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EXECUTIVE SUMMARY

National commercial market trend surveys project healthcare cost growth that substantially exceeds general inflation, and Affordable Care Act (ACA) issuer rate filings show a similar pattern of increasing projected medical and pharmacy trends. These cost increases are the primary drivers of premium increases in the ACA individual market and more generally the commercial market. When focusing on the individual market, examination of market experience through 2024 found that cost growth has been broad-based across major service categories, with particularly large increases in inpatient, outpatient, and pharmacy spending.

Meanwhile, measures of insurer retention, profit and risk loads, and medical loss ratios (MLRs) remained relatively stable, with national unadjusted MLRs remaining near 83% from 2022 through 2024, suggesting that issuers have been unable to retain a meaningfully larger share of premium revenue as premiums increased and that issuer margins did not increase in tandem with premium growth during the period studied. More recent rate increases also reflect expectations of worsening market morbidity, particularly in 2026, as issuers account for policy changes expected to adversely affect the risk pool, including the expiration of enhanced premium tax credits.

INTRODUCTION AND BACKGROUND

Rising health insurance premiums are a growing concern for consumers, employers, policymakers, and other healthcare stakeholders. Between 2016 and 2025, average commercial health insurance premiums increased by approximately 58%, representing an increase of roughly \$2,747 per covered member. Given the substantial impact of premium growth, understanding its drivers is critical to informing policy discussions and identifying opportunities to moderate future cost growth.

America's Health Insurance Plans (AHIP) engaged Wakely Consulting Group (Wakely) to examine trends in health insurance premiums and the underlying contributing factors. This report evaluates the relative contribution of claims-related and non-claims-related components of premiums, including medical and pharmacy cost trends, utilization patterns, morbidity changes, administrative expenses, taxes and fees, and insurer profit and risk loads. Using publicly available industry data, the analysis focuses on identifying the primary factors responsible for premium growth over time and assessing whether recent premium increases are primarily attributable to rising healthcare costs or to changes in insurer retention and other non-claims expenses.

Prior research focused on general trends in the commercial¹ market and the linkage between claims and premium increases. This paper examines the Affordable Care Act (ACA) individual market, where detailed data exist to examine issuer trend projections and claims experience at the category-of-service level.

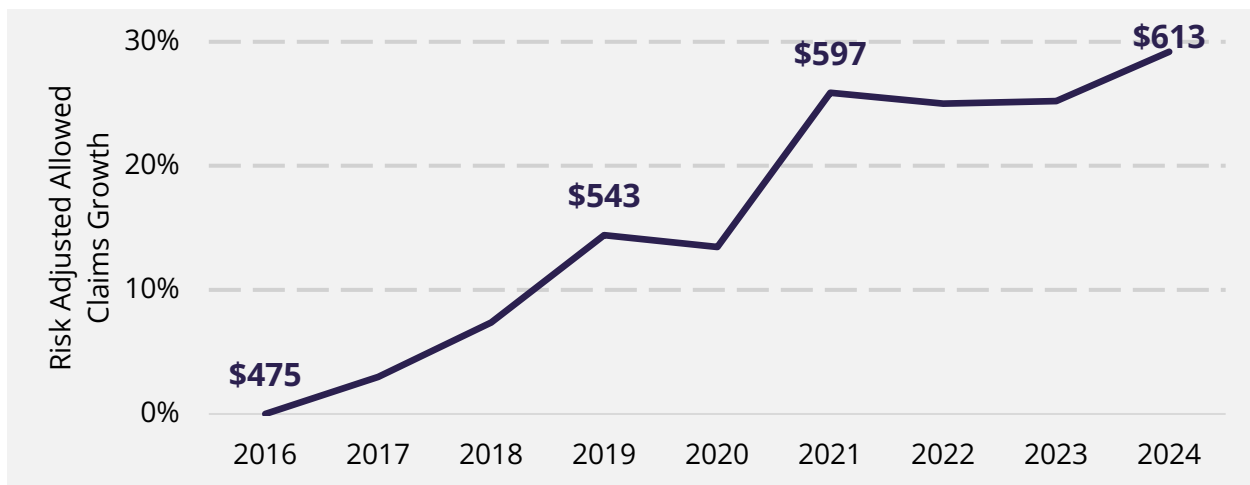
RESULTS

Individual Market Claims Increases Were Significant

Risk-adjusted claims costs are approximately 80% of premiums in the individual ACA market and the primary driver of premium rate changes over time. As shown in **Figure 1** on the next page, national average risk-adjusted ACA individual market allowed claims have increased substantially since 2016.

¹ Cooper Z, Craig SV. Health Care Spending and Insurance Premiums Among the Privately Insured. *JAMA Health Forum*. 2026;7;(9):e263005. doi:10.1001/jamahealthforum.2026.3005.

Figure 1. Growth in ACA National Average Individual Risk-Adjusted Allowed Claims, 2016–2024



After increasing rapidly through 2021, allowed claims costs briefly stabilized from 2021 through 2023, remaining approximately 25% above the 2016 level; however, costs resumed their upward movement in 2024, reaching approximately \$613 per member per month—nearly 30% above 2016. This pattern demonstrates that, apart from the temporary stabilization from 2021 through 2023, the ACA individual market has experienced sustained growth in underlying healthcare costs.

