



Marketplace and Private Insurance Provisions in the House Reconciliation Bill

May 29, 2025

3:00 – 4:00 p.m. ET

Please stand by, this webinar will begin shortly

STATE
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Manatt Health, The Urban Institute,
Georgetown Center on Health
Insurance Reforms

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Questions? Email Heather Howard at heatherh@Princeton.edu.

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Manatt Health, a division of Manatt, Phelps & Phillips, LLP, is an integrated legal and consulting practice with over 160 professionals in nine locations across the country. Manatt Health supports states, providers, and insurers with understanding and navigating the complex and rapidly evolving healthcare policy and regulatory landscape. Manatt Health brings deep subject matter expertise to its clients, helping them expand coverage, increase access, and create new ways of organizing, paying for, and delivering care. For more information, visit www.manatt.com/ManattHealth.aspx

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- Use the 'Q&A' function in Zoom to submit questions and comments to the meeting facilitators. **Note that you must select to submit a question anonymously.**
- All participant lines are muted.
- After the webinar, the slide deck and a recording will be available at www.shvs.org.

Webinar Objectives

Today's Focus

Review key changes included in the House budget reconciliation bill to **policies governing the Affordable Care Act (ACA) Marketplaces and private insurance** and discuss implications for states.

Looking Back

Last week, SHVS hosted a webinar to review key **Medicaid changes to eligibility, payment and financing, and coverage**. The slides and a recording are available on www.shvs.org.

Agenda

- **Level Setting**

- **Overview of Key Proposals Impacting Marketplaces**

- **Detail on Some Key Provisions**

- **Operational Considerations for Marketplaces**

- **Considerations for Insurance Regulation**

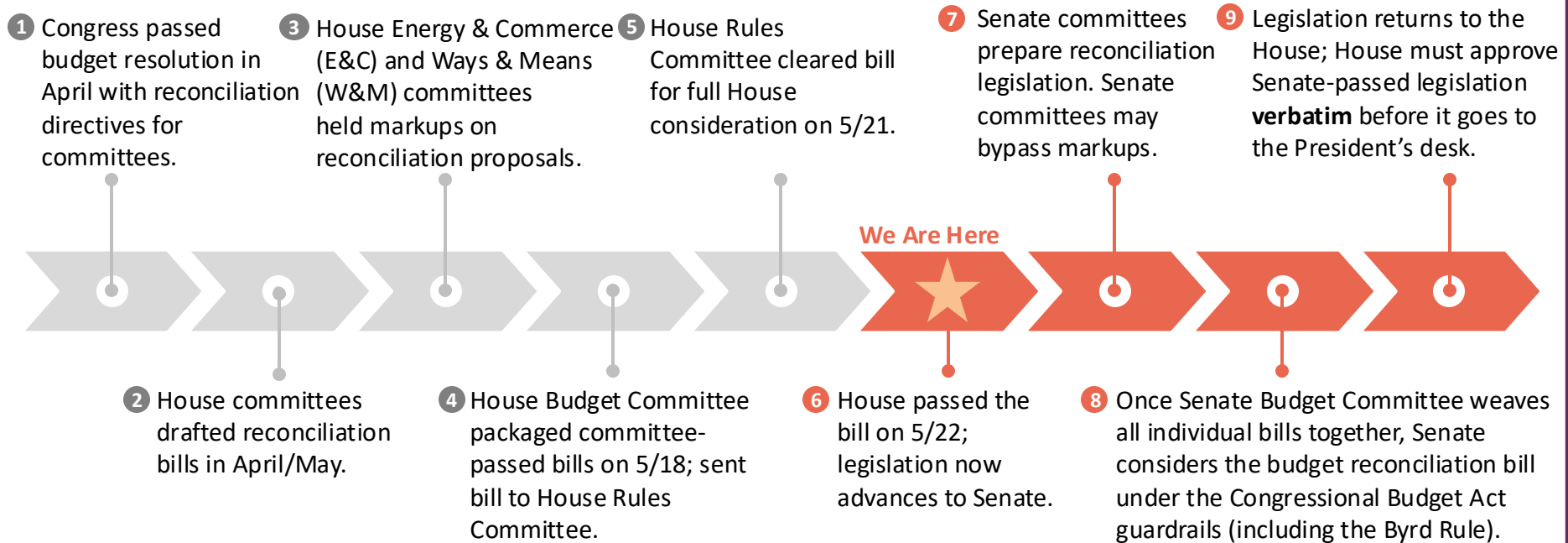
- **Discussion**



Level Setting

Reminder of the Budget Reconciliation Process

Congress is advancing large reductions in Marketplace enrollment and financial assistance through the budget reconciliation process.



