Future of the Individual Market: Impact of the House Reconciliation Bill and Other Changes on the ACA Individual Market

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Executive Summary

This analysis was current as of June 18, 2025, which was before finalization or passage of the Senate version of the reconciliation bill and Marketplace Integrity and Affordability rule. Changes after this date could affect the findings in this report.

Wakely reviewed the potential impacts of the House Budget Reconciliation Act, H.R. 1.[1] The bill includes significant changes in enrollment, eligibility, and premium tax credit rules, as well as cost-sharing reduction (CSR) payments.[2] Combined with the expiration of enhanced premium tax credits (ePTCs), the bill would result in an individual market that looks fundamentally different when the full effects of all changes occur. This analysis was completed on June 18, 2025. Subsequent changes in the policy environment since then, including the final version of the Marketplace Integrity and Affordability rule issued on June 20, 2025,[3] were excluded from the analysis.

This paper examines how the expiration of ePTCs and the House reconciliation bill, including the draft version of the Program Integrity and Affordability regulation, would affect the Affordable Care Act (ACA)-compliant individual market.[4] Various methodologies, as well as unique data provided by State-Based Marketplaces (SBM), were used to develop a range of effects on enrollment and premiums within the individual market. Data received represents roughly 50 percent of the SBM enrollment population, which provided insights into how some of the proposed policy changes could play out operationally. **While the full impact of many of the provisions may not be fully realized until 2028**

[1] If this paper is distributed to outside parties, the paper should be distributed in its entirety. Anyone receiving this paper should retain their own experts in interpreting its contents. The opinions in this paper are those of the authors and do not necessarily reflect those of Wakely. This paper is intended to discuss the impact of enrollment and premium effects on the ACA-compliant individual market; other uses may not appropriate.
[2] 119th US Congress. H.R.1 - One Big Beautiful Bill Act. Engrossed in House May 22, 2025. Available at: https://www.congress.gov/bill/119th-congress/house-bill/1/text.
[3] US Department of Health and Human Services. Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability Rule. Available at: https://www.cms.gov/files/document/cms-9884-f-2025-pi-rule-master-5cr-062025.pdf.
[4] For purposes of this paper references to the individual market only pertain to plans that are compliant with the market reform rules such as guaranteed issue.

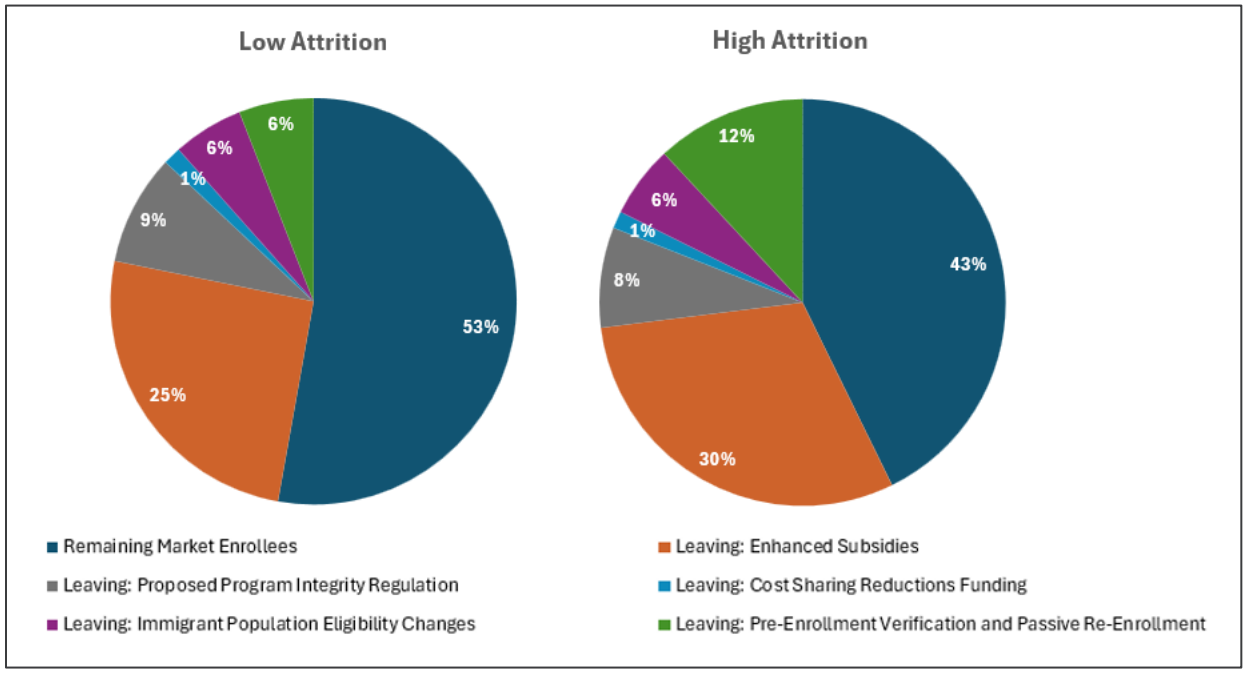
or later, for simplicity, Wakely estimated a range of steady state effects of all changes as if they were to occur in 2026.

- **The combination of ePTCs expiring and full enactment of H.R. 1 could reduce individual market enrollment by 47 percent to 57 percent, or between 11.2 to 13.6 million enrollees.**
    - This range includes direct impacts on subsidized individuals due to net premium increases after premium tax credits and **loss of unsubsidized enrollment between 3.9 percent and 6.1 percent** following significant gross premium increases.
    - Non-Medicaid expansion states would see especially large enrollment losses, with reductions in enrollment ranging between 53 percent and 64 percent.
- We estimate the combined effects could **increase gross market average premiums 7.0 percent to 11.5 percent because of market attrition and residual risk pool morbidity increases**, not accounting for incremental claims cost trend impacts.
    - These estimates refer to the gross premiums paid by individuals who are ineligible for premium tax credits or prior to the reduction of premium tax credits. The net premium (gross premium minus the premium tax credits) paid by individuals receiving premium tax credits will vary based on their household composition, income, and plan selection, but, on average, **net premiums will increase by a significantly higher percentage**.
- H.R. 1 alone **could reduce enrollment by 22 to 27 percent, or 5.2 to 6.4 million enrollees,** when layered on top of the expiration of ePTCs.[5]
- **Enrollment and premium impacts varied greatly by state**; the range of enrollment reductions in some states exceeded the national average range of 47 percent to 57 percent, and premium changes also varied more widely than the average increase of 7.0 percent to 11.5 percent.

[5] Effects of the ePTC expiring were applied first. Given duplicative results, the impact of H.R. 1 would be larger if ePTCs continue in 2026.

Figure 1 shows the projected individual market enrollment losses by provision as a percent of the estimated 2026 market absent the policy changes. A detailed list of the provisions modeled is included in Appendix B.

Figure 1. Impact of Enhanced Subsidies and H.R. 1 on 2026 Individual Market Enrollment[6]



It is important to note that the impact on premiums will vary greatly by state and by issuer. Consequently, enrollment losses and premium increases could be greater for specific states and issuers than the percentages captured in this report. The following paper outlines the key policy changes that might affect the individual market in the coming years, the methodologies used to derive these estimates, key results and findings, and our conclusions.

This document contains the results, data, assumptions, and methods used in our analyses and satisfies the Actuarial Standard of Practice (ASOP) 41 reporting requirements. Using the information in this report for other purposes may not be appropriate. The opinions and estimates included in this report are those of the authors and may not represent those of others at Wakely. Actual results will differ, potentially significantly, from the estimates in this report.

[6] Impacts of overlap and unsubsidized enrollment attrition have been removed proportionally from the provisions according to the number of non-group enrollees leaving the market. Numbers may vary slightly from Figure 4 where overlap is split out separately.

