GEORGETOWN UNIVERSITY
McCourt School of Public Policy

CENTER ON HEALTH INSURANCE REFORMS

To: Senate Requestors

From: Center on Health Insurance Reforms (CHIR)
Georgetown University McCourt School of Public Policy

Re: Request for Information on Factors Driving 2026 Individual Market Premium Changes

Date: September 2, 2025

Health insurers operating in the Affordable Care Act (ACA) Marketplaces have proposed significant premium rate changes for plan year 2026. The median 18% proposed rate increase doubles last year's median proposed premium increase and is the largest in almost a decade. You have asked CHIR to review the materials health insurers have submitted to support their requested rate changes and analyze how policymakers and Americans should prepare for the changes indicated by the filings. In particular, you have asked CHIR to provide answers to the following questions:

1. What do the double-digit increases in rate filings across states indicate about insurers' calculations regarding plan offerings? Are there specific states you can provide information on?
2. How should policymakers interpret the rate filings related to impact on patient affordability?
3. How would you describe the impact of current tariff policy on insurers' decisions to submit record-high rate filings?
4. What information is available about how the end of the enhanced premium tax credits would interact with changes made to the Marketplace in H.R.1 and impact plan availability and affordability?
5. Do rate filings provide indications about insurer decision-points with regards to Marketplace participation, including changing service areas?

This memo answers these questions and provides information on the regulatory and policy context in which insurers are designing plans, making Marketplace participation decisions, and projecting future costs. Our key findings include:

- Two commonly cited factors driving 2026 rate increases are the expected expiration of enhanced premium tax credits and increasing health care costs.
- As the loss of enhanced premium tax credits makes coverage less affordable, insurers expect enrollment to decline significantly. Healthier individuals will be more likely to drop coverage, and remaining enrollees will be sicker on average, driving up average medical claims costs and premium rates.

- When provided in filings, insurers attributed from 1 to 14 percentage points of 2026 proposed rate increases to the expiration of enhanced premium tax credits.
- A small number of insurers indicate they have built the impact of changing tariff policy on pharmaceutical prices into their proposed rates.
- Insurers expect that federal policies creating new barriers to Marketplace enrollment, including more complex eligibility verification, shorter enrollment windows, and changes to auto-reenrollment, will discourage healthy individuals from enrolling in Marketplace coverage and create a sicker risk pool. Insurers have therefore raised rates in response.
- Although rate filings do not provide substantive insight into insurers' participation decisions, we have seen a smattering of plan withdrawals from Marketplaces over the summer. By mid-September it should be clear whether this will be a larger trend.

About the Center on Health Insurance Reforms (CHIR)

CHIR is an independent, nonpartisan research center that operates within Georgetown University's McCourt School of Public Policy and is composed of leading health policy researchers with deep and nationally recognized expertise in health insurance laws, regulation, policies, and market practices. We conduct research to advance evidence-based policy solutions that improve the U.S. health care system, enabling everyone to access the coverage and care they need at a price they can afford.

Background

Insurers make decisions about market participation, plan and network design, and project future premiums based on health care costs, competitive considerations, and the policy environment within which they must operate. Insurers contemplating participation in the ACA Marketplaces in 2026 face considerable uncertainty due to recent and potential future changes to federal law.

Policy Context

The ACA Marketplaces are a critical source of high quality, comprehensive health coverage for Americans who cannot access health insurance through their employer and do not qualify for public programs such as Medicaid or Medicare. Marketplace enrollees include self-employed entrepreneurs, gig economy workers, freelancers, small business owners, early retirees, and more. These individuals and their families depend on the Marketplaces as a stable and affordable source of insurance coverage.

An estimated 93% of enrollees in Marketplace health plans receive financial assistance in the form of premium tax credits. Under the ACA, the premium tax credits lower the cost of Marketplace plan premiums on a sliding scale based on an enrollee's household income. In 2021, Congress enacted the American Rescue Plan Act (ARPA), which boosted premium tax credits and reduced the amount of income enrollees are required to contribute to premiums. Congress later extended those enhanced premium tax credits through plan year 2025 in the Inflation Reduction Act (IRA) of 2022. The enhanced premium tax credits have significantly improved the affordability of Marketplace health plans (see Table 1).

Table 1. Expected Premium Contributions for Eligible Households Under ACA and with Enhanced Premium Tax Credits, by Household Income

Household Income (as % of federal poverty level)	Expected Premium Contribution Under the ACA*	Expected Premium Contribution Under Enhanced Premium Tax Credits
100 up to 133%	2.10%	0%
133 up to 150%	3.14 - 4.19%	0%
150 up to 200%	4.19 - 6.60%	0 - 2%
200 up to 250%	6.60 - 8.44%	2 - 4%
250 up to 300%	8.44 - 9.96%	4 - 6%
300 up to 400%	9.96%	6 - 8.5%
400+%	No limit	8.5%

*Under the ACA, applicable premium contribution percentages are adjusted annually through guidance from the Internal Revenue Service (known as "indexing"); ARPA and the IRA eliminated indexing through plan year 2025.

Over 24 million people enrolled in ACA Marketplaces in 2025, more than double the number that enrolled in 2020. The enrollment growth over the last four years is largely attributable to the enhanced premium tax credits. Should Congress fail to extend the enhanced premium tax credits, the Congressional Budget Office (CBO) has estimated that 4.2 million people will become uninsured. Those remaining in the Marketplace will face, on average, a 75% increase in their net premiums (the amount they pay after accounting for their premium tax credit). Enrollees at and above 400% of the federal poverty level ($62,600 annual income for an individual, $106,600 annual income for a family of 3) will no longer be eligible for premium tax credits and must pay the full, unsubsidized premium or lose their coverage.

