The Marketplace Fallback Problem

Coverage Transitions When Work Requirements Fail

Latisha's Story

Latisha reviews her options on healthcare.gov for the third time, hoping the numbers will somehow change. Three weeks ago, she lost Medicaid coverage after missing a work verification deadline during her daughter's hospitalization. She had been working her usual 30 hours at the nursing home, but the chaos of caring for a sick child meant the verification documents sat unopened on the kitchen counter. Now she faces a coverage gap of her own.

The marketplace calculator shows a silver plan at $485 per month before subsidies. With premium tax credits, the same plan would cost $65 monthly, manageable if not easy. But the termination notice included language she did not fully understand at the time: because her coverage ended due to work requirement non-compliance, she is ineligible for premium tax credits. The $485 figure is not a starting point for subsidy calculation. It is the actual monthly cost.

At $26,000 annual income, $485 monthly means $5,820 in annual premiums before she sees any benefit from a plan with a $6,000 deductible. She would spend nearly half her gross income on healthcare premiums and out-of-pocket costs before insurance covered anything beyond preventive care. Her blood pressure medication costs $180 monthly without insurance. The nursing home does not offer health coverage for part-time workers.

Latisha closes the browser window. The marketplace technically offers her coverage. Functionally, it offers nothing at all. She will join the ranks of the uninsured, rationing her medication, skipping the follow-up appointment for the symptoms that have been worrying her, hoping nothing serious happens before she can figure out how to restart the Medicaid application process. Her daughter recovered. Latisha may not be so fortunate.

The marketplace was supposed to be the bridge. For Latisha and millions like her, the bridge leads nowhere.

The Architecture of Coverage Transitions

American healthcare coverage operates through multiple overlapping programs, each with distinct eligibility rules, cost structures, and administrative requirements. Medicaid covers people with very low incomes through a joint federal-state program with minimal cost-sharing. The ACA marketplace provides subsidized private insurance for people with moderate incomes who lack employer coverage. Employer-sponsored insurance remains the dominant coverage source for working-age adults with stable employment. Medicare serves the elderly and disabled. The uninsured fill the gaps.

These programs interact through coverage transitions. A worker whose income rises above Medicaid limits can transition to subsidized marketplace coverage. Someone losing employer coverage can enroll in a marketplace plan during a special enrollment period. The system, while fragmented, maintains pathways between coverage types that prevent most transitions from resulting in complete coverage loss.

Work requirements under OB3 / HR1 fundamentally disrupt this architecture. Section 71119 specifies that individuals who lose Medicaid eligibility due to failure to meet community

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engagement requirements are ineligible for premium tax credits. This provision closes the marketplace escape hatch for the 18.5 million expansion adults subject to work requirements beginning December 2026.

The policy rationale is straightforward: if work requirements are meant to incentivize employment, allowing non-compliant individuals to simply shift to subsidized marketplace coverage would undermine that incentive. Someone unwilling to work 80 hours monthly for Medicaid should not receive federal subsidies through an alternative program. The consequence reinforces the behavioral objective.

This rationale assumes coverage loss reflects behavioral failure rather than administrative dysfunction. Arkansas's 2018-2019 implementation found that most people who lost coverage were working or qualified for exemptions but could not document compliance. They failed to prove, not to achieve. For these individuals, ***the premium tax credit exclusion punishes verification failure with the same severity as deliberate non-compliance.***

The timing compounds the problem. Enhanced premium tax credits expired December 31, 2025, increasing average marketplace premium payments by 114%. Work requirements activate December 2026. The marketplace that might have served as a soft landing for Medicaid coverage losses becomes economically inaccessible precisely when coverage losses surge.

The December 2025 Convergence

The coverage landscape changed fundamentally when enhanced premium tax credits expired. These subsidies, originally enacted through the American Rescue Plan and extended through the Inflation Reduction Act, had more than doubled marketplace enrollment from approximately 11 million in 2020 to over 24 million by 2025. Nearly all marketplace enrollees, 93%, received premium tax credits that made coverage affordable.

The expiration hit hardest at the income margins closest to Medicaid eligibility. People with incomes between 100% and 150% of the federal poverty level had been eligible for zero-dollar benchmark silver plans. Without enhanced subsidies, these same individuals now face meaningful premium contributions for the first time. KFF analysis estimated average premium payments would more than double, rising from $888 to $1,904 annually. For individuals at higher incomes, increases were more severe.

