Premium Impacts of POS Rebate Implementation in the ACA Market in the State of Indiana

Commissioned by PhRMA

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Background

Pharmaceutical manufacturers often give significant rebates to pharmacy benefit managers (PBMs), payers (including plan sponsors and health plans), and others in the pharmacy supply chain on brand medications in exchange for favorable formulary placement and other demand incentives. Typically, payers use these rebates to reduce their pharmacy liability, which often translates into lower premium rates for all members.[1] Recent legislation in several states has required rebates to be passed along to members at the point of sale who use those prescription drugs. For members whose out-of-pocket costs are based on the cost of the drug (i.e., a coinsurance benefit or deductible), netting the rebates at the point of sale would reduce their out-of-pocket cost.

On May 4, 2023, Indiana Governor Eric Holcomb signed Senate Enrolled Act 8 into law, requiring health plans to pass manufacturer rebates directly to members in the Affordable Care Act (ACA) Individual market at the point of sale (POS) beginning January 1, 2025.[2] POS rebates reduce the gross cost of a rebated drug, and therefore, also reduce cost sharing for patients using those drugs when they pay a percentage of the gross cost (i.e., if they are subject to a deductible and / or coinsurance). In turn, under a deductible or coinsurance benefit structure the health plan forgoes a portion of the manufacturer rebate and their portion of claim costs increases. Plans generally reflect any changes in the plan's share of claim costs into their premiums.

PhRMA commissioned Milliman to study how the implementation of POS rebates impacted premiums in the Indiana ACA Individual market.[3] The ACA Individual market consists of medical health plan offerings to a single individual or family. In analyses conducted prior to the enactment of Senate Enrolled Act 8 in Indiana and similar legislation in other states, it was estimated POS rebates in the commercial market were could increase premiums by roughly 0.5% to 1.0%.[4,5,6]

In this paper, we study actual 2025 Indiana ACA Individual market rate filing submissions to understand whether actual premium changes are consistent with these expectations. Upon review of information disclosed in the publicly available materials from 2025 Indiana ACA Individual market rate filings, we did not find evidence the passing of Senate Enrolled Act 8 had a material impact on premium rates in Indiana.

ACA Rate Filings

Carriers in the ACA market are required to submit annual rate filings in early summer (typically May through July) for the following year. These filings explain how premiums were developed and are reviewed, and sometimes adjusted, by each state's department of insurance.

At a high level, premiums are developed in three steps:

1. Project plan claim costs: Claims from the prior full year are trended forward and adjusted for changes in expected member demographics, plan enrollment, morbidity, benefits, manufacturer rebates, and any other changes that may impact plan claim costs.

2. Incorporate risk adjustment transfers, reinsurance receipts (if applicable), administrative expenses, taxes and fees, and margin: These additional amounts are added to (or subtracted from) the projected plan costs.

[1] https://www.milliman.com/en/insight/A-primer-on-prescription-drug-rebates-Insights-into-why-rebates-are-a-target-for-reducing
[2] https://iga.in.gov/legislative/2023/bills/senate/8/details
[3] Senate Enrolled Act 8 does not require Small Group ACA plans to reflect manufacturer rebates at the point of sale.
[4] https://www.milliman.com/-/media/milliman/pdfs/2022-articles/1-19-22-measuring-impact-point-of-sale-rebates-commercial-health-insurance-market.ashx
[5] https://www.milliman.com/-/media/milliman/pdfs/2023-articles/6-5-23_pos-rebate-study-colorado-hb-1370.ashx
[6] https://www.sciencedirect.com/science/article/abs/pii/S1098301522021416

3. Determine member premiums: Average premium is calculated for individual members using a base premium and adjusting for allowable rating factors (i.e., benefit design, geographic area, age, family size, and tobacco use).

Any expected premium impact due to the implementation of POS rebates would be reflected in the projection of plan claim costs. Prior year claims would reflect rebates collected ***after*** the POS, so plans would need to reflect the expected impact of lost rebates in their projection of next year's costs. There is no specific requirement regarding where an adjustment would need to be made or whether it needs to be explicitly disclosed. Carriers may reflect the impact of POS rebates as an adjustment to prescription drug cost trend, an explicit "other" adjustment to projected allowed costs, an adjustment to benefit relativities, or elsewhere in the filing.

States make ACA filings publicly available, though the content may be limited depending on the state. Some states allow carriers to redact information that may be considered trade secret. Rebate information, in particular, is often redacted due to its confidential nature for both payers and pharmaceutical manufacturers.

Reported Premium Impacts[7]

To assess the premium impact of the implementation of POS rebates imposed by Senate Enrolled Act 8, we reviewed publicly available individual filings for plan year 2025.

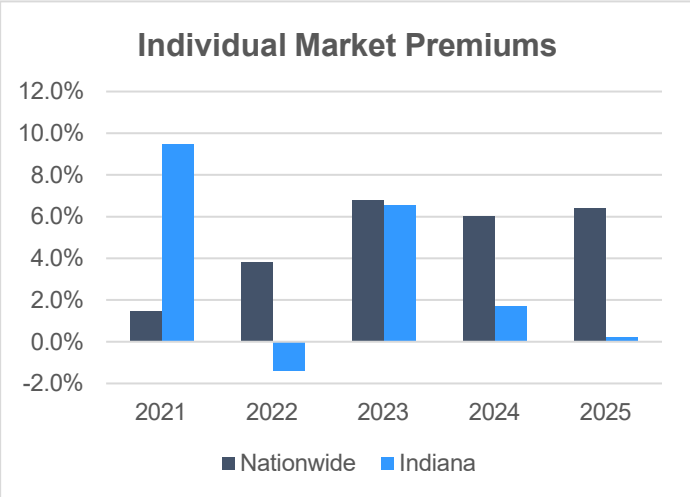
In Indiana, one payer (of seven in the market) that noted an explicit adjustment in its filing, stating there is "an estimated impact of 0.34% of premium" attributable to the implementation of Senate Enrolled Act 8.[8] This market share represents approximately 2,500 members (or roughly 1.4% of the Indiana ACA Individual market).

