

WHITE PAPER

2026 Individual Market Risk Pool Considerations

Emerging Data on Marketplace Post Expiration of Enhanced Subsidies

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EXECUTIVE SUMMARY

This white paper reviews the emerging 2026 ACA individual market, including enrollment trends and changes in the morbidity of the risk pool (as measured by normalized relative risk) compared with 2025 and prior years. This analysis is particularly timely given the significant changes affecting the 2026 individual market, including the expiration of enhanced premium tax credits, changes to premium tax credit eligibility resulting from recent legislation, and substantial premium increases between 2025 and 2026.

The analysis indicates an **overall increase of 6.3% in normalized relative risk¹ from 2025 to 2026**. Although the early year data comparison may be influenced by potential noise—both due to limited data and anomalous effects²—the data from January to April 2026 consistently show significant and comparable increases in relative risk this year versus the same period in 2025, which was similarly inflated in comparison with data from 2024, on average.

Key Findings:

- We see an **increase in overall relative risk of 6.3%** from 2025 to 2026 coupled with enrollment reductions equal to 12.0%.³
- The January to April timeframe is notable given 2025 enrollment remained generally stable from April until the end of year. Conversely, we expect continued attrition in 2026, which will likely result in **increased relative risk, on average, throughout the year and larger enrollment reductions** than summarized for the January to April timeframe. The direction and propensity of the changes throughout the year will vary by state. Changes in 2025 enrollment and morbidity, 2026 size of premium rate changes, overall member churn between issuers, and other factors should be considered.
- States saw **similar increases across State-Based Marketplaces (SBMs) and states with Federally Facilitated Marketplaces (FFMs)**. While SBMs had slightly higher relative risk, claim ratios, and total count of hierarchical condition category (HCC) increases, at this time, we do not believe the difference is significant as there are reasons that FFM states emerging experience may be lagging compared to SBM states. This phenomenon differs from what we witnessed in 2024 to 2025 when FFM states experienced much higher relative risk increases than SBMs.⁴

¹ In this paper, **normalized relative risk = adjusted PLRS/(AV * ARF)**. The full normalized relative risk formula is defined in the Methods and Data section below.

² It is likely that the large amount of enrollment churn and metal level shifting is impacting coding capture.

³ The comparative change in the prior year - between April 2024 and April 2025 relative risk increase - was equal to 8.0%, with an overall enrollment increase of 8.6%. <https://www.wakely.com/blog/2025-individual-market-risk-pool-considerations-updated/>

⁴ Table 2. [Microsoft Word - 2025 ACA Market Risk Pool Considerations](#)

- **Claimant ratios minimally increased from 2025 to 2026**, equal to 0.2% on average. Claimant ratios generally declined during the enhanced premium tax credit (ePTC) years beginning in 2022, although this trend reversed in 2025.⁵ We found little correlation between claimant ratios and relative risk, which could be for a variety of explainable and other non-explainable reasons.
 - We did find a correlation between AV decreases and claimant ratio decreases; thus, the large increase in bronze enrollment in certain states could be lowering claimant ratios.
 - The percent of enrollees with an HCC also slightly increased by 0.6%.
- Nationally, we found:
 - States that experienced lower rates of effectuation from enrolled members reported during open enrollment were correlated with higher relative risk increases and vice versa.
 - The average age of enrollees in the individual market changed minimally.
 - Increases in relative risk were correlated with increases in statewide average gross premium increases. This is likely a result of both anticipated morbidity changes by issuers as well as enrollee reactions (healthier enrollees dropping individual coverage due to higher premiums).

Although findings are subject to important limitations and caveats, the consistent pattern of elevated normalized relative risk suggests that the 2026 individual market continues to experience worsening morbidity relative to 2025, which may translate into higher underlying claim costs.

The following sections describe these findings in more detail, including the methodology used in the analysis, additional key findings, their implications, and the limitations of the analysis.

⁵ Centers for Medicare & Medicaid Services. 2019–2024 Enrollees Without Claims by State Market Metal Level. August 8, 2025. Available at: <https://www.cms.gov/files/document/enrolleeswithoutclaims-2019-24.xlsx>.

METHODS AND DATA

This analysis relied on data from the Wakely National Risk Adjustment Reporting (WNRAR) project in 2025 and 2026, using January–April data as comparison points. The WNRAR project provides Wakely with summarized data from participating Affordable Care Act (ACA)-compliant individual market plans. Data reporting is voluntary and, thus, exclusive of some issuers in a given state.