Urban Institute projections estimated 7.3 million people would lose ACA coverage in 2026 due to enhanced subsidy expiration, with 4.8 million becoming uninsured. This represents baseline coverage loss before work requirements even begin. The marketplace shrinks, premiums rise as healthier enrollees exit, and the remaining risk pool becomes more expensive to insure. This destabilized marketplace is what awaits Medicaid members who lose coverage through work requirement non-compliance.

OB3 / HR1 introduced additional marketplace restrictions beyond the premium tax credit exclusion. The low-income special enrollment period that had allowed people below 150% FPL to enroll year-round was eliminated. Automatic re-enrollment was discontinued, requiring all enrollees to actively reapply annually. Documentation requirements were enhanced, with 75% of special enrollment applications requiring verification. Open enrollment was shortened to November 1 through December 15 in most states.

These changes collectively make marketplace enrollment more difficult, more expensive, and more administratively burdensome. The bridge between coverage programs narrows from both directions simultaneously.

The Affordability Gap

The economic reality of marketplace coverage without subsidies illuminates why the premium tax credit exclusion creates effective coverage denial rather than coverage alternatives. Medicaid expansion adults have incomes below 138% of the federal poverty level, approximately $20,800 annually for an individual in 2026. At these income levels, unsubsidized marketplace premiums consume economically impossible shares of household budgets.

A 40-year-old individual at 138% FPL seeking marketplace coverage without premium tax credits faces benchmark silver plan premiums averaging $500-650 monthly depending on geography. Annual premiums of $6,000-7,800 represent 30-40% of gross income before any healthcare is actually received. Bronze plans reduce premiums to $400-500 monthly but increase deductibles to $7,000-9,000, meaning the individual pays $12,000-15,000 in premiums plus deductibles before insurance covers non-preventive services.

No rational economic actor makes this choice. The coverage is nominally available but functionally inaccessible. Insurance that costs more than half of gross income is not insurance in any meaningful sense. It is an accounting entry that serves no practical purpose for the people it theoretically covers.

The affordability gap also affects care access even for those who somehow maintain coverage. Medicaid expansion adults typically face minimal cost-sharing, often $1-4 copays for prescriptions and office visits, with no deductibles in most states. Marketplace bronze plans with $7,000 deductibles require enrollees to pay thousands out-of-pocket before coverage applies to most services. Someone managing diabetes or hypertension on Medicaid faces radically different economics on marketplace coverage, even if premium costs were identical.

Who Falls and Where They Land

The population subject to premium tax credit exclusion includes everyone who loses Medicaid coverage with documented work requirement non-compliance as the termination reason. This population will not reflect random sampling of expansion adults. Administrative research consistently shows that coverage losses concentrate among populations with specific characteristics: unstable employment patterns, limited administrative capacity, complex health needs, and barriers to system navigation.

People with steady full-time employment at a single employer who provides verification documentation will maintain coverage. ***People working multiple part-time jobs, gig economy positions, or informal employment arrangements face verification challenges that produce documentation failure regardless of actual work status.*** The staffing agency that does not track individual worker hours creates the same outcome as genuine non-compliance.

Cognitive and mental health conditions that affect executive function, including depression, anxiety, ADHD, and trauma responses, make administrative compliance more difficult. The person who cannot organize paperwork, remember deadlines, or navigate complex systems faces work requirement failure not because they refuse to work but because their conditions make documentation burdensome in ways the system does not accommodate.

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Limited English proficiency creates barriers at every step: understanding requirements, communicating with employers about verification, reading and responding to state notices, navigating appeals processes. The verification system assumes administrative sophistication that many Medicaid members do not possess.

Geographic patterns will emerge. Rural areas with limited broadband access face barriers to online verification systems. Areas with high concentrations of gig and informal employment have fewer employers who provide traditional verification documentation. Regions with limited navigation infrastructure leave members without assistance completing verification requirements.

CBO projections suggest work requirements will reduce Medicaid enrollment by 8-10 million over the decade following implementation. Brookings analysis of Arkansas-style requirements projected 34% long-run enrollment reduction. Applied to 18.5 million expansion adults, this suggests 6-7 million coverage losses, most through pathways that trigger premium tax credit exclusion.

The Coverage Pathway Architecture

Understanding why the marketplace fallback fails requires examining the coverage pathway architecture that OB3 / HR1 disrupts. Before work requirements, individuals losing Medicaid eligibility had multiple potential destinations depending on their circumstances.