The remainder of the plans in the market (representing about 181,700 members or 98.6% of the Indiana ACA Individual Market) did not publicly disclose whether or not they made an adjustment to premiums to reflect the implementation of Senate Enrolled Act 8. It is reasonable to assume that some plans did not make an adjustment for the law and others made an adjustment but did not disclose it in their public rate filing under the redaction of trade secret information.

We also reviewed overall rate increases for Individual ACA plans in Indiana relative to other states. In 2025, Indiana rate increases were lower than nationwide averages (0.2% in Indiana compared to 6.4% nationwide), and considering POS rebates would typically be expected to produce a small increase in premium, it does not appear Senate Enrolled Act 8 caused a meaningful increase in premium. However, it is not possible to isolate the impact of Senate Enrolled Act 8 on Individual ACA premiums in Indiana based on available data.

Average rate changes reported in the Uniform Rate Review Template[9] from 2021 to 2025 for Indiana and nationwide are shown in Figure 1.

FIGURE 1: 2021 to 2025 Average Rate Change for Indiana and Nationwide



[7] Rate increases were calculated as the "current" membership and premium weighted average (consistent with URRT averaging logic) of submission level rate increases reported in the URRT
[8] https://filingaccess.serff.com/sfa/search/filingSearch.xhtml
[9] https://www.cms.gov/marketplace/resources/data/rate-review-data

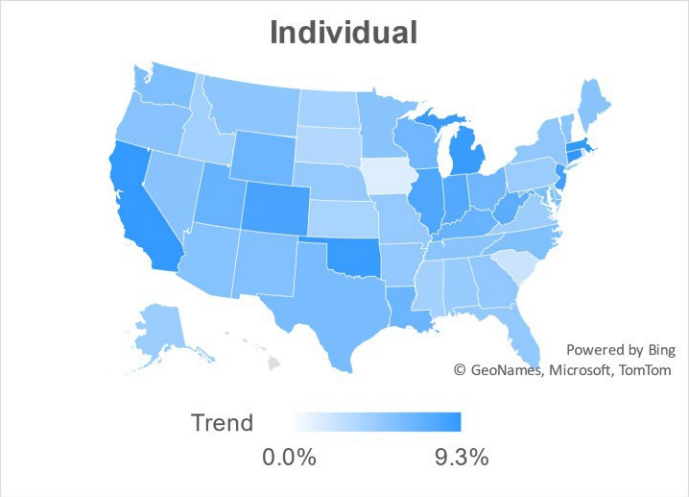
Prescription Drug Trends

Further, we reviewed prescription drug cost trends reported in the same public rate filings. All else equal, Senate Enrolled Act 8 would be expected to decrease POS drug costs, which carriers may have reflected in their assumptions. For this analysis, we utilized the trend information from the Part I Uniform Rate Review Template[10] for pricing year 2025 from the Centers for Medicare and Medicaid Services Rate Filing Justification for Single Risk Pool Plans that all carriers are required to submit for ACA filings. We also utilized public versions of actuarial memoranda submitted for carriers' ACA filings.

The projected prescription drug cost trend from 2024 to 2025 in 2025 Indiana ACA Individual market rate filings was reported between 4.9% and 8.9% for filings that included an experience rating component (i.e., claim experience in the experience period was considered partially or fully credible for pricing purposes), with an average projected prescription drug cost trend across all 2025 Indiana ACA Individual market filings of 7.7% for the 2024 to 2025 projection period for credible filings. Carriers have not explicitly stated a specific trend adjustment for the impact of POS rebates, although it is possible carriers may have included this adjustment elsewhere or spread it across the two years. Indiana's 7.7% prescription drug cost trend was above the nationwide average of 5.8%, with eight states showing a higher trend.

Assumed prescription drug cost trends from 2024 to 2025 included in 2025 Individual ACA filings are shown in Figure 2.

FIGURE 2: 2024 to 2025 Prescription Drug Cost Trend Assumptions by State



Many carriers within the state did not provide detail regarding the development of their prescription drug trend in their Actuarial Memorandum, as trend development can sometimes be considered trade secret information. The development of a carrier's prescription drug trend may adjust for the impact of POS rebates without being explicitly stated.

Conclusion

Upon review of information disclosed in the publicly available materials from 2025 Indiana ACA Individual market rate filings, we did not find evidence the passing of Senate Enrolled Act 8 had a material impact on premium rates in Indiana. This is not inconsistent with prior studies, which showed the premium impact of similar legislation to be less than 1%. Actual impacts may differ from pricing estimates and plans may adjust strategies in light of the change going forward.

[10] https://www.cms.gov/marketplace/resources/data/rate-review-data

Caveats and Limitations

This information was developed to summarize reported prescription drug trends and premium impacts due to POS rebates. This information may not be appropriate, and should not be used, for other purposes.

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We relied upon the Centers for Medicare and Medicaid Services Rate Filing Justification for Single Risk Pool Plans and publicly available rate filing information available through SERFF and the Indiana Department of Insurance. We accepted these items without audit. To the extent the data and information is not accurate or is not complete, the values provided in this report may, likewise, be inaccurate or incomplete.

Michelle Robb is an actuary for Milliman and a member of the American Academy of Actuaries. She meets the Qualification Standards of the Academy to render the actuarial opinion contained herein. To the best of their knowledge and belief, this information is complete and accurate and has been prepared in accordance with generally recognized and accepted actuarial principles and practices.

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