Introduction

On May 22, 2025, the US House of Representatives passed a budget reconciliation bill, H.R. 1, that would make several changes to the individual market. The bill would greatly reduce the number of individuals eligible for premium tax credits (PTCs) and increase the effort required to gain access to PTCs for those who remain eligible. The bill achieves these ends in part by codifying into law the proposed Program Integrity and Affordability rule. These changes would layer on top of the expiration of ePTCs, which is scheduled to happen at the end of 2025.

Despite the substantive scope each of the changes could have on the individual market, few analyses have considered the totality of these changes and their effect.

Appendix B references the full summary of provisions and timeline for each to take effect. As discussed below, the analysis includes modeling the impacts related to the following:

- Expiration of the ePTCs
- The proposed Marketplace Integrity and Affordability rule which includes:
    - Ending ACA Marketplace coverage eligibility for Deferred Action for Childhood Arrivals (DACA) recipients
    - Shortening the Open Enrollment Period (OEP)
    - Automatic reenrollment into different levels of coverage or into $0 premium plans
    - Changes to special enrollment period eligibility and verification rules.
- Cost-sharing reduction appropriation for applicable states not covering abortion
- ACA Marketplace eligibility changes for lawfully present immigrants
- Verification policies resulting in the elimination of passive re-enrollment and conditional eligibility for Marketplace financial assistance

Enhanced Subsidies

The American Rescue Plan Act (ARPA), enacted in March 2021, and later the Inflation Reduction Act (IRA), enacted in August 2022, included a provision that temporarily expanded the size and scope of PTCs. This increase in affordability has driven the Marketplace to record high enrollment levels over the past few years. Enrollment in the Marketplaces during its OEP increased from about 12 million in 2021 to 24 million in 2025. Under current law, these ePTCs expire at the end of 2025. The Congressional

Budget Office (CBO) recently estimated that expiration of ePTCs would result in a 4.2 million increase in the number of uninsured people.[7]

Proposed Program Integrity and Affordability Rule

In March 2025, the Trump Administration released a proposed rule that included impactful changes to plan design features as well as enrollment and eligibility rules for 2025 and beyond.[8] The rule overall reverses a number of changes that were implemented during the Biden Administration that increased issuer and Exchange flexibilities around enrollment and eligibility determinations. The proposed rule includes reducing the duration of the open enrollment period, increasing verification requirements for enrollment, ending certain SEP categories (e.g., the below 150 percent federal poverty level [FPL] SEP), and changes to actuarial value (AV) de minimis requirements. Overall, HHS estimated in the proposed regulation that these policies will reduce enrollment by 790,000 to 2.1 million by 2029, presumably a steady state estimate. These estimates assume ePTCs are expiring in 2026.[9]

The House reconciliation bill includes virtually all of the proposed Program Integrity and Affordability rule provisions. Consequently, whether the provisions are enacted via regulation or via H.R. 1, the impact will be similar.[10] For purposes of this analysis, we included the entire effects of the proposed regulation in the House reconciliation bill.

House Reconcilliation Bill

In addition to the Payment Integrity and Affordability rule, several additional provisions included in H.R. 1 that, if enacted, will affect individual market affordability, stability, and coverage levels. These changes include an appropriation to pay for cost-sharing reductions (CSR), revisions to the definition of immigrants qualified for Marketplace financial assistance, the elimination of passive reenrollment and conditional eligibility for Marketplace financial assistance, and the creation of a pre-enrollment verification program. These provisions are described below.

Cost-Sharing Reductions Funding

Prior to October 2017, the federal government reimbursed insurers for the cost of CSRs through a direct payment. After litigation in 2017, the Trump Administration announced that it would no longer make payments to insurers absent an appropriation from Congress. Starting in plan year 2026, H.R. 1 would make an appropriation for cost-sharing reduction payments, which, since 2018, have not been federally funded. Most issuers have accounted for the absence of CSR funding by "silver loading"—the

[7] Congressional Budget Office. Re: Estimated Effects on the Number of Uninsured People in 2034 Resulting from Policies Incorporated within CBO's Baseline Projections and H.R. 1, the One Big Beautiful Bill Act. June 4, 2025. Available at: https://www.cbo.gov/system/files/2025-06/Wyden-Pallone-Neal_Letter_6-4-25.pdf.

[8] Cohen M, Walker J, Phan V. Summary of Proposed Marketplace Integrity and Affordability Rule. October 2024. Available at: https://www.wakely.com/blog/summary-of-proposed-Marketplace-integrity-and-affordability-rule/.

[9] US Department of Health and Human Services. Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability Proposed Rule. *Federal Register*. March 19, 2025. Available at: https://www.federalregister.gov/documents/2025/03/19/2025-04083/patient-protection-and-affordable-care-act-Marketplace-integrity-and-affordability.

[10] CBO's analysis notes that the statutory language would apply the restrictions on SEPs for households with incomes below 150 percent of FPL to the SBMs that the rule does not.

practice of applying the aggregate CSR costs issuers expect to incur throughout the year into their Marketplace-only qualified health plan (QHP) silver premiums. Silver-loading has the effect of materially increasing silver premiums and the amount of available advance premium tax credits (APTC), which are tied to the price of the second lowest cost silver plan. This practice has resulted in increased premium affordability for APTC-qualified Marketplace enrollees, a higher prevalence of fully subsidized bronze plans, and in some markets, has allowed consumers to purchase gold plans at a lower cost than silver plans. The CBO has previously estimated that in 2026—after the ePTCs expire, about 70 percent of the individual market would have subsidized coverage.[11]

The resumption of CSR funding includes a limitation on the availability of that funding if the plan covers abortion services. A total of 12 states require Marketplace coverage to include nonemergency abortion services, which, if this provision becomes law, will result in those states not receiving CSR funding.[12] H.R. 1 does not limit the ability for states to silver-load, which they presumably will continue to do if their CSRs are not funded. CBO makes this assumption as well and estimates that approximately 25 percent of national enrollment is in states where silver-loading may still be allowed. CBO estimates that this provision will increase the number of people who are uninsured by 300,000.[13]

Immigrant Population Eligibility Changes

This provision makes two changes that narrow eligibility for APTC and CSR among lawfully present immigrants. Starting in 2026, lawful immigrants with household incomes below 100 percent of the FPL who are ineligible for Medicaid based on their immigration status will no longer qualify for APTC and CSR. These individuals are typically ineligible for Medicaid because they have been in the country for fewer than five years, colloquially known as the five-year bar population.

Starting in 2027, the bill eliminates APTC and CSR eligibility for lawfully present immigrants with certain immigration statuses. According to CBO,[14] immigration statuses that will no longer qualify for APTC and CSR under this provision include:

- People with pending asylum applications, those who have been granted asylum, and parolees
- People with temporary protected status and those granted deferred action, including recipients under DACA
- People granted statutory withholding of removal
- Temporary workers
- Nonimmigrants (including student exchange visitors and others admitted as nonimmigrants under the Immigration and Nationality Act)

[11] Congressional Budget Office. Health Insurance and Its Federal Subsidies: CBO and JCT's June 2024 Baseline Projections. June 2024. Available at: https://www.cbo.gov/system/files/2024-06/51298-2024-06-healthinsurance.pdf.
[12] KFF. Interactive: How State Policies Shape Access to Abortion Coverage. January 8, 2025. Available at: https://www.kff.org/womens-health-policy/issue-brief/interactive-how-state-policies-shape-access-to-abortion-coverage/
[13] Congressional Budget Office. Health Insurance and Its Federal Subsidies: CBO and JCT's June 2024 Baseline Projections. June 2024. Available at: https://www.cbo.gov/system/files/2024-06/51298-2024-06-healthinsurance.pdf.
[14] Ibid.