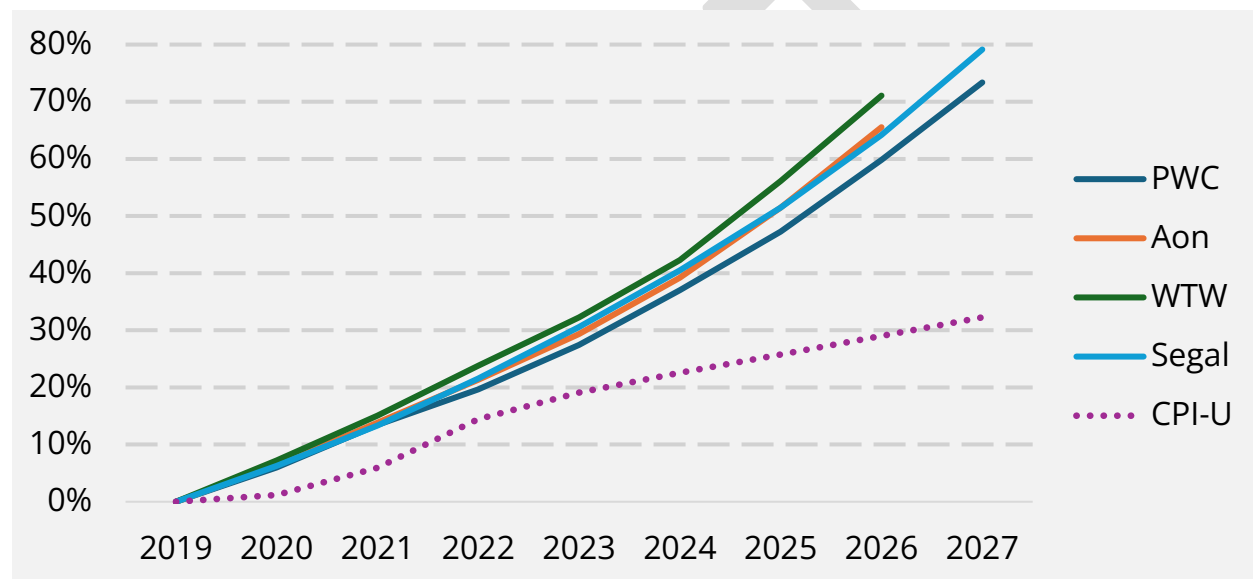
Recent increases in projected trends indicate that this period of relative stability is expected to end. The following sections examine the industrywide trends and inflationary pressures expected to substantially increase claims costs in future years and, consequently, place upward pressure on ACA premiums.

ACA Individual Market Claims Drivers

One of the principal drivers of claims cost growth is medical trend, which generally measures the annual change in healthcare costs per member. In this report, we focus on allowed trend, which reflects changes in the total cost of covered healthcare services before member cost sharing such as deductibles, copayments, and coinsurance is applied. Trend reflects changes in both the unit cost of services and the utilization or intensity of those services. Because annual trend compounds over time, even relatively stable year-over-year assumptions can produce substantial cumulative increases in healthcare costs.

Medical trend is not unique to the ACA individual market. Similar cost pressures affect the individual, small group, and large group commercial markets because they rely on many of the same providers, facilities, pharmaceuticals, and medical technologies. **Figure 2** reflects projected trends across the broader commercial insurance market and provide an independent point of comparison for the trends reported by ACA individual market issuers and presents the cumulative impact of these annual trend estimates since 2019. **Figure 2** also compares the results with growth in the Consumer Price Index for All Urban Consumers (CPI-U).²

Figure 2. Expected Cumulative Claims Growth Since 2019, National Trend Surveys Compared to CPI-U

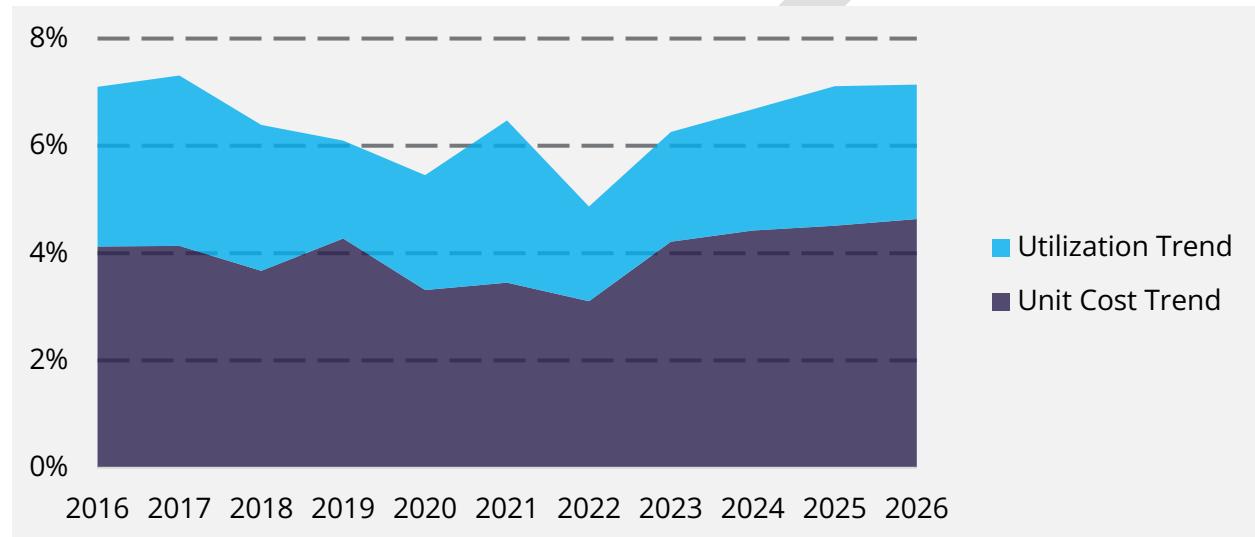


- The national survey results indicate that commercial medical trend has generally ranged from approximately 6% to 10%, with expectations increasing in recent years.
- The national trend surveys consistently indicate that healthcare costs are expected to grow more rapidly than general inflation. Based on the cumulative trend assumptions reflected in **Figure 2**, industrywide expectations indicate that commercial claims costs are projected to be approximately 70% higher in 2027 than in 2019, nearly twice the cumulative increase in CPI-U over the same period.

