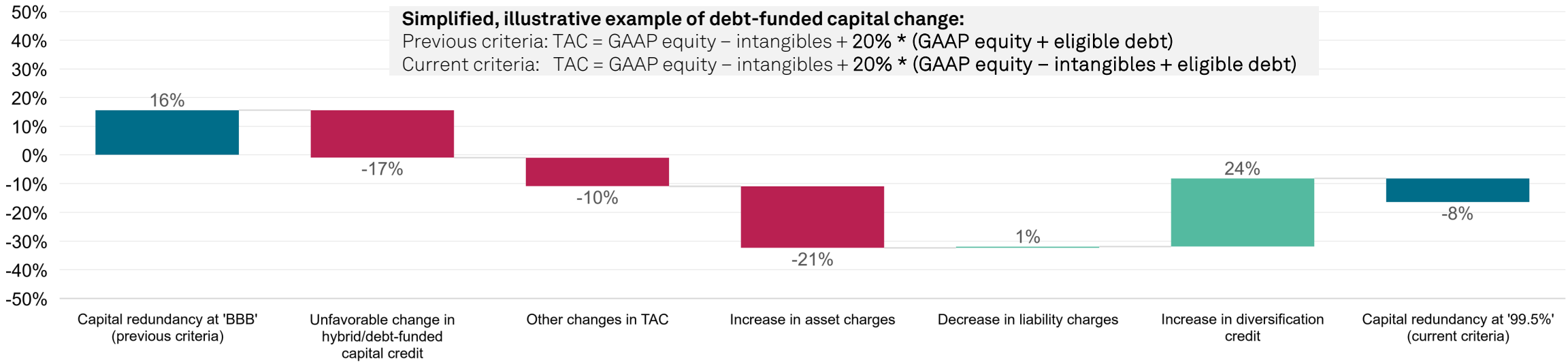
Data as of Jan. 27, 2025. Number of companies in each C&E category is reflected in the chart. C&E is ranked 1-8 from strongest to weakest: excellent (1) to vulnerable (8): Source: S&P Global Ratings.

New Capital Adequacy Criteria In 2023 Led To Rating And Outlook Changes

Ratings on several publicly-traded U.S. health insurers* were negatively affected by the criteria change

- In our capital analysis, we compare total adjusted capital (TAC) with RBC at different stress levels (99.99%, 99.95%, 99.8%, and 99.5%).
- Under the current criteria, TAC for some U.S. health insurers is lower than under our previous criteria because of less debt-funded capital credit in TAC.
- The debt-funded capital change is relatively punitive to companies with high debt leverage, a large amount of intangibles, and less noninsurance business.

Aggregate capital adequacy of health insurance sector: previous criteria versus current criteria



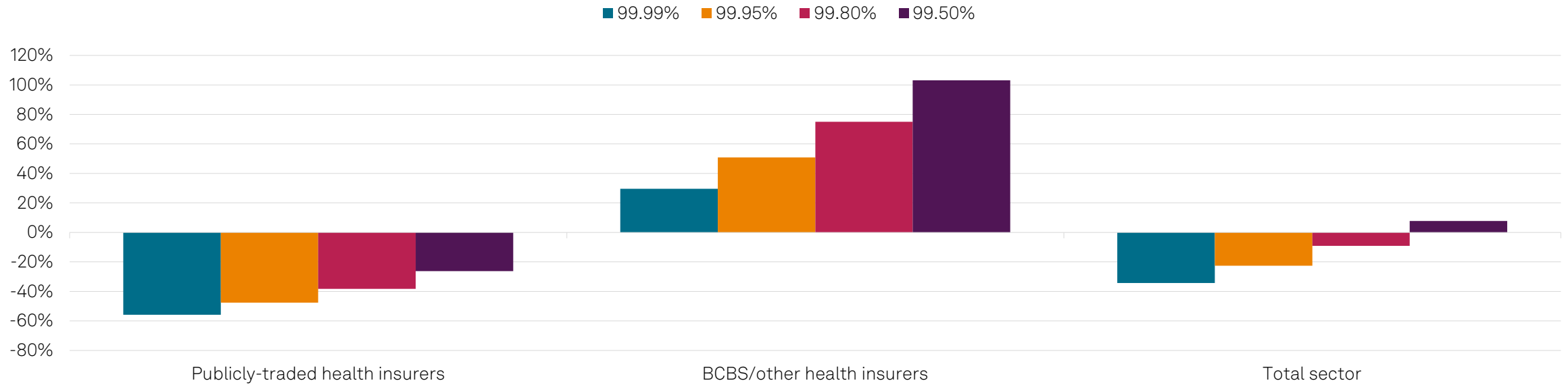
Note: Data as of the end of 2022. Aggregate capital adequacy reflects data for representative set of rated insurance groups. 'BBB' confidence level under previous criteria is equivalent to 99.5% confidence level under current criteria.
Other changes in TAC primarily reflects haircut on holding company cash credit as well as exclusion of noninsurance subsidiaries and intangibles. *Due to the criteria change, we lowered our rating on Humana Inc. and revised our rating outlooks on Elevance Health Inc. and Centene Corp. to negative from stable. Source: S&P Global Ratings.

Capital Adequacy Differs By Peer Group

Capital adequacy based on our model is an input for our overall C&E assessment, which considers other factors

- For publicly-traded health insurers, we predominantly have satisfactory C&E assessments based on long-term expectations of moderate capital deficiencies (<30%) at the 99.5% level, offset by favorable qualitative adjustments for their earnings power and financial flexibility.
- For not-for-profit and mutual BCBS health insurers, we predominantly have very strong and excellent C&E assessments based on long-term expectations of capital redundancies at the 99.95% and 99.99% levels, respectively.

Aggregate capital adequacy of different peer groups at four stress levels (high to low)

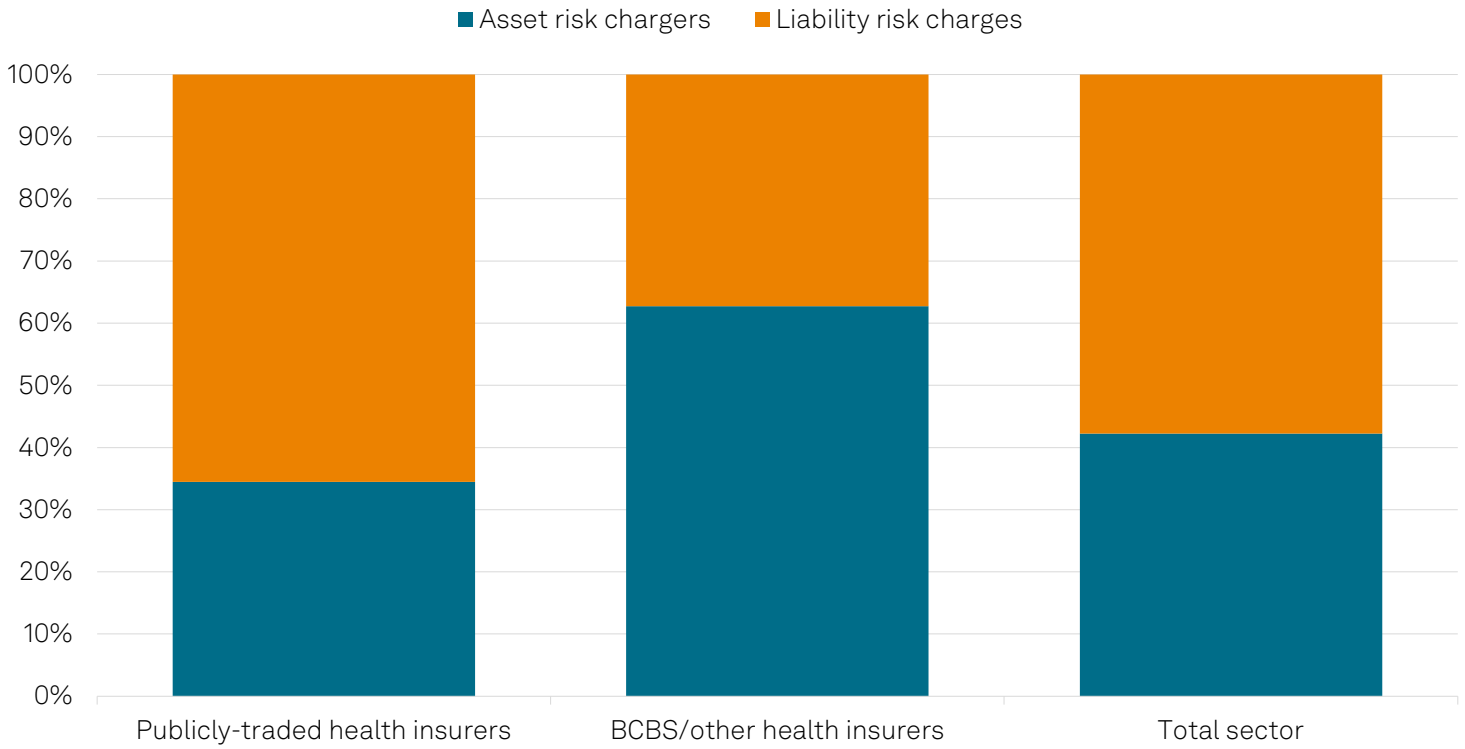


Note: Data as of the end of 2023. All three peer groups (publicly-traded, BCBS/other, total sector) include data for representative set of rated insurance groups. Source: S&P Global Ratings.