● March 10: [Marketplace program integrity proposed rule](#) released

★ Marketplace final rule under review at Office of Management and Budget (OMB)



- The only statutory deadline for congressional action is the end of the federal fiscal year (FFY) on **September 30**.
- Given the timing realities for plan year (PY) 2026 changes, the legislation or proposed rule would need to be finalized expeditiously.

Budget Reconciliation Legislation: Impact on Marketplace Spending and Enrollment

- On May 14, E&C adopted a legislative proposal that would **codify most provisions of the Marketplace program integrity proposed rule**. It also included **significant Medicaid policy changes** primarily targeting the Medicaid expansion group and state tools for financing the non-federal share of Medicaid.
- W&M separately advanced reconciliation legislation to impose **additional conditions on financial assistance available through the Federally-Facilitated Marketplace (FFM) or State-Based Marketplaces (SBMs) and eliminate automatic reenrollment**.

The Congressional Budget Office (CBO) preliminarily estimated:



- The Marketplace program integrity rule would cut spending by at least **\$210 billion** over 10 years (FFY 2025 to FFY 2034), half of which is included in the CBO baseline.
- The E&C provisions would result in **1.9 million** individuals losing health coverage.
- The W&M provisions would result in an estimated **2.1 million** more uninsured.
- Paired with Medicaid proposals and the expiration of the enhanced premium tax credit (PTC), the result would be **16 million people** becoming uninsured.

- **CBO and the Joint Committee on Taxation released preliminary cost estimates of the legislation on May 20 (linked here and here, respectively).** On May 22, the House passed the “One Big Beautiful Bill Act” **with one significant modification to the Marketplace-related provisions**.



Overview of Key Proposals Impacting Marketplaces

Marketplaces: Limiting Who Can Enroll



Limiting Immigrant Eligibility

The legislation changes Marketplace eligibility from those who are “lawfully present” to a narrower set of categories, ending premium tax credits (PTCs) for key groups:

- Rescinds, starting in PY 2026, a 2024 final rule clarifying that **Deferred Action for Childhood Arrivals (DACA) recipients** are considered lawfully present for the purpose of enrolling in the Marketplaces and receiving tax credits.
- Beginning in PY 2026, ends coverage for the **five-year bar population** of individuals who are ineligible for Medicaid due to immigration status.
- Effective in PY 2027, **limits the immigrants who qualify for PTC** to: lawful permanent residents, certain Cuban migrants, and Compact of Free Association (COFA) migrants.



Locking Out Medicaid Enrollees Losing Coverage Due to Work Requirements

The legislation creates work requirements as a condition of eligibility for Medicaid expansion enrollees. If a person is deemed not eligible for Medicaid because of the work requirement, that person is also barred from receiving APTC.

Additional limits on enrollment include coverage denial for non-payment of past premiums.

Marketplaces: Limiting When Individuals Can Enroll



Shortening Open Enrollment (OE)

The legislation requires that OE run from **November 1 to December 15**, shortened from January 15 today, beginning in PY 2026. This would apply to *all* Marketplaces, including SBMs that currently have longer OEs.



Eliminating Income-Based Special Enrollment Periods (SEPs)

The legislation ends the current SEP for people at 150% of the federal poverty level (FPL) and prevents any future income-based SEPs in the FFM and SBMs.

- The use of APTC for the current low-income SEP would be prohibited three months after enactment (potentially before OE).

Marketplaces: Limiting How Individuals Enroll



Eliminating Automatic Reenrollment

Starting in PY 2026 for the FFM and PY 2027 for SBMs:

Eliminate \$0 Premium Automatic Reenrollment. The legislation requires that people who would be automatically reenrolled in \$0 premium coverage must pay a \$5/month premium until their health plan is actively reconfirmed.

Starting in PY 2028:

Eliminate All Automatic Reenrollment. The legislation would end passive reenrollment. All enrollees would need to return to the Marketplace to verify information and enroll in a health plan. Verification for reenrollment would begin no later than August 1 and no APTC would be available prior to verification.



