AMERICAN EXPERIMENT

It All Adds Up

The High Cost of Health Insurance Exchange Regulations Under the Biden Administration

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Executive Summary

Since taking office, the Biden administration implemented a series of regulations to advance its policy agenda for the Affordable Care Act (ACA) Exchanges. A review of the administration's ACA regulations reveals a regulatory strategy aimed almost exclusively at maximizing the number of subsidized people enrolled in Exchange coverage. This approach consciously chooses to sacrifice the overall efficiency and functionality of the individual health insurance market to enroll more subsidized people whether they were eligible for subsidies or not. All of this comes at a tremendous cost.

Unsubsidized consumers in the individual market bear an immediate cost from how this single-minded approach leads to higher premiums. The federal cost of these regulations also increases in step with higher premiums. In addition, these regulations increase federal costs by expanding eligibility for premium subsidies and increasing administrative costs. Moreover, a growing body of evidence suggests these ACA regulations contributed to a substantial increase in the number of fraudulent and improper enrollments in subsidized ACA coverage, which further increases the federal cost.

This report assesses the impact of the Biden administration's regulations for ACA Exchanges on individual market premiums, the cost to the federal taxpayer, and the level of improper enrollments. Here are the key findings:

- According to the regulatory impact analyses used to support the rules, the current administration estimates five regulations will increase premiums on unsubsidized enrollees by up to 8.6 percent. This report documents another nine regulations that will increase premiums even higher.

- Fifteen regulatory changes lead to a substantial increase in federal expenditures, almost entirely through higher spending on premium subsidies.
  - In 2026, the first year when all of the Biden administration ACA regulations are projected to be in effect, these regulations are projected to cost the federal taxpayer $9.9 billion. This estimate is based on the cost estimates the administration provided in each rule to justify each of the ACA regulations.
  - Over a 10-year period from 2026 to 2035, these ACA regulations are estimated to increase federal spending by $108 billion.

- Recent evidence suggests the level of fraudulent and improper enrollments in subsidized Exchange coverage increased dramatically after these ACA regulations were implemented.
  - Many of the regulations contributing to higher premiums and federal spending also increase the level of fraudulent and improper enrollments in subsidized coverage through the Exchanges. Seven regulations and two guidance documents increase incentives and opportunities for improper enrollments.
  - Because the regulations generally and incorrectly assumed they would not weaken program integrity, the main cost estimates in this report do not account for the higher level of improper enrollments in subsidized Exchange coverage.
  - Research suggests these improper enrollments increased federal costs by up to $26 billion in 2024. Updated enrollment and cost estimates for 2024 from the Congressional Budget Office reinforce this estimate.

- The Biden administration's agenda to maximize enrollment at any cost is not just a federal spending issue. There is a human toll. It can create huge headaches with potential legal and financial implications for anyone who is enrolled without their consent or inadvertently receives APTC overpayments.

Introduction

Congress famously holds the power of the purse, which, under the U.S. Constitution, gives it the sole power to appropriate federal spending.[1] Yet, that does not mean the president has no control over federal spending. Executive branch discretion over *how* to implement federal laws can give the president substantial powers to increase or decrease the level of federal spending by issuing regulations which support the president's policy goals. These regulations can also impose direct financial costs on consumers, businesses, and state and local governments. With the end of the Biden administration approaching, this report adds up the cost of the regulatory actions the current administration finalized and proposed to date to advance their policy agenda to maximize enrollment through the ACA Exchanges.

This report begins by assessing the costs of these ACA regulations to the unsubsidized enrollees in the individual market. The cost to the unsubsidized portion of the insurance market is too often ignored. However, because this population is fully price sensitive to premiums, their purchasing decisions play a critical role in making sure the ACA health insurance markets deliver high value coverage for everyone in the market. The report then adds up the cost of these ACA regulations to the federal taxpayer based on the estimates each regulation provides in its regulatory impact analysis.

Recent evidence shows a substantial increase in the number of fraudulent and improper enrollments in subsidized coverage through the Exchanges. This report concludes by outlining how several ACA regulations increase incentives and opportunities for these improper enrollments. Because the Biden administration generally and incorrectly assumed their ACA regulations would not weaken program integrity, the additional federal cost from these improper enrollments adds to the costs reported in their regulations.

Federal Regulatory Overview

Since the ACA passed in 2010, there has been ongoing debate over the regulatory and financial burden the law imposes on health insurance consumers and taxpayers. The law fundamentally changed how health insurance is regulated by shifting primary authority from states to the federal government. This shift to federal authority gives federal regulators substantial policy discretion over how to implement key aspects of the ACA. Using this discretion, federal regulators must often balance competing goals related to cost, access, and quality.

Costs to the consumer and the taxpayer are nearly always key considerations. The ACA introduced new requirements for insurers to guarantee coverage to everyone regardless of their health status and without varying premiums based on health status. While these requirements allowed people with preexisting conditions to access coverage without restriction, they also substantially increased premiums by creating opportunities for people to select the time they enroll in coverage based on when they need health services. This is what the insurance industry calls adverse selection. Federal regulatory actions often present a choice between mitigating and aggravating this adverse selection problem.

Many consumers in the individual health insurance market are shielded from the ACA's higher costs. At the same time the ACA increased premiums, the law provided premium tax credit (PTC) subsidies for people with incomes between 100 to 400 percent of the federal poverty level (FPL). For this population, these premium subsidies entirely cover the higher cost of premiums under the ACA and give them lower premiums than they had before the ACA. However, people who do not qualify for premium subsidies, the unsubsidized, bear the full cost of the ACA's premium increase. Notably, unsubsidized people with pre-existing conditions bear the highest burden. For this higher need population, the ACA undermined access. Federal taxpayers also bear the entire cost of paying the ACA's higher premiums for the subsidized population. Federal regulatory actions often present a choice between mitigating and aggravating the higher costs the ACA imposes on the unsubsidized and the federal taxpayer.

In addition to premium subsidies, the ACA gives consumers with incomes between 100 percent and 250 percent of FPL access to cost sharing reduction (CSR) subsidies, which also raises the cost to federal taxpayers. Moreover, due to the fact that the ACA did not appropriate funding for CSRs, these subsidies get funded through higher premiums on the benchmark plan used to set the premium subsidy amount. This

increases the premium subsidies insurers receive to offset the loss of CSR funding, but it can also impact the premiums and coverage options for the unsubsidized. Federal regulatory actions often present a choice between mitigating or aggravating this situation.

Adverse selection and premium costs are not the only aspects of insurance coverage that federal ACA regulatory actions might impact. Adverse selection and cost consideration are often balanced against access considerations and whether a regulation makes it easier or harder for people to enroll in coverage. Regulations must also balance impacts on the number and quality of coverage options available on the health insurance market. While these are critical considerations, this report focuses on adding up the cost of the Biden administration's ACA regulatory actions to unsubsidized consumers and federal taxpayers.

Unsubsidized Consumer Experience

There's a substantial body of research discussing the ACA's impact on the people who directly benefit from premium and cost-sharing subsidies. Very little attention is paid to how the law impacts costs for consumers who earn too much to qualify for subsidies. However, this is a critical portion of the market. Because they are fully price sensitive to the cost of premiums, their purchasing decisions send key signals to health insurers that communicate whether their premiums and products are competitive. In short, they tell health insurers whether their products deliver value. This, in turn, informs whether taxpayers are getting value from the federal subsidies going to the rest of the market.

