MILLIMAN REPORT

Benchmarking state insurance marketplace and Medicaid enrollment changes since the beginning of the COVID-19 pandemic

10 key observations and an assessment of potential future changes

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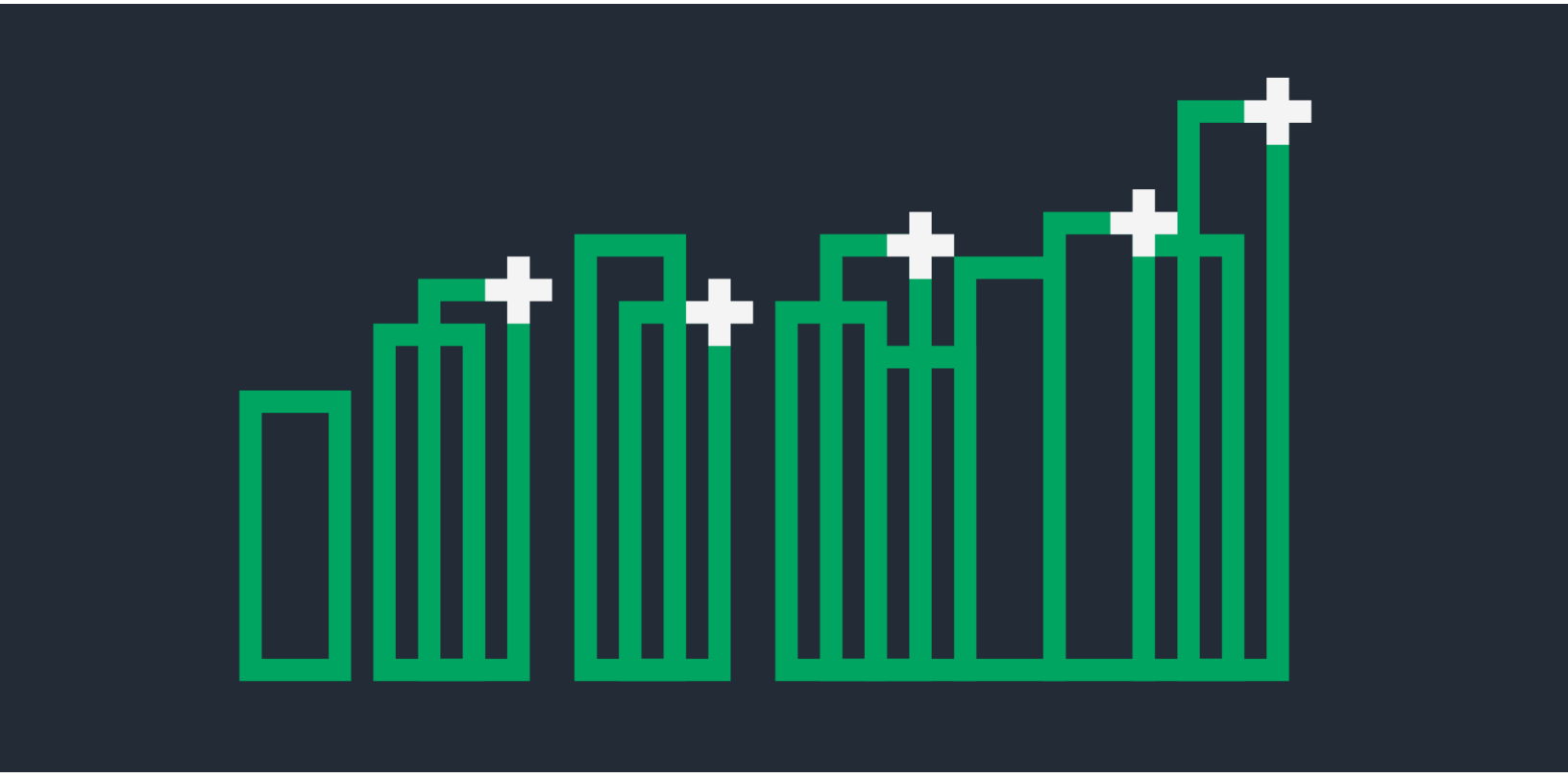

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Executive summary

Since the onset of the COVID-19 pandemic, the U.S. health insurance landscape has experienced unprecedented enrollment shifts in both the individual market and Medicaid, largely driven by federal COVID-19 pandemic policies and legislation. At the state level, wide variation has been observed in marketplace enrollment growth and Medicaid enrollment levels since 2020. While emerging individual and Medicaid enrollment data suggests that both markets are experiencing more stable enrollment entering 2025, federal regulatory and legislation changes appear likely to reintroduce enrollment changes into both markets in 2026. Similar to the observed state variation during the COVID-19 Public Health Emergency (PHE) and unwinding period, federal policy and legislation changes are also likely to have uneven impacts across the country. Based on publicly available individual market and Medicaid data, this paper makes 10 key observations related to historical market trends and comments on potential impacts of recently enacted federal regulations and legislation.

MEDICAID ENROLLMENT TRENDS

- **Medicaid PHE enrollment increase:** National Medicaid and Children's Health Insurance Program (CHIP) enrollment rose from 71.4 million in February 2020 to nearly 95 million by April 2023, primarily due to paused eligibility redeterminations during the COVID-19 PHE.
- **Post-PHE decline:** With the resumption of Medicaid redeterminations in May 2023, national Medicaid and CHIP enrollment has declined materially since its April 2023 peak, with enrollment falling to under 80 million as of December 2024. Monthly enrollment values in the fourth quarter of 2024 indicate that national Medicaid enrollment has stabilized.
- **State variation:** States showed wide variation in both the magnitude of enrollment increases during the PHE and retention levels after the PHE unwinding was completed. While some of the state variances can be attributed to state-specific policies such as Medicaid expansion or policies around the unwinding process, the drivers of other differences are not readily apparent.

KEY OBSERVATIONS

Observation 1: Nationally, growth in the individual market has been driven by subsidized marketplace enrollment, with advance premium tax credit (APTC) enrollment more than doubling from 2020 to 2024.

Observation 2: From 2022 to 2024, states operating under the federally facilitated exchange that did not expand Medicaid under the Affordable Care Act (ACA) experienced the largest percentage increase in marketplace enrollment. In addition, states that did expand Medicaid under the ACA and use the federally facilitated exchange saw significantly greater enrollment increases relative to expansion states operating a state-based exchange. These enrollment differences were driven primarily by marketplace enrollment representing individuals in households with income below 200% FPL.

Observation 3: National enrollment growth was greatest in the 100% to 138% FPL population, resulting in almost two-thirds of national marketplace growth occurring in states that have not expanded Medicaid.

Observation 4: Marketplace enrollment changes from 2022 to 2024 varied materially among the states by Medicaid expansion status and chosen exchange platform (federal vs. state-based). Differences among some states can be explained by state policy decisions, whereas drivers of other state variations are not readily apparent.

Observation 5: The overall disparity in expansion-state marketplace growth by exchange platform type is not attributable to state variances in Medicaid adult post-PHE enrollment declines. Normalizing for non-elderly adult population size, states using the federal marketplace, on average, had adult Medicaid enrollment declines that were only 1 percentage point higher relative to composite values among states operating a state-based exchange.

INDIVIDUAL MARKET ENROLLMENT TRENDS

- **Rapid growth:** The individual market (encompassing enrollment both on and off marketplace) grew from 13.7 million enrollees in 2020 to 23.6 million in 2024, with the most rapid growth (almost 8 million new enrollees) occurring between 2022 and 2024. Marketplace enrollment grew from approximately 10 million enrollees in 2020 to 21 million in 2024. While PHE Medicaid unwinding can be credited with some of this growth in 2023 and 2024, the relationship between marketplace enrollment growth and Medicaid enrollment declines following the end of the PHE varied widely across the country, with these differences driven by a state's Medicaid expansion decision and exchange type (federal or state-based).
- **Subsidy impact:** Marketplace growth was driven by enhanced premium subsidies under the American Rescue Plan Act (ARPA) and extended by the Inflation Reduction Act (IRA), notably for consumers below 150% of the federal poverty level (FPL) in non-expansion states. The 10 remaining non-expansion states accounted for nearly two-thirds of national marketplace enrollment growth between 2022 and 2024.
- **Federal vs. state exchange enrollment trends:** States using the federal exchange, both expansion and non-expansion states, saw significantly higher marketplace enrollment growth than states using state-based exchanges on average, particularly among consumers with incomes below 200% FPL who have access to cost-sharing reduction (CSR) plans. The higher marketplace enrollment trends in federal exchange states cannot be explained by variation in Medicaid disenrollment rates following the end of the COVID-19 PHE.
- **Emerging 2025 data:** Marketplace open enrollment data for 2025 indicates estimated marketplace growth of 8% in 2025, with greater marketplace enrollment increases continuing to occur among enrollees with income up to 200% of the FPL.

KEY OBSERVATIONS (CONTINUED)

Observation 6: Marketplace open enrollment data for 2025 suggests more limited marketplace enrollment growth from 2024 to 2025, with continued growth among enrollees with reported income up to 200% FPL and stable enrollment among enrollees with income greater than 200% FPL.

Observation 7: Several policy and other factors may be contributing to the variances in marketplace growth between federal exchange and state-based exchange states. While it is difficult to attribute or allocate marketplace growth differences to specific policies, many of these policies are likely to be impacted by future CMS regulatory or policy changes that could materially impact marketplace enrollment.

Observation 8: Since the onset of the COVID-19 PHE, Medicaid adult enrollment changes relative to February 2020 have varied widely by state, both in terms of growth leading up to the end of the PHE and the subsequent unwinding rates.

Observation 9: Similar to adults, Medicaid and CHIP child enrollment changes relative to February 2020 have varied widely by state, impacted by Medicaid expansion implementations that have occurred since 2020 and other state policy decisions.

Observation 10: H.R. 1 contains several provisions likely to impact Medicaid enrollment and could result in more notable shifts in enrollment levels and future coverage continuity for Medicaid beneficiaries across states.

FEDERAL POLICY AND LEGISLATIVE CHANGES

Existing and newly enacted federal policy and legislation may result in several significant impacts to health insurance markets in 2026 and beyond.

- **Expiration of enhanced premium subsidies:** The enhanced marketplace subsidies are set to expire at the end of 2025. If these enhanced subsidies expire, the effective cost of marketplace coverage in the individual market will increase for approximately 20 million subsidized individuals in marketplace plans, which may result in some enrollees electing to forgo coverage because of the additional out-of-pocket premium cost. The Congressional Budget Office (CBO) recently projected that the number of individuals receiving subsidized marketplace coverage will decrease from 21.3 million in 2025 to 15.7 million in 2026, with an overall decrease in individual market coverage of 3.5 million (the CBO projection assumes a 2.1 million increase in nonsubsidized coverage).[1]
- **Income verification and repayment of excess premium subsidies:** Recently finalized Centers for Medicare and Medicaid Services (CMS) regulations and H.R. 1 (informally referred to as the "One Big Beautiful Bill Act") have several provisions that enact stricter income verification rules for consumers who apply for federal premium assistance in the state and federal insurance marketplaces. In addition, H.R. 1 would require full repayment of excess advance premium assistance regardless of consumer income level and require active verification of income for individuals to continue receiving premium and cost-sharing assistance upon renewal of coverage. The stated rationale for these proposals by their proponents is to limit broker-driven fraud in the marketplaces and address concerns that a substantial portion of marketplace consumers are projecting future income to either gain access to federal premium assistance or receive larger amounts of premium assistance. Based on marketplace enrollment changes since 2022 and commentary from state-based exchanges, the impact of these proposals is likely to have greater effects on states using the federal exchange.
- **Medicaid enrollment:** H.R. 1 introduces several administrative changes to state Medicaid programs, particularly around the expansion population. New requirements for the expansion population include community engagement or "work requirements," eligibility redeterminations every six months, and required cost sharing for individuals with household income between 100% and 138% FPL. Reductions in permissible safe harbors for provider taxes for expansion states may also result in states making modifications to covered populations and services. These changes are likely to contribute to greater uncertainty and variation in Medicaid enrollment levels across states. State Medicaid agencies should also understand how changes in individual market affordability may change the perceived value of Medicaid coverage for some consumers and impact enrollment levels.

CONCLUSION

The last five years have seen dramatic, policy-driven shifts in Medicaid and individual market enrollment in response to the COVID-19 pandemic and corresponding federal economic policies, with state-level outcomes shaped by a complex interplay of federal incentives, state decisions, and market structures. As enhanced marketplace premium subsidies approach expiration and new regulatory measures are implemented, ongoing monitoring and agile policy and rating responses will be critical for stakeholders to consider as significant enrollment shifts potentially return to both the individual and Medicaid markets.

1. Congressional Budget Office & Joint Committee on Taxation. (June 2024). Health insurance and its federal subsidies: CBO and JCT's June 2024 baseline projections. Retrieved July 26, 2025, from https://www.cbo.gov/system/files/2024-06/51298-2024-06-healthinsurance.pdf.

