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WHITE PAPER

CHOICE: Assessing the Opportunity and Impact on the Individual ACA Market

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EXECUTIVE SUMMARY

Most people in the United States younger than age 65 get their health insurance coverage through a fully insured or self-funded employer-sponsored plan. These options are typically considered traditional employer-sponsored coverage. Individual Coverage Health Reimbursement Arrangements (ICHRAs) is an alternative means for employers to provide health insurance coverage to employees. ICHRAs have been available in the market since 2020.[1] On September 3, 2026, the federal government rebranded ICHRA to Custom Health Option and Individual Care Expense Arrangement (CHOICE).[2]

For issuers, CHOICE presents an opportunity in the individual Affordable Care Act (ACA) market. As employers evaluate alternatives to traditional employer-sponsored group coverage, CHOICE adoption could increase individual ACA market enrollment and change the demographic and morbidity mix of the risk pool. The magnitude and direction of these impacts, however, will depend on state and local market conditions, the relative cost of individual and group coverage, and the characteristics of employers and employees who transition to CHOICE.

The market is relatively small, but momentum is building. Comprehensive public enrollment data are unavailable, making the size of the CHOICE market difficult to establish. The Congressional Budget Office (CBO) noted in a recent report that CBO has not identified a good source of data on ICHRA enrollment. Moreover, issuers sometimes find it challenging to track source of enrollment to identify these members. However, the HRA Council reported at least 500,000 enrolled members in 2026. Momentum for CHOICE is building as employer-offered rates continue to increase, regulatory action encourages CHOICE enrollment, and barriers to adoption are being addressed.

Given the sustained attention on CHOICE, Wakely, an HMA Company, performed simulation modeling to estimate how the individual ACA market may change under varying CHOICE adoption scenarios. We analyzed three states—South Carolina, Iowa, and Tennessee—for

[1] Internal Revenue Service. Health Reimbursement Arrangements and Other Account-Based Group Health Plans. Federal Register. June 20, 2019. Available at: https://www.federalregister.gov/documents/2019/06/20/2019-12571/health-reimbursement-arrangements-and-other-account-based-group-health-plans.

[2] www.cms.gov/marketplace/employer-initiatives Any ICHRA reference in this paper is synonymous with CHOICE.

different reasons, which are described in detail below. The modeling is intended to answer two key questions:

1. How much could the individual ACA market grow in these specific states if small group ACA employers switch to CHOICE under a variety of scenarios?
2. How would individual ACA market characteristics such as morbidity change as a result?

Although the modeling represents a range of results under various scenarios, the analysis depends on several key assumptions, including important simplifying limitations. The results in this paper should not be analyzed without understanding those assumptions, limitations, and caveats.

This white paper provides a comprehensive background on CHOICE, a summary of what we know about the CHOICE market today, discusses historical barriers to adoption, and summarizes the modeling results

The Centers for Medicare & Medicaid Services (CMS) is expected to release new a regulation pertaining to CHOICE later in 2026 or early 2027. While details are not known at this time, we anticipate it will increase incentives for employers to adopt CHOICE. We will follow up with an additional paper summarizing the guidance and comment on the potential impact when the rule is released.

Key Findings

- **CHOICE adoption is likely to vary by geography, with some markets unlikely to attract members.** The relative affordability of individual ACA coverage compared to small group ACA is a key driver of CHOICE adoption, which varies by state or even specific geographies within a state. Our modeling suggests that South Carolina, Iowa, and Tennessee could experience materially different outcomes depending on cost savings small group ACA employers require before switching to CHOICE**.** In South Carolina, where individual ACA premiums are projected to be more competitive than small group ACA in 2027, average individual ACA enrollment increase ranges from 2.4% to 7.6%, depending on the savings employers need to switch. In Iowa, where premium rates are much more similar between lines of business, the membership increase ranges from 0.0% to 0.3%. In Tennessee, where individual ACA premium rates are higher than small group ACA, we do not anticipate much adoption, if any. As small group ACA members

switch to CHOICE, a corresponding reduction in small group ACA enrollment would occur as well.

- **CHOICE could affect individual ACA market morbidity, either positively or negatively.** When employers transition from small group ACA coverage to CHOICE, the resulting change in morbidity depends on the relative health risk of the populations moving between markets. In South Carolina, our modeling estimates individual ACA morbidity improvements of 0.5% to 1.5% across the scenarios evaluated, on average. However, if healthier employer groups select alternative coverage arrangements, such as level-funded products, CHOICE adoption could drive morbidity deterioration. Issuers should recognize that CHOICE may change not only enrollment volume but also future claims experience and pricing requirements.
- **The full economics of CHOICE must be considered.** Premium differences alone do not determine whether CHOICE is attractive to employers. Vendor fees, employee coverage preferences, network breadth, plan design, administrative considerations, and applicable tax incentives all influence the decision. In our analysis, adding an assumed vendor fee of $50 per employee per month materially reduces modeled adoption, particularly in Iowa, where individual and small group ACA premiums are projected to be similar. In markets where individual ACA premiums substantially exceed group premiums, CHOICE may be less viable without significant financial incentives. CHOICE opportunities should be evaluated annually. Even one year of rate changes could change employer CHOICE perspective and cost calculations (either positively or negatively).
- **CHOICE extends beyond small group ACA employers.** As of 2023, 10 million members were enrolled in small group ACA plans; however, group enrollment for other lines of business is much more substantial. In 2023, 38 million members were enrolled in fully insured large group plans, while 127 million members were enrolled in self-funded products.[3] In addition, approximately 9 million members were enrolled in state

[3] Rakshit S, Ortaliza J, Cotter L, Rae M, Cox C. Recent Trends in Commercial Health Insurance Market Concentration. Peterson-KFF Health System Tracker. December 11, 2025. Available at: https://www.healthsystemtracker.org/chart-collection/recent-trends-in-commercial-health-insurance-market-concentration/#Enrollment%20in%20self-funded%20large%20and%20small%20group%20health%20insurance%20plans,%202013-2023.

employee health plans in 2022.[4] Though omitted from the analysis because publicly available data required for the analysis is not generally accessible, large group and state employee health plans could be a bigger factor than small group ACA in CHOICE adoption.