The coverage loss and decline in Marketplace enrollment will be compounded by other recent legislative and regulatory changes. In particular, H.R. 1, the budget reconciliation bill signed into law in July 2025, is projected to cause 10 million people to lose insurance coverage, up to 2.4 million of whom will come from the law's Marketplace provisions. The "Marketplace Integrity" regulation finalized by the Centers for Medicare & Medicaid Services (CMS) in June 2025 is projected to result in up to 1.8 million people losing Marketplace coverage.[1] Nationwide, Marketplace enrollment is projected to decline by as much as 57%. Many of the people who lose their coverage will be relatively young and healthy, as these individuals are more likely to be deterred by the increased paperwork and costs prescribed by H.R. 1 and

[1] On August 22, a federal District Court judge in Maryland stayed, on a nationwide basis, the implementation of several provisions in the Marketplace Integrity final rule. The ultimate outcome of this litigation is unknown. The coverage and premium effects related to the final rule discussed in this memo assume all provisions go into effect on the timeline provided by CMS. *See City of Columbus v. Kennedy*.

the Marketplace regulation. With a smaller and sicker risk pool, insurers must increase their premiums to ensure they can cover their costs.

The Setting and Review of Proposed Health Care Premiums

To set their health insurance premiums for each plan year, health insurers generally assess a range of factors, including:

- Data on enrollees' use of health care services over the past year, and how it differs from their projections;
- Medical inflation (changes in the prices charged for goods and services) and changes in utilization;
- Whether the insurer expects to be a payor or a payee under the ACA's risk adjustment program;
- Changes in benefits;
- Changes in administrative expenses, including taxes and fees;
- The profit margin sought by the insurer; and
- Changes to the overall size and health of the risk pool resulting from federal or state-level policy changes.

Under the ACA, the Secretary of the Department of Health & Human Services (HHS) must work in collaboration with state departments of insurance (DOI) to conduct an annual review of "unreasonable increases in premiums" for non-grandfathered, individual and small-group market health plans. The law sets minimum standards for the review of proposed increases, which include requirements that insurers base their premium rates on reasonable cost assumptions and solid evidence. The law also requires that proposed rate increases be publicly disclosed so that the public can provide input. If a state DOI can't or won't meet those standards, then HHS conducts the rate review process.

Under current rules, plans that propose a premium increase of 15% or more are required to provide a justification for the increase to HHS, which posts those justifications on the HealthCare.gov rate review website.

Rate Review Timeline and Consumer Notices

Health insurers must determine plan designs, service areas, and premium rates long before any consumer enrolls. This year, insurers were developing proposed rates and submitting initial Marketplace applications in the midst of considerable uncertainty over federal legislative and regulatory policy.

For Marketplace insurers, the typical deadline to submit their proposed rates for the next plan year (Jan. 1-Dec. 31) is mid-July. However, many state DOIs require an earlier deadline, with some insurers submitting their rates as early as May 1. Proposed rates from all states were posted by CMS on August 1. This year, due to uncertainty over federal Marketplace policies, CMS has extended the deadline for Marketplace plans to make premium rate changes from August 13 to September 4,[2] if permitted by the

[2] On August 29, 2025, the government filed a notice of appeal in *City of Columbus v. Kennedy.* The motion seeks to reverse the District Court's stay of a Marketplace rule provision that adjusts the allowable ranges of actuarial values for Marketplace plans. In the motion, the government asserts that insurers will need at least one month to revise

insurer's state department of insurance. Insurers have until September 17 to sign their agreements to participate in the ACA Marketplaces, and open enrollment begins on November 1 (see Table 2).

Table 2. Plan Year 2026 Marketplace Plan Data Submission and Certification Timeline

Activity	Dates
Initial Marketplace application due	June 11, 2025
Initial Marketplace rates due	July 16, 2025
Final rate changes due	September 4, 2025
Limited data correction window	September 11-12, 2025
Insurers return final signed Marketplace agreements	September 9, 2025-September 17, 2025
Open enrollment begins	November 1, 2025

Typically, insurers are required to send notices to Marketplace enrollees with their projected premiums for the next plan year, net of any premium tax credits, prior to the start of open enrollment. However, this year HHS announced that insurers would be relieved of this requirement due to the uncertainty over whether Congress will extend the enhanced premium tax credits. As a result, many Marketplace enrollees will not be aware of the likely increase in their net 2026 premiums until they return to the Marketplace and re-apply for Marketplace coverage. Individuals who are auto-renewed may not learn of the change in premium costs until after December 15, giving them a limited window within which to make any changes to coverage that begins on January 1.

Research Methodology and Limitations

To assess the factors underlying insurers' proposed premium rates for 2026, we reviewed actuarial memoranda and other supporting documents for 178 Marketplace plan filings across 28 states and the District of Columbia. Insurers submitted a total of 312 filings for plans to be offered on the ACA Marketplaces. We accessed the filings through HealthCare.gov, DOI websites, and the National Association of Insurance Commissioners' (NAIC) System for Electronic Rate and Form Filing (SERFF). Study states and insurers were selected to reflect geographic, demographic, and market diversity. Insurers in our sample represented a range of plans participating in the ACA Marketplaces, including large national for-profits, Blue Cross Blue Shield companies, regional nonprofit plans, integrated HMOs, and recent market entrants. For a full list of states and insurers included in this review, see the Appendix.

Limitations

The filings reviewed for this study represent insurers' justifications for proposed, not final, 2026 premium rates. Many state insurance departments review these rates and request or require changes

their plans in accordance with the District Court's order, and the agency would need to receive the revised plans and rates no later than October 1, 2025.

before they are implemented. Further, many insurers submitted proposed rates prior to enactment of H.R. 1, and none could predict whether Congress would extend the enhanced premium tax credits. In addition, since rates were submitted, a federal district court has temporarily blocked several provisions of the Marketplace Integrity final regulation and the government has filed a notice of appeal. Uncertainty over the outcome of that litigation could affect insurers' final 2026 premiums. Many insurers have asked regulators for flexibility to amend their filings to reflect an evolving policy landscape. Our review of proposed premium rate filings took place between August 1 and August 15. It is therefore likely that some states have or will permit insurers to make changes to their filings after our review.