Increased Verification Burdens and Reduced Flexibility for Enrollment

- **Requires additional paperwork** for enrollees with missing tax data or with data indicating income below 100% of the FPL.
- **Eliminates automatic extensions for data matching issues.** Enrollees will generally have 90 days to provide verification instead of the current 150.
- **Tightens SEP verification requirements.**
- **Removes the APTC repayment cap at reconciliation.**
- **Denies APTC more quickly when IRS doesn't confirm tax filing and reconciliation** without addressing operational and communications issues.
- **Reduces premium payment threshold flexibility** for insurers accepting less than full payment to avoid grace periods or terminating enrollees.

Marketplaces: Limiting What Individuals Enroll In

Finally, the bill makes changes to what coverage individuals are offered and how much they pay for it.

- **Funds cost-sharing reduction (CSR) payments for people under 250% of the FPL**, therefore eliminating “silver loading” and decreasing the purchasing power of APTCs.
- **Widens actuarial value (AV) variation** for all plans, permitting lower AV for silver plans and reducing APTC purchasing power.
- **Eliminates the bronze to silver “crosswalk”** whereby enrollees are shifted to silver plans if they enroll in suboptimal bronze at the same price.
- **Prohibits gender-affirming care (GAC)** as an Essential Health Benefit (EHB).
- **Alters the premium adjustment percentage calculation** to include the growth of individual market premiums, which reduces APTC amounts and raises cost-sharing for both Marketplace plans and employer-sponsored coverage.



Detail on Some Key Provisions

Key Section Upends the Foundations of Marketplace Enrollment

Perhaps the most disruptive changes in the bill are in sec. 112201, entitled “Requiring Exchange Verification of Eligibility for Health Plan.”

Section 112201 does two things:



Eliminates automatic or “passive” reenrollment, so all APTC recipients must take action to keep their coverage.



Eliminates provisional eligibility during resolution of a “data matching issue” (DMI), so **individuals cannot receive APTC or CSRs while waiting** for a final eligibility determination.

Eliminating Automatic Reenrollment

For the first time, all APTC recipients—[22.4 M in 2025](#)—would need to take action to continue subsidized coverage.

Current rules:

- Individuals can opt for the Marketplace to renew coverage annually with updated eligibility information from electronic sources (e.g., tax return data).
 - *Key context: Most health insurance plans automatically renew every year.*
- In 2025, [10.8 M people were automatically reenrolled](#).

Proposal:

- Effectively eliminates auto-reenrollment, **forbidding Marketplaces from relying on electronic data sources** to verify annual eligibility for APTC and CSRs.
- PTC and CSRs are not allowed for a month unless the individual “provides or verifies” updated eligibility information, including income, immigration status, eligibility for other coverage, residence, family size, and other information required through regulations.
- **Taking no action means losing APTC and CSRs** effective January 1, resulting in a much larger binder payment and no grace period.
- Those failing to make binder payments lose coverage immediately, since the grace period does not apply without APTC, and generally could not enroll until the following year.

Potential Impact:

- A [March 2025 study](#) found ending auto-enrollment and adding a minor step reduces enrollment by 33%.
- Interactions with the rest of the bill could increase impact:**
- **Shortening OE:** enrollment window is likely closed when bigger a bill comes, so it is too late to delay coverage for a month to get APTC or change plans.
 - **Narrowing SEP:** fewer people can get back in.

Eliminating Provisional Eligibility for APTC and CSRs

For the first time, individuals awaiting final eligibility determinations must enroll without APTC and CSRs.

Current law:

- Marketplaces generally make real-time eligibility determinations using trusted data sources (e.g., tax data), so individuals can often apply for and enroll in coverage in a single setting.
- But sometimes, Marketplace needs additional information—for example, when income doesn't match the last tax return, referred to as a DMI.
- Since many people need coverage immediately, “provisional eligibility” permits APTC and CSRs for a limited time while the DMI is resolved.



In 2022, the federal Marketplace alone processed 6.3 million DMIs (some representing multiple individuals).

Eliminating Provisional Eligibility for APTC and CSRs (cont.)

The bill would eliminate provisional eligibility in the event of DMI.

- If a DMI occurs, applicants would need to pay the full premium amount until the DMI is corrected. APTC is disallowed for the entire family if only one family member has a DMI.
- If a person does not pay that full amount, they would lose coverage and likely miss their enrollment opportunity.
- The bill would create a pre-enrollment verification process starting on August 1 to avoid DMIs.