CHOICE BACKGROUND

CHOICE is the most flexible type of Health Reimbursement Account (HRA) available in the market.[5] Under CHOICE, employers provide a predetermined allowance or level of funding that employees use to purchase coverage in the individual ACA Marketplace. The funds may not be used to purchase short-term, limited duration products; faith-based coverage; or supplemental coverage (i.e., dental or vision).[6]

Employees may use the CHOICE funds to purchase any individual ACA on or off-Exchange plan available to them, but current tax rules incentivize employees to purchase coverage off the Exchange. Furthermore, employees who participate in CHOICE cannot receive premium subsidies that may be available through the individual ACA Exchange, depending on their income.[7]

Like traditional employer-sponsored coverage, there are tax benefits to CHOICE when administered according to the applicable tax regulations. CHOICE allowances provided by the employer are not considered taxable to employees. However, pre-tax payroll deductions for the employee's premium contribution under a CHOICE plan are only allowed if the employee is enrolled in an off-Exchange plan. Similarly, employers receive the same type of tax benefits for providing a CHOICE allowance as traditional employer-sponsored coverage.

[4] Center on Health Insurance Reform. State Employee Health Plans and Cost Containment Initiatives (2022). Georgetown University. Available at: https://sehpcostcontainment.chir.georgetown.edu/.
[5] The other being a Qualified Small Employer HRA (QSEHRA). QSEHRAs are not as flexible as CHOICE, so we omit further discussion in this paper.
[6] CHOICE allowances may be used to purchase certain types of Medicare coverage but not covered in this paper.
[7] If CHOICE is considered unaffordable, based on federal requirements, then the employee may opt out and purchase subsidized coverage on the individual ACA Exchange. This applies to large groups only.

Under the ACA, employers with more than 50 full-time equivalent (FTE) employees are subject to a mandate that requires them to offer affordable healthcare options to employees. Offering an affordable CHOICE allowance can help employers satisfy this mandate.[8]

CHOICE provides employers with more flexibility than traditional employer-sponsored coverage. Employers may offer CHOICE, traditional employer-sponsored coverage, or no coverage at all for certain classes of employees.[9] For example, CHOICE may be provided to part-time employees while traditional coverage is offered to FTEs. Aside from CHOICE allowances, however, the employer must offer coverage on the same terms to all employees within a class.

Employers may set any amount for CHOICE allowances, but they are subject to certain rules. Employer allowances must be the same across all employees within the same class, but the allowances may vary by age (not to exceed a 3:1 ratio, employees age 64 cannot receive more than three times that of employees age 21) and family size. Although allowances cannot vary by geography if a class of employees covers multiple geographies, the employer may establish a separate class by geography, which then allows the employer to provide different allowance amounts.

Employees who leave their employer may keep their individual ACA plan, but they can no longer receive the CHOICE allowance and are responsible for paying the full premium.

Employers that offer CHOICE must define their employee classes, establish monthly allowance amounts for employees, and choose a CHOICE platform or vendor. A CHOICE platform administers the CHOICE arrangement, handles compliance, and provides a place for employees to shop for plans, among other key functions.

WHAT DO WE KNOW ABOUT THE CHOICE MARKET TODAY?

Despite being available to employees since 2020, little is known about the CHOICE market today. Publicly available reporting is sparse, and issuers rarely comment publicly on the size or details of their CHOICE population. What we do and do not know about the market is summarized as follows.

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[8] Note: An affordable CHOICE offer precludes employees from being eligible for premium tax credits.
[9] The class definitions can be found at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Downloads/HRA-FAQs.pdf.

Official CHOICE enrollment volume is unknown. There is no comprehensive public reporting on CHOICE enrollment from any state or federal sources, so the official overall CHOICE enrollment volume is unknown. A recent CBO report noted that, "CBO has not identified a good source of data on enrollment of workers at small businesses through PEOs, ICHRAs, and QSEHRAs."[10] The HRA Council published in their 2026 report that at least 500,000 members are enrolled in CHOICE products (~2% of the individual ACA market based on 23.1 million market wide Exchange plan selections).[11] There is reason to believe this enrollment number is low because the HRA Council aggregates enrollment counts from participating sources, which captures only a portion of the market. Centene stated in its 2026 second quarter (Q2) earnings report that approximately 50,000 members have CHOICE coverage.[12]

Not every issuer knows the size of its CHOICE block, partly because tracking enrollment source can be challenging. Source of enrollment data may be maintained in a database that actuaries lack access to or CHOICE may not be a specific identifier in the data (e.g., these members may be identified as enrolled via a broker only and not also CHOICE members). As a result, some issuers may not track enrollment source closely. For example, CMS EDGE server submissions include an ICHRA field intended to indicate whether a member enrolled via an ICHRA; however, fewer than 1% of 2024 records included a populated value (either indicating yes or no), and no mechanism is available to validate the accuracy of those entries.

There is also reason to believe CHOICE enrollment is increasing. For example, Oscar noted on September 16, 2026 that, "we are already seeing 2x increase in membership from last year."[13]

CHOICE employer offer rates may be relatively low but increasing over time. KFF's (Kaiser Family Foundation) 2025 Employer Health Benefits survey, which may include employers

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[10] https://www.cbo.gov/system/files/2026-09/57984-small-business-health-insurance.pdf

[11] Congressional Budget Office. Health Insurance Options for Small Businesses. September 2026. Available at: https://www.kff.org/affordable-care-act/state-indicator/open-enrollment-marketplace-plan-selections/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[12] Gilligan J, London S, Asher A. Centene (CNC) Q2 2026 Earnings Call Transcript. The Motley Fool. October 26, 2026. Available at: https://www.fool.com/earnings/call-transcripts/2026/07/28/centene-cnc-q2-2026-earnings-call-transcript/?utm_source=chatgpt.com

[13] https://seekingalpha.com/article/4947222-oscar-health-inc-oscr-analyst-investor-day-transcript.

offering Qualified Small Employer Health Reimbursement Arrangements (QSEHRA) in addition to ICHRA, noted that 4% of employers that offer healthcare benefits offer funds to purchase non-group coverage.[14] In addition, 7% of employers that offer health benefits but do not currently offer an ICHRA are somewhat or very likely to change course in the next two years.

