

ACA Insurers Seek Higher Premiums Amid Enrollment Decline

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The Affordable Care Act (ACA) marketplace, designed to expand health insurance access, faces renewed financial strain as insurers propose significant premium hikes for the upcoming year. This development arrives as the program experiences a notable dip in enrollment, challenging the stability of its risk pools.

KEY TAKEAWAYS

- **The Pivot:** Insurers are requesting substantial premium increases for 2025, a direct response to declining enrollment and escalating healthcare utilization.
- **The Data:** Proposed premium increases range from 5% to over 20% across various states, reflecting a perceived need to stabilize financial solvency.
- **The Action:** Clinicians should anticipate potential shifts in patient insurance coverage and formulary access, requiring proactive communication with patients regarding their benefit changes.

The financial viability of the Affordable Care Act's insurance marketplaces is again under scrutiny, with major insurers signaling a need for substantial premium adjustments for the 2025 plan year. This move comes after a period of relative stability, but a recent downturn in enrollment figures, particularly among younger, healthier individuals, has prompted concerns about adverse selection and the overall health of the risk pool. The fundamental premise of the ACA relies on a broad mix of enrollees to balance the costs of sicker patients with the premiums of healthier ones. When that balance shifts, insurers must adapt their pricing to cover projected expenses.

Insurers across various states have submitted proposals to state regulators, outlining their desired premium increases. These proposals are not uniform; they reflect regional healthcare costs, competitive landscapes, and the specific risk profiles of each insurer's existing enrollee base. The process involves a detailed actuarial analysis, projecting medical claims, administrative costs, and potential profits, all while adhering to federal and state regulations designed to ensure fair pricing and consumer protection. These submissions are then subject to review and approval by state insurance departments, which often negotiate with insurers to mitigate the impact on consumers.

The numbers behind the requests

Initial filings indicate proposed premium increases ranging from 5% to over 20% for individual plans in 2025. For instance, in states like Maryland and Virginia, some carriers have requested increases in the high single digits, while others in states such as New Mexico and Texas have filed for double-digit percentage hikes. These figures represent the average increase across a carrier's plans, with specific plan types and metal tiers (bronze, silver, gold) seeing varying adjustments. The primary drivers cited for these increases include a combination of rising medical care costs,

increased utilization of services, and the aforementioned decline in enrollment, which concentrates risk among a smaller, potentially sicker population.

The Centers for Medicare & Medicaid Services (CMS) reported that national health expenditures grew by 4.1% in 2022, reaching \$4.5 trillion, or \$13,493 per person. This trend of escalating healthcare costs directly impacts insurers' bottom lines, as they must cover a greater share of these expenses. But the enrollment decline is also a critical factor. After reaching a peak of 21.3 million enrollees in 2024, driven by enhanced federal subsidies, the marketplace now faces the prospect of fewer new sign-ups and potential attrition as those subsidies expire or are reduced. This reduction in the overall pool means that the fixed costs of administering plans and covering high-cost claims are spread across fewer premium payers, necessitating higher individual premiums.

One significant aspect of the ACA's design is its rate review process, which requires insurers to justify any proposed rate increase of 10% or more. This transparency mechanism allows state and federal regulators to scrutinize the actuarial assumptions and cost projections. Regulators examine factors such as medical loss ratios (the percentage of premiums spent on claims versus administrative costs), historical claims data, and projected trends in healthcare utilization. The goal is to prevent excessive rate increases while ensuring insurers remain solvent and continue to offer coverage in the marketplace. However, even with rigorous review, the underlying economic pressures of rising healthcare costs and shifting enrollment dynamics remain.

The impact of these proposed increases extends beyond just the sticker price of premiums. Higher premiums can lead to increased out-of-pocket costs for patients, even those receiving subsidies, as the subsidies may not fully offset the increases. This can result in patients choosing plans with higher deductibles or narrower networks, potentially limiting their access to certain specialists or treatments. For clinicians, this translates to a need for heightened awareness of patient insurance limitations and a proactive approach to discussing financial implications of care. The open-label design of the ACA marketplace, where plans and prices are publicly available, does offer some transparency, but navigating the complexities remains a challenge for consumers.

The trial was not powered to detect differences in specific demographic subgroups, and that gap matters. While overall enrollment figures are tracked, the precise breakdown of health status and age within the declining pool is less granularly reported, making it difficult to definitively quantify the extent of adverse selection. The ACA was tested only in the general population; whether benefits extend to specific high-cost chronic disease groups under these new financial pressures remains unclear. The unanswered question is how long the federal government will continue to provide enhanced subsidies, which have been instrumental in maintaining enrollment levels and affordability for many.

To gain a comprehensive perspective on navigating the current challenges in healthcare systems and management, refer to The Oxford Handbook of Health Care Management.

CLINICAL IMPLICATIONS

The proposed premium increases for ACA plans are not merely an administrative detail; they represent a direct challenge to patient access and affordability. Clinicians should prepare for patients facing higher out-of-pocket costs, potentially leading to delayed care or non-adherence to prescribed treatments. This financial strain could exacerbate existing health disparities, particularly for those in lower-income brackets.

Insurers, facing a less favorable risk pool, will likely continue to refine their formularies and network designs

to control costs. This means that access to specific medications or specialist referrals may become more restricted, requiring clinicians to navigate an increasingly complex insurance landscape. The onus will fall on providers to advocate for their patients and to be acutely aware of their coverage limitations.

The stability of the ACA marketplace hinges on a balanced enrollment. If younger, healthier individuals continue to opt out due to rising premiums, the cycle of increasing costs will only accelerate. Policymakers must address the root causes of this enrollment decline, either through sustained subsidies or structural reforms, to prevent further erosion of the risk pool.

Ultimately, the financial pressures on the ACA will translate into clinical realities. Expect more conversations with patients about affordability, more prior authorization hurdles, and a renewed focus on cost-effective care pathways. The system is adapting, but not always in ways that benefit the patient at the point of care.

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