² Centers for Medicare & Medicaid Services. National Health Expenditure Data. Modified September 22, 2025. Available at: <https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data>.

The national trend survey results are consistent with trends reflected in ACA individual market rate development. **Figure 3** shows the unit cost, utilization, and total claims trends projected by ACA issuers between 2016 and 2026. Unit cost trend captures changes in the average cost of a service, including changes in provider reimbursement, pharmaceutical prices, and mix of services. Utilization trend captures changes in the number or frequency of services used per member.

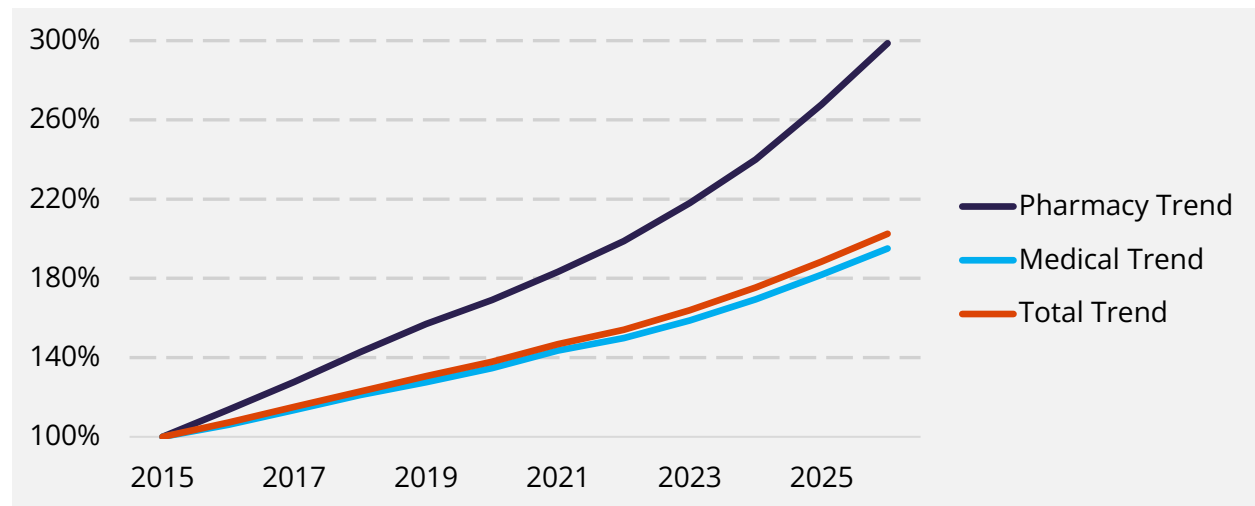
Figure 3. Projected ACA Individual Total Trends by Unit Cost and Utilization



- Projected total trend was relatively high during the early years of the ACA, before declining and briefly stabilizing at approximately 6% from 2019 to 2023. Trend estimates, however, have increased to approximately 7.5% in 2025 and 2026.
- Current claims trend increase is driven by a mix of both increased utilization and higher prices, with prices driving 64% of trend in 2026 and utilization driving 36% of total changes in 2026.

Figure 4 (on the next page) shows the cumulative medical, pharmacy, and total allowed claims trends projected by ACA issuers between 2016 and 2026, whereas **Table 1** shows the average changes in annual trend assumption both before and after COVID.