An additional limitation is that we were able to review the publicly accessible elements of insurers' rate filings. Many states allow insurers to assert that critical data within their filings is "trade secret." As a result, for a significant number of plans, key elements such as projections of enrollment changes, medical trend, morbidity, and the premium impact of federal-level policy changes were redacted.

What do the double-digit increases in rate filings across states indicate about insurers' calculations regarding plan offerings? Are there specific states you can provide information on?

Proposed rate filings for 2026 indicate that individual market rates are going up next year, often by substantial amounts, driven in large part by Congress's failure to extend enhanced premium tax credits and growing health care costs. On average, proposed 2026 rate increases are the highest seen in almost a decade.

Overview of 2026 Proposed Rate Changes

Rate filings for 2026 coverage in the individual health insurance market show widespread and substantial proposed rate increases. Nationwide, insurers that participate in the ACA Health Insurance Marketplace proposed a median 18% rate increase for 2026. Proposed average rate changes across 312 Marketplace insurers range from a decrease of 10% to an increase of 59%. In total, 307 insurers proposed average rate increases for 2026, while five insurers proposed either no change or an average rate decrease.

How the 2026 Proposed Increases Compare to Other Years

Health insurance rates go up in most years, driven by the growth in health care prices and spending, which generally outpaces inflation. The magnitude of rate changes, however, varies from year to year based on market and policy dynamics.

The median proposed increase of 18% for 2026 is nearly triple the median proposed increases of 6% in 2024 and 7% in 2025.[3] In fact, KFF found that the magnitude of the 2026 proposed increase is the

[3] Limited historical data on proposed rate increases at the insurer-level is available that would allow for an apples-to-apples comparison, unlike other data that likely shows a similar trend, such as the average annual Marketplace premium change by metal tier or final/approved rate increases at the insurer-level.

"largest rate change insurers have requested since 2018, the last time that policy uncertainty contributed to sharp premium increases." A few states have also noted how much higher the 2026 proposed increases are compared to prior years. For example, state insurance regulators said Maryland's 17.1% statewide average proposed increase is the highest increase the state has seen since 2019, and Rhode Island's 23.7% statewide average proposed increase is "the highest in over a decade." Texas's average 24% proposed increase for 2026 is the highest seen since 2018. The Arkansas Center for Health Improvement describes the state's average proposed rate increase of 36.1% as "unprecedented."

Factors Driving the 2026 Proposed Rate Increases

Health insurers adjust rates each year so that premiums will cover projected future health care costs, administrative expenses, and profit. Insurers consider many different factors when setting their rates. In their 2026 filings, insurers frequently cited increasing medical trend and impacts from the expected expiration of enhanced premium tax credits as key drivers of 2026 proposed rate increases, as discussed in more detail below.

Growing Health Care Costs Push Rates Higher

Increasing health care costs are a key driver of health insurance rate changes in 2026, as they are in most years. Rate filings include insurers' assumptions about the year-over-year change in health care costs, referred to as medical cost trend (or "trend"). Trend reflects a combination of projected changes in unit prices (the amount insurers pay for health care goods and services) and utilization. Insurers commonly assumed a 7% - 8% medical trend for 2026 in filings in our sample, and PwC projects a 7.5% medical trend in the individual health insurance market for 2026. For example, Moda Health Plan in Texas noted that "[the] most significant factor contributing to the [14.7%] increase is [its] Texas Individual experience and an 8.0% annual trend."

Impact of health care cost growth

"Premium rates for health care insurance are increasing as the cost of health care services rise. Health care service costs increase as health care providers increase their fees, members use more health care services and supplies, and the types of health care services and supplies change, among other factors. We are projecting that claims will increase by 8.2% in 2026. More than half of the change in health care service costs is driven by changes to health care provider fees." **Keystone Health Plan East (Pennsylvania)**

"The most significant factor contributing to the increase is Moda Health Plan's Texas Individual experience and an 8.0% annual trend." **Moda Health Plan (Texas)**

In their filings, insurers cite a range of factors that underlie the 2026 trend, including higher unit prices for medical services and prescription drugs, anticipated changes in utilization of services, shifts in the mix or intensity of services used, the impact of new technology, and the impact of general inflation. For

example, Keystone Health Plan East in Pennsylvania "project[s] that claims will increase by 8.2% in 2026," and that "[m]ore than half of the change in health care service costs is driven by changes to health care provider fees." In filings across multiple states, Cigna "anticipates that the cost of medical and pharmacy services and supplies in 2026 will increase over the 2024 level because the prices charged by doctors, hospitals, and other providers are increasing," and added that in addition to increasing utilization, "[t]he recent increase in Consumer Price Index (CPI) inflation is adding additional inflationary pressure for network contracts and provider payment mechanisms."[4]

Excellus in New York assumed a higher trend for hospital outpatient and pharmacy services compared to other types of health care, and explained some of the underlying dynamics. The insurer notes that savings from generic medications "is being eclipsed by another trend around the rising cost and utilization of specialty medications, including biologics." In addition, it has implemented "additional contractual cost increases" for "[l]ocal hospital systems [that] have been challenged financially due to both economic inflationary pressures as well as staffing shortages."

Expiration of Enhanced Tax Credits Also Pushes Rates Higher

In their 2026 rate filings, insurers generally assumed enhanced premium tax credits would expire at the end of 2025, as is scheduled in law unless Congress acts. A majority of insurers in our sample pointed to this change as a driver of proposed rate increases.

Many insurers anticipate a large drop in enrollment as coverage becomes less affordable. AmeriHealth Caritas in North Carolina "anticipat[es] a 31% decrease [in size] in the North Carolina market from 2025 to 2026 due to the expiration of [enhanced premium tax credits]," and MVP in Vermont assumes "overall disenrollment would be 17% of [its membership]" due to the expiration of enhanced premium tax credits. Blue Cross Blue Shield of Arizona notes that "[t]he expiration of enhanced premium subsidies is expected to lead to significant reductions to statewide enrollment." Projections from outside experts align. The CBO projects that 4.2 million people with Marketplace coverage will become uninsured if enhanced premium tax credits expire, and Wakely projects that Marketplace enrollment will drop by 6 to 7.2 million people (or a 25%-30% decline).

