American Academy of Actuaries

Issue Brief

Drivers of 2026 Premium Changes

JULY 2025

Key Points

- Key medical trend factors influencing premiums in 2026 include: inflation, increased prescription drug spending, and increased demand for behavioral health services.
- Premiums reflect the composition of the risk pool, which is expected to worsen in 2026. In the individual market, key drivers include the federal market integrity rule and the expiration of enhanced premium tax credits. In the small group market, continued shifts to level-funded and self-funded coverage are major factors.
- Premium changes will reflect local market dynamics as well as state legislative and regulatory requirements.
- Many 2026 rate filings were submitted before key federal policies were finalized, requiring insurers to price coverage amid higher-than-usual uncertainty. This lack of clarity around enrollment, utilization, and cost impacts may have led to higher risk margins among some insurers.

Note that this document is intended to describe how premiums may change in the upcoming plan year. It is not intended to be used or relied on by actuaries, insurers, or regulators for rate filings.

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The 2026 individual and small group health insurance premium rate filing process is well underway. Actuaries develop proposed premiums based on projections of medical and prescription drug claims and administrative costs for insured individuals or groups. These projections reflect expected unit costs, service utilization, and the mix and intensity of services—factors that vary by geography and health plan. The composition of the risk pool is also critical, as medical and drug claims depend heavily on the health status of covered individuals. In addition, laws and regulations governing the market, including those related to eligibility, issue and rating rules, financial assistance, and risk mitigation programs, can significantly influence expected enrollment levels, risk pool composition, and projected spending.

This issue brief by the American Academy of Actuaries' Individual and Small Group Markets Committee outlines key factors likely to drive 2026 premium changes for plans operating in the individual and small group markets subject to Affordable Care Act (ACA) rules. Medical trend—driven by unit price and service utilization growth—may exceed historical averages due to continued inflation, rising drug prices, increased use of high-cost therapies, and greater demand for behavioral health services. Recent policy changes are creating added uncertainty regarding impacts on the individual market and appear likely to reduce enrollment, worsen the risk pool, and ultimately, increase premiums. In the small group market, growing use of alternative financing arrangements, such as self-funding and account-based plans, may further erode the small employer risk pool.

Contributors to Medical Trend

Inflation

Although overall inflation has fallen from the early 2020s, it remains above pre-pandemic levels.[1] Inflation contributes to higher input costs for health care services–through higher costs of goods and services, including labor costs. As a result, elevated inflation is expected to lead to higher medical trend.

Increased drug spending

Continued growth in drug spending is expected to be a major driver to premium growth in 2026. Higher expected drug spending is due to higher unit price growth, launches of new expensive gene, cell, and biologic therapies, as well as the increased demand for expensive weight-loss drugs in plans that cover them. While a May 12, 2025, executive order[2] provides incentives for most-favored-nation prices and creates a direct-to-consumer sales entity which may offset some spending, its overall impact, at least in the short term, is expected to be limited. States are also pursuing reforms targeting pharmacy benefit managers, though costs or savings are still uncertain and expected to vary.

Many drugs—particularly newer or high-cost therapies—must be administered by a physician and are frequently covered and delivered under the medical benefit rather than the pharmacy benefit. This category is experiencing significant increases in utilization, and, in combination with the higher cost of many of these therapies, is a major contributor to overall increases in drug spending.

Increased use of behavioral health services

Post-pandemic demand for mental health and substance use disorder services remains high.[3] As states enforce parity laws and insurers expand provider networks or adjust reimbursement rates, the associated increases in cost and utilization are likely to contribute to further premium growth for affected plans.

1 12-month Percentage Change, Consumer Price Index, Selected Categories; U.S. Bureau of Labor Statistics; accessed July 9, 2025.
2 Delivering Most-Favored-Nation Prescription Drug Pricing to American Patients; White House; May 12, 2025.
3 Medical cost trend: behind the numbers 2025; PwC; 2024.

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Special thanks to American Academy of Actuaries Senior Health Fellow, Cori Uccello, MAAA, FSA, FCA, MPP, for her contributions and review of this paper.

