

WHITE PAPER

# **2026 Individual Market: Enrollment and Risk Pool Considerations**

## Mid-Year Data on Individual Market Post Expiration of Enhanced Subsidies

Michelle Anderson, FSA, MAAA

Michael Cohen, PhD

Zimo Han, ASA, MAAA

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## SUMMARY

This white paper reviews the mid-year 2026 Affordable Care Act (ACA) individual market, including enrollment trends and changes in the morbidity of the risk pool (as measured by normalized relative risk) compared with 2025. This analysis provides valuable insights given continued fluctuations and uncertainty in the individual market.

The analysis indicates an overall increase of 6.9% in normalized relative risk<sup>1</sup> from 2025 to 2026. Although the mid-year data comparison may be influenced by potential noise, both due to limited data and anomalous effects<sup>2</sup>, the data from January to July 2026 consistently show significant and comparable increases in relative risk this year versus the same period in 2025, on average. This increase is slightly higher on average than the period measured with April 2026.

## Key Findings

- We find an **increase in overall relative risk of 6.9%** when comparing January–July 2025 with January–July 2026, coupled with **enrollment reductions equal to 15.7%**.<sup>3</sup> The equivalent metrics were 6.3% increase in overall relative risk and 12.0% enrollment reduction from January–April 2025 to January–April 2026.
- The January to July timeframe is notable given that 2025 enrollment remained generally stable from July through the end of year. Conversely, we expect continued attrition in 2026, which will likely result in **increased average relative risk throughout the year and larger enrollment reductions** than summarized for the January to July 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 when reviewing impacts from 2025 to 2026.
- States saw **similar relative risk increases** in both State-Based Marketplaces (SBMs) and Federally Facilitated Marketplaces (FFMs) when comparing January to July 2025 with

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

<sup>2</sup> The large amount of enrollment churn and metal level shifting is likely affecting coding capture.

<sup>3</sup> The comparative change in the prior year, July 2024 to July 2025, relative risk increase was equal to 6.8%, with an overall enrollment increase of 7.6%. See [https://www.wakely.com/wp-content/uploads/2025/11/2025-Individual-Market-Risk-Pool-Considerations\\_Updated\\_11\\_17\\_2025-1.pdf](https://www.wakely.com/wp-content/uploads/2025/11/2025-Individual-Market-Risk-Pool-Considerations_Updated_11_17_2025-1.pdf).

January to July 2026. The changes between **April and July 2026 have very different patterns as FFM and SBM states experienced varying changes** (relative risk slightly reduced from April and FFM cohorts increased). Between years, FFM states experienced more dramatic increases in relative risk, claimant ratios, and hierarchical condition category (HCC) than SBM states. We also found a more dramatic reduction in enrollment and active member count, pointing to a higher rate of healthier individuals exiting the FFM markets compared to SBM states. Some of these impacts may be attributable to Centers for Medicare & Medicaid Services (CMS) action related to unauthorized enrollment (UE), which additionally may not yet be fully realized in calendar year (CY) 2026.

- **Claimant ratios increased, on average, 1.8% in 2025 to 2026 and 4.0% in 2024 to 2026.** Claimant ratios generally declined during the enhanced premium tax credit (ePTC) years beginning in 2022, although this trend reversed in 2025.<sup>4</sup> Claimant ratios especially increased, relative to our July data, in FFM non-expansion states. Nonetheless, we found little correlation between claimant ratios and relative risk.<sup>5</sup>
- 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.
  - Increases in relative risk were correlated with increases in statewide average gross premium increases. This finding 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).
- Enrollment Change:
  - Enrollment (as measured by member months) reduced across the board nationally, on average, by 15.7% in total. This is an additional 3.8% reduction as of July from the reduction measured as of April. There were relative reductions across all bronze, silver, and gold metal levels. More notably,

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<sup>4</sup> 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>.

<sup>5</sup> Given that relative risk is estimated based on the US Department of Health and Human Service (HHS) risk-adjustment model, the model may fail to capture costs that are omitted from the model, including certain high-cost acute episodes of care.

**there was a much more pronounced reduction from the April to July measurement period of 5.2% in FFM states that have not expanded Medicaid, mostly concentrated in bronze and gold metals.**

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.