Insurers anticipate that healthier people will be more likely to drop coverage as net premiums rise. Remaining enrollees will be sicker on average—referred to as increased "morbidity" by insurers—increasing average claims costs and driving up rates. With the loss of enhanced premium tax credits, Network Health in Wisconsin "expect[s] the morbidity of the risk pool to deteriorate as healthier members decide to terminate coverage due to increased costs." Health First in Florida "anticipates[s] a significant morbidity shift in HFCP's population once these subsidies expire," and Cigna in Colorado notes, "[t]he predicted morbidity impacts associated with this change account for a sizeable portion of the premium rate increases." Filings by Ambetter in multiple states note that "[a]s eAPTCs expire and enrollees subsequently face increased out-of-pocket premiums, we assume healthier individuals who

[4] Included in Cigna filings from Arizona, Georgia, North Carolina, Tennessee, Texas, and Virginia.

tend to be more price sensitive will leave the market, worsening the average morbidity of the individual risk pool."[5]

Given the uncertainty around whether enhanced premium tax credits would be extended during the rate development or review process, some state regulators requested that insurers submit two sets of rates—one assuming expiration and the other assuming extension. The proposed rate increase attributable to the expiration of enhanced premium tax credits ranged from 0.9% to 13.7% where noted in our sample.[6] For example, "the estimated rate impact from this change is around 4.8%," in Kaiser's Virginia rate filing.

Estimates from outside experts also anticipate a sizable impact from the expiration of enhanced premium tax credits. Wakely estimates that this change will raise gross premiums from 4.3% - 6.1%, while the CBO estimates that if Congress allows the enhanced premium tax credits to expire, gross Marketplace premiums would rise by 7.9% on average over the 2026-2034 period.

> **Impact of expiration of enhanced premium tax credits**
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> *"The expiration of enhanced premium subsidies is expected to lead to significant reductions to statewide enrollment and increases to the average healthcare costs for remaining enrollees."* **Blue Cross Blue Shield of Arizona**
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> *"The conclusion of the enhanced subsidies is expected to convey significant morbidity impacts by driving substantial decreases in enrollment from year to year…Enrollment decreases tend to increase the average healthcare cost of the remaining market enrollees. The predicted morbidity impacts associated with this change account for a sizeable portion of the premium rate increase."* **Cigna Health & Life Insurance Company (Colorado)**

Other Factors Contributing to Rate Changes

In addition to increasing medical trend and a smaller and sicker risk pool resulting from the expiration of enhanced premium tax credits, some filings cited the following factors as impacting rates:

- Experience: The emerging claims experience of enrollees' use of health care services over the past year was cited by some insurers as higher than initial projections, though some filings pointed to improving experience. At least one insurer recently announced plans to refile 2026 rates based on new information related to their 2025 market experience.
- Administrative costs: Insurers noted changes to taxes, fees, and other administrative costs. This includes a "significant" increase in user fees for the federally facilitated Marketplace—equivalent

[5] This, or nearly identical, language included in Ambetter filings from Arizona, Florida, Georgia, Louisiana, New Jersey, North Carolina, Ohio, Oklahoma, Pennsylvania, Tennessee, and Texas.

[6] Approximately 20% of proposed 2026 rate filings in our sample included this information in an unredacted form including filings from California, Colorado, Maryland, Michigan, New York, Ohio, Oklahoma, Oregon, Pennsylvania, Vermont, and Virginia.

to 1% of monthly premium—intended to support fixed Marketplace costs in light of projected steep enrollment declines due to the expiration of enhanced premium tax credits.[7]

- Benefit changes: Insurers described changes to benefits, if any, that could increase or decrease rates. For example, a few insurers pointed to the addition of new benefits required by a state policy change as increasing rates, and several insurers noted they utilized revised actuarial value de minimis ranges from the proposed Marketplace Integrity rule,[8] which has the effect of lowering premiums by increasing enrollee out-of-pocket costs.
- Risk adjustment: Rate filings reflected changes in insurers' expectations about what they would pay into or receive from the ACA's risk adjustment program.
- Uncertainty: Filings commonly noted the policy uncertainty faced by insurers, prompting some to increase their risk margins and driving average premiums higher. This is consistent with predictions from the American Academy of Actuaries noted earlier this year that the "elevated uncertainty" from federal policy changes "may have led insurers to include higher-than-usual risk margins in their 2026 filings to account for unpredictable changes in enrollment and costs."
- State-specific policy changes: Some filings noted rate impacts of state-level policy changes, such as assumptions about state-based reinsurance program parameters or state-mandated benefits. For example, a filing from Oklahoma cited a recent state law requiring a minimum reimbursement for out-of-network ambulance services as impacting costs.

How should policymakers interpret the rate filings related to impact on patient affordability?

The proposed rate increases will make gross premiums in the individual market much more expensive in 2026. These higher costs will land squarely on middle-income consumers who will be ineligible for the federal premium tax credit and will therefore be required to pay this full "sticker price" to enroll. At the same time, the expiration of enhancements to the premium tax credit will impose additional and, proportionally, vastly larger cost burdens on nearly all Marketplace enrollees. The upshot is that the more than 20 million people who currently rely on the ACA Marketplaces for health insurance will soon learn that they must pay significantly more than they do now in order to keep their coverage next year.

Just how much more expensive a consumer's coverage will be next year will depend in large part on how they are affected by the expiration of the enhanced premium tax credit. As noted above, more than 90% of Marketplace enrollees have lower out-of-pocket premiums due to these premium credits. The enhancements to the premium tax credit have reduced recipients' net premiums by an average of 44%, and these affordability improvements have contributed to a doubling of Marketplace enrollment since

[7] In 2026, user fees will increase from 1.5% to 2.5% of monthly premiums for the federally facilitated Marketplace and from 1.2% to 2% for the state-based Marketplaces that use the federal platform.

