Healthcare Insurance Costs Are a Struggle for Many and Expensive for Nation

The healthcare insurance costs are a struggle for many retirees and for those who do not have employer-sponsored coverage before being Medicare eligible at age 65. Medical inflation is annually adding to the nation’s debt.

Costs Begin with Premiums Paid to Medicare

The initial cost for original Medicare and Medicare Advantage is the standard Medicare Part B (medical coverage) premium of $202.90 per month in 2026, an increase of $17.90 (9.7%) from the 2025 premium of $185 The Social Security Cost-of-Living Adjustment for 2026 is 2.8%. The $17.90 increase takes a big chunk out of the average monthly 2026 COLA increase of $56. The annual deductible is $283 in 2026 up from $257 in 2025.

Original Medicare's Income-Related Monthly Adjustment Amoun (IRMAA) is an extra charge on top of standard monthly Part B premiums when income is above a certain level. The amount paid is based on modified adjusted gross income (MAGI) from two years prior tax return based on income brackets.

Medicare Part B IRMAA (high-income enrollees) will pay more for coverage. For example, the highest 2026 premium amount is $689.90. This top-tier rate applies to individuals with a 2024 modified

adjusted gross income (MAGI) over $500,000 and married couples filing jointly with a MAGI over $750,000.

For 2026, most Medicare beneficiaries (over 99%) will pay $0 per month for Medicare Part A, as they have worked for at least 40 quarters (10 years) and paid Medicare taxes. For those who do not qualify for premium-free, the premium will be $565 per month up from $518 in 2025.

Surge in Cost for Medigap Plans

Seniors with original Medicare and a Medicare supplement plan (Medigap) are experiencing a surge in their Medigap premiums which exposes the inflation embedded in America's healthcare system.

Medigap plans were intended to provide retirees with healthcare stability, covering deductibles, coinsurance, and copayments – the 20% left unpaid by original Medicare. For decades, these policies were considered a relatively predictable financial safeguard. According to a November 10, 2025, *Soy Arie* article, that assumption is now under pressure as policyholders confront premium increases that far exceed previous expectations.

Historically, Medigap rates rose about 5% to 7% annually. Over the past two years, however, the increases have accelerated sharply, with many beneficiaries facing jumps of 10%, 15%, or even 20%. This reflects the deeper and enduring inflationary dynamics that continue to distort healthcare costs nationwide.

Medical Inflation Driving Medigap Cost Up

The greatest factor driving up Medigap premiums is medical inflation. Hospital services, outpatient care, pharmaceuticals, and diagnostic testing have all experienced above-average price increases. Medigap insurers have increased premiums to reflect the higher cost of claims they are required to pay. Rising healthcare costs push Medigap premiums higher which puts additional strain on retirees living on fixed incomes.

A secondary inflationary factor is that during COVID millions of Americans postponed elective or non-urgent medical procedures. That pent-up demand has now returned in full force. The resulting surge in medical claims disrupted insurance company profits in 2023, 2024, and into 2025 and now they are attempting to rebound with higher Medigap premiums.

Medicare Part D Prescription Drug Plans

Participants in original Medicare usually select a Medicare Part D prescription drugs plan. (Many Medicare Advantage plans often include a prescription drugs plan.) Some Part D participants are likely to spend more for their plan in 2026. That is because there are fewer plans available. Medicare Part D premiums are decreased in 2026 in a number of states. A few plans are increasing premiums by $50, the Maximum Allowed Under the PDP Premium Stabilization Demonstration

A review by KFF (a healthcare research nonprofit) of the data shows that the total number of stand-alone drug plans available in 2026 is down for the third year in a row, as plan sponsors scale back their PDP offerings. There are 360 plans nationwide in 2026, down from 464 in 2025.

It appears that substantial premium increases for PDPs across the board didn't materialize, even as the Trump administration scaled back the level of support for PDP premium subsidies through the temporary Part D premium stabilization demonstration established by the Biden administration in 2024. For 2026, the federal government is providing participating PDPs with an across-the-board monthly premium subsidy of up to $10 (down from $15 in 2025) and limiting the monthly premium increase for 2026 to $50 (up from $35 in 2025).