## **METHODS AND DATA**

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

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 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 2026 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 SBMs<sup>6</sup>—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

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<sup>6</sup> States that transitioned during the measurement period were categorized based on the Marketplace type that best represents their operational status in 2026. State-based exchanges that continued to use HealthCare.gov for enrollment and eligibility were grouped with FFM states.

program included expansion enrollees. We further anticipated that the impact would vary between FFM and SBM 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.

CMS released information regarding anti-fraud actions that resulted in the disenrollment of certain members in FFM and was material enough to affect our analysis.<sup>7</sup> While our July 2026 data collection relies on enrollment data as of that date, our understanding is that, to the extent possible, issuers provided Wakely with data that excluded members who were expected to be disenrolled because of CMS's unauthorized enrollment criteria at the time of the data collection. There may be subsequent changes in enrollment related to CMS action that are not reflected within the data for some or all issuers. The impacts by issuer and state may vary widely.

As noted in previous papers, no one-to-one correlation is discernible between the normalized relative risk changes and morbidity. The significant member movement 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.<sup>8</sup> Some of these dynamics may have also existed in 2025. Hence, the pattern of claim cost spend throughout the year and operational impacts to risk scores used in our analysis, in both years, should be considered.

## FINDINGS

### Enrollment

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

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<sup>7</sup> Centers for Medicare & Medicaid Services. Federal Marketplace (FFE and SBM-FP) Anti-Fraud Actions. September 22, 2026. Available at: <https://www.cms.gov/newsroom/fact-sheets/federal-marketplace-ffe-sbe-fp-anti-fraud-actions>

<sup>8</sup> It may take more than one year for an issuer to fully capture an enrollee's HCCs.

**Table 1a. Percentage Change in Enrollment from July 2025 to July 2026<sup>9</sup>**

| Metal        | SBM    | FFM Expanded | FFM Not Expanded | Total  |
|--------------|--------|--------------|------------------|--------|
| Platinum     | -2.6%  | 24.3%        | -64.6%           | -7.9%  |
| Gold         | 6.7%   | -28.3%       | 31.7%            | 15.4%  |
| Silver       | -24.3% | -53.3%       | -45.4%           | -38.1% |
| Bronze       | 12.3%  | 4.3%         | 17.9%            | 12.7%  |
| <b>Total</b> | -10.0% | -26.8%       | -16.7%           | -15.7% |

**Table 1b. July 2026 and 2025 Metal Level Member Month Distribution**

|          | 2026 July |              |                  |       | 2025 July |              |                  |       |
|----------|-----------|--------------|------------------|-------|-----------|--------------|------------------|-------|
| Metal    | SBM       | FFM Expanded | FFM Not Expanded | Total | SBM       | FFM Expanded | FFM Not Expanded | Total |
| Platinum | 2%        | 0%           | 0%               | 1%    | 2%        | 0%           | 0%               | 1%    |
| Gold     | 18%       | 9%           | 26%              | 20%   | 15%       | 9%           | 16%              | 15%   |
| Silver   | 49%       | 31%          | 38%              | 41%   | 58%       | 49%          | 58%              | 56%   |
| Bronze   | 31%       | 59%          | 36%              | 37%   | 25%       | 42%          | 26%              | 28%   |

Membership decreased across all three cohorts, equal to 16% on average overall. The reduction was more significant in FFM expansion states, especially among silver plans. Moreover, this cohort enrolls almost 60% of members in bronze plans (up from 42% in 2025)—notably higher than other cohorts, which are between 31% to 36% of the total distribution in 2026. Note that

<sup>9</sup> Author's calculations; percent differences are on a member month weighted basis.

the July 2026 enrollment data, to the extent possible, excluded members who were expected to be disenrolled by CMS because of unauthorized enrollment criteria at the time of the data collection, which may have further contributed to the observed membership decreases in the FFM cohorts.

SBM and FFM non-expansion states saw less buy-down to bronze compared with FFM expanded, likely because these states typically have higher silver than gold premiums, allowing for lower-income members who are losing enhanced subsidies to have a buy-down alternative of gold instead of bronze.

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. This dynamic may present differences in claim spend patterns and bifurcation of risk by metal and CSR silver variant plan level, which can be further analyzed in the subsequent normalized relative risk section.

