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DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Parts 147, 155, and 156

[CMS-9884-F]

RIN 0938-AV61

Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS)

ACTION: Final rule.

SUMMARY: This final rule revises standards relating to denial of coverage for failure to pay past-due premium; excludes Deferred Action for Childhood Arrivals recipients from the definition of "lawfully present;" establishes the evidentiary standard HHS uses to assess an agent's, broker's, or web-broker's potential noncompliance; revises the Exchange automatic reenrollment hierarchy; revises standards related to the annual open enrollment period and special enrollment periods; revises standards relating to failure to file and reconcile, income eligibility verifications for premium tax credits and cost-sharing reductions, annual eligibility redeterminations, de minimis thresholds for the actuarial value for plans subject to essential health benefits (EHB) requirements, and income-based cost-sharing reduction plan variations. This final rule also revises the premium adjustment percentage methodology and prohibits issuers of coverage subject to EHB requirements from providing coverage for specified sex-trait modification procedures as an EHB.

DATES: *Effective Date*: These regulations are effective on [INSERT DATE 60 DAYS AFTER

PUBLICATION IN THE **FEDERAL REGISTER**].

Applicability Dates: See section III.D. of this final rule for further information on the applicability dates.

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SUPPLEMENTARY INFORMATION:

I. Executive Summary

On January 20, 2025, President Trump issued a memorandum entitled "Delivering Emergency Price Relief for American Families and Defeating the Cost-of-Living Crisis."[1] This memorandum instructed all executive departments and agencies to deliver emergency price relief for the American people and to increase the prosperity of the American worker. Health care represents a substantial portion of a family's budget and a tremendous cost to Federal taxpayers. To provide emergent relief from rising improper enrollments and health care costs, we are finalizing several regulatory actions aimed at strengthening the integrity of the Patient Protection and Affordable Care Act (ACA) eligibility and enrollment systems to reduce waste, fraud, and abuse that we proposed in the 2025 Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability proposed rule (90 FR 12942) ("2025 Marketplace Integrity and Affordability proposed rule" or "proposed rule"). We expect these actions will provide immediate premium relief to families who do not qualify for Federal premium subsidies and reduce the burden of improper ACA premium subsidy expenditures to the Federal taxpayer.

Based on our review of enrollment data and our experience fielding consumer complaints, the Department believes the temporary expansion of ACA premium subsidies

[1] Executive Office of the President. (January 20, 2025). *Delivering Emergency Price Relief for American Families and Defeating the Cost-of-Living Crisis. https://www.federalregister.gov/documents/2025/01/28/2025-01904/delivering-emergency-price-relief-for-american-families-and-defeating-the-cost-of-living-crisis.*

resulted in conditions that were exploited to improperly gain access to fully-subsidized coverage. As we detailed in the 2025 Marketplace Integrity and Affordability proposed rule and reiterate in this final rule, the widespread availability of $0 premium plans created the incentive and opportunity for fraudulent and improper enrollments at scale, either by the enrollee's own doing or by a third party without the enrollee's knowledge, including consumers who were enticed to respond to misleading advertisements promising cash or gift cards, and provided enough personal information for the agent, broker, and web-broker to enroll the consumer in a qualified health plan (QHP). Exchange eligibility verification policies in effect at the time enhanced subsidies became available, as well as those adopted and implemented since that time, were not sufficient to protect against this consumer harm and fraud, waste, and abuse of Federal funds.

In particular, consumers are at risk for accumulating surprise tax liabilities and substantial inconvenience from resolving these liabilities, as well as other issues related to coverage changes and access to care, due to improper enrollment. The substantial and unprecedented increase in consumer complaints from people who were unaware that they had been enrolled by an agent, broker, or web-broker in Exchange coverage suggests many of these improper enrollments are due to fraud, improper actions that violate agency rules and agreements, or other improper processes that result in incorrect determinations.[2] Fraudulent enrollments involve enrollments obtained through willful misrepresentations whereas improper enrollments involve enrollments

[2] For example, from January 2024 through August 2024, CMS received 90,863 complaints that consumers had their FFE plan changed without their consent (also known as an "unauthorized plan switch"). CMS (2024, October). *CMS Update on Action to Prevent Unauthorized Agent and Broker Marketplace Activity. https://www.cms.gov/newsroom/press-releases/cms-update-actions-prevent-unauthorized-agent-and-broker-marketplace-activity*. *See also*, U.S. Department of Justice. (2025, February 19). *President of insurance brokerage firm and CEO of marketing company charged in $161M Affordable Care Act enrollment fraud scheme* [Press release]. *https://www.justice.gov/opa/pr/president-insurance-brokerage-firm-and-ceo-marketing-company-charged-161m-affordable-care.*

that result from or were affected by noncompliance with agency rules and regulations, which can include fraud.[3]

The expanded subsidy regime that gave way to this environment of fraudulent and improper enrollments is expiring at the end of this year. Given the high and demonstrable levels of improper enrollment creating long-term uncertainty and instability in the marketplaces, this rule takes a carefully curated set of temporary actions to immediately reduce the crisis-levels of improper enrollments over the short-term as the market readjusts to the new subsidy environment in which enhanced subsidies are no longer available. This final rule also enacts permanent reforms to help the markets reset to the changing subsidy environment to improve affordability and stability over the long-term.

The temporary enactment of numerous policies within this rule responds directly to concerns raised by commenters about potential negative effects of making such policies permanent, while balancing the need to address the current high levels of improper enrollments created by the expanded subsidies and the holdover improper enrollments that will remain in the immediate wake of the enhanced subsidy expiration. The temporary reforms then sunset, as we share many commenter concerns. We also considered comments that the causes of the improper enrollments this rule aims to address are not known with certainty and that data related to Exchange enrollments may be skewed or misleading as marketplaces are still recovering from the COVID-19 public health emergency. The temporary codification of these policies attempts to strike a balance between these commenter concerns and the integrity of the Exchange program and the Federal funds that support it. We believe the policies will reduce the improper enrollments that can carry forward due to auto re-enrollment after the enhanced subsidies expire.

[3] *See* U.S. Government Accountability Office, Improper Payments and Fraud: How They Are Related but Different, December 7, 2023, *https://www.gao.gov/products/gao-24-106608.*

The absence of the enhanced subsidies, most notably the absence of fully-subsidized plans, will substantially mitigate the threat of future improper enrollments.

Because Federal law limits the amount that enrollees with lower household incomes must repay when they reconcile advance payments of the premium tax credit (APTC) received, these improper enrollments ended up costing Federal taxpayers billions of dollars. One analysis of improper enrollments estimated the Federal Government may have spent up to $26 billion on improper enrollments in 2024, before reconciling enrollment data.[4] The policies being finalized in this rule aim to address these imminent program integrity problems while recognizing these problems are an outgrowth of temporary policy in order to deliver a streamlined enrollment and eligibility determination process for individual market consumers.

Before summarizing these policies, we believe it is important to review the interlocking policies the ACA put in place to expand access to coverage on the individual market.[5] A full understanding of how ACA individual market policies interact helps frame why we stated in the 2025 Marketplace Integrity and Affordability proposed rule (90 FR 12943) that we believe the program integrity and premium relief policies contained within these rules are necessary to respond to present-day challenges in the individual health insurance market. As a starting point, the ACA establishes American Health Benefit Exchanges, or "Exchanges," to facilitate the purchase of QHPs. Many individuals who enroll in QHPs through individual market Exchanges are eligible to receive a premium tax credit (PTC) to reduce their costs for health insurance premiums and have their out-of-pocket expenses for health care services reduced through cost-sharing reductions (CSR). Most individuals who claim PTCs receive APTC, which subsidizes

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[4] Blase, B.; Gonshorowski, D. (2024, June). *The Great Obamacare Enrollment Fraud*. Paragon Health Institute. *https://paragoninstitute.org/private-health/the-great-obamacare-enrollment-fraud.*

[5] The Patient Protection and Affordable Care Act (Pub. L. 111-148, 124 Stat. 119) was enacted on March 23, 2010. The Healthcare and Education Reconciliation Act of 2010 (Pub. L. 111-152, 124 Stat. 1049), which amended and revised several provisions of the Patient Protection and Affordable Care Act, was enacted on March 30, 2010. In this rulemaking, the two statutes are referred to collectively as the "Patient Protection and Affordable Care Act," "Affordable Care Act," or "ACA".

lower monthly premiums, before they must file taxes. Taxpayers must then reconcile APTC paid to issuers on their behalf when they file taxes. The ACA includes limits on how much excess APTC a taxpayer must repay based on household income.

The ACA's individual market rules require issuers to guarantee coverage (with limited exceptions) to all applicants regardless of pre-existing conditions and restrict issuers from setting premiums based on health status. These requirements create an inherent bias towards adverse selection—a situation where individuals with higher risk are more likely to select coverage than healthy individuals—by allowing people to wait to enroll in coverage until they need health services. In such situations, health insurance issuers offering coverage to a larger proportion of higher risk enrollees raise premiums, which causes healthier people to drop coverage. Enough cycles of rising premiums and healthier people dropping coverage would create a "death spiral" and undermine the viability of the individual market.

Several policies included in the ACA attempt to address its adverse selection bias. For example, the ACA permits issuers to limit enrollment periods to certain times. In addition, adverse selection between plans can occur when one plan enrolls a disproportionate number of people with higher risk conditions. The ACA's risk adjustment program transfers funds from issuers with relatively low-risk enrollees to issuers with relatively high-risk enrollees, though implementation of the risk adjustment program has been criticized by some commenters for creating further distortions that limit incentives for issuers to attract lower-risk enrollees.[6] To avoid adverse selection between plans sold on and off the Exchanges, the ACA also requires issuers to keep all individual market plans that are subject to the law's main coverage mandates in the same risk pool.

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[6] Cruz, D; Fann, G. (2024, Sept.). *It's Not Just the Prices: ACA Plans Have Declined in Quality Over the Past Decade.* Paragon Health Institute. *https://paragoninstitute.org/private-health/its-not-just-the-prices-aca-plans-have-declined-in-quality-over-the-past-decade/*.

By tying an issuer's on-Exchange and off-Exchange individual market risk pools together, the ACA's unsubsidized off-Exchange market was intended to help anchor the subsidized Exchange enrollees to a more competitive and efficient market. A well-functioning market depends on consumers actively shopping for the best deal based on price and quality.[7] A well-functioning market also depends on there being 'low information asymmetry' where, for example, health insurance issuers, health care providers, and consumers have comparable information, instead of issuers and providers having more or better information than consumers. Information asymmetry in insurance markets can lead to imbalances in market predictions, inefficient operations, skewed decisions, and adverse selection.[8] Low information asymmetry generally ensures that buyers (consumers) and sellers (issuers and providers) are on a more equal footing, preventing one party from taking advantage of another due to superior knowledge. In recent years, HHS has taken steps to level the playing field between health insurance issuers, health care providers, and consumers by adopting regulations promoting transparency in health insurance coverage (85 FR 72158).

Despite the ACA's intent to create more competitive and efficient markets, in practice, the high premiums of off-Exchange plans have made these options largely unattractive to unsubsidized consumers, with only an estimated 2.5 million people enrolling in unsubsidized off-Exchange coverage (including some in plans not subject to all of the ACA's market rules, such as grandfathered and short-term plans) nationwide in 2023.[9] Further, price-linked subsidies like PTCs are directly tied to the price of a QHP such that when QHP premiums go up, PTC allowed

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[7] Garrod, L.; Waddams, C.; Hvvid, M.; and Loomes, G. (2009). Competition Remedies in Consumer Markets. *Loyola Consumer Law Review.* 21. 439-495. *https://www.researchgate.net/publication/271701344_Competition_Remedies_in_Consumer_Markets*.(last accessed Febuary 23, 2025).

[8] Akerlof, George A. (August 1970). "The Market for 'Lemons': Quality Uncertainty and the Market Mechanism". The Quarterly Journal of Economics. 84 (3): 488–500. doi:10.2307/1879431. JSTOR 1879431.

[9] Ortaliza, J.; Amin, K.; and Cox, C. (2023). As ACA Marketplace Enrollment Reaches Record High, Fewer Are Buying Individual Market Coverage Elsewhere. *https://www.kff.org/private-insurance/issue-brief/as-aca-marketplace-enrollment-reaches-record-high-fewer-are-buying-individual-market-coverage-elsewhere/#.*

also increases. Such price-linked subsidies generally distort markets and weaken competition because the subsidized enrollee is no longer price sensitive to the full cost.[10] In a market where everyone is subsidized, prices would generally be much higher due to the subsidized consumers' lower level of price sensitivity.[11] When Congress enacted the ACA, the Congressional Budget Office (CBO) projected the law would enroll 15 million unsubsidized consumers—about the same as without the law—and another 19 million subsidized consumers.[12] Those 15 million unsubsidized consumers actively shopping for the best deal were expected to support a competitive and efficient market. In turn, the benefits from this competition would spill over to the subsidized consumers who benefit from the availability of higher quality health plans and the Federal taxpayers funding the subsidies who benefit from lower premium subsidies.

The ACA did not roll out as intended when the ACA's main coverage mandates went into effect in 2014. Premiums increased much more and enrollment levels among both the subsidized and the unsubsidized were much lower than projected. Higher premiums then led to a substantial decline in unsubsidized enrollment, which undermined the competitiveness of the market. By 2019, our data showed that subsidized enrollment on the Exchanges had reached only 8.3 million while unsubsidized enrollment across the entire individual market subject to the ACA's market rules had dropped to 3.4 million.[13] To improve the attractiveness of the market, several States

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[10] *See* Sonia Jaffe and Mark Shepard, "Price-Linked Subsidies and Imperfect Competition in Health Insurance," *American Economic Journal: Economic Policy*, Vol 12, No. 3, August 2020.

[11] While subsidized consumers are willing to tolerate higher prices than unsubsidized consumers, there are certain limits on how much prices can rise overall. The ACA's rate review provision (section 2794 of the Public Health Service Act (PHS Act)) restrains prices prospectively by placing scrutiny on proposed premium rate increases before they go into effect, which can discourage or prevent issuers from implementing unreasonable rate increases. The ACA's medical loss ratio provision (section 2718 of the PHS Act) limits prices retrospectively by requiring issuers to pay rebates to consumers if premium rates end up being excessive relative to actual medical costs.

[12] Congressional Budget Office. (2010, March 20). *Letter to Nancy Pelosi*. Congress of the U.S. Table 4, https://www.cbo.gov/sites/default/files/111th-congress-2009-2010/costestimate/amendreconprop.pdf.

[13] CMS. (2020, Oct. 9). *Trends in Subsidized and Unsubsidized Enrollment*. p. 11. *https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Trends-Subsidized-Unsubsidized-Enrollment-BY18-19.pdf*. Note that, in 2019, an additional 1.4 million unsubsidized people remained enrolled in grandfathered and grandmothered individual market plans that were not subject to all of the ACA's market rules. Grandmothered coverage refers to certain non-grandfathered health insurance coverage in the

implemented reinsurance programs that lowered premiums for the unsubsidized by funding high-cost claims across the individual market. These policies helped retain unsubsidized enrollees who anchor the market in a more competitive and efficient position.

In 2021, Congress passed the American Rescue Plan of 2021 (ARP),[14] which temporarily expanded the generosity of ACA premium subsidies. In 2022, Congress extended the enhanced subsidies through 2025 under the Inflation Reduction Act of 2022 (IRA).[15] These subsidies compounded the problems associated with price-linked subsidies like PTC, but they also created the incentive and opportunity for unprecedented fraud and improper enrollments. Specifically, the enhanced subsidies provide "zero-dollar premium" benchmark silver plans for individuals with projected annual household income between 100 and 150 percent of the Federal Poverty Level (FPL). By fully subsidizing the premium for these plans, individuals could be enrolled into these plans once every month through a special enrollment period (SEP) by predatory agents and brokers without the individual's knowledge. Individuals for whom Federal law limits the amount of PTC they must repay also have a strong incentive to sign up for such plans improperly. There have been widespread reports of consumers in this income cohort having their plan switched without their knowledge. As displayed in Table 14 of this rule, there are millions of people improperly enrolled in fully-subsidized QHPs. These imminent concerns prompted our rapid rulemaking and informed our nuanced response in this final rule that balances the need to urgently reduce the high level of improper enrollments while understanding the subsidy environment that largely created the incentive and opportunity for such improper enrollment is coming to an end.

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individual and small group market with respect to which CMS has announced it will not take enforcement action even though the coverage is out of compliance with certain specified market rules. *See* CMS. (2022, March 23). *Extended Non-Enforcement of Affordable Care Act-Compliance with Respect to Certain Policies*. *https://www.cms.gov/files/document/extension-limited-non-enforcement-policy-through-calendar-year-2023-and-later-benefit-years.pdf.*

[14] Pub. L. 117-2.

[15] Pub. L. 117-169.

In the 2025 Marketplace Integrity and Affordability proposed rule (90 FR 12944), we stated that we believe that after reviewing individual market data and responding to a substantial increase in consumer complaints, we needed to implement program integrity protections to mitigate and reverse the substantial increase in improper enrollments on the Exchanges caused by the availability of enhanced premium subsidies. Some of those protections included eligibility verifications related to qualifying for APTC and CSR subsidies. Others focused on enrollment period policies by re-thinking when and under what conditions a consumer can enroll. We also stated that we believe the data and analysis presented in this preamble show how these protections could lower premiums and costs for consumers and taxpayers alike. Therefore, we proposed regulatory changes to improve program integrity and protect against adverse selection. We proposed this while also emphasizing the importance of keeping the enrollment process streamlined and accessible, especially for low-income consumers who utilize Exchanges for subsidized individual market coverage. These considerations helped inform our thinking as we amended our proposals into policies being finalized in this rule. Specifically, the finalized policies balance the urgent need to reduce the high level of improper and fraudulent enrollments with this desire to promote an efficient enrollment process over a longer-term.

The 2025 Marketplace Integrity and Affordability proposed rule was published in the **Federal Register** on March 19, 2025, with a comment period that ended on April 11, 2025. We received over 26,000 comments from State governments or entities, the National Association of Insurance Commissioners (NAIC), the American Academy of Actuaries (AAA), issuers or issuer groups, providers/provider groups/provider associations, general advocacy groups, individuals, and others. The vast majority of comments were from individuals.

In section III. of this final rule, we provide a summary of each proposed provision, a summary of the public comments received and our responses to them, and the policies we are finalizing. Below, we summarize the policies being finalized.

We are finalizing revisions to § 147.104(i) that reverse the current policy prohibiting an issuer from denying coverage due to an individual's or employer's failure to pay premiums owed for prior coverage, including by attributing payment of premium for new coverage to past-due premiums from prior coverage. The current policy, in effect, prohibits issuers from establishing premium payment policies that require enrollees to pay past-due premiums to effectuate new coverage. While we previously concluded that this prohibition would remove an unnecessary barrier and make it easier for consumers to enroll in coverage, recent enrollment data suggest people are manipulating guaranteed availability and grace periods to time enrollment in coverage to when they need health care services. Under this final rule, issuers may, to the extent permitted by applicable State law, add past-due premium amounts owed to the issuer (or owed to another issuer in the same controlled group) to the initial premium the applicant must pay to effectuate new coverage and not effectuate new coverage if the past-due and initial premium amounts are not paid in full. As this adverse selection issue was not created by the expansion of APTCs and is not related to the levels of improper enrollment brought on by them, we are finalizing this policy, which will be applicable as of the effective date of this rule and beyond. We believe this change will strengthen the risk pool and lower gross premiums.

We are finalizing modifications to the definition of "lawfully present" currently articulated at § 155.20 and used for the purpose of determining whether a consumer is eligible to enroll in a QHP through an Exchange or a Basic Health Program (BHP) in States that elect to operate a BHP.[16] The BHP regulations at 42 CFR 600.5 cross-reference the definition of lawfully present at 45 CFR 155.20. This change reflects the best view of the statutory requirements of the ACA by once again excluding "Deferred Action for Childhood Arrivals" (DACA) recipients

[16] Currently, Minnesota and Oregon operate a BHP. *See* their approved BHP Blueprints, available at: *https://www.medicaid.gov/basic-health-program/index.html.* New York had implemented a BHP since April 1, 2015 and suspended its implementation on April 1, 2024.

from the definition of "lawfully present" that is used to determine eligibility to enroll in a QHP through an Exchange, for PTC, APTC, and CSRs, and for a BHP in States that elect to operate a BHP. We are finalizing this policy to be applicable upon the effective date of this final rule and beyond.

