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Medicaid Changes in the OBBBA and Implications for the Marketplace and Individual Market in 2027

Written By
Lina Rashid
Michael Cohen
Zachary Sherman

INTRODUCTION

In recent years, the individual market has undergone significant disruption. The expiration of enhanced premium tax credits (ePTC) at the end of 2025 and sweeping eligibility changes under the 2025 Budget Reconciliation Act (OBBBA) have reshaped—and will continue to reshape—the individual market.

The number of changes facing states and issuers in coming years are significant. As a result, it is unsurprising that discussion and analysis on the individual market impacts of the new Medicaid requirements is limited and expected to result in large numbers of Medicaid beneficiaries being disenrolled. Between community engagement requirements (i.e., work requirements), increases in eligibility checks, and loss of eligibility for certain immigrant population, the expectation is that millions of people will leave Medicaid in 2027.[1]

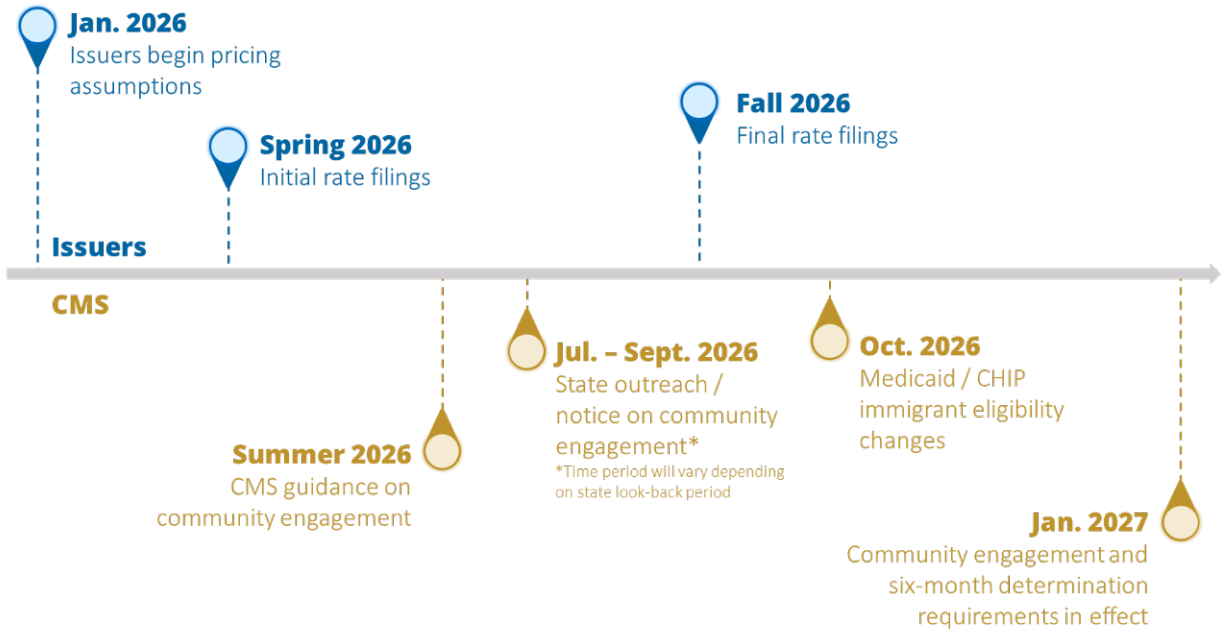
This brief explores how these coming changes will reshape coverage pathways and costs, and examines implications for consumer affordability and churn, issuer pricing and risk pools, and state administrative burdens—alongside strategies for states, issuers, and policymakers to mitigate adverse effects.