In addition, 9% of employers that offer no healthcare benefits offer funds to purchase non-group coverage, and 18% of employers that do not offer health benefits are somewhat or very likely to offer an ICHRA in the next two years. According to the survey results, there is little variation in employer size (i.e., 10–49, 50–99, and 100 or more employees).

It would seem employer interest in CHOICE is increasing. For example, according to KFF's 2022 Employer Health Benefits survey, only 7% of employers of any size that offering health benefits were somewhat or very likely to offer ICHRA in the next two years. [15] CHOICE awareness and interest have surpassed these statistics. Marsh's Health policy 2025 survey reported similar statistics. [16] When asked how likely employers are to replace their current medical plan for some or all employees with an ICHRA within five years, for some or all employees by employer size, employers reported 6%, 4%, and 3% for those with fewer than 200 employees, 200–499 employees, and 500 or more, respectively.

Although employer CHOICE offer rates may be relatively low, some employers are switching from traditional employer-sponsored coverage to CHOICE. For example, Hy-Vee and Oscar partnered to offer CHOICE plans to employees.[17]

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[14] KFF. Employer Health Benefits 2025 Annual Survey. Available at: https://files.kff.org/attachment/Employer-Health-Benefits-Survey-2025-Annual-Survey.pdf.

[15] KFF. Employer Health Benefits 2022 Annual Survey. Available at: https://files.kff.org/attachment/Report-Employer-Health-Benefits-2022-Annual-Survey.pdf.

[16] Mercer. Health Policy 2025. Marsh McLennan. Available at: https://www.mercer.com/assets/us/en_us/shared-assets/local/attachments/pdf-2025-us-health-policy-2025-survey-report-results-for-employers-with-500-or-more-employees.pdf.

[17] Oscar. From the Grocery Store to the Doctor's Office: Hy-Vee and Oscar Partner to Redefine Healthcare. August 14, 2025. Available at: https://www.hioscar.com/blog/oscar-hy-vee-announcement.

One downside of these surveys is they miss a potential market for CHOICE offerings in state employee health plans or municipalities. For example, Monongalia County in West Virginia became the first local government to adopt CHOICE for employees.[18]

Regulatory changes are intended to encourage CHOICE. States have enacted or are actively considering legislation to encourage CHOICE enrollment. For example, Mississippi passed legislation that provides state tax credits to small employers that offer CHOICE. [19] Similar legislation is under consideration in Illinois. [20] While ultimately omitted from the 2025 budget reconciliation legislation (commonly referred to as OBBBA). an earlier version of the bill included provisions intended to incentive take up of CHOICE products. Specifically, H.R. 1 (now P.L. 119-21) would have provided a federal tax credit for small employers to offer CHOICE, like the state initiatives in Mississippi and Illinois. Additionally, the legislation would allowed pre-tax dollars to be used to purchase on-Exchange individual ACA products (instead of off-Exchange only). [21]

We anticipate that CMS will release new guidance on CHOICE sometime in late 2026 or early 2027. While explicit details are still unknown, we anticipate it will formalize the name change from ICHRA to CHOICE and increase incentives for employers to adopt CHOICE (though which specific incentives are unclear).

Issuers are designing plans for the off-Exchange population. Based on a review of publicly available data, there appears to be no single plan design strategy for CHOICE products. Instead, variety is the overwhelming theme.

Issuers are designing plans that appear to cater to the CHOICE population, with a variety of benefits, including a range of non-EHBs essential health benefits), e.g., including or excluding

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[18] https://healthcarevaluehub.org/state-news-roundup/west-virginia/2025/wv-county-becomes-first-local-government-to-adopt-ICHRA-for-employees/

[19] Mississippi Legislature. House Bill 343. Available at: https://billstatus.ls.state.ms.us/documents/2026/pdf/HB/0300-0399/HB0343SG.pdf.

[20] Illinois General Assembly. Income Tax Health Insurance Credit. May 22, 2026. Available at: https://ilga.gov/Legislation/BillStatus?DocTypeID=SB&DocNum=3619&GAID=18&SessionID=114&LegID=166727.

[21] KFF. Health Provisions in the 2025 Federal Budget Reconciliation Bill. Updated July 8, 2025. Available at: https://www.kff.org/affordable-care-act/tracking-the-affordable-care-act-provisions-in-the-2025-budget-bill/.

adult dental and vision), plans that are Health Savings Account (has)-compliant while others are not, and plans offered across bronze, silver, and gold while some issuers are limiting CHOICE offerings to richer metal levels only. Issuers are considering platinum offerings as well, which are less common on the Exchange today. [22]

National issuers that service multiple states are offering plans specific to each state instead of designing a single set of CHOICE plan designs and offering them across all markets. These strategies will become more refined as the CHOICE market grows and issuers better identify the needs of this population.

Some national carriers are pairing off-Exchange only licenses with on-Exchange entities, presumably to capture the CHOICE market. This provides the off-Exchange-only issuer with additional flexibility, such as implementing different metal sloping factors to achieve attractive metal level positioning, targeted to CHOICE members differently than on-Exchange members. Currently, issuers are limited to a specific number of plan offerings on the Exchange, but that limitation does not apply to off-Exchange plans.

Enthusiasm is high. Stakeholders that participate in the CHOICE market are still bullish despite the lack of public data, challenging individual ACA market conditions and current barriers to CHOICE. Individual ACA issuers are actively considering what their CHOICE strategy is and when would be the right time to more explicitly deploy CHOICE resources.