Examples of Impacted Populations:



Families with newborns awaiting an SSN or birth certificate



People getting married or divorced, who often have income changes and whose income generally can't be verified using trusted data sources



People losing jobs, since their expected income is often lower than reported on their most recent tax return



People experiencing income changes for any reasons and reporting it to the Marketplace, as required

Eliminating Provisional Eligibility for APTC and CSRs (cont.)

Evidence shows enrollment decisions are heavily affected by premiums.



Higher premiums substantially reduce enrollment, especially among healthier individuals.

Interactions with the rest of the bill could worsen the impact.



The bill requires additional DMIs: CMS estimates 2.5 million more each year. Currently, more than half of DMIs take over three months to resolve.



The bill also shortens OE and narrows the SEPs, so those who do not make the unsubsidized binder payment would have more trouble getting back in.



Staffing and funding cuts mean DMIs likely will take longer to resolve.

Work Requirement Lock-Out Provision

Individuals denied Medicaid under new work requirements would be “locked out” of APTC.

Current rules:

- Individuals with incomes between 100% of FPL and the Medicaid income ceiling (generally 138% of FPL) who are found ineligible for Medicaid can generally still get APTC (if otherwise eligible).

Proposal:

- Individuals with Medicaid-eligible income who are **denied or disenrolled from Medicaid due to the new work requirement are also ineligible for APTC.**
- **There is no time limit on the lock-out:** individuals remain ineligible for APTC as long as they meet Medicaid eligibility criteria other than work requirements.

Impact:

- **Uninsurance rates will likely rise for adults with incomes between 100% and 138% FPL** in expansion states. The APTC lock-out would only in states that cover the adult expansion group.¹ Meanwhile, in non-expansion states, similar adults can continue to receive APTCs even if they wouldn't satisfy Medicaid work requirements.
- New data sharing between Medicaid and Marketplaces (both SBMs and FFM) will need to include work requirement information as an eligibility element.

1. This policy would also be relevant for any state that adopts a partial Medicaid expansion above 100% of the FPL. Note that GA and WI cover certain Medicaid expansion-like adults up to 100% of the FPL; these states must implement work requirements, but there is no impact on APTC eligibility for individuals with income above 100% of the FPL.

Codifying Individual Coverage Health Reimbursement Arrangements (ICHRAs): Background



Regulations finalized in 2019 permit employers to contribute pre-tax dollars to ICHRAs to help employees purchase individual market health insurance.

- The regulations include detailed rules about worker classification, interactions with APTC, notice requirements, and other parameters.
- Varying views about ICHRAs:
 - Some Marketplaces and other boosters see them as an opportunity to increase individual market enrollment and help small employers provide coverage.
 - Other stakeholders have expressed a range of concerns, including ICHRAs' complexity, the risk of firewalling employees who'd be better off with APTC, and dangers to the risk pool from permitting employers with sicker workforces to shift their risk to the community-rated individual market.
- There is little evidence of significant take-up to date, and no clear evidence about how ICHRAs are playing out on the ground or what they might do in the future.

Codifying ICHRAs: Proposal



The bill codifies a new tax-preferred health spending arrangement—the “CHOICE Arrangement”—that closely tracks the 2019 ICHRA regulations. There are a few notable differences, including that the bill:


- Eliminates the requirement to use ICHRAs off-Marketplace for maximum tax advantage.
- Exempts CHOICE Arrangements from the prohibition on discrimination based on health status, which could lead to steering sicker individuals to the individual market.
- Provides additional worker classifications for slicing and dicing the workforce between those offered ICHRAs and others.



In addition, the bill creates a new tax credit for small employers offering CHOICE Arrangements. Like the existing (and little used) small employer tax credit, an employer can claim the credit for only two years.

- The credit is generally worth \$100 per employee per month in the first year, and \$50 per employee per month in the second year.
- To receive the credit, the employer must offer an ICHRA that firewalls the employee from receiving APTC.

ICHRA: Considerations for States

 Benefits of codification are unclear, given that ICHRAs survived four years of the Biden administration, and codification eliminates flexibility to tweak rules if ICHRAs grow more popular and problems emerge.



The bill doesn't address (and makes it impossible for regulations to address) other technical considerations about ICHRAs:

- Age discrimination requirement.
- Insufficient substantiation requirement.



Most importantly: damaging the individual market would eliminate ICHRAs' value proposition.

Coverage Impacts: Reconciliation Marketplace Provisions

CBO estimates the Marketplace provisions would reduce coverage in the Marketplace and overall.