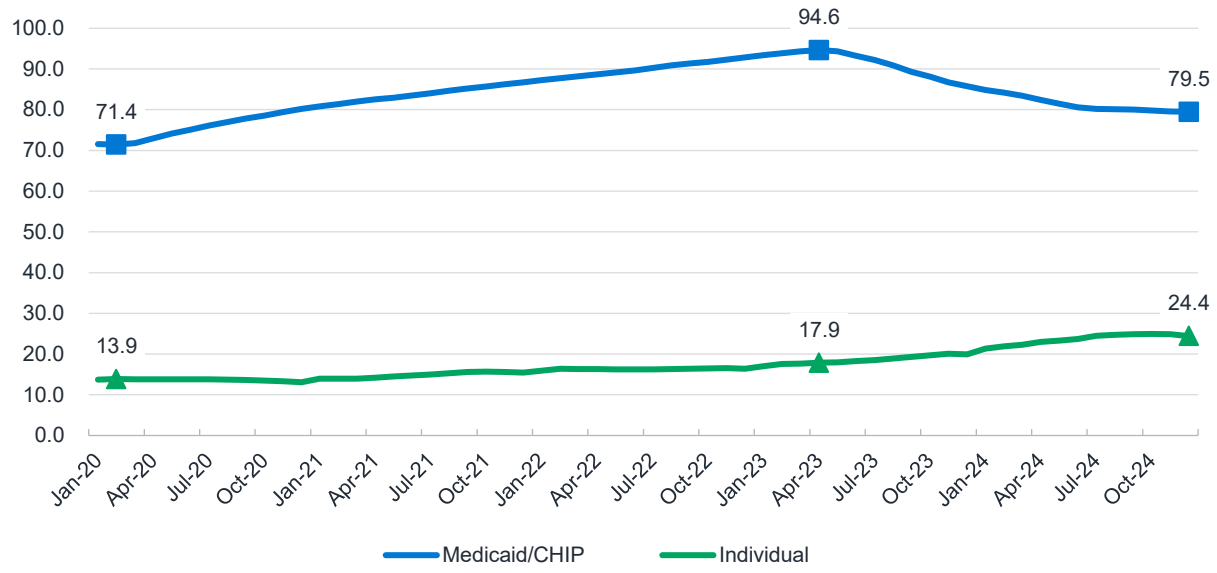
Background and introduction

Since the onset of the COVID-19 pandemic, the Medicaid and individual markets (encompassing the insurance marketplaces) have experienced significant enrollment changes.

MEDICAID

In February 2020, national Medicaid and CHIP enrollment was approximately 71.4 million. At the beginning of the COVID-19 PHE, Medicaid redeterminations were paused, allowing individuals to remain enrolled in Medicaid regardless of changes in eligibility status (e.g., household income).[2] This policy, along with economic changes, resulted in national Medicaid and CHIP enrollment reaching nearly 95 million by April 2023. However, coinciding with the end of the PHE,[3] states began resuming normal Medicaid eligibility redeterminations in May 2023 (although the timing of state-specific resumption of Medicaid redetermination varied to some degree), resulting in significant disenrollments from the Medicaid program. As of December 2024, Medicaid and CHIP enrollment had declined to just under 80 million, with only minimal declines in the last three months of 2024. While national Medicaid and CHIP enrollment was approximately 11% higher in December 2024 compared to February 2020, significant state variation is observed, as discussed in observations 8 and 9 of this report.

FIGURE 1: ESTIMATED MONTHLY NATIONAL MEDICAID AND CHIP AND INDIVIDUAL MARKET ENROLLMENT (MILLIONS)



Notes:

Medicaid/CHIP values from https://data.medicaid.gov/ monthly Medicaid enrollment dataset.

Individual market values estimated based on CMS monthly effectuated enrollment data (https://www.cms.gov/media/566281), CMS commercial medical loss ratio data, and statutory statement enrollment data for 2024. Values for 2024 are estimated by quarter, as monthly marketplace enrollment data is not publicly available at the time of this report.

2. Tolbert, J., & Ammula, M. (June 9, 2023.) 10 things to know about the unwinding of the Medicaid continuous enrollment provision. KFF. Retrieved July 26, 2025, from https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-the-unwinding-of-the-medicaid-continuous-enrollment-provision/.

3. Note that while the resumption of redeterminations coincided with the end of the PHE, the Consolidated Appropriations Act, 2023, delinked the Medicaid continuous coverage requirement from the COVID-19 PHE. For further information, please see Park, E., Dwyer, A., Brooks, T., Clark, M., & Alker, J. (January 5, 2023). Consolidated Appropriations Act, 2023: Medicaid and CHIP provisions explained. Georgetown University McCourt School of Public Policy, Center for Children and Families. Retrieved July 26, 2025, from https://ccf.georgetown.edu/2023/01/05/consolidated-appropriations-act-2023-medicaid-and-chip-provisions-explained/.

INDIVIDUAL MARKET

The individual market grew from approximately 13.7 million average monthly enrollees in 2020 to approximately 24 million by the end of 2024, with growth of nearly 8 million enrollees occurring between 2022 and 2024. Publicly available reports released by the federal government focus largely on the individual insurance marketplace, allowing us to examine the drivers of these enrollment changes by household income cohorts and other market features.[4] Enrollment changes in the individual market during the last five years have been shaped by two major factors.

1. First, ARPA introduced enhanced premium subsidies in the individual marketplaces, which were extended through the end of calendar year 2025 by the IRA.[5] These enhanced subsidies improved consumer affordability in the individual market, notably by allowing consumers with income less than 150%[6] of the FPL to purchase the second-lowest-cost silver (subsidy benchmark) plan for zero out-of-pocket premium.
2. Second, the individual market has been impacted by the previously mentioned Medicaid eligibility policies that have changed since the onset of the COVID-19 PHE. Consumers who may have purchased marketplace coverage after experiencing an income increase that rendered them ineligible for Medicaid, instead remained enrolled in Medicaid during the PHE. However, the resumption of normal Medicaid eligibility redeterminations beginning in May 2023 resulted in significant disenrollments from the Medicaid program and potential new customers for subsidized marketplace coverage for those without access to employer or other health insurance coverage.

As examined in depth in this paper, while national enrollment changes in both Medicaid and the individual market were significant, relative enrollment changes at the state level varied greatly in terms of marketplace growth, Medicaid enrollment increases during the COVID-19 PHE, and subsequent enrollment declines during the PHE unwinding process. These changes appear to be partially influenced by a state's decision to use either the federal exchange or a state-based exchange platform for insurance marketplace coverage, Medicaid expansion implementation status, and other state policy decisions.

While the last five years have produced unprecedented enrollment shifts in Medicaid and individual markets, further major changes in market enrollment are possible in 2026 and beyond because of the following factors:

- The enhanced marketplace premium subsidies are scheduled to sunset at the end of calendar year (CY) 2025.
- Recently finalized federal regulations for 2026 focus on program integrity and reducing fraud in the state and federal marketplaces, with particular emphasis on eligibility and income verification.
- Recently passed legislation will eliminate limits on the amount of excess premium tax credits that can be recovered from individuals who underestimate income and receive larger premium subsidies.
- The federal exchange is resuming checks on duplicate individual market and Medicaid coverage in 2025.
- Medicaid work or community engagement requirements, either by states or at the federal level, are being introduced.

In the context of Medicaid and individual market enrollment changes that have occurred during the last five years, further national- and state-level enrollment impacts to these markets from the above regulatory and legislative changes in 2026 are examined in detail below.

4. Centers for Medicare and Medicaid Services. (2025). 2024 marketplace open enrollment period public use files. Retrieved April 28, 2025, from https://www.cms.gov/data-research/statistics-trends-reports/marketplace-products/2024-marketplace-open-enrollment-period-public-use-files.

5. For an overview of premium subsidy changes, please see Busch, F., Karcher, J., Fink, J., Collier, B., & Sciborski, J. (2021). "A" is for affordable: Impacts of President Biden's proposed (and some passed) ACA subsidy changes [White paper]. Milliman. Retrieved July 26, 2025, from https://edge.sitecorecloud.io/millimaninc5660-milliman6442-prod27d5-0001/media/Milliman/PDFs/2021-Articles/3-17-21-A-is-for-affordable.pdf.

6. For United States citizens, household income must also be at least 100% FPL to receive federal premium assistance. Notably, these enrollees also receive the most generous level of CSRs when they enroll in silver coverage.

Observations

Observation 1: Nationally, growth in the individual market has been driven by subsidized marketplace enrollment, with advance premium tax credit (APTC) enrollment more than doubling from 2020 to 2024.

Figure 2 provides a national summary of individual market enrollment changes on and off the marketplace, as well as the number of marketplace enrollees receiving federal subsidies through APTCs and CSR plans. It illustrates covered lives in the individual market from 2020 through 2024 (values for 2024 are estimated) by market segment and subsidy status.

FIGURE 2: COMMERCIAL INDIVIDUAL HEALTH INSURANCE ENROLLMENT SUMMARY, 2020 TO 2024

COVERED LIFE YEARS	2020	2021	2022	2023	2024
ACA COMPLIANT					
Marketplace	10.3	11.7	13.5	16.2	21.0
Off-Marketplace	2.5	2.4	2.3	2.2	2.2
Total ACA Compliant	12.8	14.2	15.8	18.3	23.1
NON-ACA COMPLIANT					
Total Non-ACA Compliant	0.8	0.6	0.5	0.2	0.5
TOTAL INDIVIDUAL MARKET	**13.7**	**14.8**	**16.3**	**18.6**	**23.6**
FEDERAL SUBSIDY POPULATION					
Marketplace APTC	8.9	10.3	12.2	14.8	19.5
Marketplace CSR	5.2	5.9	6.6	7.8	10.6

Note: For details on methodology, please see https://www.milliman.com/en/insight/commercial-health-insurance-2023-results-and-trends.

As illustrated in Figure 2, individual market enrollment increased from 13.7 million in 2020 to an estimated 23.6 million in 2024, with growth accelerating in 2023 and 2024, coinciding with the resumption of Medicaid redeterminations.

- From 2022 to 2024, total individual market enrollment increased by 7.3 million enrollees (16.3 to 23.6 million), with this growth aligning with changes in APTC enrollment (12.2 million to 19.5 million) during the two-year period.
- Enrollment in CSR plans increased notably in the same two years, increasing from 6.6 million in 2022 to 10.6 million in 2024.

Observation 2: From 2022 to 2024, states operating under the federally facilitated exchange that did not expand Medicaid under the Affordable Care Act (ACA) experienced the largest percentage increase in marketplace enrollment. In addition, states that did expand Medicaid under the ACA and use the federally facilitated exchange saw significantly greater enrollment increases relative to expansion states operating a state-based exchange. These enrollment differences were driven primarily by marketplace enrollment representing individuals in households with income below 200% FPL.

To assess state marketplace variance, states were grouped into one of four cohorts as defined below:

- Non-expansion states using the federal exchange platform.
- States implementing Medicaid expansion in 2023 using the federal exchange platform. North Carolina and South Dakota implemented Medicaid expansion on December 1, 2023, and July 1, 2023, respectively.
- States implementing Medicaid expansion prior to 2022 using the federal exchange platform.
- States implementing Medicaid expansion prior to 2022 using state-based exchange platforms.

Marketplace enrollment for each cohort was also stratified based on available income data provided in the CMS marketplace open enrollment reports published each year. Figure 3 illustrates the percentage change in estimated marketplace enrollment between 2022 and 2024 using the above state cohorts and available income data.

FIGURE 3: CY 2022 TO CY 2024 ESTIMATED PERCENTAGE CHANGE IN AVERAGE MONTHLY EFFECTUATED MARKETPLACE ENROLLMENT BY ENROLLEE INCOME; STATE DATA SUMMARIZED BY EXCHANGE PLATFORM AND MEDICAID EXPANSION STATU

STATE COHORT	STATES	<100% FPL	≥100% TO ≤138% FPL	>138% TO ≤150% FPL	>150% TO ≤200% FPL	200% TO 400% FPL	UNKNOWN / ABOVE 400% FPL	TOTAL
Federal Exchange / Non-Expansion	10	104.1%	120.2%	100.5%	54.1%	30.8%	37.6%	80.0%
Federal Exchange / Expansion Post-2022	2	62.1%	55.1%	253.1%	31.8%	11.5%	27.8%	46.5%
Federal Exchange / Expansion Pre-2022	21	79.0%	140.9%	188.2%	61.1%	19.0%	28.3%	58.3%
State Exchange / Expansion Pre-2022	18	36.0%	145.6%	(3.5%)	17.3%	15.0%	13.8%	17.1%
Total	**51**	**73.4%**	**118.0%**	**98.7%**	**42.9%**	**21.0%**	**23.0%**	**55.6%**

Notes: Virginia moved to a state-based exchange in 2024. However, for the purposes of comparing 2022 to 2024 on a normalized basis, Virginia enrollment values are classified in the Federal Exchange / Expansion Pre-2022 cohort for both years. Values include the District of Columbia.