We are finalizing revisions to § 155.220(g)(2) to require HHS to apply a "preponderance of the evidence" standard of proof for terminations for cause by HHS of an agent's, broker's, or web-broker's Exchange agreements under § 155.220(g)(1). We are also finalizing the addition of the definition for "preponderance of the evidence" at § 155.20. We believe this change will improve transparency in the process for holding agents, brokers, and web-brokers accountable for compliance with applicable law, regulatory requirements, and the terms and conditions of their Exchange agreements. This change is a consumer protection unrelated to the subsidy levels set by Congress. We finalize this standard to be applicable upon the effective date of this final rule and beyond.

We are finalizing revisions to the failure to file and reconcile (FTR) process at § 155.305(f)(4) to reinstate the 1-year policy in PY 2026 that Exchanges must determine a tax filer ineligible for APTC if: (1) HHS notifies the Exchange that the tax filer (or their spouse if the tax filer is a married couple) received APTC for a prior year for which tax data will be utilized for verification of income, and (2) the tax filer or tax filer's spouse did not comply with the requirement to file a Federal income tax return and reconcile APTC for that year. This change will reduce the number of ineligible enrollees who continue to receive APTC in 2026 as a result of lingering improper and fraudulent enrollments resulting from the expansion of APTCs. As such, this policy will sunset on December 31, 2026 after addressing the imminent improper enrollment concerns and Exchanges would revert back to the two-year policy where Exchanges may not determine a tax filer eligible for APTC if HHS notifies the Exchanges that the tax filer (or either spouse if the tax filer is a married couple) received APTC for two consecutive years for

which tax data would be utilized for verification of income, and (2) the tax filer or tax filer's spouse did not comply with the requirement to file a Federal income tax return and reconcile APTC for that year and the previous year beginning in coverage year 2027. We believe this change will reduce the number of ineligible enrollees who continue to receive APTC in 2026, which will lower APTC expenditures and protect ineligible enrollees from accumulating surprise tax liabilities while the market and enrollment rolls readjust to the absence of the subsidy expansion. Finally, we are also finalizing amendments to the notice requirement at § 155.305(f)(4)(i) and removing the notice requirement at § 155.305(f)(4)(ii) for 2026 to conform with the notice policy under the previous FTR policy, while the noticing requirements will revert back to align with the 2-year policy in 2027.

We are finalizing the removal of § 155.315(f)(7) which requires that applicants receive an automatic 60-day extension to the 90-day period set forth in section 1411(e)(4)(A) of the ACA to provide documentation to verify household income when there is an income inconsistency. Removing § 155.315(f)(7) will adjust APTC payments to individuals who have failed to provide documentation verifying their income attestation within 90 days and further protect them from surprise tax liabilities if they are ineligible. We no longer believe the automatic 60-day extension is allowed by statute and we are therefore finalizing this change, which will be applicable as of the effective date of this rule and beyond.

To further protect against consumers receiving APTC and CSR subsidies when they do not meet eligibility requirements and root out the improper and fraudulent enrollments holding over from the subsidy expansion, we are finalizing temporary policies to address immediate concerns with the verification process when there is an income inconsistency with trusted data sources. We also are finalizing for the remainder of plan year (PY) 2025 starting at the effective date of the rule and PY 2026 revisions to § 155.320(c)(3)(iii) to specify that Exchanges on the Federal platform must generate annual household income inconsistencies when a tax filer's

attested projected annual household income would qualify the taxpayer as an applicable taxpayer according to 26 CFR 1.36B-2(b) and trusted data sources indicate that projected household income is under 100 percent of the FPL. Finally, we are finalizing, for the remainder of PY 2025 starting the effective date of the rule and PY 2026, the pause of § 155.320(c)(5), which pauses the exception to the standard household income inconsistency process that requires the Exchange to accept an applicant's attestation of household income and family size without verification when the Internal Revenue Service (IRS) does not have tax return data to verify household income and family size. Removing this exception will in most circumstances require Exchanges to verify household income with other trusted data sources when a tax return is unavailable and follow the alternative verification process to verify the income, which strengthens program integrity by improving the accuracy of eligibility determinations across all Exchanges. These policies directly address program integrity issues brought on by the proliferation of fully-subsidized, zero-premium benchmark plans and therefore we are finalizing them until PY 2027.

To prevent fully-subsidized enrollees from being automatically re-enrolled without taking an action to confirm their eligibility information, we are finalizing a temporary amendment to the annual eligibility redetermination regulation. We are finalizing that, when an enrollee does not submit an application for an updated eligibility determination for the future coverage year (2026) by the last day to select a plan for January 1, 2026 coverage, in accordance with the effective dates specified in § 155.410(f), and the enrollee's portion of the premium for the entire policy is zero dollars after application of APTC through the annual redetermination process, Exchanges on the Federal platform must decrease the amount of the APTC applied to the policy such that the remaining monthly premium owed by the enrollee for the entire policy equals $5 for the first month and for every following month that the enrollee does not confirm their eligibility for APTC. Consistent with § 155.310(c) and (f), enrollees automatically reenrolled with a $5 monthly premium after APTC under this policy will be able to update their Exchange application

at any point to confirm eligibility for APTC that covers the entire premium, and re-confirm their plan to thereby reinstate the full amount of APTC for which the enrollee is eligible on a prospective basis. We are finalizing that the Federally-facilitated Exchanges (FFEs) and the State-based Exchanges on the Federal platform (SBE-FPs) must implement this change with annual redeterminations for benefit year 2026. We believe implementing these policies for 2026 will strengthen the program integrity of the Exchanges and protect consumers by ensuring that those fraudulently or improperly enrolled in fully-subsidized, zero-premium plans are not unknowingly enrolled in those plans for an additional year while the market readjusts to the expiration of the expanded subsidies. In the 2025 Marketplace Integrity and Affordability proposed rule, we also sought comment on a range of other options to ensure program integrity with respect to automatic re-enrollment that would provide a more meaningful incentive to confirm eligibility for APTC, as the millions estimated to currently receive improper APTC could simply pay the $5 premium while continuing to improperly receive generous subsidies on their behalf, potentially incurring significant future surprise tax liabilities in the process. As such, we sought comment on whether $5 is the appropriate premium amount for affected individuals to pay under the proposed policy. Another such option could include requiring individuals who qualify for fully-subsidized plans to re-confirm their plan and re-verify their income before they are eligible to receive APTC. Finally, we sought comment on removing the option for Exchanges to auto-re-enroll individuals who qualify for fully or partially subsidized plans, ensuring individuals affirmatively choose their plan and verify their income during the Open Enrollment Period (OEP), dramatically reducing the likelihood of improper payments of the APTC.

We are finalizing amendments to the automatic reenrollment hierarchy by removing § 155.335(j)(4), which currently allows Exchanges to move a CSR-eligible enrollee from a bronze QHP and re-enroll them into a silver QHP for an upcoming plan year, if a silver QHP is available in the same product, with the same provider network, and with a lower or equivalent

net premium after the application of APTC as the bronze plan into which the enrollee would otherwise have been re-enrolled. We also clarify that State Exchanges may retain their flexibility regarding their re-enrollment hierarchies at the discretion of the Secretary of Health and Human Services (the Secretary) per § 155.335(a)(2)(iii) and that Exchanges may seek approval from the Secretary to conduct their own annual eligibility redetermination process. We believe the consumer awareness problem the current policy aimed to address is substantially less today than it was at the time we adopted a re-enrollment hierarchy allowing Exchanges on the Federal platform to switch a consumer's enrollment from a bronze to a silver plan. As a result, consumer awareness concerns no longer outweigh the negative consequences of not automatically re-enrolling consumers whose current plan is still available for the upcoming plan year without their active consent. These negative consequences include potential consumer confusion, undermining of consumer choice, and unexpected tax liabilities. We believe this policy is important to honor the decisions of consumers, regardless of the subsidy environment. Given that we did not find this policy as being substantially associated with fraudulent and improper enrollments, we are finalizing this policy, which will be effective for PY 2026 and beyond.

We are temporarily finalizing modifications to § 155.400(g) to pause paragraphs (2) and (3), which establish an option for issuers to implement a fixed-dollar and/or gross percentage-based premium payment threshold, with the following modification: the removal of the fixed-dollar and gross-premium threshold flexibilities will sunset after the completion of one new coverage year, PY 2026, on December 31, 2026. Thereafter, the FFE and SBE-FP will, and State Exchanges may, offer issuers the flexibility to implement the premium payment threshold flexibilities that were finalized in the Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2026; and Basic Health Program final rule (2026 Payment Notice) (90 FR 4424). As previously stated, we have significant program integrity concerns with the availability of fully-subsidized plans. Therefore, to preserve the integrity of the Exchanges,

we believe it is important to ensure that enrollees do not remain enrolled in coverage without paying at least some of the premium owed, as there are situations where the fixed-dollar and/or gross percentage-based thresholds would have allowed an enrollee to remain enrolled in coverage for extended periods of time after payment of the binder. Because this problem is effectively an outgrowth of the subsidy expansion, we are finalizing these proposals only through PY 2026 to allow the market to readjust to the non-expanded subsidy environment.

For benefit years starting January 1, 2027, and beyond, we are finalizing a change to the annual OEP for coverage through all individual market Exchanges. Rather than specifying November 1 through December 15 as the OEP period as proposed, the final rule at § 155.410(e) provides that the OEP must begin no later than November 1 and end no later than December 31 of the calendar year preceding the benefit year of enrollment. Exchanges have flexibility to determine their specific OEP dates within these guidelines as long as the OEP length does not exceed 9 weeks per § 155.410(e)(5)(ii) and all OEP plan selections are effective on January 1 of the plan year per § 155.410(f)(4). Beginning with benefit year 2027, the dates of the OEP each year for Exchanges operating on the Federal platform will be November 1 through December 15. Non-grandfathered individual health insurance coverage offered outside of an Exchange must also align with the OEP dates in the applicable State Exchange. The length of the open enrollment period is fundamentally unrelated to subsidy levels and we have not determined it to be a major source of improper and fraudulent enrollments. Therefore, we are finalizing these changes, which will be applicable for benefit year 2027 and beyond.

We are temporarily finalizing the removal of § 155.420(d)(16) and making conforming changes to pause the monthly SEP for qualified individuals or enrollees, or the dependents of a qualified individual or enrollee, who are eligible for APTC and whose projected household income is at or below 150 percent of the FPL through PY 2026. This policy is directly related to the availability of fully-subsidized plans, as under the subsidy expansion individuals with

projected annual incomes between 100 and 150 percent of the FPL are eligible for fully-subsidized plans and the SEP. Therefore, to fully ensure that improper and fraudulent enrollments are fully exercised from this population, we are pausing the SEP for PY 2026 as the market readjusts to the lack of a subsidy expansion.

Further, based on recent evidence[17] suggesting an increase in the misuse and abuse of SEPs to gain coverage primarily in fully-subsidized plans outside of the OEP, we are finalizing temporary amendments to § 155.420(g) to enable HHS to reinstate pre-enrollment verification of eligibility of applicants for all categories of individual market SEPs. We are further finalizing temporary amendments to § 155.420(g) to require all Exchanges to conduct pre-enrollment verification of eligibility for at least 75 percent of new enrollments through SEPs. Given the primary concern with fully-subsidized plans, we are finalizing these proposals through PY 2026, to give the market the opportunity to fully shed improper enrollments resulting from the subsidy expansion.

We are finalizing amendments to § 156.115(d) to provide that an issuer of coverage subject to EHB requirements may not provide coverage for specified sex-trait modification procedures as an EHB beginning with PY 2026. In response to comments, we are also adding a definition of "specified sex-trait modification procedure" at § 156.400. These changes are effective for PY 2026 and beyond, as they are a furtherance of existing EHB requirements and are not associated with subsidy levels or improper enrollments.

We are finalizing updates to the premium adjustment percentage methodology to establish a premium growth measure that comprehensively reflects premium growth in all affected markets for PY 2026 and beyond. This premium growth measure is used to ensure that certain parameters change with health insurance market premiums over time, including

[17] This conclusion is drawn from current and historic SEP data available to the Exchanges on the Federal platform through the Monthly SEP report and is current as of January 3, 2025.

parameters related to annual limits on cost sharing, eligibility for certain exemptions based on access to affordable premiums, and employer shared responsibility payment amounts. The premium adjustment percentage is also used as part of the calculation of the reduced annual limitation on cost sharing applicable to silver plan variations. This final policy re-adopts the premium growth measure that was in place for PY 2020 and PY 2021 and applies it to the related parameters starting with PY 2026. As such, we also are finalizing the PY 2026 maximum annual limitation on cost sharing, reduced maximum annual limitations on cost sharing, and required contribution percentage under § 155.605(d)(2) using the premium adjustment percentage methodology finalized in this rule.

Beginning in PY 2026, we are finalizing changes to the de minimis thresholds for the Actuarial Value (AV) for plans subject to EHB requirements to +2/-4 percentage points for all individual and small group market plans subject to the AV requirements under the EHB package, other than for expanded bronze plans,[18] for which we are finalizing a de minimis range of +5/-4 percentage points, as well as finalizing wider de minimis thresholds for income-based CSR plan variations. These changes are effective for PY 2026 and beyond as they are unrelated to the subsidy level set by Congress, but are rather important measures to promote affordability and choice.

II. Background

A. Legislative and Regulatory Overview

Section 2702 of the Public Health Service (PHS) Act, as added by the ACA, establishes requirements for guaranteed availability of coverage in the group and individual markets.

[18] Expanded bronze plans are bronze plans currently referenced in § 156.140(c) that cover and pay for at least one major service, other than preventive services, before the deductible or meet the requirements to be a high deductible health plan within the meaning of section 223(c)(2) of the Internal Revenue Code of 1986.

Section 2703 of the PHS Act, as added by the ACA, and sections 2712 (former) and 2742 of the PHS Act, as added by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), require health insurance issuers in the group and individual markets to guarantee the renewability of coverage unless an exception applies.

Section 1302 of the ACA provides for the establishment of an EHB package that includes coverage of EHBs (as defined by the Secretary), cost-sharing limits, and AV requirements. Among other things, the law directs that EHBs be equal in scope to the benefits provided under a typical employer plan, and that they cover at least the following 10 general categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Sections 1302(b)(4)(A) through (D) of the ACA establish that the Secretary must define EHB in a manner that: (1) reflects appropriate balance among the 10 categories; (2) is not designed in such a way as to discriminate based on age, disability, or expected length of life; (3) takes into account the health care needs of diverse segments of the population; and (4) does not allow denials of EHBs based on age, life expectancy, disability, degree of medical dependency, or quality of life.

To set cost-sharing limits, section 1302(c)(4) of the ACA directs the Secretary to determine an annual premium adjustment percentage, a measure of premium growth that is used to set the rate of increase for three parameters: (1) the maximum annual limitation on cost sharing (section 1302(c)(1) of the ACA); (2) the required contribution percentage used to determine whether an individual can afford minimum essential coverage (MEC) (section 5000A of the Internal Revenue Code of 1986 (the Code), as enacted by section 1501 of the ACA); and

(3) the employer shared responsibility payment amounts (section 4980H of the Code, as enacted by section 1513 of the ACA).

Section 1302(d) of the ACA describes the various levels of coverage based on their AV. Consistent with section 1302(d)(2)(A) of the ACA, AV is calculated based on the provision of EHB to a standard population. Section 1302(d)(1) of the ACA requires a bronze plan to have an AV of 60 percent, a silver plan to have an AV of 70 percent, a gold plan to have an AV of 80 percent, and a platinum plan to have an AV of 90 percent. Section 1302(d)(2) of the ACA directs the Secretary to issue regulations on the calculation of AV and its application to the levels of coverage. Section 1302(d)(3) of the ACA directs the Secretary to develop guidelines to provide for a de minimis variation in the AVs used in determining the level of coverage of a plan to account for differences in actuarial estimates.

Section 1311(c)(6)(B) of the ACA directs the Secretary to require an Exchange to provide for annual OEPs after the initial enrollment period.

Section 1311(c)(6)(C) of the ACA authorizes the Secretary to require an Exchange to provide for SEPs specified in section 9801 of the Code and other SEPs under circumstances similar to such periods under part D of title XVIII of the Act. Section 1311(c)(6)(D) of the ACA directs the Secretary to require an Exchange to provide for a monthly enrollment period for Indians, as defined by section 4 of the Indian Health Care Improvement Act.

Section 1311(c) of the ACA provides the Secretary the authority to issue regulations to establish criteria for the certification of QHPs. Section 1311(c)(1)(B) of the ACA requires among the criteria for certification that the Secretary must establish by regulation that QHPs ensure a sufficient choice of providers. Section 1311(e)(1) of the ACA grants the Exchange the authority to certify a health plan as a QHP if the health plan meets the Secretary's requirements for certification issued under section 1311(c) of the ACA, and the Exchange determines that making

the plan available through the Exchange is in the interests of qualified individuals and qualified employers in the State.

Section 1312(e) of the ACA provides the Secretary with the authority to establish procedures under which a State may allow agents or brokers to (1) enroll qualified individuals and qualified employers in QHPs offered through Exchanges and (2) assist individuals in applying for APTC and CSRs for QHPs sold through an Exchange.

Sections 1312(f)(3), 1401, 1402(e), and 1412(d) of the ACA require that an individual must be either a citizen or national of the United States or an alien lawfully present in the United States to enroll in a QHP through an Exchange, to be eligible for PTC, APTC, and CSRs. Sections 1313 and 1321 of the ACA provide the Secretary with the authority to oversee the financial integrity of State Exchanges, their compliance with HHS standards, and the efficient and non-discriminatory administration of State Exchange activities. Section 1313(a)(5)(A) of the ACA directs the Secretary to provide for the efficient and non-discriminatory administration of Exchange activities and to implement any measure or procedure the Secretary determines is appropriate to reduce fraud and abuse. Section 1321 of the ACA provides for State flexibility in the operation and enforcement of Exchanges and related requirements.

Section 1321(a) of the ACA provides broad authority for the Secretary to establish standards and regulations to implement the statutory requirements related to Exchanges, QHPs and other components of title I of the ACA, including such other requirements as the HHS Secretary determines appropriate.

Section 1321(a)(1) of the ACA directs the Secretary to issue regulations that set standards for meeting the requirements of title I of the ACA with respect to, among other things, the establishment and operation of Exchanges.

Section 1331 of the ACA provides States the option to establish a BHP and provides that only “qualified individuals”, as defined in section 1312 of the ACA, are eligible for BHP

coverage. Section 1312(f)(3) of the ACA provides that if an individual is not, or is not reasonably expected to be for the entire period for which enrollment is sought, a citizen or national of the United States or an alien lawfully present in the United States, the individual shall not be treated as a qualified individual. Accordingly, persons who are not lawfully present are not eligible for BHP enrollment.

Section 1401(a) of the ACA added section 36B to the Code, which, among other things, requires that a taxpayer reconcile APTC for a year of coverage with the amount of the PTC the taxpayer is allowed for the year.

Section 1402(c) of the ACA provides for, among other things, reductions in cost sharing for essential health benefits for qualified low- and moderate-income enrollees in silver level health plans offered through the individual market Exchanges, including reduction in out-of-pocket limits.

Section 1411 of the ACA directs the Secretary to make advance determinations for the PTC with respect to income eligibility for individuals enrolling in a QHP through the individual market. Section 1411 of the ACA further specifies that the Secretary verify income with the Secretary of the Treasury based on the most recent tax return information, and then implement alternative procedures to verify income on the basis of different information to the extent that a change has occurred or for individuals who were not required to file an income tax return.

Section 1411(f)(1)(B) of the ACA directs the Secretary to establish procedures to redetermine the eligibility of individuals on a periodic basis in appropriate circumstances.

Sections 1402(f)(3), 1411(b)(3) and 1412(b)(1) of the ACA provide that data from the most recent tax return information available must be the basis for determining eligibility for APTC and CSRs to the extent such tax data is available. Section 1412(c)(2)(B) of the ACA establishes requirements on issuers with regards to an individual enrolled in a health plan receiving an APTC.

Section 1412(d) of the ACA states that nothing in the law allows Federal payments, credits, or CSRs for individuals who are not lawfully present in the United States.

Section 1413 of the ACA directs the Secretary to establish, subject to minimum requirements, a streamlined enrollment process for enrollment in QHPs and all insurance affordability programs and requires Exchanges to participate in a data matching program for the determination of eligibility on the basis of reliable, third- party data.

Section 1414 of the ACA amends section 6103 of the Code to direct the Secretary of the Treasury to disclose certain tax return information to verify and determine eligibility for APTC and CSR subsidies.