Issuers and vendors are projecting growth in the CHOICE market, so they are investing capital to be at the forefront of CHOICE. For example, Thatch, a platform that administers CHOICE, announced a Series C funding round valuing the company at $1 billion and serving over 5,000 companies. [23] Similarly, Oscar recently launched Lucie and noted in the September 2026 investor day presentation that "the market will grow 400% to 2.5 million people by 2029." [24]

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[22] For a discussion of this strategy, see the following white paper: https://www.wakely.com/wp-content/uploads/2026/03/Platinum-Product-Design-Strategy.pdf.
[23] https://thatch.com/blog/thatch-series-c-announcement
[24] Tong N. Fresh off a Rebrand as CHOICE, ICHRA Backers Grow Confident. *Modern Healthcare*. September 21, 2026. Available at: https://www.modernhealthcare.com/insurance/mh-ichra-choice-mehmet-oz-indiana-georgia/?utm_content=article1-headline&utm_source=modern-healthcare-am&utm_medium=email&utm_campaign=20260921.

Some states are actively considering replacing their current state employee health plan with CHOICE offerings as a potential mechanism to lower costs and administrative burden. For example, Arizona recently passed legislation to commission a study that will identify whether CHOICE may be an option for the state.[25]

WHAT IS LIMITING CHOICE ADOPTION?

ICHRA adoption has been slow but is accelerating. There have been key barriers to ICHRA growth, some are being addressed, and others remain, which are discussed in this section.

There is a familiarity and strategy gap with CHOICE among issuers and brokers. Many employers and brokers are still unaware that CHOICE is an alternative option to traditional employer-sponsored coverage. Brokers unfamiliar with CHOICE will not present the product to employers. Further, the quoting infrastructure needs improvement. Brokers need to be able to efficiently compare options for employer consideration. For example, it can be challenging for brokers to get fully insured, level or self-funded, and CHOICE product offerings on the same basis in a renewal quote without manual intervention. CHOICE enrollment will likely increase as decision-makers become more aware of the product.

Employers must understand a different administrative framework. While highest level administrative functions are like traditional employer-sponsored coverage and in some ways simpler, there are key differences. Employers must get acquainted with the new administrative framework.

Employers need to partner with a CHOICE vendor, and it may be challenging for an employer to identify the right vendor partner without the help of a broker. The vendor serves several key functions, including advising employers on CHOICE set up, ensuring legal compliance, managing reimbursements, providing enrollment support, tax reporting, handling ongoing employee support, and more. Although CHOICE vendors handle the functions, employers must still understand CHOICE well enough to make an informed decision. For example, employers require education on complexity, class structure, tax implications, general compliance, and other considerations.

[25] Arizona Legislature. An Act Amending Section 20-2324, Arizona Revised Statutes; Relating To Accountable Health Plans. Available at: https://www.azleg.gov/legtext/57leg/2R/bills/hb2693s.pdf.

Employers need to determine a CHOICE allowance for employees. At the highest level, the decision is like traditional employer-sponsored coverage, but the details differ. For example, employers may choose to set the allowance based on a specific plan available in the individual ACA market rather than paying a specific portion of total premium. In addition, employees must determine how allowance varies by class, age, and family size.

Employees enrolled in a traditional employer-sponsored plan play a less active role in their coverage selection and are accustomed to selecting a health plan from a few options. In a CHOICE environment, employees have the new responsibility of selecting their health insurance coverage from a different and likely much wider set of options. Employees must better understand plan designs, provider availability, and issuer differences to make the best decision for them. While many employees may perceive a variety of options as a positive, other may view it as burdensome.

CHOICE vendors and brokers play an important role in addressing this barrier.

Stability of the individual ACA market is a concern. The individual ACA market is experiencing the most challenging environment since its inception. Regulatory changes, elevated rate increases, enrollment decline, claim cost pressure, and issuers exiting the market all contribute to potential instability in the market. Employers are concerned about the turbulence and may be more likely to pursue CHOICE offerings when the market stabilizes.

Individual rate increases are high. However, the small group ACA market is experiencing elevated rate increases as well. For example, a KFF analysis demonstrates that the median rate increase in the small group ACA market is 14% vs. 15% for individual ACA.[26] While not as readily publicly available, we anticipate that level-funded and large group rate increases are elevated as well. It is possible that individual ACA rate increases may become less of a concern to employers if traditional employer-sponsored coverage costs also continue to increase at a similar rate. But employers still need to evaluate whether CHOICE is the best fit for them and

[26] Wager E, Ferguson A, McGough M, et al. How much and why premiums are going up for small businesses in 2027. Peterson-KFF Health System Tracker. August 6, 2026. Available at: https://www.healthsystemtracker.org/brief/how-much-and-why-premiums-are-going-up-for-small-businesses-in-2027/#Distribution%20of%20proposed%202027%20rate%20changes%20among%20295%20ACA-compliant%20small%20group%20insurers.

the allowance annually as premiums continue to increase. Switching to CHOICE does not eliminate this employer function, and some combination of employers and employees will be subject to paying their respective portion of premiums as they increase. This situation will likely be an ongoing barrier to CHOICE adoption.

Offerings in the individual ACA market may be less attractive than those in the employer market. Product, network, and geographic offerings in the individual ACA Marketplace vary relative to traditional employer-sponsored coverage. Employees may perceive these differences as a downgrade in coverage.

Traditional employer-sponsored plan designs tend to be richer (i.e., have less member cost-sharing) than individual ACA plans, and employees are accustomed to these richer plan designs. For example, the proportion of calendar year 2024 small group ACA member months nationwide enrolled in gold and platinum plans was 42% and 18%, respectively, versus 15% and 1%, respectively, in the individual ACA market. Issuers can address this barrier with a range of plan design offerings.

Traditional employer-sponsored plans generally have a broader network than most networks in the individual ACA market as well. For example, 52% of small group ACA members nationwide were enrolled in PPO plans in 2024 compared to 12% for the individual ACA market. Employees may be unhappy if their new coverage options only contain narrower networks. Issuers may consider multiple network offerings to provide a range of network breadth.

Issuer participation in the individual ACA market may be minimal in select counties. This absence of options is a barrier to CHOICE. In addition, individual ACA premium rates are higher than group premium rates in many states and counties across the country. Employers are less likely to switch to CHOICE if there are affordability concerns, which may limit CHOICE take up to select states and counties.