Telehealth utilization trends

While telehealth use has declined from pandemic-era peaks, virtual care remains a significant component of the health care system. As utilization stabilizes, it may continue to affect cost and utilization patterns, particularly for primary care and behavioral health services. When setting premiums, insurers are weighing payment parity, utilization trends, and the extent to which telehealth substitutes for or is incremental to in-person visits.

Provider consolidation and site-of-service shifts

Ongoing provider consolidation—including hospital acquisitions and vertical integration—can contribute to higher negotiated payment rates. These increases may reflect greater pricing leverage due to larger size, changes in site of care (such as shifting utilization from professional offices to higher-cost hospital outpatient departments), or changes in provider affiliation that place services under a higher-paying contract. In some cases, organizational structures or operational incentives may indirectly encourage greater use of higher-cost settings. Insurers factor in these dynamics when setting premiums to account for anticipated increases in the cost of care.

Risk Pool Composition Factors

Premiums reflect the composition of the risk pool—the overall level of health care utilization—which is largely driven by the share of the risk pool that is lower cost (healthier) versus the share that is higher cost (sicker).[4] Expected risk pool composition changes in the individual market will likely differ significantly from those in the small group market.

Individual Market

Market integrity rule. Requirements finalized in the CMS Marketplace Integrity and Affordability Rule[5] will significantly tighten enrollment and eligibility verification procedures. As noted in the Academy's comment letter on the proposed rule,[6] these provisions could lead to lower overall enrollment by adding administrative hurdles. While these hurdles may discourage some individuals across the board, healthier or lower-cost individuals may be more likely to forgo coverage entirely—whereas individuals with ongoing health needs may be more motivated to navigate the process. This dynamic could raise adverse selection concerns and contribute to upward pressure on premiums.

4 Risk Pooling: How Health Insurance in the Individual Market Work; American Academy of Actuaries; June 2023.
5 Patient Protection and Affordability Act; Market Integrity and Affordability Rule, Federal Register; June 25, 2025.
6 Comments on the proposed Patient Protection and Affordability Act; Market Integrity and Affordability Rule; American Academy of Actuaries; April 11, 2025.

Expiration of enhanced premium tax credits. The enhanced premium tax credits enacted under the American Rescue Plan Act of 2021[7] and extended under the Inflation Reduction Act of 2022[8] expire at the end of 2025. As a result, both the size of premium tax credits and the pool of individuals eligible for them are expected to be lower in 2026. These reductions are expected to reduce enrollment significantly and increase morbidity in the individual market single risk pool, leading to higher premiums. While heightened awareness of subsidized coverage during the COVID-19 pandemic may offset these effects in part, significant impacts on enrollment and the risk pool are anticipated. Some states are taking action to mitigate a portion of the reduction in premium tax credits, which should reduce the overall degree of impact on the market in those states.

Section 1332 waiver implications. Section 1332 state innovation waivers (the federal ACA waiver program that is most commonly used by states to develop reinsurance programs)[9] are funded with a combination of federal pass-through funding and state funding. Federal funding is determined by the projected premium tax credit and cost-sharing reduction savings generated by the waiver. The expiration of enhanced premium tax credits (and the potential funding of cost-sharing reductions) would be expected to reduce the percentage of the market receiving premium tax credits (or cost-sharing reductions). This would result in reductions in the federal pass-through funding as a result of lower premium tax credit savings, absent other changes to a state's reinsurance program.

A state targeting a similar net premium reduction in 2026 as it provided in 2025 will need to increase funding on a per capita basis to offset the reduced federal contribution. This is likely to require increased total funding from the state. If a state retains current funding levels, the amount of premium reduction achieved by the waiver is likely to be noticeably smaller, which would put additional upward pressure on premium rates.

Medicaid redetermination. While Medicaid redeterminations are largely complete, 2026 will be the first year in which the experience of redetermined individuals is fully reflected in the individual market risk pool, offering more insight into previously uncertain morbidity level effects. In some states, members of this cohort have been younger and healthier, improving the risk profile and placing modest downward pressure on rates. In other states, this cohort appears to have higher health needs, resulting in upward pressure on rates.