[8] Implementation of this provision of the final Marketplace Integrity rule was stayed on a nationwide basis by a federal district court on August 22, 2025, and subsequently appealed by the government on August 29, raising questions about whether these insurers will need to refile their plans and rates to ensure compliance with the previous actuarial value standards.

2021. If Congress allows these enhancements to expire, many middle-income consumers will no longer receive any premium credit, while those who remain eligible will see the size of their credit shrink and their monthly premium payments rise. The real-world impact of this decision on the average consumer will be cost increases that dwarf the double-digit premium rate hikes reflected in insurers' filings.

For example, an end to the enhanced premium tax credit will mean the return of a hard cap on income eligibility for premium assistance at 400% of the federal poverty level. Consumers with annual household incomes above this threshold will lose tax credit eligibility entirely and will face premium payments that, on average, are likely to be more than 80% higher than they are now. Relative to other Americans, those newly excluded from financial assistance will be disproportionately older (age 50-64), more likely to be self-employed, and more likely to live in rural areas.

Premium spikes will be even higher for low-income enrollees. Individuals from 150-200% of the federal poverty level will see their premiums rise by more than 400%.

Millions of people will be unable to keep their coverage in the face of unaffordable out-of-pocket premiums. Enrollment in the Marketplaces will decline precipitously if the enhanced premium tax credits expire and roughly 4 million people will eventually become uninsured.

Consumers of all backgrounds will lose coverage, but on average, the end of premium tax credit enhancements will force more healthy individuals out of the market. As insurers noted in their filings, the loss of relatively healthy enrollment will result in a smaller and sicker individual market risk pool, both on- and off-Marketplace, and still higher premiums for all those who remain.

How would you describe the impact of current tariff policy on insurers' decisions to submit record-high rate filings?

Increased tariffs are likely to increase the price of imported prescription drugs, thereby escalating health care spending and, by extension, health care premiums. A relatively small number of rate filings in our sample noted the role of tariffs in their premium calculations. When these insurers included a specific pricing adjustment for tariff policy, the total price impact ranged from 0.5% to 3.6%. All of these plans identified tariff-related prescription drug price increases as a reason for increasing their rates. Several United Healthcare plans also cited "uncertainty" related to tariff policy as a rationale for its rating adjustment.

Plans have also indicated that they continue to track this issue and may seek to change their rate filings as the United States' tariff policy evolves. For example, United Healthcare of Ohio, which adjusted its risk margin by 0.5% to account for tariff-related uncertainty, has asked to "reserve the right to adjust this as more clarity becomes available."

Rate filings and tariff policy

"To account for uncertainty regarding tariffs and/or the onshoring of manufacturing and their impact on total medical costs, most notably on pharmaceuticals, a total price impact of 2.4% is built into the initially submitted rate filing." **Optimum Choice (Maryland)**

"IHBC is seeking an overall rate change of 38.4% in 2026, primarily due to increased costs due to inflation and tariffs, and changes in risk adjustment," and "Based on the proposed tariffs, specifically related to drug imports, impacts on the expected 2026 pharmacy expense have been included [in this filing]." **Independent Health Benefits Corporation (New York)**

"Material rating impacts could arise from other factors including, but not limited to... tariffs proposed by the Trump administration that could lead to increased medical and pharmacy costs." **Blue Cross Blue Shield of Nebraska**

What information is available about how the end of the enhanced premium tax credits would interact with changes made to the Marketplace in H.R.1 and impact plan availability and affordability?

Impacts from the expiration of premium tax credit enhancements will be compounded by both H.R.1, the budget reconciliation legislation Congress enacted in early July, and the Marketplace Integrity and Affordability regulation, which CMS proposed on March 19, 2025 and finalized on June 25, 2025.[9] This wide-ranging regulation addresses issues related to eligibility verification for premium tax credits and enrollment requirements for Marketplace plans, rules governing the timing and duration of annual open enrollment and the availability of special enrollment periods, and reenrollment processes, among other provisions. H.R.1 places similar policies into federal statute.

Because Congress did not enact the final bill until early summer, only a handful of plans in our sample specifically referenced H.R.1's statutory changes as a factor in their preliminary rates; however, more plans reflected the impact of the proposed Marketplace Integrity rule that CMS released in March. More than one-third of insurers in our sample specifically reference provisions of the Marketplace Integrity as notable factors in their rate development. An examination of how plans considered eligibility and enrollment-related policies in their rate filings, whether attributed to the Marketplace Integrity Rule or H.R.1, therefore provides the best indication of how plans expect policy changes such as these to affect

[9] As noted above, several provisions of the Marketplace Integrity rule were stayed by the U.S. District Court for Maryland on August 22, 2025. The outcome of this litigation is uncertain.

the health profile of likely Marketplace enrollees and the impact these changes in "morbidity" will have on premiums.

Insurance plans most frequently note two types of regulatory provisions of the Marketplace Integrity rule in their rate filings. The first regulatory change modestly reduces proposed rates by allowing greater "de minimis" variation in plans' actuarial values, which enables plans to provide less generous benefits by raising enrollee out-of-pocket costs, while still meeting Marketplace requirements. Plans such as Kaiser Foundation Health Plan in Colorado and United Healthcare of Iowa cite "wider" or "expanded" de minimis AV ranges as central to their rate development and benefit design.

Health plan consideration of expanded de minimis actuarial value requirements

"The rates and benefits represented in this filing assumed the expanded de minimis range proposed in the 2025 Marketplace Integrity and Affordability Proposed Rule." **United Healthcare (Iowa)**

The second group of regulatory changes increases proposed rates, notably by reducing Marketplace enrollment among healthy enrollees. Ambetter, for example, cited changes related to open enrollment, special enrollment periods, and auto re-enrollment as likely to drive a "meaningful decline in enrollment, particularly among healthy enrollees" in filings in multiple states. Health First of Florida pointed to more stringent eligibility verification as a possible cause of "enrollment erosion among the healthier populations," and in filings across several states, United Healthcare observed that reducing the open enrollment period and stricter verification requirements "will lead to healthier enrollees leaving the market and an overall worsening of the risk pool." Of note, regulatory changes relating to increased eligibility paperwork and reduced enrollment opportunities were codified, and expanded upon, in H.R. 1.