KEY FEDERAL CHANGES IN OBBBA

The 2025 Budget Reconciliation Act (OBBBA) tightens eligibility at every stage—entry (who can enroll), affordability (who can pay), and maintenance (who stays covered with redeterminations)—increasing financial strain for consumers and operational complexity for states. It narrows immigrant eligibility for Medicaid/Children's Health Insurance Program (CHIP) and Marketplace subsidies and introduces a new interaction between Medicaid community engagement requirements and advance premium tax credits (APTC)/CSR (cost-sharing reductions) eligibility, creating a coverage gap for individuals without affordable options. While Center for Medicare & Medicaid Services (CMS) plans to issue rulemaking on community engagement requirements in summer of 2026, issuers will begin pricing for 2027 as early as January 2026 and state planning is already underway. Key federal changes are detailed below and key timeline considerations for issuers and states are noted in **Figure 1**.

[1] Congressional Budget Office. Information Concerning Medicaid-Related Provisions in Title IV of H.R. 1. June 24, 2025. Available at: https://www.cbo.gov/publication/61510.

Figure 1. Issuer and State Planning Milestones for 2026–2027



MEDICAID COMMUNITY ENGAGEMENT REQUIREMENTS

Effective January 1, 2027, the OBBBA will require community engagement requirements which are employment/participation conditions for certain adult eligibility groups—specifically non-pregnant, non-Medicare adults in the Medicaid expansion population (under 138% FPL). In addition to the normal income requirements, states will need to verify that individuals applying for or renewing coverage for Medicaid have completed one or more activities to total 80 hours a month which includes: work, community service, a work program, or an educational program at least half-time. The requirement will also apply to certain individuals in states who gained Medicaid coverage through a section 1115 waiver demonstration program that provides expansion-like coverage.

CMS issued guidance outlining how states should implement these requirements, as well as the timeline for implementing them. States will have some flexibility on the number of consecutive months an individual must meet the community engagement requirements at the time of application for coverage to qualify for Medicaid, known as the look-back period (e.g., one, two, or three consecutive months preceding the application). The look-back period will vary by state and impact how difficult it will be for consumers to meet work requirements. States will need to start reaching out to consumers at least three months earlier than their chosen look-back

period, which means some states may be reaching out to consumers as early as July 2026. For example:

- A 1-month look-back period requires outreach to begin four months before implementation (September 2026)
- A 2-month look-back period requires outreach to begin five months before implementation (August 2026)
- A 3-month look-back period requires outreach to begin five months before implementation (July 2026)

Some states are also considering earlier implementation of this requirement.[2] States also may apply for short-term "good faith" effort toward compliance and may request additional time, but if allowed, the good faith exemption will only run until December 31, 2028, and will require additional reporting to CMS.

It is important to note that individuals who lose coverage due to community engagement requirements are **barred from receiving Marketplace subsidies**, in the form of APTCs and CSRs. Beginning January 1, 2027, individuals who lose or are denied Medicaid solely for failing to meet community engagement requirements will not be eligible for Marketplace APTCs or CSRs. This represents a departure from the norm, under which Medicaid ineligibility is a key factor of Marketplace subsidy eligibility. The nuance at issue is that the consumer denied Medicaid due to work requirements is considered by the Marketplace to have access to affordable coverage, thereby rendering the individual ineligible for Marketplace subsidy. Marketplaces must reflect this restriction when making subsidy eligibility determinations.

Questions remain about CMS's expectations for implementing this restriction. For example, loss of minimum essential coverage (MEC) special enrollment period (SEP) requires a consumer to have coverage for at least one day in the past 60 days; if a consumer had a change in circumstance (exp: change in income) but was barred from APTC because of work requirements. Would the loss of minimum essential coverage SEP be denied because the consumer was not enrolled in Medicaid? If so, this could limit consumer's ability to enroll in coverage. Consequently, the expectation is that even if work requirements do have a significant effect on Medicaid enrollment, those losing coverage will not have an affordable option through the Marketplaces and as such are unlikely to have significant effects on the individual market.

[2] Low Income Relief. Medicaid Work Requirements Starting Soon in These States. July 14, 2025. Available at: https://lowincomerelief.com/medicaid-work-requirements-starting-soon-in-these-states/.