Unfortunately, the role that the unsubsidized portion of the market plays in making the ACA work at its best for everyone has gotten lost. Congress envisioned that the ACA would deliver a robust unsubsidized individual health insurance to anchor the ACA's new coverage lifeboat for low-income people who struggled to afford coverage. When Congress enacted the ACA, the Congressional Budget Office (CBO) projected that in 2019 — six years into full implementation of the law — the ACA would settle in with around 15 million unsubsidized individual market enrollees and 19 million subsidized individual market enrollees.[2] Compared to the CBO's current law projections at the time, this basically envisioned there would be no loss in unsubsidized enrollment while the ACA's premium subsidies would add 19 million new enrollees to the market. As such, the CBO projected about 45 percent of the individual market would remain unsubsidized to anchor the market.

The ACA has not delivered on that vision. Instead, unsubsidized enrollment dropped from 6.3 million in 2016 to 3.4 million in 2019 after the ACA hiked premiums.[3] During this time, a Centers for Medicare & Medicaid Services (CMS) analysis of the market found that "unsubsidized enrollment declined by more than 70 percent in Arizona, Georgia, Iowa, Missouri, Nebraska, New Hampshire, Oklahoma, Tennessee, and West Virginia." Subsidized enrollment reached only 8.3 million in 2019. CMS further found that "states with larger declines in unsubsidized enrollment tended to experience a larger increase in average premiums."[4] Declining unsubsidized enrollment alongside rising premiums shows how the ACA failed to deliver a functional health insurance market for the unsubsidized. That doesn't mean the ACA can't be improved to deliver lower premiums and a better individual market experience for everyone. However, as the next section outlines, the Biden administration proceeded to dig a deeper hole with administrative actions that raise the cost of ACA coverage to unsubsidized consumers even higher.

Cost to Consumers

A review of the Biden administration's ACA regulations reveals a regulatory strategy aimed almost exclusively at maximizing the number of subsidized people enrolled in Exchange coverage. This approach consciously chose to sacrifice the overall efficiency and functionality of the individual market to enroll more subsidized people whether they were eligible for subsidies or not. Unsubsidized consumers in the market bear an immediate cost for this single-minded approach. Based on this analysis, at least 14 regulations raise premiums, which imposes a direct cost to unsubsidized consumers.

There are several reasons why these regulations increase premiums. The main problem involves adverse selection.

By loosening enrollment requirements to maximize enrollment, several regulations allow people to select the time they enroll, which allows them to wait to enroll until they need health services. Thus, they are not paying premiums when they are healthy to support the risk pool, which leads to higher premiums for everyone else. Other regulations increase premiums by mandating insurance benefits which increases utilization. Regulations that impose new requirements on insurers or Exchanges can also increase premiums by increasing administrative costs. Finally, regulations can also undermine competition between insurers that would otherwise lead to lower premiums.

This section describes each of the 14 regulations that can be expected to raise premiums with an explanation for why the policy will raise premiums. In some cases, the Biden administration acknowledges the regulation will raise premiums. For five regulations, the link to higher premiums was clear enough for the rule to provide an estimate of the premium increase in a regulatory impact analysis. In one case the rule agrees there is a potential impact but concludes the impact would be *minimal*. In cases where the administration does not acknowledge a premium impact, they are usually *silent* on the issue, but in two cases they *reject* any negative impact on premiums. The following policies are organized by the level of premium impact that the rules acknowledge.

Policies acknowledged to have a clear and measurable premium impact

- **Narrow de minimis variation in actuarial values.**[5] The ACA requires health insurance plans in the individual and small group market to meet specific actuarial values — 60 percent for bronze, 70 percent for silver, 80 percent for gold, and 90 percent for platinum. These actuarial values represent the percentage of the benefit the plan will pay out to the enrollee. The statute requires the Secretary of the Department of Health and Human Services to establish guidelines that provide for a "de minimis variation" in the actuarial valuations used to establish metal levels. The Biden administration narrowed this de minimis variation.

  *Premium impact: **2 percent** due to increased utilization.* By narrowing the de minimis variation, this change substantially reduced an insurer's flexibility in designing plans. This includes requiring plans to increase the actuarial value of plans to fit within the narrower de minimis variation. This increase in plan generosity requires a corresponding increase in premium.

- **Eliminate pre-enrollment special enrollment period (SEP) verification for all but one SEP type.**[6] In addition to the annual OEP, the ACA establishes SEPs to allow people to enroll mid-year if they have a change in life circumstances, such as a marriage, birth of child, move or loss of a job. The Biden administration eliminated requirements to submit documentation to verify SEP eligibility for all but the loss of minimum essential coverage SEP.

  *Premium Impact: **1.5 percent** due to increased adverse selection.*[7] Like the OEP, SEPs play an important role in the overall structure of the ACA to mitigate adverse selection and protect the risk pool. Eliminating verifications opens opportunities to abuse SEPs by timing enrollment to the need for health services, harming the risk pool and ultimately raising premiums.

- **Allow states to "update and modernize" their essential health benefit (EHB).**[8] The ACA requires Exchange plans to cover a set of EHBs which must be equal to the scope of benefits provided under a typical employer plan. States must also defray the cost of benefits the state mandates in addition to EHB. The Biden administration removed requirements on states to defray the cost of new state benefit mandates if the benefit is already provided in the EHB benchmark plan. In addition, the administration removed the prohibition against including routine non-pediatric dental services as an EHB.

  *Premium Impact: **1 percent** due to increased utilization.*[9] Giving states additional flexibility to update and modernize their EHB allows states to expand the amount of benefits in the EHB which will increase utilization and costs to the plan and the consumer.

- **Establish a permanent monthly SEP for people with incomes below 150 of percent FPL.**[10] The ACA itemizes the SEPs that Exchanges must provide which is generally limited to situations where a consumer experiences a change in their life circumstances. The Biden administration

established a monthly SEP for people with incomes below 150 of percent FPL that allows them to enroll at any time during the year based on their income regardless of whether their income changed during the year.

Premium Impact: ***3 to 4 percent*** *due to increased adverse selection.* The initial rule putting this policy in place notes "there is no limitation on how often individuals who are eligible for this special enrollment period can obtain or utilize it."[11] Therefore, individuals are free to jump in and out of health plans as often as they want. This flexibility combined with the lengthy and sometimes burdensome enrollment process provided by HealthCare.gov increases opportunities and incentives for healthy enrollees to wait until they get sick to enroll in coverage.

- **Proposed rule to require health plans to expand access to a wider variety of contraceptive items at no cost sharing.**[12] The ACA requires health plans to provide preventive services without imposing cost sharing. The Biden administration proposed to require health plans to cover additional contraceptive items without cost sharing, including recommended over-the-counter contraceptive items.

  Premium Impact: ***0.1 percent*** *due to increased utilization.* Eliminating cost sharing for a wider variety of contraceptive items will require health plans to pay more to provide care to contraceptive users. To offset these payments to contraceptive users, health plans, including individual market insurers, will need to increase premiums for everyone.

Policies acknowledged to have a minimal premium impact

- **Refine EHB nondiscrimination policy for sexual orientation and gender identity.**[13] Federal rules do not allow a plan to be defined as EHB if the benefit design or its implementation discriminates based on various factors, such as age, sex, disability, or other health conditions. The Biden administration refined the EHB nondiscrimination policy to recognize discrimination on sexual orientation and gender identity as a prohibited form of sex discrimination.

  Premium Impact: Increased utilization. The rule acknowledges this change would likely have a minimal impact on premiums. By adding sexual orientation and gender identity as characteristics that fall under the prohibition against discrimination based on sex, this policy will require some health plans to increase the benefits they cover to meet the new EHB standard and, as a result, lead to higher utilization and costs for the insurer.