1. Guaranteed Availability and Guaranteed Renewability

In the April 8, 1997 **Federal Register** (62 FR 16894), HHS published an interim final rule relating to the HIPAA health insurance reforms that established rules applying guaranteed availability in the small group market and guaranteed renewability in the large and small group market. Also, in the April 8, 1997 **Federal Register** (62 FR 16985), HHS published an interim final rule relating to the HIPAA health insurance reforms that, among other things, established rules applying guaranteed renewability in the individual market. In the February 27, 2013 **Federal Register** (78 FR 13406) (2014 Market Rules), we published the health insurance market rules. In the May 27, 2014 **Federal Register** (79 FR 30240) (2015 Market Standards Rule), we published the final rule, "Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond." In the December 22, 2016 **Federal Register** (81 FR 94058) (2018 Payment Notice), we provided additional guidance on guaranteed availability and guaranteed renewability, and in the April 18, 2017 **Federal Register** (82 FR 18346) (Market Stabilization Rule) we provided further guidance related to guaranteed availability. In the May 6, 2022 **Federal Register** (87 FR 27208) we amended the regulations regarding guaranteed availability.

2. Deferred Action for Childhood Arrivals

HHS issued an interim final rule in the July 30, 2010 **Federal Register** (75 FR 45014) to define "lawfully present" for the purposes of determining eligibility for the Pre-Existing Condition Insurance Plan (PCIP) program. In the March 27, 2012 **Federal Register** (77 FR 18310) (Exchange Establishment Rule), HHS defined lawfully present for purposes of determining eligibility to enroll in a QHP through an Exchange by cross-referencing the existing PCIP definition. In the August 30, 2012 **Federal Register** (77 FR 52614), HHS adjusted the previous definition of "lawfully present" used for PCIP and QHP eligibility, which had considered all recipients of "deferred action" to be lawfully present, to add an exception that excluded DACA recipients from the definition. In the March 12, 2014 **Federal Register** (79 FR 14112), HHS established the framework for governing a BHP, which also adopted the definition of "lawfully present" for the purpose of determining eligibility to enroll in a BHP through a cross-reference to § 155.20. In the May 8, 2024 **Federal Register** (89 FR 39392) (DACA Rule), HHS reinterpreted "lawfully present" to include DACA recipients and certain other noncitizens for the purposes of determining eligibility to enroll in a QHP through an Exchange, PTC, APTC, CSRs, and to enroll in a BHP in States that elect to operate a BHP.

3. Program Integrity

We have finalized program integrity standards related to the Exchanges and premium stabilization programs in two rules: the "Program Integrity: Exchange, SHOP, and Eligibility Appeals Rule" published in the August 30, 2013, **Federal Register** (78 FR 54069), and the "Program Integrity: Exchange, Premium Stabilization Programs, and Market Standards; Amendments to the HHS Notice of Benefit and Payment Parameters for 2014 Rule" published in the October 30, 2013, **Federal Register** (78 FR 65045). We also refer readers to the 2019 Patient Protection and Affordable Care Act; Exchange Program Integrity final rule published in the December 27, 2019, **Federal Register** (84 FR 71674).

In the May 6, 2022 **Federal Register** (87 FR 27208), we finalized policies to address certain agent, broker, and web-broker practices and conduct. In the April 27, 2023 **Federal Register** (88 FR 25740) (2024 Payment Notice), we finalized allowing additional time for HHS to review evidence submitted by agents and brokers to rebut allegations pertaining to Exchange agreement suspensions or terminations. We also introduced consent and eligibility documentation requirements for agents and brokers. In the 2025 Payment Notice, issued in the April 15, 2024 **Federal Register** (89 FR 26218), we finalized that the CMS Administrator, who is a principal officer, is the entity responsible for handling requests by agents, brokers, and web-brokers for reconsideration of HHS' decision to terminate their Exchange agreement(s) for cause. We also finalized changes to §§ 155.220 and 155.221 to apply certain standards to web-brokers and Direct Enrollment (DE) entities assisting consumers and applicants across all Exchanges. In the January 15, 2025 **Federal Register** (90 FR 4424) (2026 Payment Notice), we addressed our authority to investigate and undertake compliance reviews and enforcement actions in response to misconduct or noncompliance with applicable agent, broker, and web-broker Exchange requirements or standards occurring at the insurance agency level to hold lead agents of insurance agencies accountable. We also finalized changes to § 155.220(k)(3) to reflect our authority to suspend an agent's or broker's ability to transact information with the Exchange in instances where HHS discovers circumstances that pose unacceptable risk to accuracy of Exchange eligibility determinations, Exchange operations, applicants, or enrollees, or Exchange information technology systems until the circumstances of the incident, breach, or noncompliance are remedied or sufficiently mitigated to HHS' satisfaction.

4. Premium Adjustment Percentage

In the March 11, 2014 **Federal Register** (79 FR 13744), HHS established a methodology for estimating the average per capita premium for purposes of calculating the premium adjustment percentage. Beginning with PY 2015, we calculated the premium adjustment

percentage-based on the estimates and projections of average per enrollee employer-sponsored insurance premiums from the National Health Expenditure Accounts (NHEA), which are calculated by the CMS Office of the Actuary. In the April 25, 2019 **Federal Register** (84 FR 17454), HHS amended the methodology for calculating the premium adjustment percentage by estimating per capita insurance premiums as private health insurance premiums, minus premiums paid for Medigap insurance and property and casualty insurance, divided by the unrounded number of unique private health insurance enrollees, excluding all Medigap enrollees. Additionally, in response to public comments to the 2021 Payment Notice proposed rule (85 FR 7088), in the May 14, 2020 **Federal Register** (85 FR 29164), HHS stated that we will finalize payment parameters that depend on NHEA data, including the premium adjustment percentage, based on the data that are available as of the publication of the proposed rule for that plan year, even if NHEA data are updated between the proposed and final rules. In the December 15, 2020 **Federal Register** (85 FR 81097), HHS published the Grandfathered Group Health Plans and Grandfathered Group Health Insurance Coverage final rule, along with the Departments of Labor and the Treasury, that finalized using the premium adjustment percentage as one alternative in setting the parameters for permissible increases in fixed-amount cost-sharing requirements for grandfathered group health plans. In the May 5, 2021 **Federal Register** (86 FR 24140), Part 2 of the 2022 Payment Notice amended the methodology for calculating the premium adjustment percentage by reverting to using the NHEA employer-sponsored insurance (ESI) premium measure previously used for PY 2015 to PY 2019 and established that the premium adjustment percentage could be established in guidance for plan years in which the premium adjustment percentage is not methodologically changing.

5. Failure to File Taxes and Reconcile APTC

In the March 27, 2012 Exchange Establishment Rule (77 FR 18310), we required the Exchange to determine a primary taxpayer ineligible to receive APTC if HHS notifies the

Exchange that the taxpayer received APTC from a prior year for which tax data would be utilized for income verification and did not file a tax return and reconcile APTC as required by implementing regulations proposed by the Department of the Treasury. In the May 23, 2012 **Federal Register** (77 FR 30377), the Department of the Treasury finalized implementing regulations to require every taxpayer receiving APTC to file an income tax return.

In the December 22, 2016 **Federal Register** (81 FR 94058) (2018 Payment Notice), we provided that Exchanges cannot determine a taxpayer ineligible for APTC due to failure to file a tax return unless the Exchanges send a direct notification to that tax filer stating that their eligibility will be discontinued for failure to comply with the requirement to file taxes. We then revisited this notice requirement in the April 17, 2018 **Federal Register** (83 FR 16930) (2019 Payment Notice) and removed the notice requirement.

In the April 27, 2023 **Federal Register** (88 FR 25740) (2024 Payment Notice) we required Exchanges to wait to discontinue APTC until the tax filer has failed to file a tax return and reconcile their past APTC for 2 consecutive years rather than ending APTC after a single year. In the April 15, 2024 **Federal Register** (89 FR 26218) (2025 Payment Notice), we required Exchanges to send notices to tax filers for the first year in which they have been identified by the IRS as failing to reconcile APTC. In the January 15, 2025 **Federal Register** (90 FR 4424) (2026 Payment Notice), we required Exchanges to send notices to tax filers for the second year in which they have been identified by the IRS as failing to reconcile APTC.

6. Income Inconsistencies

In the April 17, 2018 **Federal Register** (83 FR 16930) (2019 Payment Notice), we revised income verification provisions in § 155.320(c)(3)(iii) to require the Exchange to generate annual household income inconsistencies in certain circumstances when a tax filer's attested projected annual household income is greater than the income amount represented by income data returned by IRS and the Social Security Administration (SSA) and current income data

sources. On March 4, 2021, the United States District Court for the District of Maryland decided *City of Columbus v. Cochran*, 523 F. Supp. 3d 731 (D. Md. 2021) and vacated these revisions to income verification. We then implemented the court's decision in the May 5, 2021 **Federal Register** (86 FR 24140) (Part 2 of the 2022 Payment Notice) and rescinded the income verification provisions in § 155.320(c)(3)(iii) that the court invalidated.

In the March 27, 2012 **Federal Register** (77 FR 18310) (Exchange Establishment Rule), we established the alternative verification process in § 155.320(c) for situations when a household income inconsistency occurs with IRS data or when tax return data is unavailable. This process required the Exchange to provide the applicant notice of the income inconsistency and requires applicants to provide documentary evidence to verify their income or otherwise resolve the inconsistency within a period of 90 days from which notice is sent. In the April 27, 2023 **Federal Register** (88 FR 25740) (2024 Payment Notice), we revised this process to require Exchanges to accept an applicant's or enrollee's self-attestation of annual household income when a call to IRS is completed but tax return data is unavailable and add that household income inconsistencies must receive an automatic 60-day extension in addition to the 90 days provided to applicants to resolve their income inconsistency.

7. Annual Eligibility Redetermination

In the March 27, 2012 **Federal Register** (77 FR 18310) (Exchange Establishment Rule), we implemented the Affordable Insurance Exchanges ("Exchanges"), consistent with title I of the ACA. This included standards for annual eligibility redeterminations and renewals of coverage. In the January 22, 2013 **Federal Register** (78 FR 4594), we sought comment on whether the redetermination notice should describe how the enrollee's deductibles, co-pays, coinsurance, and other forms of cost sharing would change. In the July 15, 2013 **Federal Register** (78 FR 42160) (2013 Eligibility Final Rule), we amended the notice to remove the requirement to provide the data used for the eligibility redetermination and the data used for the most recent eligibility

determination, even though we did not previously propose to change the annual redetermination notice. In the September 5, 2014 **Federal Register** (79 FR 52994), we amended the annual redetermination standards to allow for an Exchange to choose from one of three methods for conducting annual redeterminations. In the January 24, 2019 **Federal Register** (84 FR 227) (2020 Payment Notice proposed rule), we sought comment on the automatic re-enrollment processes to address program integrity concerns. In the February 6, 2020 **Federal Register** (85 FR 7088) (2021 Payment Notice proposed rule), we solicited comment on modifying the automatic re-enrollment process such that any enrollee who would be automatically re-enrolled with APTC that would cover the enrollee's entire premium would instead be automatically re-enrolled without APTC, and we solicited comments on a variation where APTC for this population would be reduced to a level that would result in an enrollee premium that is greater than zero dollars, but not eliminated entirely. We did not finalize any changes in the final rules.

8. Automatic Re-enrollment Hierarchy

In the March 27, 2012 **Federal Register** (77 FR 18309) (Exchange Establishment Rule), we implemented the Exchanges, consistent with Title I of the ACA. This included implementation of components of the Exchanges and standards for annual eligibility redetermination and renewal of coverage. In the September 5, 2014 **Federal Register** (79 FR 52994) (Annual Eligibility Redeterminations Rule), we modified the standards for re-enrollment in coverage by adding a re-enrollment hierarchy to address situations when the enrollee's plan or product is not available through the Exchange for renewal. In the March 8, 2016 **Federal Register** (81 FR 12204) (2017 Payment Notice), we amended the hierarchy to give Exchanges flexibility to prioritize re-enrollment into silver plans for all enrollees in a silver-level QHP that is no longer available for re-enrollment, and re-enroll consumers into plans of other Exchange issuers if the consumer is enrolled in a plan from an issuer that does not have another plan available for re-enrollment through the Exchange.

In the January 5, 2022 **Federal Register** (87 FR 584) (2023 Payment Notice proposed rule), we solicited comments on revising the re-enrollment hierarchy at § 155.335(j) at a later date. After considering comments, we proposed and finalized amendments and additions to the re-enrollment hierarchy in the April 27, 2023 **Federal Register** (88 FR 25740) (2024 Payment Notice), including changes to allow Exchanges to direct re-enrollment for enrollees who are eligible for CSRs from a bronze QHP to a silver QHP, if certain conditions are met.

9. Premium Payment Threshold

In the December 2, 2015 **Federal Register** (80 FR 75532), we published a proposed rule to allow issuers to adopt an optional premium payment threshold policy under which issuers could collect a minimal amount of premium, less than that which is owed, without triggering the consequences for non-payment of premiums. We established the option for issuers to implement a net premium percentage-based premium payment threshold in the 2017 Payment Notice (81 FR 12271 through 12272). In the October 10, 2024 **Federal Register** (89 FR 82366 through 82369), we proposed to add additional optional premium payment threshold flexibilities, proposing an option for issuers to adopt a fixed-dollar premium threshold amount of $5 or less and/or a percentage-based threshold based on the gross premium of 99 percent or more or the existing net premium of 95 percent or more of the premium after application of APTC. We modified and finalized this proposal in the 2026 Payment Notice (90 FR 4475 through 4480), allowing issuers to adopt a fixed-dollar premium threshold amount of $10 or less and/or a percentage-based threshold based on the gross premium of 98 percent or more or net premium of 95 percent or more of the premium after application of APTC.

10. Special Enrollment Periods (SEPs)

In the July 15, 2011 **Federal Register** (76 FR 41865), we published a proposed rule establishing SEPs for the Exchange. We implemented these SEPs in the Exchange Establishment Rule (77 FR 18309). In the January 22, 2013 **Federal Register** (78 FR 4594), we published a

proposed rule amending certain SEPs, including the SEPs described in § 155.420(d)(3) and (7). We finalized these rules in the July 15, 2013 **Federal Register** (78 FR 42321).

In the June 19, 2013 **Federal Register** (78 FR 37032), we proposed to add an SEP when the Federally Facilitated Exchange (FFE) determines that a consumer has been incorrectly or inappropriately enrolled in coverage due to misconduct on the part of a non-Exchange entity. We finalized this proposal in the October 30, 2013 **Federal Register** (78 FR 65095). In the March 21, 2014 **Federal Register** (79 FR 15808), we proposed to amend various SEPs. In particular, we proposed to clarify that later coverage effective dates for birth, adoption, placement for adoption, or placement for foster care would be effective the first of the month. The rule also proposed to clarify that earlier effective dates would be allowed if all issuers in an Exchange agree to effectuate coverage only on the first day of the specified month. Finally, that rule proposed adding that consumers may report a move in advance of the date of the move and established an SEP for individuals losing medically needy coverage under the Medicaid program even if the medically needy coverage is not recognized as minimum essential coverage (individuals losing medically needy coverage that is recognized as minimum essential coverage already were eligible for an SEP under the regulation). We finalized these provisions in the May 27, 2014 **Federal Register** (79 FR 30348). In the October 1, 2014 **Federal Register** (79 FR 59137), we published a correcting amendment related to codifying the coverage effective dates for plan selections made during an SEP and clarifying a consumer's ability to select a plan 60 days before and after a loss of coverage.

In the November 26, 2014 **Federal Register** (79 FR 70673), we proposed to amend effective dates for SEPs, the availability and length of SEPs, the specific types of SEPs, and the option for consumers to choose a coverage effective date of the first of the month following the birth, adoption, placement for adoption, or placement in foster care. We finalized these provisions in the February 27, 2015 **Federal Register** (80 FR 10866). In the July 7, 2015

Federal Register (80 FR 38653), we issued a correcting amendment to include those who become newly eligible for a QHP due to a release from incarceration. In the December 2, 2015 **Federal Register** (80 FR 75487) (2017 Payment Notice proposed rule), we sought comment and data related to existing SEPs, including data relating to the potential abuse of SEPs. In the 2017 Payment Notice, we stated that in order to review the integrity of SEPs, the FFE will conduct an assessment by collecting and reviewing documents from consumers to confirm their eligibility for the SEPs under which they enrolled.

In an interim final rule with comment published in the May 11, 2016 **Federal Register** (81 FR 29146), we made amendments to the parameters of certain SEPs (2016 Interim Final Rule). We finalized these in the 2018 Payment Notice, published in the December 22, 2016 **Federal Register** (81 FR 94058). In the April 18, 2017 Market Stabilization Rule (82 FR 18346), we amended standards relating to SEPs and announced HHS would begin pre-enrollment verifications for all categories of SEPs in June 2017. In the 2019 Payment Notice, published in the April 17, 2018 **Federal Register** (83 FR 16930), we clarified that certain exceptions to the SEPs only apply to coverage offered outside of the Exchange in the individual market. In the April 25, 2019 **Federal Register** (84 FR 17454), the final 2020 Payment Notice established a new SEP. In part 2 of the 2022 Payment Notice, in the May 5, 2021 **Federal Register** (86 FR 24140), we made additional amendments and clarifications to the parameters of certain SEPs and established new SEPs related to untimely notice of triggering events, cessation of employer contributions or government subsidies to COBRA continuation coverage, and loss of APTC eligibility. In part 3 of the 2022 Payment Notice, in the September 27, 2021 **Federal Register** (86 FR 53412), which was published by HHS and the Department of the Treasury, we established a temporary new monthly SEP for those eligible for APTC with projected household incomes at or below 150 percent of the FPL. In the May 6, 2022 **Federal Register** (87 FR 27208), we finalized updates to the requirement that all Exchanges conduct SEP verifications

and limited pre-enrollment verification for Exchanges on the Federal platform to only consumers who attest to losing minimum essential coverage. In the April 27, 2023 **Federal Register** (88 FR 25740) (2024 Payment Notice), we lengthened the SEP from 60 to 90 days to those who lose Medicaid coverage. In the April 15, 2024 **Federal Register** (89 FR 26218) (2025 Payment Notice), we aligned effective dates for coverage after selecting certain SEPs across all Exchanges and removed limitations on the monthly SEP for those eligible for APTC with incomes up to 150 percent of the FPL.

11. Essential Health Benefits

We established requirements relating to EHBs in the Standards Related to Essential Health Benefits, Actuarial Value (AV), and Accreditation Final Rule, which was published in the February 25, 2013 **Federal Register** (78 FR 12834) (EHB Rule). In the EHB Rule, we included at § 156.115 a prohibition on issuers from providing routine non-pediatric dental services, routine non-pediatric eye exam services, long-term/custodial nursing home care benefits, or non-medically necessary orthodontia as EHB. In the 2019 Payment Notice, published in the April 17, 2018 **Federal Register** (83 FR 16930), we added § 156.111 to provide States with additional options from which to select an EHB-benchmark plan for PY 2020 and subsequent plan years. In the 2023 Payment Notice, published in the May 6, 2022 **Federal Register** (87 FR 27208), we revised § 156.111 to require States to notify HHS of the selection of a new EHB-benchmark plan by the first Wednesday in May of the year that is 2 years before the effective date of the new EHB-benchmark plan, otherwise the State's EHB-benchmark plan for the applicable plan year will be that State's EHB-benchmark plan applicable for the prior year. We displayed the Request for Information; Essential Health Benefits (EHB RFI), published in the December 2, 2022, **Federal Register** (87 FR 74097), to solicit public comment on a variety of topics related to the coverage of benefits in health plans subject to the EHB requirements of the ACA. In the 2025

Payment Notice (89 FR 26218), we removed the regulatory prohibition at § 156.115(d) on issuers from providing routine non-pediatric dental services as an EHB beginning with PY 2027.

In the 2026 Payment Notice, published in the January 15, 2025 **Federal Register** (90 FR 4424), we revised § 156.80(d)(2)(i) to require the actuarially justified plan-specific factors by which an issuer may vary premium rates for a particular plan from its market-wide index rate include the AV and cost-sharing design of the plan, including, if permitted by the applicable State authority, accounting for CSR amounts provided to eligible enrollees under § 156.410, provided the issuer does not otherwise receive reimbursement for such amounts.

III. Summary of the Proposed Provisions, Public Comments, and Responses to Comments on the Proposed Rule

A. Part 147 - Health Insurance Reform Requirements for the Group and Individual Health Insurance Markets

1. Limited Open Enrollment Periods (OEPs) (§ 147.104(b)(2))

As further discussed in the 2025 Marketplace Integrity and Affordability proposed rule (90 FR 12950) and section III.B.8. of this final rule regarding the proposal to remove the monthly SEP for APTC-eligible qualified individuals with a projected household income at or below 150 percent of the FPL (§ 155.420(d)(16)), we proposed a conforming amendment to remove § 147.104(b)(2)(i)(G), which currently excludes § 155.420(d)(16) as a triggering event for a limited OEP for coverage offered outside of an Exchange. We proposed to remove § 147.104(b)(2)(i)(G) to reflect the removal of the SEP at § 155.420(d)(16). We sought comment on this proposal.