- Trafficking victims and refugees
- Cuban and Haitian entrants

Taken together, CBO projects that these two provisions will increase the number of uninsured by 1.3 million people.

Eliminating Conditional Eligibility and Passive Reenrollment

This provision includes new requirements for Marketplace members that will affect their ability to access and maintain their APTC and CSR eligibility. Starting in 2028, Marketplaces will no longer be able to determine consumers conditionally or provisionally eligible for APTC and CSR if they have a data matching inconsistency (DMI). DMIs are issued when some or all of an enrollee's application information, such as immigration or income status, cannot be verified by external data sources that Marketplaces are required to check. Consumers with DMIs typically have a 90-day reasonable opportunity period (ROP), during which they must furnish documentation demonstrating that the information on their application is accurate. If a member is unable to verify their DMI during the ROP, then the individual's eligibility is redetermined based on the information from external data sources,[15] which typically results in a change in the consumer's level of financial assistance or loss of coverage entirely. It is important to note that DMIs are issued on a household basis (i.e., if one enrollee is affected then the entire household is affected). According to SBM data, the median percentage of households who are issued a DMI is 22 percent.

Consumers who are conditionally eligible for Marketplace financial assistance are currently able to temporarily enroll in a plan, access Marketplace financial assistance, and use their health insurance during the ROP if they pay their premiums after the APTC has been applied. Under H.R. 1, these individuals will no longer be able to access Marketplace financial assistance during their ROP and instead will need to choose between waiting until their submitted documentation has been reviewed, processed, and approved by the Marketplace or paying the entire gross premium, or full price, for the plan until their DMI has been resolved. With conditional eligibility, the cost of the second lowest cost silver plan for a family of four with a household income of $50,000 living in Dallas, TX, would be less than $17 a month, or less than 1 percent of their monthly income. Without conditional eligibility, the cost of the same plan would be greater than 40 percent of the same family's monthly income, or more than $1,700, resulting in unaffordable prices and likely the sickest families continuing to purchase coverage.[16]

This provision also requires consumers to actively provide eligibility information when they initially apply, when they experience a change in circumstances, and during the annual renewal process, which will require new and returning customers to proactively verify or re-verify their eligibility. As a result, and according to the Joint Committee on Taxation (JCT), this provision "…prohibits passive reenrollment."[17]

[15] If the DMI is specific to income due to the lack of available data in external data sources, the applicant's eligibility is based on the individual's attested income. The Payment Integrity and Affordability Proposed Rule would change this outcome and result in the removal of APTC and CSR eligibility.
[16] Details are available at Healthcare.gov/see-plans.
[17] Joint Committee on Taxation. Description of the Tax Provisions of the Chairman's Amendment in the Nature of a Substitute to the Budget Reconciliation Legislative Recommendations Related to Tax. May 13, 2025. Available at:

Passive reenrollment, also known as automatic reenrollment, has been a standard Marketplace practice since the first renewal period in the fall of 2014, and a standard practice in health insurance, including employer-sponsored insurance and Medicare, for far longer. Passive reenrollment is designed to allow qualified consumers the ability to renew into their existing plan if it remains available in the new year. In the 2025 Open Enrollment, 54 percent of returning Marketplace enrollees were passively re-enrolled.[18]

Marketplace enrollees must have their eligibility for enrollment and financial assistance checked and redetermined as a part of the current reenrollment process. Their application information is checked against external data sources and if the information is consistent with external data sources, consumers can be re-enrolled in their current plan without taking any action. If inconsistencies are flagged, however, applicants are issued a DMI, which they must address to maintain their eligibility in the new plan year. These consumers are afforded a 90-day ROP to provide documentation to resolve the DMI, and, as described above, if they are conditionally eligible for APTC and CSR, they can continue to access their financial assistance during the ROP while they maintain their enrollment. Under this provision, consumers will now be required to actively verify their eligibility annually as a condition of their ability to renew their plan. If any DMIs are identified during the redetermination process and are still unresolved by the start of the plan year, renewing consumers will be expected to pay the full premium for as long as their eligibility remains unverified or to forgo coverage entirely.

CBO projects that these provisions will increase the uninsured population by 700,000 people.

Results and Findings

Using the data and assumptions described in Appendix A, Wakely estimated potential enrollment, morbidity, and premium impacts separately for each provision for individual markets in all states.[19] Enrollment reductions represent total nongroup enrollment changes. Premium impacts include morbidity shifts and assume some increase in fixed administrative expenses per member following the large loss in the enrollment base. It is likely that certain issuers will experience much larger administrative cost pressures, especially when they are not operating in other lines of businesses to spread costs across the existing membership base, which would cause further premium increases.

The tables below present the range of results. It should be noted that the range of results represent the average for states, on average, by cohort. Enrollment and premium impacts varied by state. Therefore, the range of enrollment reductions in some states exceeded the national average; premium changes also varied more widely than the average increase. The low and high estimates do not represent the full range of state-level estimates.

https://waysandmeans.house.gov/wp-content/uploads/2025/05/JCT-Description-of-AINS-to-WM-Committee-Report-Green-Sheet.pdf.

[18] Centers for Medicare & Medicaid Services. Health Insurance Exchanges 2025 Open Enrollment Report. Available at: https://www.cms.gov/files/document/health-insurance-exchanges-2025-open-enrollment-report.pdf.

[19] Massachusetts and the District of Columbia were excluded from the analysis. Enrollment in basic health plans (applicable in New York, Minnesota, and Oregon) was not considered in this analysis.

Table 1. Nationwide Range of Estimated Impact on Enrollment, Morbidity, and Premiums[20]

	Percent Change		Enrollment Change (in millions)	
Component	**Low**	**High**	**Low**	**High**
Enhanced Subsidies				
Enrollment	-25.4%	-30.3%	-6.0	-7.2
Morbidity	4.1%	5.7%		
Premium	4.3%	6.1%		
H.R. 1				
Enrollment	-21.8%	-27.0%	-5.2	-6.4
Morbidity	2.3%	4.7%		
Premium	2.5%	5.1%		
Total				
Enrollment	-47.2%	-57.3%	-11.2	-13.6
Morbidity	6.5%	10.7%		
Premium	7.0%	11.5%		

If all provisions modeled go into effect, individual market enrollment could drop by 47 to 57 percent in 2026 (assuming full impact is seen in the first year), resulting in only 10.1 to 12.5 million enrollees remaining in the individual market. Further, the enrollees who do remain could see their premiums rise solely because of shifts in single risk pool morbidity between 7.0 percent to 11.5 percent on average, based on gross premium costs before PTC. Those with PTC could experience significantly higher net premium cost increases.

It is important to note that these estimates do not account for other factors, such as rising healthcare costs or issuer market exits, which, in combination, could make the increases significantly higher. **Note these premium changes account for morbidity and fixed cost per member per month (PMPM) increases from a smaller enrollment base[21]; they do not account for metal level re-sloping, mix changes (e.g., age and region), trends, or reductions due to CSR funding and will vary based on a member's plan selection.**

The expiration of ePTCs and CSR funding could result in substantial premium increases for lower-income members. For example, in states with significant silver-loading—where gold plan premiums are lower than silver plans'—many low-income individuals now pay little or nothing for gold level coverage. Without these subsidies, monthly premiums could rise dramatically. For example, a state with this dynamic could increase net premiums for households with incomes less than 150 percent of FPL by $100 per month (from previously being free) or those with earnings of greater than 150 percent of FPL by more than $200 per month, if they want to maintain the same level of coverage. These increases

[20] Impacts of overlap and unsubsidized enrollment attrition have been removed proportionally from the provisions according to the number of non-group enrollees leaving the market. Numbers may vary from Figure 4 where overlap is split out separately.
[21] Note increased costs due to higher morbidity costs do not translate on a one-to-one basis to a premium increase. To estimate premium increases, fixed costs also need to be taken into account.

would likely be unaffordable for many households, potentially forcing them to downgrade to less generous plans or to leave the Marketplace altogether.