Though the data are not representative of the entire market, the WNRAR project collected data from over 80 carriers in 37 states and represents nearly 80% of ACA-compliant enrollment for the individual market. Market risk is measured as the HHS-HCC (Health and Human Services-Hierarchical Condition Category) risk-adjustment model plan liability risk score (PLRS) divided by the Centers for Medicare & Medicaid Services (CMS) risk-adjustment formula actuarial value (AV) and average rating factor (ARF). The PLRS calculation removes the 1.12 induced utilization factor applied to silver's 87% and 94% cost-sharing reduction (CSR) variants to adjust for changes in CSR mix to control for the impact on risk scores of members who moved from a CSR plan to a bronze or gold plan in 2026. Changes resulting from mix in geography were unaccounted for in the normalization of PLRS changes. All years were calculated based on the 2025 risk-adjustment model. In this paper, **normalized relative risk= adjusted PLRS/(AV * ARF)**.

We classified states into three distinct categories—FFM states that had expanded Medicaid, FFM states that did not expand Medicaid, and SBEs⁶—to determine whether the type of Marketplace or state Medicaid expansion influenced results. We expected that the types of current enrollees and those newly entering the individual market would differ based on whether the Medicaid program included expansion enrollees. We further anticipated that the impact would vary between FFM and SBE states because their operational processes and outreach efforts may differ. Using these three cohorts, we analyzed the change in enrollment, shifts in enrollment by metal level, and resulting relative risk score changes to best understand emerging 2026 dynamics.

⁶ For states that transitioned during the measurement period, we used their current classification for both years.

In addition, we used CMS open enrollment period (OEP) data⁷ to analyze other potential correlations between relative risk changes and the varying enrollment cohorts. These data may be useful indicators for future changes that may occur in the Marketplace.

As noted in previous papers, no one-to-one correlation is discernible between the normalized relative risk changes and morbidity. The significant member movements from one issuer to another in 2026 also may result in significant claims lag. The lack of prior information on the new members for issuers may result in poorer coding capture, and, therefore, may be limiting emerging risk scores in 2026. Hence, the pattern of claim cost spend throughout the year and operational impacts to risk scores that may be missing from the emerging results used in our analysis should be considered.

FINDINGS

Enrollment

Table 1a compares the 2025 and 2026 enrollment (member month) changes (based on January–April data for both years) by metal level and state cohort. **Tables 1b and 1c** show the final metal distribution in April 2025 and April 2026, respectively, to understand the size of each metal level in each period.

Table 1a. Percentage Change in Enrollment for April 2026 Compared with 2025⁸

Metal	SBM	FFM Expanded	FFM Not Expanded	Total
Platinum	–4.0%	5.3%	–63.6%	–8.8%
Gold	6.6%	–26.4%	39.3%	19.4%
Silver	21.8%	–49.7%	–42.7%	–35.0%
Bronze	12.0%	7.0%	26.9%	17.0%
Total	–8.4%	–23.3%	–11.5%	–12.0%

⁷ Centers for Medicare & Medicaid Services. 2026 Marketplace Open Enrollment Period Public Use Files.. Available at: <https://www.cms.gov/data-research/statistics-trends-reports/marketplace-products/2026-marketplace-open-enrollment-period-public-use-files> and <https://data.cms.gov/summary-statistics-on-beneficiary-enrollment/health-insurance-marketplace/health-insurance-exchanges-monthly-effectuated-enrollment>.

⁸ Author's calculations; percent differences are on a member month weighted basis.

Table 1b. April 2026 Metal Level Member Month Distribution

Metal	SBM	FFM Expanded	FFM Not Expanded	Total
Platinum	2.0%	0.8%	0.1%	1.0%
Gold	17.7%	9.5%	25.7%	20.3%
Silver	48.7%	31.2%	37.4%	41.3%
Bronze	31.6%	58.5%	36.8%	37.4%
Total	100.0%	100.0%	100.0%	100.0%

Table 1c. April 2025 Metal Level Member Month Distribution⁹

Metal	SBM	FFM Expanded	FFM Not Expanded	Total
Platinum	2.0%	0.5%	0.2%	1.0%
Gold	15.2%	9.9%	16.3%	14.9%
Silver	57.0%	47.6%	57.8%	56.0%
Bronze	25.8%	42.0%	25.7%	28.1%
Total	100.0%	100.0%	100.0%	100.0%

Membership decreased significantly more in FFM expansion states, notably the only cohort with a reduction in gold enrollment. Moreover, this cohort enrolls almost 60% of members in bronze plans (up from 42% in 2025)—notably higher than other cohorts, which are between 32% to 37% in 2026. SBE and FFM non-expanded states saw less buy-down to bronze compared with FFM expanded, likely because these states have higher silver than gold premiums, allowing for lower income members who are losing enhanced subsidies to have a buy-down alternative to gold instead of bronze.