The monthly premium for the most popular PDP nationally, Wellcare Value Script, is increasing in more states (33, including DC) than where it is holding steady (16) or decreasing (2), and will range from $0 to $42.40 across states and DC in 2026

The Inflation Reduction Act increased cost and risk for the drug plans by introducing a $2,000 out-of-pocket cap for 2025 ($2,100 cap in 2026). The law also shifted more responsibility for high drug costs onto those plans. The result is that insurers' profitability dropped and a whole bunch of plans left the market.

On May 12, 2025, President Trump issued an executive order titled "Delivering Most-Favored-Nation Prescription Drug Pricing to American Patients." In addition, President Trump said in a prime-time address to the nation on December 17, 2025, that he negotiated with drug companies and foreign countries to reduce the prices on drugs and pharmaceuticals by 400 to 600%. President Trump announced on December 19 that nine major pharmaceutical companies have agreed to join his "Most favored nation" pricing policy, bringing down the price of prescription drugs for Medicare and Medicaid recipients. The deal ensures that drugs will be sold at reduced prices, with many sold at the same price that they're sold at overseas, which will be purchased through the TrumpRx platform.

Increased Out-of-Pocket Costs

There's been an increase in the out-of-pocket costs among some plans as a way to try to boost. profitability. In 2025, a lot of drug plans switched away from offering zero deductibles and co-payments for preferred drugs, and added much, much higher co-insurance. The monthly premiums paid by enrollees in standalone plans in 2026 have increased significantly.

Medicare Part D also has IRMAA which has over a 6% increase in 2026 with projected surcharges ranging from $14.50 to $91.00 per month.

An example of Increasing Medicare Part D costs, an Idaho senior's Cigna (changed name to Health Springs 1/1/26) monthly premiums went over the years from $0 to $4 to $13 to $37 to $91 for 2026.

It's very important to go to www.medicare.gov and shop for the best deal for a Medicare Part D plan.

Medicare, One Big Beautiful Bill and PAYGO

Passage of the “One Big Beautiful Bill” (OBBBA) as reconciliation legislation increased the federal deficit by $3.4 trillion and should trigger sequestration requiring mandatory cuts (known as PAYGO). This would mean an automatic 4% reduction for federal spending on Medicare.. According to the Congressional Budget Office the bill causes a $45 billion cut to Medicare in 2026, growing to $75 billion in 2034 and totaling $535 billion over the 2026 through 2034 period.

During its mid-September 2025 Fly-In to Washington, DC, the NRLN advocated that Congress take action before the end of 2025 to block implementation of the cuts to Medicare.

Fortunately for Medicare beneficiaries, Congress entirely waived the existing statutory requirements to offset new borrowing under Pay-As-You-Go (PAYGO). By wiping the PAYGO scorecard clean and avoiding planned automatic offsets, Congress is officially blessing the deficit impact of the OBBBA. Wiping the PAYGO scorecard isn’t particularly unusual. Congress routinely skirts the fiscal rules it writes.

Original Medicare Prior Authorization

Original Medicare has historically required little in the way of prior authorization for beneficiaries seeking medical services. Prior authorization has been the domain of Medicare Advantage (MA). The Centers for Medicare and Medicaid Services (CMS) implemented prior authorization requirements for certain original Medicare services in six states starting January 1, 2026. The states are New Jersey, Ohio, Oklahoma, Texas, Arizona, and Washington.

The CMS Innovation Center calls the six-year trial the Wasteful and Inappropriate Service Reduction (WISeR) Model. CMS plans contracts with incentives for companies that use artificial intelligence (AI) to decide whether original Medicare beneficiaries in the six states will receive prior authorization for 17 Medicare services.

After the six-year trial is completed, the NRLN believes it is a good bet that prior authorization will be required for original Medicare beneficiaries in all 50 states. The NRLN has advocated to members of Congress that original Medicare should not be turned into an MA prior authorization program where insurance companies have denied or delayed medical services that have harmed millions of older Americans.