As shown in Figure 3, while national marketplace enrollment increased by 56%, enrollment in the 10 non-expansion states increased by 80%. Among states expanding Medicaid prior to 2022, composite marketplace enrollment increased by approximately 58% for states using the federal exchange, compared with 17% for states operating a state-based exchange.

Examining the enrollment changes by state cohort and enrollee income level shows that the higher marketplace enrollment growth in the federal exchange was primarily driven by marketplace enrollees with income up to 200% FPL.

- Among states using the federal exchange platform that expanded Medicaid prior to 2022, enrollment increased by approximately 188% among marketplace enrollees with income between 138% and 150% FPL and 61% for enrollees with income between 150% and 200% FPL.
- Among Medicaid expansion states using a state-based exchange platform, enrollment decreased by approximately 4% among enrollees with income between 138% and 150% FPL and increased by 17% for enrollees with income between 150% and 200% FPL. California was a material driver of the lower enrollment growth rates for these two income cohorts among states using state-based exchanges. Excluding California from the state-based exchange composite, enrollment increased by approximately 20% for the 138% to 150% FPL cohort and by 34% for the 150% to 200% FPL cohort.

Observation 3: National enrollment growth was greatest in the 100% to 138% FPL population, resulting in almost two-thirds of national marketplace growth occurring in states that have not expanded Medicaid.

Using the same state cohort and enrollee income framework as in Figure 3, Figure 4 illustrates the distribution of marketplace growth from 2022 to 2024.

FIGURE 4: DISTRIBUTION OF CY 2022 TO CY 2024 MARKETPLACE GROWTH BY EXCHANGE PLATFORM AND MEDICAID EXPANSION STATUS BY ENROLLEE HOUSEHOLD INCOME LEVEL (MEASURED BY FPL PERCENTAGE)

STATE COHORT	STATES	<100% FPL	≥100% TO ≤138% FPL	>138% TO ≤150% FPL	>150% TO ≤200% FPL	200% TO 400% FPL	UNKNOWN / ABOVE 400% FPL	TOTAL
Federal Exchange / Non-Expansion	10	100,000	3,115,000	524,000	565,000	453,000	155,000	4,912,000
Federal Exchange / Expansion Post-2022	2	7,000	110,000	112,000	38,000	27,000	17,000	311,000
Federal Exchange / Expansion Pre-2022	21	23,000	259,000	620,000	339,000	226,000	127,000	1,594,000
State Exchange / Expansion Pre-2022	18	29,000	142,000	(13,000)	138,000	250,000	129,000	676,000
Total	**51**	**159,000**	**3,626,000**	**1,243,000**	**1,080,000**	**956,000**	**428,000**	**7,493,000**

Notes: Virginia moved to a state-based exchange in 2024. However, for the purposes of comparing 2022 to 2024 on a normalized basis, Virginia enrollment values are classified in the Federal Exchange / Expansion Pre-2022 cohort for both years. Values include the District of Columbia.

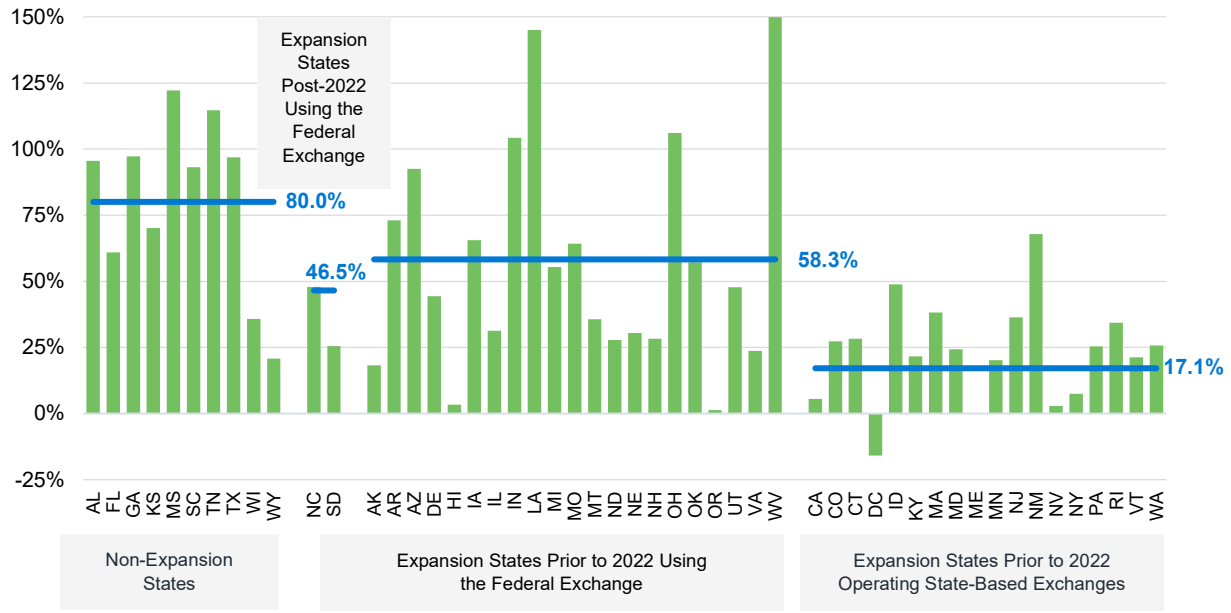
Key observations from Figure 4 include:

- Approximately 42% (3.1 million of 7.5 million) of national marketplace growth is attributable to enrollees with income between 100% and 138% FPL in non-expansion states (to the extent these states expanded Medicaid, it would be expected that most enrollees would transition to Medicaid coverage), with the 10 non-expansion states accounting for approximately 66% (4.9 million of 7.5 million) of national marketplace growth. Including expansion states, nearly 50% of national marketplace growth is attributable to the 100% to 138% FPL cohort.
- Approximately 80% of marketplace enrollment growth (6.1 million of 7.5 million) is attributable to enrollees with household income up to 200% FPL. A portion of this growth at lower income levels is likely attributable to individuals moving from Medicaid to marketplace coverage during resumption of Medicaid redeterminations.

Observation 4: Marketplace enrollment changes from 2022 to 2024 varied materially among the states by Medicaid expansion status and chosen exchange platform (federal vs. state-based). Differences among some states can be explained by state policy decisions, whereas drivers of other state variations are not readily apparent.

Figure 5 illustrates the marketplace growth rates from 2022 to 2024 by state within the four cohorts previously defined, with the orange lines representing the enrollment-weighted average growth rate for the state cohort. As previously discussed, the composite growth rates vary widely across the four cohorts, but there is also significant variance existing at the state level within each cohort. As also seen in Figure 3, non-expansion states had the highest composite market growth, with enrollment increases of approximately 80%.

FIGURE 5: ESTIMATED PERCENT CHANGE IN EFFECTUATED MARKETPLACE ENROLLMENT BY EXCHANGE PLATFORM AND MEDICAID EXPANSION STATUS, CY 2022 TO CY 2024



Note: Virginia moved to a state-based exchange in 2024. However, for the purposes of comparing 2022 to 2024 on a normalized basis, Virginia enrollment values are classified in the Federal Exchange / Expansion Pre-2022 cohort for both years.

For some states, the variation in marketplace growth relative to the state's cohort peers can be potentially explained by a policy decision. Several examples include:

- Wisconsin (lower enrollment): While Wisconsin is a non-expansion state, it provides coverage to childless adults up to 100% FPL, whereas the nine other non-expansion states do not provide Medicaid coverage to childless nondisabled adults.[7] The lack of a health insurance coverage gap in Wisconsin may have contributed to lower marketplace enrollment growth in Wisconsin relative to the other non-expansion states, where the coverage gap does exist.[8]

7. KFF. (January 2025). Medicaid income eligibility limits for adults as a percent of the federal poverty level. Retrieved July 26, 2025, from https://www.kff.org/affordable-care-act/state-indicator/medicaid-income-eligibility-limits-for-adults-as-a-percent-of-the-federal-poverty-level/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

8. For more information on the health insurance coverage gap, please see Cervantes, S., Bell, C., Tolbert, J., & Damico, A. (February 25, 2025). How many uninsured are in the coverage gap and how many could be eligible if all states adopted the Medicaid expansion? KFF. Retrieved July 26, 2025, from https://www.kff.org/medicaid/issue-brief/how-many-uninsured-are-in-the-coverage-gap-and-how-many-could-be-eligible-if-all-states-adopted-the-medicaid-expansion/.

- Oregon (lower enrollment): Oregon implemented a Section 1115 demonstration, allowing continuous Medicaid eligibility provisions that permit most individuals to stay enrolled in Medicaid for up to two years and permitted children to stay enrolled in Medicaid until their sixth birthday.[9] Oregon also implemented a basic health program (BHP) referred to as Oregon Health Plan (OHP) Bridge effective July 1, 2024, which replaces marketplace coverage for individuals with income below 200% FPL.[10] Both of these state policies limit the pool of individuals that could enroll in marketplace coverage. Note that Minnesota also operates a BHP, while New York converted its BHP to a similar program under a Section 1332 waiver for individuals with income up to 250% FPL on April 1, 2024.[11]
- District of Columbia (lower enrollment): The District of Columbia provides Medicaid eligibility up to 215% FPL for caretakers and 221% FPL for other adults.[12] As discussed, much of the national growth in marketplace enrollment has occurred below 200% FPL, which generally cannot occur in the District of Columbia because of higher Medicaid income eligibility limits.
- Maine (lower enrollment): Low marketplace growth in Maine may be attributable to greater retention of Medicaid enrollees relative to other states during the post-PHE Medicaid unwinding process. Maine's Medicaid PHE unwinding process was unable to terminate Medicaid eligibility for several months if a Medicaid member had missing or incomplete information or if a member was unresponsive to a Medicaid renewal notice.[13] It should also be noted that Maine merged its individual and small-group risk pools beginning in 2023.[14]
- Idaho (higher enrollment): Among the states with state-based exchanges, Idaho had the second-largest growth in marketplace enrollment. This may be attributable to Idaho completing its Medicaid post-PHE unwinding process by early September 2023 (whereas most state unwinding periods continued into the first half of 2024), which included enrolling 30% of individuals determined to be ineligible for continuing Medicaid coverage in marketplace coverage through Your Health Idaho, the state's exchange.[15]

There are several possible policy-driven explanations for the observed variance among the federal exchange and state exchange states. In addition, variation at the state level may be partly attributable to the level of marketplace enrollment penetration achieved in 2022 relative to the eligible population. For example, a state enrolling 50% of its eligible population in 2022 would have less room for growth relative to a state enrolling only 20% of its eligible population.

9. Oregon Health Authority. (n.d.) Oregon Health Plan (OHP) continuous eligibility. Retrieved July 26, 2025, from https://www.oregon.gov/oha/hsd/ohp/pages/continuous-eligibility.aspx?utm_medium=email&utm_source=govdelivery.

10. Oregon Health Authority. (n.d.) Oregon Health Plan (OHP) Bridge. Retrieved July 26, 2025, from https://www.oregon.gov/oha/hsd/ohp/pages/bridge.aspx.

11. Centers for Medicare & Medicaid Services. (n.d.) Basic Health Program. Retrieved July 26, 2025, from https://www.medicaid.gov/basic-health-program.

12. KFF. (January 2025). Medicaid income eligibility limits for adults as a percent of the federal poverty level. Retrieved July 26, 2025, from https://www.kff.org/affordable-care-act/state-indicator/medicaid-income-eligibility-limits-for-adults-as-a-percent-of-the-federal-poverty-level/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

13. Pendharkar, E. (August 5, 2024). Maine manages to retain most Medicaid enrollees even as pandemic-era protections end. Maine Morning Star. Retrieved July 26, 2025, from https://mainemorningstar.com/2024/08/05/maine-manages-to-retain-most-medicaid-enrollees-even-as-pandemic-era-protections-end/.

14. State of Maine. (July 15, 2022). Federal government approves Maine's plan to improve health insurance for small businesses. Retrieved July 28, 2025, from https://www.maine.gov/governor/mills/news/federal-government-approves-maines-plan-improve-health-insurance-small-businesses-2022-07-15.

15. Jeppesen, D. (September 8, 2023). From DHW Director Dave Jeppesen: Idaho completes Medicaid reevaluations efficiently and accurately. Idaho Department of Health and Welfare. Retrieved July 28, 2025, from https://healthandwelfare.idaho.gov/dhw-voice/dhw-director-dave-jeppesen-idaho-completes-medicaid-reevaluations-efficiently-and.

Observation 5: The overall disparity in expansion-state marketplace growth by exchange platform type is not attributable to state variances in Medicaid adult post-PHE enrollment declines. Normalizing for non-elderly adult population size, states using the federal marketplace, on average, had adult Medicaid enrollment declines that were only 1 percentage point higher relative to composite values among states operating a state-based exchange.