⁹ Numbers may not add to 100% due to rounding.

In addition, many enrollees who are eligible for the silver CSR are now purchasing plans with lower premiums but higher out-of-pocket cost-sharing responsibility, which may present differences in claim spend patterns and bifurcation of risk by metal and CSR silver variant plan level.

Note that there is considerable variability in the growth of each state, and the averages displayed in the **Tables 1a–1c** are not representative of actual changes. To better understand this variation, state enrollment changes by percentile are summarized in **Table 1d**.

Table 1d. Changes in Enrollment by State Distribution¹⁰

Measure	Enrollment Changes
Straight Average	–12.5%
10th Percentile	–25.2%
25th Percentile	–18.6%
Median	–10.6%
75th Percentile	–5.4%
90th Percentile	–1.7%

The average state enrollment reduction was equal to 12.5% from January to April year over year, while the 10th to 90th percentile included a range of 23%, underscoring that states inherently are changing given the varying dynamics outside of policy change impacts, including but not limited to the following:

- 2026 rate change volumes and variation by issuer
- Member churn
- Operational hurdles
- Positioning of metal levels (i.e., bronze to benchmark plan, gold to silver difference)
- Availability of \$0 net premium plans
- State subsidy or reinsurance programs
- Marketplace operational differences and outreach programs.

¹⁰ The averages included in this table are the straight average state experience. The average state had an enrollment decline of 12.5%, which differs from the 12.0% national average decline calculated on a member month-weighted basis.

Consequently, there is significant variation within each cohort of Marketplaces. For example, a particular SBE enrollment decrease may be distinctly different from other SBEs. Prior analysis of CMS's open enrollment public use files (PUFs) showed that New Mexico increased plan selections by 18%, while Georgia's Marketplace decreased by 37%.¹¹ Although some general patterns among types of Marketplaces are identifiable (e.g., FFM Medicaid expansion states more consistently had larger enrollment losses), the variation from state to state should not be underestimated.

Relative Risk

With the notable enrollment reductions and state variation, we expected continued dramatic and differential patterns in emerging individual market risk.

Table 2 shows the normalized relative risk percent changes comparing 2026 with 2025 (based on January through April data for both years) by metal level and state cohort.

Table 2. April 2025 to April 2026 Normalized Relative Risk Score Changes¹²

Metal	SBM	FFM Expanded	FFM Not Expanded	Total
Platinum	7.2%	14.1%	0.6%	-3.4%
Gold	1.6%	18.1%	-6.6%	-2.8%
Silver	10.7%	19.4%	22.6%	15.8%
Bronze	5.3%	-0.2%	4.5%	3.7%
Total	7.1%	6.3%	5.5%	6.3%

¹¹ Gehrke T, Cohen M, Sherman Z. 2026 ACA Open Enrollment: What Happened? Wakely. April 2026. Available at: https://www.wakely.com/wp-content/uploads/2026/04/2026-ACA-Open-Enrollment-_What-Happened.pdf.

¹² Source: Author's calculations.

Normalized relative risk scores increased by 6.3% between April 2025 and April 2026, on average. Both SBM and FFM states experienced large increases, although SBM states had slightly higher risk score increases than FFM states, which is a departure of what was experienced in the past two years when FFM states experienced much higher increases relative to SBMs. Notably, FFMs are already starting from a higher comparison base in 2025. Moreover, there are likely to be differences in how the risk completes throughout the year because of dynamics that could cause a delay in claim spend and risk scores lagging more in 2026 than 2025.

Silver metal levels saw the highest increase in relative risk across all cohorts, likely driven by less risky lower income individuals purchasing down to gold or bronze from an 87% or 94% CSR plan for lower premiums when possible even though gold and bronze plans have higher cost-sharing. Similar to reviewing enrollment changes, we also summarized relative risk changes by percentile to show potential variability by state.