Figure 4. Projected Cumulative Growth in Claims Costs Due to Trend, 2015–2026

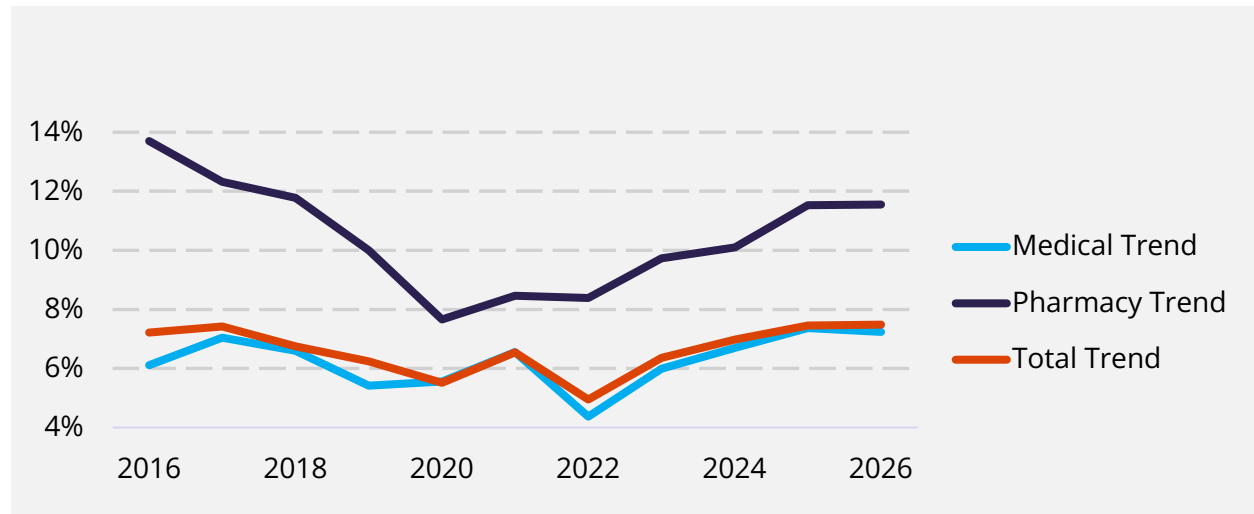


- From 2016 to 2020, projected claims trend growth was slowing, with trend falling at an average of 0.4% annually. In the post-COVID period, though, claims trend is growing at an increasing rate, rising by an average of 0.6 percentage points annually in 2022–2026.
- Prescription drug trend shows an even more pronounced change, with trend falling by an average of 1.5 percentage points per year in 2016–2020 but increasing by an average of 0.8 percentage points per year in 2022–2026.

Table 1. Comparison of Cumulative Projected Trend and Changes in Annual Average Projected Trend Before and After COVID

		Pre-COVID (2016–2020)	Post-COVID (2022–2026)
Cumulative Trend	Medical Trend	26.9%	30.2%
	Pharmacy Trend	48.7%	50.3%
	Total Trend	28.6%	31.4%
Year-to-year Change in Trend	Medical Trend	–0.1%	0.7%
	Pharmacy Trend	–1.5%	0.8%
	Total Trend	–0.4%	0.6%

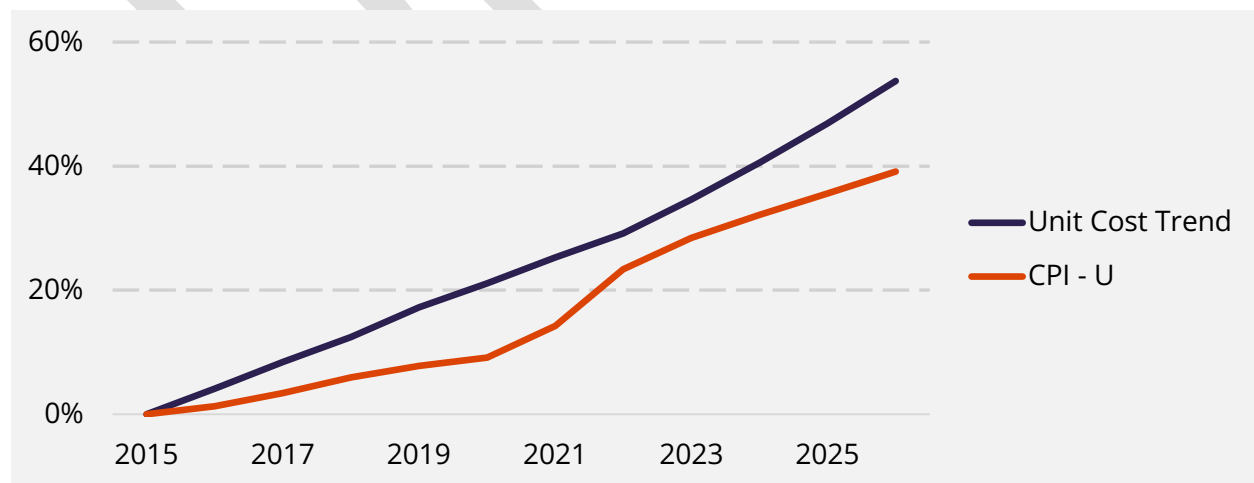
Figure 5. Projected ACA Individual Trends by Medical and Pharmacy



Inflation is an important contributor to medical trend because increases in labor, pharmaceuticals, supplies, equipment, and other operating expenses affect the cost of delivering healthcare services. The relationship is not necessarily immediate because commercial provider contracts may establish reimbursement terms for multiple years, creating a delay between increases in general inflation and their full effect on claims costs.

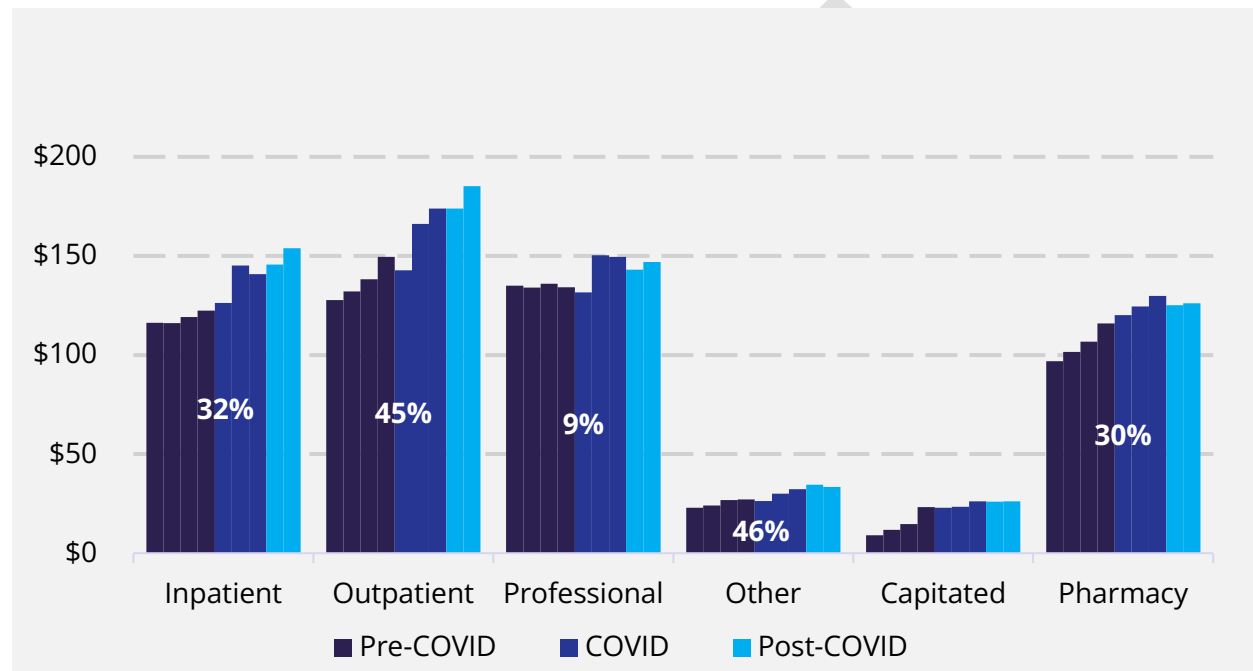
Figure 6 compares the cumulative effects of inflation with the unit cost trends projected by ACA individual market issuers. Unit cost assumptions began increasing after the post-COVID rise in inflation and continued to increase as inflationary pressures affected provider and healthcare operating costs.