What was the correlation between the magnitude of state-level post-PHE Medicaid enrollment declines and marketplace enrollment growth from 2022 to 2024? Specifically, did states experiencing a larger degree of Medicaid disenrollment also see enhanced marketplace enrollment growth? Figure 6 presents these trends by illustrating marketplace growth below 200% FPL (which is assumed to be predominantly adults since children have Medicaid/CHIP eligibility through at least 200% FPL in all states but Idaho[16]) and Medicaid adult enrollment declines following the end of the COVID-19 PHE as of December 2024 as a percent of each state's non-elderly adult population (19-to-64-year-olds). States are grouped into three cohorts, with the blue bars representing state values and orange lines representing cohort weighted averages:

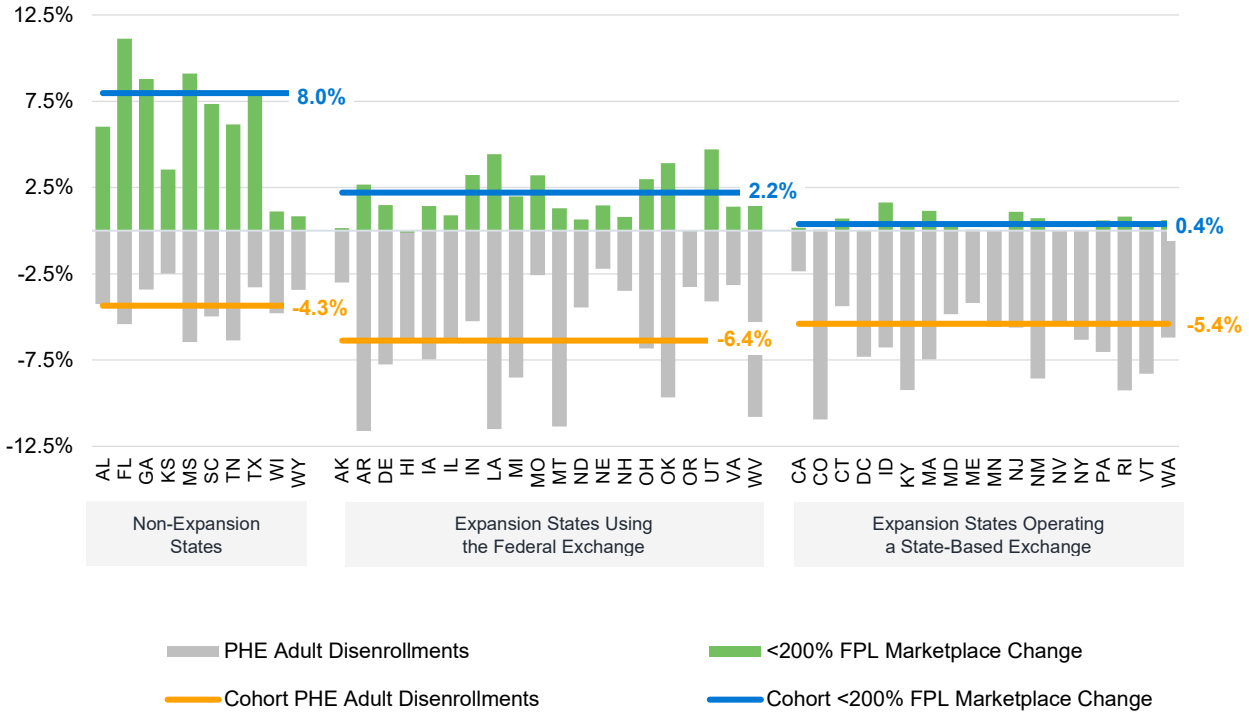
- Non-expansion states
- Expansion states using the federal exchange platform; note that Arizona is excluded because adult Medicaid enrollment was not separately reported in the dataset available on data.medicaid.gov
- Expansion states using state-based exchanges

In addition to Arizona, also excluded from the analysis are Missouri, Nebraska, North Carolina, Oklahoma, and South Dakota due to Medicaid expansion occurring during or after 2020. These recent expansion states experienced a composite 0.5% increase in Medicaid adult enrollment from April 2023 to December 2024 and a 3.6% increase in marketplace enrollments below 200% FPL from 2022 to 2024.

Note that CMS marketplace open enrollment reports provide the number of open enrollment selections by FPL cohort and age group, but selection data related to the income distribution of each age group is not available. It is likely that some state variation exists in the percentage of marketplace enrollees with income below 200% FPL who are children.

16. KFF. (January 2025). Medicaid income eligibility limits for adults as a percent of the federal poverty level. Retrieved July 26, 2025, from https://www.kff.org/affordable-care-act/state-indicator/medicaid-and-chip-income-eligibility-limits-for-children-as-a-percent-of-the-federal-poverty-level/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

FIGURE 6: MARKETPLACE ENROLLMENT GROWTH <200% FPL AND MEDICAID ADULT DISENROLLMENTS POST-PHE AS A PERCENT OF THE TOTAL NON-ELDERLY ADULT POPULATION



Notes:

1. Virginia moved to a state-based exchange in 2024. However, for the purposes of comparing 2022 to 2024 on a normalized basis, Virginia enrollment values are classified in the Federal Exchange / Expansion Pre-2022 cohort for both years.
2. Non-elderly adult population estimates from American Community Survey data for 2023 summarized by KFF: https://www.kff.org/other/state-indicator/adults-19-64/?dataView=1&currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.
3. PHE adult disenrollments reflect the change in Medicaid adult enrollment levels between April 2023 and December 2024 as a percent of the state's non-elderly adult population.

NON-EXPANSION STATES

As shown in Figure 6, 2022 to 2024 marketplace enrollment growth among individuals with income below 200% FPL was nearly double the decrease in post-PHE Medicaid adult enrollment in non-expansion states (marketplace growth equivalent to 8.0% of the non-elderly population and a post-PHE Medicaid adult enrollment decline of 4.3% of the non-elderly population). In Florida, the decline in post-PHE Medicaid adult enrollment through December 2024 was approximately 5.4% of its non-elderly population (approximately 690,000 people), while estimated marketplace growth from 2022 to 2024 below 200% FPL was equivalent to 11.1% of the non-elderly population (approximately 1.45 million individuals).

EXPANSION STATES

States using the federal marketplace had Medicaid adult enrollment declines from April 2023 to December 2024 equivalent to 6.4% of the non-elderly adult population, while states operating a state-based exchange had enrollment declines equivalent to 5.4% of the non-elderly adult population. Marketplace enrollment growth among enrollees with income below 200% FPL was equivalent to 2.2% of the non-elderly adult population in the federal marketplace relative to only 0.4% for states operating a state-based exchange. However, Medicaid disenrollment levels being slightly higher in federal marketplace states does not explain the marketplace enrollment growth disparities relative to state-based exchanges.

Among Medicaid expansion states, there were eight federal exchange states and 17 state-based exchange states where marketplace enrollment growth below 200% FPL was equivalent to less than 20% of Medicaid adult disenrollments. Idaho was the only state-based exchange with marketplace enrollment growth up to 200% FPL exceeding 20% of Medicaid adult disenrollments (marketplace enrollment growth below 200% FPL of 1.6% and Medicaid adult enrollment decline of 6.8%).

Four federal exchange states had marketplace enrollment growth below 200% FPL equivalent to more than 50% of Medicaid adult disenrollment: Indiana, Missouri, Nebraska, and Utah, with Missouri representing the highest ratio of 124%. Missouri's adult Medicaid enrollment decreased by 2.6% of its non-elderly adult population from April 2023 to December 2024, while marketplace enrollment below 200% FPL increased at a rate equivalent to 3.2% of the state's non-elderly population.

Among state-based exchanges, Colorado's Medicaid adult disenrollment was equivalent to nearly 11% of its non-elderly adult population (the largest decline amongst the state-based exchange cohort); however, Colorado marketplace enrollment below 200% FPL only increased by 0.1% of its non-elderly population.

Observation 6: Marketplace open enrollment data for 2025 suggests more limited marketplace enrollment growth from 2024 to 2025, with continued growth among enrollees with reported income up to 200% FPL and stable enrollment among enrollees with income greater than 200% FPL.

Based on the annual CMS open enrollment report and historical effectuated enrollment patterns, preliminary estimates of marketplace enrollment show more limited changes between 2024 and 2025. As illustrated in Figure 7, national marketplace enrollment is estimated to increase from approximately 21.0 million enrollees in 2024 to 22.6 million in 2025, a growth rate of 7.7%.

FIGURE 7: ESTIMATED EFFECTUATED MARKETPLACE ENROLLMENT (MILLIONS) AND PERCENT CHANGE IN ENROLLMENT BY EXCHANGE PLATFORM AND MEDICAID EXPANSION STATUS, CY 2024 TO CY 2025

STATE COHORT	2024 <=200% FPL	2024 >200% FPL	2024 TOTAL	2025 <=200% FPL	2025 >200% FPL	2025 TOTAL	% CHANGE <=200% FPL	% CHANGE >200% FPL	% CHANGE TOTAL
Federal Exchange / Non-Expansion	8.6	2.5	11.0	9.5	2.6	12.0	10.7%	2.4%	8.8%
Federal Exchange / Expansion Post-2022	0.6	0.3	1.0	0.6	0.3	1.0	(3.8%)	3.7%	(1.2%)
Federal Exchange / Expansion Pre-2022	2.2	1.8	4.0	2.5	1.8	4.3	17.0%	0.0%	9.2%
State Exchange / Expansion Pre-2022	1.8	3.1	5.0	2.1	3.2	5.2	12.8%	1.3%	5.5%
Total	**13.2**	**7.8**	**21.0**	**14.7**	**7.9**	**22.6**	**11.3%**	**1.5%**	**7.7%**

Notes:

1. We assumed that the ratio of 2025 effectuated enrollment to selections would align with 2022 ratios, as the Medicaid PHE unwinding process likely impacted these ratios in 2023 and 2024. A common effectuation rate was assumed across all income levels. While it is likely that effectuation rates will vary by income, such data is not publicly available.
2. Based on NAIC Health Industry first quarter 2025 financial data downloaded via S&P Capital IQ Pro, insurers reported composite individual market enrollment growth of approximately 8.0% from March 31, 2024, to March 31, 2025.
3. Georgia moved to a state-based exchange in 2025. However, for the purposes of comparing 2024 to 2025 on a normalized basis, Georgia enrollment values are classified in the Federal Exchange / Non-Expansion cohort for both years.

Figure 7 indicates an 3.8% enrollment decline for enrollees with income below 200% FPL in post-2022 expansion states using the federal exchange, which represents North Carolina and South Dakota, both 2023 expansion states. These states both had significant enrollment decreases among enrollees with income between 100% and 138% FPL, resulting in a composite marketplace enrollment decrease for the cohort of 1.2%. In North Carolina, the 100% to 138% FPL income cohort experienced a decrease in estimated effectuated marketplace enrollment of approximately 151,000 from 2024 to 2025. As marketplace enrollees at this income level were also eligible for Medicaid in both states during all of 2024, it indicates potential issues with proper determination of marketplace subsidy eligibility during 2024 in those states. (Federal policy that may have contributed to this issue is discussed under observation 7.)

Observation 7: Several policy and other factors may be contributing to the variances in marketplace growth between federal exchange and state-based exchange states. While it is difficult to attribute or allocate marketplace growth differences to specific policies, many of these policies are likely to be impacted by future CMS regulatory or policy changes that could materially impact marketplace enrollment.

In addition to the expiration of the enhanced premium subsidies at the end of 2025, several other federal policy changes will occur in 2025 or may be enacted based on proposed regulation or pending legislation that are likely to have material impacts on marketplace enrollment.

PERIODIC DATA MATCHING

Both state-based and the federal exchanges conduct "periodic data matches" (PDM) with state Medicaid agencies to assess whether marketplace consumers receiving an APTC and/or CSR are also enrolled in Medicaid or CHIP.[17] However, the Center for Consumer Information and Insurance Oversight (CCIIO) made notable changes to this process for 2024 that impact states using the federal exchange platform.[18]

- In an August 12, 2024, release from the CCIIO, it was indicated that, for the CY 2024 coverage year only, individuals identified as being dually enrolled in Medicaid or CHIP and subsidized marketplace coverage would receive one warning notice via U.S. Postal Service mail but would not have APTC or CSR eligibility terminated.
- For the calendar year 2025 coverage year, CCIIO indicated it would resume sending final notices of subsidized marketplace eligibility and make marketplace eligibility terminations.
- CCIIO indicated that the 2024 policy was intended to "mitigate consumer harm due to potentially inaccurate Medicaid/CHIP data."[19]
- The policy indicates that states should continue following standard coordination-of-benefit/third-party liability practices, with Medicaid generally remaining the payer of last resort.[20]

On July 17, 2025, CMS announced that in 2024, it identified a monthly average of 1.6 million Americans enrolled in both Medicaid/CHIP and a subsidized marketplace plan.[21]

- For consumers with duplicate coverage in the federally facilitated exchange, CMS indicated it had notified these individuals of their duplicate coverage, requiring them to 1) disenroll from Medicaid or CHIP if no longer eligible, 2) end their premium subsidy and coverage in the marketplace, or 3) notify the federally facilitated exchange that the data match is incorrect. After 30 days, the federally facilitated exchange will end premium subsidies for individuals who still appear to have duplicate coverage.
- For state-based exchanges, CMS will provide these exchanges with a list of individuals who potentially have duplicate coverage and direct the exchanges to implement a similar process as the federal exchange.
- CMS indicated it would also provide further guidance to state Medicaid agencies in early August 2025 with expectations of addressing duplicate enrollment.