Policies where the rules are silent on any potential premium impact

- **Set the premium adjustment percentage to track only group market premium changes.**[14] The premium adjustment percentage tracks the percentage (if any) that the per capita premium for health insurance coverage increases from the previous year. This index is used to adjust the rate of increase for three parameters: the maximum out-of-pocket (MOOP) limits on cost sharing; the required contribution percentage used to determine hardship exemptions from the individual mandate; and the employer shared responsibility payment amounts. The Biden administration changed the premium adjustment percentage from tracking premium changes across individual and group health plans to track only group health plans.

  Premium Impact: Increased utilization. Changing the premium adjustment percentage to track only group health plan premiums resulted in slower premium growth which, in turn, reduced the MOOP limits. Imposing a lower MOOP limit restricts insurers from offering lower premium plans with higher cost sharing.

- **Rescind income verification when trusted data sources show the applicant's income is below 100 percent of FPL.**[15] The ACA requires the federal government to verify the income applicants report to be eligible for premium subsidies. When an applicant's reported income conflicts with income information from federal data sources, a data matching issue (DMI) arises. The Biden administration rescinded the requirement to verify income when the applicant reports an income between 100 and 400 percent FPL but data sources show an income below 100 percent FPL.

Premium impact: Increased adverse selection. Not verifying income when federal data sources show an income below 100 percent FPL allows some lower income individuals who are ineligible for premium subsidies to enroll in subsidized coverage who would not otherwise enroll. Because lower income individuals tend to be less healthy, enrolling these ineligible individuals will likely increase claims costs and, therefore, increase premiums.

- **Extend the Open Enrollment Period (OEP):**[16] The ACA generally limits new enrollments to an annual OEP, much like Medicare Advantage and employer coverage. Instead of running from November 1 to December 15, the Biden administration extended the OEP to run from November 1 to January 15.

  Premium impact: Increased adverse selection and program administration costs. The OEP limitation on when people can enroll provides an important protection against people taking advantage of the ACA's coverage guarantees and timing enrollment to when they need health services. Extending the OEP increases opportunities to time enrollment and harms the risk pool. In addition, extending the OEP also adds administrative costs to the Exchange that will ultimately be passed on to the consumer in the form of higher premiums.

- **Require insurers to offer Exchange plans with standardized plan options.** The ACA specifies certain minimum standards that QHPs must meet. On top of these standards, the Biden administration required insurers on the federal Exchange to offer QHPs with a standardized cost-sharing structure.[17] In later rulemaking, they limited the number of non-standardized plans an insurer could offer.[18]

  Premium impact: Less competition. The government is not well suited to designing products and services for consumers in any industry, and health insurance is no exception. By requiring standardized options and limiting non-standardized options, these regulations undermine and crowd out private options. Ultimately this will discourage insurers from offering coverage and those that do will have less incentive to innovate better, more affordable plan designs.

- **Require Exchanges to wait to discontinue APTC subsidies until a tax filer has failed to file taxes and reconcile APTC for two consecutive years:**[19] The ACA sets the APTC subsidy amount based on the income the applicant reported on their previous tax return. APTC can be based on other income information in cases where the applicant was not required to file income taxes. IRS regulations require APTC recipients to file tax returns and reconcile their past APTC. The Biden administration required Exchanges to wait to discontinue APTC subsidies until the tax filer has failed to file taxes and reconcile past APTC for two consecutive years.

  Premium impact: Increased adverse selection. The timely filing of a tax return is a critical element for making an accurate determination regarding the eligibility for and the amount of the APTC subsidy. Allowing an enrollee to receive APTC subsidies for a second year without filing taxes opens the process to substantial abuse when people know they can ignore an FTR status notice for the entire plan year and more. Those who are willing to abuse the process and not file taxes are also more likely to pose a higher health risk to the insurance pool either because they are abusing the process to access coverage or have a lower income which is associated with a higher health risk.

- **Proposed rule would provide contraceptive services without cost sharing to women when their health plan or insurer would otherwise be required to provide it absent a religious exemption.**[20] Religious employers, higher education institutions, and health insurers are not required to provide certain contraceptive services when they have a religious objection. To provide contraceptive services at no cost to women who are covered by an entity with a religious objection, the Biden administration proposes to allow providers to contract with insurers on the federal Exchange for payment. In turn insurers would receive an adjustment to their federal Exchange user fee to offset the payment.

  Premium Impact: Increased utilization. Due to the loss of Exchange user fees from offsetting preventive services payments, the federal Exchange will need to increase user fees on all insurers to make the federal Exchange budget whole. This increase in Exchange user fees will be passed

on to consumers in the form of higher premiums because federal regulations require insurers to include Exchange user fees in premium rates.

Policies where the rules reject any potential premium impact

- **Undermine insurers' ability to collect past-due premiums:**[21] The ACA requires insurers to guarantee the availability of coverage and also requires Exchange plans to allow a three-month grace period. The Biden administration repealed rules that had allowed insurers to attribute premium payments for new coverage to past due premiums before enrolling in new coverage with the same insurer.

  Premium impact: Increase in adverse selection. Due to the availability of a three-month grace period, not allowing insurers to attribute premium payments to past due premiums creates the opportunity for people to game enrollment by stopping payment at the end of the year and yet still be able to sign up for coverage for the next year. This policy discourages continuous coverage which harms the risk pool and raises premiums. One commenter to the rule projected premium increases would range from 0.3 percent to three percent.[22] The rule rejects potential adverse selection issues, citing a lack of evidence, comments asserting that few insurers take advantage of the policy, reduction in administrative costs, and agreement with commenters who asserted enrollees with high health care costs are more likely to pay past-due premiums which may improve the risk pool.[23] However, the rule ignored clear evidence demonstrating a substantial drop in enrollment that generally occurs in the last few months of the benefit year. Moreover, it fails to acknowledge the limited opportunity for insurers to implement the policy due to the COVID-19 public health emergency

- **Require Exchanges to accept an applicant's attestation of projected income without verification when there is no tax information.**[24] As explained previously, the ACA relies on tax returns to determine APTC eligibility and amounts. The ACA also establishes additional procedures to verify income when there is an inconsistency with tax data or when tax data is not available. Instead of following these additional verification processes, the Biden administration required Exchanges to accept an applicant's attestation of projected income when there is no tax data available.

  Premium impact: Increase in adverse selection. Allowing an applicant to simply attest to income without verification opens the eligibility determination process to substantial fraud and abuse which is compounded by the requirement on Exchanges to wait to discontinue APTC subsidies until the tax filer has failed to file taxes for two consecutive years. The same harm to the risk pool from requiring Exchanges to wait to discontinue APTC subsidies until the failure to file taxes for two consecutive years exists here. People willing to abuse the process likely pose a higher health risk. The rule rejects potential adverse selection impacts and argues that younger consumers with a lower health risk are more likely to lose their APTC eligibility due to an income data matching issue.[25] While there may be a larger proportion of younger consumers who do not resolve their data matching issue, the differential is likely not nearly wide enough to negate the adverse selection issue across the entire age spectrum. This is especially true considering this particular data matching issue involves people who have no tax information who operate outside the normal economy and, as such, pose higher health risks.[26]

Focusing on just the regulations where the federal rules provide an estimate of the premium impact, the combination of these five regulations is estimated to increase premiums by up to 8.6 percent. In some cases where the rules are silent, there is still a clear connection between the policy and higher premiums. Cost sharing levels and premiums are directly linked. Lower cost sharing means higher premiums and vice versa. Thus, by reducing the MOOP, the change to the premium adjustment methodology clearly increases premiums by some measure. By regulation, insurers must include Exchange user fees in premiums, and so any policy that directly impacts the level of the user fee will impact the premium.[27] The proposal to reduce Exchange user fees on insurers to offset contraceptive payments will, all things being equal, require a higher user fee to make the Exchange whole which, in turn, requires higher premiums.