Table 2 illustrates average changes in enrollment, morbidity, and premium split by Medicaid expansion status.

Table 2. Nationwide Range of Estimates by Medicaid Expansion Status

	Medicaid Expansion States		Non-Medicaid Expansion States	
Component	**Low**	**High**	**Low**	**High**
Enhanced Subsidies				
Enrollment Reduction	-21.8%	-25.0%	-28.7%	-35.2%
Morbidity Impact	3.9%	5.2%	4.3%	6.4%
Premium Impact	4.1%	5.4%	4.7%	7.0%
H.R. 1				
Enrollment Reduction	-19.3%	-24.8%	-24.2%	-29.0%
Morbidity Impact	2.2%	4.6%	2.4%	5.2%
Premium Impact	2.4%	4.8%	2.8%	5.7%
Total				
Enrollment Reduction	-41.0%	-49.8%	-53.0%	-64.3%
Morbidity Impact	6.2%	10.0%	6.9%	11.9%
Premium Impact	6.5%	10.5%	7.5%	13.0%

As noted, the enrollment losses in the individual market could be extremely high, with many states reverting to enrollment levels not experienced since the early years of the Marketplaces, if not lower. Enrollment losses correlate strongly with morbidity increases and resulting premium increases. Administrative expenses will also contribute to premium increases, given lower enrollment to spread fixed costs.

Significant variation is evident among states. One driver of variation is related to Medicaid expansion status. Non-expansion states are estimated to have larger enrollment losses relative to Medicaid expansion states. These states saw the largest enrollment increases since the introduction of ePTCs, with many doubling or even tripling in size over the past four years. For example, Marketplace enrollment in Texas has grown from 1.3 million to 4.0 million enrollees during 2021−2025.[22] Consequently, it is unsurprising that these states are expected to experience the greatest decreases.

Separately, variation exists given different states are affected by different provisions. For example, states with higher silver-loading because of the lack of CSR appropriations could see larger reductions in enrollment if that provision is codified as the result of higher potential reductions in APTC and

[22] Numbers reported by CMS during the open enrollment period, prior to effectuation. Source: Centers for Medicare & Medicaid Services. 2021 Marketplace Open Enrollment Period Public Use Files. Modified: March 3, 2025. Available at: https://www.cms.gov/data-research/statistics-trends-reports/marketplace-products/2021-marketplace-open-enrollment-period-public-use-files.

corresponding increased net premiums. Conversely, states with smaller silver loads would see much smaller reductions in enrollment.

Table 3 shows estimated enrollment and premium impacts by H.R. 1 sub-policy and in total, including the likelihood of overlapping effects.

Table 3. Nationwide Range of Estimates by Policy[23]

	Enrollment Losses (in Millions)		Premium Impacts	
Policy	**Low**	**High**	**Low**	**High**
Proposed Program Integrity Regulation	-2.2	-2.2	0.4%	0.7%
Cost-Sharing Reductions Funding	-0.4	-0.4	0.6%	0.6%
Immigrant Population Eligibility Changes	-1.4	-1.6	0.8%	1.2%
Pre-Enrollment Verification and Passive Reenrollment	-1.5	-3.3	0.5%	2.1%
Subtotal H.R. 1	**-5.4**	**-7.4**	**2.3%**	**4.7%**
Enhanced Subsidies	**-6.3**	**-8.3**	**4.1%**	**5.7%**
Overlapping Impacts	+0.5	+2.2	-0.1%	0.0%
Fixed Expenses Increase			0.5%	0.8%
Total	**-11.2**	**-13.6**	**7.0%**	**11.5%**

Wakely modeled the impacts of these policies in a stepwise fashion, with the expiration of ePTCs occurring first. Given the overlapping nature of these provisions, the *incremental* influence of H.R. 1 on the post ePTCs expiration projected market composition is more muted than it would be if ePTCs were still in effect. Simply stated, it is likely that the enrollment loss because of H.R. 1 would be greater than the 5.4 to 7.4 million members suggested in Table 3 if ePTCs remain in effect for plan year 2026.

The degrading of the risk pool resulting from the large enrollment losses is expected to yield higher premium costs. Though some provisions would reduce gross premium costs (e.g., allowing plans with higher cost sharing via lower actuarial value or removing silver-loading[24]), our analysis measured the change in morbidity to more directly measure the state of the risk pool and control for changes in mix (e.g., age and metal level distribution changes). Overall, we estimate gross premiums will increase 7.0 percent to 11.5 percent.

We estimate this premium increase would result in a 3.9 percent to 6.1 percent (120,000−190,000 enrollees) reduction in unsubsidized enrollment, as included in the estimated enrollment losses in the tables above. The estimated premium increases include a range of 0.5 to 0.8 percent increase

[23] Unsubsidized attrition is included in the enrollment losses for each provision herein. Unsubsidized attrition was calculated in total for H.R. 1 and distributed proportionally to the sub-policies based on the direct non-group enrollment loss estimates.
[24] Although increasing the AV de minimis, as well as CSR payments, would reduce gross premiums for unsubsidized enrollees, it would also increase net premiums for subsidized enrollees as it decreases the benchmark premium that determines the amount of APTC that an enrollee may receive.

attributed to PMPM fixed costs from large reductions in enrollment. Incremental increases to spend due to operational considerations in the bill were not modeled.

As part of the analysis, we were able to collect unique data on current verification processes among State-Based Marketplaces (SBMs). These data provide a window into current processes and how large changes to verification could affect enrollment. The data, alongside discussions with Marketplace operations experts, yielded key insights into the operational complexities of implementing this provision and a range of potential outcomes.[25] We can find no comparable precedent for individuals being required to pre-verify information potentially months before selecting a plan.

Consequently, we believe the range of outcomes would be considerably wider than other policies included in H.R. 1. The combination of ending passive enrollment and pre-enrollment verification is estimated to reduce enrollment by 1.5 million to 3.3 million individuals. The scope of enrollment losses is driven by uncertainty about the impact of pre-enrollment verification, which will be highly dependent on how it will be defined and enforced by the Centers for Medicare & Medicaid Services (CMS) and operationalized by SBMs and the Federally Facilitated Marketplace (FFM). The pre-enrollment verification program alone is estimated to result in coverage losses of 720,000 to 2.2 million people.

Limitations and Considerations

It is important to note that we did not model every policy included in H.R. 1.[26] Specifically, a provision that would remove the limitation of premium tax credit reconciliation, which is expected to reduce enrollment, was omitted from the modeling. Modeling for Custom Health Option and Individual Care Expense (CHOICE) arrangements, formerly known as Individual Coverage Health Reimbursement Arrangements (ICHRA), also were excluded from the modeling. In addition, interactions with other provisions of H.R. 1, especially those that would affect Medicaid, might result in changes in the size and composition of the individual market. For example, limitations on Medicaid provider taxes could result in a state ending its Medicaid expansion program. Such a change could increase the size of the individual market, all else equal, which could increase the number of people affected by the provisions analyzed herein.

Nor did we model how the reduction in individual market size could drive issuer exits and how that change would impact enrollment. Earlier research has shown that marginal propensity for disenrollment was 7.1 to 12.9 percentage points higher if a returning enrollee's issuer exited the Marketplace.[27] Previous research shows that unsubsidized enrollees are especially affected by issuer exits. Given the large enrollment losses, issuer exits are likely, which should put further downward pressure on enrollment and upward pressure on premiums, potentially exacerbated by less competition.