NARROWER "QUALIFIED NON-CITIZEN" DEFINITION FOR MEDICAID/CHIP

Effective October 1, 2026, OBBBA narrows the categories of immigrants eligible for federally funded Medicaid/CHIP, excluding refugees, asylees, certain humanitarian parolees, trafficking survivors, and abused spouses/children from future Medicaid/CHIP eligibility. Immigrants who remain eligible include US citizens, lawful permanent residents (LPRs), Cuban/Haitian entrants, and citizens of Compact of Free Association (COFA) nations.[3] Before this change, many lawfully present immigrants in the listed humanitarian categories were eligible for Medicaid/CHIP under long-standing federal rules (with some subject to a five-year waiting period), and states could elect options to cover children and pregnant individuals sooner.[4] Additionally, those subject to the five-year bar because of their immigration status and denied Medicaid as a result have historically been eligible for APTC/CSR.

As of January 1, 2026, the OBBBA changed APTC eligibility for lawfully present immigrants subject to the five-year bar who no longer qualify for APTC. Beginning in 2027, OBBBA limits APTC eligibility to a similar set of immigrants that are simultaneously losing Medicaid eligibility. Consequently, lawfully present immigrants losing Medicaid due to OBBBA eligibility changes will not have an affordable option through the Marketplaces and as such are not expected to directly affect the individual market.

[3] Global Refuge. One Big Beautiful Bill Act (OBBBA) Frequently Asked Questions on Health Care. July 2025. Available at: https://www.globalrefuge.org/wp-content/uploads/2025/07/OBBBA-FAQ-on-health-care.pdf.

[4] Pillai A, Tolbert J, Artiga S, Rudowitz R. How States Verify Citizenship and Immigration Status in Medicaid. KFF. April 16, 2025. Available at: https://www.kff.org/immigrant-health/how-states-verify-citizenship-and-immigration-status-in-medicaid/.

SIX-MONTH REDETERMINATION

Beginning in 2027, the OBBBA requires states to conduct eligibility checks for Medicaid expansion adults at least every six months, replacing the current 12-month renewal and redetermination process. This policy aims to ensure ongoing compliance with Medicaid eligibility criteria but introduces significant administrative complexity for states and consumers, and potential coverage disruptions for consumers. Certain populations are exempt from this requirement, including pregnant individuals, people enrolled based on disability, children and youth under age 19, Medicare beneficiaries (dual eligibles), long-term care residents, individuals in foster care or former foster youth up to age 26, those receiving hospice care, and individuals deemed medically frail. Enrollees who are disenrolled because of the increased redetermination process may be eligible for Marketplace subsidies, if they are no longer Medicaid eligible and otherwise qualify for Marketplace coverage and financial assistance. Consequently, **this provision has the potential to more directly impact the individual market**.

Table 1 summarizes the provisions, the impacted populations, their options through the Marketplaces and the effect these provisions could have on the individual market.

Table 1. New Medicaid Eligibility Changes and Marketplace APTC Eligibility

OBBBA Provision	Population	Marketplace Options	Ind. Market Impact
Medicaid Community Engagement Requirements	Able-bodied adults categorically eligible for Medicaid	Eligible for coverage, **not eligible** for subsidies	Minimal
Removal of Eligibility for Certain Legal Immigrants	Refugees, asylees, certain humanitarian parolees, trafficking survivors, and abused spouses/children	Eligible for coverage, **not eligible** for subsidies	Minimal
Six-month Eligibility Checks	Medicaid expansion adults	Eligible for coverage and subsidies (if otherwise qualified)	Material

IMPACTS ON THE INDIVIDUAL MARKET

Below we highlight the impacts to issuers and states with respect to the individual market and opportunities to mitigate decreases in coverage and affordability. For context on the overall impact, the Congressional Budget Office (CBO) estimates that by 2034, 4.8 million able-bodied adults will become uninsured as the result of not meeting community engagement requirements, 2.2 million individuals will become uninsured because of Medicaid expansion eligibility redeterminations every six months (instead of typically 12 months), and 1.4 million will become uninsured because of the change in immigrant eligibility provisions.[5] The number of individuals exiting the Medicaid program will be larger than the total number of those becoming uninsured as some beneficiaries will gain coverage elsewhere.[6] In sum 2027 could see incredibly high number of individuals churning through different types of coverage as well as experiencing large spells of being uninsured. Data from 2012 show that the typical Medicaid enrollee is covered for less than 10 months, and 10 percent lose and regain coverage within 12 months.[7] While not discussed in this paper, over time these effects could have material effects on providers (especially those who serve lower income residents) and consumers (i.e., ability to manage chronic conditions).

