



Health Plan Profitability Challenges as a Call to Action

As we head into 2026, Health Plans are facing growing profitability pressures stemming from a mix of economic challenges, regulatory complexities, and rising consumer expectations. These issues threaten the financial sustainability for health insurers and health plans, both large and small. And consequently, this is also shaping up to be one of the worse years yet for health care providers and consumers – relative to both employer-sponsored health insurance (largest premium increases in 15 years) along with the Affordable Care Act (ACA) marketplace plans bracing for the steepest premium increases since 2018.

What is impacting health plan profitability?

Health plan profitability has essentially hit a tipping point, punctuated by surging medical cost and utilization driving up medical cost ratios (MLR), along with rising administrative expenses (driven by high labor costs, along with ineffective vendor management resulting in health care provider backlash (contractual disputes). This coupled with intense regulatory pressure as CMS and other regulatory agencies remain focused on lowering reimbursement rate growth and increased auditing to combat upcoding particularly for Medicare Advantage plans. All of this has created the perfect storm. And some of the efforts to stem the tide with respect to affordability are actually having the opposite effect.

Increased utilization of health care services, especially within the context of Medicare Advantage (MA) plans, stands out as a major factor due to the increased demand associated with an aging baby boomer population and increasing prevalence of chronic conditions. This includes growing utilization of high-cost medications, such as GLP-1 receptor agonists (e.g., Ozempic, Wegovy used to manage obesity and diabetes). These medications, while highly effective, come with a hefty price tag, placing financial pressure on health plans already facing insurance premium deficiencies.

Regulatory pressures go beyond ongoing efforts on the part of CMS and other federal government actions. Recent legislation, regulation, tariffs, and other changes enacted by the current administration are adding up to create yet more instability in the health insurance market. Based on the “Great Healthcare Plan” unveiled by the current administration in January 2026, several policies are directly aimed at reducing health insurance profitability particularly for major insurers and pharmacy benefit managers (PBMs). These efforts are focused on lowering premiums, increasing transparency, and reducing government subsidies to insurers with mixed results.

Key federal policies impacting health plan profitability



Drastic cuts to Medicare Advantage (MA) rates: net average increase of 0.9% for 2027, far lower than the 4%-6% anticipated.



Enhanced transparency mandates whereby insurers are required to publish “plain English” information on their websites, including percent of revenue spent on claims versus administration cost and profits (as well as claim denial rates).



Redirecting subsidies from insurance companies to individuals who purchase ACA plans, disrupting insurer revenue streams.



Eliminating kickbacks paid by pharmaceutical companies to PBMs, which arguably inflate insurance cost.



Targeting upcoding and overpayments.



Increased transparency and potential reductions in subsidies make ACA plan performance less predictable, forcing insurers to adjust their operating models amidst reduced margins.

What are health plans doing about it and how is that impacting the cost of health insurance across population segments?

Health plans are responding to profitability pressures through a combination of aggressive premium hikes, strategic benefit reductions, and market exits to stabilize their bottom lines.

Insurers have requested median rate increases of 18 -20% for 2026, the largest jump since 2018. MA plans are reducing supplemental benefits such as vision, dental, and transportation and otherwise curtailing benefits (e.g., higher deductibles). Further, to combat the high cost of specialty pharmaceuticals (e.g., CLP-1, weight-loss medications), some plans are discontinuing coverage for these drugs or implementing much stricter prior authorization requirements. Major insurers are also making efforts to “rationalize” markets by pulling out of unprofitable regions (for example, Aetna exited the ACA marketplace altogether in 17 states at the start of 2026).

On the health care provider side of the equation, health plans are implementing efforts to increasingly steer members toward smaller, “high value” provider networks to lower contracted reimbursement costs. At the same time, benefit restrictions and other efforts to curtail excess utilization of services (stricter prior authorization protocols, higher deductibles) are creating pressure on provider relations in addition to increasing future services demand that providers are having a hard time keeping up with.

It is easy to imagine how these short-term efforts to shore up profitability and administrative attempts to right-size both the supply and demand of services will continue to have unwarranted, unsustainable consequences for health care providers and consumers. It will also foster a fracturing of relationships between and among all stakeholders, including health plans and those working toward regulating how health care is delivered and financed. As these challenges converge, health plans will need to find ways to remain financially viable while continuing to promote the delivery of quality health care. Health care providers will also need to engage in efforts to adjust accordingly, taking a closer look at how they are organized and managing delivery of services, along with streamlining of administrative burden/efficiencies.

Let us explore some of the areas of promising focus, in this regard - directed toward health plans and health care providers. While health plans are struggling to regain financial stability, there is renewed interest and opportunity to work directly with health care providers to give rise to more sustainable improvements.