Health plan statements on the expiration of enhanced premium tax credits combined with new barriers to enrollment

"With the likely expiration of the ePTCs and implementation of the Department of Health and Human Services (HHS) proposed Marketplace Integrity and Affordability rule, there may be significant shifts in enrollment, especially of low-income members, out of the ACA market." **Jefferson Health Plan (Pennsylvania)**

Oscar anticipated changes to the market morbidity associated with the change in Iowa's enrollment … due to the ending of the enhanced subsidies introduced by the American Rescue Plan Act, as well as the several new procedures and requirements introduced by the 2025 Marketplace Integrity and Affordability Rule and the H.R.1 - One Big Beautiful Bill Act. A factor of 1.037 is applied for these legislative impacts." **Oscar Health Plan (Iowa)**

In some cases, plans' actuarial memoranda indicate that they have increased their rates to account for both the loss of enhanced premium tax credits and policies included in either the Marketplace Integrity and Affordability regulation or H.R.1, with both policies driving reduced enrollment of healthy individuals eligible for Marketplace coverage. For example, Oscar cited both the expiration of enhanced premium tax credits and "new procedures and requirements" included in the Marketplace Integrity rule and H.R.1 as drivers of increased morbidity among enrollees in Iowa.

> **Insurers' analysis of reduced enrollment periods, stricter eligibility verifications, changes to auto-reenrollment, and other policies that restrict Marketplace enrollment**
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> *"Key provisions included in the proposed rule related to open enrollment, special enrollment periods and annual eligibility redeterminations (e.g. requiring $5 premium obligation for auto re-enrollees) are still expected to drive a meaningful decline in enrollment, particularly among healthier enrollees and adversely affect the average morbidity of the single risk pool."* **Celtic Insurance Company (Ambetter) (Texas)**
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> *"The expected implementation of the Market Integrity Rule is anticipated to further compound the increase in morbidity, as stronger scrutiny on eligibility of subsidized members may lead to further enrollment erosion among the healthier populations."* **Health First (Florida)**
>
> *"We believe that the changes in the proposed rule, including shortening of the open enrollment period and stricter verification requirements, will lead to healthier enrollees leaving the market and an overall worsening of the risk pool."* **Optimum Choice, (Maryland)**

These insurance carriers' observations and adjustments are consistent with findings from other analysts. For example, the recent Wakely analysis anticipates a "much smaller and less stable individual market" with the expiration of enhanced premium tax credits and implementation of the burdensome eligibility verification and enrollment restrictions included in the House version of H.R.1. Many of the House proposals are included in the enacted legislation and mirrored in the final Marketplace Integrity rule. In this scenario, Wakely estimates that nationwide individual market enrollment would fall by 47% to 57%, while total premiums would increase 7% to 11.5%.

Do rate filings provide indications about insurer decision-points with regard to Marketplace participation, including changing service areas?

As plans consider whether nationwide enrollment in the individual market will fall dramatically as enhanced premium tax credits expire and states implement federally mandated eligibility and enrollment restrictions, insurance carriers may determine that the risk and uncertainty of offering coverage on the Marketplace preclude participation in this market. In their rate filings, plans often

reserved the right to update their proposed rates, and carriers are not required to finalize their participation in the 2026 plan year until mid-September. State-based Marketplaces and the federally facilitated Marketplace will know in short order whether some plans that filed rates with the intention of offering coverage in 2026 have decided to withdraw from the market.

In the meantime, some early plan withdrawals may be signals of a larger plan exodus. In May, prior to most rate filing deadlines, Aetna announced that it would no longer offer coverage in the Marketplace; this decision affects approximately 1 million current Aetna members. More recently, United Healthcare and Elevance announced their decisions to pull out of seven and 16 Colorado counties, respectively. Rural markets, such as the state of Wyoming and San Juan County in Washington State, have also seen carrier departures.

Additional observations

Consumer Notices and Informed Coverage Choices

In a typical year, Marketplace enrollees have an opportunity to learn about their expected premiums for the next plan year prior to the start of the annual open enrollment period. Marketplace insurers are required to send notices to their enrollees that include information about plan options and projected premiums; for premium tax credit-eligible enrollees, the notice includes information about their premium net of any tax credit. Consumers use this information to budget for and select health insurance plans that work for their health and their pocketbooks.

This year, however, CMS has relieved insurers of the obligation to include information about net premiums in these notices, due to uncertainty over whether Congress will extend the enhanced premium tax credits. This means that many Marketplace enrollees will not learn about potential increases in their premiums until after open enrollment has begun. Enrollees who do not proactively return to their Marketplace application and update their accounts may not find out about premium changes until after December 15, 2025, after the window has closed to change their plan for January 1, 2026. Without an opportunity to select a more affordable plan, many consumers may decide they can no longer afford their coverage and become uninsured. In general, younger and healthier enrollees can be expected to drop their coverage in greater numbers than those with significant health care needs, further increasing costs—and ultimately premiums—for Marketplace health plans.

Transparency of Insurer Pricing Decisions

The Affordable Care Act requires that insurance regulators engage in a robust and detailed review of insurers' proposed rate increases, and conduct an independent evaluation of the assumptions and projections that insurers use to justify their premiums. The law also requires regulators to allow the public to review insurers' proposed rates and provide input into the rate review process. In short, the law envisioned that insurers' pricing decisions would be transparent and subject to public scrutiny.