Employees and employers are accustomed to traditional employer-sponsored coverage. Although CHOICE is a type of employer-sponsored coverage, employees may not perceive the product in the same way and could be unhappy with the shift. Health insurance coverage is often used as a recruitment and employee retainment tool. There may be instances in which CHOICE is a better economic option for employers (and potentially employees), but they may be hesitant to switch offerings and risk employee dissatisfaction.

MODEL METHODOLOGY, CRITICAL ASSUMPTIONS, AND CAVEATS

We designed a simulation model using 2024 Wakely ACA (WACA) data, calibrated to our best estimate projected 2027 small group ACA populations for South Carolina, Iowa, and Tennessee. Given the inherent uncertainty and likely range of potential outcomes in the modeling, the small group ACA simulation was run 100 times per state to produce a range of results. Subscribers and dependents were randomly selected from the WACA data to simulate our best approximation of volume, distributions, and plan liability risk scores (PLRS) for 2027. We ran detailed claims data through the 2024 CMS Hierarchical Condition Categories CMS-HCC risk adjustment model to produce a risk score for each member and used nationwide small group ACA data for sampling credibility purposes.

We modeled the impact on the individual ACA market if all employer groups switch to CHOICE if they can save varying levels of premium (e.g., 10% of premium). We have assumed that employer groups evaluate coverage decisions based on fully insured premiums only and ignore claim cost (e.g., employers do not factor in group morbidity when making decisions) or stop-loss considerations.

The WACA data is limited to small group ACA data for employer groups, so level-funded, large group, and state employee health plan considerations were omitted. Modeled results may not be extrapolated to level-funded, large group, or any other type of employer coverage. Each of these coverage types is unique and would require independent evaluation.

Every individual ACA and employer market is different for each state. To evaluate different scenarios, each state was selected for specific reasons. Tennessee has individual ACA premium rates that are significantly higher than small group ACA, similar to many states across the country. We did not model Tennessee in detail given the significant gap in premium rates between individual ACA and small group ACA offerings, as discussed below. It is reasonable to believe CHOICE adoption in these types of states would be limited. Individual ACA premium rates in South Carolina are significantly lower than small group ACA, but the small group ACA market is relatively small. Finally, individual ACA premium rates in Iowa are slightly lower than small group ACA, but the small group ACA market is large. As demonstrated below, conclusions will vary by state based on a wide variety of circumstances such as market size, premium differential by line of business, morbidity differences, and many more, so it is not appropriate to extrapolate findings to other states.

The modeling was performed as if all small group ACA members would switch to CHOICE at the same time, but the shift is more likely to occur over several years, if at all, as the barriers to adoption described above are removed. Similarly, there is even more uncertainty regarding long-term implications that CHOICE may have on the individual ACA or employer market. We did not attempt to model impacts over multiple years.

We assumed that the entire group would switch to CHOICE coverage. In practice, employers may set up classes such that only certain classes will be offered CHOICE coverage while others will not. Similarly, we assumed that all employees would take up CHOICE when offered since they are currently enrolled in coverage. It is possible that some employees will decline CHOICE coverage to enroll in other products or go uninsured. One reason this may occur is if employees do not successfully complete enrollment in an individual ACA plan.

While simulation modeling was not necessary for individual ACA, we still needed to estimate what individual ACA enrollment volume, metal mix, morbidity, etc., may be in 2027based on what we believe is a reasonable set of assumptions; however, there is uncertainty regarding these projections that would influence results.

Wakely relied on several data sources for this analysis, including historical URRTs, 2026 open enrollment data, historical CMS risk adjustment data, 2025 Medical Expenditure Panel Survey (MEPS) data, and 2024 WACA data. To the extent that any of these data sources contained inaccurate information, results may vary. Additionally, the analysis is limited by the lack of publicly available data in the employer market (e.g., morbidity variation by county, plan selection by county, etc.). Any additional data will influence results. The model assumes current law, but the impacts of upcoming regulatory changes (e.g., delayed impact of the expiration of enhanced subsidies) are unknown and would influence results. Additionally, any new regulatory changes could affect results favorably or unfavorably.

Below is a description of the simulation and calibration methodology and a comparison of key metrics between 2024 and simulated 2027 populations.

Market Volume:

The projected market volume was calibrated to match our best estimate volume in each market in 2027. We assumed the 2027 individual ACA market enrollment will equal February 2026 effectuated enrollment counts adjusted downward by 15% and 10% to 2027 for South

Carolina and Iowa, respectively.[27] These assumptions were based on an evaluation of the 2027 rate changes, delayed impact of the expiration of enhanced subsidies, review of attrition from 2025 to 2026, and impact of other policy changes. For the small group ACA market, we have assumed membership will decline 9% and 1% annually from 2025 to 2027 for South Carolina and Iowa, respectively. These assumptions were developed based on a review of historical attrition observed in the small group ACA market. The average duration was assumed to equal the underlying WACA data. The modeling does not account for any small group ACA members switching to CHOICE coverage between 2024 and 2026, since market composition would change.

Group Assignment:

WACA does not contain data to identify employers for small group employees, so subscribers were randomly assigned to groups and calibrated to the 2025 MEPS average group size.[28] Employers of different sizes may react to CHOICE differently (e.g., a two-employer group vs. a 40-employer group), and group characteristics may vary by group size (e.g., demographic mix, morbidity, etc.); however, this possibility was not considered in the modeling given the lack of publicly available data. Because we sampled subscribers and their dependents, the modeling captured a realistic dependent to subscriber ratio and was assumed to be unchanged from 2024 to 2027, outside of sampling variation.

Projected 2027 Age, Metal, and CSR Mix

We assumed the individual ACA population will match 2026 open enrollment distributions and assumed no age, metal, or Cost-Sharing Reduction (CSR) mix shifts from 2026 to 2027. For small groups, we sampled the small group data to match the 2024 allowable rating factor (ARF) and actuarial value (AV) and assumed no age or metal shifts from 2024 to 2027. We believe it is reasonable to assume that the small group ACA market age and metal mix will remain static from 2024 to 2027 as these metrics have largely stayed the same over time despite any churn or decline in membership that has occurred.