However, a significant share of enrollees who shifted from Medicaid may be currently enrolled in $0-premium plans made possible by enhanced premium tax credits. With those subsidies set to expire, these enrollees may face substantial net premium increases.

7 American Rescue Plan Act of 2021; March 11, 2021.
8 Inflation Reduction Act of 2022; Aug. 16, 2022.
9 Section 1332. State Innovation Waivers; Centers for Medicare & Medicaid Services; June 25, 2025.

As a result, insurers may anticipate that many partially subsidized enrollees—especially those with low utilization—will drop coverage in 2026, potentially reversing recent risk pool changes.

Alternative coverage options. Rising premiums and ongoing regulatory changes have led some employers and consumers to explore lower-cost coverage alternatives. Options outside the ACA-compliant individual market—such as Short-Term Limited Duration Insurance (STLDI), Health Care Sharing Ministries, and Farm Bureau plans—may offer lower premiums for healthier individuals. However, these alternatives options often exclude less healthy individuals through limited benefits or underwriting, contributing to a sicker, more expensive risk pool in the ACA market.

At the same time, the individual market has become an alternative for some employers through Individual Coverage Health Reimbursement Arrangements (ICHRAs)[10], which allow employers to fund employee coverage through the individual market. The impact of ICHRA adoption on the individual market risk pool remains uncertain and depends on factors such as the health status of enrollees, adequacy of employer contributions, availability of affordable individual market plans, and employee understanding of how to use these arrangements. Significant adoption of ICHRAs could affect individual market risk pools, increasing premiums if incoming groups are less healthy than the current individual market population or lowering premiums if incoming groups are healthier on average.

Small Employer Coverage

While enrollment in the ACA-compliant individual market has grown, the small group market in most states has continued to experience a slow but steady decline.[11] As healthier employees leave the market, average costs increase, prompting further disenrollment and creating a feedback loop that can drive up premiums. This dynamic can be accelerated when small employers have access to alternative coverage options outside the ACA-compliant small group pool.

Level-funded and self-funded small group coverage. While fully insured coverage in the small group market is subject to the single risk pool requirement, most provisions of the ACA do not apply to self-funded coverage. In the small group market, the most common type of self-funded plan structure is referred to as level funding. Under level funding arrangements, an employer purchases stop loss insurance and then pays an expected average monthly cost amount into a fund that is used to pay for claims up to the stop loss

10 Individual Coverage Health Reimbursement Arrangements; Centers for Medicare & Medicaid Services; July 2025.
11 Final Risk Adjustment Summary Reports for Benefit Years 2018–2024, Appendix A (billable member-months by market segment).

attachment point. These arrangements can reflect the health status of the specific small employer, which allows employers with covered members who are healthier than the rest of the small group market to access lower total costs for the same level of coverage. Additionally, by self-funding, small employers are not held to the same benefit mandates, other state insurance regulations, and premium taxes that apply to as fully insured plans. The increasing popularity of self-funded options, such as level funded plans, contributes to the continued struggles of the small group single risk pool, as the departure of these healthier members increases the average cost level of those that remain.

Account-based plans. As discussed above, ICHRAs present a unique set of challenges and opportunities in the individual market. The dynamic is somewhat different in the small group market. For employers who are unable to pursue self-funded or level-funded coverage, ICHRAs may offer a more cost-effective alternative. These arrangements can be particularly attractive in areas where ACA-compliant individual market premiums are similar to or lower than small group premiums. Continued movement toward account-based plans and other alternative funding arrangements could further reinforce the shift away from the ACA-compliant small group market.

Other Factors

All health care is local, and so are health premiums

Premium rate changes can vary significantly by geographic area. Premium rates reflect state legislative and regulatory requirements, as well as local market conditions. Examples of state-related factors include Medicaid expansion status, presence/absence of/changes to a reinsurance program, state benefit mandates, utilization management restrictions, public option programs, and supplemental premium or cost-sharing subsidies.