Unfortunately, in many states, this vision has not been realized. A significant proportion of insurers in our sample are permitted to declare that large portions of their rate filing are "trade secret" and thus

exempt from public review. These redactions hide information related to enrollment, medical trend, morbidity, and the projected impact of federal policy changes, for example. The information subject to redaction is highly inconsistent across states, and redactions sometimes shield nearly all of an insurer's nominally public filing. In many cases, the same insurer is allowed to hide the very same data in one state that it is required to disclose in another state. This level of secrecy undermines insurer accountability and the public's understanding of the factors affecting the cost of coverage. It also runs counter to the ACA and other recent federal policy efforts to increase transparency around the factors driving health care costs in the commercial insurance market.

Appendix

CHIR reviewed actuarial memoranda and other supporting documents for 178 Marketplace plan filings across 28 states and the District of Columbia, listed below.

State	Company	Requested Rate Change*
Arizona	Antidote Health Plan of Arizona	6.51%
Arizona	Arizona Complete Health	48.95%
Arizona	Blue Cross Blue Shield of Arizona, Inc.	29.88%
Arizona	Cigna HealthCare of Arizona, Inc.	33.02%
Arizona	Imperial Insurance Companies Inc.	9.56%
Arizona	Oscar Health Plan, Inc.	16.60%
Arizona	UnitedHealthcare of Arizona, Inc.	43.67%
California	California Physicians' Service (Blue Shield of California)	9.30%
California	Kaiser Foundation Health Plan, Inc. (Kaiser Permanente)	7.23%
California	Health Net of California, Inc.	14.78%
California	Blue Cross of California (Anthem Blue Cross)	14.71%
California	Molina Healthcare of California	14.57%
California	Inland Empire Health Plan (IEHP)	17.91%
Colorado	Cigna Health and Life Insurance Company	29.19%
Colorado	Denver Health Medical Plan, Inc.	23.80%
Colorado	HMO Colorado, Inc.	34.05%
Colorado	Kaiser Foundation Health Plan of Colorado	15.11%
Colorado	Rocky Mountain Health Maintenance Organization, Incorporated	36.84%
Colorado	SelectHealth	19.61%
District of Columbia	CareFirst BlueChoice, Inc.	4.13%
District of Columbia	GHMSI, Inc.	12.53%
District of Columbia	Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	12.87%
Florida	AvMed, Inc.	22.86%
Florida	Blue Cross Blue Shield of Florida	27.17%
Florida	Centene Venture Company Florida	18.73%
Florida	Health First Commercial Plans, Inc.	19.42%
Florida	Molina Healthcare of Florida, Inc	40.81%
Georgia	Alliant Health Plans	18.04%
Georgia	Ambetter of Peach State Inc.	39.99%
Georgia	Blue Cross Blue Shield Healthcare Plan of Georgia, Inc.	21.96%
Georgia	CareSource Georgia Co.	15.92%

Georgia	Cigna HealthCare of Georgia	44.88%
Georgia	Kaiser Foundation Health Plan of Georgia	15.63%
Georgia	Oscar Health Plan of Georgia	31.75%
Iowa	Iowa Total Care	26.92%
Iowa	Medica Insurance Company	26.76%
Iowa	Oscar Insurance Company	12.47%
Iowa	UnitedHealthcare Plan of the River Valley, Inc.	19.77%
Iowa	Wellmark Health Plan of Iowa, Inc	12.57%
Kentucky	Anthem Health Plans of Kentucky, Inc.	22.98%
Kentucky	Molina Healthcare of Kentucky, Inc.	15.12%
Kentucky	WellCare Health Plans of Kentucky	37.02%
Louisiana	Ambetter Health of Louisiana	23.11%
Louisiana	HMO Louisiana, Inc.	23.25%
Louisiana	Louisiana Health Service & Indemnity Company	35.40%
Louisiana	UnitedHealthcare Insurance Company	23.26%
Maine	Anthem Health Plans of Maine, Inc.	23.15%
Maine	Harvard Pilgrim Healthcare, Inc.	21.19%
Maine	Maine Community Health Options	30.13%
Maine	Taro Health	32.74%
Maryland	CareFirst BlueChoice, Inc.	18.74%
Maryland	CFMI, Inc.	14.25%
Maryland	GHMSI, Inc.	14.23%
Maryland	Kaiser Foundation Health Plan of the Mid-Atlantic States	11.82%
Maryland	Optimum Choice, Inc.	18.60%
Maryland	Wellpoint Maryland, Inc.	7.35%
Michigan	Blue Care Network of Michigan	16.30%
Michigan	Blue Cross Blue Shield of Michigan	18.15%
Michigan	HAP CareSource	16.96%
Michigan	McLaren Health Plan Community	19.20%
Michigan	Meridian Health Plan of Michigan	16.89%
Michigan	Molina Healthcare of Michigan, Inc.	18.61%
Michigan	Oscar Insurance Company	4.40%
Michigan	Priority Health	14.39%
Michigan	UHC Community Plan, Inc.	25.25%
Minnesota	HealthPartners Insurance Company	18.91%
Minnesota	HealthPartners, Inc.	13.13%
Minnesota	HMO MINNESOTA	16.63%
Minnesota	Medica Insurance Company	26.03%
Minnesota	Quartz Health Plan Minnesota Corporation	7.15%

