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Summary of Proposed Marketplace Integrity and Affordability Rule

On March 10, 2025, the Department of Health and Human Services (HHS) released a proposed Marketplace Integrity and Affordability rule.[1] *The rule includes important proposed changes to plan design features for 2026 and eligibility and enrollment rules for 2025 and beyond. Comments are due within 30 days after display in the Federal Register.*

Overview

HHS estimates that overall, the cumulative impact of the proposed rules could **reduce enrollment by up to two million consumers**. It's important note some of the requirements will be enforced when the rule is effective (i.e., at the time of the finalization of the rule) while others will go into effect in 2026 or beyond. The following highlights the key changes included in this proposed rule:

1. **Changes for 2026 AV De Minimis:** HHS is proposing changes to widen the de minimis variation in actuarial value (AV) ranges starting in the 2026 benefit year. HHS proposes adjusting the de minimis range for individual and small group market plans to +2/-4%, except for expanded bronze plans, which would have a range of +5/-4%. Furthermore, the proposal includes a revision to the de minimis variation for income-based silver CSR plan variations to +1/-1%.

2. **Maximum Out of Pocket:** HHS proposes to increase the maximum out of pocket (MOOP) for 2026 amount to $10,600 for self-only coverage and $21,200 for other than self-only coverage. This is approximately 4.4 percent higher than the previously published guidance and 15.2 percent higher than in 2025. Silver CSR variant MOOPs were also proposed to increase.

[1] Department of Health and Human Services, "Proposed Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability Rule", https://www.federalregister.gov/documents/2025/03/19/2025-04083/patient-protection-and-affordable-care-act-marketplace-integrity-and-affordability

3. **Ending Eligibility for DACA Recipients:** HHS proposes to end eligibility for the Marketplace and Basic Health plans for deferred action for childhood arrivals (DACA) recipients.[2]

4. **Increased Documentation Requirements:** HHS proposes to require additional documentation for consumers whose tax data shows incomes below 100% of the federal poverty level (FPL) or whose tax data is unavailable. HHS also proposes to limit the amount of time individuals have to resolve income verification issues.

5. **Restriction on Premium Payment Thresholds**: HHS proposes to restrict issuer flexibility in waiving non-payment of premiums.

6. **Shortening Open Enrollment Period**: HHS proposes to limit the annual OEP for all Marketplaces to between November 1 and December 15 for all Marketplaces starting in 2026. The reduces OEP by approximately a month for the majority of Marketplaces.

7. **Ending SEP For Those Under 150% FPL/Increase SEP Verification:** HHS proposes to end the low-income Special Enrollment Period (SEP) for those below 150% FPL. It also proposes requiring that 75% of SEP enrollment be subject to advanced verification.

8. **Auto-Enrollment Changes:** HHS proposes requiring that consumers with zero-dollar net premiums (i.e., free plan), due to APTCs, be required to pay a $5 minimum payment per month until they actively confirm their information. This proposed policy would result in more people entering a grace period. HHS also proposes to eliminate the mapping of Bronze enrollees to silver-level plans at auto-enrollment if the net premium is the same or less than their current plan price.

9. **Changes for those that Fail to Reconcile Taxes (FTR)** HHS proposes to end APTCs for those with FTR issues in the prior year. Under current policy consumers who have filed in the prior two years have their APTCs removed.

10. **Changes to Essential Health Benefits (EHB):** HHS proposes to prohibit individual and small group insurers from covering “sex-trait modification” as EHB starting in plan year 2026.

The following provides more detail on each of the items summarized above.

Changes for 2026 AV De Minimis

HHS proposes to change de minimis actuarial value (AV) range for plans, starting for plan year 2026, for individual and small group market plans to +2/-4%, except for expanded bronze plans, which would have a range of +5/-4%. Furthermore, the proposal includes a revision to the de minimis variation for income-based silver CSR plan variations to +1/-1%. This change aims to balance the flexibility for issuers in

[2] The DACA policy enacted deferred deportation action on certain individuals and was set forth in 2012 under the Obama Administration. For further information please see Zach Baron’s article on the issue https://www.healthaffairs.org/content/forefront/biden-administration-finalizes-rule-expanding-access-health-coverage-daca-recipients

designing plans. This change would allow plans to produce lower premium plans (albeit with higher cost-sharing) especially for silver plans. Currently, the de minimis ranges are +2/-2 for individual and small group plans with the exceptions for bronze being +5/-2, silver non-CSR qualified health plans are restricted to a de minimis of +2/0 percentage points and silver CSR plans of +1/0.

