Milliman

2025 Milliman Medical Index

How have healthcare costs changed over the past 20 years?

AUTHORS

Deana Bell, FSA, MAAA **Jason Clarkson,** FSA, MAAA

Brent Jensen, FSA, MAAA **Dave Liner,** FSA, CERA, MAAA

Annie Man, FSA, MAAA, PhD **Andrew Naugle,** MBA

Andrew Timcheck, FSA, CERA, MAAA

20th Anniversary Edition

2025 Milliman Medical Index

In 2025, the cost of healthcare for a hypothetical American family of four in a typical employer-sponsored health plan is $35,119, up from $33,067 in 2024, according to the Milliman Medical Index (MMI).[1]

$35,119
for a family of four

$7,871
for an average person

The MMI segments healthcare costs into five service categories: inpatient facility care, outpatient facility care, professional services, pharmacy, and other services.

Healthcare costs for the average person increased 6.7%, from $7,378 in 2024 to $7,871 in 2025. Outpatient facility care and pharmacy are the primary drivers of this increase, with pharmacy costs rising 9.7% and outpatient facility care costs rising 8.5%. Together, these service categories contributed to 69% of the year-over-year cost increase for the average person.

This year marks the twentieth anniversary of the MMI. Since its inception, the MMI has always quantified the cost of healthcare for the same family of four: a male age 47, a female age 37, a child age 4, and a child under age 1. The MMI family was "mathematically average" when it was created in 2005, with healthcare costs four times that of an individual. However, the composition of a 'typical' family unit and the distribution of healthcare costs among family members has changed significantly in the last 20 years, and this is no longer the case. While we will continue to publish the index based on the original MMI family for tracking consistency with prior versions of this report, we have introduced an interactive tool where users can model healthcare costs using their own definitions of a family.[2] We encourage users to explore different family units and compositions, and to observe how the costs of healthcare vary based on those assumptions.

In its early years, the MMI excluded the effect of pharmacy rebates. Pharmacy costs and pharmacy rebates were much smaller in 2005, and rebates did not have a significant impact on the results. Today, pharmacy rebates are a significant component of the model for financing prescription drugs. We continue to present the MMI family of four cost gross of rebates to ensure the values remain comparable from year to year. However, all other values presented in this report are for an average person and net of pharmacy rebates, unless otherwise noted.

OUTPATIENT FACILITY CARE

Costs for outpatient facility care continue to rise, driven by a combination of clinical and contractual factors. One major contributor to these costs is the increased use and cost of outpatient-administered drugs, including radiopharmaceuticals and high-cost oncology treatments, which are often delivered in hospital outpatient settings. The adoption of new technologies, such as advanced implants and minimally invasive surgical tools, has also added to procedure complexity and associated costs. In addition, reimbursement structures that tie payment to a percentage of billed charges, particularly for drugs and implants, have amplified cost growth, especially in cases where list prices have increased significantly. These dynamics together contribute to the outsized growth seen in the outpatient facility care category.

1 The MMI family of four value ($35,119) represents healthcare costs for a specific family of four, gross of pharmacy of rebates. The average person cost ($7,871) and all other costs in this paper are net of pharmacy rebates unless otherwise noted.

2 See 2025 Milliman Medical Index at www.milliman.com/mmi.

PHARMACY

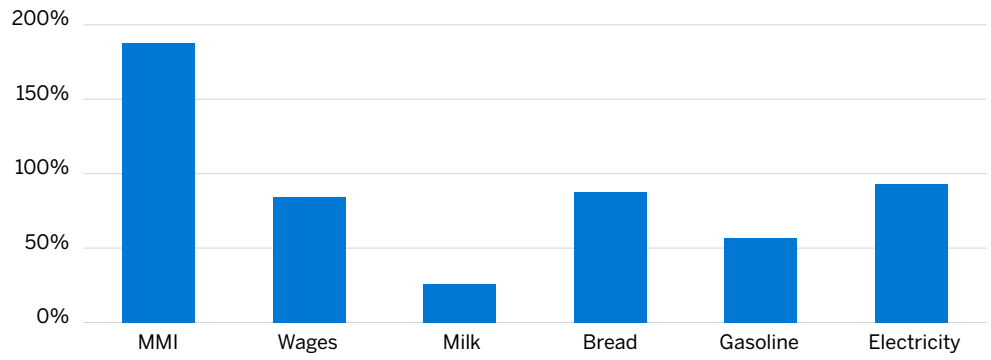
In the 2024 MMI report, we identified U.S. Food and Drug Administration approvals for new drugs or new uses for existing drugs as well as increased utilization of glucagon-like peptide-1 (GLP-1) receptor agonists, such as Ozempic, Wegovy, Mounjaro, and Zepbound, as drivers of prescription drug costs. We anticipate these market forces will continue to contribute meaningfully to prescription drug trends in 2025.