RBC Requirements Differ By Peer Group

Premium mix and investment portfolio allocations drive differences in RBC requirements

Percentage of RBC requirement (the 99.8% level) by risk category



- Publicly-traded health insurers' RBC requirements are weighted toward their premium and liability risks.
- BCBS and other health insurers' RBC requirements are weighted toward their asset risks because many of these companies invest a higher portion of their investment portfolio in equity securities than their publicly-traded peers.

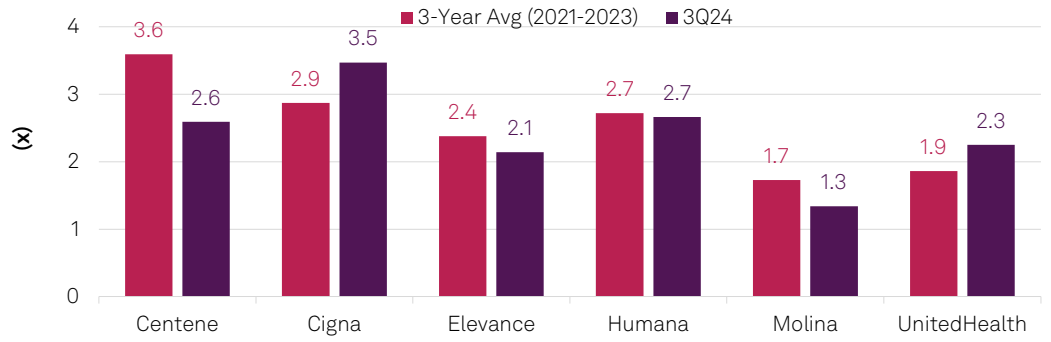
Note: Data as of the end of 2023 for a representative set of rated insurance groups. Source: S&P Global Ratings.

Key Credit Metrics

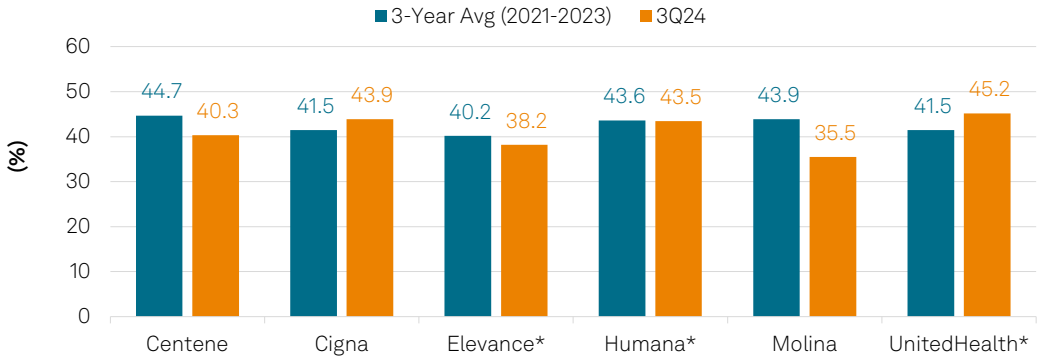
Financial leverage managed to our rating threshold (about 40%)

- **Publicly traded health insurers have debt-to-capital targets of 35%-40%.** They will go above 40% for certain acquisitions, with a plan to reduce leverage to their target within 12 months for smaller deals and 18-24 months for larger deals. Financial leverage of close to 40% (our rating threshold) is balanced by healthy financial obligations to EBITDA and EBITDA fixed-charge coverage ratios.
- **Privately owned health insurers, which rely less on acquisitions for growth, have debt-to-capital ratios of 0%-25%.** Some companies use their lines of credit or Federal Home Loan Bank facilities for working capital purposes.

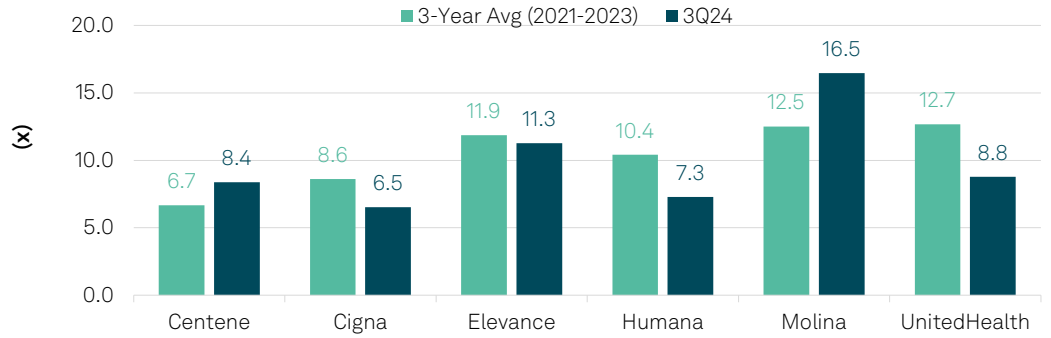
Financial obligations-to-adjusted EBITDA



Financial leverage



EBITDA fixed-charge coverage

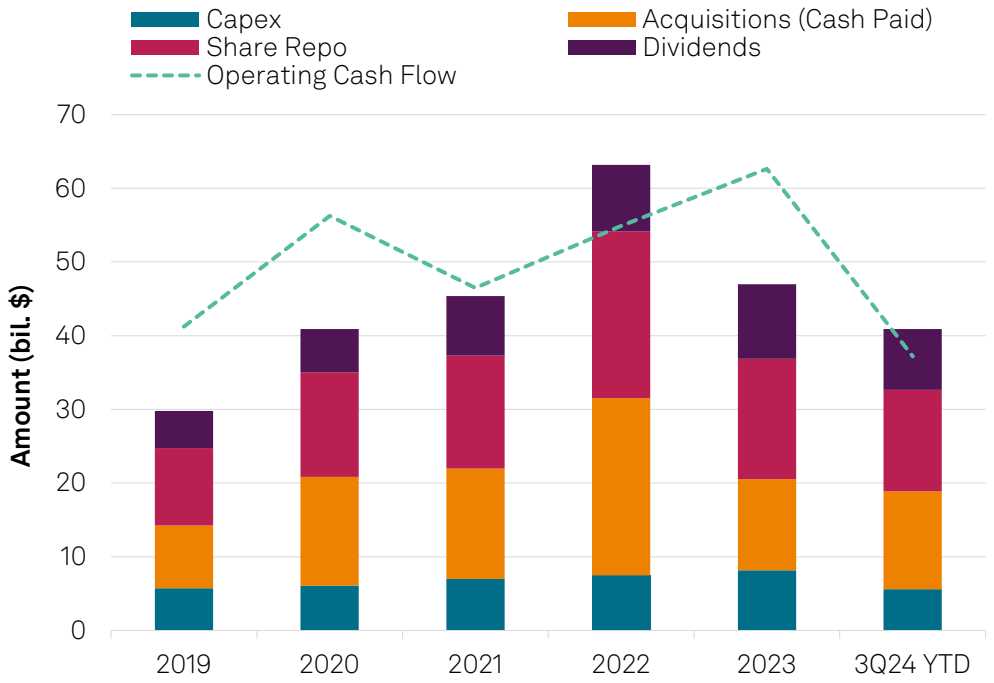


Note: Financial leverage ratios do not reflect November 2024 debt issuances by Elevance Health of $5.2 billion and Molina Healthcare of $750 million. Financial leverage including adjustments for operating leases and unfunded post-retirement obligations. EBITDA for Q3 2024 is reflected on an annualized basis for the financial obligations to adjusted EBITDA and EBITDA fixed-charge coverage ratios. Source: Company filings, S&P Capital IQ, and S&P Global Ratings.