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

**Table 1c. Changes in Enrollment by State Distribution<sup>10</sup>**

| Measure          | Enrollment Changes |
|------------------|--------------------|
| Straight Average | -15.4%             |
| 10th Percentile  | -31.1%             |
| 25th Percentile  | -24.6%             |
| Median           | -13.9%             |
| 75th Percentile  | -6.3%              |
| 90th Percentile  | -4.2%              |

The average state enrollment reduction was equal to 15.4% from January to July year over year, while the 10th to 90th percentile included a range of 27%. Not only did the average state reduction increase relative to the April data, but so did the range between 10th and 90th percentile.<sup>11</sup> The increase in variation between states underscores that state outcomes 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
- Operational hurdles
- Availability of \$0 net premium plans
- State subsidy programs
- Newly enrolled members through special enrollment periods
- Marketplace operational differences and outreach programs
- Removal of unauthorized enrollments in 2026.

<sup>10</sup> The averages in this table represent the straight average state experience. The average state had an enrollment decline of 15.4%, which differs from the 15.7% national average decline calculated on a member month-weighted basis.

<sup>11</sup> April data showed an average reduction of 12.5% and the range between 10th and 90th percentile of 23%.

Consequently, significant variation is evident within each cohort of Marketplaces. For example, a particular SBM enrollment decrease may be distinctly different from other SBMs. Previous 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%.<sup>12</sup> 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 July data for both years) by metal level and state cohort.

**Table 2. July 2025 to July 2026 Normalized Relative Risk Score Changes<sup>13</sup>**

| Metal                             | SBM         | FFM Expanded | FFM Not Expanded | Total       |
|-----------------------------------|-------------|--------------|------------------|-------------|
| Platinum                          | 3.4%        | 10.0%        | 9.2%             | -6.8%       |
| Gold                              | 2.3%        | 21.1%        | -4.8%            | -1.2%       |
| Silver                            | 9.3%        | 21.0%        | 23.1%            | 15.3%       |
| Bronze                            | 6.0%        | 1.3%         | 8.3%             | 5.6%        |
| <b>Total</b>                      | <b>6.5%</b> | <b>7.7%</b>  | <b>7.3%</b>      | <b>6.9%</b> |
| <i>Total July 2024 to 2025</i>    |             |              |                  |             |
| <i>(Jan to July)<sup>14</sup></i> | 2.5%        | 9.2%         | 8.6%             | 6.8%        |

<sup>12</sup> Gehrke T, Cohen M, Sherman Z. 2026 ACA Open Enrollment: What Happened? Wakely. July 2026. Available at: [https://www.wakely.com/wp-content/uploads/2026/04/2026-ACA-Open-Enrollment-\\_What-Happened.pdf](https://www.wakely.com/wp-content/uploads/2026/04/2026-ACA-Open-Enrollment-_What-Happened.pdf).

<sup>13</sup> Source: Author's calculations.

<sup>14</sup> This row reflects the normalized relative risk score changes from July 2024 to July 2025, initially published in: [https://www.wakely.com/wp-content/uploads/2025/11/2025-Individual-Market-Risk-Pool-Considerations\\_Updated\\_11\\_17\\_2025-1.pdf](https://www.wakely.com/wp-content/uploads/2025/11/2025-Individual-Market-Risk-Pool-Considerations_Updated_11_17_2025-1.pdf).

Normalized relative risk scores increased by 6.9% between January to July 2025 and January to July 2026, on average. All cohorts experienced significant increases, although FFM states had higher risk score increases than SBM states, which is consistent with what occurred in the past two years. Notably, FFMs are already starting from a higher comparison base in 2025. For example, in the same January to July timeframe from 2024 to 2025, the relative risk increases were equal to 2.5%, 9.2%, and 8.6% for the three cohorts above, respectively. 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 at varying degrees in 2025 and 2026.

FFM states had slightly higher normalized relative risk growth in July than April. Some of this increase may partially be explained by the removal of unauthorized enrollments. Because these members likely had no associated claims,<sup>15</sup> their exclusion from the July data increased the average risk of the remaining FFM population and thus increased the markets' normalized relative risk.