17. Brill-Ortiz, J., & Brown, K. (n.d.) Medicaid/CHIP periodic data matching (Medicaid/CHIP PDM): Identifying, notifying and reducing the number of consumers enrolled in marketplace coverage with APTC or CSRs and Medicaid or CHIP [Slide presentation]. Centers for Medicare and Medicaid Services. Retrieved July 28, 2025, from https://www.cms.gov/marketplace/technical-assistance-resources/overlapping-coverage-session.pdf.

18. Center for Consumer Information and Insurance Oversight. (August 12, 2024). Medicaid/CHIP periodic data matching (PDM): External frequently asked questions (FAQ). Centers for Medicare and Medicaid Services. Retrieved July 28, 2025, from https://www.cms.gov/marketplace/technical-assistance-resources/medicaid-chip-periodic-data-matching-faq-2024.pdf.

19. Ibid.

20. Ibid.

21. Centers for Medicare and Medicaid Services. (July 17, 2025). CMS finds 2.8 million Americans potentially enrolled in two or more Medicaid/ACA exchange plans. Retrieved July 28, 2025, from https://www.cms.gov/newsroom/press-releases/cms-finds-28-million-americans-potentially-enrolled-two-or-more-medicaid/aca-exchange-plans.

CMS did not provide any state-level information related to duplicate enrollment. However, 1.6 million average monthly individuals equates to approximately 7.5% of national marketplace enrollment in 2024. To the extent that duplicate enrollment was more concentrated in certain states, addressing duplicate enrollment could have substantial impacts to both the individual market and Medicaid risk pools. In addition, state Medicaid agencies, given Medicaid is the payer of last resort, should evaluate whether coordination of benefits was properly handled by insurers when duplicate coverage did exist.

Broker-driven enrollment fraud

The submission of fraudulent applications for marketplace coverage has received widespread attention. A notable case of fraudulent enrollment includes an executive vice president of an insurance brokerage firm in Florida pleading guilty to submitting fraudulent marketplace enrollments that resulted in federal subsidies of at least $133.9 million, generating millions of dollars in commission payments for the brokerage firm.[22] This scheme targeted low-income populations that included individuals experiencing homelessness, unemployment, and behavioral health disorders.[23] In a similar scheme, the U.S. Department of Justice alleges that fraudulent activity by brokers in Florida and Texas resulted in at least $161.9 million in inappropriate subsidies.[24] While the overall scale of improper enrollments is far from clear, the issue is clearly present and has a significant cost for both consumers and taxpayers.

For the 2025 open enrollment period, CMS implemented new rules designed to limit broker-driven fraud in the federally facilitated marketplace.[25] CMS also reported the suspension of 850 agents' and brokers' marketplace agreements for "reasonable suspicion of fraudulent or abusive conduct related to unauthorized enrollments or unauthorized plan switches" from June to October 2024.[26]

In June 2025, CMS released the 2025 Marketplace Integrity and Affordability Final Rule (Marketplace Integrity Rule).[27] The Marketplace Integrity Rule has several provisions that CMS indicates are aimed at reducing improper enrollments and improving the risk pool. In comments as part of the rulemaking process, several states operating a state exchange indicated that they believe broker fraud and improper enrollments were limited to the federal marketplace and not present in state-based exchanges, and they cited activities undertaken by their state-based exchanges to maintain program integrity and reduce fraud.[28] The rule notes that since many of the issues are amplified by the enhanced premium tax credits, which are scheduled to end after 2025, many of these finalized provisions will be allowed to revert to the prior state after they have had a chance to "right-size enrollment.[29]"

22. United States Department of Justice. (April 18, 2025). Executive vice president of insurance brokerage pleads guilty in $133M Affordable Care Act fraud scheme. Retrieved July 28, 2025, from https://www.justice.gov/opa/pr/executive-vice-president-insurance-brokerage-pleads-guilty-133m-affordable-care-act-fraud.

23. Ibid.

24. United States Department of Justice. (February 19, 2025). President of insurance brokerage firm and CEO of marketing company charged in $161M Affordable Care Act enrollment fraud scheme. Retrieved July 28, 2025, from https://www.justice.gov/opa/pr/president-insurance-brokerage-firm-and-ceo-marketing-company-charged-161m-affordable-care

25. Corlette, S. (October 25, 2025). What's new for the 2025 plan year open enrollment. Georgetown University McCourt School of Public Policy, Center for Children and Families. Retrieved July 28, 2025, from https://ccf.georgetown.edu/2024/10/25/whats-new-for-the-2025-plan-year-open-enrollment/.

26. Centers for Medicare and Medicaid Services. (October 17, 2024). CMS update on actions to prevent unauthorized agent and broker marketplace activity. Retrieved July 28, 2025, from https://www.cms.gov/newsroom/press-releases/cms-update-actions-prevent-unauthorized-agent-and-broker-marketplace-activity.

27. Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability. 90 F.R. 27074–27224. Retrieved July 29, 2025, from https://www.federalregister.gov/documents/2025/06/25/2025-11606/patient-protection-and-affordable-care-act-marketplace-integrity-and-affordability.

28. Pogue, S. (May 12, 2025). Stakeholder perspectives on CMS' proposed "Marketplace Integrity" rule: State insurance departments and marketplaces. CHIRblog. Retrieved July 29, 2025, from https://chirblog.org/stakeholder-perspectives-on-cms-proposed-marketplace-integrity-rule-state-insurance-departments-and-marketplaces/.

29. Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability. 90 F.R. 27127. Retrieved July 31, 2025, from https://www.govinfo.gov/content/pkg/FR-2025-06-25/pdf/2025-11606.pdf

The Marketplace Integrity Rule eliminates the monthly special enrollment period (SEP) for individuals with projected household incomes at or below 150% of the FPL for the last part of 2025 and 2026, citing concerns over unauthorized enrollment and exploitation by brokers to enroll consumers in marketplace coverage without their knowledge. In the final rule, CMS states that the 150% FPL SEP was "one of the primary mechanisms that certain agents, brokers, and web-brokers used to conduct unauthorized enrollment to improperly enroll consumers in fully subsidized exchange plans."[30] Further, H.R. 1 eliminates eligibility for APTCs and CSRs for individuals enrolling in a marketplace plan during a SEP on the basis of the enrollee's household income level (as measured by FPL) beginning after December 31, 2025, which also effectively eliminates the 150% FPL SEP.[31]

The federal marketplace and all state-based exchanges with the exception of Maryland, Nevada, and Virginia have permitted the 150% FPL SEP, with New Jersey's, New Mexico's, Vermont's, and Washington's state-based exchanges allowing a SEP for individuals with income up to 200% FPL (250% FPL in Washington).[32] Therefore, while it is possible that the 150% FPL SEP allowed some level of improper enrollment, it does not readily explain the differences in marketplace growth observed between the federal marketplace and state-based exchanges.

Incentives to underestimate and overestimate income in marketplace applications

The structure of ACA premium tax credits creates incentives for some consumers to overstate projected household income and for others to understate projected household income when applying for coverage. Moreover, policy choices made by federal regulators during the pandemic have made it easier for some consumers to act on these incentives.

Based on information submitted at the time of application, the exchange determines a preliminary premium assistance amount and provides an APTC directly to the insurer. This advance amount is reconciled against actual income in a taxpayer's filing in the following year. Any additional amount owed to the insurer is refunded to the taxpayer through the tax filing, while excess amounts are recaptured as part of the filing. Recapture is limited for taxpayers with household income up to 400% FPL, as indicated in Figure 8.

FIGURE 8: ANNUAL REPAYMENT LIMITS OF EXCESS PREMIUM TAX CREDIT PAYMENTS, 2025

HOUSEHOLD INCOME (MEASURED BY FPL)	APPLICABLE DOLLAR LIMIT FOR A TAXPAYER WITH A FILING STATUS OF SINGLE
<200%	$375
200% to <300%	$975
300% to <400%	$1,625

Note: The applicable dollar limit for all other tax filing statuses is twice the amount shown above.

- Why would a consumer underestimate income? The federal premium assistance schedule operates on a sliding scale that reduces the amount of premium assistance as income increases. Furthermore, individuals with incomes below 250% FPL are eligible for CSRs that decrease out of pocket spending requirements, with even more generous reductions available to individuals below 200% FPL and then below 150% FPL (but still above 100% FPL).[33] Understatement of income can thus increase the benefit generosity of coverage, and limits on recapture serve to increase the effective amount of premium assistance, creating an incentive to understate

30. Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability. 90 F.R. 27141. Retrieved July 29, 2025, from https://www.govinfo.gov/content/pkg/FR-2025-06-25/pdf/2025-11606.pdf.

31. An act to provide for reconciliation pursuant to title II of H. Con. Res. 14, H.R. 1, 119th Cong. (2025). Section 71304. Retrieved July 29, 2025, from https://www.congress.gov/119/bills/hr1/BILLS-119hr1eas.pdf.

32. Norris, L. (December 20, 2024). An SEP if your income doesn't exceed 150% of the federal poverty level. HealthInsurance.org. Retrieved July 29, 2025, from https://www.healthinsurance.org/special-enrollment-guide/an-sep-if-your-income-doesnt-exceed-150-of-the-federal-poverty-level/#:~:text=The%20rest%20of%20the%20state,income%20attested%20by%20the%20consumer.

33. For additional information on federal health insurance subsidies available for individual market coverage, see KFF. (October 25, 2024). Explaining health care reform: Questions about health insurance subsidies. Retrieved July 29, 2025, from https://www.kff.org/affordable-care-act/issue-brief/explaining-health-care-reform-questions-about-health-insurance-subsidies/.

income. While the exchange has an income inconsistency verification process for consumers whose projected income is less than suggested by trusted data sources, many households still project income that is too low relative to their actual income. Based on Internal Revenue Service (IRS) Statistics of Income (SOI) data from 2022, 8.6 million taxpayers indicated receipt of $61 billion in APTC. Approximately 2.3 million households received about $2 billion less APTC than they were ultimately due, while 5.1 million households received about $9.5 billion in excess APTC. After accounting for the 3.8 million households subject to the recapture limit, only about $7 billion was repaid.[34]

- Why would a consumer overestimate income? Individuals with income below the federal poverty line but ineligible for Medicaid (most commonly nondisabled adults in the nine states that have not expanded eligibility up to at least 100% FPL) typically do not have access to other affordable comprehensive coverage. Premium assistance is not available for most consumers unless projected income for the upcoming year is at least 100% FPL.[35] This creates an incentive for such an applicant to project income above 100% FPL in order to qualify for premium assistance, as otherwise they would lack access to affordable comprehensive coverage. As long as the information is not provided with intentional or reckless disregard to the facts, the applicant generally does not have to repay the APTC received if actual income during the coverage years falls below 100% FPL.[36] During the pandemic, regulators eliminated a requirement to validate income projections higher than those found in trusted data sources and allowed individuals without any trusted income data to complete a simple attestation which is then accepted without further verification. These changes effectively allowed consumers whose income appeared likely to be below 100% FPL to simply sign some paperwork without any meaningful documentary support requirements, making it much easier to act on this incentive.

CMS addressed the asymmetry in income documentation in the Marketplace Integrity Rule, finalizing multiple policies around income verification for individuals applying for federal premium assistance.[37]

- For the last part of 2025 and all of 2026, the Marketplace Integrity Rule requires exchanges to generate annual income inconsistencies when a tax filer's attested projected annual household income is equal to or greater than 100% FPL and up to 400% FPL, while the income data returned by the IRS, Social Security Administration, or current income data sources are less than 100% FPL and at least 10% lower than projected income.[38]
- For the last part of 2025 and all of 2026, the Marketplace Integrity Rule removes the requirement that exchanges accept an applicant's or enrollee's self-attestation of projected annual household income when the IRS cannot provide any corresponding tax return data. Under this provision, marketplaces would be required to verify income with other trusted data sources (if available) and follow the alternative verification process, which requires applicants to submit documentary evidence or otherwise resolve the income inconsistency.[39]

34. Internal Revenue Service. (2022). Individual income tax returns, line item estimates, 2022. Publication 4801 (Rev. 12–2024), 218–219. Retrieved July 29, 2025, from https://www.irs.gov/pub/irs-pdf/p4801.pdf.

35. Immigrants who are legally present in the U.S. but who are ineligible for Medicaid because of a state waiting period receive premium assistance as if their income is exactly 100% FPL when either projected or actual income falls below that threshold.