[25] For full documentation on the methodology used in estimating the effect of this provision. See Appendix A.
[26] The list of policies that were included in the modeling, and the time they are scheduled to go into effect under the current interpretation of H.R. 1, is included in Appendix B.
[27] McGough M, Ortaliza J, Cotter L, Cox C. Early Indications of the Impact of the Enhanced Premium Tax Credit Expiration on 2026 Marketplace Premiums. Peterson-KFF Health System Tracker. June 3, 2025. Available at: https://www https://www.healthsystemtracker.org/brief/early-indications-of-the-impact-of-the-enhanced-premium-tax-credit-expiration-on-2026-Marketplace-premiums/.healthaffairs.org/doi/full/10.1377/hlthaff.2018.05475.

Another source of uncertainty is regulatory implementation of the statute. For example, our interpretation of the statute is that plans that offer nonemergency abortions would be able to maintain silver-loading status; however, it is unclear whether regulatory action would alter that possibility. For example, a requirement to broad-load CSR costs (i.e., costs are spread across all plan metal levels instead of just silver plans) that are not reimbursed by federal funds, could reduce enrollment further than estimated.

Finally, premium increases may be understated due to issuers pricing for uncertainty. Given the scope of changes, the composition of the individual market in the future is uncertain. Ambiguity about competitive pricing positioning and potential market issuer exits can also contribute to issuers pricing more conservatively. Consequently, explicit issuer risk margin or implicit assumption conservatism may be higher until a level of market stability is achieved, which may take multiple years.

Conclusion

The expiration of enhanced premium tax credits at the end of 2025 is expected to significantly decrease enrollment and increase gross premiums in 2026 and beyond. If enacted, H.R. 1, would also contribute to large enrollment reductions and gross premium increases. Few analyses have combined the potential effects of both changes in relationship to individual market enrollment. Our analyses are generally consistent with CBO estimates on the impacts[28] of the provisions, as well as Urban Institute estimates,[29] with the key difference centering on the effects of the verification provisions.

Our analysis provides several significant projections on the potential future trajectory of the individual market, including the holistic impacts potential changes would have on the individual market enrollment and resulting changes in the risk pool. It uses unique data from SBM current data matching verification processes to estimate the impact that the verification provisions could have on the individual market. This analysis includes a range of potential impacts. The ultimate impact of these changes will depend on myriad unknowable factors—from regulatory language to operational implementation.

Though we have provided an estimated range of reasonable estimates, the full range of potential outcomes extends beyond the estimates included. Nonetheless, this analysis does make clear that should the policies analyzed be fully implemented, the individual market would be significantly smaller and sicker relative to today, and less affordable for many enrollees who remain in the market. For those enrollees who drop coverage their access to major medical coverage will be significantly limited resulting in higher levels of uninsured and strains on hospital budgets due to increases in uncompensated care.

[28] Congressional Budget Office. Re: Estimated Effects on the Number of Uninsured People in 2034 Resulting From Policies Incorporated Within CBO's Baseline Projections and H.R. 1, the One Big Beautiful Bill Act. June 4, 2025. Available at: https://www.cbo.gov/system/files/2025-06/Wyden-Pallone-Neal_Letter_6-4-25.pdf.

[29] Buettgens M, Carter J, Levitis J, Banthin J, Simpson M. Reconciliation Bill Would Cut Marketplace Enrollment by over 5 Million People. Urban Institute. June 13, 2025. Available at: https://www.urban.org/research/publication/reconciliation-bill-would-cut-marketplace-enrollment-over-5-million-people.

Appendix A: Methodology and Assumptions

Wakely conducted modeling on the potential impact of ePTCs ending and reconciliation bill on the individual market[30]. For each key provision, a low and a high scenario was run for each state including different assumptions for enrollment and morbidity impacts for specific changes. Premium changes were a function of enrollment and morbidity changes under each scenario. The following data sources and assumptions were used in the development of the estimated range of impacts.

It is important to note that the impacts modeled are estimated market average impacts. It is likely that issuer-level impacts will vary from these estimates, potentially significantly. Other factors, such as competitive pressures, market positioning of the benchmark plan issuer, premium metal level sloping, and changing risk adjustment dynamics may impact the extent to which individual market issuers are impacted by the proposed premium payment threshold. For example, the risk adjustment transfer component of the premium rate change may not offset the claim cost increase realized.

2026 Baseline

The initial step of the analysis was estimating what 2026 enrollment would be if ePTCs continued. The starting point for historical market enrollment (years 2019 through 2025) was the OEP enrollment data, with an effectuation adjustment applied. Since the historical OEP enrollment data is reflective of early year plan selections, the data was adjusted to reconcile to the effectuated number of on-exchange enrollees and the number of enrollees with APTC in each year, based on CMS annual effectuation data for years 2019 - 2024. The 2025 enrollment was estimated from the 2025 open enrollment data as reported by CMS, with a similar level of net attrition as observed in the year 2022. This year was used to remove Medicaid redetermination impacts that would be present in 2023 and 2024 experience. 2026 enrollment was assumed to remain stable compared to 2025, in the environment that ePTCs continues. 2026 enrollment was adjusted by the effectuation observed in 2019 (prior the effect of ePTCs) in the environment that ePTCs expires.

Off-exchange enrollment in years 2019 through 2024 was estimated by relying on the Risk Adjustment Report (Final for years 2023 and prior, and the Interim report for 2024) billable member months (assuming average enrollment using monthly enrollment data) and removing the on-exchange enrollment from this total.

We used historical averages as reported in the Unified Rate Review Template (URRT) public use files (PUFs) and Wakely discretion to arrive at the target loss ratios and allowed cost trends in the projection of 2024 to 2026 premiums to determine elasticity of membership.

Given expected high premium increases, even before the impacts of the ePTCs expiration, we estimated a negative effect on unsubsidized enrollment.

Overall, we estimate that baseline enrollment would be approximately 24 million enrollees.

[30] Massachusetts and the District of Columbia were excluded from the analysis given their merged market status. Additionally, no analysis was conducted on how these provisions would impact BHP enrollment.

Expiring ePTCs

In 2026, changes in subsidized enrollment were modeled as a function of the change in net premium post-expiration of ePTCs combined with a price elasticity of demand for health insurance. This method was used to estimate the proportion of membership dropping coverage and the proportion of consumers switching to a less expensive plan metal tier, from gold to silver (and vice versa in states where silver premiums exceed gold) and from silver to bronze. The attrition and plan switching changes were modeled based on prior research elasticities. The function computes expected enrollment change based on net premium changes.

One caveat is that applying the elasticity function to net member premiums may not exactly correlate to what was measured by the study, i.e., going from $1 PMPM to $3 PMPM is a 300 percent increase which may result in different member behavior than moving from $100 PMPM to $300 PMPM. Actuarial judgment was applied to the elasticity function to account for these dynamics.

One key dynamic included was the shift in net premiums for many enrollees moving from zero net premiums to non-zero premiums. For the lowest income consumers, the change in net premium after the expiration of ePTCs was an increase from a potential zero cost to a non-zero net premium (depending on the plan purchased), which cannot be quantified as a percentage. For those cases, Wakely selected a static percentage change in the net premium (e.g., 200%) to use in the enrollment change analysis, based on a net premium threshold.

Proposed Program Integrity and Affordability Regulation

Given the overlapping nature of the proposed changes within the Program Integrity and Affordability rule, Wakely relied on CBO's estimate of 2.2 million decrease in nongroup coverage for enrollment losses.[31] CBO's estimate was distributed to the state level using count of APTC recipients from 2025 OEP data. The effects of this regulation were subsumed into the effects of H.R. 1.

