April 11, 2025

Centers for Medicare & Medicaid Services (CMS)
Department of Health and Human Services (HHS)
Attention: HHS-9884-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Proposed Rule: Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability

To Whom It May Concern:

On behalf of the Individual and Small Group Markets Committee (Committee) of the American Academy of Actuaries,[1] we appreciate the opportunity to provide comments regarding the 2025 Patient Protection and Affordable Care Act (ACA) Marketplace Integrity and Affordability proposed rule. Specifically, the Committee would like to address Coverage Denials for Failure To Pay Premiums for Prior Coverage; Income Verification When Data Sources Indicate Income Less Than 100 Percent of the FPL/Income Verification When Tax Data Is Unavailable; Annual Eligibility Redetermination ($5 premium requirement, Bronze plan auto-re-enrollment); Premium Payment Threshold; Limited Open Enrollment Periods; Pre-enrollment Verification for Special Enrollment Period; Premium Adjustment Percentage; and Levels of Coverage (Actuarial Value).

General Comments

The Committee acknowledges that federal policymakers are seeking to strike a balance between ensuring that eligible individuals can access benefits and preventing ineligible individuals from receiving them. This proposed rule consists of a range of administrative procedures that clearly lean toward limiting access to ineligible individuals, even at the risk of excluding some who are eligible. The Committee cautions, however, that policies designed to block ineligible individuals can often unintentionally create barriers for eligible individuals as well. Conversely, efforts to guarantee access for all eligible individuals can make it easier for ineligible individuals to receive benefits.

In the insurance context, such barriers tend to result in anti-selection, as healthier individuals are less likely to complete more rigorous documentation requirements. The individual effects of many of the proposals are likely to be small in isolation. In total, however, the effects may be

[1] The American Academy of Actuaries is a 20,000-member professional association whose mission is to serve the public and the U.S. actuarial profession. For 60 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

material, particularly if the enhanced premium tax credits are not extended by Congress and higher net premium levels for many market participants result in significant coverage losses. As healthier lives leave the risk pool due to increased barriers to coverage, the overall health status of the risk pool will degrade, which in turn will increase premiums. These premium increases will be most greatly felt by individuals at higher income levels and those not eligible for premium tax credits. Subsidized enrollees may be largely insulated from the bulk of any such change.

Coverage Denials for Failure To Pay Premiums for Prior Coverage (§ 147.104(i))

The Department of Health and Human Services (HHS) is proposing to remove the current prohibition on issuers requiring payment of past due premiums prior to effectuating a new plan selection during the annual open enrollment period, which was finalized in the 2023 Payment Notice. In the Academy's 2022 comments on that proposal, the Committee noted that it would increase access to coverage but could create an opportunity for adverse selection. Removing the current prohibition will likely reduce access to coverage while reducing this particular opportunity for adverse selection.

HHS also requested comments on alternatives and parameters, including whether issuers should be required to recoup past due premiums prior to effectuating new coverage and what lookback window should be applied.

Requiring issuers to recoup past due premiums could result in additional adverse selection relative to making recoupment optional. In this case, the least healthy individuals with past due premiums would be most likely to pay those amounts in order to re-effectuate coverage, with healthier individuals opting for alternative coverage or foregoing coverage altogether. As a result, such a provision would reduce access to comprehensive coverage. The impact could be larger in markets with limited competition, where individuals may lack both alternative options for comprehensive coverage and the funds to repay premiums.

In contrast, in areas with greater competition, healthy individuals who have past due premiums with one issuer may have the option to pursue coverage with other issuers participating in that market, which could reduce the overall level of anti-selection relative to regions with fewer options and coverage alternatives. In these regions, issuers that choose to collect past due premiums may benefit from lower premiums due to reduced anti-selection and potentially a reduction in uncollectable premium amounts, which could in turn attract more enrollees into the market relative to less competitive regions. In this way, competitive market dynamics may help balance the trade-offs, potentially achieving cost and enrollment benefits while limiting access issues compared to regions with fewer coverage options. As such, adverse selection is likely to be more limited, particularly in competitive regions, where lookback periods are shorter, or where recoupment is optional.