Dual Eligibles

Dual Eligibles are low-income individuals who have both Medicare and Medicaid, allowing them to have their healthcare costs covered by both programs. Medicare is the primary payer, and Medicaid acts as the secondary payer to cover costs not met by Medicare, such as copayments, deductibles, and other services. These individuals can enroll in special needs plans (D-SNPs) to receive coordinated care and potentially extra benefits like dental or vision care, which may not be available through original Medicare or Medicaid alone. Or. Dual Eligibles may enroll in a Medicare Advantage plan, which often includes Part D (prescription drug) coverage, and Medicaid may cover the cost-sharing for the plan.

Dual Eligibles qualify for the U.S. government's Supplemental Nutrition Assistance Program (SNAP) that provides food-purchasing assistance to low-income individuals and families. It is the largest anti-hunger program in the United States, helping millions of people afford a nutritionally adequate diet through monthly benefits distributed via state and local agencies. The program was formerly known as the Food Stamp Program.

A report from the advocacy group Justice in Aging, released on November 8, 2025, warns that the simultaneous pressure on Dual Eligibles could create a "perfect storm" of benefit cuts and increased hardship in 2026. Medicare Advantage insurers quest for higher profits could lead to higher out-of-pocket costs or reduced supplemental benefits. For a Dual Eligible senior, the loss of a plan's dental benefit isn't an inconvenience; it could mean untreated infections or the inability to eat properly. An increase in a copay from $5 to $10 might seem small, but for someone living on less than $1,200 a month, it can be the breaking point.

Simultaneously, on the SNAP side, the new rules for stricter work requirements could inadvertently affect older adults and those with disabilities. While many Dual Eligibles would be exempt due to age or disability status, the administrative hurdles to prove that exemption can be daunting. A recent analysis from the National Council on Aging highlighted that bureaucratic errors are a leading cause of Dual Eligible seniors losing benefits, a problem that will be exacerbated by more complex rules slated for the 2026.

Medicare Advantage Terminating Plans

Medicare Advantage (MA), or Part C, is a Congress-authorized alternative to original Medicare offered by private insurance companies. These plans bundle hospital coverage (Part A), medical coverage (Part B), and typically prescription drug coverage (Part D) into a single plan. They can also include extra benefits like dental, vision, and hearing care, transportation to medical appointments, gym memberships, etc.

The biggest news in MA for 2026 was the termination of plans on December 31, 2025. UnitedHealthcare dropped MA plans that were serving over 1.1 million users. Humana terminated plans for 450,000 MA members. CVS-Aetna ended 90 MA plans across 34 states for 2026. UCare, a large MA plan provider in Minnesota, eliminated MA plans for 2026 impacting 158,000 members. About 8% of 34 million U.S. MA enrollees have experienced a plan termination for 2026.

CMS has stated that there is a total of 5,600 MA plans across the country in 2026, down from 5,633 in 2025.

Medicare Guaranteed Issue Right and Special Enrollment Period

When a Medicare Advantage (MA) plan or an original Medicare supplement (Medigap) plan is ceased or terminated such as a company-sponsored benefit or by a healthcare insurance company, federal law requires plan participants to be informed of their Medicare Guaranteed Issue Right (GIR) and Special Enrollment Period (SEP).

A GIR prohibits insurance companies from denying coverage or overcharging an applicant for a Medigap or MA policy, regardless of pre-existing health conditions. A SEP allows one to shop for the best deal possible for a Medigap or MA plan.

While employers, MA and Medigap plan insurance companies may legally terminate their plans, Federal Minimum Standards require that terminated beneficiaries must be sent GIR and a SEP notice.

The Social Security Act provides Federal Minimum Standards for GIR and SEP in **Sec 1882[42 U.S.C. 1395ss]** (https://www.ssa.gov/OP_Home/ssact/title18/1882.htm). The Federal Minimum Standards are replicated in Sec 12 of the National Association of Insurance Commissioners (NAIC) **Model 650 regulations** (https://content.naic.org/sites/default/files/model-law-state-page-651.pdf).

