June 3, 2025

The Honorable John Thune
Majority Leader, U.S. Senate
S-230 Capitol Building
Washington, DC 20510

The Honorable Chuck Schumer
Democratic Leader, U.S. Senate
S-221 Capitol Building
Washington, DC 20510

Via E-mail

Re: Senate Budget Reconciliation of H.R.1, One Big Beautiful Bill Act

Dear Leader Thune and Leader Schumer:

On behalf of the Individual and Small Group Markets Committee (Committee) of the American Academy of Actuaries' (Academy)[1] Health Practice Council, we offer the following comments for your consideration as the Senate develops its budget reconciliation legislation. In particular, we have focused these insights on provisions within H.R. 1, the One Big Beautiful Bill Act, which passed the House on May 22, 2025, and would make changes to the individual health insurance market.

The Academy's longstanding mission is to inform public policy deliberations in an objective and nonpartisan manner. The Committee shares the goal of promoting access, affordability, choice, and competition in the individual health insurance market. This market is governed by a framework of laws and regulations designed to support these objectives, including uniform market rules, premium tax credits, cost-sharing reductions, and consumer protections. As you know, risk pooling is a fundamental component of this framework.

A health insurance risk pool is made up of a group of individuals whose medical costs are combined to determine premiums. Pooling allows the higher costs associated with less healthy enrollees to be balanced by the lower costs of healthier individuals, either within a plan or a premium rating category. In general, larger risk pools lead to more predictable and stable premiums.

Any policy change affecting the individual market should be evaluated for its potential impact on the composition of the risk pool, as this in turn could influence access, affordability, choice, and competition.

[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.

Provisions Aimed at Improving Market Integrity

The House-passed legislation would codify nearly all of the regulations recently proposed by the Centers for Medicare and Medicaid Services (CMS) in the 2025 Marketplace Integrity and Affordability rule (Marketplace Integrity Rule). Many of these proposed provisions, along with additional provisions in the legislation, would modify enrollment procedures. As of June 2, 2025, the proposed rule has not been finalized and references to current policy below do not incorporate any of the proposed provisions.

The Committee acknowledges that federal policymakers are aiming to balance two goals: ensuring that eligible individuals can access benefits while preventing ineligible individuals from receiving them. The proposed legislation includes a range of administrative procedures that generally emphasize limiting access for ineligible individuals, even at the risk of inadvertently excluding some who are eligible. In our April 2025 comment letter to CMS, the Committee cautioned that policies designed to prevent ineligible individuals from enrolling can unintentionally create barriers for eligible individuals. Conversely, efforts to ensure access for all eligible individuals may also increase the risk of ineligible individuals enrolling.

In the context of insurance, barriers to enrollment can contribute to adverse selection, as healthier individuals are less likely to navigate burdensome documentation requirements. The increase in adverse selection may lead to upward pressure on premiums. While the individual impact of many of the proposals may be modest, the cumulative effect could be significant, particularly if Congress does not extend the enhanced premium tax credits. In that case, higher net premiums could result in significant coverage losses. As healthier individuals leave the risk pool due to increased barriers, the overall health status of the pool could deteriorate, leading to significant premium increases. These premium increases would most affect individuals with higher incomes and those ineligible for premium tax credits, while subsidized enrollees may be largely shielded from these effects.

Provisions in the House-passed legislation that raise adverse selection concerns, as they generally tend to discourage healthy enrollees from enrolling or re-enrolling, which could in turn increase premiums include:

- Reducing the open enrollment period to 45 days;
- Imposing new income verification requirements when data sources indicate income below 100% of the federal poverty level;
- Requiring new special enrollment period (SEP) verifications;
- Requiring income verification for all marketplace applicants, including those enrolling during open enrollment, effectively eliminating automatic re-enrollment;
- Requiring a $5 premium payment for automatic re-enrollees until their premium tax credit eligibility is confirmed (this provision is moot if income verification is required for all marketplace applicants during open enrollment);
- Prohibiting premium tax credits for individuals who didn't file an income tax return or reconcile prior-year advanced premium tax credits; and
- Removing caps on consumer liability for repayment of excess advanced premium tax credits when actual income exceeds estimated income.

The House-passed legislation also includes a provision eliminating the low-income SEP, which could help mitigate adverse selection. It is unclear whether the additional provision disqualifying individuals who enrolled through this SEP would also prohibit such individuals from receiving premium tax credits in a future plan year. If so, it may be overly restrictive, as it could result in these enrollees being treated differently than others who enroll during the standard open enrollment period.

Bronze auto re-enrollment

The House-passed legislation would codify the provision from the proposed Marketplace Integrity Rule that eliminates the current limited automatic re-enrollment policy for cost-sharing reduction (CSR) eligible individuals enrolled in bronze coverage. Under current policy, marketplaces may automatically re-enroll these individuals into a silver qualified health plan within the same product using the same provider network, if the silver plan 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, current policy ensures that consumers obtain the highest level of benefits to which they are entitled for the premium paid. Eliminating this policy could increase cost-sharing requirements for those affected by the provision, especially if concerns about a lack of eligibility are addressed by other provisions of the bill that require verification of eligibility prior to receipt of premium tax credits, as receipt of premium tax credits is a prerequisite for enrollment in a CSR plan variation.