ISSUER CONSIDERATIONS

The combination of key statutory Medicaid changes embedded in OBBBA, and uncertainty regarding implementation, may result in higher premium rates in the Individual Affordable Care Act (ACA) market in 2027 and beyond. For example:

- The Individual ACA risk pool could deteriorate to the extent sicker and older consumers churn into Individual ACA coverage. This would result in an increase to premium rates in 2027 and beyond. This could exacerbate the risk pool in future years as consumers react to continued upward premium rate pressure.

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

[6] Gore D. The CBO Breakdown on Medicaid Losses, Increase in Uninsured. FactCheck. July 11, 2025. Available at: https://www.factcheck.org/2025/07/the-cbo-breakdown-on-medicaid-losses-increase-in-uninsured/.

[7] Ku L, Steinmetz E, Bysshe T. Medicaid Should Be Coverage We Can Count On. Available at: https://www.communityplans.net/Portals/0/Policy/Medicaid/GW_ContinuityInAnEraOfTransition_11-01-15.pdf; The Commonwealth Fund. Reducing Medicaid Churn: Policies to Promote Stable Health Coverage and Access to Care. Available at: https://www.commonwealthfund.org/publications/issue-briefs/2025/jun/reducing-medicaid-churn-policies-promote-stable-health-coverage.

- Issuers may need to invest additional resources which would lead to higher operating costs and ultimately higher premium rates. For example:
    - Managing healthcare results for a population with significant churn.
    - Maintaining continuity of care for members when moving between lines of business.
    - Assisting with consumer outreach on eligibility and those not actually eligible for coverage.
    - Educating brokers on changes to prevent enrollment inconsistencies.
    - Training staff and call center representatives to provide correct and clear guidance to consumers.
- In general, in an environment of uncertainty, issuers may choose to be more conservative when selecting rating assumptions leading to higher premium rates.

The enrollment, risk, and premium impacts described above may not be felt equally across states. Recent experience with Medicaid unwinding provides us with recent information about how Medicaid to Marketplace enrollment activity can vary across states. The number of individuals who lost Medicaid and are enrolling in a QHP has improved over time with interventions. In 2018, prior to the enhanced subsidies, only 3 percent[8] of people who lost Medicaid successfully transitioned to the Marketplace. However, 85 percent of individuals who lost Medicaid or CHIP coverage in April 2023 had their accounts transferred by their state Medicaid agency to HealthCare.gov, of which 11 percent applied for Marketplace coverage, and a mere 7 percent ultimately selecting a plan.[9]

[8] Walsh-Alker E. Unpacking the Unwinding: Medicaid to Marketplace Coverage Transitions. Georgetown University McCourt School of Public Policy. September 18, 2024. Available at: https://ccf.georgetown.edu/2024/09/18/unpacking-the-unwinding-medicaid-to-marketplace-coverage-transitions/#:~:text=In%20May%202023%20California%20launched,premium%20tax%20credits%20have%20enrolled.

[9] Center on Budget and Policy Priorities. Unwinding Watch: Tracking Medicaid Coverage as Pandemic Protections End. January 7, 2025. Available at: https://www.cbpp.org/research/health/unwinding-watch-tracking-medicaid-coverage-as-pandemic-protections-end?item=28533.