CMS Takes Action on NRLN Proposal

Since August 2022 the NRLN advocated with the Centers for Medicare and Medicaid (CMS) and members of Congress that the federal statutes for Guaranteed Issue Rights (GIR) and Special Enrollment Period (SEP) must be enforced when a Medicare Advantage (MA), Medicare supplement (Medigap) and/or Part D prescription drug plan will not be renewed or reduced for the next year.

In March 2025 Bill Kadereit, NRLN President, Alyson Parker, NRLN Executive Director, and Jay Kuhnie VP Legislative Affairs, met with CMS officials at its headquarters in Baltimore, MD and presented the NRLN's GIR and SEP position paper on the urgent need to enforce Sec 1882 [42 U.S.C. 1395ss]. In August a new case summary was sent to the acting Director for CMS Operations, noting new plan terminations would affect more than a million retirees on January 1, 2026.

On September 22, 2025, CMS issued a letter to insurance companies, corporations and unions who provide healthcare plans that they must provide notice to each of its affected enrollees at least 90 days before the end of the current contract period. As NRLN proposed, along with the notification letter, CMS provided sample letters to be used to inform enrollees to "**Keep this letter. It's proof that you have a special right to buy a [type of policy] or join a Medicare plan.**"

If your plan was not renewed for 2026 the letter to be receive by October 2 stated, "You have a special right to buy a [type of policy] because your plan is ending. This letter is proof that you have a special right to buy a [type of policy]. You'll have this special right for 63 days after your coverage with [Plan Name] ends. See the enclosed Medigap fact sheet for more information on your [type of plan] rights."

CMS's enforcement action is a great victory for seniors whose Medicare plans were not renewed for 2026.

MA Premiums, Out-of-Pocket and Benefits

According to CMS, MA premiums decreased slightly in 2026, falling from an estimated $16.40 per month in 2025 to $14.00 per month in 2026. However, actual premiums depend on the specific plan and location.

The federal maximum out-of-pocket (MOOP) limit for in-network services under MA plans in 2026 is $9,250, a decrease from $9,350 in 2025. The combined in- and out-of-network cap for PPO plans is $13,900. Most plans set limits lower than this maximum.

In 2026, the supplemental benefits (so-called "extras" like meal delivery, transportation, or other non-medical perks) are often scaled back.

Many MA Plans Have Deductibles

Many MA plans have deductibles, which are the amounts paid for healthcare services before the plan begins to pay. However, some plans may have no deductible, and the deductible can vary depending on the specific plan and whether it includes prescription drug coverage. Each MA plan sets its own deductibles, and the amount can differ between plans. When there is a deductible, after the deductible is met, typically there is a copayment or coinsurance for covered services.

MA Prior Authorization and In-Network

Almost all MA plans require prior authorization for some services, especially for higher-cost options like inpatient hospital stays, skilled nursing facilities, MRI and chemotherapy. MA plans use prior authorization frequently as a tool to manage costs which can affect access to care.

MA plans are limited to a provider network, requiring use of specific doctors and hospitals within a certain geographic area to receive full coverage. This can be a drawback for those who travel frequently, have established relationships with out-of-network providers, or live in areas with limited options. Additionally, these plans can change annually, drop providers, increase out-of-pocket costs, or reduce extra benefits.

The NRLN has often cautioned that MA plans may not have in-network access to national clinics for their healthcare needs. For example, in 2026, Mayo Clinic is no longer in-network in Minnesota, Wisconsin and Iowa for Medicare Advantage plans offered by UnitedHealthCare (UHC) and Humana.

MA Cost to Federal Government

The data forecast in the June 2025 Medicare Trustees Report and March 2025 MedPAC report told Congress that:

- Over the ten-year budget period 2025-2034, Medicare Advantage (MA) plan rebates will add over $1.5 trillion to the deficit. Examples: $89 billion 2025, $111 billion 2027, $155 billion 2030 and $240 billion 2034.

- After 53 years, private MA plan insurers have failed on their promises to be competitive with Medicare Fee-for-Service (FFS). MA rebate-to-bid ratios grew from 10.1% in 2015 to 19.9% in 2025. Trustees projected 24.2% by 2034. Rebate dollars include 15% insurer overhead and profit.