We also anticipate the introduction of additional biosimilars—drugs made from living organisms that are very similar to existing biologic medications—will be a moderating force by increasing competition in the specialty drug market. The impact from biosimilars is reflected in the pharmacy trend.

Looking back (2005–2025)

The 2005 inaugural edition of the MMI reported that the MMI family of four healthcare cost was **$12,214**. That same family's healthcare cost in 2025 is $35,119, almost triple the 2005 amount. Healthcare costs have outpaced wage increases and inflation during this time. Figure 1 shows the 2005 to 2025 percent increase in the MMI compared to median wages and common household items included in the consumer price index (CPI).[3]

FIGURE 1: PERCENT INCREASE OF SELECTED INDICES, 2005–2025



This demonstrates that, when comparing our MMI family's 2005 and 2025 healthcare costs, those costs increased more relative to many other common household expenses.

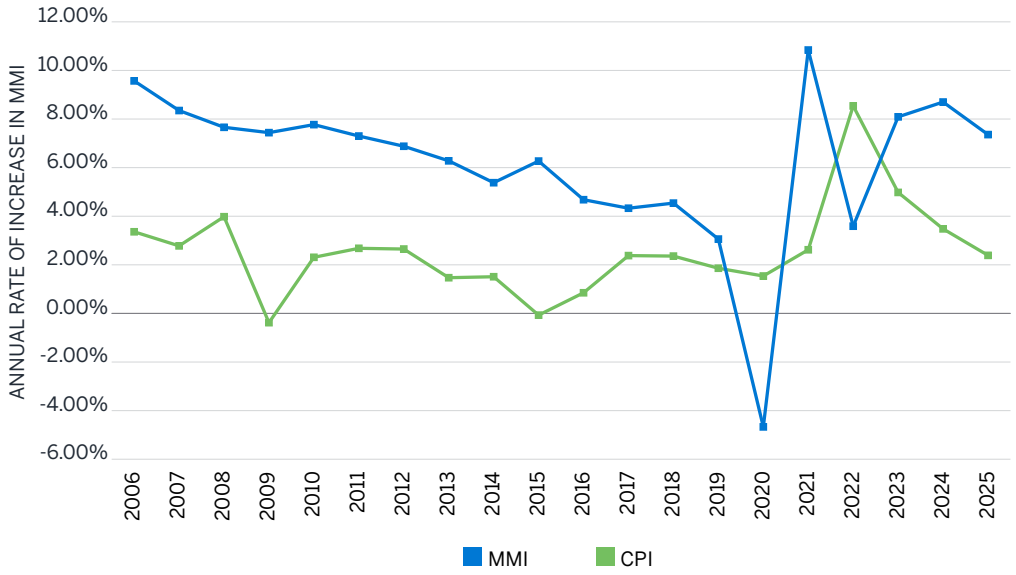
A LOOK AT HEALTHCARE TREND (2005–2025)

The average annual increase in the MMI has been 6.1% throughout its twenty-year history. This compares to an average inflation rate of 2.5% during the same period. Figure 2 summarizes the annual change in MMI and the Consumer Price Index for All Urban Consumers (CPI-U) by year.[4]

3 Data from U.S. Bureau of Labor Statistics: Median earnings represent median usual weekly earnings of full-time wage and salary workers from first quarter 2005 to first quarter 2025 (**https://www.bls.gov/charts/usual-weekly-earnings/usual-weekly-earnings-over-time-total-men-women.htm**). Other items are from the consumer price index average price data from March 2005 to March 2025 (**https://www.bls.gov/charts/consumer-price-index/consumer-price-index-average-price-data.htm**). Retrieved May 10, 2025.

4 Data from U.S. Bureau of Labor Statistics: Consumer price index for all urban consumers (CPI-U) from March 2005 to March 2025 (**https://data.bls.gov/timeseries/CUUR0000SA0**). Retrieved May 10, 2025.

FIGURE 2: PERCENT CHANGE IN MMI AND CPI-U



The MMI increase has outpaced inflation for most years during the MMI's history except during the COVID-19 pandemic disruption from 2020 to 2022, which affected each index in different ways and at different times.