Other regulations where CMS remains silent or rejects an impact may not have a tight dollar-for-dollar link to higher premiums, but fundamental insurance principles still point to higher premiums. Without any safeguards to protect the risk pool, the ACA's guaranteed coverage requirement and prohibition against rating on health status will be abused by people waiting to enroll until they need health services. Regulations that loosen the ACA's safeguards against this adverse selection will harm the risk pool and raise premiums.

These premium impacts are in addition to the substantial premium impact from the initial implementation of the ACA's market reforms. In 2013, before the ACA's main market reforms took effect, average monthly premiums on the individual market cost $245.[28] Today, average monthly premiums on the Exchanges exceed $600.[29] That represents a 146 percent increase compared to a 34 percent increase in the overall inflation rate and a 33 percent increase in the inflation rate for medical care over that time.[30] No one policy created that disparity. It reflects the accumulation of 0.3 percent here and 2 percent there and so on from various ACA policies over a decade.

In each case where the Biden administration determined their policy would increase premiums, they made the conscious decision that the benefit outweighed the cost. This is a normal part of the regulatory process. There are nearly always tradeoffs with any government policy decision. However, in the case of ACA regulations, there is often a deep unfairness regarding who bears the cost.

Too often, the Biden administration's policy choices aimed at maximizing subsidized enrollment impose a direct cost on the unsubsidized in the form of higher premiums. By their own estimate, the Biden administration's decision to establish a permanent monthly SEP to allow people with incomes below 150 percent of FPL to enroll any time through the year will increase premiums on the unsubsidized by up to four percent. No one else, but the unsubsidized individual market enrollee, bears that surcharge on their insurance premium to support a program to maximize subsidized enrollment on the Exchanges. In fact, people who get health coverage through their employer get a tax break.

This direct connection between federal policy decisions to broaden access to the ACA's premium subsidies on the Exchanges — a public program — and the premium amounts that unsubsidized people pay both on and off the Exchanges reflects one of the ACA's fundamental flaws. Unsubsidized people in the private individual health insurance market should not bear a special cost to support public policies that benefit someone else. Rather, public programs should be fully supported by public tax dollars. The next section itemizes how much the Biden administration's policies increased the cost of the ACA to the federal taxpayer.

Cost to the Taxpayer

Unlike unsubsidized enrollees, subsidized enrollees are held harmless when premiums go up. Due to the ACA's subsidy structure, the federal taxpayer picks up the entire cost of higher premiums for the subsidized because the subsidy increases in lock step with premium increases.[31] In addition to driving up premiums, ACA regulations can also increase federal costs by expanding eligibility for premium subsidies and adding administrative costs. This section adds up the cost of the Biden administration's ACA regulations to the federal taxpayer. This is a more straightforward analysis than accounting for the cost of higher premiums to the unsubsidized consumer because it relies exclusively on the estimates that are reported in the regulatory impact analysis for each rule.

The following table outlines the Biden administration's ACA Exchange regulations that are projected to result in a substantive increase in federal expenditures. Many of the regulations below overlap with regulations discussed in the previous section on premium impact. However, this table only includes regulations where the Biden administration estimates a premium impact and the corresponding increase in premium subsidies. Because the table omits regulations with premium impacts that are harder to measure, it likely understates the cost to taxpayers. Included in the table is a short description of the regulatory action and the annual cost for 2026. This is the first year when each of the new Biden regulations are projected to be in force and, therefore, reflects the full annual cost of the Biden administration's Exchange-related regulations.

Table 1

Impact of the Biden Administration's ACA Regulations on Federal Expenditures, 2026

Regulatory Action	Impact on Federal Expenditures, 2026
Set the premium adjustment percentage to track only group market premium changes.[54] Changing the premium adjustment percentage to track only group health plan premiums slowed the growth of this index which, in turn, reduced the MOOP limits. This means enrollees pay less cost sharing and insurers must raise premiums to cover those costs. Higher premiums result in higher APTC expenditures.	**$510,000,000**
Extend the Open Enrollment Period.[55] Instead of running from November 1 to December 15, the Biden administration extended the OEP to run from November 1 to January 15. Extending the OEP increases the risk of adverse selection but the Biden administration was silent on how this might impact premiums. By extending the OEP an additional four weeks, this change increased the cost to operate the federal Exchange.	**$8,608,466***
Narrow de minimis variation in actuarial values.[56] As discussed previously, the Biden administration narrowed the de minimis variation in actuarial values necessary for a plan to meet the level of plan generosity for each metal tier. This requires plans to increase the actuarial value of plans to fit within the narrower de minimis variation. This increase in plan generosity requires a corresponding increase in premium. Higher premiums result in higher APTC expenditures.	**$760,000,000**
Determine the affordability of employer coverage based on the employee's share of the cost to cover their family.[57] Longstanding interpretations of the ACA concluded that the law based the affordability of employer coverage on the employee's share of the cost of self-only coverage. Under this interpretation, if the employee's share of self-only coverage is affordable, then their family does not qualify for premium subsidies. The Biden administration changed the definition of affordability of employer coverage and based it on the employee's share of the cost of family coverage. The Department of the Treasury projects this change will increase the number of people enrolled in subsidized Exchange coverage by approximately 1 million.	**$3,800,000,000**
Add a 1332 waiver factor to the Basic Health Program (BHP) payment methodology.[58] The ACA allows states to operate a BHP as an alternative to APTC subsidized coverage for people with incomes between 138 percent and 200 percent of FPL. The BHP is funded by 95 percent of the PTC subsidies state residents would have otherwise received without the BHP. States may also establish alternative programs under section 1332 waivers that replace a portion of PTC funding with pass through funding to support the new program. The Biden administration added an adjustment factor to the payment methodology for the BHP to consider pass through funding under a 1332 waiver as part of the PTC in the BHP payment methodology.	**$148,386,594***
Require Exchanges to wait to discontinue APTC subsidies until a tax filer has failed to file taxes and reconcile APTC subsidies for two consecutive years.[59] As discussed previously, the Biden administration required Exchanges to wait to discontinue APTC subsidies until the tax filer has failed to file taxes and reconcile past APTC subsidies for two consecutive years. This policy will increase APTC expenditures on the enrollees who have not followed the requirement to file taxes and are, nonetheless, allowed to retain their APTC eligibility.	**$373,000,000**
Require Exchanges to accept an applicant's attestation of projected income without verification when there is no tax information.[60] Prior regulations required applicants to submit documentation to verify their income if there was no tax data available. By allowing an applicant to simply attest to income without verification, this policy allows applicants to remain enrolled in APTC coverage who would otherwise have lost APTC coverage for failing to provide the required documentation.	**$175,000,000**
Provide earlier coverage effective dates for individuals who attest to a future loss of minimum essential coverage.[61] Previous SEP policy set the coverage effective date for the first day of the month after a loss of minimum essential coverage, which left a potential for a gap in coverage. The Biden administration set an earlier effective date for the first day of the month of the loss of minimum essential coverage when a plan selection is made in the month before the loss. This policy increases APTC expenditures by allowing an earlier effective date for APTC coverage.	**$161,000,000**