- The average cost for each of 35.5 million enrollees in MA in 2025 is 120% of the cost of Medicare FFS enrollees. MA plans hold a 51% share of the Medicare market but fail to deliver better quality or service, and insurers have delayed, withheld and denied Medicare payments, and are repeatedly cited for upcoding and risk adjustment payment practices.

- The 2006 Medicare Modernization ACT (MMA) authorized subsidy payments of 15% that the HHS Inspector General called Wrong and Improper in 2008 and 2009.

- A Capitation Payment plan passed by Congress in 1972 and subsidies that were added through 2005, plus the 2006 MMA Wrong and Improper payments of 15%, opened the door for the 2010 Affordable Care Act (ACA) and new rebate legislation, the Medicare Shared Savings Plan (MSSP), Quality Bonus Plan (QBP) and Innovation Team (IT) were added to the ACA.

- The Trump administration handed MA plans a major gift on April 7, 2025 for calendar year 2026 by approving an average federal payment increase of 5.1%. That is more than double the 2.2% increase proposed by the Biden administration in January 2025. The increase is projected to result in more than $25 billion in additional payments to MA plans in 2026. However, the Trump administration proposed on January 26, 2026, that that the federal government's payments to Medicare Advantage insurers in 2027 be increase only an estimated 0.09% on average.

MA Chronic Disease Rebates

- The 2018 Balanced Budget Act added 19 new Chronic disease benefits for those age 65 and older, purportedly to improve care and control Medicare costs. CMS records show that 85% of total Medicare payments made are paid to 25% of those in original Medicare who are the older and more chronically ill.

- However, Congress had no intention of funding chronic benefits for those in Medicare who were well beyond 65 years old and in need of such benefits. Instead, Congress wrote the Act to mandate that only MA plan enrollees would be eligible for these paid benefits. This was a colossal mistake!!!

- Before 2018, rebates had been paid to MA plans to subsidize Medicare D drug plan premiums, deductible, and copay costs. Rebates could also be used to pay for portions of enrollee cost for eyecare, hearing, and dental.

- MA insurance companies selectively included the 2018 chronic rebates in MA plans and marketed them to eligible enrollers through television commercials and advertisements.

Ballooning Enrollment and Rebates

- From 2017-2025 MA plan enrollment grew from 19.8 to 35.5 million, up 79%. Total Medicare enrollment grew from 58.78 to 69.5 million, up just 18%. MA plan enrollee market share grew from 33.7% to 51.0%.

- MA total rebate payments ballooned from $21 billion in 2017 to $89 billion in 2025, up 424%. Rebates drove MA market share and profit. Congress pays 74% of Medicare B and D rebate payments from general revenue.

- The 2025 MedPAC report shows that MA plans received chronic rebate payments $40 billion higher than Medicare would have paid for younger enrollee benefits after adjusting out higher costs built into rebates for older retiree risks. MA plans benefit from this “Selection Bias.”

- Congress approved Chronic benefits for the 2025 younger class of 36 million in MA plans but denied the same benefits to 27 million FFS enrollees.

What MA Has Done

Chronic disease rebates paid to MA insurance companies since 2018 have inflated insurer financial performance to very high levels.

Aging of 36 million MA enrollees each year and higher cost of healthcare per enrollee due to annual inflation threaten future insurer net income and shareholder value. Without more rebates, insurers are likely to increase MA enrollee deductible, copay, and premium costs to avoid financial losses.

MA insurers’ broken promises to compete with Medicare FFS are evident. At 51% market share and 20% higher cost per enrollee than FFS, Congress would have to ask taxpayers to pay even higher rebates to protect insurers.

The Purpose of Medicaid

Medicaid is a joint federal-state program that provides healthcare coverage to low-income individuals and families, including the elderly and people with disabilities. It is a crucial part of the U.S. healthcare system, ensuring millions of people have access to necessary services they couldn’t otherwise afford.

Medicaid was enacted as part of the Social Security Amendments of 1965, the same legislation that created Medicare. Like Medicare, Medicaid is an “entitlement” program, meaning that eligible individuals have rights to payment for medically necessary healthcare services defined in statutes, and the federal government is obligated to fund a share of the outlays for those services.

