Understanding the Extraordinary Increase in ACA Premiums in 2026

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Analyses show that Marketplace benchmark premiums, the second-lowest-cost silver plans, have increased by more than 20 percent in 2026.[1] These premiums were set assuming that the enhanced premium tax credits (PTCs) would expire and reflect federal policy changes announced in 2025. These increases have led to claims by some observers that the Affordable Care Act (ACA) is a deeply flawed, financially out of control, unsustainably expensive, and wasteful.[2] This paper attempts to understand the large increase in 2026 premiums, given that premiums in the employer-sponsored insurance market are projected to be in the 6 to 7 percent range.[3]

This paper focuses on the increases in full or gross premiums. This is a separate, though related, issue from the increases in net premiums paid by enrollees resulting from the expiration of enhanced PTCs, which were a major issue behind the recent government shutdown.[4] The expiration of the current PTCs and reversion to the original, less generous ACA tax credits will increase net premiums (i.e., the amount that individuals actually pay net of the PTC) at each income level, regardless of the level of full premiums (Buettgens et al. 2025b). The amount that individuals pay in net premiums after the tax credit is based on their income; that is, net premiums are capped as a percentage of income, with the caps increasing with income. The enhanced subsidies also extend premium assistance to higher income levels by capping the amount that individuals have to pay to 8.5 percent of income; with the ACA tax credits, there are no tax credits for those with incomes above 400 percent of the federal poverty level. These increases in net premiums at each income level are expected to dissuade many individuals—particularly those with lower expected health spending—from purchasing insurance in the Marketplace, thereby

worsening the risk pool, which in turn has presumably affected the full premiums that insurers have submitted and that we report here.

We present data on premiums by state and estimate an average national increase of 21.7 percent, using population to weight by region and state. The difference between our estimate of 21.7 percent and the 26 percent reported by KFF is likely because of differences in how benchmark premiums are weighted across rating regions and states.[5] We also show that the 21.7 percent increase in 2026 followed five years during which the average annual change was only 2.0 percent, much lower than the increases in employer-sponsored plans. We believe that the 21.7 percent increase in Marketplace benchmark premiums reflects three major factors:

- The first is medical care cost trends affecting all private health insurance, which have caused premiums in employer-sponsored plans to increase by about 6 to 7 percent in 2026.[6] This includes higher wages for health care providers, price increases because of the consolidation of hospital systems, increased intensity in the utilization of specific treatments such as new weight-loss drugs, and other factors.
- Second, the expiration of enhanced PTCs is expected to reduce subsidized Marketplace enrollment by 7.3 million people in 2026. Enrollees who are less healthy and have higher costs are more likely to remain enrolled. The resulting increase in the cost of the risk pool is estimated to increase total premiums by at least another 4 to 6 percent in 2026 (Buettgens et al. 2025b).[7] However, there is uncertainty regarding the magnitude of this change.
- The final 9 to 10 percentage points are more difficult to account for and likely stem from several factors. Beyond the expiration of enhanced PTCs, changes in federal Marketplace policy under the recent reconciliation package, the 2025 CMS Integrity Rule,[8] and other areas (such as cuts in assistor and outreach spending) are reducing 2026 Marketplace enrollment and contributing to general uncertainty (Anderson et al. 2025). Some insurers may anticipate that these changes will worsen risk. Some insurers have decided to exit certain rating regions or all Marketplaces altogether, reducing pressure on the remaining insurers to keep premium increases low. We find that 21 states have lost at least one insurer in 2026. Insurers that remain in the Marketplace have raised their 2026 premiums to reflect this general uncertainty.

During the first few years after the Marketplaces were established, annual increases in total premiums were fairly small.[9] Insurers were gaining information on the health risk of their enrolled populations. Marketplace premiums increased by 34 percent in 2018 as insurers responded to the administration's announcement that the federal government would no longer provide reimbursement for cost-sharing reductions (Banthin and Grazevich 2022). Since 2019, however, Marketplace premium increases have been very small and much smaller than increases in the employer market. Similarly, premiums may stabilize or even decline in 2027 as insurers gain a better understanding of the risk pool. However, changes enacted in the One Big Beautiful Bill Act (OBBBA) that will be implemented in plan years 2027 and 2028, such as eliminating auto-reenrollment with subsidies and eliminating conditional eligibility for subsidies, may create more uncertainty for Marketplace insurers and cause them to further increase premium prices.[10]

Prior research has shown that the ACA has been fairly successful in controlling premium growth, with average annual premiums growing at 2.0 percent per year between 2020 and 2025. This rate of growth is much slower than the growth in employer premiums (4.5 percent) and national health expenditures (6.3 percent) between 2020 and 2025 (Keehan et al. 2025; Martin et al. 2024).[11] As we have shown elsewhere, ACA premiums before 2026 were lower than those in employer and small-group markets by 15 percent and 23 percent, respectively (Holahan and Wengle 2024). This analysis controlled for differences in the actuarial value of plans (richness of benefits), utilization, and the need for Marketplace premiums to finance cost-sharing reductions. We have also shown that the ACA does not subsidize rich insurance plans; deductibles and out-of-pocket costs are high. We showed that in 2024, deductibles averaged $5,000 for silver plans and $7,500 for bronze plans, and out-of-pocket maximums were between $9,000 and $10,000 (Holahan, Simpson, and Wengle 2025).

In this paper, we present data by state on changes in premiums between 2025 and 2026, comparing increases to previous years since 2020. We then conduct a regression analysis that identifies various factors associated with premium levels and the 2025–26 growth in premiums. Finally, we examine changes in insurer participation in 2026 as insurers face greater uncertainty in the Marketplaces.

