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Pricing Considerations for the Program Integrity Rule

The enhanced premium tax credit subsidies (ePTC) implemented under the American Rescue Plan Act (ARPA) in 2021 and extended through the Inflation Reduction Act (IRA) in 2022 are likely to expire at the end of 2025. These are expected to cause large enrollment losses in Affordable Care Act (ACA) marketplace plans.[1] On top of this, the Centers for Medicare & Medicaid Services (CMS) and Department of Health and Human Services (HHS) have proposed a Marketplace Integrity and Affordability rule[2] that would also result in decreased marketplace enrollments in 2026. On top of the disenrollments from coverage due to ARPA expiration, HHS estimates that an additional 750,000 to 2,000,000 individuals would lose coverage in marketplace plans in 2026 because of the proposals in the rule.[3]

Paradoxically, HHS estimates this reduction in enrollment would actually lead to a reduction in average claims of between -0.9% and -5.4%. This outcome is counterintuitive to most pricing actuaries as decreases in enrollment typically result in a worsening risk pool. In other words, healthier enrollees are more likely to leave a market than unhealthy enrollees, which is supported by historical trends and prior research. HHS claims reductions are driven by the following estimates:

- Claims impact due to enrollees dropping coverage between -0.5% to +4.0%, including impacts from:
  - Autoenrollment changes
  - Shortening the annual Open Enrollment Period
- Removing the special enrollment period (SEP) for 150% federal poverty level (FPL) individuals equal to -3.4%
- SEP verification equal to -0.5%
- De minimus actuarial value (AV) change equal to -1.0%

In this article, we will further examine considerations that insurance industry pricing actuaries are likely to take into account when developing 2026 pricing impacts for the proposals outlined in the Marketplace Integrity rule and why they may differ from the rules' estimates. The impact of layering these rules onto expiration of enhanced subsidies originally passed through the ARPA has not been considered in this article. However, these impacts are expected to hit the same populations that will be impacted by the removal of enhanced subsidies, which will make 2026 pricing difficult for actuaries. The specific factors each issuer needs to consider when developing ACA premiums will vary according to their specific circumstances. The impact of the proposals outlined in the Marketplace Integrity rule will vary by market and issuer. This article does not provide a comprehensive list of all considerations that should be made.

[1] https://www.rwjf.org/en/insights/our-research/2024/12/household-spending-on-premiums-would-surge-if-enhanced-premium-tax-credits-expire.html
[2] https://www.federalregister.gov/documents/2025/03/19/2025-04083/patient-protection-and-affordable-care-act-marketplace-integrity-and-affordability
[3] You can find a full description of the program integrity rule here: https://www.wakely.com/wp-content/uploads/2025/03/Wakely-Summary-2025-Program-Integrity-Rule_3_20_25.pdf.

General Pricing Considerations

Despite the rules' impact analysis, we believe most pricing actuaries are likely to estimate either no impact or a potential premium increase. This is largely due to the significant uncertainty surrounding the rule. The rule estimates a very wide range in the reduction of enrollment - between 750,000 and 2,000,000 – making precision more difficult. Additionally, the rule itself is unlikely to have fully accounted for all of the potential outcomes that implementation may introduce. Marketplaces have differing levels of operational effectiveness. Consequently, introducing policies that require implementation under a short-time frame could result in very different outcomes.

The risks of pricing too low have become clearer in recent years. For example, low-cost carriers Bright Health and Friday Health Plans grew rapidly but experienced heavy losses, leading to their exits in 2022 and 2023. Conversely, pricing too high may lead to lower enrollment levels, less administrative expense scalability, and MLR rebates. However, subsidized members, who will make up the majority of the Marketplace enrollment even after ARPA subsidies expire, are insulated from price increases because of APTC. Thus, the market is unlikely to go into a premium death-spiral, as feared in early lead-up to the passage of the ACA. And, paying out a MLR rebate is preferable to unsustainable losses, especially because that payout can be muted given that three years of data are considered. The risks of underpricing on insurer plan margin seems higher than overpricing in the current environment. Consequently, if a pricing actuary believes that there could be premium savings due to reduced enrollment like the rule implies, they may be more likely to assume no change and allow any savings to flow through to claims costs, which would impact premiums in 2028, at the very earliest.

Issuers that do choose to include a price impact could potentially raise premium . Actuaries examining this rule are likely to conclude that younger or healthier highly subsidized members, a portion of whom are already going to be hit with premiums increase due to the expiration of ARPA subsidies, will be less likely to deal with the hassle factor of small premium payments than their sicker counterparts who rely on marketplace coverage for ongoing treatments. The younger and healthier are also less likely to notice that they have not been auto reenrolled like they have in previous years, and due to tightened open enrollment timeframes, they will have less time to take action to enroll. Additionally, because of tightening SEP rules, they will not be able to easily enroll later in the year. As the younger and the healthier exit the market, the expectation is that claims costs per member will increase, which will flow through to increases in premiums. Beyond general concerns over enrollment losses, there are specific considerations that may result in actuaries estimating higher claims costs.