Medicaid varies across states. States establish their own eligibility standards, benefit packages, provider payment policies, and administrative structures under broad federal guidelines, effectively creating 56 different

The Medicaid program is one for each state, territory, and the District of Columbia. Medicaid financing is a joint responsibility of the federal government and the states. The federal medical assistance percentage (FMAP) determines the federal share of spending for most Medicaid services and ranges from 50 percent to 83 percent across states. The Medicaid statute sets minimum requirements that states must meet to operate a Medicaid program.

Federal Spending Cuts to Medicaid

The One Big Beautiful Bill Act" (OBBBA) enacted July 4, 2025, resulted in an estimated $911 billion in federal Medicaid spending cuts over a 10-year period (2025-2034), according to the nonpartisan Congressional Budget Office (CBO).

These cuts are primarily achieved through several key provisions:

Medicaid work reporting requirements: Estimated to account for $326 billion of the savings, by requiring adults aged 19-64 to work, volunteer, or attend school for at least 80 hours per month to maintain coverage.

Limits on state provider taxes: Restricting how states can use provider taxes to finance their share of Medicaid costs, generating approximately $191 billion in savings.

Restrictions on state-directed Medicaid payments: Limiting the use of these payments to finance the state's share of the program, saving an estimated $149 billion.

Increased administrative burden: Implementing more frequent eligibility verifications and blocking rules that would streamline enrollment, which is expected.

States React to Federal Spending Cuts

Legal Action: A coalition of over 20 states and the District of Columbia filed lawsuits against the federal government over the billions of dollars in cuts.

Public Warnings and Lobbying: State officials and hospital executives have warned their federal representatives about the devastating impact of the cuts. States predict benefit reductions, lower provider pay, and lost coverage for millions of enrollees.

Implementing State-Level Cuts: To mitigate the federal funding cuts, some states have begun to implement their own cost-cutting measures. For example:

North Carolina and **Idaho** announced cuts to provider reimbursement rates, ranging from 3% to 10%.

Colorado has suspended previously planned Medicaid rate increases.

Some states are considering cutting optional benefits like dental, behavioral health, and home- and community-based services, or introducing cost-sharing measures such as premiums.

"Trigger" Laws: Some states that expanded Medicaid under the Affordable Care Act (ACA) have "trigger" laws in place that could automatically terminate the expansion when the federal funding match rate drops, potentially causing millions to lose coverage. Proposals to remove or scale back these trigger laws have been introduced in states like Illinois and North Carolina, indicating an effort to preserve coverage despite the federal cuts.

Political Engagement: State leaders and health policy advocates are using widespread public opposition to the cuts as a political issue and encouraging continued policy engagement to push for reversals in a future Congress.

Overall, many states are not passively accepting the federal cuts and are pursuing a mix of legal, administrative, and political avenues to fight the reductions and manage the significant fiscal and public health challenges presented.

The Battle to Continue ACA Subsidies

The Affordable Care Act (ACA) is the comprehensive healthcare reform law enacted in March 2010.for those under age 65. The rapidly rising cost of healthcare is also affecting the ACA, showing that everyone is impacted no matter how old they are.

On November 12, President Donald Trump signed legislation to end the 43-day federal government shutdown following successful votes in the Senate on November 9 and in the House on November 11. The shutdown was the result of a Continuing Budget Resolution short-term spending bill that did not include an extension of expanded COVID-era Affordable Care Act (ACA) subsidies scheduled to expire in November 2025.

The subsidies, initially passed as an emergency response to COVID in 2021, were always supposed to be temporary. But Democrats feared that the sudden expiration of the subsidies would leave millions of healthcare insurance policyholders with substantially higher premiums if allowed to expire. Had the enhanced ACA subsidies been made permanent it would have added roughly $488 billion in new spending over the next decade, significantly boosting the deficit,

The legislation that President Trump signed on November 12 will keep government open until January 30, 2026. Senate Majority Leader John Thune has promised Democrats a December vote on the expanded ACA subsidies. The vote did not take place. President Donald Trump signed a major $1.2 trillion, five-bill funding package passed by Congress into law on February 3, 2026, ending a partial government shutdown, ad funds 11 of 12 annual appropriations bills through September 30, 2026. ACA subsidies were not addressed in the legislation.