36. Norris, L. (November 13, 2023). If my income is less than expected this year, I might be eligible for Medicaid. What can I do to cover my bases? HealthInsurance.org. Retrieved July 29, 2025, from https://www.healthinsurance.org/faqs/if-my-income-is-less-than-expected-this-year-i-might-be-eligible-for-medicaid-what-can-i-do-during-open-enrollment-to-cover-my-bases/#reconcile.

37. Centers for Medicare and Medicaid Services. (March 10, 2025). 2025 Marketplace Integrity and Affordability Proposed Rule [Fact sheet]. Retrieved July 29, 2025, from https://www.cms.gov/newsroom/fact-sheets/2025-marketplace-integrity-and-affordability-proposed-rule.

38. Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability. 90 F.R. 27121. Retrieved July 29, 2025, from https://www.govinfo.gov/content/pkg/FR-2025-06-25/pdf/2025-11606.pdf.

39. Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability. 90 F.R. 27130. Retrieved July 29, 2025, from https://www.govinfo.gov/content/pkg/FR-2025-06-25/pdf/2025-11606.pdf.

H.R. 1 adds on to the themes of the Marketplace Integrity Rule, with additional program integrity provisions.[40]

- Consumers will be required to actively verify income and eligibility with exchanges prior to receiving premium and cost-sharing support beginning in 2028.
- Beginning with 2026 coverage, excess premium tax credit recapture limits for taxpayers with income at or below 400% of FPL will be repealed. This would require individuals who receive more premium tax credits due to intentional over- or understatement of income to pay back the full amount of excess premium tax credits. H.R. 1 also formalizes current regulation that exempts taxpayers who reasonably estimate income above 100% FPL but whose actual income is below 100% FPL from repayment of their premium tax credits, which should address some concerns about household income fluctuations for households near the federal poverty level.

In a June 2025 letter addressed to several members of Congress, 18 state-based exchanges expressed concern about the marketplace provisions in the then-pending reconciliation bill, including "unprecedented restrictions and administrative barriers for consumers trying to access private health insurance."[41]

The excess premium tax credit limits illustrated in Figure 8 provide the largest effect if the taxpayer indicates income between 100% and 200% FPL, and more specifically between 138% and 150% FPL in expansion states and between 100% and 150% FPL in non-expansion states if at all supportable. Such an approach maximizes premium assistance and allows the taxpayer to enroll in the most generous levels of CSRs. As shown in Figure 3, 2022 to 2024 marketplace enrollment percentage increases among individuals with reported income up to 200% FPL was far greater in the federal marketplace than in state-based exchanges.[42] This suggests that income verification provisions included in the final Marketplace Integrity Rule and H.R. 1 may result in 2026 coverage year impacts (and future years) that are greater in states using the federal marketplace.

Observation 8: Since the onset of the COVID-19 PHE, Medicaid adult enrollment changes relative to February 2020 have varied widely by state, both in terms of growth leading up to the end of the PHE and the subsequent unwinding rates.

Figure 9 illustrates the percentage change in monthly Medicaid adult enrollment as of April 2023 and December 2024 relative to February 2020 by individual states, grouped into three cohorts:

- Non-expansion states
- Expansion states using the federal exchange platform; note that Arizona is excluded because adult Medicaid enrollment was not separately reported in the dataset available on data.medicaid.gov
- Expansion states using state-based exchanges; note that Viriginia moved to a state exchange in 2024 but is illustrated in the second cohort for comparison purposes

In addition to Arizona, also excluded from the analysis are Missouri, Nebraska, North Carolina, Oklahoma and South Dakota due to Medicaid expansion occurring after January 1, 2020.

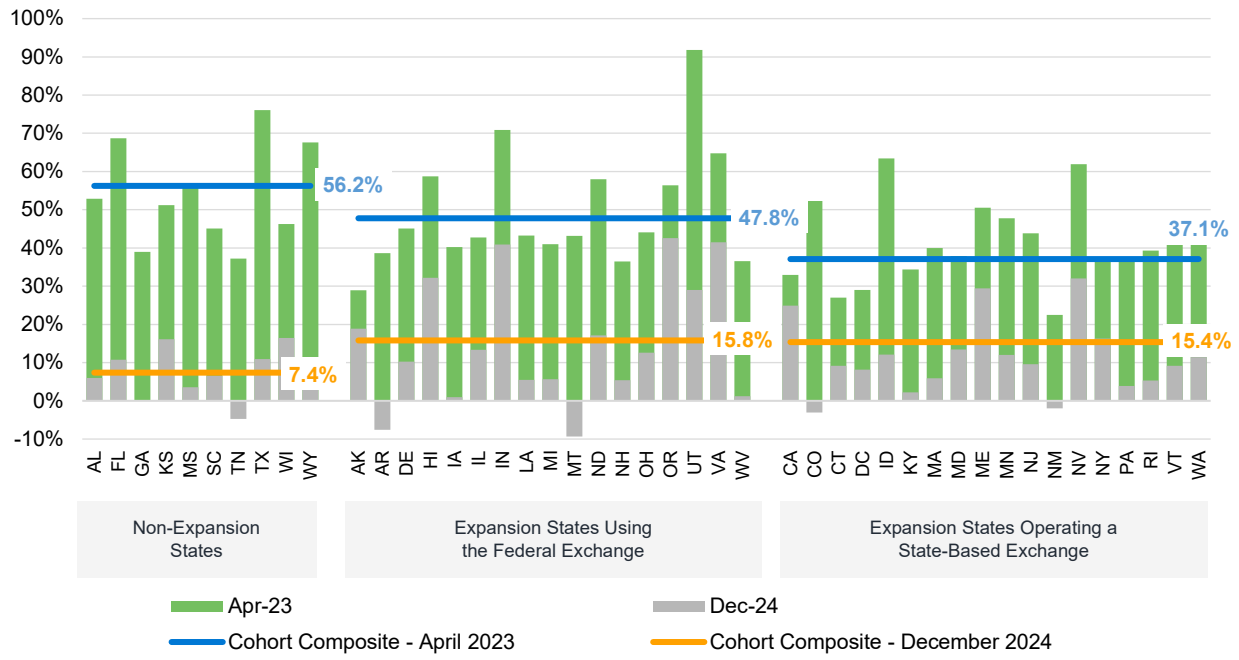
The gray line for each cohort represents the weighted average Medicaid adult enrollment percentage change from February 2020 to April 2023. The orange line for each cohort represents the weighted average Medicaid adult enrollment percentage change from February 2020 to December 2024. Note that this analysis assesses enrollment levels rather than the number of unique individuals disenrolled from Medicaid following the end of the PHE.

40. An act to provide for reconciliation pursuant to title II of H. Con. Res. 14, H.R. 1, 119th Cong. (2025). Retrieved July 29, 2025, from https://www.congress.gov/119/bills/hr1/BILLS-119hr1eas.pdf.

41. Altman, J., Caulum, L., Eberle, M., Flowers, C., Gasteier, A., Gilbert, B., Holahan, D., et al. (June 2, 2025). SBM reconciliation letter to Senate [Letter]. Retrieved July 29, 2025, from https://eadn-wc02-12144036.nxedge.io/wp-content/uploads/2025/06/SBM-Reconciliation-Letter-to-Senate.pdf.

42. Among non-expansion states, marketplace enrollment below 200% FPL increased by 103% from 2022 to 2024. For states expanding Medicaid prior to 2022, states using the federal exchange platform had a composite marketplace enrollment increase below 200% FPL of approximately 115%, relative to 25% for states operating a state-based exchange.

FIGURE 9: PERCENTAGE CHANGE IN MEDICAID MONTHLY ADULT ENROLLMENT RELATIVE TO FEBRUARY 2020: APRIL 2023 AND DECEMBER 2024, SEGMENTED BY EXCHANGE PLATFORM AND MEDICAID EXPANSION STATUS



Notes:

1. Missouri, North Carolina, Nebraska, Oklahoma, and South Dakota have been excluded from the figure because Medicaid expansion occurred after the onset of the COVID-19 PHE.
2. Arizona has been excluded from the figure because adult Medicaid enrollment is not separately reported in data.medicaid.gov until May 2024.
3. Idaho implemented Medicaid expansion on January 1, 2020; it is likely that the ramp-up of Idaho's expansion coincided with the onset of the COVID-19 PHE.
4. December 2024 enrollment data for Rhode Island was not reported in the CMS dataset; therefore, Rhode Island's December 2024 enrollment was set equal to November 2024 for this analysis.

As shown in Figure 9, the percentage change in Medicaid adult enrollment from February 2020 to April 2023 varied widely across the country.

- Utah experienced nearly 92% Medicaid adult enrollment growth between February 2020 and April 2023, representing the highest percentage growth rate in the country. The high growth rate is likely partially attributable to Utah's Medicaid expansion having been implemented on January 1, 2020 (with enrollment ramp-up occurring over several months).[43]
- Conversely, New Mexico had Medicaid adult enrollment growth of approximately 22% between February 2020 and April 2023, representing the lowest percentage growth rate in the country.
  - In assessing enrollment growth variances across states, it is important to also consider what proportion of the total population was enrolled in Medicaid/CHIP prior to the COVID-19 pandemic. Based on KFF data from CY 2019, 19.8% of the U.S. population was enrolled in Medicaid. However, this percentage varied from a low of 9.3% in Utah to a high of 32.7% in New Mexico.[44] Therefore, while the growth percentages varied widely for these two states, the increase in the proportion of the total population enrolled in Medicaid was much more comparable. For perspective, 34 states' populations were within 5 percentage points (+/-) of the national average of 19.8% in 2019.

43. HealthInsurance.org. (n.d.) Medicaid eligibility and enrollment in Utah. Retrieved July 30, 2025, from https://www.healthinsurance.org/medicaid/utah/.

44. KFF. (2019). Health insurance coverage of the total population. Retrieved July 30, 2025, from https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=3&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

- Among expansion states, states using the federal exchange platform had a greater February 2020 to April 2023 percentage increase in Medicaid adult enrollment (47.8%) on average relative to states using state-based exchanges (37.1%). However, there are large differences among states within each cohort, which makes it difficult to infer that the type of exchange platform influenced Medicaid enrollment growth during the PHE.

Reviewing Medicaid adult enrollment in December 2024 relative to February 2020, similar wide variances are observed across the country in terms of the PHE enrollment increase retained as of December 2024.

- December 2024 enrollment for non-expansion states was approximately 7% higher on a composite basis than February 2020, reflecting a retention of 13% of the PHE enrollment increase.
- Among expansion states using the federal exchange, December 2024 enrollment was approximately 16% higher than February 2020, reflecting a retention rate of 33% of the PHE enrollment increase.
- Expansion states operating state-based exchanges had a composite December 2024 enrollment increase of 15% relative to February 2020, reflecting a retention rate of 42% of the PHE enrollment increase.

Figure 10 highlights the five states that reported December 2024 Medicaid adult enrollment levels below that of February 2020 and the eight states that retained at least 50% of the Medicaid PHE enrollment increase through December 2024. Figure 10 also illustrates national values for comparison. As stated previously, this analysis is not tracking whether individual Medicaid members maintained eligibility but rather overall enrollment levels.

FIGURE 10: SELECT STATE MEDICAID ADULT ENROLLMENT CHANGES SINCE FEBRUARY 2020

	MONTHLY ADULT ENROLLMENT			PERCENT CHANGE IN ADULT ENROLLMENT RELATIVE TO FEBRUARY 2020		
STATE	FEB-20	APR-23	DEC-24	APR-23	DEC-24	RETENTION RATE
Colorado	700,000	1,066,000	679,000	52.3%	(3.1%)	(5.9%)
New Mexico	412,000	505,000	404,000	22.4%	(1.9%)	(8.7%)
Tennessee	626,000	859,000	596,000	37.2%	(4.8%)	(12.8%)
Arkansas	432,000	599,000	399,000	38.7%	(7.6%)	(19.6%)
Montana	138,000	197,000	125,000	43.1%	(9.4%)	(21.7%)
Nevada	330,000	534,000	436,000	61.9%	32.0%	51.7%
Hawaii	187,000	297,000	247,000	58.8%	32.2%	54.9%
Indiana	682,000	1,165,000	960,000	70.8%	40.9%	57.7%
Maine	159,000	239,000	206,000	50.5%	29.5%	58.3%
Virginia	670,000	1,104,000	948,000	64.8%	41.5%	64.0%
Alaska	126,000	162,000	149,000	28.9%	18.9%	65.3%
Oregon	585,000	915,000	834,000	56.4%	42.5%	75.5%
California	6,784,000	9,021,000	8,476,000	33.0%	24.9%	75.6%
National	36,136,000	52,322,000	41,753,000	44.8%	15.5%	34.7%

Notes:

1. Enrollment data from https://data.medicaid.gov/.
2. Enrollment values are rounded to the nearest thousand.
3. Percentages are calculated from non-rounded values.
4. Retention rate calculated as (December 2024 enrollment – February 2020 enrollment) ÷ (April 2023 enrollment – February 2020 enrollment).