Maximum Out of Pocket Updates

HHS proposes to change the index by which the maximum out-of-pocket (MOOP) amounts would increase. By changing the index, HHS proposes to increase the 2026 MOOP to $10,600 for self-only coverage and $21,200 for other than self-only coverage. This is approximately 4.4 percent higher than the previously published guidance[3] 2026 benefit year MOOP amounts for non-CSR plans[4] and CSR variations. If finalized as proposed, MOOP amounts will be **increasing 15.2%** from the 2025 amounts for non-CSR plans of $9,200 and $18,400 (single/family).

- 100%-150% FPL: $3,500, $7,000 (single/family). In 2025, these amounts were $3,050/$6,100 (single/family) so 2026 represents a significant increase relative to last year's value.
- 150%-200% FPL: $3,500, $7,000 (single/family). Similarly, 2026 represents an increase relative to 2025's value of $3,050/$6,100 (single/family).
- 200%-250% FPL: $8,450/$16,900 (single family). This amount is an increase from 2025 levels, which was set at $7,350/$14,700 (single/family).

Ending Eligibility for DACA Recipients:

HHS proposes to eliminate DACA recipient eligibility for Marketplace or Basic Health Plans. Under a recent Biden Administration rule, DACA enrollees become eligible for both starting in 2025. Under the proposed rule, Marketplaces in most states (19 states currently have a court ordered injunction preventing DACA recipients from enrolling) would need to update their eligibility and terminate coverage for DACA recipients already enrolled as well as prevent any DACA recipients from future coverage as soon as the rule was final (i.e., in 2025). HHS estimates that would affect about 11,000 current enrollees, although, the previous Biden Administration rule estimated that up to 100,000 DACA recipients would have gained coverage if they were eligible.

[3] https://www.HHS.gov/files/document/2026-PAPI-Parameters-Guidance-2024-10-08.pdf
[4] Standard plans include platinum, gold, silver non-cost sharing variation, enhanced bronze metal offerings as well as catastrophic plans.

Increase Documentation Requirements

HHS proposes a number of changes to eligibility determination, all of which will increase documentation requirements and reduce enrollment.

Requiring Income Documentation for those Below 100% FPL

HHS proposes to require consumers whose data shows their income to be below 100% FPL to show documentation that proves that their income is in line with their projected income. This proposal has not been implemented before, and HHS estimates it would reduce enrollment by approximately 80,000 enrollees.

Requiring Documentation When Tax Data is Unavailable

HHS proposes to require additional verification if tax data is unavailable. Tax data being unavailable can occur if there were changes in family status (e.g., divorce) or the consumer did not have to file a tax return. In the event that tax data is unavailable, consumers would have to provide additional documentation to provide projected income (or other eligibility criteria). HHS estimates this would reduce enrollment by about 400,000 consumers.

Require Documentation Within 90 Days

HHS proposes to require consumers to provide documentation within 90 days from receipt of a data matching notice. Starting in 2024, HHS allowed consumers to have an additional 60 day (i.e., 150 days total), in addition to the 90 days, to resolve data inconsistencies if they had made efforts to provide some documentation. The proposed change would revert to earlier rules that did not allow the additional time.

Updating Premium Payment Thresholds

HHS proposes to disallow the recent Biden Administration regulation that would have allowed issuers greater flexibility in waiving minimal amounts of unpaid member premiums. HHS proposes allowing insurers to offer only net premium thresholds. This means that issuers are only able to wave up 5 percent of a consumer's net premium. For example, if a consumer's net premium is $1 and the consumer does not pay it, the issuer would no longer have the flexibility the waive the non-payment of premiums.

Shorterning OEP

HHS proposes to limit the annual OEP for all Marketplaces to the period of November 1 to December 15 starting for the 2026 OEP. This is the length of OEP during the prior Trump Administration (OEP 2018 to 2021). The Biden Administration had extended OEP from November 1 to January 15 starting with the 2022 OEP and multiples SBMs have OEP end dates of January 31. If this rule is finalized as proposed state-based Marketplaces would not have the flexibility to lengthen OEP.

Ending SEP For Those Under 150% FPL/Increasing SEP Verification

HHS proposes to end the monthly SEP for those under 150% FPL for all marketplaces. Currently, Healthcare.gov and many SBMs allow consumers whose incomes at 150% FPL or below to have access to a SEP. Last year, over 2 million consumers utilized the low-income SEP. This proposal would end this practice as soon as the rule finalizes (2025).

HHS also proposes that 75% of SEP enrollees eligibility should be subject to verification, regardless of the Marketplace. While its unclear what level of verification is currently being conducted in all Marketplaces, the requirement is expected to put downward pressure on enrollment.