After consideration of comments and for the reasons outlined in the proposed rule and section III.B.8. of this final rule, including our responses to comments, we are finalizing a pause of the SEP at § 155.420(d)(16), and therefore are temporarily finalizing the proposed conforming change to remove § 147.104(b)(2)(i)(G). We summarize and respond to public comments

received on the proposed removal of the SEP at § 155.420(d)(16) in section III.B.8. of this final rule.

2. Coverage Denials for Failure to Pay Premiums for Prior Coverage (§ 147.104(i))

In the 2025 Marketplace Integrity and Affordability proposed rule (90 FR 12950 through 12953), we proposed to remove § 147.104(i) that prohibits an issuer from denying coverage due to failure of an individual or employer to pay premiums owed under prior coverage, including by attributing payment of premium for new coverage to past-due premiums from prior coverage. Similar to the policy in the Market Stabilization Rule (82 FR 18349 through 18353), we proposed to allow issuers to attribute the initial premium the enrollee pays to effectuate new coverage to past-due premium amounts owed for prior coverage and then to not effectuate new coverage if the initial premium and past-due amounts are not paid in full. Under the proposal, consistent with the Market Stabilization Rule, an issuer would be required to apply its past-due premium payment policy uniformly to all employers or individuals in similar circumstances in the applicable market regardless of health status, and consistent with applicable nondiscrimination requirements,[19] and would be prohibited from conditioning the effectuation of new coverage on payment of past-due premiums by any individual other than the person contractually responsible for the payment of premium.

Unlike the policy in the Market Stabilization Rule (82 FR 18346), the proposal would not limit the policy to past-due premium amounts accruing over the prior 12 months or require the issuer to provide any notice of the policy. States would remain free to apply additional parameters governing issuers' premium payment policies, to the extent permitted under Federal law.

[19] Issuers may also have obligations under other applicable Federal laws prohibiting discrimination, and issuers are responsible for ensuring compliance with all applicable laws and regulations. There may also be separate, independent nondiscrimination obligations under State law.

We sought comments on the proposal and specifically on whether we should leave other parameters to States or codify additional parameters to establish a more uniform Federal regulatory approach. We also sought comment on whether issuers should be required to establish terms of coverage that attribute the initial premium an enrollee pays for subsequent coverage to past-due premium amounts owed, and the associated costs for issuers to implement such a requirement.

After consideration of comments and for the reasons outlined in the proposed rule and this final rule, including our responses to comments, we are finalizing this policy with a modification by removing the regulatory text that prohibited this policy, and replacing it with regulatory text that codifies the proposed policy. Under the finalized policy, States may choose whether to allow issuers in their market and State to attribute the initial premium paid to effectuate new coverage to past-due premium amounts owed and to refuse to effectuate new coverage if the past-due and initial premium amounts are not paid in full. If an issuer does so, then under the final rule, it must apply its past-due premium payment policy uniformly to all employers or individuals in similar circumstances in the applicable market and State regardless of health status, and consistent with applicable nondiscrimination requirements, and are not permitted to condition the effectuation of new coverage on payment of past-due premiums by any individual other than the person contractually responsible for the payment of premium. We are codifying this policy by revising § 147.104(i) instead of removing § 147.104(i) as proposed. As the issue this provision is intended to resolve was not created by the expansion of APTCs that are expiring after PY 2025, this policy will not sunset. We are finalizing this policy to be applicable as of the effective date of this rule and beyond.

We summarize and respond to public comments received on the proposed policy below.

Comment: Several commenters supported the proposal, stating it would incentivize enrollees to maintain 12 months of continuous coverage, provide issuers with a tool to reduce

adverse selection, reduce opportunities for enrollees to game the system by circumventing required premium payments, and allow issuers to more accurately price products. One commenter stated that the proposal would reduce premium inflation caused by gaming the rules, ultimately easing the burden on taxpayers and ensuring that ACA subsidies are better targeted.

Response: We agree that finalization of the policy contained in the proposal will help to promote continuous coverage, reduce gaming and adverse selection, ensure that ACA subsidies are targeted to those who are eligible, and allow issuers to more accurately predict costs and price plans.

Comment: Several commenters agreed with the proposal to defer to the States to determine whether issuers in their State are permitted to attribute payments for new coverage to past-due premiums and to refuse to effectuate new coverage unless both the past-due premium and the initial payment for new coverage are paid. One commenter stated that States, who maintain the closest interaction with their consumers and issuers, are best positioned to regulate issuers' premium payment policies. Another commenter acknowledged that issuers in some areas of the country are facing high fraud rates and the proposal could reduce gaming, adverse selection, and ultimately premiums by requiring payment of past-due premiums. However, the commenter stated that issuers in areas with little evidence of gaming would likely not want to require payment of past-due premiums to effectuate new coverage.

Response: We agree that States are in the best position to decide whether it is appropriate to permit or prohibit this policy. For that reason, we proposed, and are finalizing, the policy contained in the proposal in such a way that States may choose whether to allow issuers in their State to attribute the initial premium an enrollee pays to effectuate new coverage to past-due premium amounts the issuers are owed and to refuse to effectuate new coverage if the past-due and initial premium amounts are not paid in full.

We solicited comment in the proposed rule about whether to make the premium payment policy mandatory or optional. Comments in response to that solicitation are discussed below.

Comment: Many commenters, some of whom supported and some of whom opposed the proposal, stated that if the proposal is adopted, there should be parameters around how issuers implement the policy. For example, commenters suggested the final rule should prohibit issuers that apply the past-due premium policy from collecting past-due premiums for debts older than 12 months; provide advance notice of their past-due premium policy; accept installment payments; take into account the individual's payment history; prohibit charging interest; set limits on amounts owed; allow enrollment after partial repayment; create exemptions for low-income individuals, those experiencing hardship, or those whose failure to pay was not their fault or whose enrollment was due to fraud; prohibit an issuer from insisting on payment of past-due premiums for other lines of insurance; and require issuers to allow consumers to appeal the amount of past-due premiums owed and to effectuate coverage pending appeal.

Response: Under this final rule, an issuer adopting the past-due premium policy must apply it uniformly to all employers or individuals in similar circumstances in the applicable market and State regardless of health status, and consistent with applicable nondiscrimination requirements, is not permitted to condition the effectuation of new coverage on payment of past-due premiums by any individual other than the person contractually responsible for the payment of premium, and the amount required to be paid must be subject to any premium payment threshold the issuer has adopted pursuant to 45 CFR 155.400(g). We are codifying these minimum standards in the regulation and defer to States on any additional parameters or standards that issuers must satisfy when implementing the past-due premium policy, as States are best positioned to set and oversee parameters of this nature. States that permit issuers to adopt the past-due premium policy are encouraged to require such issuers to provide advance notice of

the policy to applicants. We will consider addressing acceptable past-due premium payment policies in future guidance.

Comment: One commenter noted that, based on the analysis of Exchange data in the 2026 Payment Notice, over 10 percent of enrollees, or about 180,000 consumers, were terminated for non-payments in which the amount owed was less than or equal to $10 and stated that HHS should carefully balance the goals of securing program integrity with achieving operational efficiency.

Response: While the debt owed by some individuals might be relatively small, all individuals who enroll for coverage, including those who benefit from APTC, are required to pay their share of the premium for every month of coverage. In addition, issuers of individual or small group market coverage subject to section 2701 of the PHS Act are not permitted to forgive debt owed for past-due premiums, and allowing issuers to attribute payment for new coverage to past-due premiums may create operational efficiencies for issuers in how they collect payment for such debts. We note that States and issuers have flexibility with regard to the past-due premium policy under this final rule. This includes the flexibility to decide that the policy will not apply with respect to de minimis amounts owed consistent with 45 CFR 155.400(g), as long as an issuer's past-due premium payment policy applies uniformly to all employers or individuals in similar circumstances in the applicable market and State regardless of health status and consistent with applicable nondiscrimination requirements.

Comment: One commenter stated that the best way to address the problem of people waiting to get sick before getting coverage is for the individual shared responsibility payment to be a positive dollar amount. According to the commenter, requiring individuals to make such a payment if they do not have minimum essential coverage would provide an incentive to pay premiums to maintain continuous coverage.

Response: In 2017, the Tax Cuts and Jobs Act[20] set the amount of the individual shared responsibility payment to zero dollars, effective 2019, for non-exempt individuals who do not maintain minimum essential coverage. Statutory changes would be needed to change that amount.

Comment: One commenter asserted that once coverage is terminated, the enrollee would be responsible for paying his or her own medical bills. Therefore, according to the commenter, if enrollees are required to pay for any outstanding premiums for any plan year, they are likely paying for coverage from which they will not benefit. By contrast, another commenter expressed concerns that individuals could owe a large bill because they followed instructions to stop paying premiums in order to terminate coverage. One commenter stated that if the proposal is adopted, issuers should be required to effectuate new coverage without requiring payment of past-due premiums if no claims were made during the period of delinquency.

Response: For any period of time after coverage is terminated, no premium would be due. Therefore, "past-due premiums" under this final rule refers to premiums due but not paid for periods during which the individual was covered, such as during a grace period. During such a coverage period, individuals have the benefit of financial protection from unforeseen medical expenses, even if they do not ultimately receive covered benefits. However, the grace period rules function in a manner that allows enrollees to avoid paying their premium while maintaining that financial protection for a short period of time. The policy finalized in this rule provides issuers with an additional tool to collect payments owed for months of coverage, regardless of whether the individual incurs medical expenses during the period for which they owe premiums.

Because applying the past-due premium policy with regard to claims history would discriminate based on health status, we do not adopt the commenter's suggestion to require

[20] Pub. L. 115-97.

issuers that adopt the past-due premium policy to create exceptions for instances in which no claims are incurred during the period in which past-due premiums are owed. These practices are not permitted under this final rule.

Comment: One commenter asked how the policy related to past-due premiums would impact claims payment.

Response: If an individual pays past-due premiums for months during which the individual was covered, the issuer must pay any unpaid claims incurred during such month. For example, if an individual seeks to enroll in new coverage while in the 3-month grace period and pays past-due premiums owed for prior coverage, any claims that a QHP issuer pended for services rendered to the enrollee in the second and third months of the grace period, as permitted under § 156.270(d)(1), must be paid in accordance with the terms of the coverage.[21]

Comment: One commenter asked how the policy would impact enrollment in new coverage.

Response: Under the past-due premium policy in this final rule, an issuer, to the extent permitted by applicable State law, may attribute a payment for new coverage to past-due premiums for prior coverage. The issuer then could lawfully refuse to effectuate new coverage unless the individual or employer, as applicable, pays any past-due premium amounts owed for prior coverage and the initial premium (also known as a binder payment) for new coverage by the applicable payment deadline. For example, if an individual applies for coverage during the individual market open enrollment period and owes 1 month of premiums in the amount of $10,

[21] Section 156.270(d) requires issuers to observe a 3-consecutive month grace period before terminating coverage for those enrollees who when failing to timely pay their premiums are receiving APTC. Section 155.430(d)(4) requires that when coverage is terminated following this grace period, the last day of enrollment in a QHP through the Exchange is the last day of the first month of the grace period. Therefore, individuals whose coverage is terminated at the conclusion of a grace period would owe at most 1 month of premiums, net of any APTC paid on their behalf to the issuer. Individuals who attempt to enroll in new coverage while in a grace period (and whose coverage has not yet been terminated) could owe up to 3 months of premium, net of any APTC paid on their behalf to the issuer.

and the individual fails to pay past-due premiums of $10 and the binder payment for new coverage by the applicable premium payment deadline, the issuer could refuse to effectuate the individual's enrollment in coverage, subject to any premium payment threshold the issuer has adopted pursuant to 45 CFR 155.400(g). Following the open enrollment period, the individual could enroll in coverage for that benefit year only through a special enrollment period and may be required to satisfy any past-due premium obligations at that time.

Comment: Many commenters, while acknowledging incentives for individuals not to pay premiums and enroll in coverage only when medical needs arise, asserted that the guardrails in place, such as short grace periods and requirements to retroactively pay medical expenses, limit these incentives.

Response: We believe that those who seek to circumvent paying premiums have already weighed their personal health and financial risks of doing so. Therefore, we believe that existing guardrails, such as the prospect of having to pay medical expenses not covered by insurance, are not sufficient to discourage individuals from taking advantage of grace period and guaranteed availability rules.

Comment: One commenter asserted that those who are unable to effectuate enrollment due to unpaid premiums may end up in other forms of "non-ACA compliant" coverage, such as short-term, limited-duration insurance, leading to market distortions and further driving up health insurance premiums in the individual market risk pool. In addition, since these types of plans do not have to cover essential health benefits, the commenter observed that increased reliance on such plans would lead to more uncompensated care, putting hospitals and emergency departments at significant risk of financial instability.

Response: We agree that individuals with unpaid past-due premiums might seek other types of coverage (for example, in markets where the types of coverage described by the commenter are more prevalent). However, in other markets, that might not be the case. This is

why we defer to the States, who know their markets best, to determine whether issuers in their State are permitted to adopt the past-due payment policy set forth in this final rule.

Comment: One commenter supporting the policy related to past-due premiums stated that, in deferring to States on parameters for applying the policy uniformly and consistently, HHS should ensure States are not requiring issuers to apply the past-due premium policy, but rather allowing for the option to do so, consistent with the intent of the proposal. Some commenters commented on the applicability of the policy for issuers offering coverage through State Exchanges. One commenter asked that State Exchanges be permitted, but not required, to implement the policy. One commenter said that some State Exchanges perform premium collection, making the requirement administratively challenging for issuers that do not have premium collection capabilities, and another commenter noted that implementing a past-due premium policy would require significant configuration of the Exchange's system.

Response: This final rule removes the Federal prohibition on attributing payments for new coverage to past-due premiums owed for prior coverage and leaves it to States to determine whether to permit the practice, and if permitted, any restrictions on the practice. States are permitted, but not required, to allow issuers participating in their State Exchanges to implement a past-due premium policy. We recognize that some Exchanges may not have the functionality in place to allow QHP issuers to apply the past-due premium policy to coverage purchased through that State's Exchange. States may take these and other considerations into account in determining whether to allow the past-due payment policy finalized in this rule.

Comment: One commenter was in favor of the proposal, so long as the issuer is the party that must deal with outstanding balances, and not the agent or broker. Other commenters were concerned that agents and brokers will be forced to spend unpaid time navigating billing issues instead of focusing on helping clients get covered.

Response: This final rule does not address which entity is responsible for collecting premiums owed, including any past-due premiums. To the extent an issuer adopts the past-due premium policy in this final rule, the party that collects the past-due premium, for example, the issuer, agent, or broker, would be determined by State law or by agreement of those parties.

Comment: A few commenters expressed concern about the effects of the proposal on the individual market risk pool, asserting that young and healthy individuals are more price-sensitive and less likely to enroll if they must pay past-due premiums. One commenter also observed that these young and healthy enrollees are far more likely to have fallen out of coverage in the first place for past non-payment of premiums.

Response: We believe that, regardless of an individual's age or health status, they potentially will be more inclined to remain in their coverage if they have to pay past-due premiums in order to effectuate new coverage. In addition, to the extent young and healthy enrollees fell out of coverage due to non-payment of premium, the extra effort to resume coverage suggests they may need coverage due to a change in their health status. A policy that keeps them continuously covered is better for them and the risk pool. Moreover, there are minimum standards that must be met to enroll regardless of the impact on the risk pool. Improving the risk pool is no argument to excuse non-payment of premium.

We also note that, under the premium rating rules in section 2701 of the PHS Act, young peoples' premiums are lower in most States, making it likely (particularly for unsubsidized individuals) that, to the extent they have accrued past-due premiums, the amount owed would be lower than it would be for older individuals.

Comment: Many commenters asserted that the proposal is inconsistent with the guaranteed availability requirements in section 2702 of the PHS Act. One commenter stated that the proposed policy is unconstitutional.

Response: We continue to believe that allowing issuers to require payment of past-due premiums is consistent with the guaranteed availability requirements in section 2702 of the PHS Act. In the Market Stabilization Rule (82 FR 18350 through 18351), we noted it is clear from reading the guaranteed availability provision in section 2702 of the PHS Act, together with the guaranteed renewability provision in section 2703 of the PHS Act, that an issuer's sale and continuation in force of an insurance policy is contingent upon payment of premiums. Notably, this recognizes how the guaranteed renewability requirement is not just about renewals but also includes a requirement on issuers to continue the coverage in force throughout the year. Read together, we concluded that the guaranteed availability provision is not intended to require issuers to provide coverage to applicants who have not paid for such coverage. To the extent an individual or employer makes payment in the amount required to effectuate new coverage, but the issuer lawfully credits all or part of that amount toward past-due premiums, we conclude that the consumer has not made sufficient initial payment for the new coverage. We also note that decisions regarding payment of the first month's premium (the binder payment) have traditionally been business decisions made by issuers, subject to State rules. Accordingly, as noted in the proposed rule (90 FR 12953), although we have established certain uniform standards for premium payment deadlines, we ultimately defer to issuers, subject to State rules. Thus, we conclude that refusing to effectuate coverage to an individual or employer who does not pay past-due premiums is indeed permissible under section 2702 of the PHS Act, though a State does not need to allow for it.

Finally, with respect to the commenter raising constitutional concerns, the commenter did not offer any rationale to explain why the proposal would be unconstitutional, and we have not identified any reason why it would be unconstitutional.

Comment: Many comments opposing the proposal asserted that the proposal would disproportionately harm marginalized people, such as individuals with lower economic status.

One commenter asserted that the proposed rule did not provide evidence to support the statement that any past-due amounts would be "quite small" or "would not impose a substantial financial burden" and that the proposed rule made no attempt to quantify that amount in dollars, compare it to the incomes of affected individuals, rebut the findings in the 2023 Payment Notice, or address the potential for multiple years of lookback. One commenter challenged our assertion in the proposed rule that enrollment loss from the proposed changes would be "minimal" because a large proportion of enrollees receive APTCs and therefore would not experience financial hardship because of the proposed changes. According to the commenter, this is not accurate, because people who receive APTCs have very low incomes and lack the funds to pay multiple months of past-due premiums while also paying the premium to effectuate coverage for a new year.

Response: We anticipate that enrollment loss from requiring payment of past-due premiums would be minimal and not impose a substantial financial burden. APTCs are paid on behalf of the vast majority of individuals who enroll in coverage through the Exchanges. The APTC lowers the amount of premium that they pay out of pocket, and therefore also reduces the amount of past-due premium debt that can accrue. In addition, rules regarding grace periods and termination of coverage for individuals receiving APTC result in such individuals generally owing no more than 1 to 3 months of past-due premium amounts per year.[22] Therefore, we conclude that past-due premium amounts generally would not impose a substantial financial burden to enroll in coverage. States can also take additional steps to limit the potential for individuals to owe significant amount of past-due premium by prohibiting the policy, or limiting the lookback period, or capping the amount of past-due premium due to effectuate coverage, based on factors including the socioeconomic demographics of their populations.

[22] Id.

Comment: Several commenters stated that this proposal would cause the uninsured population to increase, causing more medical debt, illness, and death. Some commenters also stated that the proposed rule did not provide sufficient evidence for the assertion that the proposal would cause the uninsured population to decrease and the assertion that the similar policy implemented in the Market Stabilization Rule encouraged individuals to continue to pay their premiums and stated that HHS did not provide data to show that the proposal was needed.

Response: We acknowledge there is always some uncertainty regarding the net effects of any new policy. Here, we cannot know with certainty whether the coverage gains resulting from more moderate premium trends and the promotion of continuous coverage will be higher than any coverage losses resulting from issuers requiring payment of past-due premiums to effectuate new coverage. However, given the importance of health coverage and the fact that most consumers are accustomed to paying in full for one contract before they are allowed to enter another with the same contracting party, we anticipate that any discouragement from enrollment will be minimal. When a similar policy was previously in place, the percentage of enrollees in Exchanges using the Federal platform who had their coverage terminated for non-payment of premiums dropped substantially. While there could have been other reasons for this substantial drop, it is reasonable to conclude the policy was, at least in part, a driving factor by encouraging more people to maintain continuous coverage.