Income increases above 138% FPL triggered transition to subsidized marketplace coverage. The member remained in the healthcare system, often with the same insurer offering both Medicaid and marketplace plans. Provider networks might differ, but coverage continuity was maintained. Premium tax credits ensured affordability scaled with income, preventing coverage gaps at the eligibility boundary.

Life events like marriage, new employment, or turning 26 created special enrollment periods allowing marketplace entry outside annual open enrollment. Job loss could trigger COBRA coverage or marketplace enrollment. Having a child or losing dependent status opened enrollment windows. The system, while complex, maintained pathways that prevented most transitions from resulting in uninsurance.

Work requirement non-compliance creates a different pathway: direct to uninsurance with no affordable alternatives. The member does not qualify for Medicaid, cannot afford marketplace coverage without subsidies, and faces no special enrollment trigger that would make marketplace enrollment financially viable. The pathway terminates in coverage loss, not coverage transition.

The asymmetry matters for system design***. A coverage system that assumes all pathways lead to some coverage type can invest in smooth transitions, maintaining care relationships and preventing gaps.*** A coverage system where some pathways terminate in uninsurance must either prevent those pathways entirely or accept that some population will fall outside the system completely.

States designing work requirement systems face this architectural choice. They can invest heavily in preventing non-compliance terminations through navigation, verification assistance, and exemption support. Or they can accept that a predictable fraction of members will lose coverage with no viable alternative. The premium tax credit exclusion ensures this is a binary choice rather than a continuum.

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The MCO Strategic Calculation

Managed care organizations face a complex strategic environment when members lose coverage through work requirement non-compliance. Traditional MCO strategy during Medicaid coverage transitions has focused on maintaining relationships with members as they move to marketplace coverage, often offered by the same parent organization. The premium tax credit exclusion disrupts this strategy for a significant portion of coverage losses.

MCOs that also operate marketplace plans can offer coverage to members losing Medicaid, but without premium tax credits, few members can afford to purchase. The transition pipeline that worked during Medicaid unwinding, where plans reported 10-15% of disenrolled members transitioning to affiliated marketplace products, will not function for work requirement terminations. The member cannot afford the product, regardless of brand loyalty or continuity-of-care preferences.

This creates a different calculus for navigation investment. ***MCOs invest in helping members maintain coverage because enrolled members generate capitation revenue and allow care management investments to pay off through improved outcomes.*** Members who will lose coverage regardless, and who cannot transition to an affiliated marketplace plan, generate no future revenue stream. The ROI on navigation investment for these members is zero from a pure enrollment perspective.

However, MCOs serving Medicaid populations maintain relationships with the healthcare delivery system. Members who become uninsured do not disappear from healthcare utilization; they shift to emergency departments and safety-net providers who then seek cost recovery through rate negotiations with commercial payers, including the same MCOs operating marketplace and employer plans. The cost does not vanish; it redistributes through channels that eventually affect MCO economics.

MCOs with multi-line businesses face the most complex calculations. Their Medicaid plan loses the member. Their marketplace plan cannot enroll the member at affordable rates. Their provider network absorbs uncompensated care costs that affect contracting across all business lines. The strategic optimization is not obvious, and short-term incentives may conflict with system-level economics.

The Basic Health Program Alternative

The ACA's Section 1331 authorized Basic Health Programs as bridges between Medicaid and marketplace coverage for individuals with incomes between 138% and 200% FPL. States implementing BHPs contract with insurers to provide coverage at reimbursement rates closer to Medicaid than commercial insurance, using federal funding equal to 95% of what marketplace subsidies would have cost.

Minnesota's MinnesotaCare and New York's Essential Plan demonstrated that BHPs can provide more affordable, more generous coverage than marketplace plans. MinnesotaCare features premiums from $0 to $28 monthly with no deductibles and copayments from $0 to $250. New York's Essential Plan eliminated premiums entirely for most enrollees while maintaining actuarial values above 95%, far more generous than marketplace silver plans.

Oregon launched its OHP Bridge program in 2024, and Washington, DC planned Healthy DC for January 2026. These programs provide year-round enrollment, important for populations

whose circumstances change frequently. BHP coverage does not require tax reconciliation, eliminating the risk of subsidy repayment that can create financial hardship for marketplace enrollees whose incomes fluctuate.