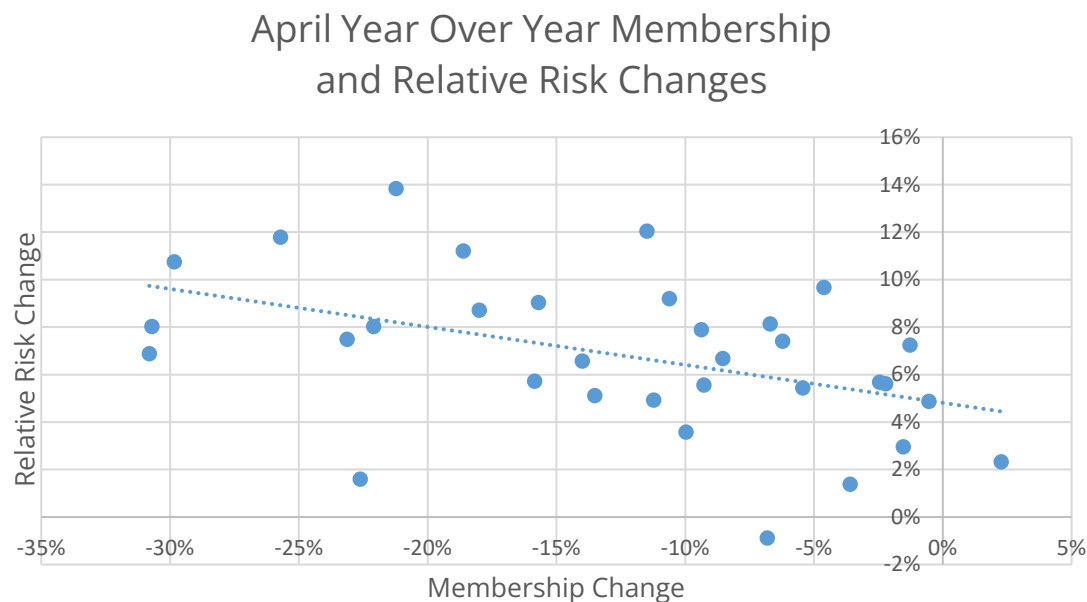
Table 3. Changes in Relative Risk by State Distribution¹³

Measure	Relative Risk Changes
Straight Average	6.8%
10th Percentile	2.5%
25th Percentile	5.1%
Median	6.9%
75th Percentile	8.7%
90th Percentile	11.1%

¹³ Note the averages included in this table are the straight average state experience. The average state had a relative risk increase of 6.8%, which differs from the 6.3% national average increase, calculated on a member month weighted basis.

While state relative risk increased an average of 6.8%, we found the 10th to 90th percentile shows large variation, with differences of up to almost 9% between both percentiles. When reviewing these results, changes that may occur from May to December 2026 should be considered. For example, a state with significant shift in issuers that are offering the lowest cost plans between 2025 and 2026 may see significant member churn, which could create a lag in claims and risk scores that differ from the 2025 data. As a result, normalized relative risk may increase at a higher rate in later months (i.e., risk score duration lag).

Figure 1. 2025 to 2026 Enrollment Changes Compared With Relative Risk Changes



Similar to enrollment changes, we found significant variation between states as the magnitude of relative risk score changes. As **Figure 1** shows, states with higher enrollment losses typically had higher relative risk score increases, but there was still considerable departure from that trend. Consequently, as the underlying data indicated, a state with an average enrollment drop of 12% could have a relative risk change of 12%, or conversely, a state with a membership drop of 23% could have a relative risk change of 8%. In other words, enrollment changes are just one cause contributing to relative risk changes. Furthermore, it is possible, even likely, that in some states, risk score changes measured in April can lag behind what the actual experience will be (i.e., could see significant increases later in the year) and are not aligned perfectly with the changes in claim costs.

Claimant Ratios and HCC Changes

Table 4 examines the claimant ratios (percent of enrollees with claims) from April 2024 to April 2026 by year for each of the state cohorts.