Capital Deployment Trends And Mix

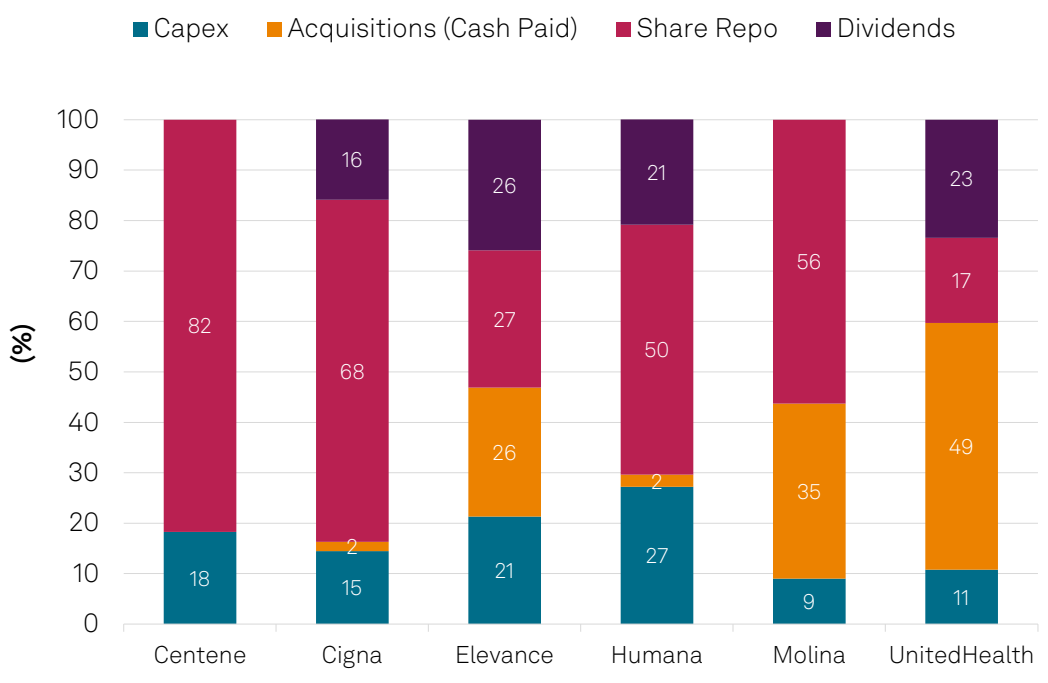
Good cash flow provides financial flexibility for debt repayment and capital deployment

Peer group total: Capital deployment by year



Data excludes impact of divestitures. Peer group includes UnitedHealth, Elevance Health, Centene, Cigna, Humana, and Molina. Source: Company filings and presentations, S&P Capital IQ, and S&P Global Ratings.

Capital deployment mix by company (Q3 2024 YTD)



Data excludes impact of divestitures. Source: Company filings, S&P Capital IQ, and S&P Global Ratings.

S&P Global
Ratings

Mergers And Acquisitions (M&As)

Change in DOJ/FTC leadership should facilitate M&A, though mega-mergers will remain elusive

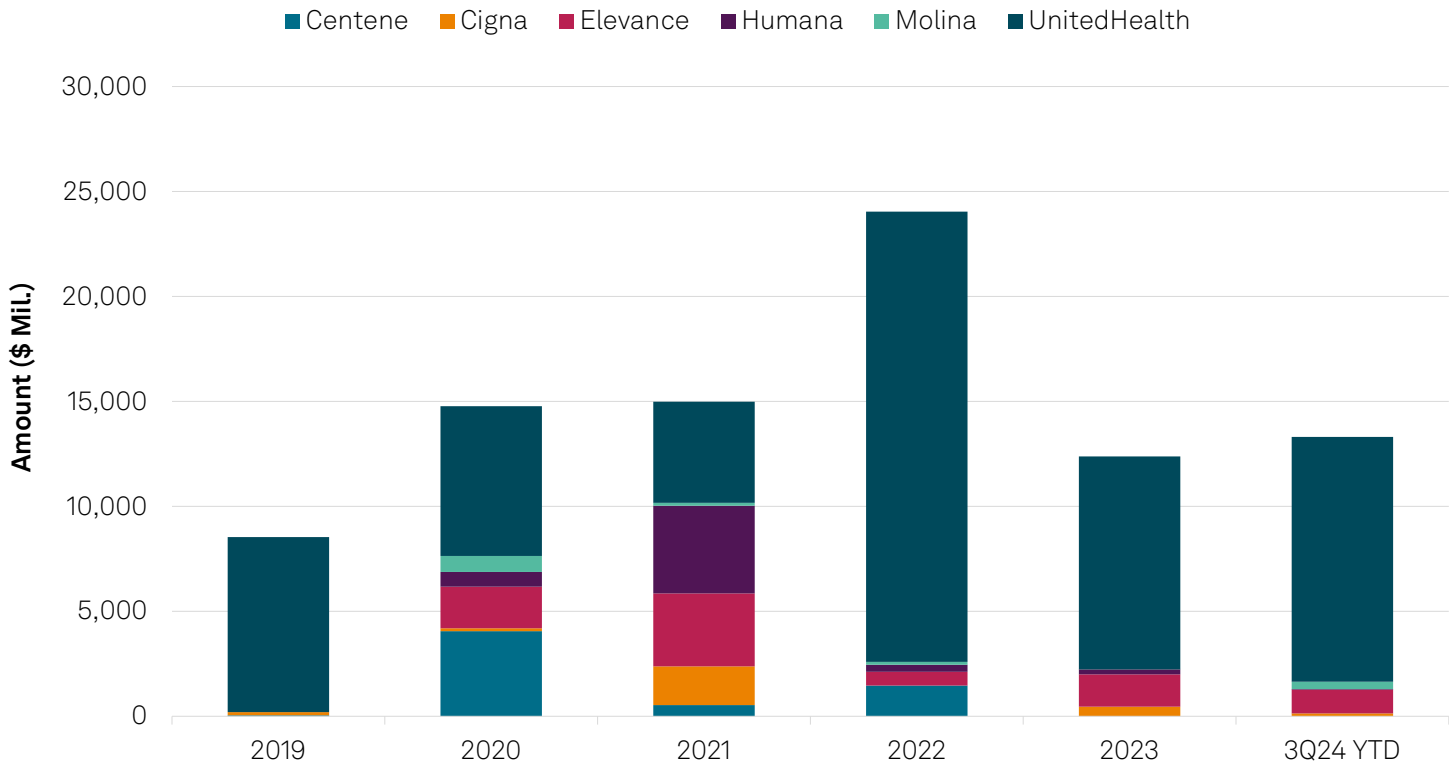
M&As are a key part of all publicly traded health insurers' growth strategies.

Even with new DOJ/FTC leadership, health insurance mega-mergers will be difficult to execute because of anti-trust concerns. The sector will continue to focus on small- to mid-size deals to bolster their presence in government business in select geographic markets.

We expect further M&A activity focused on noninsurance assets. Health insurers will continue to diversify into care delivery, pharmacy services, home health, and health care technology. These businesses can provide a competitive advantage in managing medical and pharmacy costs. They also can generate nonregulated earnings that enhance financial flexibility.

Within the BCBS system, Elevance Health's withdrawn deal to acquire BCBS Louisiana in 2024 will likely put a pause on for-profit/not-for-profit deals for awhile. Meanwhile, HCSC is likely to close on its acquisition of Cigna's Medicare business in Q1 2025. Separately, we expect BCBS health plans will increasingly work together on pharmacy services-related ventures.

Acquisition activity driven by UnitedHealth and Elevance Health in 2023-2024



Source: Company filings, S&P Capital IQ, and S&P Global Ratings.