Comment: One commenter observed that HHS had concluded in the 2023 Payment Notice that the past-due premium policy in the 2017 Market Stabilization Rule "had the unintended consequence of creating barriers to health coverage that disproportionally affect low-income individuals." The commenter explained that the proposal to reinstate the past-due premium policy without the 12-month maximum lookback period would create even more significant barriers for low-income individuals and that HHS had not provided a reasoned explanation for its conclusion that these individuals would not be significantly impacted.

Response: In neither the proposed rule nor this final rule do we deny that the past-due premium policy as finalized in this rule will possibly have at least some negative impacts on low-income individuals. Nor does the change in policy in this final rule rely on any belief or assertion that low-income individuals will be less harmed by this policy, as compared to the policy adopted in the 2017 Market Stabilization Rule. Rather, the change in policy in this final rule is supported by the fact that data suggest that more individuals, including low-income individuals, might maintain coverage as a result of the policy in this final rule, as compared to the current policy, which prohibits the past-due premium policy. Continued enrollment suggests that individuals, including those with lower incomes, will not be harmed by the policy, as they will remain covered for any unexpected health issues. Each State, however, including those with large numbers of low-income individuals, are free to disagree, based on their specific market dynamics, and not permit issuers to adopt the policy.

Comment: Several commenters observed that if the expanded premium subsidies sunset at the end of 2025, coverage will become less affordable for a large number of individuals, thereby exacerbating the number of individuals who will not be able to pay their premiums and making the payment of past-due premiums (plus the binder payment for new coverage) that much more difficult.

Response: At the time of publication of this final rule, the expanded subsidies will sunset on December 31, 2025, under current law. States may take this sunset into account in determining whether to permit issuers to apply the past-due premium policy finalized in this rule.

Comment: In the preamble to the proposed rule (90 FR 12951 through 12952), we noted that Exchange enrollment data show a steady decline in the percent of enrollees in Exchanges using the Federal platform that had their coverage terminated for non-payment of premiums between 2017 and 2020. Based on these enrollment trends, we suggested that the past-due premium policy in the Market Stabilization Rule (82 FR 18346) may have successfully

encouraged enrollees to continue paying premiums, while acknowledging limitations on our ability to draw a causal inference. One commenter took issue with this analysis, suggesting that it failed to account for the fact that overall Exchange enrollment also fell, and premiums rose significantly, during this time period – suggesting that a combination of policies led to fewer healthy enrollees retaining coverage, increasing the percentage of total enrollees who might be at risk of health events remaining in coverage, who are more likely to pay premiums throughout. The commenter stated that the proposed rule failed to account for these negative effects on this risk pool.

Response: In the preamble to the proposed rule, we stated that the decline in the rate of enrollees who had their coverage terminated from 2017 to 2020 might have occurred in part because of the interpretation of the guaranteed availability requirement in the Market Stabilization Rule. We acknowledged that due to data limitations, we were unable to directly attribute any changes in enrollment behavior in the Exchanges using the Federal platform to that interpretation. We continue to believe these data, though not conclusive, suggest that the past-due payment policy in the Market Stabilization Rule may have contributed to fewer individuals losing coverage due to non-payment of premiums. However, to the extent States do not believe this would be the case in their specific markets, they may refrain from allowing issuers in their State to adopt the past-due premium policy.

Comment: Several commenters disputed that there are large numbers of individuals who intentionally stop paying premiums in order to gain 1 month of free coverage through the coverage grace period when they know they will submit medical claims for that month, go without coverage for subsequent months when they are confident they will not need it, and then purchase new coverage. Rather, commenters stated that there are a number of legitimate reasons why individuals fail to pay premiums, such as illness, unemployment or job loss, caregiving responsibilities, a natural disaster, household changes that result in higher premiums, and not

realizing that they missed a payment or payments. One commenter stated that some people intentionally stop paying their premiums because their eligibility changes – for example, they become eligible for Medicaid – without understanding the need to terminate their Exchange plan or how to terminate it. Many commenters stated that individuals often experience insurance churn with job loss or access to new coverage. This churn can confuse what plans, coverage, and support are available to them, and patients may not realize they need to terminate coverage, especially if they are not using the insurance.

Response: We acknowledge that many individuals cease paying premiums for various reasons, such as those mentioned by the commenters. In instances where an individual's household income decreases during the policy year, due to illness, job loss, or other circumstances, the individual has the opportunity to report their changed income to the Exchange and might qualify for new or additional APTC to help with their premiums. We also believe that in the overwhelming majority of cases where individuals cannot pay their premiums, the individual has the ability to contact their issuer and terminate coverage before becoming delinquent, avoiding the need to pay past-due premiums. We also note that, even where issuers adopt the past-due premium policy under this final rule, individuals may purchase coverage on a guaranteed issue basis from a different issuer (in all cases, outside the controlled group of the issuer to whom past-due premiums are owed), without having to pay past-due premiums.

Comment: A few commenters stated that denying individuals health insurance, due to not paying past-due premiums or other reasons, would be detrimental not only to those individuals, but to providers and health care systems, with effects reaching well beyond Exchange enrollees.

Response: As we stated in the proposed rule and reiterate in this final rule, we generally believe the past-due premium policy will result in more individuals retaining their coverage.

Comment: Under the proposed rule, an issuer could not condition the effectuation of new coverage on payment of past-due premiums by any individual other than the person contractually

responsible for the payment of premium. One commenter asked which individual is considered the contractually responsible person for payment of premium with respect to a child-only policy and with respect to a family covered by an individual market policy.

Response: For purposes of the past-due premium policy in this final rule, the person contractually responsible for payment of premium is the policyholder. In the case of child-only coverage, the policyholder would typically be the covered child's parent or legal guardian. In the case of an individual market policy covering a family, the policyholder would not be one of the covered dependents. In the case of coverage in the group market, the policyholder is typically the employer or union, not covered employees or their dependents. This means, for example, that a dependent spouse on an individual market policy cannot be required to pay past-due premiums if that dependent spouse wishes to purchase coverage as a policyholder. Similarly, an employer's failure to pay premiums for group health insurance coverage would not result in an employee or dependent owing past-due premiums for coverage in the individual market.

Comment: Several commenters raised concerns that consumers enrolling in coverage with an issuer that applies a past-due premium policy would not be fully informed or would not fully understand the implications of such a policy, and noted potential consumer confusion, as well as financial harm if consumers incorrectly believe they have enrolled in coverage that was never effectuated.

Response: We encourage issuers to be transparent about the application of any past-due premium policy to help ensure that individuals understand how much they must pay to effectuate coverage as well as the consequences of non-payment. Issuers, as a matter of practice, instruct their agents and brokers on how to collect premiums in order to effectuate new coverage, how to determine the amount due in order to effectuate new coverage, and the payment due date. We anticipate that issuers adopting the past-due premium policy would continue to work with their

agents and brokers to ensure that consumers understand what payments must be made, thus minimizing potential confusion.

Comment: One commenter asked whether the proposed rule would permit application of past-due premiums when enrollees switch to a plan offered by a different issuer.

Response: Under the proposed rule and this final rule, subject to applicable State law, an issuer may require a consumer to pay past-due premiums owed to that issuer, or owed to another issuer in the same controlled group, plus the initial (binder) payment for new coverage, before effectuating the new coverage. This reflects the fact that, to the extent an applicant makes payment in the amount required to effectuate new coverage, but the issuer lawfully credits all or part of that amount toward past-due premiums, the applicant has not made sufficient payment for new coverage. There is no mechanism, however, by which an issuer can credit amounts paid to premiums owed to an unrelated issuer. Therefore, an issuer cannot deny coverage under section 2702 of the PHS Act based on an individual's or employer's failure to pay past-due premiums owed to any issuer other than that same issuer or another issuer in the same controlled group.

Comment: Several commenters observed that the proposal to shorten the length of the OEP would give applicants for new coverage less time to figure out how to acquire the funds to pay past-due premiums.

Response: As explained in section III.B.7 of this final rule, the changes to the OEP will take effect beginning with the OEP for PY 2027. Because the proposal to shorten the OEP will not be implemented in PY 2026, enrollees and other interested parties will have sufficient time to adjust to the changes to the OEP such that they understand and are better prepared for the changes when the time period for active enrollment during OEP is shortened for PY 2027.

Comment: Several commenters asserted it would be inappropriate for an issuer to condition enrollment in new coverage on payment of past-due premiums where the non-payment resulted from actions of the issuer or third parties. The commenters gave examples in which non-

payment of premiums was due to actions, inactions, or delays on the part of issuers, Exchanges, agents, and brokers, including cases of fraudulent enrollment, or lag time between when an individual reports information and when an Exchange processes and effectuates changes related to that information.

Response: In instances where an issuer or an Exchange was responsible for non-payment of premium, or incorrectly determined that an individual did not pay premium, we expect the issuer or Exchange to expediently work with the consumer to resolve the situation and enroll them in new coverage without requiring payment of past-due premiums. If there is a delay between when an individual reports changes to their income or household size and when that change is processed, we expect Exchanges to internally document that, so that there is evidence that the individual should not have been charged a higher premium during the lag time. We also note that in situations where an individual was improperly enrolled in coverage, and coverage is rescinded (that is, cancelled or discontinued retroactively to the date of enrollment), as permitted under § 147.128, the individual would not owe any past-due premiums.

Comment: Several commenters raised concerns about the potential impacts on coverage access, particularly in markets with limited competition, where there may be a limited number of issuers servicing that geographic area.

Response: We note that this policy provides States flexibility to address adverse selection based on their specific market conditions and allows for appropriate market-specific solutions that recognize the differences between competitive and less competitive regions. We believe this flexible approach strikes an appropriate balance between preserving consumer access to coverage and accounting for varying market conditions across regions.

Comment: Several commenters observed that there are other mechanisms by which issuers can attempt to collect debt in form of past-due premiums, other than by requiring past-due premiums be paid in order to effectuate new coverage.

Response: Although issuers may have other methods to collect debt, we note that other forms of debt collection, such as placing the debt into collections, can be costly and time consuming. In addition, although the past-due premium policy will facilitate issuer premium collection efforts, it is principally intended to prevent the premium debt in the first instance by ensuring that individuals pay premiums for months in which they have coverage.

Comment: One commenter raised concerns about how the past-due premium policy would interact with an individual coverage health reimbursement arrangement (ICHRA) or a qualified small employer health reimbursement arrangement (QSEHRA). Specifically, the commenter observed that the past-due premium policy could complicate the enrollment process and necessitate additional administrative procedures and costs for employers if they are unable to make an ICHRA offer because employees cannot enroll in individual health insurance coverage. The commenter suggested this could subject the employer to a possible tax penalty if the employer has no way to make another offer of affordable health coverage to their employees. The commenter recommended that employees offered an ICHRA should not be required to pay past-due premiums.

Response: The commenter does not explain why allowing issuers to attribute initial premium payments to past-due premiums would make it so that employers cannot offer ICHRAs, and we do not see a reason why that would be the case. Therefore, we do not believe it is necessary to prohibit an issuer that chooses to apply the past-due premium policy from applying the policy to individuals offered an ICHRA or have a QSEHRA.[23]

ICHRAs must have reasonable procedures for covered participants and beneficiaries to substantiate that they are enrolled in individual health insurance coverage, or enrolled in

[23] In the event an individual is initially enrolled in individual health insurance coverage and subsequently fails to timely pay premiums for the coverage, with the result that the individual is in a grace period, the individual is considered to be enrolled in individual health insurance coverage and the ICHRA must reimburse qualified medical expenses incurred by the individual during that time period to the extent the qualified medical expenses are otherwise covered by the ICHRA.

Medicare Parts A and B or Part C, for each month that they are covered under the ICHRA. ICHRAs also must require participants to forfeit the ICHRA if they are not enrolled in individual health insurance coverage or Medicare.

However, nothing prevents an employer from offering an ICHRA to employees who do not have individual health insurance coverage and reimbursement from an ICHRA for the initial payment of premiums to effectuate the coverage will often not be for the full amount owed.[24,25] In addition, an employer's liability for the employer shared responsibility tax under section 4980H of the Code is determined with respect to whether the employer offered a plan (including an ICHRA) that meets certain requirements, not whether employees enrolled or received benefits under the plan.[26] We note that QSEHRAs are similarly prohibited from providing tax-favored reimbursements to employees for any month that the employee does not have MEC and may only be offered by small employers that are not subject to the employer shared responsibility tax.[27]

Comment: Under the proposed rule, issuers would be permitted to apply the past-due premium policy taking into account premium amounts owed to an issuer in the same controlled

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[24] The Department of the Treasury and the IRS assisted with the consideration and response to this comment. In general, the Treasury and the IRS take the position that, in the case of an HRA, sections 105 and 106 of the Code do not permit a payment to be excluded from a taxpayer's gross income in one plan year if the reimbursed expense was incurred in a different year. This is why the IRS provided a special rule in Notice 2020-33, section IV, that allows ICHRAs to pay premiums for individual health insurance coverage prior to the beginning of the plan year (for example, the plan can pay the initial premium due in December for coverage that starts in January). However, if an issuer attributes an initial premium payment to past-due premiums from the previous year, the issuer is, in effect, applying a surcharge on the initial premium needed to effectuate new coverage that is equivalent to the past-due amount, so long as the individual was covered during the period for when the premiums are past-due and there has not been a rescission. Although the issuer might have pended some claims from the period when premiums were not being paid and those claims would be freed up as a result of the payment, that is secondary to the fact that the payment is being made for the purpose of effectuating the new coverage.

[25] An ICHRA must provide that if any individual covered by the HRA ceases to be covered by individual health insurance coverage, the HRA will not reimburse medical care expenses that are incurred by that individual after the individual health insurance coverage ceases. In addition, if the participant and all dependents covered by the participant's HRA cease to be covered by individual health insurance coverage, the participant must forfeit the HRA. Furthermore, ICHRAs are prohibited from reimbursing amounts for expenses incurred after an individual's individual health insurance coverage ceases.

[26] 26 U.S.C. 4980H.

[27] 26 U.S.C. 9831(d)(3)(B).

group. One commenter replied that this should be left to the States, while two commenters opposed allowing issuers to demand past-due premiums from an issuer in the same controlled group. One commenter recommended the final rule establish the definition of a controlled group rather than leaving the definition to the States.

Response: Consistent with the proposed rule, we are finalizing that States adopting the proposal regarding past-due premiums may determine whether to allow issuers to attribute payment for new coverage to past-due premiums owed to an issuer in the same controlled group. This is consistent with our broader objective to give States flexibility with regard to the past-due premium policy, and we believe that permitting issuers to collect past due premiums owed to other issuers in the same controlled group would be reasonable approach for States to adopt, as solvency is typically measured at the parent-company level, as opposed to the licensed-entity level. The final rule refers to the definition of controlled group in the guaranteed renewability regulations at § 147.106(d)(4), which is a group of two or more persons that is treated as a single employer under sections 52(a), 52(b), 414(m), or 414(o) of the Code. States have flexibility to adopt a narrower definition of a controlled group.

Comment: We solicited comments on whether issuers should be required to establish terms of coverage that attribute the premium the enrollee initially pays for subsequent coverage to past-due premium amounts owed to an issuer. One commenter suggested that States are better situated to set and oversee parameters of this nature. One commenter stated that *requiring* issuers to adopt the past-due premium policy could result in more adverse selection than making the policy optional. This is because, as the commenter explained, less healthy individuals would be most likely to pay past-due premiums in order to effectuate new coverage, while healthier individuals opt for alternative coverage or no coverage. The commenter stated that the impact could be larger in markets where individuals may lack both alternative options for comprehensive coverage and the funds to repay premiums. In contrast, in areas with greater

competition, the commenter stated that healthy individuals who have past-due premiums may have the option to pursue coverage with other issuers, which could reduce the overall level of anti-selection relative to regions with fewer coverage options. In these regions, issuers that *choose to* collect past-due premiums may benefit from lower premiums due to reduced anti-selection and potentially a reduction in uncollectable premium amounts, which could attract more enrollees into the market relative to less competitive regions. As such, adverse selection is likely to be more limited, particularly in competitive regions, where lookback periods are shorter, or where recoupment is optional. Another commenter stated that because every issuer does not have the necessary data or technology to operationalize this change, it is important to keep this provision optional for issuers, as proposed. The commenter emphasized the importance of providing issuers and State Exchanges flexibility in how they implement the proposed policy and to continue deferring to issuers on payment and business decisions. Furthermore, according to this commenter, due to the nominal amount many enrollees owe in past-due premiums, for many issuers the implementation costs may outweigh revenue from potential collections of past-due premiums. Another commenter stated that issuers need the flexibility to set billing policies based on unique factors in their environments. Another commenter stated that States maintain the closest interaction with their consumers and issuers and are best positioned to regulate issuers' premium payment policies. One commenter stated that a mandatory approach could create significant operational burdens on issuers, particularly in managing delinquent accounts, enrollment files and billing procedures. One commenter said that one particular State's existing statutes and regulations, which include grace periods, notice, and restatement of coverage requirements, aim to balance consumer protection with a health insurance issuer's fiscal health. Therefore, the commenter asserted that a uniform Federal regulatory approach is not necessary. One commenter stated that the policy should be optional, because issuers may not be able to identify enrollees whose coverage was terminated for non-payment during the enrollment

process. In addition, many commenters asserted that States should be free to either permit or prohibit the practice.

Response: We agree with commenters who stated that the final rule should not require issuers to adopt the policy related to past-due premiums. States are most familiar with their local insurance markets and are therefore best positioned to determine whether allowing issuers in their State and market to adopt the past-due premium policy is appropriate. We also recognize that some issuers' operations may not currently support such practices. For these reasons, should the State in which an issuer operates allow issuers to condition the effectuation of new coverage on payment of past-due premiums, the final business decision will remain at the discretion of individual issuers and what they determine is in their best interest.

Comment: With respect to the applicability date of the past-due premium policy, one commenter supported this provision applying on the effective date as proposed, stating that consumers will continue to have all the applicable protections of Federal and State law, including protection from discrimination in the application of this policy and Federal and State law grace periods. Several other commenters recommended delaying implementation to PY 2027, stating that issuers need time to make appropriate system and operational changes, and arguing that applying the policy any earlier would effectively change the terms of individuals' current coverage by affecting their ability to purchase future coverage.

Response: The past-due premium policy finalized in this final rule applies on the effective date of the final rule. We are not persuaded that a later applicability date is necessary because the final rule removes the current Federal regulatory prohibition and does not impose any new burdens on States or issuers. Nothing in this final rule requires States to permit, or issuers to implement, the past-due premium policy. Nor does the final rule prevent States or issuers from implementing the policy at a later date. We do not agree that allowing issuers to start applying the past-due premium policy on the effective date of the final rule changes the

terms of an insured individual's current coverage, as insurance policies commonly include contract provisions addressing timely premium payment. Moreover, the past-due premium policy relates to an individual's or employer's ability to purchase a new contract of insurance rather than the existing contract.

Comment: One commenter urged HHS to actively monitor compliance with the past-due premium policy, should we finalize it, to protect both patients and providers.

Response: Under section 2723 of the PHS Act, States are the primary enforcers of the requirements of title XXVII of the PHS Act, including section 2702, with respect to health insurance issuers. We enforce against issuers in a State only if we determine that the State has failed to substantially enforce one or more of the requirements. Therefore, States with primary enforcement authority for section 2702 of the PHS Act will enforce the past-due premium policy in this final rule, to the extent they decide to permit it. We will enforce the policy against issuers in States where HHS is responsible for enforcement of the guaranteed availability requirements in section 2702.

B. Part 155 - Exchange Establishment Standards and Other Related Standards Under the Affordable Care Act

The Marketplace Integrity and Affordability proposed rule included a number of proposed revisions to 45 CFR part 155 of title 45 of the **Code of Federal Regulations** that were intended to improve the integrity of the Exchanges, protect Federal funds, and protect consumers from the ill-effects of unauthorized enrollments, including surprise tax liability. We received a substantial number of comments weighing both for and against these proposals. The Department has concluded, after careful consideration of public comments, that while most of the proposals should be finalized as proposed, some proposals should not be finalized for State Exchanges, and other proposals will adopt a temporary position under which we will finalize the policies to be effective through the end of PY 2026. We address in this section policies the Department is

finalizing to address acute improper and fraudulent enrollment concerns brought about by the expansion of APTC. Given the expiration of the enhanced APTC, the Department has concluded it would be reasonable to accept some risk of future improper enrollments after these policies sunset, in favor of limiting overall disruptions as the market adjusts and sheds holdover improper enrollments. The Department will finalize the following policies temporarily, requiring them to sunset at the end of PY 2026:

● Failure to File Taxes and Reconcile APTC Process; Delay of FTR Process until after 2 consecutive years of FTR removed (§ 155.305(f)(4));

● Income Verification When Data Sources Indicate Income Less Than 100 Percent of the FPL (§ 155.320(c)(3)(iii));

● Income Verification When Tax Data is Unavailable (§ 155.320(c)(5));

● Annual Eligibility Redetermination (§ 155.335)

● Premium Payment Threshold (§ 155.400);

● Monthly Special Enrollment Period for APTC-Eligible Qualified Individuals with a Projected Household Income at or Below 150 Percent of the Federal Poverty Level (§ 155.420); and

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

The Department is of the view that immediate action to codify these proposed policies in this final rule represents the best policy to swiftly stop the substantial fraud, waste, and abuse in connection with expanded subsidies for Exchange coverage. However, based on the broad range of feedback for and against these policies and the difficulty in assigning with certainty the causes of improper enrollments, we believe there could be more efficient long-term solutions to these immediate problems. We expect that after the market has purged the massive amounts of improper and fraudulent enrollments it is currently experiencing that it would be reasonable to

accept the risk that some improper enrollments will come back after the policies sunset. As such, we are finalizing these provisions only through PY 2026.