Table 4. Claimant Ratios April 2026 Versus Prior Years¹⁴

Year	SBM	FFM Expanded	FFM Not Expanded	Total
April 2024	52.9%	40.7%	38.6%	43.4%
April 2025	52.1%	43.8%	41.0%	45.9%
April 2026	52.5%	43.6%	40.8%	46.0%

Overall, claimant ratios in 2026 have not materially changed when comparing 2025 to 2026.¹⁵ It is also noteworthy that claimant ratios and relative risk scores have lower correlation than expected (e.g., FFM non-expansion relative risk increased, while claimant ratios decreased) and perhaps are out of alignment with what occurred between 2024 and 2025.¹⁶ There is a large limitation associated with extracting definitive determinations on claims cost/morbidity trends based only on four months of emerging data. It is possible that overall enrollees are incurring services much later in the year for 2026. It is also possible that there are bifurcated responses in that those enrollees who are sicker use more services, while other enrollees use fewer benefits. This situation could yield a pattern of no change in the percentage of enrollees with claimant ratios but an increase in morbidity/costs.

¹⁴ Source: Authors' calculations.

¹⁵ It should be noted that 2024 the change in health incident likely constrained claims in the first quarter of 2024.

¹⁶ 2025 relative risk increases were smaller later in the year than they were earlier in the year. Source: <https://www.wakely.com/wp-content/uploads/2025/07/2025-Individual-Market-Risk-Pool-Considerations.pdf>.

Table 5. Change in Percent of Enrollees with HCCs April 2026 Versus April 2025

Year	SBM	FFM Expanded	FFM Not Expanded	Total
0 HCCs	-0.8%	0.0%	-0.6%	-0.6%
1 + HCC	0.8%	0.0%	0.6%	0.6%
2+ HCC	0.4%	0.1%	0.4%	0.4%
3 + HCC	0.2%	0.0%	0.2%	0.2%

Table 5 summarizes the distribution of members with zero or varying HCCs, which may potentially align better with morbidity increases and indicate shifts in severity of claim cost spend patterns. Interestingly, while claimant ratios remained relatively stable, we observed an increase in the percent of enrollees with a HCC, which partially explains the increase in normalized risk scores. Thus, even though we have yet to see a spike in number of enrollees with claims (as measured by claimant ratios), the proportion of members who are considered higher risk through the ACA risk adjustment model has increased for the same period between 2025 and 2026.

Implications

How Do These Morbidity Changes Align with Premium Increases in 2026?

As **Figure 1** demonstrates, plan premiums and relative risk were correlated, which could show that issuers, on average, rated appropriately; however, the graph also points to considerable variation among specific states and issuers. Therefore, while it does appear morbidity changes were anticipated and included in the high 2026 gross premium rate increases, uncertainty remains regarding how each state's and issuer's results align with what was assumed in 2026.

It's important to note that these data include only the first quarter of claims experience, so changes are still possible, and anticipated, as the year progresses. Our expectation is that morbidity will generally worsen over the course of 2026 compared with the numbers in this analysis. Thus, the final year-over-year differences will be higher than the data currently indicate.

What Does this Data Mean for 2027 Rate Increases?

The data captured in the measure of normalized relative risk/morbidity include changes in market composition and behavior. This is an important concept; it means that the morbidity measured in this report differs from many other policy impacts estimated elsewhere. This metric includes both the concept that individuals leaving the market are healthier than those remaining and those remaining in the market are getting sicker.

For example, KFF (Kaiser Family Foundation) noted that issuers estimated the premiums would need to be 4% higher due to the expiration of ePTCs,¹⁷ which generally would be attributed to healthier members exiting the market and unrelated to those remaining getting sicker—i.e., impacts to claim cost trend.

The morbidity increases observed in the WNRAR data include **all changes**. If enrollees who maintain coverage get sicker (i.e., different utilization patterns), that finding would not be captured in the 4% policy related change that KFF calculated but could have been captured in other rating factors (i.e., higher morbidity assumptions, trend, etc.). Consequently, it's unclear how these data may influence issuer profitability or 2027 pricing at this time, but multiple components of the rate filing should be considered when drawing a conclusion.

What Could Average 2026 Enrollment Losses Be?

Based on early non-payment data Wakely collected,¹⁸ we estimated that average enrollment in the individual market could decline 17% to 26% from 2025 to 2026. With four months of data, we were able to refine enrollment estimates, although there remains considerable uncertainty. Given we see that through April, enrollment has already declined 12%, and that initial SBM data net attrition is expected to exceed 2025, we now estimate that average enrollment losses would result in a reduction of approximately **19% to 23%**, on average. Considerable uncertainty remains as to how enrollees will respond to the large premium increases over the course of the year as well as potential operational decisions CMS may make over suspected unauthorized enrollment, which would be excluded from the estimates above¹⁹.