Despite less variation in relative risk across the three cohorts, significant variation can be seen at the metal level, pointing to key dynamics that may exist by cohort and by state. Silver metal levels saw high increases in relative risk, likely driven by less risky, lower-income individuals purchasing down to gold or bronze from an 87% or 94% CSR plan for lower net premiums when possible despite the fact that 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 2B. Changes in Relative Risk by State Distribution<sup>16</sup>**

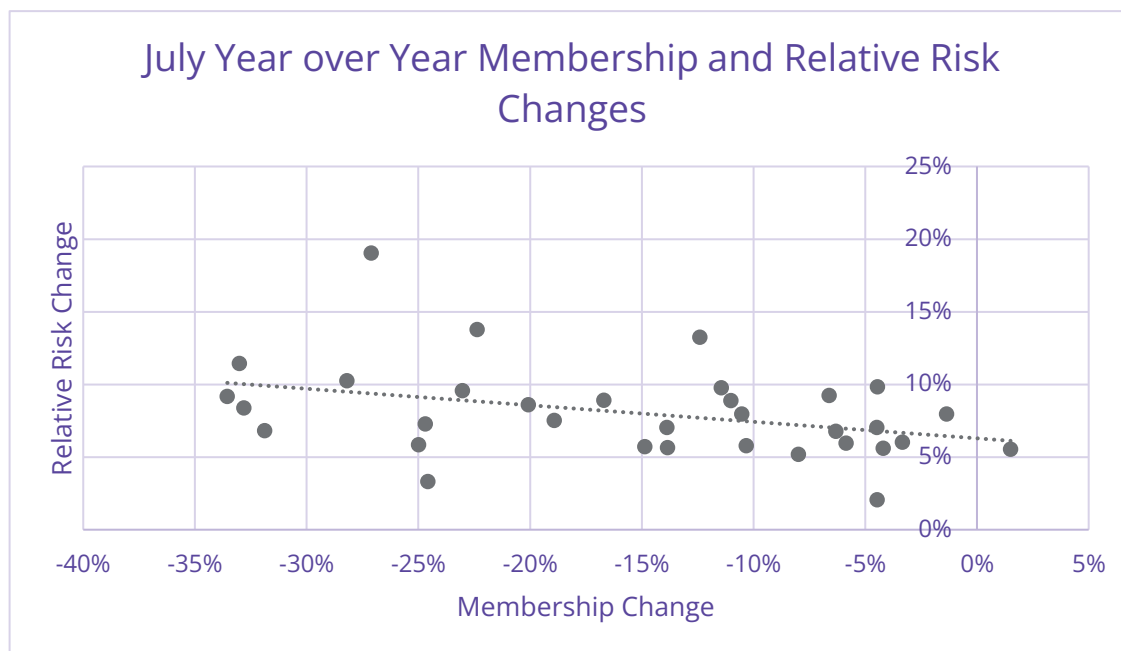
| Measure          | Relative Risk Changes |
|------------------|-----------------------|
| Straight Average | 8.0%                  |
| 10th Percentile  | 5.5%                  |

<sup>15</sup> <https://www.nytimes.com/2026/09/22/us/politics/aca-obamacare-vance-fraud.html>.

<sup>16</sup> Note: The averages included in this table are the straight average state experience. The average state had a relative risk increase of 8%, which differs from the 6.9% national average increase, calculated on a member month weighted basis.

| Measure         | Relative Risk Changes |
|-----------------|-----------------------|
| 25th Percentile | 5.9%                  |
| Median          | 7.5%                  |
| 75th Percentile | 9.2%                  |
| 90th Percentile | 11.2%                 |

Normalized relative risk increased by 8.0% on average across all states. State-level results showed meaningful variation, ranging from 5.5% at the 10th percentile to 11.2% at the 90th percentile. Despite enrollment showing a wider variation than seen in the April results, the relative risk variation is narrower when compared with the April data, which was 2.5% at the 10th percentile and 11.1% at the 90th percentile. Potential market changes from August through December should be considered when reviewing results, including impacts of potential CMS actions, continued attrition, and completion in risk scores.

**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. 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 July 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 3** examines the claimant ratios (percent of enrollees with claims) from 2024 to July 2026 by year for each of the state cohorts.