Regulatory Action	Impact on Federal Expenditures, 2026
Expand the timeframe to report a loss of Medicaid coverage to qualify for an SEP.[62] The Biden administration increased the number of days for an individual to report the past loss of Medicaid coverage from 60 to 90 days. A state Exchange may extend the reporting period longer if the state Medicaid program has a longer eligibility reconsideration period. This longer time period will increase APTC expenditures by allowing more people to enroll in APTC coverage through this SEP.	**$98,000,000**
Amend the re-enrollment hierarchy to allow Exchanges to direct re-enrollment for individuals who qualify for CSRs to a CSR-qualified silver plan.[63] Federal regulations automatically re-enroll Exchange enrollees into a health plan for the next benefit year if the enrollee does not take active steps to re-enroll. Generally, enrollees are re-enrolled into the same plan. Bronze plans do not qualify for CSR subsidies. For people enrolled in a bronze plan who are determined eligible for CSRs, the Biden administration allowed Exchanges to direct their re-enrollment to a CSR-eligible silver plan. This policy increases APTC expenditures by directing re-enrollments into plans with CSR subsidies.	**$48,000,000**
Establish a permanent monthly SEP for people with incomes below 150 percent of FPL.[64] As discussed previously, the Biden administration established a monthly SEP for people with incomes below 150 percent of FPL that allows them to enroll at any time during the year based on their income regardless of whether their income changed during the year. This policy increases APTC expenditures in two ways. First, the flexibility to enroll any time during the year allows people to time enrollment to when they need health services, which increases adverse selection that harms the risk pool and, in turn, requires higher premiums. Second, the year-round availability of this SEP increases the number of people who enroll in APTC coverage outside the OEP.	**$2,500,000,000**
Make Deferred Action for Childhood Arrival (DACA) recipients eligible for APTC coverage.[65] The ACA requires an individual to be "lawfully present" in the United States to qualify for APTC subsidies. The Biden administration redefined lawfully present to include DACA recipients, which increases the number of people who qualify to enroll in APTC coverage.	**$305,000,000**
Establish an optional fixed-dollar premium payment threshold for triggering a grace period or terminating coverage.[66] Insurers currently have the option to set a percentage-based premium payment threshold to effectuate coverage for an enrollee who has not paid their full premium, which avoids triggering a grace period or termination of coverage for non-payment of premium. 95 percent or more of the enrollee's premium responsibility is considered a reasonable threshold. The Biden administration allowed insurers to adopt a fixed-dollar threshold of $10 or less. Such a threshold substantially increases the number of enrollees who may maintain APTC subsidized coverage despite not paying the full premium.	**$847,956,554**
Proposed rule to establish an arrangement where individuals enrolled in plans or coverage sponsored by an entity with a religious objection to covering contraceptive services can access such services at no cost.[67] In cases where an individual cannot receive contraceptive services at no cost because their health plan is sponsored by an entity with a religious objection to such services, the Biden administration has proposed an arrangement where the individual can still receive contraceptive services at no cost from a provider. Under this arrangement, the provider would be reimbursed by an insurer on the federal Exchange and the insurer cost would be offset by a reduction in the Exchange user fee. This arrangement would result in a transfer of federal funds from the federal Exchange to individuals receiving contraceptive services. (Note that the proposed rule does not discuss how the loss in Exchange funding would be offset, which would likely be borne by individual market enrollees in the form of higher premiums because federal regulations require insurers to include the Exchange user fee in the premiums they charge to consumers across the entire individual market.)	**$49,900,000**
Proposed rule to require health plans to expand access to a wider variety of contraceptive items at no cost sharing, including recommended over-the-counter contraceptive items.[68] As discussed previously, eliminating cost sharing for a wider variety of contraceptive items will require health plans to pay more to provide care to contraceptive users. To offset these payments to contraceptive users, health plans, including individual market insurers, will need to increase premiums for everyone. A portion of these higher premiums will be funded through APTC expenditures.	**$83,100,000**
Total	**$9,867,951,615**

* These regulations did not have specific projections for 2026 included in the rule's regulatory impact analysis. Therefore, this estimate reflects the estimate provided in the regulatory impact analysis with an adjustment based on the CBO baseline projections.

As Table 1 shows, the total federal cost for all of the Biden administration's ACA Exchange and insurance market reform regulations is projected to add up to $9.9 billion in 2026. Again, this represents the federal cost for the first year when each of the regulations are expected to be in force. Starting with the federal expenditure estimates from each rule and adjusting for the annual change in premium tax credit outlays from the CBO's June 2024 baseline projections, the federal cost across a 10-year window from 2026 to 2035 reaches $108 billion.[32]

This increase in federal spending represents a substantial portion of the projected spending on APTC and APTC-related programs.[33] The latest CBO projections estimate that federal spending on APTC and related programs will total $100 billion in 2026.[34] Therefore, the cost of the Biden administration's ACA regulations is projected to account for about 10 percent of total spending on APTC and APTC-related programs under the ACA in 2026. The ability to increase federal spending in this proportion to the overall program in just four years reflects an extraordinary exercise of executive authority.

Impact on Fraudulent and Improper Enrollments

A growing body of evidence shows that fraud and abuse began to spread across ACA Exchanges after these rules and associated legislative changes began to roll out in 2021. This is not a coincidence. These changes in law and regulation substantially increase the opportunity and incentive to enroll consumers in coverage with APTC subsidies when they are not eligible for such subsidies. The regulatory impact analysis for each regulation generally did not account for any increase in fraudulent and improper enrollments in subsidized APTC coverage due to the regulatory changes. Therefore, the estimated impact reported here must be viewed as a very conservative estimate.

The rise in fraud and abuse came into public view on April 2, 2024 when *KFF Health News* reported on a substantial increase in consumer complaints from people who were enrolled in coverage or switched to different coverage without their knowledge.[35] Two weeks later a lawsuit was filed against companies selling APTC subsidized coverage and their lead generators alleging they were enrolling consumers and switching plans without their knowledge or consent.[36] Then in May, CMS acknowledged they received around 50,000 complaints of unauthorized enrollments and 40,000 complaints of unauthorized plan switches in the first three months of 2024.[37] The Paragon Health Institute published a report that quantified the level of fraudulent and improper enrollments. By comparing the level of enrollment in APTC subsidized coverage among people with incomes between 100 and 150 percent of FPL and Census estimates of the total state population in that same income range, they estimate four to five million people at this income level fraudulently enrolled in subsidized coverage in 2024 at a federal cost of $15 to $26 billion.

The Paragon cost estimate for fraudulent and improper enrollments represents up to 23 percent of total federal spending on APTC and APTC-related programs in 2024, according to CBO spending estimates.[38] This level of fraud may seem hard to believe. However, these sizable cost estimates appear quite reasonable when viewed alongside the chronology of changes in law and regulation that have increased the opportunity and incentive to enroll ineligible consumers in subsidized health coverage through the Exchanges. The following bullets outline this chronology.

- **March 4, 2021:** In *City of Columbus v. Cochran*, the U.S. District Court for the District of Maryland vacates federal requirements on Exchanges to verify income in cases where an applicant for subsidized health coverage reports income between 100 and 400 percent of FPL and federal data sources show their income is below 100 percent of FPL.[39] This allowed consumers at that income level to inflate their incomes above 100 percent of FPL with impunity.

- **March 11, 2021:** Congress passes and President Biden signs the American Rescue Plan Act (ARPA) which substantially expanded the availability of fully subsidized health coverage through the Exchanges.[40] Specifically, ARPA temporarily set the percentage of premium that a consumer with an income between 100 and 150 percent of FPL must pay to zero. That made the silver benchmark plan with CSR subsidies through Exchanges free to anyone in this income range for tax years 2021 and 2022. Because people enrolled in free health coverage do not receive a monthly bill for premium, they do not receive regular notice of their enrollment. This opened opportunities for unscrupulous agents and brokers to enroll people in fully

subsidized plans without their knowledge. It also allowed people to stay inadvertently enrolled in subsidized coverage after they had moved on to other coverage and lost eligibility.