Methods

We provide premium and insurer participation data from Healthcare.gov for 31 states and from 20 state-based Marketplace websites, including DC. We collect data at the rating region level for 503 rating regions to calculate state-average benchmark premiums and growth rates from 2025 to 2026. We also show the average annual increase in benchmark premiums from 2020 to 2025 for comparison. By weighting by rating region population, we provide state averages of the benchmark premiums, that is, the second-lowest-cost silver plan premium in the rating region. We use the benchmark premium because it is used to calculate federal PTCs, and there is competitive pressure for insurers to be in the lowest two silver options. Benchmark and lowest-cost silver plans are typically very closely priced. On average, the difference between them is $19 a month for a 40-year-old.

Second, we estimate linear regression models to explain variations in benchmark premiums and differences in growth rates among rating regions. We control for factors likely to affect Marketplace premiums, such as the number and types of participating insurers, Medicaid expansion, state-specific community rating, state reinsurance programs, whether a state operates its own state-based Marketplace, and rurality. We additionally control for the area wage index, hospital concentration, and census region. Finally, we examine changes in the number of insurers in states that saw the average number of insurers decrease and, among a subset of rating regions, the number of rating regions in which major insurers participated.

Results

Premium Increases by State

Table 1 shows premiums for 2020, 2025, and 2026, as well as the average annual increase between 2020 and 2025, and the increase between 2025 and 2026. Premiums are shown for a 40-year-old nonsmoker. Premiums in Vermont and New York were among the highest, primarily because those states use community rating, in which premiums are based only on the average risk within a geographic area rather than the insured's age. For that reason, community-rated premiums are not strictly comparable to the other premiums shown in table 1. Table 1 shows that, nationally, benchmark premiums jumped by 21.7 percent in 2026, when weighted by rating region population. State variation in premium growth is substantial. Ten states—Arizona, Arkansas, Florida, Illinois, Kansas, Kentucky, Mississippi, Tennessee, Texas, and Washington—all had increases in excess of 30 percent. Another 18 states had increases between 20 and 30 percent. Only five states—Alaska, New Jersey, New York, South Dakota, and Vermont—had increases of less than 5 percent in 2026.

TABLE 1

State Average Monthly Benchmark Premium for a 40-Year-Old Nonsmoker and Percent Change, 2020–26

	Benchmark Premium			Percent Change	
	2020	2025	2026	Average annual change, 2020–25	2025–26
US average	$454	$500	$609	**2.0%**	**21.7%**
Alabama	$551	$532	$646	-0.6%	21.3%
Alaska	$721	$1,050	$1,037	8.2%	-1.2%
Arizona	$437	$403	$524	-1.5%	30.0%
Arkansas	$365	$458	$774	4.7%	69.1%
California	$427	$509	$569	3.7%	11.9%
Colorado	$374	$460	$549	4.7%	19.3%
Connecticut	$565	$690	$866	4.1%	25.6%
DC	$414	$578	$610	7.4%	5.4%
Delaware	$548	$534	$692	-0.5%	29.6%
Florida	$472	$516	$684	1.9%	32.5%
Georgia	$437	$504	$622	3.4%	23.4%
Hawaii	$471	$494	$543	1.0%	9.8%
Idaho	$522	$437	$490	-3.4%	12.2%
Illinois	$444	$476	$633	1.5%	33.0%
Indiana	$393	$383	$480	-0.5%	25.5%
Iowa	$689	$410	$475	-9.1%	15.9%
Kansas	$486	$506	$669	0.9%	32.1%
Kentucky	$460	$446	$590	-0.5%	32.3%
Louisiana	$498	$518	$642	1.0%	23.9%
Maine	$498	$550	$711	2.4%	29.2%
Maryland	$397	$365	$414	-1.4%	13.5%
Massachusetts	$354	$449	$495	4.9%	10.2%
Michigan	$351	$394	$505	2.4%	28.2%
Minnesota	$312	$361	$448	3.0%	24.2%
Mississippi	$483	$486	$641	0.2%	32.0%

	Benchmark Premium			Percent Change	
	2020	2025	2026	Average annual change, 2020–25	2025–26
Missouri	$478	$488	$609	0.6%	24.7%
Montana	$472	$546	$689	3.0%	26.1%
Nebraska	$674	$592	$694	-2.4%	17.3%
Nevada	$379	$419	$502	2.1%	19.9%
New Hampshire	$405	$324	$388	-4.0%	19.7%
New Jersey	$389	$488	$508	4.8%	4.1%
New Mexico	$346	$520	$632	8.7%	21.5%
New York*	$599	$789	$812	5.9%	2.9%
North Carolina	$540	$499	$629	-1.5%	26.1%
North Dakota	$333	$480	$510	8.1%	6.4%
Ohio	$360	$439	$515	4.1%	17.2%
Oklahoma	$545	$470	$573	-2.7%	22.0%
Oregon	$440	$499	$535	2.6%	7.4%
Pennsylvania	$441	$492	$606	2.3%	23.3%
Rhode Island	$332	$425	$506	5.1%	19.2%
South Carolina	$509	$474	$568	-1.2%	19.9%
South Dakota	$563	$575	$597	0.5%	3.9%
Tennessee	$510	$517	$716	0.5%	38.5%
Texas	$415	$485	$653	3.2%	34.5%
Utah	$481	$544	$640	2.6%	17.8%
Vermont*	$662	$1,277	$1,299	15.3%	1.8%
Virginia	$517	$374	$460	-6.0%	23.2%
Washington	$385	$434	$628	2.5%	44.9%
West Virginia	$622	$920	$1,074	8.2%	16.7%
Wisconsin	$478	$484	$601	0.4%	24.1%
Wyoming	$877	$868	$1,086	0.0%	25.2%

Source: Authors' analysis of state-based Marketplace websites and "Health Plan Datasets: Individuals & Families," Healthcare.gov, accessed December 15, 2025, https://www.healthcare.gov/health-plan-information/.
Notes: State average is the average of the second-lowest silver premium offered in each rating area. Prices are weighted by rating area population size. Premiums are for a 40-year-old nonsmoker. * = Premiums for Vermont and New York, which have community rating, are not strictly comparable to those of other states.