CBO Estimates of Coverage Impacts of Reconciliation Bill Marketplace and Tax Provisions, 2034

Pieced together from various recent sources, including unpublished scores—see notes below.

Provisions	Marketplace Coverage Effect	Effect on Uninsured
E&C – Codifying Marketplace Rule	↓ <u>2.2 million</u>	↑ <u>1.9 million</u>
W&M – Additional Marketplace Cuts	↓ 2.5 million (not public)	↑ <u>2.1 million</u>
Manager’s Amendment – Appropriating CSRs	↓ 0.5 million (not public)	↑ 0.3 million (not public)
Codifying ICHRAs, expanding HSAs	Little impact (not public)	Little impact (not public)
Sum of these estimates	↓ 5.2 million	↑ 4.3 million

Notes:

- Values shown here may not reflect CBO’s final scores. CBO has not yet estimated the effects of interactions between the W&M cuts and other provisions. There are multiple interactions in offsetting directions.
- The figures for the W&M provisions (especially eliminating auto-reenrollment and provisional eligibility) are surprisingly low, given the magnitude of those changes. This may be because CBO does not have a recent example of such changes from which to deduce the impact.

Coverage Impacts: Combined With Other Looming Changes

The reconciliation bill Marketplace cuts contribute to a perfect storm of potential coverage loss that could decimate Marketplaces and the healthcare system.

Approximate Combined Impact of Reconciliation Bill and Enhanced PTC Expiration, 2034

Provision	Marketplace Coverage Effects	Effect on Uninsured
Expiration of PTC enhancements	↓ <u>more than 7.3 million</u>	↑ <u>4.2 million</u>
Reconciliation Medicaid cuts	N/A	↑ <u>7.6 million</u>
Reconciliation Marketplace provision	↓ 5.2 million	↑ 4.3 million
Sum of these Estimates	↓ 12.5 million	↑ 16.1 million

Notes

- Values shown here may not reflect CBO's final scores. CBO has not yet estimated the effects of interactions among reconciliation bill provisions. There are multiple interactions in offsetting directions.
- The 7.3 million figure for Marketplace coverage losses due to expiration of the PTC enhancements is likely too low, since it assume part of the reconciliation bill in the baseline. As discussed on the previous slide, the figures for the reconciliation bill Marketplace provisions also appear too low.

*The Urban Institute estimates that such coverage losses would reduce **provider revenue** by about **\$1 trillion in revenue** between 2025 and 2034.*



Operational Considerations for Marketplaces

Reminder: Major Medicaid Proposals with Marketplace Impact

Starting December 31, 2026:



Mandatory work requirements for the expansion group.



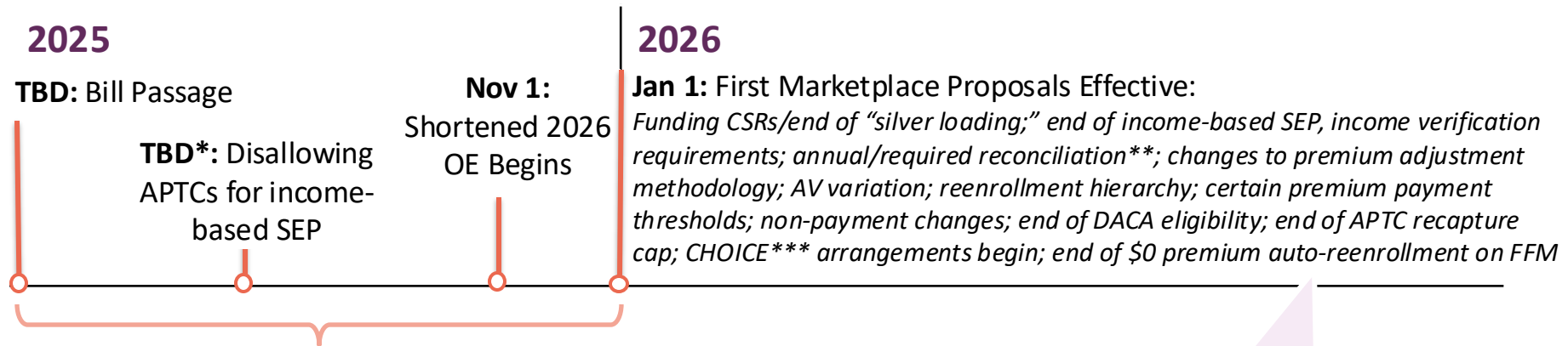
Individuals denied/disenrolled in Medicaid due to work requirements are ineligible for subsidized Marketplace coverage.