As shown in Figure 10, California's reported Medicaid adult enrollment increased from approximately 6.8 million in February 2020 to 9.0 million in April 2023, decreasing to 8.5 million as of December 2024, making California the state with the highest adult retention rate.

The high enrollment retention rates observed in Maine and Oregon can be directly attributed to state policy decisions around PHE disenrollment processes. However, the driving factors behind other states' ability to retain a large degree of the PHE enrollment increase remain less clear and in some cases were unexpected.[45] In some states, it is possible that robust navigator programs, advertising, outreach, and consumer education campaigns played a role in enhancing individuals' access to healthcare coverage and facilitating increased enrollment. Over the past four years, navigators, who focus on outreach and provide free application and enrollment assistance, have received significant federal funding in states using the federal exchange. This funding boost followed a period of considerable federal budget cuts to navigator programs from 2018 to 2020.[46] Several studies have demonstrated that these initiatives have significant impacts on health care coverage.[47]

Hawaii's Med-QUEST program launched the "Stay Well Stay Covered" communications campaign in March 2023, employing a variety of outreach methods over a 12-month period to inform members about renewals and provide clear information on the month their eligibility would be reassessed. Hawaii also streamlined the renewal process by enabling households to renew all members simultaneously, rather than sending separate renewal letters for each individual. In addition to operating a healthcare outreach branch to support renewals, a Hawaii community-based organization received $294,882 in CMS navigator grant funding in 2023[48] to assist individuals across the state with accessing marketplace coverage, with a focus on young adults transitioning off their parents' insurance, individuals experiencing insurance loss due to a parent's job loss, and homeless populations.

Virginia has leveraged the flexibility afforded by a state-run eligibility and enrollment website to establish a facilitated enrollment program that may contribute to the high enrollment retention rates observed in the state. The state allows residents to indicate on their tax forms if they are uninsured and interested in coverage. The state then uses income information from the return to provide an eligibility determination and direct the consumer to the Medicaid enrollment window for subsidized marketplace plans.[49] The Virginia Medicaid agency took a phased approach to implementing tax-return-based facilitated enrollment, beginning with tax-filing seasons 2022 and 2023 for Medicaid and then 2024 for marketplace coverage.[50,51]

45. Corbin Girnus, A. (August 16, 2024). Post-pandemic disenrollment may spell budget troubles for Nevada Medicaid, lawmakers warned. Nevada Current. Retrieved July 30, 2025, from https://nevadacurrent.com/2024/08/16/post-pandemic-disenrollment-may-spell-budget-troubles-for-nevada-medicaid-lawmakers-warned/.

46. Jost, T. (August 31, 2017). CMS cuts ACA advertising by 90 percent amid other cuts to enrollment outreach. Health Affairs. Retrieved July 30, 2025, from https://www.healthaffairs.org/content/forefront/cms-cuts-aca-advertising-90-percent-amid-other-cuts-enrollment-outreach.

47. Orzol, S., & Hula, L. (December 2016). Impact of Enroll America on the number of individuals covered through the federally facilitated marketplace. Health Services Research, 53(1), 341–365.

48. Centers for Medicare and Medicaid Services. (n.d.). 2023-2024 CMS navigator cooperative agreement awardees. Retrieved July 30, 2025, from https://www.cms.gov/files/document/2023-2024-navigator-awardee-summariesfinal-508-08-24-2023.pdf.

49. HB 1884 Income tax, state; voluntary inclusion of personal & contact information on appropriate forms. (2021). Retrieved July 30, 2025, from https://legacylis.virginia.gov/cgi-bin/legp604.exe?212+sum+HB1884.

50. Schwab, R., Giovannelli, J., Lucia, K., & Corlette, S. (August 3, 2021). State "Easy Enrollment" programs gain momentum, lay groundwork for additional efforts to expand coverage. Commonwealth Fund. Retrieved July 30, 2025, from https://www.commonwealthfund.org/blog/2021/state-easy-enrollment-programs-gain-momentum-lay-groundwork-additional-efforts-expand.

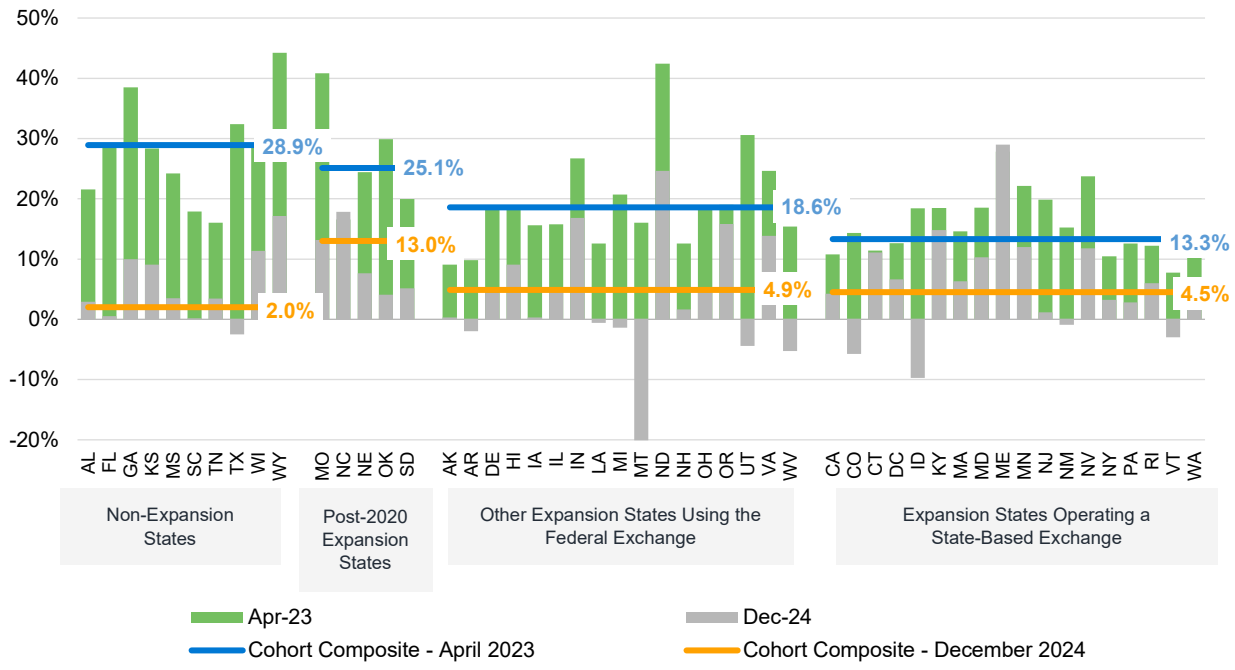
51. Myerson, R., Tilipman, N., Feher, A., Li, H., Yin, W., & Meashe, I. (January 2022). Personalized telephone outreach increased health insurance take-up for hard-to-reach populations, but challenges remain. Health Affairs, 41(1), 129–137.

Observation 9: Like enrollment changes for adults, Medicaid and CHIP child enrollment changes relative to February 2020 have varied widely by state, impacted by Medicaid expansion implementations that have occurred since 2020 and other state policy decisions.

While Medicaid/CHIP child enrollment was impacted to a lesser degree than Medicaid adult enrollment during the COVID-19 PHE (20% vs. 45% enrollment increases), substantial enrollment changes did occur during the PHE and its subsequent unwinding. Figure 11 illustrates the percentage change in monthly Medicaid/CHIP child enrollment as of April 2023 and December 2024 relative to February 2020 by individual states, grouped into four cohorts:

- Non-expansion states (which all used the federal exchange for marketplace coverage until 2025)
- States expanding Medicaid after 2020 and that use the federal exchange for marketplace coverage
- Other expansion states using the federal exchange for marketplace coverage; note that Arizona is excluded because adult Medicaid enrollment was not separately reported in the dataset available on data.medicaid.gov
- Other expansion states using state-based exchanges for marketplace coverage; note that Viriginia moved to a state exchange in 2024 but is illustrated in the second cohort for comparison purposes

FIGURE 11: PERCENTAGE CHANGE IN MEDICAID/CHIP MONTHLY CHILD ENROLLMENT RELATIVE TO FEBRUARY 2020: APRIL 2023 AND DECEMBER 2024, SEGMENTED BY EXCHANGE PLATFORM AND MEDICAID EXPANSION STATUS



Key observations from Figure 11 include:

- Non-expansion states had the largest Medicaid/CHIP child enrollment growth percentage from February 2020 to April 2023—28.9%—relative to the other three state cohorts, while also having the smallest enrollment growth percentage from February 2020 to December 2024 at 2.0%.
- States expanding Medicaid after 2020 had the largest composite Medicaid/CHIP child enrollment growth from February 2020 to December 2024—13.0%. While Medicaid/CHIP eligibility criteria did not change in these states, Medicaid expansion may have resulted in a "welcome mat" effect as newly eligible adults enrolled in the program and concurrently enrolled their children.

- As in the adult Medicaid population, among expansion states, the exchange platform does not appear to be influencing Medicaid enrollment declines post-PHE, as both federal and state-based exchange states have a composite Medicaid/CHIP child enrollment increase of approximately 5% from February 2020 to December 2024.

Figure 12 highlights Medicaid/CHIP child enrollment changes for states where December 2024 enrollment is below February 2020 levels, as well as states that have retained at least 10% of the PHE enrollment growth as of December 2024. Figure 12 also illustrates national values for comparison.

FIGURE 12: SELECT STATE MEDICAID/CHIP CHILD ENROLLMENT CHANGES SINCE FEBRUARY 2020

	MONTHLY CHILD ENROLLMENT			PERCENTAGE CHANGE IN CHILD ENROLLMENT RELATIVE TO FEBRUARY 2020		
STATE	Feb-20	Apr-23	Dec-24	Apr-23	Dec-24	RETENTION RATE
Louisiana	717,000	807,000	713,000	12.6%	(0.6%)	(4.6%)
New Mexico	333,000	383,000	330,000	15.2%	(0.9%)	(5.8%)
Michigan	944,000	1,140,000	931,000	20.7%	(1.4%)	(6.8%)
Texas	3,301,000	4,370,000	3,219,000	32.4%	(2.5%)	(7.7%)
Utah	185,000	241,000	176,000	30.6%	(4.4%)	(14.4%)
Arkansas	432,000	475,000	424,000	9.8%	(2.0%)	(19.8%)
West Virginia	214,000	247,000	203,000	15.4%	(5.3%)	(34.3%)
Vermont	61,000	66,000	59,000	7.7%	(3.0%)	(38.4%)
Colorado	566,000	648,000	534,000	14.3%	(5.7%)	(39.9%)
Idaho	175,000	208,000	158,000	18.4%	(9.7%)	(52.7%)
Montana	115,000	133,000	92,000	16.0%	(20.1%)	(125.4%)
District of Columbia	90,000	102,000	96,000	12.7%	6.6%	52.3%
Minnesota	531,000	648,000	594,000	22.2%	12.0%	54.1%
Maryland	622,000	737,000	686,000	18.5%	10.3%	55.5%
Virginia	757,000	943,000	862,000	24.6%	13.9%	56.3%
North Dakota	43,000	61,000	53,000	42.5%	24.7%	58.1%
Indiana	706,000	895,000	825,000	26.7%	16.8%	62.9%
Kentucky	548,000	649,000	629,000	18.5%	14.8%	79.9%
Oregon	417,000	496,000	483,000	19.0%	15.8%	83.2%
Connecticut	332,000	370,000	369,000	11.4%	11.1%	97.4%
Maine	109,000	139,000	140,000	27.8%	29.0%	104.2%
North Carolina	1,209,000	1,409,000	1,425,000	16.5%	17.9%	108.0%
National	35,310,000	42,326,000	37,701,000	19.9%	6.8%	34.1%

Notes:

1. Enrollment data from https://data.medicaid.gov/.
2. Enrollment values are rounded to the nearest thousand.
3. Percentages are calculated from non-rounded values.
4. Retention rate calculated as (December 2024 enrollment – February 2020 enrollment) ÷ (April 2023 enrollment – February 2020 enrollment).

Several states have implemented policies resulting in additional children retaining coverage following the end of the PHE, some of which are shown in Figure 12 as having retained more than 50% of PHE enrollment growth as of December 2024.

- As previously mentioned, Oregon implemented a Section 1115 demonstration allowing children to be continuously enrolled in Medicaid until their sixth birthday.[52]
- Kansas (2022), Arizona (2024), Maine (2024), and North Dakota (2024) have increased Medicaid/CHIP child income limits.[53]
- Kentucky and North Carolina used Section 1902(e)(14)(A) waiver flexibility to delay children's redeterminations for one year.[54]

Observation 10: H.R. 1 contains several provisions likely to impact Medicaid enrollment and could result in more notable shifts in enrollment levels and future coverage continuity for Medicaid beneficiaries across states.