Table 1 also shows that the increases between 2020 and 2025 averaged 2.0 percent nationwide. Premium increases were fairly low in most but not all states, reflecting the impact of high levels of competition, particularly in urban markets. As we have shown previously, a large number of insurers, including Medicaid (plans that began in Medicaid and extended to participating in Marketplaces) and provider-sponsored plans, participated in this period (Holahan, O'Brien, and Wengle 2024; Holahan, Simpson, and Kennedy 2025; Holahan, Wengle, and O'Brien 2023). Insurers competed by using both high deductibles and narrow networks that consisted of providers willing to accept lower payment rates. In terms of cost containment, it would be difficult to see better outcomes. Premiums did, in fact, jump by 21.7 percent in 2026, but, for the reasons discussed above, we believe this will be an aberration.

There is still considerable variation among states in the level of premiums in 2026. Seven states, including Alaska, Arkansas, Connecticut, West Virginia, and Wyoming, and the community-rated states, New York and Vermont, all had premiums greater than $750 per month. On the other hand, several states still had relatively low premiums. Idaho, Indiana, Iowa, Maryland, Massachusetts, Minnesota,

New Hampshire, and Virginia all had premiums less than $500 per month. Many of these have relatively competitive markets, particularly in urban areas.

Factors Associated with Premium Variation: Regression Results

Table 2 shows the results of a multivariate regression analysis of the factors correlated with benchmark premium levels in 2026 and the change in benchmark premiums from 2025 to 2026 at the rating area level. We regressed benchmark premiums against the number of insurers participating in the rating area in 2026, the types of insurers participating (e.g., Blue Cross Blue Shield, national commercial insurers, provider-sponsored), a measure of hospital concentration, the area wage index, and other factors. We found that the number of insurers participating was a highly significant predictor of benchmark premiums. Compared with rating areas with five or more insurers, those with only one or two insurers had higher monthly premiums by more than $247 (compared with the mean monthly premium of $646 across all rating regions). Markets with three and four insurers also had higher premiums than those in more competitive areas ($81 and $37 more, respectively).

TABLE 2

Regression Coefficients Associated with Benchmark Premium, 2025, and Percent Change in Benchmark Premium Costs, 2025–26, in Rating Region

	Monthly benchmark premium 2026 ($)	Change in benchmark premium, 2025–26 (%)
Number of insurers participating in 2026		
One or two	247.20***	11.96***
Three	81.37***	5.93***
Four	36.61***	2.49*
Type of insurer participating in 2026		
Blue Cross Blue Shield	41.97	-1.80
Medicaid	-6.94	5.46***
National	47.63***	3.54***
Provider	-42.52***	-1.00
Regional/local	46.07***	2.36*
Other factors		
Hospital system Herfindahl-Hirschman Index, 2018	0.01**	9.63e-05
Teaching hospitals share, 2022	30.62	-0.26
Area wage index, 2023	73.68*	-5.44
Medicaid expansion status, 2026	-63.05***	-3.45**
Community-rated, 2026	147.71***	-16.77***
Reinsurance, 2026	-44.28**	-3.58*
State-based Marketplace, 2026	-45.18**	4.54**
Small urban area	37.19***	0.96
Rural area	57.18***	-0.29
Census region		
South	22.74	1.13
Northeast	105.03***	-0.09
West	107.53***	-0.37
2025 benchmark premium		-0.02***
Constant	400.31***	32.88***
Observations	503	503
R-squared	0.419	0.246

Source: Authors' analysis of state-based Marketplace websites and "Health Plan Datasets: Individuals & Families," Healthcare.gov, accessed December 15, 2025, https://www.healthcare.gov/health-plan-information/.
Notes: The benchmark premiums are taken from each rating area. Robust standard errors were used. ** p < 0.05; *** p < 0.01. For the hospital Herfindahl-Hirschman Index variable, p = 0.119; and for the teaching variable, p = 0.114 as indicated by ^. Premiums are for a 40-year-old nonsmoker.

The insurer type was also a highly significant predictor of the benchmark premium level. Provider-sponsored plans were associated with lower Marketplace premiums, presumably because they control their own provider payment rates. National and local/regional plans have somewhat higher premiums, often because of their broader provider networks. In previous years, we found that rating regions with insurers who offered major Medicaid managed care plans had significantly lower benchmark premiums (Holahan, Simpson, and Kennedy 2025; Holahan, O'Brien, and Wengle 2024; Holahan, Wengle, and O'Brien 2023). However, we did not find a statistically significant effect in 2026, potentially because other Marketplace plans have adopted the same narrow network plans that Medicaid insurers have historically offered.

We used the Herfindahl-Hirschman Index (HHI) at the rating area level to measure hospital concentration. The results showed that it was statistically significantly related to 2026 benchmark premiums—the more concentration, the higher the premiums. Many of the areas with high HHIs were in small urban and rural areas, which have fewer hospitals and more highly concentrated markets. However, HHI was a statistically significant factor despite controlling for the rating region's rurality. The presence of a teaching hospital was not significantly related to the 2026 premium. The area wage index was also a significant predictor, indicating, not unsurprisingly, that areas with higher wages have higher premiums.