Income Verification When Data Sources Indicate Income Less Than 100 Percent of the FPL (§ 155.320(c)(3)(iii))/Income Verification When Tax Data Is Unavailable (§ 155.320(c)(5))

HHS is proposing to reinstate a policy requiring the generation and resolution of income inconsistencies for individuals applying for advance premium tax credits (APTCs) for whom

federal trusted data sources suggest income is below 100 percent of the federal poverty level (FPL). In addition, HHS is proposing to eliminate the current exception that allows ACA marketplaces to accept self-attested income from individuals lacking tax data for verification, which would effectively subject those individuals to the same income inconsistency process described above. Together, these provisions target potential abuses of the generous premium tax credits, benefit levels, and enrollment flexibilities currently available to individuals with household incomes between 100 percent and 150 percent of the FPL. The Committee notes that much of the analysis cited, like much commercial health insurance research, relies heavily on U.S. Census Bureau surveys. While these surveys provide the best publicly available estimates of coverage and income, they are not (and in many ways cannot be) calibrated against administrative data to confirm their accuracy. Additionally, responses given can vary from the intended data collection based on how survey respondents interpret questions. Differences between survey estimates and marketplace application data are often explainable, especially given that applicants must project their future income, an especially volatile and uncertain task for lower-income households. Because subsidy eligibility is not finalized until after the tax year ends, proposals that rely too heavily on income documentation at the time of application may want to consider flexibility. Exploring the extent of income variability both within and across years could help inform more reasonable and equitable verification processes for the affected population.

Annual Eligibility Redetermination (§ 155.335) [$5 premium requirement]

HHS is proposing a requirement that fully subsidized enrollees actively confirm their subsidy eligibility in the federal marketplace in 2026 and in state-based marketplaces in 2027. This proposal has the potential to increase the administrative burden for the marketplaces and issuers, lead to enrollee confusion, and may potentially introduce adverse selection issues. Under this proposal, marketplaces would be responsible for identifying, notifying, and adjusting APTC amounts for affected enrollees, as well as reassessing subsidy eligibility for all enrollees in this cohort. Issuers would face increased call volumes, increases in billing, and increased proactive communication with enrollees. These additional burdens could result in higher premiums for all members due to higher administrative costs and higher marketplaces fees.

Increased termination rates could arise due to enrollee confusion, which could in turn lead to increased adverse selection. Some individuals may disenroll to avoid the $5 premium if they do not expect to use services, while others may be unaware of the new charge and lose coverage unintentionally. The 2021 American Rescue Plan Act's (ARPA) enhanced APTCs resulted in $0 premiums for many enrollees. A return to pre-ARPA levels will likely reduce that number of eligible enrollees. If these subsidy reductions coincide with the new $5 premium requirement, consumer confusion is likely to increase, which may further depress enrollment. Together, these changes could create greater uncertainty around 2026 enrollment projections, plan mix, and population morbidity. Increased uncertainty about enrollment is likely to drive higher premiums, as insurers increase margin to retain the same level of risk tolerance. This increase would be in addition to any increases attributable to the composition of the risk pool itself.

Annual Eligibility Redetermination (§ 155.335(j)) [Bronze auto re-enrollment]

HHS is proposing to remove the limited automatic re-enrollment provision that currently applies to individuals who appear to be cost-sharing reduction (CSR) eligible but are enrolled in bronze coverage. Under current policy, marketplaces are allowed to automatically re-enroll these individuals from a bronze qualified health plan (QHP) into a silver QHP, if the silver QHP is in the same product, has the same provider network, and has a lower or equivalent net premium compared to the bronze plan. As long as the individual remains eligible for a CSR plan variation in the new plan year, this policy ensures that consumers obtain the highest level of benefits to which they are entitled for the premium paid. In states that permit silver loading, this situation typically only happens when a zero-premium silver plan is available, as bronze plans generally have significantly lower net premiums. This situation is expected to become less common if the enhanced premium tax credits are not extended into 2026, as the availability of zero premium silver plans would be expected to decrease substantially.

Overall, removing this provision could lead to less enrollment in silver CSR plan variations, which may impact carriers' projected distribution of enrollment by metal level and the magnitude of their CSR loads. Specifically, carriers may see increased bronze enrollment in the future. CSR loads may increase or decrease, depending on whether the average load attributable to individuals no longer being re-enrolled into CSR plan variations is higher or lower than the overall load applied. CSR loads could materially affect benchmark silver premiums and net premiums for individuals that receive premium tax credits. Any reduction in CSR loads could put additional pressure on the risk pool and upward pressure on gross premium levels.

Premium Payment Threshold (§ 155.400)

In the 2026 Payment Notice, HHS initially proposed and ultimately finalized two new premium forgiveness thresholds for issuers in the marketplace—the gross premium percentage-based threshold and the fixed dollar threshold. The Committee noted in its November 2024 comments on the proposed 2026 Payment Notice that both new provisions would more generally benefit lower income individuals with smaller net premiums, while having limited effect on individuals at higher incomes. The direct effects on the risk pool are likely to be limited due to the limited period of time for which these provisions have been effective. However, many issuers may have already made substantial investments to implement the new thresholds. Reversing course now could render those investments as sunk costs and could exert modest upward pressure on premiums.