Minnesota	UCare Minnesota	19.80%
Montana	Blue Cross and Blue Shield of Montana	24.83%
Montana	Montana Health Cooperative	25.18%
Montana	PacificSource Health Plans	11.00%
Nebraska	Blue Cross and Blue Shield of Nebraska	20.64%
Nebraska	Medica Insurance Company	36.09%
Nebraska	Oscar Insurance Company	8.94%
Nebraska	UnitedHealthcare Insurance Company	25.03%
New Jersey	AmeriHealth Insurance Company of New Jersey	15.52%
New Jersey	Horizon Healthcare Services, Inc.	17.05%
New Jersey	Oscar Garden State Insurance Corporation	4.59%
New Jersey	UnitedHealthcare Insurance Company	18.36%
New Jersey	WellCare Health Insurance Company of New Jersey, Inc.	17.13%
New York	Anthem HP, LLC	10.31%
New York	CDPHP	13.17%
New York	Excellus Health Plan, Inc.	24.8%**
New York	Health Insurance Plan of Greater New York (HIP)	0.83%
New York	Healthfirst PHSP, Inc.	12.70%
New York	Highmark NY	23.81%
New York	Independent Health Benefits Corporation	38.42%
New York	MetroPlus	10.05%
New York	MVP Health Plan, Inc.	8.20%
New York	New York Quality Healthcare Corporation	8.07%
New York	Oscar Insurance Corporation	17.04%
New York	UHC	36.62%
North Carolina	Ambetter of North Carolina Inc.	25.60%
North Carolina	AmeriHealth Caritas North Carolina, Inc.	36.40%
North Carolina	Blue Cross Blue Shield of North Carolina	29.36%
North Carolina	CareSource North Carolina Co.	13.54%
North Carolina	Cigna HealthCare of North Carolina, Inc.	27.49%
North Carolina	Oscar Health Plan of North Carolina, Inc.	6.94%
North Carolina	UnitedHealthcare of North Carolina, Inc.	32.27%
Ohio	Antidote Health Plan of Ohio	4.15%
Ohio	Buckeye Community Health Plan	27.25%
Ohio	CareSource	17.20%
Ohio	Community Insurance Company	19.09%
Ohio	Medical Health Insuring Corp of Ohio	13.50%
Ohio	Molina Healthcare of Ohio, Inc.	20.02%
Ohio	Oscar Buckeye State Insurance Corporation	12.66%

Ohio	Oscar Insurance Corporation of Ohio	17.58%
Ohio	UnitedHealthcare of Ohio, Inc.	30.29%
Oklahoma	Blue Cross and Blue Shield of Oklahoma	32.70%
Oklahoma	Celtic Insurance Company	24.55%
Oklahoma	CommunityCare HMO, Inc.	7.86%
Oklahoma	Medica Insurance Company	19.56%
Oklahoma	Mending Health	20.87%
Oklahoma	Oscar Insurance Company	13.90%
Oklahoma	UnitedHealthcare of Oklahoma, Inc.	8.49%
Oregon	BridgeSpan Health Company	12.47%
Oregon	Kaiser Foundation Health Plan of the Northwest	12.53%
Oregon	Moda Health Plan, Inc	9.13%
Oregon	PacificSource Health Plans	4.01%
Oregon	Providence Health Plans	8.72%
Oregon	Regence BlueCross BlueShield of Oregon	11.95%
Pennsylvania	Ambetter Health	39.51%
Pennsylvania	Capital Advantage Assurance Company	32.95%
Pennsylvania	Geisinger Health Plan	11.59%
Pennsylvania	Highmark Benefits Group (HBG)	17.92%
Pennsylvania	Jefferson Health Plan	7.05%
Pennsylvania	Keystone Health Plan East	22.04%
Pennsylvania	Oscar Health Plan of Pennsylvania, Inc.	23.59%
Pennsylvania	UPMC Health Options, Inc.	17.94%
Tennessee	Alliant Health Plans	0.71%
Tennessee	BlueCross BlueShield of Tennessee, Inc.	41.79%
Tennessee	Celtic Insurance Company	37.21%
Tennessee	Cigna Health and Life Insurance Company	39.02%
Tennessee	Oscar Insurance Company	30.02%
Tennessee	UnitedHealthcare Insurance Company	31.05%
Texas	Baylor Scott & White Health Plan	23.71%
Texas	Blue Cross Blue Shield of Texas	39.28%
Texas	Celtic Insurance Company	41.48%
Texas	Cigna HealthCare of Texas, Inc.	42.30%
Texas	Community First Insurance Plans	17.58%
Texas	Community Health Choice Texas, Inc.	18.02%
Texas	Imperial Insurance Companies Inc.	8.15%
Texas	Moda Health Plan, Inc.	14.74%
Texas	Molina Healthcare of Texas, Inc.	29.30%
Texas	Oscar Insurance Company	26.10%

Texas	Sendero Health Plans, Inc.	16.22%
Texas	Superior Health Plan	35.95%
Texas	UnitedHealthcare of Texas, Inc.	23.02%
Texas	Wellpoint Insurance Company	27.72%
Utah	BridgeSpan Health Company	15.71%
Utah	Imperial Health Plan of the Southwest, Inc.	14.18%
Utah	Molina Healthcare of Utah, Inc.	31.60%
Utah	Regence BlueCross BlueShield of Utah	14.22%
Utah	SelectHealth, Inc.	12.82%
Utah	University of Utah Health Insurance Plans	17.60%
Vermont	Blue Cross and Blue Shield of Vermont	23.25%
Vermont	MVP Health Plan, Inc.	6.24%
Virginia	CareFirst BlueChoice, Inc.	17.37%
Virginia	Cigna Health and Life Insurance Company	16.81%
Virginia	GHMSI, Inc.	1.09%
Virginia	HealthKeepers, Inc.	20.36%
Virginia	Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	11.63%
Virginia	Optimum Choice, Inc.	35.00%
Virginia	Oscar Insurance Company	3.00%
Virginia	Sentara Health Plans	20.58%
West Virginia	CareSource West Virginia Co.	7.10%
West Virginia	Highmark Blue Cross Blue Shield West Virginia	16.97%
Wisconsin	Aspirus Health Plan, Inc.	12.56%
Wisconsin	Common Ground Healthcare Cooperative	13.33%
Wisconsin	Dean Health Plan	13.14%
Wisconsin	Group Health Cooperative of South Central Wisconsin	6.91%
Wisconsin	Network Health	9.83%
Wisconsin	Quartz Health Benefit Plans Corporation	16.88%
Wisconsin	Security Health Plan of Wisconsin, Inc.	24.29%
Wisconsin	UnitedHealthcare of Wisconsin, Inc.	34.51%

* Requested rate changes retrieved from RateReview.HealthCare.gov on August 26, 2025.
**The requested rate change from Excellus Health Plan, Inc. was pulled from the company's rate filing on the New York Department of Financial Services' website. The filing was not listed on the HealthCare.gov website.