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[27] Centers for Medicare & Medicaid Services. Health Insurance Marketplace. Related Summary Statistics on Beneficiary Enrollment Datasets. Available at: https://data.cms.gov/summary-statistics-on-beneficiary-enrollment/health-insurance-marketplace.

[28] Agency for Healthcare Research and Quality. Medical Expenditure Panel Survey. Available at: https://meps.ahrq.gov/mepsweb/.

Projected 2027 Geographic Mix:

The WACA data are not available at the state or rating region level, so simulated groups were randomly assigned to geographic rating region to align with the distribution of members by rating region from the 2025 CMS risk adjustment report data. While the data are not publicly available to refine the analysis, a limitation of the modeling is that we may not be capturing true metal mix, age mix, morbidity, etc. by rating region.

Projected 2027 Morbidity Levels:

Morbidity levels in both the individual and small group ACA market are expected to deteriorate by 2027. There is significant uncertainty regarding potential morbidity level associated with the individual ACA market because of the expiration of enhanced subsidies, other regulatory changes, and other population changes. We assumed that individual ACA market morbidity will deteriorate 17% and 5% from 2024 to 2027 for South Carolina and Iowa, respectively, on the basis of several important assumptions.

We estimate that morbidity worsened by 8% and 2% from 2024 to 2025 for South Carolina and Iowa, respectively, based on an evaluation of the change in statewide normalized risk score from 2024 to 2025 (i.e., statewide average risk score normalized for age, metal, CSR impact on Plan Liability Risk Score (PLRS), and risk adjustment model differences). We are assuming that morbidity will worsen by 7% and 2% from 2025 to 2026 for South Carolina and Iowa, respectively. Based on a Wakely analysis, enrollment in federally facilitated states that did not expand Medicaid was projected to decrease by between 16% and 25% and expansion states may decrease by 27% to 35% while morbidity increase by between 3% to 7% from 2025 to 2026 (on average, though state variation will exist).[29] South Carolina effectuated individual ACA enrollment decreased by 29% from February 2025 to February 2026. We anticipate that the increase in morbidity will be related to the drop in enrollment, so we are assuming morbidity will increase by 7%. Similarly, Iowa effectuated enrollment decreased by 17%, so we have assumed morbidity will deteriorate by 2%. Finally, we are assuming that morbidity will compound by 2% and 1% from 2026 to 2027 for South Carolina and Iowa, respectively. This assumes that enrollment will decline by 15% and 10% from 2026 to 2027 for South Carolina

[29] Anderson M, Chin CY, Cohen M. Who Paid, and Who Stayed? Early 2026 Enrollment Trends in the Individual Market. April 2026. Available at: https://www.wakely.com/wp-content/uploads/2026/04/Who-Paid-and-Who-Stayed-%E2%80%93-Early-2026-Enrollment-Trends-in-the-Individual-Market.pdf.

and Iowa, respectively, and that the change in morbidity will be proportionate to the change in enrollment, as described above. We did not make any adjustments to morbidity or enrollment for the potential of unauthorized enrollment impacts.

For the small group ACA market, we assumed that market morbidity will get worse by 3% annually from 2024 to 2027 for South Carolina. For Iowa, we assumed morbidity will deteriorate by 1% in total from 2024 to 2027. These assumptions are based on an evaluation of historical changes in statewide normalized risk scores (i.e., statewide average risk score normalized for age, metal, and risk adjustment model differences) relative to the annual decrease in enrollment. We have assumed morbidity for those that stay in each risk pool is unchanged over time. This assumption is not critical to the modeling as we compare small group ACA and individual ACA morbidity levels, and it is reasonable to believe that the morbidity of the stayers will deteriorate at similar levels for each line of business (i.e., so any adjustments will mostly cancel out).

Projected 2027 Premium Levels

Plan year 2026 premiums were assigned to each small group member based on age and the assigned rating region, adjusted to 2027 based on publicly available issuer level average rate increases (noting that at the time of writing, 2027 individual and small group ACA premium rates by county and metal was not available). Because the modeling was designed to identify employer movement into the individual ACA market, we assigned both individual and small group ACA premiums to each small group ACA member.

We are unable to identify the specific plans small group ACA members have enrolled in and consumer preferences (e.g., network dynamics, issuer preferences, etc.). The third lowest cost premium rate for each market by rating region was assigned to each small group ACA member, with the understanding that employer plan offerings generally have broader networks (and higher premiums as a result). We used the 2026 Unified Rate Review Template (URRT) data to produce premium rates by rating region. We assumed that every plan was offered in every rating region and that issuers offer plans across all counties in the rating regions where they participate. This was a necessary simplifying assumption given the gap in publicly available premium rates (especially for off-Exchange only individual ACA premiums and small group ACA premiums).

Small group ACA rates effective in Q1 were used in the analysis. We are not capturing any new plans or new entrants offered in 2027. Premium rates were assumed to be $0 for unratable

dependents (i.e., only the three oldest dependents under the age of 21 in a family are assigned a premium rate). We did not consider tax complexities in CHOICE modeling. Instead, we assumed there are no employer or employee tax disadvantages or advantages to changing coverage types.

Simulated Populations

Tables 1 and 2 are a summary of actual calendar year 2024, estimated 2027 individual ACA, and simulated 2027 small group ACA population statistics by state. The simulated 2027 small group population metrics represent an average across all 100 runs.

Table 1. Simulated Population Comparison from 2024 to 2027 for South Carolina

	Individual ACA			Small Group ACA		
	2024 Actual	Estimated 2027	% Change	2024 Actual	Simulated 2027	% Change
Member Months	6,945,090	4,125,620	-41%	534,303	429,110	-20%
PLRS	1.377	1.562	13%	1.199	1.292	8%
ARF	1.602	1.582	-1%	1.465	1.464	0%
AV	0.652	0.644	-1%	0.747	0.749	0%
CSR Adjustment[30]	1.050	1.042	-1%	1.000	1.000	0%
Normalized PLRS[31]	1.255	1.471	17%	1.096	1.178	7%

[30] The silver risk adjustment model coefficient includes a 12% adjustment for 87% and 94% CSR members. This adjustment is normalized out for morbidity measurement purposes.
[31] Normalized PLRS = PLRS/ARF/AV/CSR Adjustment; a proxy for morbidity.