States that had expanded their Medicaid program had lower 2026 monthly benchmark premiums ($63 lower on average) because the lowest income group—those earning between 100 and 133 percent of the federal poverty level— would be covered under Medicaid rather than the Marketplaces. Since health status is usually inversely related to income (Finkelstein et al. 2022), these results reflect the healthier Marketplace-insured populations in expansion states. The use of community rating in New York and Vermont was associated with substantially higher 2026 monthly benchmark premiums for 40-year-olds, by $148; as noted earlier, the community-rated premiums, which apply at all ages, reflect the costs of the entire covered population. States with reinsurance had lower premiums ($44 lower on average), as reinsurance policies absorb some of the risk, reducing the need for insurers to incorporate that risk into their premiums. States that have a state-based Marketplace had significantly lower premiums ($45 lower on average). Rural and small urban rating regions had significantly higher premiums than urban areas ($57 and $37 higher on average, respectively). Rating areas in the Northeast and West had significantly higher premiums (about $100 higher on average) than those in the Midwest and South.

We then regressed the percent change in benchmark premiums between 2025 and 2026 against the same factors and the 2025 benchmark premium. Rating regions with fewer than five insurers had higher growth in premiums between 2025 and 2026. For example, rating regions with one or two insurers had premium growth that was 12 percentage points higher than regions with five or more

insurers. Rating regions with insurers who offered a Medicaid managed care plan, and national insurers had significantly higher growth in premiums. Premiums grew significantly more slowly in rating regions in states with Medicaid expansion and reinsurance. Premiums grew significantly more slowly in rating regions with community rating because, in New York, which represents the vast majority of rating regions with community rating, premiums fell because of changes to their Essential Plan, which will bring many healthier people into the Marketplace.[12] Premiums grew significantly faster in rating regions located in states with a state-based Marketplace.

Selected Large and Small Cities and Rural Areas

To better understand premium increases in 2026, we examined changes in specific cities and rural areas; premium levels; changes in lowest-cost silver premiums; and insurer entry and exits for each of 20 large cities and 10 small cities or rural areas (areas selected to be geographically representative). The results are shown in table 3. Four things of particular note are as follows.

1. Ten of the 20 large cities had premiums below the national average of $590 in 2026. On the other hand, six of the 10 small cities and rural areas had premiums above the national average, with the highest premiums in Charleston, WV, and Cheyenne, WY, where the lowest-cost premiums were over $1,000 per month.
2. Almost all markets had very low or negative increases between 2020 and 2025, and most had very large increases between 2025 and 2026. There were a few exceptions, such as Los Angeles, San Francisco, and Baltimore, that had small increases in 2026. A notable exception was New York City, where, because of changes to New York's Essential Plan, a large number of relatively healthy individuals enrolled in Marketplace plans, causing premiums to fall despite other changes to the Marketplaces.[13]
3. We also found that 14 of the 30 areas lost at least one insurer; four gained an insurer. Still, most markets had four or more insurers in 2026. If the large premium increases in 2026 prove excessive, premium increases should be much lower in 2027, and the number of insurers participating could increase. But this all depends on other factors. For example, several other OBBBA changes that could affect enrollment are scheduled to take effect in 2027 and 2028.[14]
4. A much greater mix of insurers are listed as among the lowest- or second-lowest-cost plans. In previous years, these would be dominated by Medicaid plans such as Ambetter and Molina (Blumberg, Holahan, and Wengle 2016). Now it is not unusual for Blue Cross, Kaiser Permanente, Anthem, and Oscar to be among the lowest-cost plans (table 3). This most likely reflects the development of Medicaid-like narrow network plans by these insurers.

A related finding, shown in the appendix tables, is that premium increases are remarkably consistent across insurers within regions.[15] For example, if the average premium increase for the lowest-cost plan in a region is 25 percent, the approved increases for other insurers are generally within that range. This may reflect agreement among insurers or among the actuaries in the state about the amount of uncertainty. Or it could reflect the impact of rate regulators who refuse to accept premium bids that are wildly inconsistent across insurers.

TABLE 3

Summary of Premiums and Number of Insurers in Selected Rating Regions

Region	Lowest Silver Monthly Premium	Percent Change		Number of Insurers		Lowest-Cost Insurers in 2026	
	2026	2020–25	2025–26	2025	2026	Lowest	Second-lowest
Large cities							
National average	$590	2.2%	21.2%	5.6	5.1	N/A	N/A
Birmingham, AL	$625	0.2%	18.9%	3	4	Blue Cross Blue Shield	Ambetter
Phoenix, AZ	$472	-2.5%	37.2%	8	7	Imperial Insurance Companies	Oscar
East Los Angeles, CA	$392	1.7%	10.5%	6	6	L.A. Care Health Plan	Health Net
San Francisco, CA	$710	5.3%	6.1%	4	4	Kaiser Permanente	Blue Cross Blue Shield
Miami, FL	$682	3.0%	32.5%	10	9	Blue Cross Blue Shield	Oscar
Atlanta, GA	$621	4.9%	18.1%	7	7	Kaiser Permanente	Oscar
Chicago, IL	$497	3.0%	27.2%	7	5	Molina	Ambetter
Indianapolis, IN	$469	-1.7%	22.0%	6	5	Anthem	Ambetter
Baltimore, MD	$403	-1.1%	11.2%	5	4	UnitedHealthcare	Kaiser Permanente
Boston, MA	$475	5.2%	13.6%	7	7	BMC HealthNet (WellSense)	Fallon Health
Detroit, MI	$508	3.0%	43.5%	8	5	Blue Care Network of Michigan	UnitedHealthcare
New York, NY	$807	6.1%	-2.7%	7	7	Ambetter	HealthFirst
Charlotte, NC	$575	3.5%	20.3%	8	5	Oscar	Blue Cross Blue Shield
Cleveland, OH	$489	4.8%	21.8%	9	8	Molina	Antidote
Oklahoma City, OK	$561	-1.9%	26.8%	7	7	Ambetter	Oscar
Philadelphia, PA	$455	-5.3%	30.5%	4	4	Jefferson Health Plan	Independence Blue Cross (Highmark)
Houston, TX	$586	2.7%	37.1%	9	7	Community Health Choice	Ambetter
DC suburbs, VA	$447	-6.8%	26.3%	8	7	Sentara (Optima Health)	Anthem
Seattle, WA	$584	2.0%	40.7%	9	10	Community Health Network	Ambetter
Milwaukee, WI	$642	1.4%	40.3%	7	3	Network Health	UnitedHealthcare
Small cities and rural areas							
Rural AL	$634	1.4%	24.6%	3	3	Ambetter	Blue Cross Blue Shield
Little Rock, AR	$753	4.9%	66.7%	4	4	Octave	Blue Cross Blue Shield
Rural CA	$656	5.3%	8.3%	3	3	Kaiser Permanente	Anthem
Rural GA	$488	3.2%	24.7%	4	5	Oscar	Alliant Health Plans
Rural IN	$440	2.0%	21.6%	3	4	Blue Cross Blue Shield	Ambetter
Rural NC	$702	-3.5%	27.4%	9	6	Ambetter	AmeriHealth Caritas Next
Rural OH	$536	2.4%	24.5%	7	7	Oscar	Antidote
Rural OK	$568	-2.4%	22.3%	6	7	Medica	Ambetter
Charleston, WV	$1,056	7.3%	13.9%	2	2	Blue Cross Blue Shield	CareSource
Cheyenne, WY	$1,026	0.3%	26.9%	3	2	Blue Cross Blue Shield	UnitedHealthcare