The expiration of enhanced subsidies creates a level of uncertainty within the individual health insurance market regarding the expected level of enrollment and morbidity of the risk pool for PY 2026 and beyond. Moving into PY 2021, the individual market had experienced an increasing level of stability. Since then, various policy decisions introduced a high level of uncertainty by pulling back enforcement of various regulatory requirements that had previously maintained more predictable enrollment patterns. For instance, Medicaid periodic data matching regulations have not been enforced since the fall of 2020. This nonenforcement posture likely contributed to the substantial increase in enrollment experienced over the past four years. Data presented in this rule suggest this allowed millions of additional people to enroll in the individual market risk pool with subsidized coverage who are otherwise not eligible for premium subsidies. In addition, as described throughout the rule, Federal law enacted in 2021 temporarily increased the level of premium tax credit subsidies which, in particular, made fully-subsidized health plans available to people with incomes between 100 percent and 150 percent of the Federal poverty level. This law dramatically changed the market composition as improper and fraudulent enrollments soared. This temporary policy is now set to expire at the end of PY 2025 and, as such, we believe it is imperative to take decisive action to address improper and fraudulent enrollments to help the market shed the waste, fraud, and abuse currently obscuring evaluation of the market. These actions will help the market gradually reset in the context of a renewed subsidy environment that should inherently reduce improper and fraudulent enrollments through the lack of fully-subsidized benchmark plans.

Given these dynamics, coupled with extensive public feedback, the Department has determined it would be reasonable to sunset certain policies after PY 2026 and accept some risk that improper enrollments will become more likely once the policies sunset. Regulatory sunsets

can be an especially useful strategy to adapt to uncertain circumstances, like those created by the vast amount of improper and fraudulent enrollments created by the subsidy expansion, which the Department feels it must address as the subsidy expansion winds down to prevent short-term consumer pain. Once those currently improperly or fraudulently enrolled have been removed, the potential for consumer harm is significantly lessened as fully-subsidized benchmark plans will no longer exist. As such, while these policies are critical short-term tools to allow the market to readjust to the expanded subsidy expiration, it is not clear that the long-term burden associated with these policies outweighs the program integrity benefits in the absence of abuse-prone fully-subsidized plans. Accordingly, we follow the example of other Federal agencies that have codified short-term, temporary rules in response to urgent needs.[28]

We believe striking this balance will reduce improper and fraudulent enrollments in the near-term without implicating longer-term concerns over these policies, for which it is less clear that the benefits would outweigh such concerns in the absence of the high level of improper enrollments held over from the subsidy expansion. For these reasons, we are finalizing these policies for PY 2026 only, with a reversion to the previous policies for PY 2027 and beyond.

We address each of the policies we are finalizing to sunset after PY 2026 in section III. of this final rule.

1. Definitions; Deferred Action for Childhood Arrivals (§ 155.20)

Section 1312 of the ACA specifically excludes individuals who are not "lawfully present" from eligibility for enrollment in a QHP or for insurance affordability programs.[29] Section 36B

[28] *See, e.g.*, Home Mortgage Disclosure (Regulation C) Final Rule, 82 FR 43088 (Sep. 13, 2017) (in response to comments that it set a reporting threshold to low, the Consumer Financial Protection Board finalized a new, temporary rule increasing the reporting threshold for only two years to allow the agency to study the issue and consider whether to initiate another rulemaking to address the appropriate level for the reporting threshold). *See also,* Securities and Exchange Commission Final Rule 202T, 69 FR 48008, 48012 (August 6, 2004) (adopting a temporary rule to facilitate the collection of data sufficient to assess the effectiveness of certain regulations concerning short sale prices on securities).

[29] 42 U.S.C. 18032(f)(3).

of the Internal Revenue Code, and sections 1412 and 1402 of the ACA provide that PTC,[30] APTC,[31] and CSRs,[32] respectively, are not allowed for individuals who are not lawfully present. Section 1331 of the ACA excludes individuals who are not "lawfully present" from eligibility and enrollment in a BHP in States that elect to operate a BHP.[33] From 2012 through 2024, HHS long took the position that a noncitizen in the United States under the Deferred Action for Childhood Arrivals (DACA) policy was not "lawfully present" for purposes of determining eligibility to enroll in a QHP through an Exchange or for these insurance affordability programs.[34] However, in the DACA Rule (89 FR 39392), HHS updated the definition of "lawfully present" to include DACA recipients for purposes of determining eligibility to enroll in a QHP through an Exchange, to be eligible for PTC, APTC, and CSRs, and to enroll in a BHP in States that elect to operate a BHP. In the 2025 Marketplace Integrity and Affordability proposed rule (90 FR 12953 through 12955), we proposed to realign our policy with the longstanding view of the text of the ACA by updating the definition of "lawfully present" such that DACA recipients are no longer considered "lawfully present" for purposes of enrollment in a QHP through an Exchange, eligibility for PTC, APTC, and CSRs, and for BHP coverage in States that elect to operate a BHP.

On June 15, 2012, the United States Department of Homeland Security (DHS) issued a memorandum entitled "Exercising Prosecutorial Discretion with Respect to Individuals who Came to the United States as Children" ("DHS Memo").[35] The DHS Memo established, for the first time, the DACA policy, and set forth three principles. First, certain individuals who were

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[30] 42 U.S.C. 18082(d); 26 U.S.C. 36B(e)(2).
[31] 42 U.S.C. 18082(d).
[32] 42 U.S.C. 18071(e).
[33] 42 U.S.C. 18051(e).
[34] *See* the definition of "insurance affordability program" at 45 CFR 155.300(a) and 42 CFR 435.4.
[35] Napolitano, J. (2012). *Exercising Prosecutorial Discretion with Respect to Individuals Who Came to the United States as Children*. U.S. Department of Homeland Security. https://www.dhs.gov/xlibrary/assets/s1-exercising-prosecutorial-discretion-individuals-who-came-to-us-as-children.pdf.

brought to the United States as children from another country and who were in the United States in violation of immigration laws were not considered to be an immigration enforcement priority. Second, with respect to these individuals, DHS officials were instructed to exercise enforcement discretion and generally defer from placing them into removal proceedings. Finally, United States Citizenship and Immigration Services (USCIS) was instructed to accept applications to determine whether these individuals were eligible for work authorization during a period of deferred action.

On August 30, 2012, HHS issued an Interim Final Rule (77 FR 52615 through 52616) that amended the definition of "lawfully present" at § 155.20 to conform with the law as enacted by the ACA by making clear that an individual whose case had been deferred under the DACA policy "will not be able to enroll in coverage through the Affordable Insurance Exchanges and, therefore, will not receive coverage that could make them eligible for premium tax credits." The Interim Final Rule noted at that time (77 FR 52615) that "the reasons that DHS offered for adopting the DACA process do not pertain to…extend[ing] health insurance subsidies under the [ACA] to these individuals." For that reason, HHS explained that it did not intend to "inadvertently expand the scope of the DACA process" (77 FR 52615).

On May 8, 2024, after notice and comment, HHS issued the DACA Rule (89 FR 39392) reversing this longstanding interpretation. In the final rule, HHS announced that it had chosen to "reconsider" its prior interpretation from 2012. The DACA Rule, which became effective on November 1, 2024, advanced several arguments for reversing the agency's prior interpretation.[36] Consistent with our statutory authority[37] to define "lawfully present" for use in determining eligibility for our programs, we are now reconsidering these arguments.

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[36] On December 9, 2024, the United States District Court for the District of North Dakota issued a preliminary injunction in *Kansas v. United States of America* (Case No. 1:24-cv-00150) partially blocking implementation of the DACA Rule.

[37] Sec. 1411 of the ACA, 42 U.S.C. 18081(a).

In the DACA Rule (89 FR 39392 through 39395), HHS concluded that because DHS had determined that a DACA recipient is "lawfully present" for purposes of eligibility for certain Social Security benefits under 8 U.S.C. 1611(b)(2), the agency should "align" its position to that of DHS, even while acknowledging that we were operating under separate statutory and policy considerations. However, as demonstrated by HHS' prior policy with regard to DACA recipients (89 FR 39392 through 39395), the "separate statutory authority and policy considerations" did not compel HHS to "align" its position on DACA recipients with the position that DHS took with regard to DACA recipients' eligibility for certain Social Security benefits.

In the DACA Final Rule (89 FR 39395), HHS also posited that it saw "no statutory mandate to distinguish between recipients of deferred action under the DACA policy and other deferred action recipients." The final rule noted that Federal agencies have considered deferred action recipients to be "lawfully present" for purposes of certain Social Security benefits since 1996.[38] However, DACA recipients, unlike other deferred action recipients, received deferred action under a large-scale presidential initiative whose purposes did not include extending ACA access to health insurance Exchanges. As HHS originally explained, it is not consistent with the reasons offered for adopting the DACA process to extend health insurance subsidies under the ACA to these individuals (77 FR 52615). This original policy reflected the better view of the appropriate intersection of DACA and the ACA.

The Fifth Circuit concluded in 2022 that "Congress created an intricate statutory scheme for determining which classes of aliens may receive lawful presence, discretionary relief from removal, deferred action, and work authorization" and that "Congress's rigorous classification

[38] *See* Definition of the Term Lawfully Present in the United States for Purposes of Applying for Title II Benefits Under Section 401(b)(2) of Pub. L. 104-193, interim final rule (61 FR 47039).

scheme forecloses the contrary scheme in the DACA Memorandum."[39,40] In the DACA Rule, HHS acknowledged the Fifth Circuit's opinion but proceeded to consider DACA recipients "lawfully present" for purposes of eligibility to enroll in a QHP through an Exchange, to be eligible for PTC, APTC, CSRs, and to be eligible to enroll in a BHP in States that elect to operate a BHP because the "rule reflects our independent statutory authority under the ACA to define 'lawfully present.'" Upon further reconsideration and as stated in the proposed rule (90 FR 12954), we now believe HHS should not have defined "lawfully present" under the ACA in a way that departed from the longstanding understanding of that term with respect to DACA recipients.

To support the DACA Rule, HHS stated that the policy would increase insurance coverage, reduce delays in care, improve the ACA's risk pool, and make DACA recipients more productive members of society. However, these benefits the agency previously noted do not mean that DACA recipients should be considered to have met the "lawfully present" standard that Congress set in order to enroll in a QHP through an Exchange, for PTC, APTC, CSRs to be allowed for their Exchange coverage, and to enroll in a BHP in States that elect to operate a BHP. In the proposed rule (90 FR 12954), we stated that we believe the use of the term "lawfully present" in the ACA is best implemented by excluding DACA recipients for purposes of eligibility to enroll in a QHP through an Exchange, for PTC, APTC, CSRs to be allowed for their Exchange coverage, and to be eligible to enroll in a BHP in States that elect to operate a BHP. DHS' decision that DACA recipients are not priorities for removal does not, as DHS has acknowledged, mean that they have "lawful status" within the United States, nor does that DHS' decision control anything regarding "eligibility rules" for health-related benefits administered by

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[39] *Texas v. United States*, 50 F.4th 498, 526 (5th Cir. 2022).

[40] On January 17, 2025, the U.S. Court of Appeals for the Fifth Circuit issued a decision (*State of Texas, et al. v. U.S.A*, et al., 23-40653) regarding DHS' final rule "Deferred Action for Childhood Arrivals" (87 FR 53152), which found the benefits granting provisions of the rule to be substantively unlawful, limited injunctive relief to the State of Texas, and remanded the case to the district court for further proceedings.

"[o]ther departments and agencies, such as HHS" (87 FR 53211 through 53212). Therefore, in the proposed rule (90 FR 12955), we stated that we believe it was improper for HHS to have advanced a policy goal that was contrary to the ACA's statutory limitations as they had been understood since the inception of DACA. Furthermore, DHS' decision that enforcement resources should be focused on other unlawful immigrants does not compel the conclusion that taxpayer dollars should be expended to subsidize the healthcare of those unlawful immigrants, as HHS recognized in its 2012 rule. Indeed, Congress has expressed a clear immigration policy that "aliens within the Nation's borders not depend on public resources to meet their needs" and public benefits should "not constitute an incentive for immigration to the United States" (8 U.S.C. 1601(2)). While HHS acknowledged this goal in previous rulemaking (89 FR 39399), it did not explain why the understanding that it had adopted prior to the DACA Rule did not better comport with this statutory goal.

After reconsidering these arguments and as stated in the proposed rule (90 FR 12955), we believe that, with respect to DACA recipients, defining the term "lawfully present" as set forth in the August 30, 2012 Interim Final Rule (77 FR 52614 through 52616) better adhered to the policy considerations underlying the statutory scheme. As previously noted, HHS' statutory authority and policy considerations for defining "lawfully present" with regard to its programs are separate from DHS', and there is no requirement that HHS aligns its definition of "lawfully present" with DHS'. There is also no requirement that HHS align its treatment of DACA recipients with other recipients of deferred action, particularly given the fundamental differences between DHS' DACA policy and other policies under which DHS may grant deferred action. In the 2012 Interim Final Rule (77 FR 52614 at 52615), HHS noted that the reasons DHS offered in the DHS Memo for adopting the DACA process did not include providing access to insurance affordability programs, and that any such expansion would "inadvertently expand the scope of the DACA process." Under section 42 U.S.C. 18032(f)(3), section 36B(e)(2) of the Code, 42

U.S.C. 18082(d), 42 U.SC. 18071(e)(1)(A), and 42 U.S.C. 18051(e), enrollment in a QHP offered on an Exchange, PTC, APTC, CSRs, and enrollment in a BHP in States that elect to operate a BHP, respectively, is allowed only for individuals who are "lawfully present" in the United States, and the better view is that a DACA recipient does not meet that requirement and would therefore, under this rule, be ineligible for these benefits.

We sought comment on this proposal.

After consideration of comments and for the reasons outlined in the proposed rule and this final rule, including our responses to comments, we are finalizing this policy as proposed. This policy will be applicable immediately upon the effective date of this rule as it conforms regulatory policy to the best statutory reading of the ACA. We summarize and respond to public comments received on the proposed changes to the definition of "lawfully present" below.

General Support

Comment: We received several comments in support of the proposed change to exclude DACA recipients from the definition of "lawfully present." Commenters noted that including DACA recipients in the definition of "lawfully present" imposed additional costs on taxpayers and that reverting the definition to exclude DACA recipients would better protect taxpayers.

Response: We appreciate comments received in support of our proposal to modify the regulatory definition of "lawfully present" at § 155.20 in alignment with the definition set forth in the August 30, 2012 Interim Final Rule (77 FR 52614 through 52616) to exclude DACA recipients for purposes of eligibility to enroll in a QHP through an Exchange, for PTC, APTC, CSRs to be allowed for their Exchange coverage, and to be eligible to enroll in a BHP in States that elect to operate a BHP. We agree that this proposal would result in less PTC being paid out, given that DACA recipients would no longer be eligible to enroll.

Comment: Many commenters supported that the proposed rule did not propose to modify the technical and clarifying changes to the definition of "lawfully present" at § 155.20 that were

made by the 2024 DACA rule (89 FR 39392). Commenters noted that these changes eliminated complexity in eligibility determinations and eased burden on service providers and consumers.

Response: We appreciate comments received in support of our proposal to retain these adjustments. We agree that these changes were primarily technical and clarifying in nature and that these changes simplify eligibility determinations.

General Opposition

We received several comments opposing the proposed change to the definition of "lawfully present" in this rule. The following is a summary of the comments we received and our responses.

Comment: The majority of commenters noted general opposition to CMS' proposal to exclude DACA recipients from the definition of "lawfully present." Many commenters noted that DACA recipients are essential members of their community that contribute to the economy and that excluding DACA recipients delegitimizes their status. Many commenters stated that individuals undergo extensive vetting to obtain and maintain their DACA status and are hence "legally present." Commenters also noted that DACA recipients have work authorization and pay taxes and therefore should have access to Exchange coverage. One commenter noted that the opportunity to purchase Exchange coverage is consistent with the goals of the DACA policy. Similarly, another commenter noted that giving DACA recipients access to the Marketplace does not change anything about their legal immigration status, and hence DACA recipients should be allowed to buy insurance on the Marketplace. One commenter noted that the ACA only states that the Exchange is unavailable to individuals who are not "lawfully present" without explicitly referencing any categories of noncitizens, and that the ACA instead "defers to 45 CFR 155.20."

Response: We note that individuals who are not "lawfully present" are ineligible for enrollment in a QHP through an Exchange and for insurance affordability programs.[41] As mentioned in the proposed rule consistent with our statutory authority[42] to define "lawfully present" for use in determining eligibility for our programs, we are reconsidering our prior interpretation from the 2024 DACA rule at 89 FR 39392. As noted in the 2012 DHS Memo, the DACA process was designed to provide temporary relief from removal for certain individuals on a case-by-case basis as a mechanism to preserve governmental resources for high-priority removal cases. We note that the reasons for adopting the DACA process did not pertain to health insurance affordability programs, such as access to Exchange coverage. We believe that the original interpretation of the term "lawfully present" better reflects the appropriate intersection of DACA and the ACA.

Comment: Some commenters noted that HHS has maintained Exchange eligibility for all other individuals with deferred action, and DACA recipients should be allowed to enroll in Exchange coverage such that eligibility standards are consistently applied to all recipients of deferred action. One commenter noted that deferred action is a long-standing administrative mechanism that predates the ACA, and that DACA recipients are therefore not unique among deferred action recipients to the extent that the policy under which they were granted deferred action was not explicitly intended to extend access to Exchange coverage. Another commenter noted that DACA recipients can be considered as having "quasi-legal" status, which warrants access to care. One commenter noted that HHS has no authority to independently define "lawfully present," and the Congress did not intend to confer on HHS the authority to define lawful presence for immigrants.

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[41] 42 U.S.C. 18032(f)(3), 42 U.S.C. 18032(f)(3), 42 U.S.C. 18082(d), 42 U.SC. 18071(e)(1)(A), 42 U.S.C. 18051(e).
[42] 42 U.S.C. 18081(a).

Response: As noted in the proposed rule, DACA recipients, unlike other deferred action-recipients, received deferred action under a large-scale presidential initiative, the purpose of which did not include extending ACA access to health insurance Exchanges. We note that in prior rulemaking, the Department of Homeland Security (DHS) acknowledged that DACA has "never conferred lawful immigration status on recipients," and further declined to label DACA as "identical" to all other forms of deferred action (87 FR 53211 through 53212). We reiterate that HHS maintains its separate and independent statutory authority to codify a regulatory definition of "lawfully present"' for use in determining eligibility to enroll in a QHP through an Exchange, in a BHP in States that elect to operate a BHP, and eligibility for PTC, APTC, CSRs. We believe that the definition of "lawfully present" as set forth in the August 30, 2012 Interim Final Rule (77 FR 52614 through 52616) best adheres to the statute and is consistent with the benefits afforded by the DACA policy, which are forbearance from removal from the United States and employment authorization. We note that HHS retains separate statutory authority and policy considerations to define the term "lawfully present" for its programs. This authority does not compel HHS to align its definition of "lawfully present" with DHS, especially since the reasons DHS offered for adopting the DACA policy do not pertain to eligibility for insurance affordability programs.[43] We also note that other definitions of "lawfully present," such as those by DHS, should not be used as a criterion to gauge eligibility for health insurance coverage. Therefore, extending health insurance subsidies and cost-sharing reductions to DACA recipients for Exchange coverage, or coverage through a BHP in states that elect to operate a BHP, would improperly expand the scope of the DACA process.

Legal Concerns

[43] As defined in 45 CFR 155.300(a); 42 CFR 435.4

We received several comments that highlighted legal concerns with the proposed change to the definition of "lawfully present" in this rule. The following is a summary of the comments we received and our responses.