Proactive Strategies: Transitioning from reactive cost-cutting to proactive data-driven and structural interventions

It is often said that through difficult times and circumstances, the best opportunities for innovation and fundamental change for the good present themselves. In this current environment where health care costs and related financial struggles for all participants (health plans, health services providers, patients) are front and center, forward looking organizations are understanding the need to both accelerate and forge new avenues to think and act differently across the entire spectrum of delivery and financing. Here are some of the more prominent examples of areas for promising proactive strategies.

ACCELERATING VALUE-BASED CARE (VBC): Shift away from fee-for-service models to VBC, which ties payments to quality outcomes and total cost reductions. This includes implementing “centers of excellence” (COEs) for specialized care (e.g., oncology, musculoskeletal) to ensure high-quality, reduce unnecessary procedures, and lower cost.

Health plans are also taking a fresh look at strategies for streamlining benefit offerings in concert with provider network-based configurations like accountable care organizations (ACOs) and narrow networks. In doing so, there are lessons to be learned from past implementation of alternative networks relative to ensuring continued appropriate and rational access to care for patient populations enrolled in plans that include these features.

ADOPTING ARTIFICIAL INTELLIGENCE (AI) AND ASSOCIATED ADVANCED DATA ANALYTICS: Payers are using AI to identify potential high-cost claimants early and to power predictive modeling for risk management. This is a perfect example of an area where health care providers can either partner or take the initiative themselves to get on top of opportunities to proactively manage care.

Taking advantage of the greater accessibility of these advancements in data aggregation, processing, and creation, it is much more feasible for health care services providers to take the initiative, on behalf of their patient populations, to rationalize and sequence clinical interventions and activities aimed at managing overall delivery of the right services at the right time.

TECHNOLOGY-DRIVEN PAYMENT INTEGRITY: Leveraging a technology-driven shift from a reactive “pay and chase” model to a more proactive “predict and prevent” approach presents both tactical and strategic advantages.

Health plans now have the opportunity to move upstream more aggressively in the claim lifecycle, prioritizing pre-payment edits to detect errors and fraud prior to payment. This helps in reducing provider abrasion caused by retrospective audits which are slow and costly. These actions can be accomplished via implementation of new automation tools that offer immediate insights into claims, allowing for more dynamic monitoring focused on identification of overbilling and/or noncompliance.

REIMAGINING UTILIZATION MANAGEMENT (UM): To foster improved provider efficiency and both provider and patient experience, health plans are moving toward hybrid or “insourced” UM models, bringing decision-making, technology, and data back under their control to reduce reliance on external, often fragmented service vendors. This is another area where providers in working more proactively with health plans can partner to effect change, as opposed to being left on the sidelines, and even suggest areas where care can be better delivered (right service, right place, right time) obviating the risk that health plans might focus on the wrong opportunities (acting without the benefit of clinical experience).

MANAGING HIGH-COST DRUGS AND SERVICES: There are efforts afoot to optimize medical and pharmacy benefits through “site of care” management, promoting the use of lower-cost settings (e.g., in-home, ambulatory surgery centers) and

adopting biosimilar and generic pharmaceuticals in order to mitigate specialty drug spending. There is much to be gained from a quality of care and affordability perspective in helping direct patients to the most appropriate place of service now that there are so many more options available for receiving the right care at the right time.

This is once again a good example of where partnerships with providers of care can yield important gains relative to better utilization of alternative sites of care and/or therapies.

ENHANCING DIGITAL SELF-SERVICE: To reduce administrative costs health plans are moving member interactions (such as scheduling, checking eligibility, and benefit questions) to digital, AI-driven platforms, such as chatbots and advanced portals. Provider organizations are also finding ways to maximize administrative protocols by having patients complete health questionnaires and other visit related paperwork in advance. In some cases, this can result in an appropriate re-direction of care and help to prioritize delivery of preventive services and other routine follow-up care.

In Summary

These proactive measures are needed at this moment in time to effectively address and manage a projected 9.6% increase in U.S. health care costs for 2026, driven largely by high-cost claims and specialty pharmacy. They also introduce a somewhat unprecedented opportunity (and in some cases imperative) for actions to be taken by both health plans and health care providers (separately and in partnership) to work toward a more fundamental (and sustainable) shift in the direction of how care is delivered and financed.

Areas of strategic focus to directly impact cost of care



Optimize cost management relative to value-based contracting (chronic disease focus)



Alternative pricing models (link reimbursement to outcomes potentially reducing the burden of high-cost interventions)



Increasing operational efficiency (streamline processes and improve efficiency of care delivery to manage cost and improve overall member experience)



Leverage predictive analytics to identify members at risk for high-cost conditions and intervene earlier (AI and machine learning)



Invest in compliance technologies (e.g., toward improved transparency)



Enhance digital access – user friendly platforms that allow patients to engage with their care, manage follow ups, medication adherence etc.



Strengthen data security – protect patient data and comply with data privacy regulations