¹⁷ Ortaliza J, McGough M, Vu K, et al. How Much and Why ACA Marketplace Premiums Are Going Up in 2026. Peterson-KFF. August 6, 2025. Available at: <https://www.healthsystemtracker.org/brief/how-much-and-why-aca-marketplace-premiums-are-going-up-in-2026/#Distribution%20of%20proposed%202026%20rate%20changes%20among%20312%20ACA%20Marketplace%20insurers>.

¹⁸ Anderson M, Chin CY, Cohen M. Who Paid, and Who Stayed? Early 2026 Enrollment Trends in the Individual Market. Wakely. April 2026. Available at: <https://www.wakely.com/blog/who-paid-and-who-stayed-early-2026enrollment-trends-in-the-individual-market/>.

¹⁹ Nelson P, Malani A, Collieran J, Volkov E, Mulligan CB. ACA Exchange Enrollment in 2026. US Department of Health and Human Services Assistant Secretary for Planning and Evaluation. *Issue Brief*. June 26, 2026.

Of note, these results reflect only partial year data, and final results for 2026 may vary, potentially significantly. With the scheduled expiration of ePTCs in 2026, we saw the anticipated large shifts in metal level distribution and shifts in relative risk. Given these notable changes and inherent uncertainty in 2026 premium rate setting, there could be alterations on overall and metal level profitability. Issuers should continue to monitor and help with future rate setting, if possible. The shifts will differ by geographic region given varying competitive positioning changes from 2026 and relative position of the premium rates and metal level positioning.

Please refer to the Key Limitations section for a full listing of important considerations and caveats associated with the changes in relative risk scores and which factors may be contributing to the increases.

Key Limitations

Following are the key limitations in this analysis. Although the preliminary data do point to increased risk scores, given the limitations in the data, more information is needed for the exact changes and their drivers to be definitively identified.

- **Limited months of data.** The analysis was based on only the first four months of data in both 2025 and 2026. With any analysis involving emerging experience, it is important to consider associated caveats and the range of plausible outcomes with incomplete data as the annual completion will vary year over year. Furthermore, partial year risk scores may not fully account for morbidity.
- **Risk score to claims correlation.** The HHS-HCC risk adjustment model offers an imperfect approximation of morbidity. Risk scores are calculated based on member-level enrollment and medical and pharmacy data. They are influenced by a variety of factors, including morbidity, claims volume, accuracy of coding and documentation, member engagement, data integrity, etc.
- **Coding trend.** Member risk scores are expected to increase yearly based on a member's established care network, medical history, coding documentation, and other factors. The relative risk score increases were not normalized by coding trend, which would be nonreflective of a shift in morbidity.

Available at: <https://aspe.hhs.gov/sites/default/files/documents/f5f29954221d5b5713070ac2541fda8e/aca-enrollment-report-2026-final-version.pdf>.

- **Membership mix.** Not all membership mix changes were considered, including any shift in geographic mix by region between 2025 and 2026. Further, the normalization of AV and ARF was based on the risk adjustment model factors, which are an inaccurate representation of claim cost curves.
- **Market premium levels and pricing slopes.** Market premium changes in total or by issuer, the slope of metal levels, and the benchmark silver plan movement would influence member plan selections and the potential health status of individuals enrolling in the market in 2025 compared with 2026 enrollees. There is also potential variation in issuers' coding completeness such that members choosing different plans, and therefore moving from one issuer to another, may affect risk scores contained in our results. Consequently, changes in benchmark silver status could influence both morbidity of the risk pool as well as coding completeness.
- **Data reliance.** The information used in this study included summarized data from health plans that were reviewed for reasonableness but not audited. Any deficient data submitted may affect the results, potentially significantly. Further, the data collected are dependent on issuer participation and, therefore, not fully representative of all issuers and markets.
- **Variability.** The conclusions will vary by state, and any additional data will influence results as well. Additionally, unanticipated changes in policies or operations at the federal or state level could influence net attrition and morbidity beyond what we have estimated here.

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Founded in 1999, Wakely Consulting Group, an HMA Company, is well known for its top-tier healthcare actuarial consulting services. With nine locations nationwide, Wakely boasts deep expertise in Medicare Advantage, Medicaid managed care, risk adjustment and rate setting, market analyses, forecasting, and strategy development. The firm's actuaries bring extensive experience across all sectors of the healthcare industry, collaborating with payers, providers, and government agencies.

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