**Table 3. Claimant Ratios 2026 Versus Prior Years<sup>17</sup>**

| Year                           | SBM          | FFM Expanded | FFM Not Expanded | Total        |
|--------------------------------|--------------|--------------|------------------|--------------|
| July 2024                      | 63.7%        | 49.0%        | 46.0%            | 52.0%        |
| April 2025                     | 52.1%        | 43.8%        | 41.0%            | 45.9%        |
| July 2025                      | 62.3%        | 51.8%        | 47.9%            | 54.1%        |
| April 2026                     | 52.5%        | 43.6%        | 40.8%            | 46.0%        |
| July 2026                      | 62.8%        | 52.6%        | 50.6%            | 56.0%        |
| <b>July 2026 v. July 2025</b>  | <b>0.5%</b>  | <b>0.8%</b>  | <b>2.7%</b>      | <b>1.9%</b>  |
| <b>July 2026 v. April 2026</b> | <b>10.3%</b> | <b>9.0%</b>  | <b>9.8%</b>      | <b>10.0%</b> |

Overall, claimant ratios in 2026 have increased when comparing 2025 with 2026, with FFM non-expansion states experiencing the largest increase. It is also noteworthy that claimant ratios and relative risk scores have lower correlation than anticipated (i.e., the magnitude of increase in claimant ratio does not indicate higher relative risk increase in our study). The increased claimant ratio suggests that aggregate cost per member may have increased. These results may also be influenced by changes in the enrolled population, including the removal of members identified as unauthorized enrollment, who generally had limited or no claims experience. Therefore, observed increases may reflect both changes in underlying morbidity and shifts in membership composition.

<sup>17</sup> Source: Authors' calculations.

**Table 4. Change in Percent of Enrollees with HCCs July 2026 Versus July 2025**

| HCC Count | SBM   | FFM Expanded | FFM Not Expanded | Total |
|-----------|-------|--------------|------------------|-------|
| 0 HCCs    | -0.7% | -0.5%        | -1.6%            | -1.1% |
| 1 + HCC   | 0.7%  | 0.5%         | 1.6%             | 1.1%  |
| 2+ HCC    | 0.4%  | 0.2%         | 0.9%             | 0.6%  |
| 3 + HCC   | 0.2%  | 0.1%         | 0.4%             | 0.3%  |

**Table 4** 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 at least one 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

While uncertainty and caveats are inherent within the analysis using mid-year data, questions remain regarding how coming months will be affected and what this information means for issuers going forward.

### How will these estimates change toward the end of the year?

As the July update shows, enrollment losses are increasing and acuity is worsening. Attrition, especially among healthier enrollees, is expected to continue as the year progresses. Recent CMS announcements<sup>18</sup> on subsidy removals as well as potential future actions would not be reflected in the July data and are likely to increase enrollment losses/morbidity increases in FFM states. Given the buy-down effects, there are also varying patterns related to the seasonality of

<sup>18</sup> Kuchno K. CMS Ends ACA Subsidies for 189,000 Duplicate or Deceased Enrollees: 5 Notes. *Becker's Payer Issues*. October 14, 2026. Available at: <https://www.beckerspayer.com/payer/aca/cms-ends-aca-subsidies-for-189000-duplicate-or-deceased-enrollees-5-things-to-know>.

claim cost spend (i.e., how many and when members will reach their deductible and maximum out-of-pocket costs subject to different cost-sharing levels).

### What implications does this analysis have for 2027 and 2028?

Generally in 2026, plan premiums and relative risk have been correlated, which could show that issuers, on average, rated appropriately; however, considerable variation remains among specific states and issuers. Further reductions in enrollment and changes in morbidity raise the possibility of misalignment of issuer expectations relative to actual outcomes. Divergence may be possible even though 2027 premium increases were at a median increase of 15%,<sup>19</sup> which is higher than historical premium increases. Individual issuer and market analysis will be required to determine rate sufficiency for 2028.

**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 of 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 seven 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.

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<sup>19</sup> McGough M, Ortaliza J, Ferguson A, et al. Marketplace Premiums Are Going up in 2027. Peterson-KFF Health System Tracker. July 8, 2026. Available at: <https://www.healthsystemtracker.org/brief/how-much-and-why-aca-marketplace-premiums-are-going-up-in-2027/>

- **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.
- **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 the risk scores 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.
- **Other market uncertainty.** Results may continue to evolve due to emerging market developments whose ultimate effects are not yet known, including CMS's ongoing efforts to identify and remove unauthorized enrollments, as well as other changes in enrollment and market composition.

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## ABOUT THE AUTHORS

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**Michelle Anderson***Director*

michelle.anderson@wakely.com

**Michael Cohen***Principal (Actuarial)*

michael.cohen@wakely.com

**Zimo Han***Consulting Actuary*

zimo.han@wakely.com

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