Companies Are Diversifying And Divesting

Select deals in recent years (deals announced or completed in 2024-2025 are highlighted)

Small to midsize
Health plans and TPAs

- **BCBS Florida:** Triple-S Management
- **BCBS North Carolina:** Brighton Health
- **Elevance:** MMM Holdings, Integra Managed Care, IU Health Plan, Centers Plan for Healthy Living LLC and Centers for Specialty Care Group IPA*
- **Excellus:** Capital District Physicians' Health Plan* (affiliation)
- **Health Care Service Corp:** Trustmark Health Benefits, The Cigna Group's Medicare and CareAllies businesses*
- **Highmark:** HealthNow NY, Gateway Health Plan
- **Humana:** Inclusa
- **Molina:** AgeWell NY, Cigna TX Medicaid, My Choice Wisconsin, Bright HealthCare CA Medicare, ConnectiCare*

Noninsurance
Health Care Services

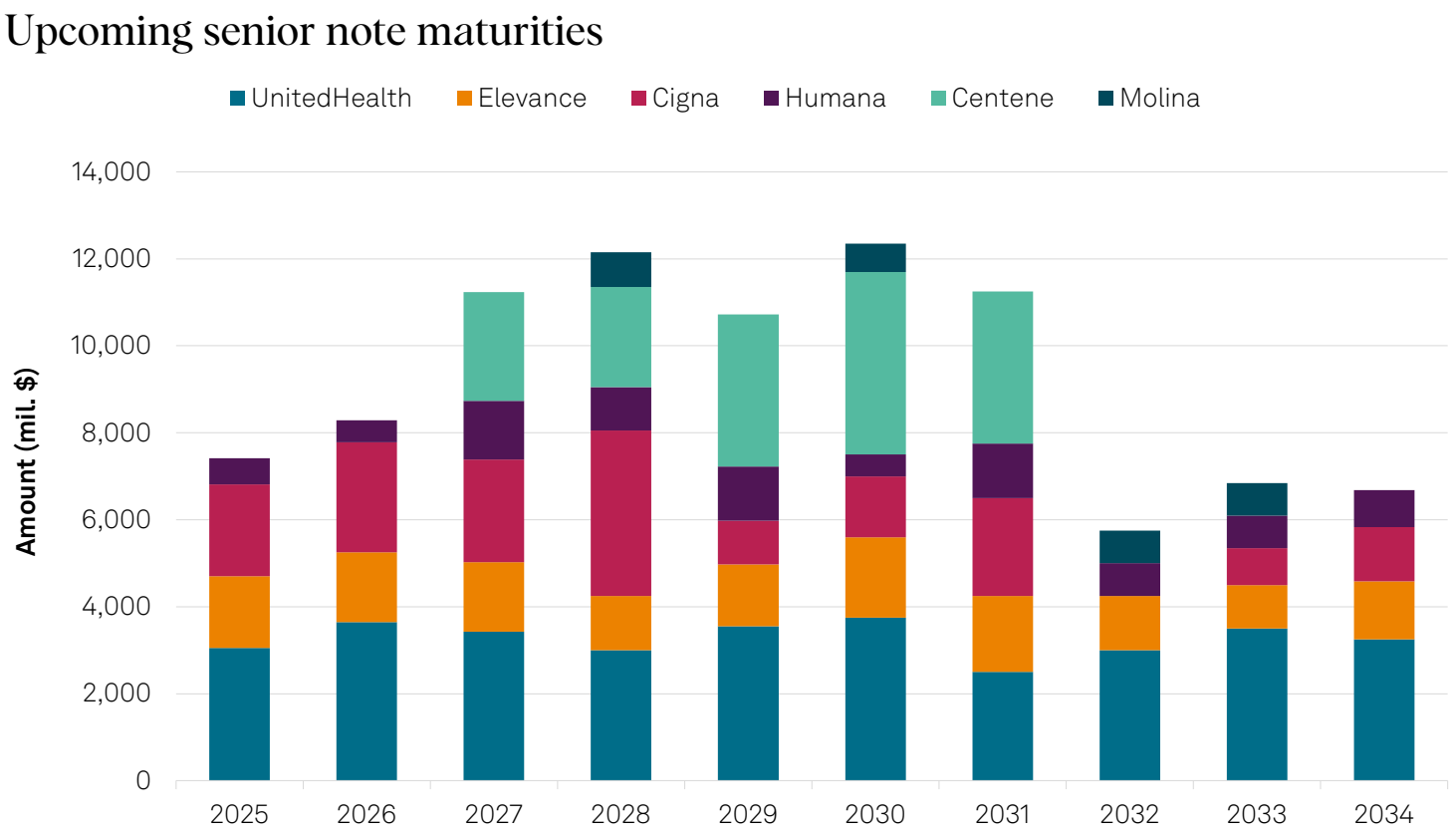
- **BCBS North Carolina:** FastMed (urgent care)
- **Elevance:** MyNexus (MA home health), BioPlus (specialty pharmacy), Paragon Healthcare (infusion services), Kroger Specialty Pharmacy, CD&R partnership (primary care), CareBridge (home health)
- **Cigna:** MDLive (telehealth), Summit Health (investment w/VillageMD, multispecialty practice/urgent care)
- **CVS Health:** Signify Health (home health), Oak Street Health (primary care)
- **Humana:** Kindred at Home (home health), One Homecare Solutions (home health), Cano Health (TX, NV centers), 23 former Walmart Health centers (primary care)
- **UnitedHealth:** Change Healthcare (health IT), LHC Group (home health), Crystal Run (primary care), EMIS (UK Health IT), Amedisys* (home health)

Non-core
Divestitures

- **Centene:** US Medical Management LLC (sale of majority stake), PantherRx, MagellanRx, Magellan Specialty Health, Spanish & Central European businesses, Apixio, Circle UK
- **Cigna:** International Supplemental Business, TX Medicaid, Medicare and CareAllies businesses*
- **CVS Health:** bswift, PayFlex, international healthcare (Thailand)
- **Elevance Health:** Life & Disability business
- **Humana:** Kindred at Home Hospice (sale of majority stake), Commercial Group business (phased exit)
- **UnitedHealth:** Amil (Brazil), Banmedica (rest of South American operations)*

*Pending deal. Source: S&P Global Ratings.

Debt Maturity Schedule



As of Jan. 27, 2025. Source: Company filings, S&P Capital IQ, and S&P Global Ratings.

2025 senior note maturities:

UnitedHealth Group:

- $2.0 billion (July 2025)
- $750 million (October 2025)
- $300 million (December 2025)

Elevance Health:

- $1.25 billion (January 2025)
- $400 million (October 2025)

Cigna:

- $900 million (April 2025)
- $1.216 billion (November 2025)

Humana:

- $600 million (April 2025)

Appendix

Segment outlooks
BCBS snapshot
Rating list

Segment Outlooks

MA
Medicaid
ACA Marketplace
Commercial

Segment Outlooks: MA

The sector's strongest long-term growth opportunity, solid growth expected in 2025

- **Weak MA rates for 2025--driven by the v28 risk model and lower average MA Star Ratings--will slow segment growth to 5%-6% in 2025, which is still a solid rate overall.**
- Many MA health plans reacted to weak MA rates for 2025 by reducing supplemental benefits and increasing out-of-pocket costs, as well as exiting certain products/markets, which will moderate overall membership growth.
- MA health plans with stable premiums/benefits are likely to outperform, while others may lose membership as they trade growth for margin.

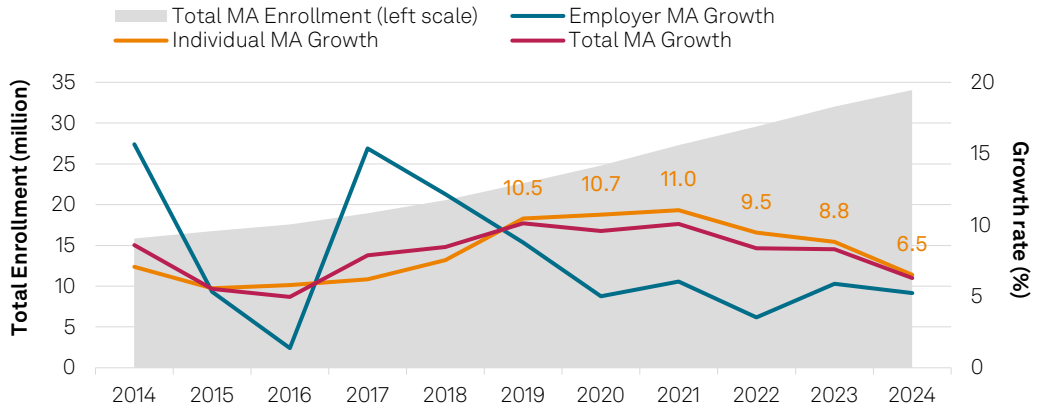
Tailwinds

- Aging population drives growth
- Rising MA penetration (54%) has the upside potential of 60%-70%
- The new administration could be more favorable on rates and regulations
- High premiums versus other segments with target margins of 3%-5%

Headwinds

- Weak MA rates for 2025
- Intense competition and reduced plan benefits driving higher member churn
- MA Star Ratings volatility
- Cost pressures from two-midnight rule and IRA Part D changes in 2025
- Regulatory and compliance risks

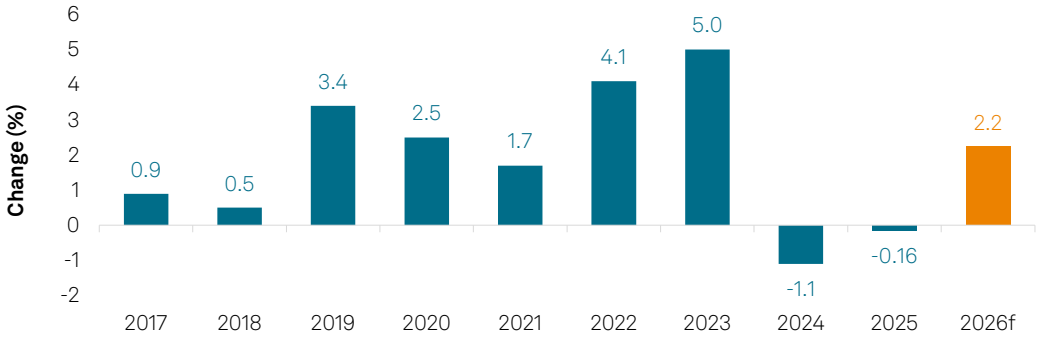
MA industry growth: Individual MA growth decelerating



Source: CMS and S&P Global Ratings.