Figure 6. Cumulative Growth in Projected ACA Unit Costs and Inflation, 2015–2026



Although projected pharmacy trend is higher than projected medical trend, as shown in **Figure 5**, the available experience does not indicate that a single category of service is solely responsible for the increase in ACA claims costs. Instead, cost growth is broadly distributed across the major categories of medical and pharmacy services. **Figure 7** below compares the annual costs by category of service in national ACA individual market from 2016 to 2024.

Figure 7. ACA Allowed Costs (PMPM) by Category of Service (2016–2024)



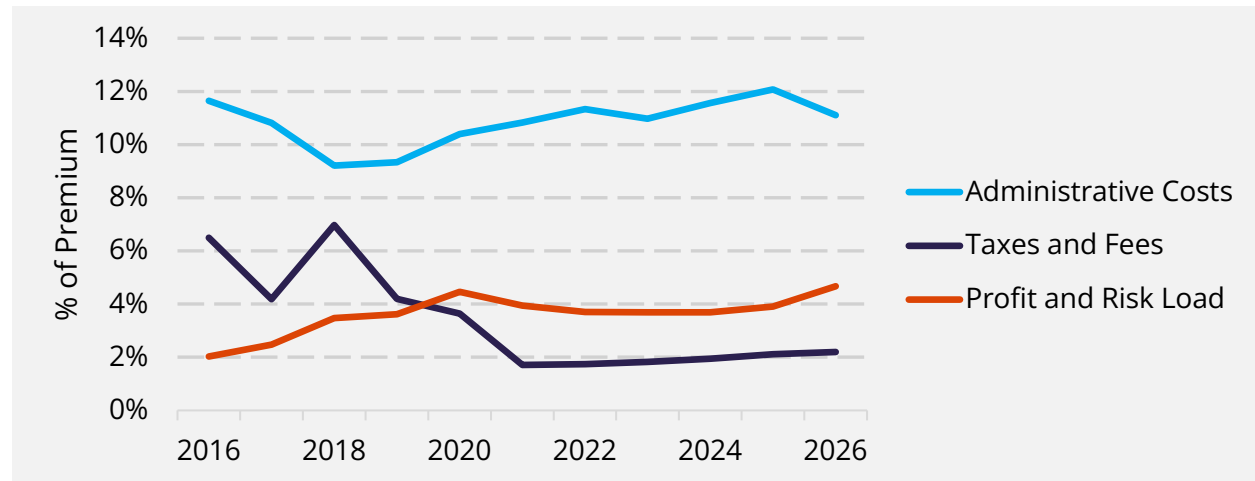
- The largest increases were observed for inpatient, outpatient, and pharmacy services, which increased by approximately 32%, 45%, and 30% from 2016 to 2024, respectively.
- The increases observed across all service categories demonstrate that the market is experiencing broad-based cost pressure rather than an isolated increase attributable to a single type of care.

Historical experience data are available only through 2024. National trend surveys project continued and accelerating growth in 2025 through 2027. The magnitude of actual cost increases will need to be evaluated as complete experience data become available.

Plans Did Not Increase Administrative or Profit Load Relative to Premiums

Recent increases in premiums do not appear to be driven by changes in non-claims costs. **Figure 8** shows the administrative expenses, taxes and fees, and profit and risk load in the ACA premiums between 2016 and 2026.