The Committee also notes that finalizing this provision would not result in a complete reversion to a pre-2026 Payment Notice status quo. The 2026 Payment Notice included modifications to the net premium percentage-based threshold, significantly limiting issuer flexibility in administering the net premium threshold. CMS may wish to consider restoring the prior regulatory text addressing these thresholds and conduct further study, as was noted by the Committee in our 2026 Payment Notice comment letter.

Limited Open Enrollment Periods (§ 155.410)

HHS is proposing shortening the annual open enrollment period (OEP) by 30 days, so that it would end on December 15. This restores a policy originally finalized in the 2017 Market

Stabilization Rule. The Committee would like to refer HHS to our March 2017 Market Stabilization Proposed Rules comments. Specifically, the Committee noted that a shortened OEP reduces some specific opportunities for adverse selection, as individuals must select coverage prior to the start of the plan year. At the same time, it may also result in lower overall enrollment, as individuals who fail to select coverage prior to the end of OEP do not have an opportunity to correct their oversight upon termination of coverage at the end of the year. This is more likely to happen for younger and healthier individuals, who are less likely to actively purchase coverage early in the OEP. Overall, enrollment in ACA individual markets decreased slightly over the 2018-2020 period, during which this OEP applied, relative to 2016 and 2017, though it is not possible to fully assign prior effects to any single proposal.

Monthly Special Enrollment Period for APTC-Eligible Qualified Individuals with a Projected Household Income at or Below 150 Percent of the Federal Poverty Level (§ 155.420)/Limited Open Enrollment Periods (§ 147.104(b)(2))

HHS is proposing to remove the special enrollment period (SEP) for APTC-eligible qualified individuals with a projected household income at or below 150 percent of FPL. This provision was finalized in Part 3 of the 2022 Payment Notice in conjunction with a $0 silver net premium requirement. In the Committee's July 2021 comments on the Updating Payment Parameters proposed rule, it was noted that adverse selection was possible but likely to be limited due to the enhanced subsidies. The Committee also described situations where greater adverse selection could occur. In particular, the Committee noted that adverse selection risk was significantly greater if the enhanced premium tax credits made available under ARPA were to cease. The Committee reiterated this point in their January 2024 comments when the zero-dollar premium limitation was removed in the proposed 2025 Proposed Notice of Benefit and Payment Parameters rule.

Pre-enrollment Verification for Special Enrollment Period (§ 155.420(g))

HHS is proposing to strengthen the pre-enrollment SEP verification requirements for federal marketplaces. Currently, federal marketplaces are only required to conduct pre-enrollment verification for the loss of minimum essential coverage SEP. Under the proposal, HHS would conduct pre-enrollment verifications for most categories of SEPs for federal marketplaces, in line with operations prior to the 2023 Payment Notice. The proposed rules would also require that marketplaces, including all state marketplaces, conduct pre-enrollment SEP verification for at least 75 percent of new enrollments through SEPs.

These changes to SEP enforcement have the potential to impact the overall risk profile of marketplace enrollees. On one hand, enhanced verification of a greater number of SEP scenarios could address program integrity concerns by reducing potential abuses of SEP eligibility. At the same time, implementing additional burdensome paperwork requirements may deter or discourage enrollment by healthier individuals. This could have a negative impact on the risk pool and result in higher premiums.

In addition, this proposed rule could add uncertainties to the autoenrollment process of some state marketplace programs for members losing eligibility in the Medicaid market. It is unclear

how the pre-enrollment SEP verification would disrupt this auto-enrollment process, and how it would disrupt patient care for this vulnerable population.

HHS notes that the proposed rule would moderately increase the regulatory burden on the federal and state marketplaces. HHS notes that 11 of the 15 state marketplaces are already conducting SEP verifications for those that comprise at least 75 percent of their SEP enrollments. However, federal marketplaces and the remaining four state marketplaces will need to anticipate and budget for increased one-time and ongoing administrative costs resulting from the creation of the necessary infrastructure to support such broader SEP pre-enrollment verification. The increase in reviews will also result in associated increases in annual staffing costs. These increased administrative costs will likely necessitate an increase in marketplace user fees, further increasing enrollee premiums in addition to the resulting adverse selection due to the administrative hurdles themselves.