House Reconciliation Bill (H.R. 1)

Immigrant Population Eligibility Changes

5-Year Bar Population

Starting in 2026, lawfully present immigrants with household income less than 100 percent FPL, otherwise known as the "5-year bar" population, will no longer qualify for APTC and CSR. Given the drastic change in net premium these individuals would realize upon elimination of their subsidies, we anticipate all these members will disenroll from the individual market as they will no longer be able to afford coverage. 2025 OEP data by state was used to estimate the proportion of the population less than 100 percent FPL in 2026, which our analysis assumes is synonymous with the five-year bar

[31] Congressional Budget Office. Estimated Effects of Proposed Marketplace Rule. April 9, 2025. Available at: https://democrats-waysandmeans.house.gov/sites/evo-subsites/democrats-waysandmeans.house.gov/files/evo-media-document/cbo-aca-coverage-loss-estimates.pdf?source=email.

population.[32] These individuals were removed from the modeling following the effects of ePTCs expiring to limit overlap.

Lawfully Present Immigrants

For other changes in lawfully present immigrant APTC and CSR eligibility, limited data is available regarding the number of lawfully present immigrants currently receiving subsidies on the Marketplace. Rather than completing detailed modeling, we relied on CBO's estimate that changes in immigration status (absent the 5-year bar population) will increase the uninsured population by 1.0 million.[33] CBO's estimate was distributed to the state level using March 2024 Temporary Protected Status data posted by US Citizenship and Immigration Services (USCIS).[34] Wakely substituted estimates with data provided by states where available.

CSR Appropriation

Many markets will experience changes in premium relativities by metal tier, particularly in states with currently high mandated CSR silver loads in place in plan year 2025.[35] In most instances, the mandated CSR silver loads are predicated on the expectation of rational consumer behavior with the majority of silver enrollment comprised of members in the 87 percent and 94 percent CSR variant plans. These members have much lower cost sharing relative to the standard silver plan and may also exhibit higher levels of induced utilization. The cost of the additional CSR payments and any induced utilization impacts lead to a high silver CSR load and, in turn, high gross silver premiums. High silver premiums increase the PTC, which lowers the net premiums, including those for bronze and gold metal level plans. While the enrollment impact of this change is largely overlapping with the impact of the expiration of the ePTCs in 2026, since both of these regulatory changes lower PTCs, the impacts vary by state and generally lower consumers' purchasing power through higher net premiums than they would have experienced otherwise, particularly those in the lowest income brackets, or those remaining in the market who are sicker and will be more likely to utilize will experience higher out-of-pocket costs.

The impact of CSR appropriation was modeled for the market as a whole, for those not covering abortion and presumably assumed to be allowed to silver-load, by projecting the change in premiums by metal tier, and the subsequent impact on APTCs, enrollment attrition and morbidity consistent with the methodology above. Each carrier in the market would have a different CSR load reflected in their current rating based on carrier specific mix, plan designs, etc. The estimated CSR load in the market utilizes average distributions of market membership by CSR variant, AVs, and induced utilization (IU) to back into the pure AV adjustment to remove while maintaining IU differentials. There are varying dynamics in a mandated load state or states with higher silver-loading regarding how gold will be positioned after the CSR appropriation and competitive pressures in the market. The premium relativity changes combined

[32] Our modeling assumes that all enrollees listed as less than 100 percent FPL population in the OEP data are the five-year bar population.
[33] Congressional Budget Office. Re: Estimated Effects on the Number of Uninsured People in 2034 Resulting From Policies Incorporated Within CBO's Baseline Projections and H.R. 1, the One Big Beautiful Bill Act. June 4, 2025. Available at: https://www.cbo.gov/system/files/2025-06/Wyden-Pallone-Neal_Letter_6-4-25.pdf.
[34] Congressional Research Service. Temporary Protected Status and Deferred Enforced Departure. Updated September 23, 2024. Available at: https://sgp.fas.org/crs/homesec/RS20844.pdf.
[35] Tolman L. Effects of State Cost-Sharing Reduction Pricing Guidelines on ACA Plan Premiums. *Health Watch*. May 2025. Available at: https://www.soa.org/sections/health/health-newsletter/2025/may/hw-2025-05-tolman/.

with the impact on the net premiums after APTC informed the metal distributional shifts and were specific to each state modeled.

Pre-Enrollment Verification and Passive Reenrollment Provision Impacts

This analysis relied on OEP data to estimate the proportion of passive re-enrollees, also known as auto-enrollees, in the individual market in 2026 and the makeup of the passive reenrollees by FPL, metal, and age. A blend of 2019 and 2025 OEP data was leveraged as to not overstate the proportion of passive reenrollment in an environment where ePTCs expire given recent higher reenrollment rates. Attrition rates were applied based on prior research indicating that removal of a passive reenrollment option reduces take-up by 33 percent on average, with greater impacts on younger, healthier, and lower-income individuals.[36]

The impact of the pre-enrollment verification program and elimination of passive reenrollment on the market enrollment and morbidity overlaps with the impacts of ePTCs expiration. As a result, the incremental impact of these previsions on the post ePTCs expiration projected market composition is more muted than it would be if ePTCs were still in effect.

The pre-enrollment verification results were informed, in part, by DMI data from SBMs who provided information in response to a data call. Respondents represent roughly 50 percent of the SBM enrollment population.

To estimate the impact of the enhanced verification requirements on Marketplace consumers, the affected population was broken down into three cohorts:

- Cohort 1: Applicants who are highly motivated to achieve and maintain their eligibility and enrollment, regardless of the verification process
- Cohort 2: Applicants motivated to achieve and maintain their eligibility and enrollment but who are less likely to complete the verification process and overcome administrative barriers
- Cohort 3: Applicants who attempt to enroll through a qualifying Special Enrollment Period with high barriers to initial and ongoing eligibility and enrollment

2019 national Wakely ACA (WACA) experience data were used to segment the impacted population into these three cohorts because most Marketplaces had shorter Open Enrollment durations (November 1 to December 15) and stricter eligibility verification policies in that year, representing a market dynamic more closely aligned with what was included in the proposed Payment Integrity and Affordability regulation and in H.R. 1. Cohort 1 is based on the percentage of new and renewing consumers who actively enrolled early on during the 2019 Open Enrollment, demonstrating motivation to finalize their enrollment for the upcoming plan year as quickly as possible. The percentage of consumers who enrolled before November 25 in 2019 are in Cohort 1 for the low scenario and the

[36] Shepard M, Wagner M. Reducing Ordeals through Automatic Enrollment: Evidence from a Health Insurance Exchange *HKS Working Paper No. RWP23-002*. Harvard Kennedy School. January 26, 2023. Available at: https://papers.ssrn.com/sol3/papers.cfm?abstract_id=4336992.

percentage of enrollment during the first week of 2019 Open Enrollment is Cohort 1 in the high scenario. Cohort 2 is the percentage of Open Enrollment enrollees who actively enrolled or passively re-enrolled after Cohort 1 and Cohort 3 is the percentage of enrollees who enrolled during a SEP in 2019. The distribution of the three cohorts was made on a member month weighted basis.

To identify the percentage of enrollees expected to receive DMIs due to the pre-enrollment verification program, SBM DMI data was used to inform the estimates. For the low scenario, the median SBM DMI percentage was used, based on the assumption that the new verification policies will increase DMIs for all Marketplaces. The high scenario was estimated to be higher than the highest SBM DMI percentage based on the assumption that the pre-enrollment verification program will result in considerably more DMIs than have been issued historically.