Annual premium adjustment percentage

The House-passed legislation would codify a provision from CMS' proposed Marketplace Integrity Rule that would base the premium index on a measure of premiums that incorporates individual market premiums from 2013. Given that this measure would reflect the significant benefit enhancements resulting from reforms in the Affordable Care Act (ACA), it overstates premium trend and does not serve as an appropriate proxy for premium growth since 2014. As a result, the annual adjustments to the maximum out-of-pocket limit and the premium contribution percentage would be higher than under current policy, leading to increased out-of-pocket costs and higher premiums net of premium tax credits for consumers.

Actuarial value *de minimis* standards

The House-passed legislation would codify changes in the proposed rule that would adjust the actuarial value (AV) *de minimis* standards, reverting to ranges first established CMS' 2017 Market Stabilization Rule. Expanding the *de minimis* ranges may facilitate greater compliance with AV requirements, particularly in future plan years. 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). It may also inadvertently make it possible to create plan designs that are simultaneously compliant with both the bronze and silver metal tiers in the 2026 AV calculator. Although permitting lower AVs within each metal tier could lead to lower premiums, any reduction in AV would generally be associated with increased out-of-pocket cost-sharing for enrollees.

Custom Health Option and Individual Health Care Expense Arrangements

The House-passed legislation would codify rules governing Individual Coverage Health Reimbursement Accounts (ICHRAs) and rename them as Custom Health Option and Individual Health Care Expense (CHOICE) arrangements. These arrangements allow employers to contribute funds that employees can use to purchase individual market coverage. Under certain conditions and for some employers, CHOICE arrangements may offer employees more coverage choices at a more predictable cost for employers.

The impact of CHOICE arrangements on the individual market risk pool depends on the health status of the employees in firms that adopt them. Employers entering CHOICE arrangements may be more likely to have higher-cost employee populations. The effect on a state's individual market will vary depending on how the costs of CHOICE participants compare to the average costs in that market, potentially raising or lowering premiums based on the specific risk profile of that state's individual market.

For example, requiring CHOICE arrangements to be offered uniformly (i.e., to all employees rather than targeted to workers or classes of workers with high health costs) will tend to lead to a healthier risk pool of CHOICE enrollees. This, in turn, could improve the individual market's risk profile and help reduce premiums. Conversely, allowing employers to limit CHOICE offerings to employees with higher health costs could worsen the individual market risk pool and drive-up premiums.

Restricting CHOICE arrangements to ACA-compliant plans could further support market stability. In contrast, allowing funds to be used for non-ACA-compliant plans, such as short-term, limited duration insurance or other excepted benefits, could destabilize the market. Healthier employees may be drawn to these lower-cost, less comprehensive plans, while employees with greater health care needs would likely choose to remain in ACA-compliant plans, ultimately negatively skewing the individual market risk pool.

It is important to keep in mind that, if employers were restricted to ACA-compliant plans, they would be more likely to offer CHOICE arrangements when the individual market appears stable and affordable. Public policies that lower premiums and improve market stability could increase employer interest in CHOICE arrangements. In contrast, policies that lead to higher premiums or destabilize the individual market could discourage their adoption by employers.

Expiration of enhanced premium subsidies

If Congress does not extend the enhanced premium tax credits beyond 2025, net premiums will increase for tax credit-eligible enrollees. These increased costs would likely lead to reductions in enrollment, particularly among healthy individuals, leading to adverse selection and higher premiums for those who are ineligible for tax credits. This dynamic could further drive premiums higher and potentially destabilize the individual market.

Funding for Cost-Sharing Reductions

Under the House-passed legislation, Congress would appropriate federal funds for CSRs provided to eligible low-income marketplace enrollees who enroll in silver tier plans as well as eligible American Indians and Alaska Natives who enroll in plans in any metal tier. Although these CSRs were initially federally funded, that funding was terminated in October 2017. Beginning in 2018, most insurers increased premiums to cover the extra CSR-related claim costs. Currently, most states allow or require insurers to increase the premiums only for silver plans, often specifically only on-exchange silver plans. The advent of increasing premiums and increasing silver premiums led to higher benchmark premiums, and therefore higher premium tax credits.

The House-passed legislation would appropriate federal funds for CSRs beginning in 2026. Federally funding CSRs would eliminate the need to increase premiums and would alleviate the difficulty inherent in calculating the appropriate premium load needed to reflect the cost of the CSRs currently borne by issuers.

Funding CSRs would be consistent with the intention of the ACA. Nevertheless, it is important to recognize the potential impact on enrollees and the risk pool. Funding CSRs removes the need for a CSR load, which will, all else equal, reduce the gross premiums of plans with CSR loads. However, the lower gross premiums will lead to reductions in premium tax credits which would then result in increased net premiums for tax credit eligible enrollees, in particular those who used tax credits to purchase bronze or gold plans. Subsidized enrollees in benchmark silver plans would not be affected. It is unclear how such changes, especially in combination with market integrity provisions, the expiration of enhanced premium subsidies, and other provisions in the legislation, would affect adverse selection and its impact on premiums.

In the House-passed legislation, a caveat to the CSR appropriation is that funding would not be available to qualified health plans that include abortion coverage, unless that coverage is limited to cases in which abortion is necessary to save the life of the pregnant woman or the pregnancy is a result of rape or incest. However, due to ambiguities in the legislation and variations in related state laws and regulations, responses to this provision could differ by jurisdiction. As a result, it's unclear whether and how plans and enrollees would be affected by this funding condition and how the impact may vary by state.

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We would welcome the opportunity to discuss these comments or other issues as you move forward with the budget reconciliation work in the Senate. If you have any questions or would like to discuss these issues further, please contact Matthew Williams, health policy project manager (williams@actuary.org).

Sincerely,

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