Premium Adjustment Percentage (§ 156.130(e))/Maximum Annual Limitation on Cost Sharing for PY 2026/Reduced Maximum Annual Limitation on Cost Sharing for PY 2026/Proposed Required Contribution Percentage at § 155.605(d)(2) for PY 2026

HHS is proposing to revise the premium index used to determine the premium adjustment percentage. Under the proposal, the index would be based on a measure of premiums that was originally proposed and finalized for the 2020 benefit year. Consistent with the Committees' February 2019 comments on the 2020 proposed Notice of Benefit and Payment Parameters, the use of a measure that incorporates individual market premiums in 2013 (as the revised index does) implicitly incorporates the significant enhancement of benefits in the individual market as a result of the ACA's reforms. Consequently, it may not provide an appropriate proxy for premium increases since 2014.

Levels of Coverage (Actuarial Value) (§§ 156.140, 156.200, 156.400)

HHS proposes adjusting actuarial value (AV) *de minimis* standards, reverting to ranges first established in the 2017 Market Stabilization Rule. As the Committee noted in our March 2017 comments on that proposed rule, expanding the *de minimis* ranges may facilitate greater compliance with AV requirements, particularly in future plan years. Under the current narrower ranges and the updated AV calculator, issuers are often required to make frequent cost-sharing adjustments to maintain compliance. Broader *de minimis* ranges would reduce the frequency of these changes. In general, the AV calculator is used to evaluate both individual and small group plan designs, therefore any efforts to promote plan design stability through the expansion of the AV *de minimis* range would benefit both markets.

Wider *de minimis* ranges would increase the variety of possible plan designs, which could in turn increase consumer choice in both the individual and small group markets. However, it also can create confusion as plan designs in one metal tier may be more similar to plans in a different metal tier than within the same metal tier (e.g., a gold plan with 76 percent AV would be more similar to a silver plan with a 72 percent AV than another gold plan with an 82 percent AV). This may be more confusing in the individual market. At the same time, this wider *de minimis* range may make it easier for small group insurers to provide options for small employers seeking to buy down benefits and reduce upfront employer contributions and employee premiums. The

Committee also notes that these rules make it possible to create plan designs that are simultaneously compliant with the bronze and silver metal tiers in the 2026 AV calculator. This could occur because the upper end of the *de minimis* range is +5 percent for expanded bronze plans.[2]

Impact on Premiums and Out-of-Pocket (OOP) Costs

Permitting lower AVs within each metal tier could offer rate relief to enrollees through lower premiums, potentially benefiting both the individual and small group markets. However, it is important to note that premiums are not determined by the AV calculator values. Instead, they are developed independently by plan actuaries. As a result, the impact of changes to the *de minimis* ranges may be limited, particularly given the high price sensitivity among consumers in the individual market. More broadly, any reduction in AV would generally be associated with increased OOP cost sharing for enrollees.

This provision is likely to have limited impact on bronze plans, as the least generous possible plan design in the AV calculator still has an AV above 58 percent. The impacts are likely to be largest for gold and, where offered, platinum plans. It is also important to note that silver QHP premiums are influenced by "silver loading." The proposed rule permits the standard QHP silver plan to decrease the AV by 4 points from the current *de minimis* range (+2/0 to +2/-4), while the CSR plan variations are only permitted to decrease by 1 point (+1/0 to +1/-1). If the relativity between the standard QHP silver plan and the CSR plan variations expand, there is potential for the "silver load" to increase, depending on changes in the distribution of an issuer's CSR membership. Where the "silver load" is applied only to silver QHPs, this would offset some portion of the potential silver premium decrease. Where the "silver load" is applied to all plans, it would similarly offset premium decreases for other metal tiers as well. Additionally, in states that prescribe a specific CSR loading methodology, any mismatch between plan design and pricing assumptions may introduce unnecessary actuarial or regulatory risk.

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The Committee appreciates the opportunity to provide comments on the Proposed Rule on Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability. The Committee welcomes the opportunity to speak with you to provide additional details or answer any questions you might have regarding these comments. Please contact Matthew Williams, policy project manager, health (williams@actuary.org).

Sincerely,

Jason Karcher, MAAA, FSA
Chairperson, Individual & Small Group Markets Committee
American Academy of Actuaries

[2] In particular, a plan design with a $2,500 deductible, 50 percent plan coinsurance, a $10,600 out of pocket maximum, and generic drugs not subject to the deductible has a 66.51 percent AV under the silver continuance tables and 64.51 percent under the bronze continuance tables.