Specific Considerations

Hassle Factors

HHS has proposed rules that will add a "hassle" factor to signing up for marketplace coverage during the annual open enrollment period. These barriers make it more difficult to sign up for and keep coverage. For example, one of the proposals functionally ends passive auto-enrollment for those fully subsidized. Instead of continuing to have coverage, these enrollees with zero net premiums instead will have a small ($5) charge.

Prior research has shown that hassle costs often lead to younger enrollees lapsing coverage. For example, a study on the post-ACA Massachusetts market examined individuals who were in a free plan that moved to a non-free plan and then were switched to a free option when they lapsed due to premium non-payment. It found that those who were switched automatically were younger, less likely to have chronic illness, and had a lower medical risk score.[4] This implies that without outside intervention, the younger and healthier are more likely to drop coverage when they have to take affirmative action to keep coverage rather than being auto-enrolled as compared to their older or sicker counterparts.

There have also been several studies on Marketplace and Medicaid populations indicating that even very small transaction costs can be a significant barrier to take-up of subsidized coverage, especially for families with low income. This barrier does not appear to be financial in nature, rather the barrier is considered an "ordeal"[5]. These ordeals can include lack of access to the internet or being unbanked and unable to set up a payment online, long wait times to speak with customer service representatives, opaque eligibility rules, etc. [5,6,7]

Thus, pricing actuaries should also consider the impact to the distribution of their enrollment within metal levels, and the impact to their CSR loading factor, especially in states that have not expanded their Medicaid programs since lower income members are more likely to experience additional barriers to enrollment under the proposed rule.

Tightened SEP rules

Tightening SEP verification, according to analysis from HHS, suggests that the tightening of these rules could result in significant savings (-3.4% for removal of <150% SEP and -0.5% for SEP verification). However, there is the potential that these savings are far less given individual issuers' specific circumstances.

The first reason is that the loosening of SEP verification, coupled with other changes such as risk adjustment, resulted in relatively more profitable SEP members. Wakely's nationwide ACA individual database (WACA), which aggregated detailed claims for millions of members each year, indicates that members joining via SEP[8] have a similar loss ratio (claims/premium)[9] as those who joined during the open enrollment period in 2022. This is generally beneficial for insurance plans, because they have a bigger pool to spread risk and administrative costs. In 2019, however, prior to the loosening of SEP rules, loss ratios for SEP joiners were 15% higher than those joining during the open enrollment period. This implies that prospective joiners who are sicker will be more likely to gain coverage even under tightened

[4] https://www.nber.org/system/files/working_papers/w28630/w28630.pdf
[5] https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3743009
[6] https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2023.00649
[7] https://www.sciencedirect.com/science/article/abs/pii/S0167629614000642
[8] WACA data does not contain enrollment reason codes. To be counted as an imputed SEP member, the triggering member must have begun enrollment or been added to a plan after the specified SEP start date of March 1st. There must have been no continuous enrollment span for the member prior to the trigger span. February 1st effective dates were excluded since those enrolling later during the annual open enrollment period have coverage start dates of February 1st.
[9] Risk adjustment was not considered since the impacts discussed are market level, and risk adjustment is $0 in total for a market.

rules compared healthier prospective joiners. While 2025 SEP claims experience may seem far removed from the 2022 experience, more recent experience in 2023 and 2024 is skewed by large one-time impacts of Medicaid redetermination, which dramatically increased "loss of coverage" SEPs. These impacts are not expected to continue into 2025 and 2026. Therefore, pricing actuaries may be hesitant to include savings, given the uncertainty around enrollment numbers, unclear morbidity impacts of those members, and a dearth of more recent data.

Secondly, pricing actuaries may consider that the impacts will vary widely by state. In the South region,[10] where most states have not expanded Medicaid[11], over 40% of SEP[8] members appear to be enrolling due to the special <150% SEP in 2022. However, in non-South regions, where only three states have not expanded Medicaid,[12] these make up less than 15% of SEP reasons in 2022. Nationally, these members make up around one third of all SEP reasons in 2022, so extrapolating national data to fit state or regional level pricing may not make sense.

Conclusion

HHS and most pricing actuaries will agree that the new Marketplace Integrity and Affordability rule is going to lead to losses in individual market enrollment in 2026. However, what many pricing actuaries will likely not price into their 2026 rates are the reduction in average claims (-0.9% to -5.4%) HHS is projecting. Rather, we would expect these changes to increase average costs, especially with premium pressures due to the expiration of ARPA enhanced subsidies.

[10] Region as defined by the Census definitions for Northeast, Midwest, South, and West

Geographic Levels

[11] "Most" is defined by total population. Non-Medicaid expansion states in the South region are: Alabama, Florida, Georgia, Mississippi, South Carolina, Tennessee, Texas; Medicaid expansion states in the South region are: Arkansas, Kentucky, Louisiana, North Carolina, Oklahoma, Virginia, West Virginia

[12] Non-Medicaid expansion states outside the South region are: Kansas, and Wisconsin, Wyoming

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