Medicaid expansion eligibility redetermination every six months, for certain adults.

Operational Considerations for Marketplaces: Short-Term

Marketplace provisions will require significant systems and business operation changes, especially for SBMs; the FFM will implement these changes at a national level.



- Key Required Preparation**
- Loading updated rates and CSR re-implementation
 - Consumer noticing/outreach
 - Call center/Navigator training
 - Large scale system and website changes
 - New scope for existing vendors or new vendors for increased verifications

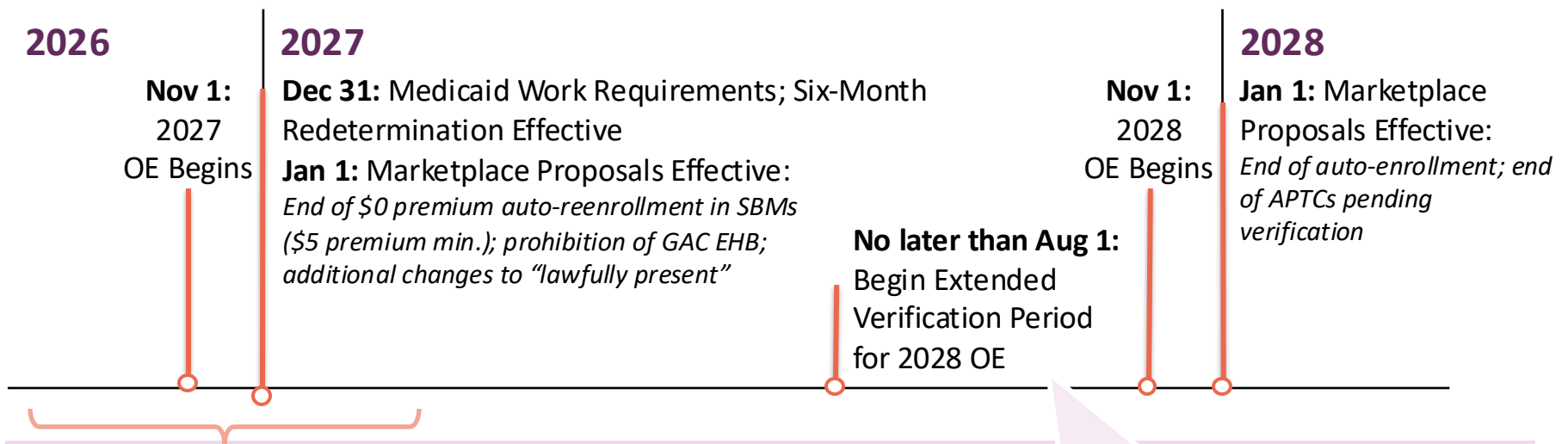
 This will require new communications between the Marketplace and plans to identify impacted consumers.

- Key Operational Questions**
- Given bandwidth constraints, what does the 2026 minimal viable product look like? What work should be prioritized to get there and minimize consumer disruption?
 - What additional staffing and contracting resources will be needed?
 - What will these modifications cost? And how/when will user fees be adjusted to compensate?
 - What additional data sources could be used to increase automation?

Notes: * Third Calendar Month Ending After the Date of Enactment; **Effective for the 2026 enrollment period, implementation in Fall 2025; ***Custom Health Option and Individual Care Expense.

Operational Considerations for Marketplaces: Longer-Term

Changes to the Medicaid program and Marketplace auto-enrollment will require continued advancement of changes implemented for 2026 and new operations for verifications.



Key Required Preparation

- Updates to account transfer systems/protocols
- Coordination with Medicaid on consumer noticing
- Coordination on applicants denied due to work requirements
- Plan and consumer communications/education

While some of the backend coding will already exist, a new consumer interface is needed.



Key Operational Questions

- What investments will be necessary to move from the 2026 minimal viable product to advanced account transfers updates preparing for the Medicaid work requirements and end of autoenrollment?
- What will plans and consumers need to understand about auto-enrollment changes?