Federal data source availability

While insurers primarily rely on internal data, actuaries also depend on federal and state data sources to assess policy impacts beyond current market conditions. Key sources include reports and datasets from the Census Bureau, the Health and Human Services Assistant Secretary for Planning and Evaluation, the Agency for Healthcare Research and Quality, and assorted public use data from CMS. Recent organizational changes and resource constraints within federal agencies may affect the availability, reliability, or consistency of these data products. Reduced availability or quality of federal data may hinder actuarial analysis and increase the level of uncertainty in actuarial estimates.

Uncertainty and risk margins

Many individual market rate filings were submitted before key federal rules and legislation were finalized, requiring insurers to make pricing decisions amid uncertainty. Even now, the effects of these policy changes on enrollment, costs, and risk pool composition remain uncertain. This elevated uncertainty may have led insurers to include higher-than-usual risk margins in their 2026 filings to account for unpredictable changes in enrollment and costs, contributing modestly to overall premium increases.

Summary

Premiums for 2026 individual and small group health insurance plans are being shaped by a complex mix of medical cost trends, regulatory changes, and shifts in market dynamics. While inflation has moderated, it remains above pre-pandemic levels and continues to drive up input costs for health care services. Rising drug spending—especially for high-cost therapies like gene treatments and weight-loss drugs—along with sustained demand for behavioral health services, are contributing to above-average medical trend. Structural factors such as provider consolidation and changes in telehealth use may also influence cost projections.

In the individual market, the risk pool faces significant disruption. The expiration of enhanced premium tax credits and the implementation of stricter enrollment verification under the federal market integrity rule are both expected to reduce enrollment and increase morbidity, leading to higher premiums. In the small group market, the steady shift toward level-funded and self-funded arrangements continues to erode the single risk pool, especially as healthier employers seek lower-cost options outside the ACA framework.

These pressures are amplified by new and significant uncertainty. Many 2026 rate filings were developed and submitted before key federal rules and legislation were finalized, requiring insurers to make pricing decisions without full clarity on enrollment dynamics, cost impacts, or risk pool shifts. At the same time, reduced availability of federal data sources may limit the ability of actuaries to fully assess market conditions. In response, some insurers may have included higher-than-usual risk margins in their 2026 filings to account for potential unpredictable changes. As always, the effects of these overlapping factors will vary considerably across state and local markets.

Appendix

2026 Illustrative Premium Rate Development Timeline Individual Health Insurance Market

Open enrollment for 2026 individual health insurance market coverage will begin on Nov. 1, 2025. However, developing plan designs and premiums is a process that spans more than a year, with actuaries and insurers starting premium rate development for plan year 2026 as early as fall 2024. The timeline varies based on each insurer's internal business practices, as well as federal and state rate filing requirements. The table below outlines the typical timing of key steps in the rate-setting process.

Approximate Internal Insurer Deadlines (assumes early June submission deadline)	
Product development and experience analysis	Sept. 2024–Feb./March 2025
Plan design development and actuarial value (AV) testing	Nov. 2024–April 2025
Examine prior experience and make necessary adjustments	March 2025
Set target provider reimbursement levels	Early-mid April 2025
Project data based on expected medical and Rx trend	Mid-late April 2025
Obtain internal approvals, finalize rates, prepare filing materials	May 2025
External Deadlines	
Initial rate filing submission deadlines*	May-July 2025 (varies by state)
Final federal marketplace application deadline*	Aug. 13, 2025
Final limited data correction window*	Sept. 12-13, 2025
Rate filing data published	Oct. 15, 2025
Open enrollment begins	Nov. 1, 2025
Plan year begins	Jan. 1, 2026

* State-based exchanges have some flexibility to set their own deadlines, and some follow the federal deadlines.

The premium development process must account for any updates to federal or state rules, such as those related to the benefit and payment parameters or the AV calculator. Timely finalization of these rules helps insurers meet internal timelines and external filing deadlines. Likewise, legislative changes made earlier in the process are more readily reflected in premium rates. Depending on the nature of the change, updating rates to fully reflect new policies—particularly those affecting enrollment, the risk pool, premium tax credits, or other major factors—can take six weeks or more.