MIX BY SERVICE CATEGORY

The MMI segments healthcare costs into five categories of services: inpatient facility care, outpatient facility care, professional services, pharmacy, and other services. Note that professional services include costs for all professional fees, including those from physicians and other healthcare professionals, that are incurred when a patient uses a hospital, clinic, surgical center, stand-alone lab or imaging center, or a physician's office. Other services include home healthcare, ambulance services, durable medical equipment, and prosthetics.

Growth in the MMI has varied across service categories. Outpatient facility care rose the fastest, from $1,858 in 2005 to $7,173 in 2025. Prescription drugs followed, climbing from $1,785 in 2005 to $5,954 in 2025. Inpatient facility care and professional services also more than doubled while other services grew modestly. Outpatient facility care and pharmacy now represent 37% of the total MMI amount, up from 30% in 2005. Outpatient facility care and pharmacy are the largest trend drivers in more recent years and throughout the MMI's entire history. Figure 3 summarizes costs by service category in 2005 and 2025.

FIGURE 3: MMI ANNUALIZED INCREASE BY SERVICE CATEGORY, 2005-2025

CATEGORY	2005	2025	% INCREASE
Inpatient Facility Care	$3,704	$9,876	167%
Outpatient Facility Care	$1,858	$7,173	286%
Professional Services	$4,527	$11,541	155%
Pharmacy	$1,785	$5,954	234%
Other Services	$339	$575	70%
Total	**$12,214**[5]	**$35,119**	**188%**

5 Note: 2005 total does not add up precisely due to rounding.

EMPLOYEE COSTS

In the employer group insurance market, the total cost of healthcare is shared by employers and employees in three categories.

- **Employer contribution:** Employers that sponsor health plans subsidize the cost of healthcare for their employees by allocating dollars to pay a large share of the cost. The portion paid by the employer can vary according to the benefit plan option the employee selects.
- **Employee contribution:** Employees who choose to participate in the employer's health benefit plan typically also pay a share of the premiums, usually through payroll deduction.
- **Employee out-of-pocket (OOP) cost:** When employees receive care, they also often pay for a portion of these services via health plan deductibles and/or point-of-service copayments or coinsurance. While these payments are capped by OOP maximums, the costs can still be substantial.

Employee contributions and OOP costs have shifted from 2005 to 2025. Employers still pay most of the bill, but their share decreased from 61% in 2005 to 58% in 2025. Employees now shoulder more through payroll deductions; their contributions rose from 21% in 2005 to 27% in 2025. Employee OOP spending decreased from 18% to 15%, showing that higher employee contributions have displaced lower OOP cost sharing. Figure 4 summarizes employee and employer share of cost in 2005 and 2025.

FIGURE 4: CHANGE IN EMPLOYER AND EMPLOYEE COST SHARING, 2005–2025

	2005	2025
Employee OOP	18%	15%
Employee Contribution	21%	27%
Employer Contribution	61%	58%

While employees are paying more through payroll contributions, they are paying less out of pocket at the point of care. This trend reflects a shift toward plan designs with higher fixed premiums but relatively stable cost-sharing structures. Because OOP maximums have not kept pace with medical inflation, families are somewhat insulated from the full impact of rising healthcare costs in years when they use more services.

A deeper look at the MMI

HOW THE MMI IS CONSTRUCTED

The MMI represents the projected total cost of covered healthcare services for an average person as well as for a hypothetical family of four (two adults and two children) covered under an average employer-sponsored Preferred Provider Organization (PPO) health benefit program for a calendar year. The MMI reflects the following:

- Nationwide average provider fee levels negotiated by insurance companies and preferred provider networks
- Average PPO benefit levels offered under employer-sponsored health benefit programs
- Utilization levels representative of the average for people covered by large employer group health benefit plans in the United States

The MMI plan pays approximately 85% of the total cost of care in 2025, meeting the minimum requirement of 60% for a large employer's health plan under the Affordable Care Act.

HOW THE MMI DIFFERS FROM OTHER INDICES

The MMI dollar amounts are the best estimates of annual healthcare costs grounded in actual health insurance claims incurred over multiple years. The most recent year of data reflects approximately 60 million lives. We have projected it forward from 2023 to 2024 and 2025 using estimated trend rates, and restated past MMI values to reflect information collected since last year's publication.