Considerations for Insurance Regulation

Implications for Insurance Regulation and Market Stability

- Implementation timeline and effective dates
- New limits on state flexibility
- Appropriation of CSRs
- Rate and form review
- Reinsurance
- Other considerations
 - Non-ACA compliant products
 - Consumer communications

Reconciliation Bill and Marketplace Rule: Early Effective Dates

Provision	H.R. 1 Effective Date	Marketplace Integrity Rule Effective Date
<i>Energy & Commerce Title</i>		
Appropriation of CSRs (Sec. 44202)	Jan. 1, 2026	N/A
Shortened Open Enrollment (Sec. 44201(a))	2025 (for PY 2026)	2025 (for PY 2026)
SEP provisions (Sec. 44201(a))	Jan. 1, 2026	Effective date of final rule
Data matching inconsistencies (Sec. 44201(b))	Jan. 1, 2026	Effective date of final rule
Actuarial value targets (Sec. 44201(c))	Jan. 1, 2026	Jan. 1, 2026
Ending fixed dollar premium payment thresholds (Sec. 44201(e))	Jan. 1, 2026	Effective date of final rule
Prohibiting coverage of gender affirming care as EHB (Sec. 44201(h))	Jan. 1, 2027	Jan. 1, 2026
Eliminating guaranteed issue for premium debt (Sec. 44201(j))	Jan. 1, 2026	Jan. 1, 2026
Appropriation of CSRs (Sec. 44202)	Jan. 1, 2026	N/A
<i>Ways & Means Title</i>		
Disallowing income-based SEPs (Sec. 112202)	3 months after enactment	N/A

State Flexibility

New limits on state insurance authority.



Enrollment periods

- Elimination of income-based SEPs.
- HHS authority to determine SEPs.



Essential Health Benefits

- Prohibition on gender-affirming care as EHB.
- States with mandates must defray.

CSRs, Silver-Loading, and Abortion Coverage

Section 44202:

- Appropriates funding to reimburse issuers for CSR plans.
- Prohibits plans that cover abortion care from receiving CSR reimbursements (Hyde).
- Effective January 1, 2026.



Implications:

- Ends silver loading.
 - **1.2 million more uninsured.**
 - Reduction in federal PTCs; higher premiums for many enrollees.
 - Effects vary widely state-to-state.
- New considerations for states that mandate abortion coverage.
- Unclear if Hyde language survives “Byrd Bath”.



If enacted as written, states mandating abortion coverage could:

- Continue to mandate coverage and silver load to compensate for lost CSRs (unclear if CMS would allow this).
- Revise state mandate to apply only to bronze/gold and off-Marketplace plans.
- Fund CSRs with state dollars.
- Repeal or not enforce state mandates.

Rate and Form Review: Implications of Uncertainty

PY 2026 Rate Review is already underway in several states; proposed rates in all states must be submitted by July 16, 2025.



Premium factors. Issuers will need to adjust rates to reflect smaller and sicker risk pools, as a result of increases in net premiums, limited enrollment windows, termination of lawfully present immigrants, and increased paperwork burdens.



Benefit design. Plans would no longer be able to cover gender-affirming care as part of EHB, unless states defray the cost. States with abortion coverage mandates may need to adjust policy due to Hyde language in CSR appropriation.



Issuer participation. Issuers could decide to exit the market or shrink their service areas due to risk pool volatility; rural and historically under-resourced communities in particular could see a reduction in plan choices.

Reinsurance

States operating reinsurance programs include: Alaska, Colorado, Delaware, Georgia, Idaho, Maine, Maryland, Minnesota, Montana, New Hampshire, New Jersey, North Dakota, Oregon, Pennsylvania, Rhode Island, Virginia, and Wisconsin.



State reinsurance programs lower gross premiums. Federal pass-through payments under **section 1332 waivers** equal the cost of premium tax credits saved due to the reinsurance program.



If benchmark premiums decline, so too will federal PTC payments. The amount of federal PTC payments saved through 1332 waivers will decline, thus reducing federal pass-through payments.

Other Considerations: Non-ACA Compliant Products and Consumer Communications

Non-compliant products

- Issuers of short-term plans, fixed indemnity, healthcare sharing ministries, association health plans and more, are likely to market their products as cheaper alternatives
- Looking ahead: expected federal rollback of regulations

Consumer Information

- Consumer questions about price, plan changes
- Support for new paperwork demands
- Marketplace noticing
- Issuer communications and marketing
- Alternative coverage arrangements

Discussion

The slides and a recording of the webinar will be available at www.shvs.org after the webinar

Thank You

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