Weak MA rates in 2024-2025, possibly improving in 2026

Three-year phase-in of new risk model reduces MA rate in 2024-2026



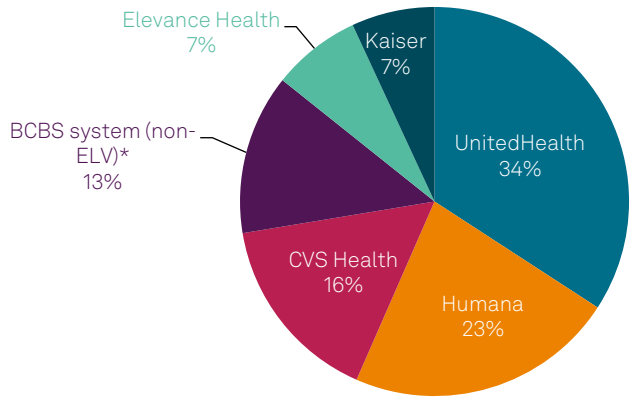
Note: MA rate growth reflects CMS' estimate of the average change in revenue industry-wide. IRA—Inflation Reduction Act. f--forecast. Source: CMS and S&P Global Ratings.

Segment Outlooks: MA

After a challenging 2024, focus on margins over membership in 2025

- **We expect market share shifts, as some MA health plans pull back in 2025.** Market share gainers in 2025 will include UnitedHealth (up by 800,000 members), which will benefit from stable products/benefits, after modest growth in 2024, and Elevance Health (7%-9% growth or 134,000 – 185,000 new members). Outsized growth for some companies in 2025 will raise some concerns on adverse selection.
- Market share losers in 2025 will include CVS Health (5%-10% membership loss), after being the biggest gainer in 2024, as well as Humana (down 200,000 – 300,000). Both companies are exiting certain products/markets, as they seek to improve margins in 2025 after weaker-than-expected performance in 2024.
- **MA Star Ratings can be volatile and affect competitive dynamics.** CMS rates MA health plans based on Star Ratings on a scale of 1 to 5 (lowest to highest). MA health plans with ratings of 4 and above receive a 5% revenue bonus.
- Regulatory changes affecting the MA Star Ratings methodology in recent years have made Star Ratings slightly lower and more volatile for the sector.
- In response, Humana, UnitedHealth, Elevance Health, and Centene have filed lawsuits against CMS, claiming incorrect calculations. So far, UnitedHealth and Centene have won their lawsuits, prompting CMS to recalculate their ratings. Humana has the most at stake, given its notable Star Ratings drop for 2025.

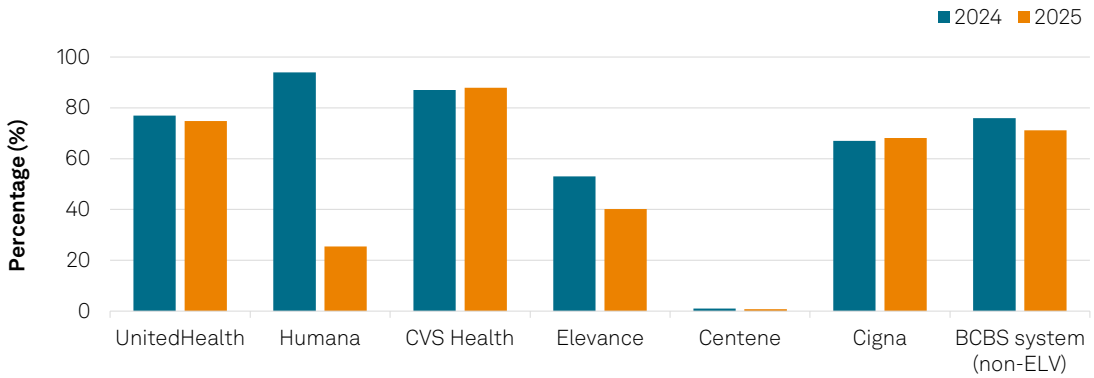
MA market leaders



Data as of October 2024. Note: BCBS system represents total membership across all BCBS health plans excluding Elevance Health. Source: October 2024 CMS enrollment data and S&P Global Ratings.

MA star ratings are a key competitive differentiator

Percentage of MA members (%) in bonus-eligible 4+ rated health plans



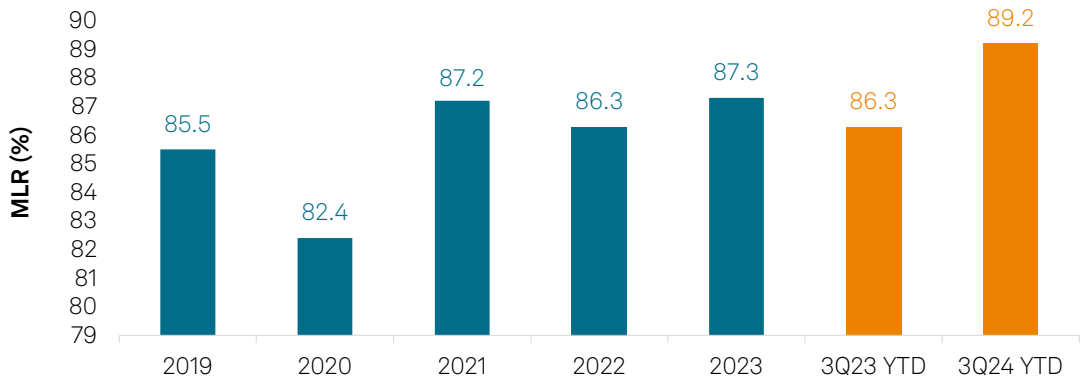
BCBS system (non-ELV)--aggregate of all BCBS health plans excluding Elevance Health. 2024 based on October 2024 enrollment and 2024 Star Ratings (affecting 2025 payments). 2025 based on October 2024 enrollment and 2025 Star Ratings (affecting 2026 payments). Source: CMS and S&P Global Ratings.

Segment Outlooks: MA

We remain cautious about elevated utilization trends in 2025

- **Unit cost pressures from upcoding by providers is a risk in 2025.** Health insurers have called out a regulatory change, the "two-midnight rule" implemented in 2024, as lifting inpatient admissions. Health insurers likely varied in how they incorporated this risk in their MA pricing for 2025.
- **Elevated utilization for a third year in a row in 2025.** Health insurers started to note higher-than-expected utilization, particularly of outpatient surgeries in 2023. In 2024, this trend continued, along with higher specialty drug spend due to IRA-driven Medicare Part D changes, as well as significant supplemental benefits usage. We expect similar pressure points in 2025.
- **For 2026, CMS' preliminary MA rates are favorable.** The favorable rate update primarily reflects higher utilization seen in fee-for-service Medicare (the basis for MA rates). The Trump Administration has a chance to slightly adjust these rates when it finalizes them in April 2025.
- **Proposal for Medicare to cover GLP-1 drugs for weight loss in 2026 adds some risk.** Health insurers should be able to incorporate this change--if the Trump Administration approves it—into their 2026 pricing for MA-PD and stand-alone Medicare Part D products. However, high prices and limited supply of these drugs will be another area of risk for 2026.

Sector-level MA MLR increased in 2024



MLR based on aggregate NAIC Health statutory financials. MLR excludes changes in unearned premiums and reinsurance recoveries. Source: S&P Capital IQ and S&P Global Ratings.

Favorable preliminary MA Rates for 2026

Impact	2025 advance notice	2025 final	2026 advance notice
Effective growth rate	2.44%	2.33%	5.93%
Rebasing/re-pricing	TBD	0.07%	TBD
Change in Star Ratings	-0.15%	-0.11%	-0.69%
Risk model revision / FFS normalization	-2.45%	-2.45%	-3.01%
Avg. MA revenue change	**-0.16%**	**-0.16%**	**2.23%**
Avg. MA revenue change (with risk score trend)	3.70%	3.70%	4.33%

Note: FFS-fee-for-service. Source: CMS and S&P Global Ratings.