Figure 8. ACA National Average Individual Retention (% of Premium), 2016–2026



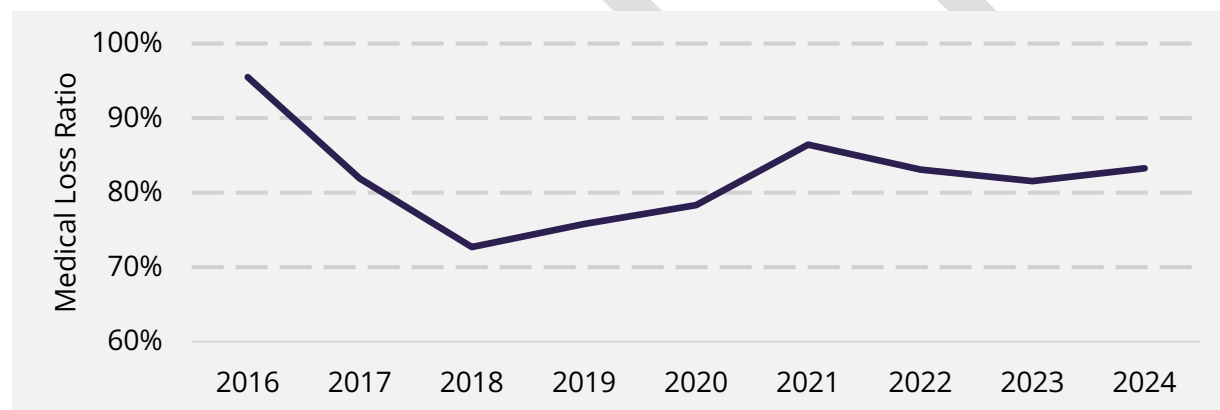
- Total retention has remained relatively stable over the past decade. Following some volatility in the early years of the ACA market, average retention ranged from 16.5% to 17.2% in 2021–2024 before increasing modestly to approximately 18% in 2025 and 2026.
- Profit and risk loads have remained relatively stable as well. Profit and risk loads were relatively modest in the early years of the ACA market, ranging from 2.0% to 2.5% during 2016 and 2017, as many issuers prioritized membership growth and market stabilization. As the market matured, profit and risk loads increased and stabilized at approximately 4% from 2020 through 2025. The minimal year-to-year variation observed is likely reflective of differences in issuer-specific pricing strategies and changes in issuer market share. Furthermore, the recent uptick to 4.7% in 2026 may reflect additional uncertainty associated with evolving federal and state policy changes.

The observations regarding non-claims expenses and higher profit loads not being a material driver of premiums increases are also supported by an examination of the medical loss ratio (MLR) across the market. MLR measures the portion of premium revenue used to pay healthcare claims. A higher MLR indicates that a greater share of premium revenue is being used for both claims and risk transfers, leaving a smaller share available for administrative expenses, taxes and fees, profit, and contributions to surplus. When MLRs are higher than anticipated, issuers may need to increase premiums to cover expected costs.

Under the federal ACA MLR standard, issuers must spend at least 80% of premium revenue on clinical services and qualifying activities that improve healthcare quality.³ As part of this calculation, MLRs are calculated over a three-year window and assessed against the 80% applicable standard. If an issuer's federally calculated MLR falls below 80%, the issuer may be required to pay rebates to consumers. The federal standard limits the share of premium that issuers may retain for administration, marketing, and profit over a three-year period.

Figure 9 shows the unadjusted MLR that the ACA individual market experienced in 2016–2024. These values are calculated using experience reported in the Uniform Rate Review Template (URRT) rather than the federal MLR reporting forms used to determine rebate requirements. The simplified calculation considers only premiums, claims, risk adjustment, and reinsurance. Unlike the federal MLR calculation, no special accounting is made for quality improvement expenses or other prescribed adjustments.

Figure 9. National Average ACA Individual Unadjusted MLR, Calculated from URRT



- The market experienced significant claims pressure during the earlier years of the ACA. The estimated market-wide loss ratio was 95.5% in 2016, indicating that nearly all premium revenue went toward claims-related costs. This result is consistent with broader evidence⁴ that many individual market issuers initially underpriced coverage and incurred losses as the reformed market developed.
- After experiencing high MLRs in the early years of the ACA, regulators approved issuers' premium increases to account for their capital position and for policy changes, including the cessation of federal cost-sharing reduction payments. These adjustments contributed to an overcorrection, as the market-wide loss ratio declined to 81.9% in 2017 and 72.7% in 2018.

³ Centers for Medicare & Medicaid Services. Medical Loss Ratio. Modified March 13, 2026. Available at: <https://www.cms.gov/marketplace/private-health-insurance/medical-loss-ratio>.

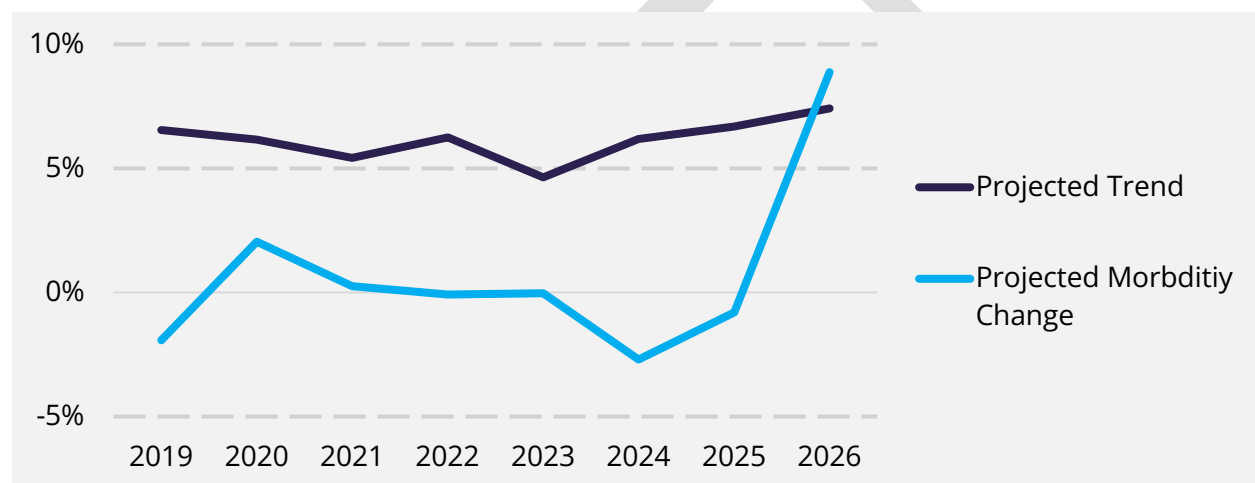
⁴ McGough M, Ortaliza J, Cox C. Medical Loss Ratio Rebates. Kaiser Family Foundation (KFF). July 2026. Available at: <https://www.kff.org/private-insurance/medical-loss-ratio-rebates/>

More recent results suggest that the market has arrived at a comparatively stable relationship between premiums and claims. The loss ratio remained within a relatively narrow range of 81.5% to 83.3% from 2022 through 2024.