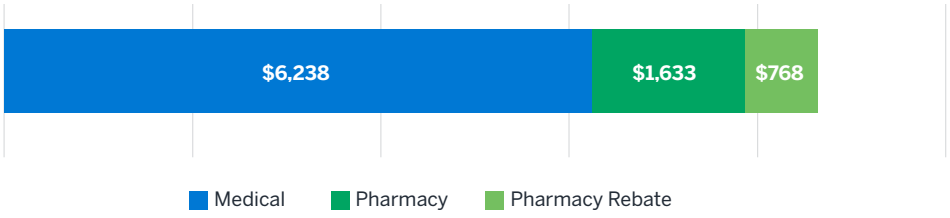
The MMI reflects the most recent data from Milliman's ongoing research on healthcare costs. The MMI is derived from our flagship health cost research tool, **Milliman's Health Cost Guidelines™**, as well as a variety of other Milliman and industry data sources, including **Milliman's Mid Market Survey**, **Milliman MedInsight® Emerging Experience research database**, and **Milliman Health Trend Guidelines™**.

PHARMACY REBATES

Pharmacy rebates are channel incentives negotiated between payers (including pharmacy benefit managers (PBMs)) and life sciences companies for preferred formulary placement and other benefit and plan design features that result in preference for particular pharmaceutical products. Rebate agreements are treated as proprietary information by the parties that negotiate them and thus it can be challenging to assemble a comprehensive picture of the volume and scope of rebates and other channel incentives. Health insurers report rebates and paid drug claims for fully insured businesses in statutory financial statements. However, the rebates for self-insured employers are not publicly available. PBMs typically provide the rebate to employers after paying for the claims with a lag of 90 to 180 days. Changes to the treatment of prescription drug rebates, including returning rebates to the consumer at the point of sale, have been, and continue to be, a hot topic of discussion among PBMs, pharmaceutical manufacturers, and regulators.

In most employer-sponsored PPO plans, rebates do not affect an employee's OOP costs but could reduce employee contributions to their premiums. We project rebates in 2025 to be approximately 31% to 33% of allowed drug costs for an average person for the commercial large group market. Figure 5 illustrates the impact of rebates on the 2025 MMI value for the average person. If employers were not receiving the rebates, the MMI average person cost would have been $768 (or 9.8%) higher.

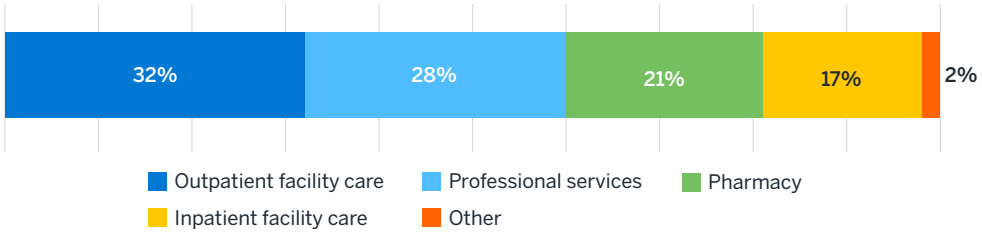
FIGURE 5: ILLUSTRATIVE IMPACT OF PHARMACY REBATE ON THE MMI FOR AN AVERAGE PERSON



COMPONENTS OF COST

Figure 6 shows that outpatient facility care and professional services for the MMI's average person are the two largest components of cost, each accounting for approximately 30% of the total healthcare cost. Inpatient facility cost has slightly decreased its share to approximately 17% while the pharmacy cost net of rebates is expected to increase to approximately 21% of the total cost. Other services remain at 2% of the total cost.

FIGURE 6: 2025 MMI COMPONENTS OF SPENDING FOR AN AVERAGE PERSON



EMPLOYEE SHARE OF COST

Figure 7 shows the cost breakdown of employee and employer share for the MMI average person in 2025. Of the $7,871 total cost for an average person, the employer pays about $4,564 (58% of the total). The employee pays the remaining $3,307 (42% of the total), which is made up of $2,096 in payroll deductions for the employee contribution and $1,211 in OOP costs paid when utilizing healthcare services. The employer's cost would be 11.5% higher if they did not receive pharmacy rebates.

FIGURE 7: HEALTHCARE COST BY SOURCE OF PAYMENT FOR AN AVERAGE PERSON

	AVERAGE PERSON	TOTAL %
Employer Contribution	$4,564	58%
Employee Contribution	$2,096	27%
Employee OOP	$1,211	15%
Total	**$7,871**	**100%**

In addition to the variation in the total cost of care, the distribution of the cost among the five health service categories will be different for the MMI average person and other family compositions. For example, inpatient hospital costs vary by age. For very young people, costs are higher due to complications associated with birth and infancy. A family that includes a child under age 1 may have a higher proportion of inpatient costs than an average person.