Segment Outlooks: MA

Company comments on MA growth and margins in 2025

UnitedHealth: Total MA membership growth of up to 800,000 in 2025 (exceeding industry growth); strong annual enrollment period represents 50% of total growth in 2025; higher overall MLR guidance for 2025 reflects the MA rate cut, provider upcoding, and elevated specialty drug spend due to Part D changes; **on MA margins "not a lot of catch up" they need to do relative to target margins.**

Humana: Individual MA membership decline of a "few hundred thousand" (5%-10%) in 2025 due to product changes including plan/county exits, to improve margins; **MA margin improvement should occur in 2025 but will be limited by how much they could change products in 2025, as well as necessary Star Rating investments in 2025;** weak MA Star Ratings for 2025 (affecting 2026) is a headwind for reaching the target MA margin of 3% in 2027.

CVS Health: Total MA membership decline of 5%-10% in 2025 due to product changes including plan/county exits; have restructured problematic supplemental benefits such as FlexCards and dental; **possible MA margin improvement of 100-200 bps in 2025 (as of August 2024 comments), bolstered by higher 2024 Star Ratings (affecting 2025);** operational issues in managing MA members should not recur in 2025; MA book running at a modest negative margin in 2024; multi-year recovery to reach target MA margins of 3%-5%.

Centene: MA membership decline of about 20% in 2025 due to strategy to refine MA footprint to align with Medicaid business; exited six states for 2025; focus is on dual-eligible members (about 40% of Medicare book today); **MA margins are currently negative, goal is to get to breakeven by 2027;** making progress on MA Stars, 55% of members are in health plans with 3.5+ Star Ratings (post-appeal), goal is 85% by October 2025.

Elevance: Individual MA membership growth of 7%-9% will be above industry growth in 2025 due partly to stronger retention; the company believes it took the right actions in 2024 (exiting underperforming markets, making benefit reductions) to set up for stronger growth year in 2025; it acknowledged that it stopped paying broker commissions on select MA products for 2025; **MA margins were below target of 3%-5% in 2024, slight improvement is expected in 2025, though still not at target levels.**

The Cigna Group: On track for Q1 2025 divestiture of its Medicare business to Health Care Service Corp.; **2024 margins likely to fall below Cigna's target of 4%-5%.**

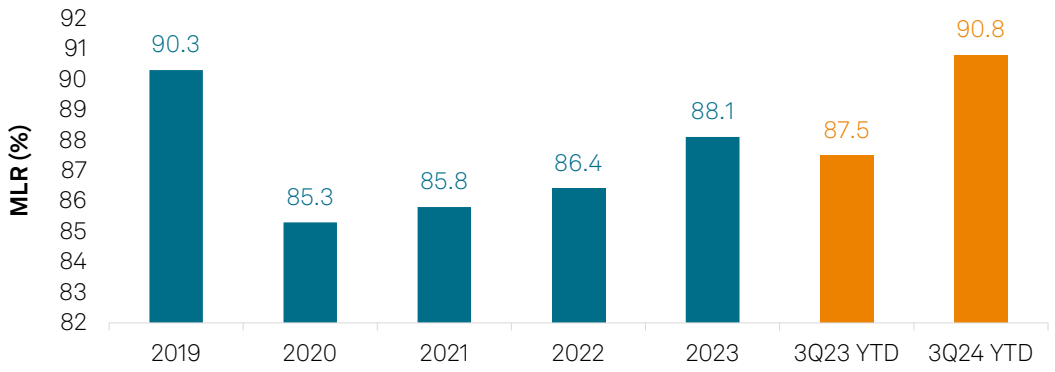
Source: Company filings and transcripts, S&P Capital IQ, S&P Global Ratings.

Segment Outlooks: Managed Medicaid

Temporary earnings pressure from inadequate Medicaid rates related to redeterminations

- **The primary issue in 2025-2026 is a temporary mismatch between capitation rates received by companies—and the increased health acuity of members, a change stemming from redeterminations process.**
- Redeterminations, completed in 2024, led to substantial losses in Medicaid membership, particularly among low acuity members who typically incur lower average medical costs than those who retained coverage.
- Some companies said that the medical cost trend during parts of 2024 was running at unprecedented multiples (2x-5x) of typical levels.
- **The sector should benefit from higher Medicaid rates in 2025-2026, which should help increase segment margins toward target levels (2%-4%)**
- Federal regulations mandate that states establish Medicaid rates that are actuarially sound, supporting rates that are higher than historical averages.
- Nonetheless, states face varying budgetary situations and have some discretion in setting these rates, often relying on outdated data.
- Consequently, rate increases may take time, and the sector may need more than one annual rate cycle to get adequate rates.

Sector-level Medicaid MLR increased in 2024



MLR based on aggregate NAIC Health statutory financials. MLR excludes changes in unearned premiums and reinsurance recoveries. Source: S&P Capital IQ and S&P Global Ratings.

Company comments on size and pace of rate increases

Centene	Avg. rate increase of 4.5%-5% in H2 2024, 3%-4% in 2025 Rate cycle is ~35% on 1/1, 15% on 4/1 (incl. NY), ~50% 7/1-10/1
CVS Health	Rates won't be fully resolved in 2025 Rate cycle is nearly half the book on 1/1
Elevance Health	2024 rate updates have been among the highest in a decade Rate cycle is split roughly half between H1 and H2
Molina Healthcare	On-cycle rate adjustments in Q3 2024 averaged 4.5% Rate cycle is ~55% of premiums in Q1, ~10% in Q2, ~35% in H2

Source: Company filings and transcripts, S&P Global Ratings.

Segment Outlooks: Managed Medicaid

Favorable long-term growth prospects, clouded by legislative/regulatory risks

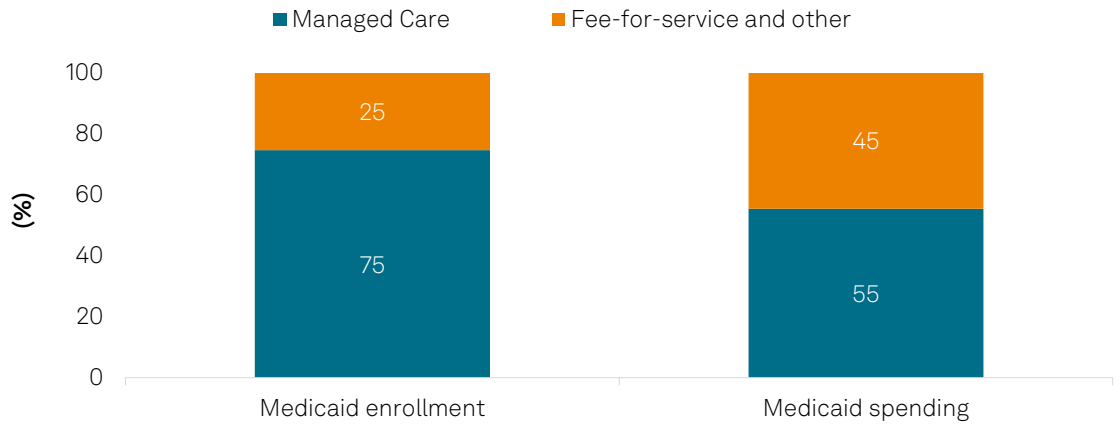
- **Medicaid contract wins and losses will continue to add volatility to each company's enrollment and earnings, as contracts can be relatively large and below-target margins in the first one to two years of a new contract.**
- The Medicaid request-for-proposal (RFP) calendar is relatively light for 2025.
- As usual, we expect Medicaid contract awards will be highly contested. Unsuccessful bidders often protest the awards, which can result in revised awards and delayed contract implementation dates.
- **We have a stable long-term outlook on Managed Medicaid based on normalized rates after 2025-2026 and favorable growth prospects from contracts covering complex, high acuity populations (see chart below).**
- However, this outlook is clouded by the high likelihood that the new administration and Congress will discuss (but not necessarily implement) changes that will cut federal Medicaid funding and lower enrollment. Companies would likely have time to adjust to major changes, though the segment would face weaker long-term growth prospects.