The percentage of consumers with DMIs who will successfully resolve their DMI and obtain enrollment and Marketplace financial assistance by cohort was informed by DMI resolution data from SBMs. For the low scenario, Cohort 1 was assigned the highest SBM DMI success rate which is more than 75 percent of DMIs. Cohort 2's resolution rate was estimated to be lower based on the assumption that this population will be less successful at resolving their outstanding verifications because of the limited time that an enrollee will have to resolve verification issues as well as this cohort being less likely to overcome administrative barriers. Cohort 3 has the lowest resolution rate based on the assumption that pre-enrollment verification barriers will be most significant for SEP applicants which is consistent with DMI resolution data from SBMs, and due to SEP applicants having the least amount of time to resolve inconsistencies. The high scenario aligns Cohort 1's DMI resolution rate to the lowest SBM DMI success rate, just over 50 percent, based on the assumption the high volume of DMIs created by the pre-enrollment verification program will increase demands on Marketplace operations, customer service, and enrollment assistance professionals, which in turn will result in resource constraints, processing delays, consumer confusion, and ultimately coverage gaps, delays, and drops. Cohorts 2 and 3 are estimated to have similar decreases in their DMI resolution rates in the high scenario.

In both the low and high scenarios, the elimination of conditional APTC and CSR eligibility is expected to motivate consumers to address their DMIs faster which will mitigate some but not nearly all the administrative barriers to successful initial and ongoing Marketplace eligibility and enrollment. In addition, another mitigation factor was applied based on the assumption that some consumers will "pause" their enrollment, waiting out the verification process, and effectuating coverage whenever their DMI is resolved. Again, this group is estimated to be significantly smaller than those who will not be able or willing to wait or resolve their DMIs due to the pre-enrollment verification program's administrative barriers to coverage and financial assistance. Finally, we assumed some marginal percent of enrollees will pay (or have third parties pay) the full cost of premiums without financial assistance.

The attrition assumptions below were applied to the low and high scenarios, separately for SBM and FFM states, to estimate the proportion of APTC recipients that would leave the market due to pre-enrollment verification requirements. The rates were applied to the number of APTC enrollees that were remaining in the market following enrollment loss from the other provisions modeled to limit overlap. It was assumed that 5 percent of the APTC enrollees affected would remain unsubsidized in the market.

Table 4. Pre-Enrollment Verification Attrition Assumptions by Marketplace Type and Scenario

Marketplace Type	Low	High
FFM	-8%	-33%
SBM	-8%	-30%

Morbidity Impacts

For the morbidity impacts, Wakely relied on either published estimates of morbidity of individuals leaving ACA Marketplace, or when possible, analyzed morbidity differences in Wakely's national ACA experience (WACA) between relevant cohorts of members (by age and metal / CSR type). We then combined the two estimates (volume and morbidity) to estimate the overall impact of this change on the market risk pool and premiums. The volume and overlap in the affected cohorts of members was used to assess the overlap of the various policies. The final morbidity estimate accounted for this overlap.

Using the range of the estimated enrollment attrition described in the above sections, we estimated corresponding impacts on the risk pool morbidity. Wakely made assumptions around the likelihood of consumer disenrollment, assuming that healthier consumers would have a relatively higher likelihood of dropping coverage than the less healthy consumers. Relative morbidity estimates vary by state due to the proportion of members affected, under the notion that as the proportion of the affected population rises, the average morbidity of affected members will be closer to the market average of 1.0.

The assumptions were developed by age range and metal tier and based on the national distribution of enrollment by allowed cost level in the national WACA 2022 experience database, with actuarial judgment, around the relative attrition of healthier members compared to sicker members (i.e., the rate of attrition by claims probability distribution). The allowed costs from national experience were calibrated to the state-specific average allowed 2023 costs, by metal tier, as reported in the 2025 URRT.

Separate analysis was performed to estimate the likely morbidity of the SEP members leaving the ACA risk pool. Based on the analysis of 2022 WACA experience of the SEP enrollees, these members were estimated to have 5.4 percent higher morbidity relative to the current market average. The SEP provision of the Marketplace Integrity regulation eliminates the eligibility of low-income SEP members after the open enrollment period. As a result, the residual risk pool morbidity is estimated to decrease by 0.5 percent to 0.6 percent.

Premium Impacts

Impacts of changes in the market average premium[37] due to morbidity and fixed PMPM cost increases were modeled for a given individual at a constant age, metal, and geography; demographic mix changes were not considered in premium impacts (i.e., premium rate changes including differences in average age, plan selection, and geographic region) nor were any explicit changes made to risk adjustment, assuming a net zero market transfer. The assumption regarding premium rates not changing due to risk adjustment transfer changes may be significant, as changing populations, demographic factors, and varying impacts by carrier could materially impact pricing. The estimated premium impacts assume that issuers would price the modeled morbidity impacts into their 2026 premium rates through claim cost increases and the variable portion of non-benefit expenses, in line with historical medical loss ratios (MLR) in the state. Premium changes accounted for a higher fixed cost component of the premium given the lower market enrollment. These costs are expected to be allocated over a smaller market enrollment and as a result contribute to a higher premium. Using these assumptions, the overall range of premium changes was estimated to be 7.0 percent to 11.5 percent.

State Groupings

For purposes of this analysis, states were grouped by Medicaid Expansion and Non-Medicaid Expansion. We also grouped states by Exchange status as there may be operational differences when implementing the verification provisions between State-Based Marketplaces (SBMs) and states whose Exchange enrollment and eligibility systems are operated by HHS (FFM).[38]

Limitations and Uncertainties

The assumptions and resulting range of estimates included in this analysis are inherently uncertain. Changes to the legislation, regulatory, or economic environments will cause deviation in results, potentially materially. Not all provisions of the H. R. 1 bill were modeled in this analysis.

Users of the results should be qualified to use it and understand the findings and the inherent uncertainty. Actual results may vary, potentially materially, from our estimates. Wakely cannot guarantee the estimated values included in the analysis. It is the responsibility of the organization that receives the feedback to review the assumptions carefully and notify Wakely of any potential concerns.

The effects and changes of state premium and CSR wrap assistance program were not modeled in these scenarios. We assumed that the state subsidies' funding levels would remain at the current levels and the 1332 waivers would continue to be in effect. Changes to the waiver or cancellation of a waiver would have material effects on the estimates.

The modeling did not include Massachusetts and the District of Columbia due to their merged market status. Additionally, no analysis was conducted on enrollment in basic health plans (BHP). Inclusion of

[37] The market average premium includes the total membership - both on and off-Exchange.
[38] While there are key legal distinctions between different types of Exchanges, for purposes of the analysis any state that utilizes Healthcare.gov was classified as a federally-facilitated Marketplace (FFM).

these states/programs would increase the total enrollment losses. The inclusion of CBO's impacts for the program integrity rule provisions or temporary immigration were prorated for their exclusion.

The current analysis was completed on June 18, 2025, and does not reflect the effect of potential policies that could be passed/enacted by Congress or the federal administration after the analysis was conducted, including changes in federal outreach budget or silver-loading. Additionally, unless explicitly noted, unique state regulatory changes or requirements were not included.

Except for the impacts described above, we did not assume any significant changes to the plan offerings. Changes to federal law, state law (beyond what was modeled), or economic conditions could materially impact the estimates.

There is inherent uncertainty in these estimates for the following reasons:

- Operational uncertainty in implementation of the provisions.
- Lack of historical data on the impact of similar provisions (national or state-specific).
- Limited information available to infer the impact on disenrollment and the associated morbidity of affected population.
- Uncertainty around the consumer reaction to the regulatory provisions analyzed.
- Uncertainty in the issuer reactions to the regulatory provisions analyzed, such as market exits, consolidation, and pricing decisions.
- The morbidity impacts were estimated by using national experience and applying it to state-specific populations and a subset of members assumed to be affected by the rule.
- There is a significant overlap of the effect of the rule components and Wakely made best effort at estimating the overlap.
- Wakely assumed rational consumer enrollment reaction to the proposed rule; actual consumer behavior is not known and can vary significantly from these assumptions, affecting the characteristics of the single risk pool and therefore the impact on premiums.
- Rapidly changing policy and economic environments that directly interact with and affect the rules impact. There is also uncertainty in the baseline enrollment and premiums. These estimates align with the known policy and economic environment at the time the analysis was completed on June 18, 2025.
- Short timeframe to complete the analysis.