Source: Authors' analysis of state-based Marketplace websites and "Health Plan Datasets: Individuals & Families," Healthcare.gov, accessed December 15, 2025.
Notes: Premiums are for a 40-year-old nonsmoker.

Changes in Insurer Participation

The same factors that drove premiums to increase dramatically (i.e., increased risk and uncertainty) could cause insurers to exit markets entirely. We examine insurer exits in tables 4 and 5. Table 4 shows the number of insurers participating in each of 50 rating regions in 28 states. These rating regions account for 27.4 percent of the US population. The largest change was Aetna, which participated in 19 of these regions in 2025 but zero in 2026. Molina, a prominent insurer that has largely participated in Medicaid, participated in 13 of the 50 regions in 2025, but only eight in 2026. Twenty-four provider-sponsored plans participated in 2025, but only 19 of 50 in 2026. Centene dropped out of one rating region in 2026. Blue Cross Blue Shield and UnitedHealthcare were unchanged. Oscar increased participation by one rating region in 2026 compared with 2025.

TABLE 4

Insurer Participation in Rating Regions among Select Study Regions, by Insurer, 2017–26

Insurer	2020	2021	2022	2023	2024	2025	2026
Aetna	0	0	9	13	18	19	0
Anthem	6	8	10	10	10	10	10
Blue Cross Blue Shield[a]	43	44	44	43	44	44	44
CareSource	7	7	7	8	8	9	7
Centene (Ambetter, HealthNet, Fidelis Care, Coordinated Care)	24	29	33	33	35	34	33
Cigna	6	8	11	13	13	11	10
Friday and Bright	6	13	21	4	0	0	0
Humana	0	0	0	2	0	0	0
Kaiser Permanente	10	10	10	10	9	9	9
Molina Healthcare	11	11	12	13	13	13	8
Oscar	16	19	22	21	21	23	24
UnitedHealthcare	3	10	20	26	27	31	31
Provider	11	15	21	27	27	24	19
Other	33	34	35	38	40	44	42
Total number of participating insurers	**176**	**208**	**255**	**261**	**265**	**271**	**237**

Source: Authors' analysis of state-based Marketplace websites and "Health Plan Datasets: Individuals & Families," Healthcare.gov, accessed December 15, 2025, https://www.healthcare.gov/health-plan-information/. Selected study regions represent 50 rating regions in 28 states.
Notes: [a] This excludes Anthem.

Table 5 presents insurer participation by state and the insurers that left each state in 2026. Delaware, Illinois, Kansas, Maryland, Michigan, North Carolina, Utah, Wisconsin, and Wyoming lost at least one insurer. Several other states lost insurers in at least one rating region. Aetna left the rating regions in which it participated in 2025 in Arizona, Arkansas, California, Delaware, Florida, Illinois, Indiana, Kansas, Maryland, Missouri, North Carolina, Ohio, Texas, and Utah. Molina left markets in Kentucky, Michigan, South Carolina, Texas, Utah, and Wisconsin. CareSource, another important Medicaid insurer, left markets in Kentucky, Michigan, and North Carolina. The remaining insurers that left the markets were all local insurers.

TABLE 5

Average Number of Insurers per ACA Rating Area, 2025 and 2026

State	Number of rating regions	Average number of insurers, 2025	Average number of insurers, 2026	Change in average number of insurers	Notes
Alabama	13	2.8	2.9	0.2	
Alaska	3	2.0	2.0	0.0	
Arizona	7	5.0	4.7	-0.3	Banner Aetna left the 6 rating regions in which it participated in 2025.
Arkansas	7	2.0	2.0	0.0	
California	19	3.5	3.5	-0.1	Aetna left the 4 rating regions in which it participated in 2025.
Colorado	9	4.2	4.4	0.2	
Connecticut	8	2.0	2.0	0.0	
District of Columbia	1	2.0	2.0	0.0	
Delaware	1	4.0	3.0	-1.0	Aetna left the market.
Florida	67	5.0	4.4	-0.5	Aetna left the 49 rating regions in which it participated in 2025. Health First left 9 of the 14 rating regions in which it participated in 2025.
Georgia	16	4.2	4.4	0.2	
Hawaii	1	2.0	2.0	0.0	
Idaho	6	6.5	6.7	0.2	
Illinois	13	4.2	3.0	-1.2	Aetna, Health Alliance, and Quartz left the market. In 2025, each participated in 8, 7, and 1 rating regions, respectively. MercyCare left 1 of the 2 rating regions in which it participated in 2025.
Indiana	17	3.9	3.5	-0.4	Aetna left the 8 rating regions in which it participated in 2025. BCBS left 1 of the 8 rating regions in which it participated in 2025. United left 1 of the 4 rating regions in which it participated in 2025.
Iowa	7	4.0	4.4	0.4	
Kansas	7	4.6	3.1	-1.4	Aetna left the 6 rating regions in which it participated in 2025. United left 4 of the 7 rating regions in which it participated in 2025.
Kentucky	8	2.9	2.1	-0.8	CareSource left 4 rating regions in which it participated in 2025. Molina left the 2 rating regions in which it participated in 2025.
Louisiana	8	2.6	2.0	-0.6	United left the 6 rating regions in which it participated in 2025.
Maine	4	3.3	3.8	0.5	
Maryland	4	5.0	4.0	-1.0	Aetna left the 4 rating regions in which it participated in 2025.
Massachusetts	7	7.0	7.0	0.0	