RFP calendar in 2025

December 2024 - Delayed	Illinois D-SNP *Award*	79,000 members	Incumbents: Aetna, BCBS IL, Humana, Meridian, Molina
February - March 2025	Nevada *Award*	674,000 members	Incumbents: UnitedHealthcare, Elevance, Centene, Molina
March 2025	Florida Children's Medical Services *Award*	88,000 members	Incumbent: Centene
Summer 2025	Illinois *RFP Release*	2.8 million members	Incumbents: Aetna, BCBS IL, Meridian, Molina, CountyCare
December 2025 - February 2026	Texas STAR Kids *Award*	150,000 members	Incumbents: Aetna, BCBS TX, Centene, Elevance, UnitedHealthcare, and four others

Source: Health Management Associates and S&P Global Ratings.

Sizable opportunity to manage more Medicaid spending



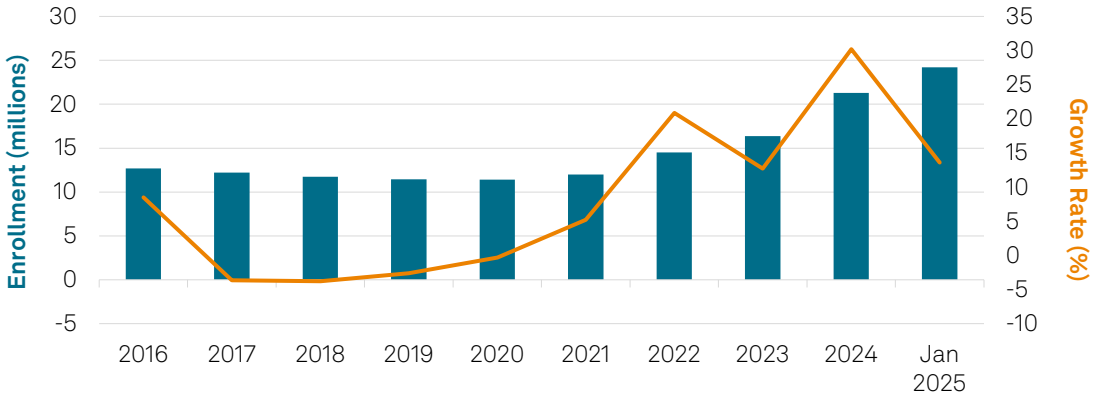
Note: Complex, high acuity populations include Medicaid populations such as the Aged, Blind & Disabled (ABD) and those requiring Long-Term Services & Supports (LTSS) in fee-for-service Medicaid. Source: Medicaid enrollment based on MACPAC (2022 data, the 2024 report), Medicaid spending based on KFF (2023 data), and S&P Global Ratings.

Segment Outlooks: Will ACA Marketplace Enrollment Peak In 2025?

Enhanced subsidies for consumers will expire at the end of 2025

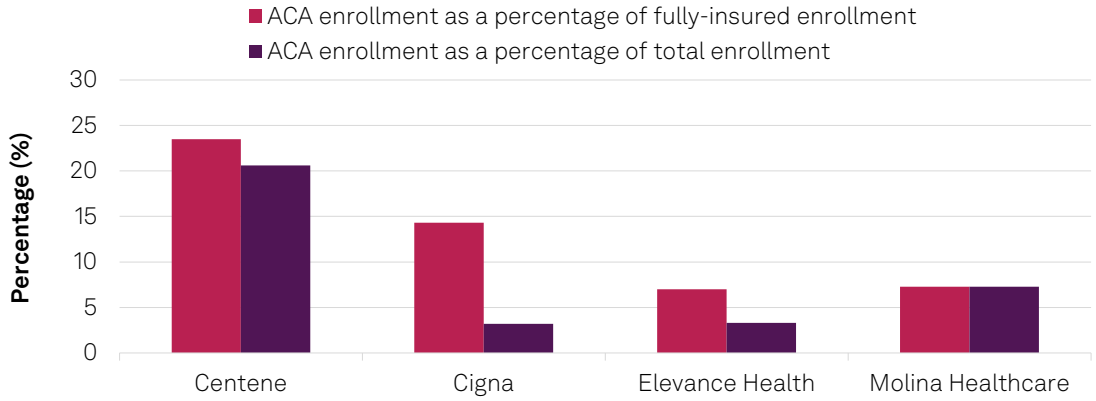
- **The ACA Marketplace, the smallest of the major segments, is seeing record enrollment, with 24.2 million consumers enrolled as of January 2025.**
- Enrollment has nearly doubled since 2021 due to enhanced premium subsidies (from the 2021 legislation), greater marketing and outreach, and effective distribution efforts (helped by lower premium products).
- We expect solid growth in 2025, though lower than in 2024 because of less growth from Medicaid redeterminations (completed in 2024) and regulatory measures affecting distribution and subsidy eligibility checks.
- **The primary issue in 2025 is whether the enhanced premium subsidies will get extended (but reduced) beyond 2025 by Congress.**
- **In a worst-case scenario, ACA enrollment could fall by 20%-30% during 2026-2027 based on CBO estimates.** The sector would likely increase premiums significantly, expecting a worsening risk pool.
- Centene, the leader in ACA enrollment, estimates that the worst-case scenario, which they view as unlikely, would translate to a ~$1 EPS headwind (14% of its 2025 adjusted EPS guidance of at least $7.25).

ACA enrollment growth has accelerated since 2021



Note: Enrollment reflects individuals who selected an ACA Marketplace Plan. Source: Kaiser Family Foundation, CMS (for January 2025 data) and S&P Global Ratings.

Modest to moderate ACA segment exposures



Note: Based on Q3 2024. ACA enrollment includes all individual product enrollment. Source: Company filings and S&P Global Ratings.

Segment Outlooks: Will ACA Marketplace Enrollment Peak In 2025?

It's not all or nothing on the enhanced premium subsidies

- **If Congress extends the enhanced subsidies, the CBO estimates that it would cost the federal government about $335 billion for 10 years.**
- Alternatively, Congress could also extend the subsidies but reduce them. For example, they could reinstate the maximum income threshold for receiving subsidies (400% of the Federal Poverty Level [FPL]).
- **In the scenarios where the enhanced subsidies are partly or fully removed, some states may decide to limit the impact by funding (or "filling in") part of the enhanced subsidies.**
- **The enhanced subsidy issue primarily affects 2026, though it could also affect 2025.** The sector could experience medical cost pressure in late 2025 if ACA members "pull-forward" their medical utilization in anticipation of losing coverage in 2026.
- **For 2026, the sector would face pricing risks in estimating enrollment losses and changes in the risk pool.** However, they should be able to submit "dual-filings" for their ACA products for 2026, which cover two subsidy scenarios—an approach allowed by regulators in 2022.

Maximum individual contribution to ACA premiums

For a Benchmark 'Silver' Plan in 2025 (Illustrative)

Household income (% of FPL)	Enhanced subsidies	No enhanced subsidies
Less than 150%	0%	1.8%-3.64%
150% - 199%	0%-2%	3.6%-5.7%
200% - 249%	2%-4%	5.7%-7.3%
250%- 299%	4%-6%	7.3%-8.6%
300% - 399%	6%-8.5%	8.65%
400% and higher	8.5%	Not eligible for subsidies

Source: KFF, CBO, and S&P Global Ratings.

Annual timeline for insurer premium filings

March 2025	Insurers plan rate filing submission	**Sept**	Consumers receive 90-day discontinuation notices
April	Insurers begin submitting filings to states	**Oct**	Consumers receive 60-day renewal notices
May	State rate filing deadlines begin	**Nov**	Open enrollment begins
June-July	State rate filing deadlines and state reviews continue	**Dec**	Open enrollment continues
August	Federal deadline for plan withdrawal and final rates	**Jan 2026**	Open enrollment ends and rates go into effect

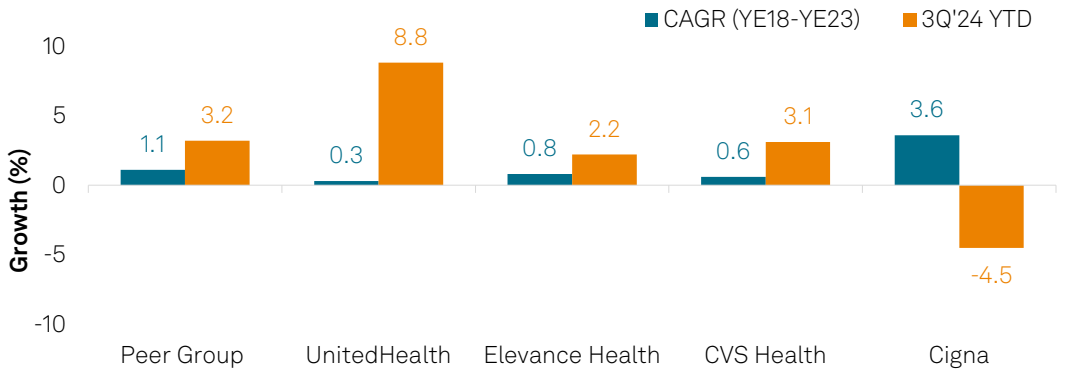
Source: KFF and S&P Global Ratings.