H.R. 1 introduces several provisions that may reshape the landscape of health insurance markets in 2026 and beyond. These changes, along with other regulatory updates, have the potential to have both direct and indirect impacts on Medicaid enrollment and expenditures. As discussed below, state-level impacts from these changes may vary based on existing state policy and decisions made in the implementation of H.R. 1 provisions.

Medicaid eligibility provisions: There are multiple provisions in H.R. 1 that will impact eligibility processes and likely ultimately Medicaid enrollment and expenditure levels. Major provisions include community engagement requirements (also commonly referred to as "work requirements"), the introduction of cost-sharing requirements for expansion adults with income above 100% FPL, and eligibility redeterminations every six months for expansion adults.[55]

- **Community engagement requirements:** H.R. 1 requires state implementation of community engagement requirements by January 1, 2027 (with delays permissible until January 1, 2029, if the secretary of the Department of Health and Human Services determines that a "good faith" effort is being made toward implementation) for a state's expansion population. The impact of community engagement requirements may vary materially from state to state based on each state's Medicaid population but also based on features of the policy (which may have some state flexibility under H.R. 1). For nonexempt populations, compliance must be determined in the immediate one to three months immediately prior to Medicaid application or redetermination.[56]

  States are permitted to establish ex parte verification methodologies to identify exempt populations or compliant activities that would not require Medicaid consumers to submit additional information. For example, clinical history in encounter data could be used to identify individuals with chronic conditions that would meet the "serious or complex medical condition" exemption. Likewise, wage data[57] could be used to demonstrate that an individual had 80 hours or more of employment during a month. See Figure 13.

52. Oregon Health Authority. (n.d.). Oregon Health Plan (OHP) continuous eligibility. Retrieved July 30, 2025, from https://www.oregon.gov/oha/hsd/ohp/pages/continuous-eligibility.aspx?utm_medium=email&utm_source=govdelivery.

53. Diana, A., Tolbert, J., & Mudumala, A. (October 29, 2024). Medicaid and CHIP eligibility expansions and coverage changes for children since the start of the pandemic. KFF. Retrieved July 30, 2025, from https://www.kff.org/medicaid/issue-brief/medicaid-and-chip-eligibility-expansions-and-coverage-changes-for-children-since-the-start-of-the-pandemic/.

54. Haley, J. M., Allen, E. H., Brooks, T., Kenney, G. M., Gardner, A., Verdeflor, A., & Nelson, T. (October 2024). Improving Medicaid/CHIP redeterminations for children. Urban Institute. Retrieved July 30, 2025, from https://www.urban.org/sites/default/files/2024-10/Improving%20MedicaidCHIP%20Redeterminations%20for%20Children.pdf.

55. KFF. (July 8, 2025). Health provisions in the 2025 federal budget reconciliation bill. Retrieved July 30, 2025, from https://www.kff.org/tracking-the-medicaid-provisions-in-the-2025-budget-bill/.

56. An Act To provide for reconciliation pursuant to title II of H. Con. Res. 14, H.R. 1, 119th Cong. (2025). Section 71119. Retrieved July 29, 2025, from https://www.congress.gov/119/bills/hr1/BILLS-119hr1eas.pdf.

57. Centers for Medicare and Medicaid Services. (November 20, 2024). Financial eligibility verification requirements and flexibilities [CMCS informational bulletin]. Retrieved July 29, 2025, from https://www.medicaid.gov/federal-policy-guidance/downloads/cib11202024.pdf.

FIGURE 13: EXAMPLES OF POPULATION EXEMPTIONS AND COMPLIANCE ACTIVITIES UNDER H.R. 1

POPULATION EXEMPTIONS	COMPLIANCE ACTIVITIES
▪ Non-expansion populations ▪ Inmates of public institutions ▪ Caretakers of children under age 14 or disabled individuals ▪ Native Americans ▪ Disabled veterans ▪ Medically frail individuals, which includes persons meeting any of the following criteria: ▪ Blindness or disability ▪ Substance abuse disorder ▪ Cannot complete one or more activities of daily living because of physical, intellectual, or development disability ▪ Serious or complex medical condition ▪ Participating in a drug addiction or alcoholic treatment program ▪ Pregnant or entitled to postpartum medical assistance	▪ Employment of not less than 80 hours per month ▪ Community service of not less than 80 hours per month ▪ Participating in a work program for not less than 80 hours per month ▪ Enrolled in an educational program at least half-time ▪ Engagement in a combination of the above activities not less than 80 hours per month ▪ Monthly income that is not less than minimum wage multiplied by 80 hours ▪ Qualifies for short-term hardship exemption by meeting one of the following criteria (specific procedures developed by the state): ▪ Receives inpatient or outpatient nursing facility services during the month ▪ Resides in a county where an emergency or disaster has been declared by the president ▪ Resides in a county where the unemployment rate is 1.5 times the national unemployment rate ▪ Must travel outside their community for an extended period of time for medical treatment of a serious or complex condition

The short-term hardship exemption for county unemployment is one example where state Medicaid programs may see disparate impacts. Based on CY 2024 economic data, the national unemployment rate was 4.0%.[58] Based on CY 2024 county-level unemployment rate, 24 states have zero counties where the unemployment rate exceeded 6.0%, which would result in no short-term hardship exemptions. However, three states (Alaska, California, and Kentucky) have more than 15% of their unemployed population residing in counties eligible for this short-term hardship exemption.[59]

- **Cost-sharing requirements for the expansion population with income between 100% and 138% FPL:**[60] Effective October 1, 2028, states must implement cost-sharing provisions for expansion population members with income between 100% and 138% FPL. Copays for individual services can be up to $35, but cannot be imposed on primary care, behavioral health, or clinic services. Per Section 1916A(c)(2) of the Social Security Act, prescription drug copays cannot exceed nominal cost sharing[61] for individuals with family incomes at or below 150% of the FPL, or 20% of the drug's cost for those with incomes above 150% of the FPL. In addition, cost-sharing payments for all applicable family members cannot exceed 5% of the family's monthly or quarterly income. As with commercial insurance, the design of copayment requirements is likely to come with some state flexibility.

58. United States Bureau of Labor Statistics. (March 5, 2025). Unemployment rates for states, 2024 annual averages. Retrieved July 30, 2025, from https://www.bls.gov/lau/lastrk24.htm.

59. For a more current county-level unemployment map, please see United States Bureau of Labor Statistics. (n.d.). Unemployment rates by county, July 2024-June 2025 averages. Retrieved July 30, 2025, from https://www.bls.gov/web/metro/twmcort.pdf.

60. An act to provide for reconciliation pursuant to title II of H. Con. Res. 14, H.R. 1, 119th Cong. (2025). Section 71120. Retrieved July 29, 2025, from https://www.congress.gov/119/bills/hr1/BILLS-119hr1eas.pdf.

61. Medicaid and CHIP Payment and Access Commission. (November 2017). Federal requirements and state options: Premiums and cost sharing. Retrieved July 30, 2025, from https://www.macpac.gov/wp-content/uploads/2017/11/Federal-Requirements-and-State-Options-Premiums-and-Cost-Sharing.pdf.

- **Expansion population redetermination every six months:** Effective January 1, 2027, state Medicaid agencies must redetermine eligibility for expansion population members every six months.[62] The impact of this provision on states is likely to differ based on existing eligibility verification practices. While Medicaid redetermination is typically required only every 12 months, a person can lose Medicaid eligibility if they experience a "change in circumstances" that would result in them no longer being Medicaid eligible (e.g., additional income from a new job). As of 2020, 30 states performed quarterly checks on wage data and other sources to identify potential changes in circumstances.[63] If a state is already performing activities such as regular data verification, the impact of this six-month redetermination provision is likely to be less than for a state that is not performing such activities.

Provider tax cap: Historically, states have been permitted to use healthcare-related taxes to finance the nonfederal share of Medicaid costs to the extent the tax is considered broad-based and uniform and does not hold taxpayers harmless.[64] Prior to H.R. 1, state provider taxes that hold taxpayers harmless from taxes were permissible to the extent that the tax did not exceed 6% of net patient revenue.[65] For expansion states, H.R. 1 reduces provider taxes from a maximum of 6.0% to 3.5%, with 0.5 percentage point reductions per year starting in federal fiscal year 2028. This new provider tax cap will have varying impacts across expansion states. North Carolina funds its Medicaid expansion entirely through provider taxes,[66] generating sufficient revenue at the current 6% cap to cover its 10% share of expansion costs; a reduction in the cap may jeopardize this funding model.[67] If North Carolina is unable to generate enough revenue from provider taxes under the new, lower cap, it could be forced to terminate the expansion or seek alternative funding sources to maintain coverage for the expansion population.

Periodic data matching: As discussed under observation 7, while not a provision of H.R. 1, the resumption of periodic data matching in the federal marketplace during 2025 is likely to result in a considerable number of individuals having either marketplace or Medicaid coverage terminated. For individuals dropping marketplace coverage, Medicaid will become the primary source of insurance coverage. This will impact the average cost for healthcare services covered by Medicaid, as qualified health plan coverage in the individual market will no longer be the primary payer. With 1.6 million Americans potentially having duplicate coverage,[68] Medicaid health plans and state Medicaid agencies should closely monitor this issue during 2025. To the extent this is a significant issue in a state, state agencies should also review the identification of third-party liability (TPL) coverage in their eligibility system and the degree to which TPL payments are appropriately administered.

62. An act to provide for reconciliation pursuant to title II of H. Con. Res. 14, H.R. 1, 119th Cong. (2025). Section 71107. Retrieved July 29, 2025, from https://www.congress.gov/119/bills/hr1/BILLS-119hr1eas.pdf.

63. Medicaid and CHIP Payment and Access Commission. (October 2021). An updated look at rates of churn and continuous coverage in Medicaid and CHIP. Retrieved July 30, 2025, from https://www.macpac.gov/wp-content/uploads/2021/10/An-Updated-Look-at-Rates-of-Churn-and-Continuous-Coverage-in-Medicaid-and-CHIP.pdf.

64. Medicaid and CHIP Payment and Access Commission. (May 2021). Health care-related taxes in Medicaid. Retrieved July 30, 2025, from https://www.macpac.gov/wp-content/uploads/2020/01/Health-Care-Related-Taxes-in-Medicaid.pdf.

65. Ibid.

66. Burns, A., Hinton, E., Williams, E., & Rudowitz, R. (March 26, 2025). 5 key facts about Medicaid and provider taxes. KFF. Retrieved July 30, 2025, from https://www.kff.org/medicaid/issue-brief/5-key-facts-about-medicaid-and-provider-taxes/.

67. Senate proposed Medicaid policy: Fiscal impact on North Carolina. (n.d.). Office of Senator Thom Tillis. Retrieved July 30, 2025, from https://www.tillis.senate.gov/services/files/41E71724-D0FE-43B7-98C0-0E7821013421.

68. Centers for Medicare and Medicaid Services. (July 17, 2025). CMS finds 2.8 million Americans potentially enrolled in two or more Medicaid/ACA exchange plans. Retrieved July 30, 2025, from https://www.cms.gov/newsroom/press-releases/cms-finds-28-million-americans-potentially-enrolled-two-or-more-medicaid/aca-exchange-plans.

Individual market affordability: As discussed in detail in observation 7, if enhanced premium tax credits expire as scheduled at the end of 2025, the out-of-pocket premium requirements for marketplace consumers will increase materially,[69] with the availability of marketplace plans with zero out-of-pocket premium significantly shrinking. In addition, potential changes in income verification and a requirement to repay the full amount of any excess APTC received will also likely increase out-of-pocket premium requirements. Given that individual market coverage may become considerably more expensive in 2026, Medicaid enrollment will also become incrementally more financially attractive to low-income households relative to marketplace coverage and available premium assistance. For example, it is possible that consumers currently enrolled in a zero-premium qualified health plan (QHP) that has reduced cost sharing may not question whether they are alternatively eligible for Medicaid coverage. However, if QHP coverage now requires a monthly premium payment, that perspective may change.

Limitations

The analyses presented in this research paper have relied on data and other information related to Medicaid and insurance marketplace enrollment and subsidy data obtained from publicly available federal government data. The data and other information have not been audited or verified, but a limited review was performed for reasonableness and consistency. If the underlying data or information is inaccurate or incomplete, the results of this analysis may likewise be inaccurate or incomplete.

The views expressed in this report are made by the authors of this report and do not represent the collective opinions of Milliman. Other Milliman consultants may hold different views and reach different conclusions.

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Qualifications

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. Paul Houchens is a member of the American Academy of Actuaries and meets the qualification standards for performing the analyses in this report.

69. Hempstead, K., & Valeta, M. (April 15, 2025). Marketplace pulse: What if enhanced premium tax credits expire in 2026? Robert Wood Johnson Foundation. Retrieved July 30, 2025, from https://www.rwjf.org/en/insights/our-research/2025/04/marketplace-pulse-what-if-enhanced-premium-tax-credits-expire-in-2026.html.

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