Morbidity Increases Are a Key Driver of Recent Rate Increases

A key driver of recent rate increases is the projected deterioration of market morbidity. To assess expectations of market morbidity, we use morbidity assumptions reported in the URRT, which represent issuers' expectations in how changes in the health status of the covered population will affect claims costs. **Figure 10** compares national average trend assumptions and morbidity assumptions in recent years.

Figure 10. Annual Changes in ACA Individual Rate Development Assumptions, 2019–2026



- Historically, the market-wide average morbidity adjustment was close to zero, indicating that morbidity changes generally had only a minor net effect when considered across all issuers. The average projected morbidity change ranged from approximately negative 3% to positive 2% between 2019 and 2025, compared with an increase of approximately 9% in 2026.
- The substantial 2026 increase reflects broad issuer expectations that the ACA individual market risk pool would deteriorate. Policy changes were a primary source of these expectations, most notably the expiration of the enhanced premium tax credits after 2025.
- The substantial 2026 rate increases reflected the combined effects of elevated medical trend and an unusually large projected deterioration in market morbidity.⁵

⁵ Anderson M, Chin CY, Cohen M. 2026 Individual Market Risk Pool Considerations: Emerging Data on Marketplace Post Expiration of Enhanced Subsidies. July 2026. Available at: <https://www.wakely.com/blog/emerging-2026-aca-data-enrollment-drops-12-as-relative-risk-rises-6-3/>.

CONCLUSION

National commercial trend surveys project cumulative healthcare cost growth substantially above general inflation, while ACA issuer rate filings show a similar increase in projected claims trend. A deeper analysis of the individual market identifies the service-level contributors to these claims cost increases. Actual experience through 2024 further indicates that cost growth has been broad-based across service categories, with the most pronounced increases in inpatient, outpatient, and pharmacy costs.

At the same time, retention and MLR analyses do not indicate that premium increases have been driven by higher issuer retention for administrative expenses or profit. The national unadjusted MLR⁶ stabilized at approximately 83% from 2022 through 2024, while total retention and profit loads remained relatively stable. Accordingly, issuer margins did not increase in proportion to premiums during the period studied.

These findings support the conclusion that, holding constant changes in morbidity, recent ACA premium increases have been driven primarily by underlying claims cost growth and medical trend rather than by increases in administrative expenses, issuer retention, or profit margins. More recent rate increases also reflect expectations of continued claims cost pressure and deterioration in market morbidity associated with significant policy changes, particularly for 2026.

⁶ The unadjusted MLRs cited in this report are not the final adjusted MLRs used in MLR rebate calculations. The unadjusted MLR equals the ratio of issuer-paid claims, net of risk adjustment and reinsurance transfers, to total premium revenue.

METHODOLOGY AND ASSUMPTIONS

- Data were obtained from the 2016–2026 URRTs,⁷ as published by the Centers for Medicare & Medicaid Services (CMS) on March 27, 2026.
- Reported trend figures are sourced from Worksheet I of the URRT. URRT trends represent annual projected trend assumptions rather than observed experience totals.
- URRTs include annualized trend projections from the experience period to the projection period, generally representing a two-year projection horizon. First-year trend projections are used in all years except payment year (PY) 2026, for which only second-year trend projections were available during development of this report.
- National average trends are calculated by weighting issuer-specific trend projections based on experience premium. This approach reduces the influence of issuers relying primarily on external trend sources rather than ACA market experience. As a result, greater weight is assigned to states with larger ACA markets, most notably Florida, California, and Texas.
- Medical trends are calculated by weighting category of service trend projections (inpatient, outpatient, professional, and other services). Costs and trend projections associated with capitated claims are excluded because URRT-reported capitated claim amounts and trend adjustments often reflect issuer-specific provider contracting changes across a non-uniform set of benefits.
- When evaluating trends at a more granular level, issuers that did not differentiate trends at the specified level are excluded from the corresponding averages. For example, issuers reporting identical trend assumptions across all medical categories of service are excluded from exhibits presenting category-specific trend comparisons.
- Reported category-of-service costs include only essential health benefits (EHBs). Total paid claim amounts cited elsewhere in the report are inclusive of both EHB and non-EHB claim costs. Average category-of-service costs are compiled using issuer-level claim costs as weights, resulting in greater influence from states with larger ACA markets, including Florida, California, and Texas.
- Category-of-service costs are reported using the following descriptions:
 - Inpatient: Includes non-capitated facility services for medical, surgical, maternity, mental health and substance abuse disorder, skilled nursing, and other services provided in an inpatient facility setting and billed by the facility.

⁷ Centers for Medicare & Medicaid Services. Rate Review Data. March 30, 2026. Available at: <https://www.cms.gov/marketplace/resources/data/rate-review-data>.