Segment Outlooks: Commercial Segment Will See Modest Growth In 2025

Given solid U.S. economic growth

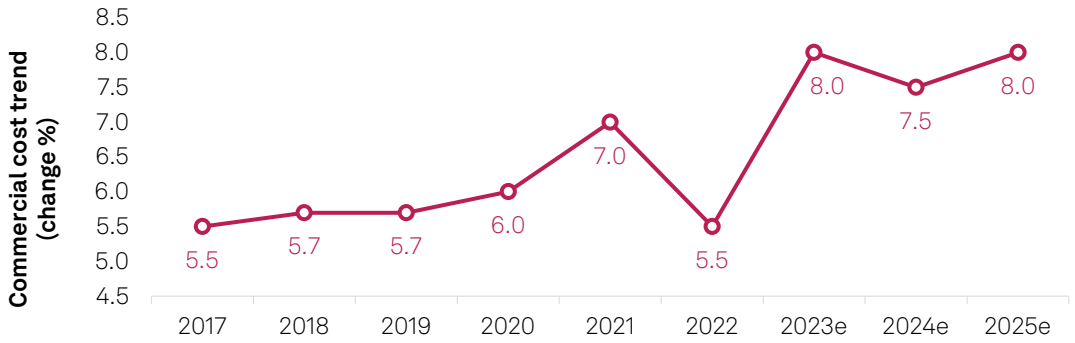
- **We have a stable outlook on the commercial group segment, the sector's largest at 154 million members (37% fully insured, 63% self-funded), according to the Kaiser Family Foundation.** We anticipate modest commercial group enrollment growth in 2025 based on our expectations for solid U.S. economic growth and healthy employment conditions.
- Companies typically gain market share in this segment through product and service innovation and group-level pricing strategies. However, companies can often replicate product and pricing strategies; we expect continued market share trades over time.
- **For 2025, we expect pricing will be broadly disciplined with the lower MLR risk than in other segments.** However, CVS Health and some BCBS health plans observed some MLR pressure in their commercial group business in 2024, which could carry over to 2025.
- **Pricing needs to remain disciplined as medical cost trend continues to be elevated compared with pre-pandemic levels of 5%-6%.**
- Higher medical cost trend is driven by higher provider unit costs, pharmacy costs (for drugs such as GLP-1s), and expanded behavioral access and utilization.

Commercial group/individual membership growth



Note: Cigna's growth would be -2.1% for Q3 2024 YTD excluding the individual business.
Source: Company filings and presentations, S&P Capital IQ, and S&P Global Ratings.

Health insurers are pricing for higher medical cost trend



Note: Commercial group cost trend based on PwC Health Research Institute Study.
Source: PwC Health Research Institute and S&P Global Ratings.

Blue Cross Blue Shield System

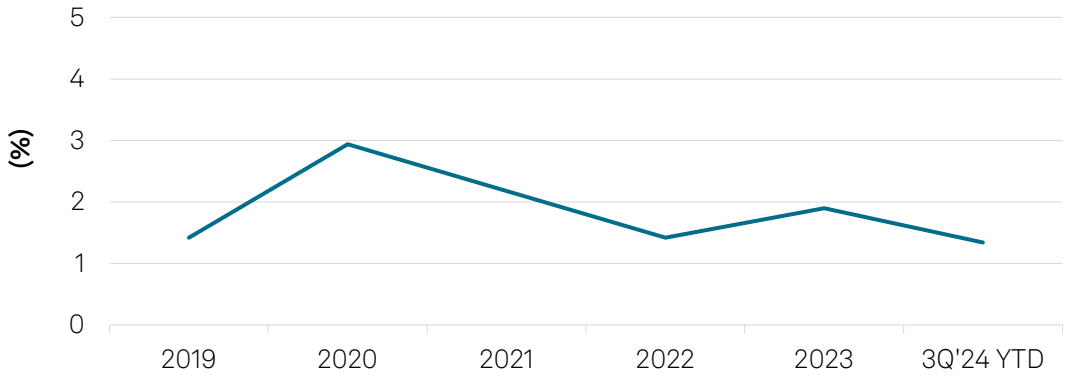
Ratings snapshot & key trends

BCBS System

Rating snapshot and key trends

About one in three Americans is enrolled in a BCBS health plan. We rate 11 of the 33 independently operated BCBS health plans within the BCBS system. BCBS health plans are a mix of not-for-profit, mutual, and for-profit health plans. Ratings on BCBS health plans typically reflect strong local market positions, particularly in commercial risk business, as well as robust capital adequacy and zero to moderate financial leverage. Conversely, geographic concentration, modest operating margins (compared to those of for-profit peers), and limited noninsurance diversification are typically rating constraints.

Rated BCBS health plans: median pretax operating margin



Note: Based on statutory financials. Pre-tax operating margin is defined as operating income (including investment income) as a percentage of operating revenue. Source: S&P Capital IQ and S&P Global Ratings.

Forming JVs and partnerships to leverage collective scale

- Pharmacy services is a growing area of interest for collaboration because of escalating pharmacy costs and competitive landscape concerns. Notable recent collaborations include Evio, which focuses on various pharmacy cost management services, and Synergie, which focuses on medical benefit drug contracting.

Moving to holding company structures for financial flexibility

- BCBS health plans continue to evaluate and pursue holding company structures to improve their financial flexibility, which can make it easier to invest in noninsurance businesses. Companies that have recently restructured (or are in the process of doing so) include Horizon BCBS, BCBS North Carolina, and Blue Shield of California.

Anti-trust settlements may change intra-Blues competition

- The BCBS *subscriber* anti-trust lawsuit settlement (reached in 2020) allowed BCBS plans to pursue more non-Blue branded business and allowed a “second Blue bid” for certain national accounts. The *provider* anti-trust lawsuit settlement (reached in 2024) will make changes to the BlueCard program, as well as provider contracting.

Occasional M&A activity

- Elevance Health's aborted deal to acquire BCBS Louisiana in 2024 will likely put a pause on for-profit/not-for-profit deals for awhile. Meanwhile, HCSC is likely to close its acquisition of Cigna's Medicare business in Q1 2025. Excellus BCBS is seeking to affiliate with CDPHP to bolster its New York State presence.

Ratings List

Company	Financial strength rating/outlook	Holding company long-term rating/ outlook/short-term rating
Elevance Health Inc.	AA-/Negative	A/Negative/A-1
Health Care Service Corp.*	AA-/Negative	NR
Kaiser Foundation Health Plan Inc.	AA-/Stable	NR
UnitedHealth Group Inc.	AA-/Stable	A+/Stable/A-1
Blue Cross & Blue Shield of Florida Inc.	A+/Stable	NR
Blue Cross & Blue Shield of North Carolina	A+/Negative	NR
BlueCross BlueShield of Tennessee Inc.	A+/Stable	NR
The Cigna Group	A/Stable	A-/Stable/A-2
HealthPartners Inc.	A/Negative	NR
Highmark Inc. (d/b/a Highmark BCBS & Highmark Blue Shield)	A/Stable	NR
Horizon Mutual Holdings Inc. (Horizon BCBS of New Jersey)	A/Negative	BBB/Negative
Louisiana Health Service & Indemnity Co.§	A/Stable	NR
Aetna Inc.	A-/Negative	BBB/Negative
Blue Cross & Blue Shield of Minnesota	A-/Stable	NR
Blue Cross Blue Shield of North Dakota	A-/Stable	NR
Centene Corp.	A-/Negative	BBB-/Negative
Humana Inc.	A-/Stable	BBB/Stable/A-2
Excellus Health Plan Inc.	BBB+/Stable	NR
Blue Cross & Blue Shield of Rhode Island Inc.	BBB/Stable	NR
Molina Healthcare Inc.	NR	BB/Stable

Ratings as of Jan. 27, 2025. *Health Care Service Corp. d/b/a Blue Cross Blue Shield of Illinois, New Mexico, Oklahoma, Texas and Montana. §Louisiana Health Service & Indemnity Co. (d/b/a Blue Cross and Blue Shield of Louisiana)
Source: S&P Global Ratings.

Related Research

- Industry Credit Outlook 2025: Health Care, Jan. 14, 2025
- U.S. Not-For-Profit Acute Health Care 2025 Outlook: Stable But Shaky For Many Amid Uneven Recovery And Regulatory Challenges, Dec. 4, 2024
- Economic Outlook U.S. Q1 2025: Steady Growth, Significant Policy Uncertainty, Nov. 26, 2024

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