- **May 5, 2021:** Federal rulemaking officially removes the income verification requirements vacated by the federal district court in *City of Columbus v. Cochran*. In its opinion, the federal district court failed to review the full rulemaking record. Specifically, they failed to acknowledge how the prior rule relied on a U.S. Government Accounting Office study on improper payments that found "CMS does not check for potentially overstated income amounts, despite the risk that individuals may do so in order to qualify for advance PTC."[41] The federal government had an opportunity to reinstate this rule with a clearer statement on the basis and need for the rule to correct this judicial oversight.

- **September 27, 2021:** Federal rulemaking creates a new special enrollment period that allows people with incomes between 100 and 150 percent of FPL to enroll at any time during the year.[42] The Biden administration specifically adopted this change "to provide low-income individuals who generally will have access to a premium-free silver plan … with more opportunities to enroll in coverage." This change dramatically expanded opportunities for fraudulent and improper enrollments from consumers who inflate their incomes, as well as from unscrupulous agents and brokers who encourage applicants to inflate their income or, worse, enroll people without their knowledge. This special enrollment period was contingent on the percentage of premium that a consumer with an income between 100 and 150 percent of FPL must pay being set to zero. This means it would expire when the temporary expansion of premium subsidies under ARPA and later extended under the Inflation Reduction Act (IRA) ends.

- **June 7, 2022:** CMS publishes guidance requiring health insurers to pay agents and brokers the same commission for enrollments during a special enrollment period as they pay for enrollment during the OEP.[43] By requiring insurers to pay the same commissions throughout the year, this guidance increased the commissions that insurers pay during special enrollment periods. These higher broker commissions increased the financial incentives for brokers to fraudulently enroll people in subsidized coverage throughout the entire year.

- **July 1, 2022:** Federal rulemaking eliminates pre-enrollment verification of eligibility for all special enrollment periods with the exception of the loss of minimum essential coverage. Eliminating pre-enrollment verification of eligibility for all but one special enrollment period greatly expanded opportunities for anyone with an income between 150 to 400 percent of FPL to improperly enroll in subsidized health coverage at any time during the year by falsely claiming eligibility for a special enrollment period.

- **August 16, 2022:** Congress passes and President Biden signs the Inflation Reduction Act, which extends fully subsidized health coverage through Exchanges made available under ARPA until the end of 2025.

- **April 27, 2023:** Federal rulemaking implements three changes that substantially weaken the income verification process for subsidized APTC coverage.
    - Exchanges must now wait to discontinue subsidized APTC coverage until a tax filer has failed to file taxes and reconcile APTC for two consecutive years. Restricting Exchanges from discontinuing subsidized coverage in these circumstances creates a clear opening for ineligible people who have refused to follow federal requirements in place to verify income to stay enrolled in subsidized APTC coverage when they are not eligible.
    - Exchanges must now accept an applicant's attestation of projected income without verification when the IRS does not have tax information available to verify their income. When there is no tax information available, other data sources are available to verify income such as social security income data, state employment data, and private data sources like Equifax. The absence of tax information makes these alternative data sources an even more critical component of the verification process.

      By banning the use of these income verification sources, federal rules take away an obvious program integrity protection that opens the door to more ineligible enrollments.

- When an applicant's reported income conflicts with data sources used to verify income, Exchanges must extend the time for an applicant to verify income from 90 days to 150 days. This extension gives people who cannot verify their income 60 more days to remain enrolled in subsidized APTC coverage.

- **August 14, 2023:** CMS issues guidance that allows an Exchange to redetermine an enrollee eligible for APTC subsidies based on the projected income from their most recent application even when the enrollee failed to file a tax return for that corresponding year or, if they filed a tax return, when tax return data reported their income was below the income threshold to qualify for APTC subsidies. The latter basically directs the Federal Exchange and allows state Exchanges to violate the statute because the statute clearly directs Exchanges to set the APTC amount based on the income from the previous tax return.[44]

- **April 15, 2024:** Federal rulemaking makes the monthly special enrollment period for people with incomes below 150 percent of FPL permanent. Recall that the prior rule governing this special enrollment period made it contingent on the continuation of enhanced premium subsidies made available under ARPA and extended to the end of 2025 under the IRA. This rule makes this income-based special enrollment period permanent.

Federal changes reinforce and amplify program integrity problems

Any one of these changes in law and regulation weaken Exchange program integrity. However, when combined, they reinforce each other and amplify the program integrity problem. Expanding the availability of fully subsidized plans boosts opportunities and incentives for unauthorized fraudulent enrollments and inadvertent reenrollments. In both cases, consumers may not know they are enrolled because they don't pay a premium each month. Fully subsidized plans also boost incentives for people below 100 percent of FPL in non-Medicaid-expansion states to knowingly inflate their income to qualify for these free health plans. For people who inflate their income — so long as they don't fudge their income projection "with intentional or reckless disregard for the facts"[45] — federal law substantially limits repayments for people with incomes less than 400 percent of FPL. For people with incomes less than 200 percent of FPL, the current repayment limit is $375.[46] Four years ago, federal regulations were in place to counter anyone looking to take fraudulent or improper advantage of fully subsidized plans. However, as the chronology shows, the Biden administration has taken several steps to undermine the income verification process that was previously in place to ensure that only eligible people enroll in subsidized coverage. This began with the decision to not pursue income verifications when federal data sources show an applicant's income is below 100 percent of FPL. This decision allowed any applicant — including a fraudulent broker filling out an application — to inflate their income with impunity. Income verification was further weakened by the decision to not enforce tax filing requirements even though tax returns are the primary source the statute relies on to set an accurate APTC subsidy amount. Currently, there's no further income verification if there is no tax information available, and enrollees are given one more year to not file taxes before being cut off from APTC subsidies.

On top of eliminating these basic income verifications, the chronology shows how the Biden administration opened opportunities to take advantage of these new income verification weaknesses by allowing consumers to enroll year-round without limit. Under the statute, enrollment is supposed to be limited to an annual OEP with some exceptions to allow people to enroll mid-year through a special enrollment period if they experience a change in life circumstances, such as the loss of coverage, a move, a marriage or the birth of a child. The Biden administration removed verifications for all but the loss of coverage special enrollment period. Removing these verifications opened opportunities to abuse special enrollment periods. However, the largest opening for abuse stems from the decision to create a new special enrollment period that allows anyone to enroll at any time during the year if they report an income between 100 and 150 percent of FPL.

Changes clearly intended to undermine program integrity, maximize enrollment

Taken together, these changes in law and regulation reveal a clear intent from the Biden administration to allow fraudulent and improper enrollments to go unchecked at nearly every stage. These changes did not just weaken Exchange program integrity, they eliminated program integrity. They stopped

verifying income on applications when federal income data sources showed the applicant was inflating their income to qualify for fully subsidized plans. They greatly expanded access to these fully subsidized plans, increasing the incentive to inflate income. They allowed people to stay enrolled in subsidized coverage even if they didn't file taxes and stopped using alternative income verification sources when there is no tax return information. They implemented a special enrollment period based on income level to allow enrollment in fully subsidized plans year-round. For everyone else with a higher income level, they stopped verifying all but one special enrollment period.

CMS had identified problems with fully subsidized plans as early as the 2016 benefit year. A CMS presentation from July 2017 noted complaints from consumers who only learned they had been enrolled in subsidized coverage when the IRS alerted them that it would not process tax refunds until they reconciled their premium subsidies.[47] One of the commonalities among these unauthorized enrollments included "100% APTC which covered premium payments, so the consumer did not have to make recurring payments."[48] As a result, this factor became and remains one of the key criteria used to allow insurers to cancel unauthorized enrollments.[49] Nonetheless, over the past four years, changes in law and regulations systematically eliminated protections against unauthorized enrollments. This record reveals the Biden administration's clear focus on maximizing enrollment at any cost, regardless of whether enrollees are eligible for APTC subsidies.