Comment: Some commenters opposed the modification of the definition of "lawfully present" and stated that the change is inconsistent with the intent and goals of the ACA. Specifically, one commenter noted that the exclusion of DACA recipients may constitute discrimination based on national origin, which is prohibited under section 1557 of the ACA. Another commenter noted that the proposed rule did not address section 1554 of the ACA, which disallows HHS from promulgating regulations that may constitute unreasonable barriers to care or impede timely access to services. Several commenters highlighted that excluding DACA recipients from the definition of "lawfully present" restricts their ability to access medical care, which violates the Equal Protection Clause of the Fourteenth Amendment of U.S. Constitution. Commenters also stated that the proposed definition of "lawfully present" denies DACA recipients' rights under title VI of the Civil Rights Act.

Response: The Department disagrees that excluding DACA recipients from the definition of lawfully present violates sections 1554 or 1557 of the ACA, the Equal Protection Clause of the Fourteenth Amendment, or title VI of the Civil Rights Act.

Section 1557 of the ACA (42 U.S.C. 18116) prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in a health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, except where otherwise provided in title I of the ACA. Section 1557 of the ACA also prohibits discrimination on the basis of race, color, national origin, sex, age, or disability under any program or activity that is administered by an executive agency, or any entity established under title I of the ACA or its amendments. We disagree that this rule's proposal to define "lawfully present" for purposes of HHS programs constitutes discrimination on the basis of national origin,

as DACA status may be obtained by individuals who came to the United States as children regardless of their national origin, if they meet all other DHS eligibility criteria. Additionally, as outlined in prior rulemaking (89 FR 37522), section 1557 of the ACA does not include immigration status. Similarly, this proposal does not violate section 1554 of the ACA. In *California v. Azar*, the Ninth Circuit held that section 1554 of the ACA is intended to ensure that HHS does not "improperly impose regulatory burdens on doctors and patients," not to restrict HHS' ability to "ensure government funds are not spent for an unauthorized purpose."[44]

Furthermore, we do not agree that the proposed change to the definition of "lawfully present" violates the Equal Protection Clause of the Fourteenth Amendment or title VI of the Civil Rights Act. The Equal Protection Clause prohibits States from denying anyone within their jurisdiction the equal protection of the laws and thus is not applicable here. Nevertheless, we note that HHS' action to modify the definition of "lawfully present" is consistent with the Equal Protection Clause as the Federal government has a rational basis to distinguish between DACA recipients and other categories of "lawfully present" noncitizens, as detailed in this section.[45] Title VI of the Civil Rights Act, 1964, likewise, is not relevant here. Title VI provides that no person shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance and reaches only acts of intentional discrimination.[46] A rule providing that DACA recipients do not qualify as lawfully present is consistent with the premise of the DACA program under which DACA recipients have no lawful immigration status, but enjoy deferred deportations given the low priority the Federal government places on their deportations. Moreover, the policy we finalize does not constitute discrimination based on any

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[44] *California v. Azar*, 950 F.3d 1067 (9th Cir. 2020).
[45] *Toro v. Sec'y, U.S. Dep't of Homeland Sec*., 707 F.3d 1224, 1230 (11th Cir. 2013)
[46] *Alexander v. Sandoval*, 532 U.S. 275, 280 ("Title VI itself directly reach[es] only instances of intentional discrimination.") (internal citations and quotations omitted).

protected ground, as it does not distinguish based on a DACA recipient's particular race, color, or national origin. As we explain earlier in this preamble, lawful presence is one of many critical eligibility criteria required by the ACA. We reiterate that HHS has the authority under the ACA to facilitate the operation of its programs, including the issuance of regulations that define "lawfully present," and we believe the exclusion of DACA recipients represents the best interpretation of Congressional intent.

Comment: A few commenters noted that there is ongoing litigation regarding HHS' 2024 DACA rule and that the proposed change to the definition of "lawfully present" is improper and attempts to prevent a judicial decision.

Response: We note that there is ongoing litigation regarding the 2024 DACA rule. In August 2024, several plaintiff States filed a lawsuit in the United States District Court for the District of North Dakota in response to the agency's 2024 DACA rule that newly included DACA recipients in the definition of "lawfully present."[47] On December 9, 2024, the court issued a preliminary injunction applicable to the plaintiff States, and as a result DACA recipients are ineligible for Exchange coverage in the nineteen plaintiff States involved in the lawsuit.[48] On December 16, 2024, the preliminary injunction was appealed to the Eighth Circuit Court of Appeals. Ultimately, this rulemaking may render as moot the pending legal challenge to the DACA Rule, and the appeals court granted the Government's motion to hold the appeal in abeyance. At present, DACA recipients in all other States continue to be eligible for Exchange coverage. We disagree that it is improper to propose and finalize this change to the definition of "lawfully present." We note that the resolution and timing of a final disposition for this litigation

[47] *Kansas v. United States of America* (Case No. 1:24-cv-00150).

[48] These States are Alabama, Arkansas, Florida, Idaho, Indiana, Iowa, Kansas, Kentucky, Missouri, Montana, Nebraska, New Hampshire, North Dakota, Ohio, South Carolina, South Dakota, Tennessee, Texas, and Virginia. All States are served by Federal platform, except for Idaho, Kentucky, and Virginia, which are State Exchanges that operate their own platforms.

is unknown and without this proposed modification, the agency would fail to align with the better interpretation of the term "lawfully present" and would continue to incorrectly expend taxpayer dollars.

Impact on Health and Health Care Systems

We received many comments opposing the proposed change to the definition of "lawfully present" in this rule out of concern for the health and well-being of individuals, families, communities, and health care organizations. Commenters expressed concerns regarding increased costs associated with shifts from preventive care to emergency room care, a weaker individual market risk pool, and increased tax burdens on Americans with the removal of eligibility of DACA recipients under the ACA. The following is a summary of the comments we received and our responses.

Comment: Many commenters shared that increasing access to health insurance coverage and health care has positive impacts on individual and population health, and, conversely, that decreasing access to coverage harms individual and population health.[49] Many commenters stated that they expected the provision would result in decreased community public health and decreased well-being for DACA recipients as these individuals become uninsured, noting that leaving thousands of DACA recipients without health coverage could lead to dire health consequences in their communities.

Commenters noted that insured individuals are more likely to have a regular source of care and to receive timely and appropriate preventive care and are less likely to experience certain health complications than uninsured individuals. Nonprofit medical and advocacy organizations commented that having access to health insurance is associated with increased

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[49] American Hospital Association. *Report: The Importance of Health Coverage.* https://www.aha.org/guidesreports/report-importance-health-coverage#:~:text=Impact%20of%20Coverage&text=Studies%20confirm%20that%20coverage%20improves,on%20individuals%2C%20families%20and%20communities.

utilization of preventive care, and that early testing is critical to detect life threatening health conditions like lung, blood, and breast cancer, HIV/AIDS, diabetes, chronic conditions, and disabilities.[50] Commenters also noted that access to health insurance is associated with preventing maternal mortality in immigrant women.

Commenters expressed concerns that without access to health insurance, the cost to treat complex health conditions within the DACA population would be higher than if DACA recipients remained eligible for health insurance and received preventive care. Some commenters noted the disproportionate rate of uninsurance among DACA recipients is due to their prior exclusion from Exchange coverage and continued exclusion from Medicaid. Some commenters noted that taking away eligibility for DACA recipients undermines the goal of the ACA to expand access to health care services.

Response: We appreciate commenters' feedback and acknowledge that one of the broad goals of the ACA is to increase access to health insurance coverage. We also acknowledge commenters' concerns regarding the potential impacts of the changes proposed in this rule on the ability of some DACA recipients to access health care services. We note that, because DACA recipients generally have employment authorization, they may have the option to access health insurance coverage through their employer. Additionally, we note that DACA recipients remain eligible for limited Medicaid coverage for the treatment of an emergency medical condition, if they meet all other eligibility requirements for Medicaid in the state (for example, income and state residency), except for U.S. citizenship or satisfactory immigration status.

We reiterate that the ACA's broad goal of increasing access to health insurance exists within a specific statutory scheme that requires that individuals be lawfully present in order to

[50] "Access to Primary Care." Office of Disease Prevention and Health Promotion, 2020, www.odphp.health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/access-primary-care.

access coverage. HHS is obligated to promulgate regulations that best effectuate the statutory guardrails of the ACA, and as previously stated, we believe that the definition of "lawfully present" finalized in this rule best achieves Congress's intent.

Comment: Commenters noted that decreased access to health insurance coverage and preventive care would increase the burdens on hospitals, Federally Qualified Health Centers (FQHCs), State and community programs, safety-net providers, and emergency departments which would provide more urgent and emergent care to uninsured individuals as a result. Commenters stated that visits to hospitals and emergency rooms are more costly than preventive care visits, and commenters argued that an increase in emergency services would increase the overall cost of health care.[51] Some commenters stated that an increase in emergency room visits would put undue strain on hospitals and emergency room providers who already face overcrowding. Other commenters noted that FQHCs see patients regardless of insurance status and that the removal of DACA recipients from Exchange eligibility would require FQHCs to make challenging decisions about the services they can provide.

Commenters cited that, on average, uninsured individuals generate over $1,000 in uncompensated costs annually, which the rest of the health care system absorbs.[52] In addition to the potential burdens on providers, commenters expressed concerns that DACA recipients would face undue financial hardship when they finally seek care. Commenters noted DACA recipients' fear of medical debt, which contributes to skipping needed preventive medical and dental care and difficulty finding resources to improve their mental health.[53]

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[51] American Hospital Association. Report: The Importance of Health Coverage. https://www.aha.org/guidesreports/report-importance-health-coverage#:~:text=Impact%20of%20Coverage&text=Studies%20confirm%20that%20coverage%20improves,on%20individuals%2C%20families%20and%20communities.

[52] Kaiser Family Foundation. Key Facts About the Uninsured Population (2023). https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/.

[53] Center for American Progress. The Demographic and Economic Impacts of DACA Recipients: Fall 2021 Edition. (2022). *https://www.americanprogress.org/article/the-demographic-and-economic-impacts-of-daca-recipients-fall-2021-edition/*

Comments from providers expressed concerns about the possibility that DACA recipients may lose coverage in the middle of a treatment program or may return to the emergency room or other acute care settings after their health has deteriorated. These providers commented that these emergency services are much more expensive and less effective than if treatment had continued in the patients' primary care setting. One commenter, who is a provider, noted that epilepsy has a higher cost associated with emergency care rather than preventive care and has higher incidence in immigrant populations. Additionally, some commenters noted that DACA recipients face unique stressors that impact their acute mental health and can lead to increased vulnerability to chronic medical conditions.[54] These stressors include trauma from violence, persecution, and poverty in addition to general fear and anxiety compounded by the stress of the unknown future of the DACA program and immigration status implications.

Many commenters stated that an increase in the cost of health care, due to increased emergency room use, would mean that American taxpayers would pay even higher amounts to insurance companies to defray these increased costs. Commenters also stated that removing eligibility of DACA recipients would not deliver the economic relief needed for American families and may instead increase the financial burden on individual, American taxpayers. Other commenters noted that HHS did not provide evidence of how this proposed change would generate cost savings.

Response: We acknowledge commenters' feedback regarding the potential impact of uninsurance on DACA recipients, and that some DACA recipients may become uninsured as a result of the changes proposed in this rule. Although we are unable to quantify potential costs related to shifting care to emergency settings, uncompensated care, or changes to the risk pool as a result of this provision, we expect that this proposal will result in savings in the form of

[54] Henderson, S. W., & Baily, C. D. Parental deportation, families, and mental health. Journal of the American Academy of Child & Adolescent Psychiatry (2013). 52(5), 451-453.

reduced PTC expenditures. We refer to this rule's Regulatory Impact Assessment for further information regarding these estimates. Additionally, we believe that the concerns expressed here, such as emergency room strain or changes in coverage during a course of treatment, represent common, existing issues that healthcare providers are generally well-equipped to address. Finally, we note that these concerns do not overcome Congress's direction in the ACA that only "lawfully present" individuals are eligible for Exchanges coverage.

Comment: Many commenters cited concerns about how removing access to Exchange coverage for DACA recipients would impact the 300,000 U.S. citizen children who have at least one parent that is a DACA recipient.[55] These commenters noted that insurance coverage for parents is also tied to the health of their children, where children are more likely to access health insurance and health care services when their parents are insured, a phenomenon known as the "welcome mat" effect.[56] They noted that barriers to health insurance access for parents often increases the uninsured rate of their children who are U.S. born and U.S. citizens, but that children who have access to preventive care often have better health outcomes as adults. Commenters also noted that access to health insurance is linked to the financial stability of the family as insured parents are better equipped to support their families.[57]

Response: While we acknowledge these commenters' concerns, we note that the U.S. citizen children of DACA recipients remain eligible for QHPs through an Exchange, for PTC, APTC, and CSRs, as well as for Medicaid, CHIP, and BHP in States that elect to operate a BHP,

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[55] Center for American Progress. The Demographic and Economic Impacts of DACA Recipients: Fall 2021 Edition. (2022). https://www.americanprogress.org/article/the-demographic-and-economic-impacts-of-daca-recipients-fall-2021-edition/.

[56] Hudson, Julie L., and Asako S. Moriya. "Medicaid Expansion for Adults Had Measurable "Welcome Mat" Effects on Their Children." Health Affairs, vol. 36, no. 9, Sept. 2017, pp. 1643–1651, https://doi.org/10.1377/hlthaff.2017.0347.

[57] Wright Burak, Elisabeth. "Parents' and Caregivers' Health Insurance Supports Children's Healthy Development." Society for Research in Child Development, June 2019, https://www.srcd.org/research/parents-and-caregivers-health-insurance-supports-childrens-healthy-development.

if they meet all eligibility requirements in the state. This rule's provisions do not impact their eligibility.

Comment: Many commenters stressed the important role that DACA recipients hold in our communities and workforce, noting that during the COVID-19 pandemic nearly 203,000 DACA recipients worked at the frontlines in health care, education, and food distribution.[58] Commenters also noted that DACA recipients contribute billions of dollars in Federal and State taxes each year, paying into the ACA Exchanges that they would not be eligible for if this rule was finalized as proposed. Additionally, these commenters noted that if DACA recipients were not eligible for health insurance through the ACA, there could be a negative impact on the economy as sickness or the need for emergency care rather than preventive care would impact these frontline workers and frontline communities. Commenters also noted that studies[59] show DACA recipients may avoid seeking medical attention out of fear that doing so would impact their immigration status, and these commenters express concern that this will increase for DACA recipients when they are no longer eligible for coverage under the ACA.

Response: We disagree that these factors constitute a compelling reason to maintain a regulatory definition of "lawful presence" that we do not believe is consistent with the statute.

Comment: Many commenters stated that removing the eligibility of DACA recipients from Exchange coverage would negatively impact the risk pool. Commenters noted that DACA recipients are generally younger and healthier, which would benefit the risk pool, citing studies of likely eligible DACA recipient self-reporting excellent or very good health.[60] Commenters

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[58] Nicole Svajlenka, A Demographic Profile of DACA Recipients on the Frontlines of the Coronavirus Response, Ctr. for Am. Progress (Apr. 6, 2020), *https://www.americanprogress.org/article/demographic-profile-daca-recipients-frontlines-coronavirus-response/.*

[59] National Immigration Law Center (2024, May 29). DACA Recipients' Access to Health Care: 2024 Report. Retrieved April 8, 2025, from *https://www.nilc.org/wpcontent/uploads/2024/05/NILC_DACA-Report_2024_06-27-24.pdf.*

[60] Key Facts on Deferred Action for Childhood Arrivals (DACA) (2025), *https://www.kff.org/racial-equity-and-health-policy/fact-sheet/key-facts-on-deferred-action-for-childhood-arrivals-daca/.*

noted that the removal of DACA recipients from the Exchange risk pool would increase the overall cost of the health care system, including the cost of premiums and copays for other consumers. One State Exchange also noted that the elimination of DACA recipients from their Exchange would erode their merged market and would result in premium increases for all market segments and ultimately increasing costs for families and individuals in their State. One commenter suggested that DACA recipients who are currently enrolled in Exchange coverage should be "grandfathered" in to reduce the impact of individuals' exclusion on the risk pool. The same commenter noted that State Exchanges should be given the option to allow DACA recipients in their Exchanges if doing so would benefit their population.

Response: While we are unable to quantify the potential impacts of this policy on Exchange risk pools, we note that HHS is obligated to promulgate regulations that best effectuate the guardrails outlined in the ACA. HHS believes the definition of "lawfully present" finalized in this rule best achieves Congress' intent. Accordingly, granting State Exchanges the flexibility to cover DACA recipients if they choose is not appropriate.

Implementation Concerns and Effective Date

We received several comments that highlighted concerns with the time within which all Exchanges would be required to exclude DACA recipients from Exchange (or BHP) participation and the associated operational concerns. The following is a summary of the comments we received and our responses.

Comment: Many commenters expressed significant concerns that the proposed modification to the definition of "lawfully present" would be applicable upon the effective date of the rule, as a mid-year eligibility change would negatively impact consumers. Many commenters noted that due to rapid policy shifts, additional time is necessary to identify and communicate with impacted consumers. Several State Exchanges that do not use the Federal platform underscored the need for additional lead time to implement changes, including

information technology (IT) system changes, modifications to business operations, and retraining staff. Commenters noted that implementing changes without additional lead time impacts system accuracy, market stability, and overall member experience. Commenters also highlighted that two State Exchanges indicated that IT system changes require lead time to ensure alignment with other State agency partners to coordinate IT release schedules. One State Exchange indicated that they utilize an integrated eligibility system which requires additional time to coordinate a planned technical release and testing. Several commenters strongly urged HHS to delay the effective date of this provision until January 1, 2026. One commenter also noted that a mid-year eligibility change would affect assumptions that carriers make about their enrollees in a plan year.

Several commenters noted that an effective date earlier than January 1, 2026, would impact rate filing submissions by issuers. One issuer noted that the proposed effective date does not provide sufficient time for State Exchanges to accurately identify individuals, share necessary documentation with issuers, and send termination notices to consumers following termination. The same commenter noted that insufficient time may result in delayed or erroneous terminations, which may result in consumer harm and increased administrative burden for Exchanges and issuers. Two issuer commenters noted that issuers do not have information on the immigration status of enrollees and requested additional clarification on how Exchanges will terminate DACA recipients, including if the proposed change impacts current or future enrollees. One commenter suggested that HHS consider grandfathering in current DACA recipients for PY 2026 to promote continuity of care. Another commenter requested flexibility in the timeline to terminate and notify consumers for any current DACA recipient enrollees without any penalty to the consumer.

Response: We acknowledge commenters' concerns about operational challenges regarding the implementation of this provision, as well as commenters' suggestions on

alternative approaches. While we understand that there are existing technical and operational constraints that impact interested parties, including issuer concerns with rate filing submissions for PY 2026, we reiterate that without the proposed modification to the definition of "lawfully present," the agency would fail to align with the better interpretation of the term "lawfully present" and incorrectly expend taxpayer dollars. This provision will continue to be applicable on the effective date of this final rule and will apply to current and future enrollees who are DACA recipients for enrollment in a QHP offered on an Exchange and eligibility for PTC, APTC, CSRs, and enrollment in a BHP in States that elect to operate a BHP. We acknowledge concerns regarding technical and operational constraints that may hinder some State Exchanges that are not on the Federal platform from implementing this provision. We intend to provide technical assistance and educational materials targeted at State Exchanges not on the Federal platform and state agencies that operate BHPs in states that elect to operate BHPs (BHP agencies) to assist in successful implementation of this rule. We intend to begin providing such technical assistance after the publication date of this rule and in advance of its effective date. Importantly, we note that Exchanges and BHP agencies should continue to submit requests to verify an applicant's immigration status through a data match with DHS via the Hub using DHS' Systematic Alien Verification for Entitlements (SAVE) system, which allows Exchanges and BHP agencies to correctly identify enrollees who are DACA recipients. We anticipate that Exchanges and BHP agencies will be responsible for terminating coverage for any DACA recipients currently enrolled in coverage upon the effective date of the rule. Pursuant to 45 CFR 156.270(b)(1), we note that issuers must send termination notices to enrollees for all termination events, even when a termination is initiated by an Exchange. We also acknowledge the possibility of erroneous terminations as Exchanges implement this provision. If Exchanges inadvertently and erroneously disenroll eligible individuals during the course of implementing

this provision, Exchanges have broad authority to take steps to reinstate coverage under 45 CFR 155.430(e)(3).