Some states will implement more robust redetermination processes than others, leading to a clearer environment for consumers, regulators, and issuers. Variation in disenrollment and Marketplace uptake is likely, as seen during Medicaid unwinding. For example, disenrollment ranged from 57 percent in Montana to 12 percent in North Carolina, with differences driven by state policy choices and interventions.[10]

Additionally, some states may respond to the policy environment with interventions to mitigate coverage loss. For example, during Medicaid redetermination, Covered California used an "opt-in" auto-enrollment approach, resulting in 33 percent of eligible individuals effectuating coverage. Rhode Island adopted an "opt-out" model, giving consumers 60 days to switch plans and covering the first two months of premiums, leading to 25 percent enrollment among terminated Medicaid members and 50 percent uptake among those eligible for tax credits. While outcomes vary by state, these examples illustrate how targeted interventions can significantly influence enrollment.

In addition, there are also differences states may experience depending on whether a state has expanded Medicaid and/or has their own Marketplace. States that expanded Medicaid will be impacted differently than those that did not. On average, disenrollment during unwinding among non-expansion states was 40 percent, while disenrollment in Medicaid expansion states was 30 percent.[11] States operating State-Based Marketplaces (SBMs) will be impacted differently than those participating in the Federally Facilitated Marketplace (FFM). SBMs experienced about 20 percent enrollment into Qualified Health Plans (QHPs)/Basic Health Programs (BHPs), with about 11 percent going into QHPs from Medicaid terminations during unwinding. Conversely, the FFM saw about 13 percent transition to QHPs.[12] Moving forward, states heavily impacted by the Medicaid redetermination unwinding in 2023 and 2024 may feel prospective impacts differently depending on the enrollment impacts the state experienced.

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[10] KFF. Medicaid Enrollment and Unwinding Tracker. January 5, 2026. Available at: https://www.kff.org/medicaid/medicaid-enrollment-and-unwinding-tracker/#8815e057-6ee9-4945-8ca1-705913d143b8.

[11] KFF. Medicaid Enrollment and Unwinding Tracker. January 5, 2026. Available at: https://www.kff.org/medicaid/medicaid-enrollment-and-unwinding-tracker/.

[12] Data.Medicaid. State-Based Marketplace (SBM) Medicaid Unwinding Report. Available at: https://data.medicaid.gov/dataset/5670e72c-e44e-4282-ab67-4ebebaba3cbd/data.

Issuers should implement strategies that lead to more informed pricing decisions and flexibility in the future. Issuers offering Medicaid and Marketplace plans in the same market should be coordinating to understand the potential enrollment and risk impact of the population that will be churning between lines of business. Additionally, issuers could invest in resources to more accurately capture reasons for enrollment and disenrollment and communicate key data across stakeholders. This would make monitoring the risk of this type of population easier going forward.

IMPACTS ON STATES/MARKETPLACES

Higher Uninsured Rates and Higher Premiums

As noted above, the Medicaid changes in OBBBA are expected to result in considerable coverage losses. Some of the individuals losing Medicaid may be able to access affordable coverage through the Marketplaces. Some may be eligible for Marketplace subsidies, but unable to afford the premium and will forgo coverage. Some may be confused, unaware of their coverage and financial assistance options through the Marketplace and will slip through the cracks. Some will fall into a coverage gap and will not have affordable options. Given these dynamics, the potential for uncertainty in 2027, coupled other complexity in 2026 due to the expiring subsidies, is high and could lead to a further deterioration of the individual risk pool and in turn, premium increases. This could cause further enrollment losses and worsen risk pool morbidity.

Potential Mitigations

States could take proactive steps to minimize coverage losses and protect the stability of the individual market. Examples include:

- *Bridge programs/premium wraps:* States may consider temporary subsidies or premium assistance to maintain coverage for individuals who have lost Medicaid eligibility to purchase coverage in the Marketplace. For consumers ineligible for APTC, consumers may want to consider off-Marketplace plans without CSR loading if offered,[13] which may offer lower premiums. For some unsubsidized consumers, catastrophic plans may offer the lowest premium coverage to protect against catastrophic health events.