Auto-Enrollment Changes

HHS proposes a significant change to auto-enrollment. Auto-enrollment allows consumers to be re-enrolled during OEP without their active participation. HHS proposes to require consumers with no net premiums, due to APTCs, to pay $5 per month until they actively confirm their information. This policy would apply to Healthcare.gov states in 2026 and State-based Marketplaces (SBMs) starting in 2027. HHS solicited comments if the $5 requirement should be increased or if auto-enrollment more generally should be eliminated. Prior research has shown that small dollar payment requirements can have a substantial negative effect on enrollment.[5]

Changes for those that Fail to Reconcile Taxes

HHS proposes to end the Biden-era policy of allowing APTCs for individuals who may not filed their taxes (or FTR). Under the current rules, individuals who have not filed taxes in the past two years are forbidden from receiving APTCs. Under the proposed rule, the IRS must have a record of having taxes filed in the previous year to avoid APTC amount from being ended. Administering and resolving FTR issues is complex and burdensome for Marketplaces and often unclear and confusing to consumers due to restrictions the IRS puts on tax information notifications. Consequently, ending the Biden-era policies on FTR is expected to reduce the number of people with APTCs between 265,000 and 424,000.

Changes to EHB

HHS proposes a change to EHB requirements. HHS proposed to prohibit individual and small group insurers from covering what it terms “sex-trait modification” as EHB beginning with the 2026 plan year. According to HHS, “The EHB-benchmark plans for California, Colorado, New Mexico, Vermont, and Washington specifically include coverage of some sex-trait modification. The EHB-benchmark plans of six other States do not expressly include or exclude coverage of sex-trait modification. The EHB-benchmark plans of 40 States include language that excludes coverage of sex-trait modification.”

[5] https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2023.00649

Overall Impact

Overall, HHS estimates that the cumulative effect of the proposed changes is a reduction of up to 2 million Marketplace enrollees in 2026. The vast majority of the reduction will be among lower income households who otherwise would have access to APTCs absent the proposed rule.

The 2026 Actuarial Value Calculator (AVC)

HHS did not make any mention of an AVC. However, given the changes to MOOP limitations and de minimis requirements, it is likely that HHS will be releasing an updated AVC.

Appendix: Summary of Key Provisions[6]

Issue	Effective Benefit Year	HHS Estimated Enrollment Impact	HHS Estimated Impact on Claims
Shorter Open Enrollment Period	2026	Lower Enrollment (larger impact in SBMs with previously longer OEPs)	Higher (morbidity)
End DACA Eligibility	2025[7]	-10,000	Unclear (impact only for select states)
Changes to FTR Verification	2026	-260,000 to -420,000	Higher (morbidity)
Increased Verification Requirements	2026	Up to -500,000	Higher (morbidity)
Requiring $5 Premium responsibility	2026 FFM (2027 SBMs)	Negative	Higher (morbidity)
Subtotal: Enrollment Reduction Provisions		**Negative**	**-0.5% to +4 %**
End Low-Income SEP	2025	Negative	-3.4% (larger impact in non-Medicaid Expansion states)
Require Verification of 75% of SEPs	2026	Negative	-0.5%
AV De Minimis	2026	Unclear (negative impact on subsidized enrollees/positive impact on unsubsidized)	-1.0%
Total Impact	**2026**	**-750,000 to -2,000,000**	**Claims 0.9% to 5.4% lower on a pmpm basis**

[6] All estimates cited are from the Regulatory Impact Analysis of the Market Integrity and Affordability proposed rule. Wakely has not independently validated the estimated impacts of these policies on enrollment and premiums

[7] Unless otherwise noted, we expect this to be effective immediately as of the release of final rule

If you have any questions or want to follow up on any of the concepts presented here, please contact Michael Cohen, PhD at michael.cohen@wakely.com.

OUR STORY

Five decades. Wakely began in 1969 and eventually evolved into several successful divisions. In 1999, the actuarial arm became the current-day Wakely Consulting Group, LLC, which specializes in providing actuarial expertise in the healthcare industry. Today, there are few healthcare topics our actuaries cannot tackle.

Wakely is now a subsidiary of Health Management Associates. HMA is an independent, national research and consulting firm specializing in publicly funded healthcare and human services policy, programs, financing, and evaluation. We serve government, public and private providers, health systems, health plans, community-based organizations, institutional investors, foundations, and associations. Every client matters. Every client gets our best. With more than 20 offices and over 400 multidisciplinary consultants coast to coast, our expertise, our services, and our team are always within client reach.

Broad healthcare knowledge. Wakely is experienced in all facets of the healthcare industry, from carriers to providers to governmental agencies. Our employees excel at providing solutions to parties across the spectrum.

Your advocate. Our actuarial experts and policy analysts continually monitor and analyze potential changes to inform our clients' strategies – and propel their success.

Our Vision: To partner with clients to drive business growth, accelerate success, and propel the health care industry forward.

Our Mission: We empower our unique team to serve as trusted advisors with a foundation of robust data, advanced analytics, and a comprehensive understanding of the health care industry.