State	Number of rating regions	Average number of insurers, 2025	Average number of insurers, 2026	Change in average number of insurers	Notes
Michigan	16	5.0	4.0	-1.0	University of Michigan Health Plan, Molina, and CareSource left the market. In 2025, each participated in 7, 6, and 3 rating regions, respectively. Ambetter left 2 of the 12 rating regions it participated in 2025.
Minnesota	9	3.6	3.4	-0.1	Quartz left the market in 1 rating region in which it participated in 2025.
Mississippi	6	4.8	4.7	-0.2	Primewell, which was previously in all rating regions, left the market.
Missouri	10	4.9	4.3	-0.6	Aetna left the 7 rating regions in which it participated in 2025.
Montana	4	3.0	3.0	0.0	
Nebraska	4	5.0	5.0	0.0	
Nevada	4	5.0	5.8	0.8	
New Hampshire	1	4.0	4.0	0.0	
New Jersey	1	5.0	5.0	0.0	
New Mexico	5	4.0	4.0	0.0	
New York	8	4.9	4.9	0.0	
North Carolina	16	6.4	4.1	-2.3	Aetna, CareSource, and Wellcare left the market. In 2025, each participated in 14, 7, and 16 (i.e., all) rating regions, respectively.
North Dakota	4	3.0	3.0	0.0	
Ohio	17	8.2	7.2	-0.9	Aetna and AultCare left the market. In 2025, each participated in 12 and 3 rating regions, respectively. Paramount left 1 of the 2 rating regions in which it participated in 2025.
Oklahoma	5	5.2	5.4	0.2	
Oregon	7	4.7	4.7	0.0	
Pennsylvania	9	3.4	3.7	0.2	
Rhode Island	1	2.0	2.0	0.0	
South Carolina	46	4.1	3.7	-0.4	Molina left 8 of the 45 rating regions in which it participated in 2025. United left 16 of the 33 it participated in 2025.
South Dakota	4	2.8	2.8	0.0	
Tennessee	8	4.1	4.4	0.3	
Texas	27	6.2	5.6	-0.7	Aetna left the 13 rating regions in which it participated in 2025. Molina left 9 of the 12 rating regions in which it participated in 2025.
Utah	6	5.3	4.0	-1.3	Aetna left the 4 rating regions in which it participated in 2025. Molina left 4 of the 5 rating regions in which it participated in 2025.
Vermont	1	2.0	2.0	0.0	
Virginia	12	2.8	2.9	0.1	
Washington	9	6.9	7.1	0.2	
West Virginia	11	2.0	2.0	0.0	

State	Number of rating regions	Average number of insurers, 2025	Average number of insurers, 2026	Change in average number of insurers	Notes
Wisconsin	16	6.2	4.5	-1.7	Chorus Community Health Plans and Molina left the market. In 2025, each participated in 5 and 9 rating regions, respectively. Blue Cross Blue Shield left 2 of the 16 rating regions. Common Ground Healthcare Cooperative left 3 of 7 rating regions. Group Health Cooperative-SCW left 1 of 4 rating regions. Quartz left 6 of 12 rating regions.
Wyoming	3	3.0	2.0	-1.0	Mountain Health Co-Op left the 3 rating regions in which it participated in 2025.

Source: Authors' analysis of state-based Marketplace websites and "Health Plan Datasets: Individuals & Families," Healthcare.gov, accessed December 15, 2025, https://www.healthcare.gov/health-plan-information/.

Discussion

We have shown the extraordinary 21.7 percent premium growth between 2025 and 2026 and how this varies by state, assuming the expiration of PTCs and the contribution of this to risk and, therefore, to premiums. (Our estimate differs from the widely cited KFF estimate of 26 percent likely because of how we weighted by rating regions population estimates). This is in sharp contrast to the average 2.0 percent growth between 2020 and 2025. This 21.7 percent is higher than the medical trend reflected in the increases by employer-sponsored plans, as well as estimates of increased risk because of the expiration of PTCs. Another roughly 10 percent increase is difficult to account for. This seems to reflect the market's pricing of uncertainty, in part due to other federal changes to the Marketplace.

The OBBBA and the expiration of PTCs will create havoc in the ACA's Marketplaces. Our colleagues have estimated that the expiration of PTCs will result in 7.3 million fewer marketplace enrollees and an increase of 4.8 million Americans without insurance (Buettgens et al. 2025b). Other changes in regulations and within the OBBBA will affect Marketplace enrollment. Our colleagues have also estimated that these will result in an overall decrease in Marketplace enrollment of 5.0 million and an increase in the number of uninsured by 2.6 million (Buettgens et al. 2025a). There will not only be a reduction in the number of Marketplace enrollees but most likely a less healthy population, meaning more risk for insurers. This accounts for the increases in premiums we attribute to uncertainty.