[13] Department of Health & Human Services. Centers for Medicare & Medicaid Services. Offering of plans that are not QHPs without CSR "loading." Available at: https://www.cms.gov/cciio/resources/regulations-and-guidance/downloads/offering-plans-not-qhps-without-csr-loading.pdf.

- *Outreach and Education:* States may partner and scale community based, multilingual campaigns, and assister programs to reach vulnerable populations; trusted messengers (FQHCs, CBOs, faith groups) will also remain important to educate consumers (particularly limited-English proficiency consumers) on the new requirements, timing of changes, and subsidy consequences.
- *Effective Rate Review:* Effective rate review helps keep premiums affordable by ensuring carrier assumptions are reasonable and aligned with market dynamics—supporting enrollment retention and reducing the risk of coverage loss. States may want to collect additional information on assumptions related to enrollment and morbidity impacts specific to these APTC and eligibility changes.

Increased Administrative Costs

States will face higher operational burdens, including system upgrades, staffing, and outreach to manage the Medicaid and Marketplaces changes and the resulting enrollment churn. For example, Marketplaces will need to revise application questions, eligibility systems, minimum essential coverage (MEC) checks, and account transfer processes to reflect that consumers terminated for work noncompliance are ineligible for APTC. This may increase notice costs, call center volume, assister outreach appeals, and re-enrollment processing, especially during initial implementation and subsequent redetermination cycles.

Potential Mitigations

States could take proactive steps to design affordability initiatives and improve procedures and coordinate to minimize coverage losses and better utilize resources. Examples include:

- *Lessons from Medicaid Unwinding:* States can replicate successful strategies from the Medicaid unwinding period, such as matching consumers to zero-premium plans, auto-enrolling eligible populations, and waiving CHIP premiums or enrollment fees.[14]

[14] Unwinding Should Be A Call to Action To Fix Fragmented System. Available at: https://www.healthaffairs.org/content/forefront/unwinding-should-call-action-fix-fragmented-system; Connecting to Coverage Coalition. Medicaid: Looking Beyond the Unwinding. Available at: https://medicaidplans.org/wp-content/uploads/2024/06/MHPA-CCC-Policy-Recommendations-06122024.pdf.

- *Improve Data Integration:* As state Medicaid agencies develop processes to match income and work requirements, there could be opportunities to jointly leverage data sources with the Marketplace to reduce enrollment loss from data matching issues. Integrated eligibility systems make this easier, but all state Medicaid agencies and Marketplaces could leverage shared resources and potentially decrease administrative burden.
- *Cost Allocation:* Updating cost allocation plans to reflect joint services and data use may also be necessary and appropriate to ensure Exchanges receive federal funding for Medicaid related activities such as shared technology, customer service operations and outreach.
- *Preventing Procedural Denials*: States can reduce avoidable terminations by adopting interventions used during Medicaid unwinding. Nearly 70 percent of disenrollments then were due to procedural issues.[15] Some SBMs use targeted data matching, prepopulated forms, and SMS reminders to keep consumers covered. As discussed above, states can also consider opt-in or opt-out strategies to move Medicaid ineligible consumers to Marketplace coverage.

CONCLUSION

OBBBA will significantly reshape the eligibility landscape for low-income adults and lawfully present immigrants, concurrently tightening Medicaid access and removing Marketplace affordability pathways (APTC/CSR) for targeted groups. The result will be higher churn, greater consumer confusion, premium pressure from deteriorating risk pools, and elevated administrative costs for issuers and states. Proactive strategies—data driven monitoring, multilingual outreach, procedural denial prevention, Medicaid–Marketplace coordination, and market stabilization measures—will be essential to protecting consumers, moderating pricing volatility, and sustaining market participation among carriers.

ACKNOWLEDGMENTS

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[15] Tolbert J, Corallo B. An Examination of Medicaid Renewal Outcomes and Enrollment Changes at the End of the Unwinding. KFF. September 18, 2024. Available at: https://www.kff.org/medicaid/an-examination-of-medicaid-renewal-outcomes-and-enrollment-changes-at-the-end-of-the-unwinding/.

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