Table 2. Simulated Population Comparison from 2024 to 2027 for Iowa

	Individual ACA			Small Group ACA		
	2024 Actual	Estimated 2027	% Change	2024 Actual	Simulated 2027	% Change
Member Months	1,378,776	876,991	-36%	1,086,385	1,059,688	-2%
PLRS	1.357	1.338	-1%	1.109	1.129	2%
ARF	1.751	1.703	-3%	1.437	1.455	1%
AV	0.695	0.680	-2%	0.724	0.726	0%
CSR Adjustment	1.038	1.022	-2%	1.000	1.000	0%
Normalized PLRS	1.074	1.131	5%	1.066	1.069	0%

Simulation Validation

To verify the simulation approach was working as intended, we performed a test calibrated to 2024 data. We replicated the methodology described above using publicly available 2024 age mix, metal mix, etc. to simulate 2024 South Carolina and Iowa small group ACA markets. We confirmed that AV, ARF, PLRS, and other key metrics matched publicly available control totals within reasonable sampling error and variability.

MODELED SCENARIOS AND FINDINGS

Based on the simulation and calibration methodology described above, we performed scenario testing to model the potential change in individual ACA enrollment, age, morbidity, etc. if groups switch from small group ACA coverage to CHOICE in South Carolina and Iowa. This section describes those scenarios and modeling results.

Overall Results

One scenario measured the change in the individual ACA market if employers switch coverage from the third lowest cost small group ACA plan to the third lowest cost individual ACA plan under various premium saving differentials (but do not change metal levels).

As noted above, CHOICE vendors play an important role for employers, but there is a cost for their services. We assumed that the vendor fee is $50 per employee per month, which is approximately equivalent to pricing that is publicly available for a particular vendor, though fee structure and amounts likely vary across vendors. A 10% savings translates to approximately $130 per member per month (PMPM) for South Carolina and $50 PMPM for Iowa in the modeling.

If all small groups in South Carolina are willing to switch to CHOICE at a 10% premium savings, we estimate enrollment in the individual ACA market will increase 7.6%, the market will get younger by 0.5%, and statewide morbidity will improve by 1.5%. We use normalized PLRS as a proxy for morbidity but claim cost may move at a different magnitude (i.e., the interaction between normalized PLRS and claim cost may not be one-to-one). A sicker individual ACA population than assumed would produce more favorable morbidity improvement, while a healthier pool would decrease the improvement. If small employers require a 20% premium savings, the increase in enrollment is estimated to equal 2.4%.

Although the South Carolina small group ACA market is much smaller than the individual ACA market, the individual ACA market population appears to be much sicker than that of the small group ACA, producing an observable improvement in morbidity with the enrollment shift.

As **Table 3** indicates, under the 5% savings scenario, the estimated increase in enrollment in the Iowa individual ACA market is estimated to equal only 0.3%. The impact is small because individual ACA rates are estimated to be only slightly lower than small group ACA, but premium rates are roughly equivalent after consideration of the vendor fee (i.e., so the premium differential is estimated to be too small for employers to switch to CHOICE). As shown, there is little to no CHOICE adoption at the 10% or 15% premium savings scenarios. Although we recognize that this scenario is unlikely, if Iowa small employers were willing to switch to CHOICE at a 0% premium savings, we estimate individual ACA enrollment could increase by roughly 20% but only improve morbidity by 2%. This is because we estimate that the average morbidity levels between individual ACA and small group ACA will be similar in 2027 (i.e., small employers switching to CHOICE increase enrollment volume but does not materially change morbidity). See Table 3 for a full summary of results.

Table 3. Change in Individual ACA Market by Premium Savings for Employers (Same Metal Level and Third Lowest Cost Plan), Including $50 Per Employee Per Month Vendor Fee, Average of 100 Simulations

	South Carolina			Iowa		
% Premium	**-10%**	**-15%**	**-20%**	**-5%**	**-10%**	**-15%**
PMPM	**-$85**	**-$130**	**-$170**	**-$25**	**-$50**	**-$80**
Member Months	7.6%	4.4%	2.4%	0.3%	0.0%	0.0%
PLRS	-1.2%	-0.7%	-0.3%	0.0%	0.0%	0.0%
ARF	-0.5%	-0.3%	-0.1%	0.1%	0.0%	0.0%
AV	1.1%	0.7%	0.4%	0.0%	0.0%	0.0%
Normalized PLRS	-1.5%	-0.9%	-0.5%	-0.1%	0.0%	0.0%

Table 3 represents the average results of the 100 simulations, but we observed a range of results across the various simulations. The range of enrollment and morbidity impacts is shown in Table 4.

Table 4. Range of Impacts to Individual ACA Market by Premium Savings for Employers (Same Metal Level and Third Lowest Cost Plan), Includes $50 Per Employee Per Month Vendor Fee

	South Carolina			Iowa		
% Premium	**-10%**	**-15%**	**-20%**	**-5%**	**-10%**	**-15%**
PMPM	**-$85**	**-$130**	**-$170**	**-$25**	**-$50**	**-$80**
Member Months	7.2% to 7.9%	3.9% to 4.7%	2.1% to 2.6%	0.2% to 0.5%	0.0%	0.0%
Normalized PLRS	-1.8% to -1.2%	-1.2% to -0.7%	-0.7% to -0.3%	-0.2% to 0.1%	0.0%	0.0%

It is not enough to evaluate which states in aggregate may be poised for CHOICE products. Instead, premium rate differential by rating region must be analyzed within each state. For example, we estimate CHOICE enrollment in Iowa would be primarily attributed to rating regions 3 and 7 because the premiums between lines of business are roughly equivalent in other geographies. In contrast, we project movement across all rating regions in South Carolina.

While not modeled, if employees were willing to purchase lower cost individual ACA products (either for a narrower network or leaner benefit levels), premium savings would increase.