Even after outlining the Biden administration's strategic steps to maximize enrollment by undermining program integrity, the dramatic increase in fraudulent and improper enrollments and the attendant $15 to $26 billion cost estimated by Paragon may still seem hard to believe. But those estimates seem reasonable next to how the CBO projections for APTC enrollment and federal APTC spending in 2024 have escalated as the Biden administration's regulatory strategy fell into place.

Table 2 provides the CBO projections for APTC enrollment and spending for the 2024 benefit year from their May 2022, September 2023, and June 2024 baseline projections. The May 2022 baseline projection estimated that just 11 million people would be enrolled in APTC subsidized coverage at a cost of $59 billion. At this time, the IRA had not become law and so this projection assumed expanded premium subsidies would expire at the end of 2022. By the time CBO made their September 2023 baseline projections, the IRA had extended the premium subsidy expansion to the end of 2025. Also, most of the regulations aimed at maximizing enrollment by

Table 2

Congressional Budget Office Projections for APTC Subsidized Enrollment and Federal Spending for the 2024 Benefit Year

	May 2022 Baseline Projections	September 2023 Projections	June 2024 Baseline Projections
Enrollment APTC Subsidized Nongroup Coverage	11 million	17.4 million	21.4 million
Federal spending on APTC Subsidized Nongroup Coverage	$59 billion	$95 billion	$114 billion

Note: This table includes the total enrollment and federal spending for all coverage subsidized by APTC and APTC-related programs, including 1332 waiver programs and basic health programs. Sources: Congressional Budget Office, *Health Insurance and Its Federal Subsidies: CBO and JCT's June 2024 Baseline Projections* (June 2024), available at https://www.cbo.gov/system/files/2024-06/51298-2024-06-healthinsurance.pdf; Congressional Budget Office, *Federal Subsidies for Health Insurance: 2023 to 2033* (Sept. 2023), available at https://www.cbo.gov/publication/59273; and Congressional Budget Office Congressional Budget Office, *Federal Subsidies for Health Insurance Coverage for People Under Age 65: CBO and JCT's May 2022 Baseline Projections* (May 2022), available at https://www.cbo.gov/system/files/2022-06/51298-2022-06-healthinsurance.pdf.

weakening program integrity were in effect. As such, the September 2023 projections for APTC subsidized enrollment and spending in 2024 increased substantially, rising to 17.4 million subsidized enrollees at a cost of $95 billion. Despite little to no change in federal policy between the September 2023 projections and the June 2024 baseline projections, the CBO's updated baseline raised their estimate for APTC subsidized enrollment and spending in 2024 to 21.4 million subsidized enrollees at a cost of $114 billion.

Considering how federal policies largely remained the same between the September 2023 and June 2024 projections, there is clearly a major outside factor influencing enrollment that CBO did not account for in the September 2023 projection. To explain the differences between these projections, the CBO noted that "recent data suggest that the availability of enhanced Marketplace subsidies through 2025 have had a larger impact than the CBO previously projected, in part because of the availability of the zero-premium benchmark plans for people with incomes below 150 percent of poverty."[50] This is certainly true, but it does not explain *why* the availability of fully subsidized benchmark plans increased enrollment beyond expectations.

The likely explanation for why the availability of fully subsidized plans had a greater impact on enrollment than anticipated is that fully subsidized plans increased the incentive and opportunities for fraudulent and improper enrollments in such plans. The CBO also noted they anticipate a long-term impact on enrollment from the special enrollment period that allows people with incomes below 150 percent of FPL to enroll at any time during the year and the "elimination of multiple income verification steps". Those regulatory changes make up much of the chronology outlined previously. However, CBO never discussed how these regulatory changes enable fraudulent and improper enrollments. If these regulatory changes are left in place, their long-term impact on APTC subsidized coverage and federal spending may be much larger than anticipated after fully accounting for the higher level of improper enrollments they allow.

No one appears to have been accounting for this fraud and abuse until news reports, consumer complaints, and actual enrollment data for 2024 began to emerge last spring. Because the CBO's June 2024 baseline projection draws from actual 2024 enrollment data, it now reflects the actual amount of fraud and abuse in the system. As discussed previously, the Paragon report estimates that four to five million people improperly enrolled in subsidized coverage through the Exchanges in 2024 at a cost of $15 to $26 billion. This level of fraudulent and improper enrollment aligns closely with the changes between CBO's September 2023 and June 2024 projections which increased subsidized enrollment by four million at a cost of $19 billion. This alignment suggests that unaccounted for fraud and abuse explains much of the unanticipated difference between the CBO projections. While this is certainly not a precise measure, this alignment suggests the cost of improper enrollments due to the changes in law and regulation under the Biden administration in 2024 reasonably sits in the $20 billion neighborhood.

Impacts on people unknowingly or mistakenly enrolled

The Biden administration's agenda to maximize enrollment at any cost is not just a federal spending issue. There is a human toll. It can create huge headaches with potential legal and financial implications for anyone who is enrolled without their consent or inadvertently receives APTC overpayments. As the 2017 CMS presentation noted, an IRS notice on withholding tax refunds can be the first alert that someone has been enrolled in subsidized coverage. Many families depend on their tax refunds, and any delay can create substantial hardship.

The tax filing process can also be the first time someone receives notice that they erroneously received APTC overpayments. Anyone finding this out so late in the game has missed the window for an easy cancelation of their insurance policy. An insurance cancelation can be done through the Exchange through a process that requires insurers to refund the APTC to the federal government. However, when that cancelation window closes, the consumer must now contend with the IRS.

Honest mistakes can also lead to people receiving excess APTC without their knowledge, such as when an enrollee properly reports an income change, but the Exchange never lowers the APTC payment. In these cases, enrollees are generally still on the hook for repayment because the U.S.

Tax Court does not have the authority to consider equity when assessing repayment liabilities.[51] Income verifications through the Exchange enrollment and redetermination process help avoid these situations. However, as the chronology shows, the Biden administration severely weakened these protections.

Conclusion

As the U.S. Supreme Court explained in *King v. Burwell*, the ACA "adopts a series of interlocking reforms designed to expand coverage in the individual health insurance market."[52] The ACA relies on these interlocking reforms to meet the law's main coverage expansion goal while at the same time avoiding undesirable outcomes that had plagued so many health reforms in the past. Instead of an ACA agenda that appreciates the interlocking elements of the ACA, this report documents how the Biden administration followed an ACA regulatory strategy aimed almost exclusively at one element — maximizing the number of subsidized people enrolled through ACA Exchanges.

The Biden administration's single-minded ACA regulatory approach consciously chose to sacrifice the overall efficiency and functionality of the market. This imposes a tremendous cost to people who must pay higher premiums without subsidies. According to the regulatory impact analyses used to support the rules, the administration estimates five regulations will increase premiums by up to 8.6 percent. This report documents another nine regulations that increase premiums even higher. These higher premiums combined with regulatory changes that expand eligibility for APTC subsidies also lead to a substantial increase in federal spending. Using conservative assumptions that rely on cost estimates from each rule's regulatory impact analysis, the Biden administration's ACA regulatory changes are projected to cost $108 billion from 2026 to 2035. This projection does not account for the substantial increase in fraudulent and improper enrollments in APTC subsidized coverage that these regulatory changes generate.

Altogether, the annual costs itemized in the regulatory impact analyses from each rule and the annual cost due to fraudulent and improper enrollments add up to around $30 billion. At over 25 percent of federal spending on APTC subsidized enrollment, this represents a tremendous cost to federal taxpayers and an extraordinary exercise of executive authority.