The contribution between employer and employee will vary by the size of the organization, industry, location of the employer and employees, the employee's demographics, claim histories, market competitiveness for employees, and the employer's financial health. Additionally, in general, employees with single coverage would pay 20% of their health insurance premiums[6] but employees who elect family coverage would pay 32% of their premiums.[7] This indicates that the contribution to the total cost of care (i.e., allowed cost) by employers can be higher for employees with single coverage compared to those with family coverage. The employer and employees could also benefit from potential tax benefits to fund the total cost of care through lowering the employer's taxable income, providing health savings accounts or health reimbursement arrangements, and receiving tax credits, if eligible.

VARIABILITY IN COSTS

Any family or individual could have significantly different costs. Variables that affect health insurance costs include:

- **Age and gender.** There is wide variation in costs by age, with older people generally having higher average costs than younger people. Variation also exists by gender, driven primarily by maternity costs and differing healthcare needs by gender. Average utilization and costs of specific services will be different for other demographic groups.
- **Individual health status.** Tremendous variation in utilization of services and costs also results from health status differences. People with severe or chronic conditions are likely to have much higher average healthcare costs than people without these conditions.
- **Geographic area.** Significant variation exists among healthcare costs by geographic area because of differences in population density, healthcare provider practice patterns, access to healthcare services, and average costs for the same services. For example, the relative cost of living affects healthcare costs as labor costs (e.g., nurse and technician wages) tend to be higher in areas where the cost of living is higher. Access to advanced technology also affects the utilization of services by geographic area.

6 See U.S. Bureau of Labor Statistics Economic news release (Table 3) at https://www.bls.gov/news.release/ebs2.t03.htm.

7 See U.S. Bureau of Labor Statistics Economic news release (Table 4) at https://www.bls.gov/news.release/ebs2.t04.htm.

- **Provider variation.** The cost of healthcare depends on the specific providers used. Even in the same city, costs for the same service can vary dramatically from one provider to another. The cost variation results from differences in billed charge levels, discounted payment rates that payers have negotiated, and implementation of payment methodologies that may influence utilization rates, such as capitation or case rates.
- **Insurance coverage.** The presence of insurance coverage and the amount of required OOP cost sharing also affect healthcare spending. With all other variables being equal, richer benefit plans usually have higher utilization rates and costs than leaner plans.
- **Provider network and choices.** Although the MMI has been assuming a PPO health benefit program, health maintenance organization plans and narrow network plans could be good choices for some employers that look for cost savings in the lower negotiated provider payment rates.
- **Pharmacy rebate agreements.** Drug rebates are generally paid by pharmaceutical manufacturers to PBMs for preferred formulary placement. PBMs often share a portion of rebates with their health plan and employer clients, but there is wide variation in how much rebates are shared with employers and what employers do with those funds. Some small employers may have difficulty negotiating a market average rebate arrangement with their PBMs.

Acknowledgments

Many have contributed to this work. The authors thank Liam Kussman and Rachel Madden for their technical contributions, Jeremy Engdahl-Johnson and Rebecca Driskill for editorial contributions, and other Milliman professionals for their input and advice.

Solutions for a world at risk™

Milliman leverages deep expertise, actuarial rigor, and advanced technology to develop solutions for a world at risk. We help clients in the public and private sectors navigate urgent, complex challenges—from extreme weather and market volatility to financial insecurity and rising health costs—so they can meet their business, financial, and social objectives. Our solutions encompass insurance, financial services, healthcare, life sciences, and employee benefits. Founded in 1947, Milliman is an independent firm with offices in major cities around the globe.

milliman.com

Milliman

CONTACT

Deana Bell, FSA, MAAA
deana.bell@milliman.com

Jason Clarkson, FSA, MAAA
jason.clarkson@milliman.com

Brent Jensen, FSA, MAAA
brent.jensen@milliman.com

Dave Liner, FSA, CERA, MAAA
dave.liner@milliman.com

Annie Man, FSA, MAAA, PhD
annie.man@milliman.com

Andrew Naugle, MBA
andrew.naugle@milliman.com

Andrew Timcheck, FSA, CERA, MAAA
andrew.timcheck@milliman.com

© 2025 Milliman, Inc. All Rights Reserved. The materials in this document represent the opinion of the authors and are not representative of the views of Milliman, Inc. Milliman does not certify the information, nor does it guarantee the accuracy and completeness of such information. Use of such information is voluntary and should not be relied upon unless an independent review of its accuracy and completeness has been performed. Materials may not be reproduced without the express consent of Milliman.