The premium tax credit exclusion for work requirement non-compliance does not explicitly address BHP eligibility. The statutory language targets premium tax credits specifically, which BHPs do not use. This creates potential interpretive questions about whether individuals barred from marketplace subsidies could enroll in BHPs where available.

However, BHPs exist in only a handful of states. The vast majority of individuals subject to work requirements live in states without BHP coverage options. Even if BHPs technically remain available to those with premium tax credit exclusions, the geographic limitation means this alternative helps relatively few people.

States considering BHP implementation face timing challenges. Establishing a BHP requires CMS approval, insurer contracting, eligibility system modifications, and enrollment infrastructure development. Oregon's timeline from legislative mandate to program launch was approximately two years. States that have not already initiated BHP development cannot implement programs before work requirements activate.

Cross-Program Interactions

Work requirement non-compliance and premium tax credit exclusion interact with other benefit programs in ways that compound disadvantage. Many Medicaid expansion adults also receive SNAP, housing assistance, or other means-tested benefits. These programs increasingly share data and align verification requirements, creating cascading effects when compliance fails in one program.

SNAP already requires able-bodied adults without dependents to meet work requirements in many states. ***The SNAP requirements differ from Medicaid requirements in hour thresholds, exemption categories, and reporting cycles.*** Someone navigating both sets of requirements faces doubled administrative burden, with failure in either program potentially affecting the other through data sharing.

Housing assistance programs, particularly Housing Choice Vouchers, increasingly incorporate work or self-sufficiency requirements. HUD's Moving to Work demonstration allows participating housing authorities to impose work requirements on able-bodied adults. Someone losing Medicaid for work requirement non-compliance may simultaneously face scrutiny of their housing assistance eligibility.

Childcare subsidies carry their own work requirements, typically requiring parents to engage in work or education to maintain benefits. The work thresholds, verification methods, and reporting cycles differ from Medicaid requirements. A parent struggling to document compliance with Medicaid work requirements may face similar challenges with childcare verification.

These cross-program interactions create multiplicative complexity for individuals and families receiving multiple benefits. Administrative failure in one program can trigger cascade effects across the safety net. The navigation burden to maintain compliance across multiple programs with different rules, deadlines, and verification requirements exceeds the capacity of many low-income households.

The premium tax credit exclusion adds another layer. Someone who loses multiple benefits due to documentation failures cannot access subsidized marketplace coverage as a partial mitigation. They fall entirely outside the coverage system rather than having marketplace insurance as a floor beneath other coverage losses.

State administrative systems that share data across programs can either help or harm depending on implementation. Unified verification that allows documented work in one program to satisfy requirements in others could reduce burden. Data sharing that propagates compliance failures across programs could compound harm. States face design choices that will significantly affect cross-program dynamics.

State-Level Mitigation Possibilities

States retain some policy options for mitigating marketplace fallback problems within existing federal constraints. These options vary in cost, administrative complexity, and political feasibility.

State-funded subsidies could supplement or replace federal premium tax credits for populations barred from federal assistance. Several states already operate subsidy programs that reduce marketplace costs beyond federal minimums. Extending these programs to cover work requirement terminations would require significant state expenditure but would maintain coverage pathways. The political challenge is substantial: states that embraced work requirements may not simultaneously fund alternatives for non-compliant populations.

Medicaid reinstatement pathways could be designed to facilitate rapid coverage restoration for individuals who resolve compliance issues. Rather than treating termination as a cliff, states could create streamlined reenrollment processes that minimize coverage gaps. Good cause exceptions, retroactive compliance recognition, and accelerated processing for members with documented work activity could reduce the population facing sustained coverage loss.

Provider-sponsored coverage options might emerge in some markets. ***Health systems with substantial charity care exposure have financial incentives to develop affordable coverage products for populations falling off Medicaid.*** These products would not qualify as marketplace plans and would not benefit from ACA consumer protections, but they might provide some coverage floor for populations otherwise facing complete uninsurance.

Navigation investment at scale could reduce the population that experiences work requirement termination in the first place. States that build robust verification assistance, outreach infrastructure, and exemption support systems will generate fewer terminations than states that implement requirements with minimal member support. Prevention is more effective than remediation once coverage loss occurs.

The Provider Perspective

Healthcare providers will absorb the consequences of marketplace fallback failure through increased uncompensated care. The pattern is well-established: uninsured patients delay care until conditions become acute, present to emergency departments that cannot refuse them, generate costs that hospitals must absorb or shift to other payers.