Why were increases in premiums so low for so many years? We believe this is largely because of the significant competition resulting from the ACA Marketplaces' general structure. PTCs or subsidies are tied to the second-lowest-cost plan. Any insurer offering a policy for significantly more than the benchmark premium risks having very little market share, i.e., attracting few enrollees. Individuals must pay the full marginal cost of the premium of a higher-cost insurer. Competition over premiums has been intense, leading to lower premiums, particularly in urban markets. Marketplace enrollment has expanded over time, improving the risk pool, and more insurers have entered, further reducing premiums through increased competition.[16] With fewer participating insurers in rural areas, premiums can be somewhat higher. Low premiums are often not without their problems. Deductibles can be very high, and networks can be narrow, consisting only of providers willing to accept lower payment rates.[17] Nonetheless, the incentives in the system to control costs have clearly worked.

Our regression results provide statistical evidence that markets with fewer insurers had substantially higher premiums. Premiums are also lower for provider-sponsored plans, probably because of better control over payment rates. In previous analysis, we have shown that areas with Medicaid insurers have lower premiums, presumably because of the narrow networks offered by these plans. Other insurers now offer narrow network plans, so Medicaid insurers are no longer outside the norm. The regression also shows that hospital concentration, which is generally higher in small cities and rural areas, is also associated with higher premiums. Premiums also tend to be higher in small urban and rural areas, independent of the effect of hospital concentration. Marketplace premiums are also lower in states that have not expanded Medicaid because they cover somewhat lower-income populations; these groups have more generous subsidies, thus these markets attract a broader mix of

risks. Finally, premiums are lower in a state-based Marketplace, presumably because many have tighter regulation over rates and/or offer state subsidies that result in healthier people enrolling.[18] We also showed that premium increases have been greater in markets with fewer insurers.

Along with increasing premiums to protect against the uncertainty of ending up with a sicker risk pool, insurers might also leave the market. Surprisingly, we saw relatively few insurers leave Marketplaces. The most prominent was Aetna, which left all Marketplace regions in which it participated. This seems to reflect not only increased risks in the Marketplaces, but their broader problems, including issues with Medicare Advantage and concerns about rising health care costs in general.[19] Several smaller insurers also left the Marketplaces in some regions.

Notes

[1] Cynthia Cox, "ACA Insurers Are Raising Premiums by an Estimated 26%, but Most Enrollees Could See Sharper Increases in What They Pay," *KFF*, October 28, 2025, https://www.kff.org/quick-take/aca-insurers-are-raising-premiums-by-an-estimated-26-but-most-enrollees-could-see-sharper-increases-in-what-they-pay/.

[2] Leo Briceno, "Republicans Turn Their Attention to Bashing Obamacare as Shutdown Enters Day 39," *Fox News*, November 8, 2025, https://www.foxnews.com/politics/republicans-turn-attention-bashing-obamacare-shutdown-enters-day-39; "Read the Full Transcript of Norah O'Donnell's Interview with President Trump Here," *CBS News*, November 8, 2025, https://www.cbsnews.com/news/read-full-transcript-norah-odonnell-60-minutes-interview-with-president-trump/; and "Senator Marshall: The Big Winner of Obamacare Has Always Been Large Insurance Companies," Doc Marshall, November 8, 2025, https://www.marshall.senate.gov/newsroom/press-releases/senator-marshall-the-big-winner-of-obamacare-has-always-been-large-insurance-companies/.

[3] Craig Palosky and Emily Zeigenfuse, "Annual Family Premiums for Employer Coverage Rise 6% in 2025, Nearing $27,000, with Workers Paying $6,850 Toward Premiums Out of Their Paychecks," KFF, October 22, 2025, https://www.kff.org/affordable-care-act/annual-family-premiums-for-employer-coverage-rise-6-in-2025-nearing-27000-with-workers-paying-6850-toward-premiums-out-of-their-paychecks/.

[4] Jasmine Li and Anna Wilde Matthews, "The ACA Subsidies at the Center of the Government Shutdown Fight," *The Wall Street Journal*, October 1, 2025, https://www.wsj.com/politics/policy/government-shutdown-aca-subsidies-obamacare-762ed9a9; and Cheyenne M. Daniels, "Johnson Says Obamacare Debates Shouldn't Be Focus in Shutdown Showdown," *Politico*, September 28, 2025, https://www.politico.com/news/2025/09/28/johnson-obamacare-debates-00583652.

[5] Cox, "ACA Insurers Are Raising Premiums by an Estimated 26."

[6] Palosky and Zeigenfuse, "Annual Family Premiums for Employer Coverage Rise 6% in 2025, Nearing $27,000, with Workers Paying $6,850 Toward Premiums Out of Their Paychecks,"; Beth Umland and Sunit Patel, "Employers Prepare for the Highest Health Benefit Cost Increase in 15 Years," *Mercer*, September 3, 2025, https://www.mercer.com/en-us/insights/us-health-news/employers-prepare-for-the-highest-health-benefit-cost-increase-in-15-years/; and "No Let up in Sight. Medical Cost Trend Set to Grow at 8.5%. Is Your Playbook Ready?," *PWC*, July 16, 2025, https://www.pwc.com/us/en/industries/health-industries/library/behind-the-numbers.html.

[7] Phillip L. Swagel, "Re:" The Effects of Not Extending the Expanded Premium Tax Credits for the Number of Uninsured People and the Growth in Premiums," Congressional Budget Office, December 5, 2024, https://www.cbo.gov/publication/59230.

[8] "2025 Marketplace Integrity and Affordability Final Rule," CMS.gov, June 20, 2025, https://www.cms.gov/newsroom/fact-sheets/2025-marketplace-integrity-and-affordability-final-rule.