The shift from small group ACA to CHOICE coverage also implies that the small group ACA market would shrink. **Table 5** is a summary of modeled decrease in small group ACA enrollment, which corresponds to the scenarios from Table 3. As shown, the small group ACA market is estimated to decrease substantially in South Carolina for each scenario because of the wide premium differential estimated between the individual and small group ACA markets in 2027.

Based on the premium methodology described above, all bronze members and roughly 90% of silver and gold members in South Carolina are estimated to have access to an individual ACA premium rate 10% below small group ACA. It is important, however, to understand the key assumptions and critical caveats described above. It is likely that CHOICE adoption will occur more slowly than presented here and some groups will not consider CHOICE at all. The

impact in Iowa is less significant because the individual ACA and small group ACA premiums are far more similar.

Table 5. Change in Small Group ACA Market Enrollment by Premium Savings for Employers (Same Metal Level and Third Lowest Cost Plan)

	South Carolina			Iowa		
% Premium	**-10%**	**-15%**	**-20%**	**-5%**	**-10%**	**-15%**
Min	-69.5%	-37.7%	-20.2%	-0.2%	0.0%	0.0%
Average	-72.6%	-41.9%	-22.6%	-0.2%	0.0%	0.0%
Max	-75.3%	-45.3%	-25.2%	-0.4%	0.0%	0.0%

The Level-Funded Interaction:

It is possible that the healthiest small groups would experience more favorable cost savings by switching to level-funded instead of CHOICE. We replicated the −−−10% scenario described in Table 3 for South Carolina, but we assumed the healthiest 10%, 25%, and 50% of small groups consider level-funded over CHOICE (e.g., in the 90th percentile scenario, we assumed that the 10% healthiest groups will enroll in level-funded products instead of CHOICE). See **Table 6** for a summary of results.

Table 6. Change in Individual ACA Market Depending on Group Morbidity (Same Metal Level and Third Lowest Cost Plan; 10% Premium Savings Required for CHOICE Adoption); Average of 100 Simulations

	South Carolina		
	90th	**75th**	**50th**
Member Months	7.4%	6.9%	4.8%
PLRS	-1.1%	-0.7%	0.5%
ARF	-0.5%	-0.5%	-0.3%
AV	1.1%	1.0%	0.7%

	South Carolina		
	90th	75th	50th
Normalized PLRS	-1.4%	-1.0%	0.3%

As **Table 6** shows, assuming the healthiest groups prefer level-funded over CHOICE products, the enrollment and morbidity impacts are expected to be less favorable. For example, the morbidity improvement for South Carolina under the 90th percentile scenario is modeled to improve by 1.4% vs. 1.5%, assuming all groups consider CHOICE. Under the 50th percentile scenario, individual ACA morbidity is estimated to deteriorate by 0.3%. Any deterioration of morbidity could increase future individual ACA premium rates, which may result in less favorable premium savings compared to group coverage.

Markets Where Individual ACA Premium Rates are Higher than Small Group ACA

CHOICE may not be a viable option for all states or counties. Part of the incentive for employers to switch to CHOICE is cost savings. In some states, ACA premium rates are higher than small group ACA, and potentially large group as well (though we did not attempt to model large group). For example, the 2027 lowest cost individual ACA plan compared to the 2027 lowest cost small group ACA at each metal level and rating region in Tennessee is estimated to be at least 50% higher. Employers and their employees are not likely to experience cost savings through CHOICE in this instance. At this premium differential, even state and federal tax credits may be unlikely to drive CHOICE adoption unless the credit is significant.

Enrollment Impact Could Be Overstated:

There are reasons why the modeled results could be overstating the potential impact of CHOICE.

- Employers may make decisions based on qualitative or behavioral considerations, which could limit adoption. For example, an employer may prefer to maintain the status quo on employee benefit offerings over fears of employees perceiving CHOICE as not as favorable as traditional employer-sponsored coverage.
- Employers may offer CHOICE to certain classes of employees, while the modeling assumed each employer would offer CHOICE to each employee.

- Not every employee will take up CHOICE when offered. It is possible some employees will enroll in other products or go uninsured (e.g., if the employee does not complete the enrollment process).
- The model assumes every employer is aware of CHOICE and switches to the product at one time.

Enrollment Impact Could Be Understated

Similarly, there are reasons why results may be understated, specifically:

- We only measured small group ACA in this analysis, but CHOICE is available for large employers and state employee health plans as well. There is evidence that an increasing number of large groups and state employee health plans are considering CHOICE adoption. Given the size of these markets, it is possible they will drive CHOICE growth more dramatically than small group ACA (with unknown morbidity implications).
- Employers that do not offer health coverage today may offer coverage for the first time through CHOICE offerings.
- Future changes in policies or operations at the federal or state level could influence results.
- As noted above, behavioral considerations could be a driver for why results are overstated. The same consideration could be a reason why the results may be understated. For example, employers may be willing to switch to CHOICE to simplify administrative burden even if there are little to no cost savings.

CONCLUSION

CHOICE represents an opportunity to expand individual ACA enrollment, but its impact will vary significantly by geography, market economics, and the characteristics of the populations that transition to individual coverage. Our modeling demonstrates that CHOICE could produce meaningful enrollment growth in certain markets, while offering limited to no opportunities in others. Importantly, increased enrollment does not necessarily translate into improved morbidity, and the movement of healthier groups into alternative coverage arrangements could create additional morbidity pressure for the individual ACA market. We anticipate that CMS will release new guidance on CHOICE sometime in 2026 or early 2027. Details are

unknown, but we anticipate it will increase CHOICE adoption. We will follow up with an additional paper summarizing the guidance and comment on the potential impact when released.

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If you have any questions or want to follow up on any of the concepts presented here, please contact the authors.

ABOUT WAKELY

Founded in 1999, Wakely Consulting Group, an HMA Company, is well known for its top-tier healthcare actuarial consulting services. With nine locations nationwide, Wakely boasts deep expertise in Medicare Advantage, Medicaid managed care, risk adjustment and rate setting, market analyses, forecasting, and strategy development. The firm's actuaries bring extensive experience across all sectors of the healthcare industry, collaborating with payers, providers, and government agencies.

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