- Outpatient: Includes non-capitated facility services for surgery, emergency services, lab, radiology, therapy, observation, and other services provided in an outpatient facility setting and billed by the facility.
 - Professional: Includes non-capitated primary care, specialist, therapy, the professional component of laboratory and radiology, and other professional services, other than hospital based professionals whose payments are included in facility fees.
 - Other: Includes non-capitated ambulance, home health care, DME, prosthetics, supplies, vision exams, dental services, and other services.
 - Prescription Drug: Includes drugs dispensed by a pharmacy. This amount should be net of rebates received from drug manufacturers.
- Requested average premium changes are calculated by weighting issuer-level rate changes using premium in force at the time of filing.
 - To address gaps created by issuer market exits, issuer paid claims experience is presented net of risk adjustment transfers and High-Cost Risk Pool (HCRP) recoveries. This adjustment is intended to improve comparability of claim costs on a state average basis.

RELIANCES

- All trend, premium, morbidity, and experience information derived from rate filings relies on data reported by issuers in the URRT.
- Average premium values reported by renewing issuers in the URRT are compared against average premium values reported in Appendix C of the CMS Premium Stabilization Reports⁸ to assess whether issuer exits materially affect results. These appendices include all issuers participating during the applicable plan year. Reports from 2014–2025 were considered.
- Final risk adjustment transfer amounts and HCRP recoveries used in the analysis reflect any applicable adjustments resulting from completed Risk Adjustment Data Validation (RADV) audits for benefit years 2017 through 2023. RADV audit results are sourced from CMS premium stabilization appendices for HHS-RADV.⁹
- External trend studies cited in this report are published by Aon,¹⁰ PWC,¹¹ Segal,¹² and WTW.¹³ These studies were compiled as of October 19, 2026.
- The cited studies are used for contextual comparison to marketplace trend experience but reflect a mix of survey respondents, including health plans, providers, and industry consultants.
- Figures for inflation, as measured by CPI-U, are sourced from the National Health Expenditure (NHE) Projections¹⁴ published by CMS. The NHE projections data reflect aggregate healthcare expenditures across all payers and market segments, including Medicare, Medicaid, and commercial coverage.

⁸ Centers for Medicare & Medicaid Services (CMS). Premium Stabilization Programs. July 15, 2026. Available at: <https://www.cms.gov/marketplace/health-plans-issuers/premium-stabilization-programs>.

⁹ Ibid

¹⁰ AON. The Global Medical Trend Rates Report 2026. 2026. Available at: <https://www.aon.com/en/insights/reports/the-global-medical-trend-rates-report>.

¹¹ PWC. Behind the Numbers 2027: Medical Cost Trend Is Expected to Hit 9%, Highest in 17 Years. Can Cost Management Strategies Bend the Trend? June 11, 2026. Available at: <https://www.pwc.com/us/en/industries/health-industries/library/behind-the-numbers.html>.

¹² Segal. What Are the Projected Health Plan Cost Trends for 2027? July 23, 2026. Available at: <https://www.segalco.com/consulting-insights/2027-health-plan-cost-trend-survey/>.

¹³ WTW. 2026 Global Medical Trends Survey. November 10, 2025. Available at: <https://www.wtwco.com/en-us/insights/2025/10/2026-global-medical-trends-survey>.

¹⁴ Centers for Medicare & Medicaid Services. National Health Expenditure Data: Projected. June 24, 2026. Available at: <https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/projected>.

DISCLOSURES AND LIMITATIONS

- All URRT data included in this report are limited to the ACA individual market. Merged markets, including Massachusetts, Maine, and Vermont, as well as ACA small group market data, are excluded.
- At the time of this report, the most recent available URRT data are from PY2026 and include experience through PY2024. The latest version of the PY2026 URRT, published March 27, 2026, was used for this analysis.
- Because issuers that exit the market no longer file URRTs, a two-year gap can exist in compiled URRT experience data. Although adjustments were made to improve comparability, market exits may still affect certain results.
- URRT-reported experience is often not fully complete at the time of publication. While adjustments for incurred but not reported and paid claims are typically included, the reported figures may differ from fully complete data.
- Requested average premium changes do not necessarily equal actual changes in average premium because enrollment shifts by age, metal level, plan selection, or other characteristics can affect realized premium levels.
- URRT-reported trend and morbidity adjustments are intended to reflect the impact of each factor independently. Some issuers, however, may develop trend assumptions that implicitly incorporate morbidity changes, provider contracting changes, or other overlapping pricing considerations.
- External trend studies cited in this report may not be fully representative of ACA individual market experience. These studies often include a blend of commercial market segments, including the ACA individual, ACA small group, and large group markets.

Responsible Actuary

We, Karan Rustagi and Freddy Quiram, are the actuaries responsible for this communication. Karan Rustagi is a Member of the American Academy of Actuaries, and both are Associates of the Society of Actuaries. We meet the Qualification Standards of the American Academy of Actuaries to issue this report.

Conflict of Interest

Wakely provides actuarial services to a variety of clients throughout the health industry. Our clients include commercial, Medicare, and Medicaid health plans, the federal government and state governments, medical providers, and other entities that operate in the domestic and international health insurance markets. Wakely has implemented various internal practices to reduce or eliminate conflict of interest risk in serving our various clients. Except as noted here, the responsible actuaries are financially independent and free from conflict concerning all matters related to performing the actuarial services underlying this analysis. In addition, Wakely is organizationally and financially independent to AHIP.

Data and Reliance

We have relied on others for various information used in the report. If the underlying information is incomplete or inaccurate, our conclusions may be impacted, potentially significantly.

Subsequent Events

There are no known relevant events subsequent to the date of information received that would impact the results of this report.

Deviations from Actuarial Standards of Practice (ASOPs)

Wakely completed the analysis using sound actuarial practice. To the best of our knowledge, the report and methods used in the analysis are compliant with the appropriate ASOP with no known deviations.

- ASOP No. 23, Data Quality
- ASOP No. 41, Actuarial Communication



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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