Endnotes

1 U.S. Constitution, Article I, Section 9 ("No Money shall be drawn from the Treasury, but in Consequence of Appropriations made by Law.").
2 Congressional Budget Office, *Selected CBO Publications Related to Health Care Legislation, 2009–2010*, Table 4 (December 2010), available at https://www.cbo.gov/sites/default/files/111th-congress-2009-2010/reports/12-23-selectedhealthcarepublications.pdf.
3 Centers for Medicare & Medicaid Services, *Trends in Subsidized and Unsubsidized Enrollment* (October 9, 2020), available at https://www.cms.gov/cciio/resources/forms-reports-and-other-resources/downloads/trends-subsidized-unsubsidized-enrollment-by18-19.pdf.
4 Id.
5 Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023, 87 Fed. Reg. 27208, 27305-11 (May 6, 2022).
6 Id. at 27277-80.
7 Patient Protection and Affordable Care Act; Market Stabilization, 82 Fed. Reg. 18346 (April 18, 2017).
8 Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2025; Updating Section 1332 Waiver Public Notice Procedures; Medicaid; Consumer Operated and Oriented Plan (CO-OP) Program; and Basic Health Program, 89 Fed. Reg. 26218, 26338-50 (April 15, 2024).
9 Note that this premium increase applies to only states that choose to change their EHB-benchmark plans. CMS anticipates that no more than 5 states will choose to do so in any given year.
10 89 Fed. Reg. 26218, 26320-24.
11 Patient Protection and Affordable Care Act; Updating Payment Parameters, Section 1332 Waiver Implementing Regulations, and Improving Health Insurance Markets for 2022 and Beyond, 86 Fed. Reg. 53412, 53433 (Sept. 27, 2021).
12 Enhancing Coverage of Preventive Services Under the Affordable Care Act, 89 Fed. Reg. 85750, 85782-83 (Oct. 28, 2024).
13 Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023, 87 Fed. Reg. 27208, 27295-306 (May 6, 2022).
14 Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2022 and Pharmacy Benefit Manager Standards, 86 Fed. Reg. 24140, 24233-36 (May 5, 2021).
15 Id. at 24216. The rescission of this rule was taken, in part, to comply with a decision from a federal district court judge in *City of Columbus, et al., v. Cochran* that vacated the existing rule at the time. However, the Biden administration was free to reintroduce the rule in a manner that addresses the Administrative Procedure Act issues the judge identified or appeal the judge's decision.
16 86 Fed. Reg. 53412, 55429-33.
17 Id. at 27310-22.
18 Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2024, 88 Fed. Reg. 25740, 25855-66 (April 27, 2023).
19 Id. at 25814-19.
20 Coverage of Certain Preventive Services Under the Affordable Care Act, 88 Fed. Reg. 7236 (February 2, 2023).
21 Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023, 87 Fed. Reg. 27208, 27218-19 (May 6, 2022).
22 Id. at 27370.
23 Id. at 27370-71.
24 Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2024, 88 Fed. Reg. 25740, 25818-21 (April 27, 2023).
25 Id. at 25820.
26 *See* Sharon R Silver, Jia Li, and Brian Quay, "Employment Status, Unemployment Duration, and Health-Related Metrics among U.S. Adults of Prime Working Age: Behavioral Risk Factor Surveillance System, 2018–2019," *American Journal of Industrial Medicine*, Vol. 65, Iss. 1, pp. 59-71, Nov. 8, 2021, available at https://pmc.ncbi.nlm.nih.gov/articles/PMC8678322/; and William M. Schultz, et al., "Socioeconomic Status and Cardiovascular Outcomes: Challenges and Interventions," *Circulation*, Vol. 137, Iss. 20 (May 2018), pp. 2166-78, available at https://www.ahajournals.org/doi/full/10.1161/CIRCULATIONAHA.117.029652.
27 45 CFR § 156.80(d)(ii).
28 Centers for Medicare & Medicaid Services, 2013 Medical Loss Ratio data.
29 Centers for Medicare & Medicaid Services, February 2024 Effectuated Enrollment data.
30 The rate of inflation increase reflects the change from the first half of 2013 to the first half of 2024. U.S. Bureau of Labor Statistics, Consumer Price Index for All Urban Consumers (CPI-U), All items in U.S. city average, all urban consumers, not seasonally adjusted; and U.S. Bureau of Labor Statistics, Consumer Price Index for All Urban Consumers (CPI-U), Medical care in U.S. city average, all urban consumers, not seasonally adjusted.
31 *See* 89 Fed. Reg. 85750, at 85782 fn. 197 (noting that "each dollar of increased silver plan premiums generates exactly a dollar of additional net Federal PTC spending for individuals receiving PTCs" when estimating the increase in federal APTC expenditures due to the proposal to require health plans to expand access to a wider variety of contraceptive items at no cost sharing).
32 Specifically, the 10-year projection was calculated by starting with the federal cost for the last year under which the RIA for the rule provides an estimate. Generally, the RIAs provide estimates covering a five-year window, but some estimates cover a ten-year window. Because these RIA cost estimates cover four years of rulemaking with various starting points and projection periods, there are also various end points for the final year of the projection period in each RIA. To project beyond the close of these projection periods in each rule, the remaining years are adjusted based on the change in the CBO baseline projections for premium tax credit outlays. Specifically, this adjustment reflects the average annual growth rate in federal APTC expenditures from 2028 to 2034. The adjustment is limited to APTC expenditures because over 99 percent of the projected increase in federal expenditures reported in the rules is due to an increase in expenditures on APTC and APTC-related programs. In addition, the adjustment period begins in 2028 to avoid enrollment distortions due to the expiration of the temporary premium subsidy expansions under the Inflation Reduction Act that expire at the end of 2025. The adjustment period ends in 2034 to avoid any distortion related to the expiration of New York's 1332 waiver which will likely be extended. Congressional Budget Office, *Baseline Projects: The Premium Tax Credit and Related Spending* (July 2024), available at https://www.cbo.gov/system/files/2024-07/60523-2024-07-premium-tax-credit.pdf.
33 APTC-related programs include spending on 1332 waiver programs and the basic health program.
34 Congressional Budget Office, *Health Insurance and Its Federal Subsidies: CBO and JCT's June 2024 Baseline Projections* (June 2024), available at https://www.cbo.gov/system/files/2024-06/51298-2024-06-healthinsurance.pdf. CBO projections account for regulatory changes as of April 3, 2024. Thus, CBO's projected spending for 2026 would likely not account for the proposed changes included in Table 1. They may also not include the recent changes establishing a permanent monthly SEP for people with incomes below 150 percent of FPL and expanding APTC eligibility to DACA recipients. Though, Exhibit 2 in an article by CBO analysts published in Health Affairs suggests CBO included the 150 percent FPL SEP in their recent projections. Jessica Hale, et al., " Health Insurance Coverage Projections For The US Population And Sources Of Coverage, By Age, 2024–34," *Health Affairs*, Vol. 43, No. 7, pp. 922-32 (July 2024), available at https://www.

healthaffairs.org/doi/10.1377/hlthaff.2024.00460.
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37 Press Release, Centers for Medicare & Medicaid Services, "CMS Statement on Agent and Broker Marketplace Activity, Update," May 6, 2024, available at https://www.cms.gov/newsroom/press-releases/cms-statement-agent-and-broker-marketplace-activity-update.
38 Congressional Budget Office, *Baseline Projects: The Premium Tax Credit and Related Spending* (July 2024), available at https://www.cbo.gov/system/files/2024-07/60523-2024-07-premium-tax-credit.pdf.
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