Safety-net hospitals and federally qualified health centers face concentrated exposure. These facilities serve disproportionately low-income populations and will see the highest density of coverage losses. DSH payments and FQHC cost-based reimbursement provide some cushion, but these funding streams do not scale with uncompensated care volume in real-time.

Provider attestation of work requirement compliance, discussed in Article 9D, creates additional complexity. Providers may be asked to verify patient work status or attest to exemption qualifications. The resulting documentation becomes part of the verification record that determines whether coverage loss triggers premium tax credit exclusion. Providers thus participate in creating the cliff even as they absorb the costs of patients falling from it.

Emergency departments will see the clearest pattern. Patients managing chronic conditions on Medicaid will lose coverage, discontinue medications, and eventually present with complications that require emergency intervention. The emergency visit generates no reimbursement from the uninsured patient and contributes to the department's financial strain. The subsequent hospitalization, if required, compounds the loss.

Mental health and substance use providers face particular challenges. Medications for opioid use disorder require ongoing access. Psychiatric medications that stabilize conditions require continuity. Coverage disruption for these populations produces crisis-level presentations that burden both the clinical system and the broader community. The premium tax credit exclusion ensures that marketplace coverage cannot serve as an alternative for these high-need populations.

The Uninsured Population Profile

The population that will become uninsured through marketplace fallback failure will not be randomly distributed. Research on administrative barriers in benefit programs consistently shows that coverage losses concentrate among populations least equipped to navigate complex systems.

Educational attainment correlates with administrative capacity. People with higher educational levels demonstrate greater ability to understand complex requirements, maintain documentation, meet deadlines, and navigate appeals processes when initial attempts fail. Work requirements that demand continuous verification and documentation will produce higher non-compliance rates among populations with limited formal education.

Digital literacy creates barriers in systems that rely heavily on online verification portals and electronic communication. Members without reliable internet access, smartphone ownership, or comfort with digital systems face obstacles at every interaction point. Arkansas's online-only verification system contributed substantially to coverage losses, disproportionately affecting populations without consistent digital access.

Social capital, the networks of relationships that provide information and assistance, ***varies dramatically across populations.*** Someone with family members or friends who have navigated benefit systems can draw on that knowledge and support. Someone without such networks faces the system alone, without the informal guidance that helps others succeed.

Health status itself affects administrative capacity. People managing chronic conditions, mental health challenges, or cognitive limitations face greater difficulty maintaining the continuous compliance that work requirements demand. The conditions that make healthcare coverage most important also make compliance most difficult.

The resulting uninsured population will concentrate the most vulnerable members of the expansion adult population. People who could navigate verification systems will maintain coverage or transition to employer plans. People who could not will become uninsured regardless of their actual work status. The system will filter for administrative capability rather than work activity, producing an uninsured population disproportionately composed of those least equipped to manage healthcare needs without coverage.

Conclusion: The Bridge to Nowhere

The marketplace was designed as a bridge between coverage types, providing subsidized private insurance for people who lose or lack other coverage options. Work requirements under OB3 / HR1 convert this bridge into a dead end for millions of expansion adults who fail to document compliance with community engagement requirements.

The policy creates a coverage architecture where working-age adults with incomes at or below 138% FPL face three possibilities: maintain Medicaid through continuous documented compliance with work requirements, secure employer-sponsored coverage that most low-wage jobs do not offer, or become uninsured with no affordable alternatives. The marketplace technically exists as an option but is priced beyond reach.

The premium tax credit exclusion assumes that coverage loss reflects behavioral failure. Evidence from previous implementations suggests that most coverage losses will result from verification failure among people who were actually working or eligible for exemptions. The cliff falls equally on the person who refused to work and the person who worked but could not prove it. Both lose Medicaid and both lose access to subsidized marketplace coverage. Only one made a choice that the policy was designed to address.

The December 2025 convergence ensures that the marketplace these individuals are excluded from is already more expensive, more administratively burdensome, and less accessible than it was when enhanced subsidies were available. The safety net shrank before the population falling from it expanded.

Latisha will join the uninsured. So will millions of others whose stories differ in detail but share the fundamental structure: working people unable to document compliance, falling through a system that offers no viable alternative. The marketplace she cannot afford will continue enrolling people with higher incomes and premium tax credit eligibility. The emergency department will see her eventually, as it sees everyone who goes too long without care. The costs will redistribute through channels that obscure their origin.

The bridge leads nowhere. The fall continues.

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