Facing Skyrocketing ACA Premiums

The enhanced subsidies have enabled many lower-income Americans to obtain coverage with no or very low monthly premiums and broadened eligibility for assistance to many middle-class consumers. ACA’s original subsidies, which are part of the 2010 health reform law and are not expiring, are only available to those who earn less than four times the federal poverty level, or about $63,000 for an individual and $129,000 for a family of four.

Enacted in 2021, the extra assistance COVID era subsidies helped ACA healthcare enrollees grow to 24 million in 2025. But what enrollees will actually pay in premiums for 2026 will be far higher because they won’t have additional aid. Premium payments will more than double, on average, according to KFF.

Certain policyholders will be hit harder than others. Those with incomes just above the poverty level will go from paying $0 or nearly $0 in premiums to being on the hook for a few hundred dollars a year. It may be enough of an increase that they can’t afford it.

Also, enrollees in their 50s and early 60s, who already pay a lot for coverage, will have to shell out even more. An older couple, not yet eligible for Medicare or MA, making $85,000 a year could see their premiums skyrocket by more than $20,000 a year.

Examples of Higher Premium Hardships

A November 9, 2025 CNN story reported that Sunni Montgomery, at age 63, is fighting lung cancer. Since 2022, she's undergone multiple rounds of chemotherapy and radiation, relying on her ACA healthcare insurance plan to cover the costs. Thanks to enhanced subsidies, her premium in 2025 was $541 a month – just manageable with Social Security Disability and a part-time job.

But in 2026, without the enhanced subsidies, her premium is $1,758 a month – far outside her budget.

"I have to face the reality that I am probably going to become a late-stage cancer patient who's uninsured," Montgomery said. "I have fought this so hard. I want to live."

Now on daily oxygen and getting scans every three months, she says she's at high risk for recurrence. Without insurance, those lifesaving treatments will be out of reach.

"If I'm not getting scans and we don't know if something's recurred, then what that can mean is the end of me," said Montgomery, who is racing to squeeze in every scan and checkup she can before her coverage expires.

Similarly, Chris and Donna have made the agonizing decision to drop their health insurance for 2026, saying they simply cannot afford it.

Chris, 62, is a retired federal worker, and Donna, 60, runs a small medical billing business. They relied on their ACA plan – reduced to $401 a month by the enhanced subsidies – to manage Donna's asthma and Chris' atrial fibrillation. But for 2026 their premiums have skyrocketed to $1,975 a month - nearly half their income.

They pored over options on the ACA marketplace but say even the cheapest plans hovered near $1,000 a month. Yet those policies have huge deductibles, big copays, and they don't cover a lot. Now, they are bracing for a future without coverage, expecting to cancel appointments, forgo screenings, skip medications, and cross their fingers that a health disaster doesn't strike.

Soaring premiums have also left Alison and her husband, Chris, debating over what to do about their ACA coverage. They began buying policies on the exchange three years ago, when Chris, a former police officer, had to retire after a serious injury.

In 2025, they paid $183 a month after nearly $1,350 in subsidies. But in 2026, their policy cost is $936 per month.

Conclusion

The speed and severity of healthcare coverage increases for Americans and the skyrocketing cost to the federal budget offer an unfiltered look at how expensive care has truly become, and how deeply inflation has penetrated the medical industry.

With the significant increases in Medigap, MA, Part D premiums, deductibles, copays and out-of-pocket, it is important for retirees to reassess during each Medicare annual enrollment period, October 15 – December 7, their coverage and shop www.medicare.gov for the best possible deals for which they can qualify. Seniors must be vigilant that they receive their Guaranteed Issue Right and Special Enrollment Period notice when their employer-sponsored coverage or Medigap or Medicare Advantage plan is terminated. Without a GIR/SEP a switch to a different healthcare insurance plan requires a review of medical history that could result in medical underwriting for a higher premium or rejection for coverage.

Yet even the best shopping efforts may not fully offset the inflation that continues to drive up healthcare costs.

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