For these reasons, the ranges of results presented in this analysis represent reasonable estimates with the information available at the time of performing this analysis. It is possible that the actual results would fall outside of the ranges discussed.

Appendix B: Summary of Provisions Modeled and Timeline

Provision[39]	Included in Analysis?	Timeframe for Implementation
Cost-sharing reduction (CSR) appropriation	Y	2026
ACA Marketplace coverage eligibility for Deferred Action for Childhood Arrivals (DACA) recipients	Y	2026
Prohibits coverage of gender affirming care as an essential health benefit	N	2027
CHOICE arrangements	N	2026
Open Enrollment Period shortening (OEP)	Y	2026 / 2027
Failure to file and reconcile	N	2026
Employer credit for CHOICE arrangements	N	2026
ACA Marketplace coverage eligibility for lawfully present immigrants: 5-Year Bar	Y	2026
ACA Marketplace coverage eligibility for lawfully present immigrants: All Other	Y	2027
Premium underpayments and effectuation of coverage	Y	2026
Limitation on use of CSR funds for abortions	Y	2026
Recapture of excess premium tax credits	N	2026
AV changes	Y[40]	2026
Premium adjustment percentage (PAP) methodology	N[41]	2026
Automatic reenrollment into different levels of coverage or into $0 premium plans	Y	2026
Verifying personal information	Y	2026
Increased Special Enrollment Periods Verification (SEPs)	Y	2026
Ending Low-Income SEPs	Y	2026
Pre-enrollment verification of eligibility for premium tax credit	Y	2028

[39] Provisions are defined as outlined in this article: https://www.kff.org/tracking-the-affordable-care-act-provisions-in-the-2025-budget-bill/v

[40] AV changes were modeled as part of the aggregate impact of the Marketplace Integrity and Affordability rule resulting in enrollment and premium impacts.

[41] Enrollment impacts were modeled but premium impacts were not.

Data and Reliance

We have relied on multiple sources of data and assumptions used in this analysis. We have reviewed the data for reasonableness but have not performed any independent audit or otherwise verified the accuracy of the data/information. If the underlying information is incomplete or inaccurate, our estimates may be impacted, potentially significantly.

Wakely utilized the following data sources for this analysis:

- CMS OEP PUFs: https://www.cms.gov/data-research/statistics-trends-and-reports/Marketplace-products
- CMS effectuation data: https://www.cms.gov/files/document/first-half-effectuated-enrollment-tables-2017-2024.xlsx
- Risk Adjustment Report data: https://www.cms.gov/Marketplace/health-plans-issuers/premium-stabilization-programs
- URRT data: https://www.cms.gov/Marketplace/resources/data/rate-review-data
- 2025 Rate Table PUFs: https://data.healthcare.gov/public-use-files
- Title: Impact of Key Provisions of the American Rescue Plan Act of 2021 COVID-19 Relief on Marketplace Premiums | KFF
    - https://www.kff.org/report-section/impact-of-key-provisions-of-the-american-rescue-plan-act-of-2021-covid-19-relief-on-Marketplace-premiums-appendix/
- Title: Average Marketplace Premiums by Metal Tier, 2018-2025 | KFF
    - https://www.kff.org/affordable-care-act/state-indicator/average-Marketplace-premiums-by-metal-tier/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.
- Data submissions from SBMs on impacts of H.R.1 including data on temporary immigration, BAR population, and historical DMI experience.
- Estimated maximum income percentage for health insurance premium projected in 2024 and 2026 after the expiration of ePTCs.
- State-specific enrollment loss assumptions from Urban Institute included in the article titled "Who Would Lose Coverage if Enhanced Premium Tax Credits Expire?" dated November 14, 2024, due to the ARP enhanced subsidies expiring.
- https://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/66xx/doc6620/08-24-healthinsurance.pdf
- NBER WORKING PAPER SERIES. INERTIA, MARKET POWER, AND ADVERSE SELECTION IN HEALTH INSURANCE: EVIDENCE FROM THE ACA EXCHANGES. Saltzman et al. http://www.nber.org/papers/w29097. July 2021
- https://aspe.hhs.gov/system/files/pdf/77161/ib_Targets.pdf
- Estimated Effects on the Number of Uninsured People in 2034 Resulting From Policies Incorporated Within CBO's Baseline Projections and H.R. 1, the One Big Beautiful Bill Act. https://www.cbo.gov/system/files/2025-06/Wyden-Pallone-Neal_Letter_6-4-25.pdf
- Wakely ACA national 2019 and 2022 databases (WACA), an aggregated database based on de-identified external data gathering environment (EDGE) Server input and output files (including

enrollment, claims, and pharmacy data) from the 2019 benefit year and 2022 benefit year submitted through April of the following year, along with supplemental risk adjustment transfer and issuer-reported financial information. We added publicly available data published by CMS such as the plan finder data and the MLR data. The de-identification applies to identifiers specific to enrollee, issuer, and location. We performed reasonability tests on the data but did not audit or verify the data. The dataset is subject to change if issues are found or reported to us. We may release updates to the dataset if the changes are significant and relevant to the analyses.

Disclosures and Limitations

Responsible Actuary. Michelle Anderson, Ksenia Whittal and Jenna Hegemann are the actuaries responsible for this communication. They are Members of the American Academy of Actuaries. Michelle and Ksenia are both Fellows of the Society of Actuaries and Jenna is an Associate of the Society of Actuaries. They meet the Qualification Standards of the American Academy of Actuaries to issue this report. Michael Cohen, PhD, and Zachary Sherman also contributed to this report.

Intended Users. This paper is intended for informational purposes only; other uses may not be appropriate. The information presented in this paper is available for public reading and is intended to provide our thought leadership. Parties reading this report should retain their own actuarial experts in interpreting the results presented. Any distribution of this paper should be made in its entirety and should be evaluated only by qualified users. The authors are not representing or acting on behalf of any external parties and that any reliance on the content within this paper is at your own risk.

Risks and Uncertainties. The assumptions and resulting estimates included in this analysis are inherently uncertain. Users of the results should be qualified to use them and understand the results and the inherent uncertainty. **Actual results may vary, potentially materially, from our estimates.** Results will vary by state, issuer, and year. Wakely does not warrant or guarantee the projected values included in the analysis.

Conflict of Interest. We are financially independent and free from conflict concerning all matters related to performing the actuarial services underlying these analyses. While Covered California commissioned the publication of this white paper, Wakely is organizationally and financially independent to Covered California.

Data and Reliance. We have relied on others for data and assumptions used in the development of this paper. We have reviewed the data for reasonableness but have not performed any independent audit or otherwise verified the accuracy of the data/information. If the underlying information is incomplete or inaccurate, our estimates may be impacted, potentially significantly.

Subsequent Events. Subsequent events may impact the findings in this report. Changes in state policy, economic conditions, federal legislation, and other factors and emerging data could result in material changes to this analysis.

Significant shifts have occurred in the ACA individual market over the past few years, in particular beginning with 2020, that have resulted in an increase in enrollment and corresponding market impacts. These impacts vary greatly by state. These may have been a result of the Public Health Emergency

(PHE), Medicaid re-determinations, and new regulations under the Biden administration, etc. **Therefore, it is not unreasonable that significant enrollment and corresponding market risk pool impacts may occur in 2026 and future years beyond what was modeled in this report. Consequently, other subsequent events in addition to the Wakely modeling impacts should be considered**.

Deviations from ASOPs. Wakely completed the analyses using sound actuarial practice. To the best of our knowledge, the report and methods used in the analyses comply with the appropriate ASOPs with no known deviations. A summary of ASOP compliance is listed below:

ASOP No. 23, Data Quality

ASOP No. 41, Actuarial Communication

ASOP No. 56, Modeling

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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.

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