[9] "Marketplace Enrollment, 2014-2025," KFF, accessed December 5, 2025, https://www.kff.org/affordable-care-act/state-indicator/marketplace-enrollment/.

[10] "Changes to the Marketplaces: Implementing New Regulatory and Legislative Requirements," State Health and Value Strategies, July 10, 2025, https://shvs.org/resource/changes-to-the-marketplaces-implementing-new-regulatory-and-legislative-requirements/.

[11] Lynne Cotter, Matthew Rae, Matthew McGough, Shameek Rakshit, and Cynthia Cox, "How ACA Marketplace Costs Compare to Employer-Sponsored Health Insurance," KFF-Peterson Health System Tracker, November 3, 2025, https://www.healthsystemtracker.org/brief/how-aca-marketplace-costs-compare-to-employer-sponsoredhealth-insurance/.

[12] Because of provisions in the OBBBA, New York has requested to terminate their 1332 waiver, beginning July 1, 2026, which will result in consumers with incomes between 200 percent and 250 percent of the federal poverty line being moved into the Marketplace. Modeling shows that this population is healthier than the Marketplace population, see "NY State of Health 1332 Waiver Information Page," NY State of Health, accessed December 1, 2025, https://info.nystateofhealth.ny.gov/1332.

[13] See endnote 12. "NY State of Health 1332 Waiver Information Page," NY State of Health.

[14] "Changes to the Marketplaces," State Health and Value Strategies.

[15] For the full appendix, visit: John Holahan, Claire O'Brien, and Noah Kennedy, "Understanding the Extraordinary Increase in ACA Premiums in 2026," Urban Institute, December 18, 2025, https://www.urban.org/research/publication/understanding-extraordinary-increase-aca-premiums-2026.

[16] "Marketplace Enrollment, 2014-2025," KFF.

[17] "Deductibles in ACA Marketplace Plans, 2014-2026," KFF, November 6, 2025, https://www.kff.org/affordable-care-act/deductibles-in-aca-marketplace-plans/.

[18] Jason Levitis and Sonia Pandit, "Supporting Insurance Affordability with State Marketplace Subsidies," State Health and Value Strategies, March 11, 2021, https://shvs.org/supporting-insurance-affordability-with-state-marketplace-subsidies/.

[19] Ryan Benk and Ayesha Rascoe, "Aetna to Exit Health Insurance Exchange, Leaving Millions Without Coverage," *NPR*, May 4, 2025, https://www.npr.org/2025/05/04/nx-s1-5385009/aetna-to-exit-health-insurance-exchange-leaving-millions-without-coverage and Penny Min, "Aetna Drops Out of ACA Exchange In 2026—Here's How It Could Affect You," *Forbes*, July 15, 2025, https://www.forbes.com/advisor/d/aetna-exit-aca-2026-impact/.

References

Anderson, Michelle, Ksenia Whittal, Jenna Hegemann, and Zachary Sherman. 2025. "Future of the Individual Market: Impact of the House Reconciliation Bill and Other Changes on the ACA Individual Market." Tampa, FL: Wakely.

Banthin, Jessica, and Elizabeth Grazevich. 2022. "Trends in Small-Group Market Insurance Coverage." Washington, DC: Urban Institute.

Blumberg, Linda J., John Holahan, and Erik Wengle. 2016. *Increases in 2016 Marketplace Nongroup Premiums: There is No Meaningful National Average*. Washington, DC: Urban Institute.

Buettgens, Matthew, Jameson Carter, Jason Levitis, Jessica Banthin, and Michael Simpson. 2025a. "Reconciliation Bill Would Cut Marketplace Enrollment by over 5 Million People: Most States' Enrollment Losses Exceed One-Third." Washington, DC: Urban Institute.

Buettgens, Matthew, Michael Simpson, Jason Levitis, Fernando Hernandez-Lepe, and Jessica Banthin. 2025b. "4.8 Million People Will Lose Coverage in 2026 If Enhanced Premium Tax Credits Expire." Washington, DC: Urban Institute.

Finkelstein, Daniel M., Jessica F. Harding, Diane Paulsell, et al. 2022. "Economic Well-Being and Health: The Role of Income Support Programs in Promoting Health and Advancing Health Equity." *Health Affairs* 41 (12), https://doi.org/10.1377/hlthaff.2022.00846.

Holahan, John, and Erik Wengle. 2024. "How Do Marketplace Premiums Compare with Premiums in the Large- and Small-Group Markets?" Washington, DC: Urban Institute.

Holahan, John, Claire O'Brien, and Erik Wengle. 2024. *Targeting Highly Concentrated Insurer and Provider Markets for Rate Regulation*. Washington, DC: Urban Institute.

Holahan, John, Michael Simpson, and Erik Wengle. 2025. *Low Marketplace Premiums Often Reflect High Deductibles*. Washington, DC: Urban Institute.

Holahan, John, Erik Wengle, and Claire O'Brien. 2023. *Changes in Marketplace Premiums and Insurer Participation, 2022–2023*. Washington, DC: Urban Institute.

Holahan, John, Michael Simpson, and Noah Kennedy. 2025. "Marketplace Premiums in 2025: Insurer and Provider Concentration Contributes to Wide Variation in Rates." Washington, DC: Urban Institute.

Keehan, Sean P., Andrew J. Madison, John A. Poisal et al. 2025. "National Health Expenditure Projections, 2024–33: Despite Insurance Coverage Declines, Health to Grow as Share Of GDP." *Health Affairs* 44 (7), https://doi.org/10.1377/hlthaff.2025.00545.

Martin, Anne B., Micah Hartman, Benjamin Washington, and Aaron Catlin. 2024. "National Health Expenditures In 2023: Faster Growth as Insurance Coverage and Utilization Increased." *Health Affairs* 44 (1), https://doi.org/10.1377/hlthaff.2024.01375.

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