Out of Scope

Comment: Some commenters noted that DACA recipients pay taxes and contribute positively to U.S. society and requested that the Federal government create pathways for DACA recipients to obtain U.S. citizenship.

Response: We note that this rule does not address the DACA policy itself, only the eligibility of DACA recipients for coverage under an Exchange (and related eligibility for insurance affordability programs) or BHP in States that elect to operate a BHP. While these comments are related to the DACA policy broadly, they do not seek to support or change specific provisions set forth in the proposed rule, and no response is required.

Comment: A few commenters stated that they opposed declaring DACA recipients illegal and excluding DACA recipients from receiving Medicare coverage.

Response: This rule does not address the DACA policy itself, and DACA recipients are not eligible for Medicare under current law. While these comments are related to the DACA policy broadly, these topics are out of scope for this final rule, and no response is required.

After consideration of comments and for the reasons outlined in the proposed rule and this final rule, including our responses to comments, we are finalizing this policy as proposed to modify the definition of "lawfully present" at § 155.20 used for the purpose of determining whether a consumer is eligible to enroll in a QHP through an Exchange, to be eligible for PTC, APTC, CSRs, and to be eligible to enroll in a BHP in States that elect to operate a BHP, which excludes DACA recipients from Exchange (and from eligibility for insurance affordability programs) and BHP coverage. As previously discussed, this policy will be applicable immediately upon the effective date of this rule.

2. Standards for Termination of an Agent's, Broker's, or Web-broker's Exchange Agreements for Cause (§ 155.220(g)(2))

As discussed in the 2025 Marketplace Integrity and Affordability proposed rule and this final rule, there have been dramatic levels of improper enrollments involving agents, brokers, and web-brokers. Examining agent, broker, and web-broker practices and taking enforcement action against noncompliant agents, brokers, and web-brokers is critical to program integrity and safeguarding consumer personally identifiable information (PII), and HHS is committed to holding noncompliant agents, brokers, and web-brokers accountable to protect Exchanges and consumers. In the 2025 Marketplace Integrity and Affordability proposed rule (90 FR 12955 and 12956), we proposed to amend § 155.220(g)(2) to improve transparency in the process for holding agents, brokers, and web-brokers accountable for compliance with applicable law, regulatory requirements, and the terms and conditions of their Exchange agreements.[61]

Section 1312(e) of the ACA provides that the Secretary shall establish procedures under which a State may allow agents or brokers to enroll individuals and employers in any QHPs in the individual or small group market as soon as the plan is offered through an Exchange in the State; and to assist individuals in applying for PTC and CSRs for plans sold through an Exchange. Regulations at 45 CFR 155.220 implement this statutory requirement.[62] Among other things, § 155.220 includes termination for cause standards in paragraphs (g)(1) through (3), which generally provide that if, in HHS' determination, a specific finding of noncompliance or pattern of noncompliance is sufficiently severe, HHS may terminate an agent's, broker's, or web-

[61] Consistent with § 155.220(d), there are currently three Exchange agreements with CMS that extend to agents, brokers, and web-brokers assisting consumers in the FFEs and SBE–FPs: (1) the Agent Broker General Agreement for Individual Market FFEs and SBE–FPs, (2) the Agent Broker Privacy and Security Agreement for Individual Market FFEs and SBE– FPs, and (3) the Agent Broker SHOP Privacy and Security Agreement. Web-brokers assisting consumers in the FFEs and SBE–FPs are required to sign the Web-broker General Agreement, and web-brokers who are primary Enhanced Direct Enrollment (EDE) entities that assist consumers in the FFEs and SBE–FPs are required to sign the EDE Business Agreement and the Interconnection Security Agreement.
[62] *See also* §§ 155.221 and 155.222.

broker's agreements with the FFE for cause. Consistent with § 155.220(l), the termination for cause standards apply to agents, brokers, and web-brokers participating in SBE-FPs. Paragraph (h) sets forth procedures for subsequent review (that is, "reconsideration") of the termination action.

We proposed to improve transparency in the process for holding agents, brokers, and web-brokers accountable for noncompliance with applicable law, regulatory requirements, and the terms and condition of their Exchange agreements. Specifically, we proposed to add text to § 155.220(g)(2) stating that HHS would apply a "preponderance of the evidence" standard of proof with respect to issues of fact to assess potential noncompliance under § 155.220(g)(1) and make a determination there was a specific finding or pattern of noncompliance that is sufficiently severe. We proposed at § 155.20 to capture a new definition, similar to definitions adopted by other HHS agencies and offices,[63] which would state that "preponderance of the evidence" means proof by evidence that, compared with evidence opposing it, leads to the conclusion that the fact at issue is more likely true than not.[64]

In proposing the preponderance of the evidence standard, we considered the severity of the potential consequences involved in our termination for cause framework in § 155.220(g)(1) through (3),[65] and how evidentiary standards have traditionally been used in court cases. Federal administrative and civil cases generally use a preponderance of the evidence standard, while criminal cases, in order to sustain a conviction, demand the highest standard, guilt "beyond a

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[63] *See* 42 CFR 93.228 (preponderance of the evidence means "proof by evidence that, compared with evidence opposing it, leads to the conclusion that the fact at issue is more likely true than not"); 45 CFR 412.001 ("Preponderance of the evidence means proof, after assessing the totality of available information, that leads to the conclusion that the fact at issue is more probably true than not."); and 45 CFR 1641.2 ("Preponderance of the evidence means proof by information that, compared with that opposing it, leads to the conclusion that the fact at issue is more probably true than not.").

[64] *See also INS v. Cardoza-Fonseca*, 480 U.S. 421 (1987) (defining "more likely than not" as a greater than 50 percent probability of something occurring).

[65] HHS acknowledged in the proposed rule that there are additional enforcement actions under 45 CFR 155.220(g) that are not addressed by this proposal (90 FR 12955 through 12956). We noted in the proposed rule that we are considering future rulemaking to implement additional regulation changes to the frameworks for those actions that may further strengthen our oversight and the integrity of the program.

reasonable doubt," under which evidence must be so strong that there is no reasonable doubt about a defendant's guilt.[66] Between those two evidentiary standards are the "clear and convincing evidence" standard, under which a trier of fact must have an abiding conviction that the truth of the factual contention is "highly probable,"[67] and the "substantial evidence" standard, which means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion.[68]

As stated in the proposed rule (90 FR 12956), HHS is of the view that the preponderance of the evidence standard is appropriate in our termination for cause framework under § 155.220(g)(1) through (3) because it is the standard used in most Federal civil cases and administrative proceedings. However, we stated in the proposed rule that we also appreciate that the termination of an agent's, broker's, or web-broker's Exchange agreements may affect their State licensure, given that we inform State insurance oversight agencies of these enforcement actions.[69] In addition, after the applicable period in § 155.220(g)(3) elapses and the Exchange agreement(s) under § 155.220(d) are terminated, the agent, broker, or web-broker will no longer be permitted to assist with or facilitate enrollment of a qualified individual in coverage in a manner that constitutes coverage through an FFE or SBE-FP, or be permitted to assist individuals in applying for APTC and CSRs for QHPs offered through an FFE or SBE-FP.[70] Once an agent's, broker's, or web-broker's Exchange agreements are terminated, they are unable to assist with applying for or enrolling in QHPs offered through the Exchange in any of the more than 30

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[66] *See* Maurice, R.; updated by Barrett, S. (2024, Oct. 31). *Legal Standards of Proof*. Nolo. https://www.nolo.com/legal-encyclopedia/legal-standards-proof.html (from lowest to highest standard: preponderance of the evidence, substantial evidence, clear and convincing evidence, and beyond a reasonable doubt). *See* Maurice, R., & Barrett, S. (2024, October 31). Legal standards of proof: You've probably heard that prosecutors have to prove criminal charges "beyond a reasonable doubt." But do you know about the other legal standards of proof? NOLO. https://www.nolo.com/legal-encyclopedia/legal-standards-proof.html
[67] Ibid. (citing *Colorado v. New Mexico*, 467 U.S. 310 at 316 (1984)).
[68] *See Reed v. Sec. of Health and Human Serv*., 804 F. Supp. 914 at 918 (E.D. Mich. 1992).
[69] *See* § 155.220(g)(6).
[70] *See* § 155.220(g)(4) and (l).

States served by Exchanges on the Federal platform. Given these potential consequences, we sought comment not only on the proposal to use a "preponderance of evidence" standard of proof in assessing potential noncompliance under § 155.220(g)(1), but also whether a different standard would be more appropriate to make a determination there was a specific finding or pattern of noncompliance by agents, brokers, and web-brokers that is sufficiently severe. We also sought comment on our proposed definition for this new "preponderance of evidence" standard.

In addition, we stated in the proposed rule (90 FR 12956) that we intend to provide greater specificity and precision in the Exchange agreements for PY 2026 and beyond regarding impermissible conduct by agents, brokers, and web-brokers, and to address the requirements for ensuring agents, brokers, and web-brokers have obtained and documented receipt of consumer consent to collect their personally identifiable information and help them apply for and/or enroll in QHP coverage offered through the applicable FFE or SBE-FP. These changes will provide additional, clear guidance to agents, brokers, and web-brokers, as well as additional information on how HHS will address compliance failures. In the proposed rule, we solicited comment on what should be addressed in the Exchange agreements for PY 2026 and beyond, States' oversight practices, guidance for obtaining and documenting consumer consent, how to protect consumers from improper enrollments, and oversight enhancement for agents, brokers, and web-brokers.

After consideration of comments and for the reasons outlined in the proposed rule and in our responses to comments later in this section of this final rule, we are finalizing this provision as proposed. These provisions are important consumer protections that address longstanding concerns with enforcement against noncompliant agents, brokers, and web-brokers. As these concerns exist regardless of the subsidy levels set by Congress, we are finalizing these provisions to be applicable as of the effective date of this rule and beyond. We summarize and respond to public comments received on the use of a "preponderance of the evidence" standard when taking

enforcement actions for agent, broker, and web-broker noncompliance under § 155.220(g)(1) through (3) later in this section, as well as on our proposed definition of "preponderance of the evidence" in § 155.20.

Comment: Numerous commenters stated that adopting the "preponderance of the evidence" standard will create a fair, uniform, and universal standard for assessing noncompliance by agents, brokers, and web-brokers assisting consumers with enrollment through the FFEs and SBE-FPs, while adding greater transparency to the enforcement process under § 155.220(g)(1) through (3).

Response: We appreciate commenters' support and agree that holding all compliant agents, brokers, and web-brokers to this same evidentiary standard supports fairness and uniformity in agent, broker, and web-broker enforcement actions under § 155.220(g)(1) through (3). We also agree that, as we explained in the proposed rule (90 FR 12944, 12955), adoption of the "preponderance of the evidence" standard will improve transparency in the process for holding agents, brokers, and web-brokers accountable for noncompliance with applicable law, regulatory requirements, and the terms and conditions of their Exchange agreements.

Comment: We received several comments expressing that adopting the "preponderance of the evidence" standard will enhance agent, broker, and web-broker accountability and build on past protections added in previous years, leading, ultimately, to greater consumer protection.

Response: We agree with the commenters that utilizing the "preponderance of the evidence" standard in agent, broker, and web-broker enforcement actions under § 155.220(g)(1) through (3) enhances agent, broker, and web-broker accountability and builds on protections added in previous years, including our agent, broker, and web-broker policies finalized in the 2026 Payment Notice (90 FR 4431 through 4432): to hold lead agents at insurance agencies responsible for agency-level misconduct and noncompliance and expand our authority to suspend an agent or broker's ability to transact information with the FFEs and SBE-FPs if we

discover circumstances that pose an unacceptable risk to the accuracy of FFE or SBE-FP eligibility determinations, operations, applicants, or enrollees under § 155.220(k)(3). In particular, using this evidentiary standard will ensure that when an agent, broker, or web-broker is subject to enforcement action under § 155.220(g)(3)(i), CMS will generally terminate their Exchange agreements unless the evidence they submit to resolve the matter to CMS' satisfaction consists of proof that, compared with the evidence supporting CMS' determination of a specific finding or pattern of noncompliance that is sufficiently severe, leads to the conclusion that the agent, broker, or web-broker was more likely than not compliant with applicable law, regulatory requirements, and the terms and condition of their Exchange agreements. This will help ensure that agents, brokers, and web-brokers are held accountable for noncompliance with applicable law, regulatory requirements, and the terms and condition of their Exchange agreements and will help ultimately prevent agents, brokers, and web-brokers who are noncompliant from assisting consumers with enrollment in coverage through the FFEs and SBE-FPs.

Comment: We received several comments expressing that adopting the "preponderance of the evidence" standard is appropriate because it is the standard used in civil cases at the Federal level.

Response: We agree with commenters and appreciate their support. As we explained in the proposed rule (90 FR 12942) and previously in this final rule, we have determined the preponderance of the evidence standard is appropriate for use in our termination for cause standards framework under § 155.220(g)(1) through (3) because it is the standard used in most Federal civil cases and administrative proceedings.

Comment: We received one comment in favor of the "preponderance of the evidence" standard stating that compliant agents, brokers, and web-brokers will benefit from our use of the standard and asking HHS to also pair the new standard with continuous monitoring tools to further target noncompliant agents, brokers, and web-brokers.

Response: We agree with the commenter that compliant agents, brokers, and web-brokers will benefit from the "preponderance of the evidence" standard, which clarifies the termination for cause process for agents, brokers, and web-brokers under § 155.220(g)(1) through (3). We will continue to assess the need for additional agent, broker, and web-broker continuous monitoring tools, particularly after we develop experience implementing our agent, broker, and web-broker policies finalized in the 2026 Payment Notice: to hold lead agents at insurance agencies responsible for agency-level misconduct and noncompliance and expand our authority to suspend an agent or broker's ability to transact information with the FFEs and SBE-FPs if we discover circumstances that pose an unacceptable risk to the accuracy of FFE or SBE-FP eligibility determinations, operations, applicants, or enrollees under § 155.220(k)(3). We continue to believe that all of these policies will enhance agent, broker, and web-broker accountability and public trust in the FFEs and SBE-FPs and reduce the risk of misconduct that puts consumers' healthcare coverage at risk.

Comment: We received several comments stating that the "preponderance of the evidence" standard is too demanding of an evidentiary standard to use to assess potential noncompliance by agents, brokers and web-brokers. In particular, commenters asserted that adopting the "preponderance of the evidence" standard would make it too easy for CMS to terminate agent, broker, and web-broker Exchange agreements, punish agents, brokers, and web-brokers for "minimal" errors, eliminate agent, broker, and web brokers' due process rights, and deprive agents, brokers, and web-brokers of their livelihoods.

Response: We disagree with comments asserting that the proposed standard is inappropriate for use in our termination for cause framework under § 155.220(g)(1) through (3). As we explained previously in this final rule and in the proposed rule, in proposing the preponderance of the evidence standard, we considered how evidentiary standards have traditionally been used in court cases and the severity of the potential consequences involved in

our termination for cause standards framework in § 155.220(g)(1) through (3), including those consequences' impact on the ability of agents, brokers, and web-brokers to assist consumers with enrollment in coverage through the FFEs and SBE-FPs. Federal administrative and civil cases generally use a preponderance of the evidence standard, while criminal cases, in order to sustain a conviction, demand the highest standard, guilt "beyond a reasonable doubt," under which evidence must be so strong that there is no reasonable doubt about a defendant's guilt. Between those two evidentiary standards are the "clear and convincing evidence" standard, under which a trier of fact must have an abiding conviction that the truth of the factual contention is "highly probable," and the "substantial evidence" standard, which means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion. In the proposed rule, we explained – and we continue to believe – that the preponderance of the evidence standard is appropriate in our termination for cause framework under § 155.220(g)(1)-(3) because it is the standard used in most Federal civil cases and administrative proceedings.

In addition, using the preponderance of the evidence standard will ensure that when an agent, broker, or web-broker is subject to enforcement action under § 155.220(g)(3)(i), CMS will generally terminate their Exchange agreements unless the evidence they submit to resolve the matter to CMS' satisfaction consists of proof that, compared with the evidence supporting CMS' determination of a specific finding or pattern of noncompliance that is sufficiently severe, leads to the conclusion that the agent, broker, or web-broker was more likely than not compliant with applicable law, regulatory requirements, and the terms and condition of their Exchange agreements. This will help ensure that agents, brokers, and web-brokers are held accountable for noncompliance with applicable law, regulatory requirements, and the terms and condition of their Exchange agreements, prevent agents, brokers, and web-brokers who are noncompliant from assisting consumers with enrollment in coverage through the FFEs and SBE-FPs, and

support consistent decision-making in our enforcement actions under § 155.220(g)(1) through (3).

With respect to commenters' points that this evidentiary standard will punish agents, brokers, and web-brokers for "minimal" errors and deprive them of their livelihoods, we remind commenters that CMS only takes enforcement action under § 155.220(g)(3)(i) when, in its determination, an agent, broker, or web-broker's conduct reflects a specific finding of noncompliance or pattern of noncompliance that is sufficiently severe, and an agent, broker, or web-broker may be determined noncompliant only if CMS finds that they violated applicable law, regulatory requirements, or the terms and condition of their Exchange agreements.[71]

As to commenters' claim that this evidentiary standard eliminates agents, brokers, and web-brokers' due process rights, we remind commenters that this policy only finalizes an evidentiary standard used in enforcement actions under § 155.220(g)(1) through (3). When an agent, broker, or web-broker is subject to enforcement action under § 155.220(g)(3)(i), CMS will notify the agent, broker, or web-broker of the specific finding of noncompliance or pattern of noncompliance made under paragraph (g)(1) of this section, and the agent, broker, or web-broker has 30 days from the date of the notice to resolve the matter to CMS' satisfaction. If the agent, broker, or web-broker does not submit rebuttal evidence resolving the matter to CMS' satisfaction and CMS terminates their Exchange agreements under § 155.220(g)(3)(i), the agent, broker, or web-broker has the right to submit a request for reconsideration to the CMS Administrator within 30 calendar days of the written notice from CMS.[72] The CMS Administrator will provide the agent, broker, or web-broker with a written notice of the reconsideration decision within 60 calendar days of the date the CMS Administrator receives the

[71] *See* § 155.220(g)(1) and (2).
[72] *See* § 155.220(h)(1) and (2).

request for reconsideration, and this decision will constitute the agency's final determination.[73] Use of the "preponderance of the evidence" standard to determine whether an agent, broker, or web-broker violated applicable law, regulatory requirements, or the terms and condition of their Exchange Agreement(s) does not alter this existing rebuttal and appeal framework.[74]

Comment: We received several comments stating that the preponderance of the evidence standard is too lenient of an evidentiary standard for CMS to use in assessing potential noncompliance by agents, brokers, and web-brokers under § 155.220(g)(1) through (3). Some commenters claimed that lowering evidentiary standards helps agents, brokers, and web-brokers exploit consumers by reducing the number of noncompliant agents, brokers, and web-brokers whose Exchange Agreements are suspended and/or terminated. Further, some commenters asserted that this standard weakens accountability and makes it more difficult to prevent noncompliant agents, brokers, and web-brokers from assisting consumers with enrollment through the FFEs and SBE-FPs. Some commenters suggested that HHS should use a "beyond a reasonable doubt" or other stricter standard. One commenter asserted that the proposed evidentiary standard lacks strength because it relies on what a "prudent" person would do.

Response: We disagree with comments asserting that the proposed standard is too lenient, risks endangering consumers, or weakens agent, broker, and web-broker accountability. We refer commenters to previous responses to comments in this section of this final rule for detailed discussions on these issues, including our explanation of why we continue to believe the "preponderance of the evidence" standard is appropriate for us to use to assess potential noncompliance by agents, brokers, and web-brokers under § 155.220(g)(1) through (3).

Comment: A few commenters stated applying a "preponderance of the evidence" standard will increase agent, broker, and web-broker scrutiny, leading to a reduction in the

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[73] *See* § 155.220(h)(3).
[74] *See* § 155.220(g)(2).

number of agents, brokers, and web-brokers who will be willing to assist consumers with enrollment through the SBE-FPs and FFEs in the future.

Response: We believe that adoption of the "preponderance of the evidence" standard is unlikely to increase agent, broker, and web-broker scrutiny in a manner that will reduce the number of agents, brokers, and web-brokers willing to assist consumers with enrollment through the SBE-FPs and FFEs in the future. As we explained previously in this final rule, in proposing the preponderance of the evidence standard, we considered how evidentiary standards have traditionally been used in court cases and the severity of the potential consequences involved in our termination for cause standards framework in § 155.220(g)(1) through (3), including those consequences' impact on the ability of agents, brokers, and web-brokers to assist consumers with enrollment in coverage through the FFEs and SBE-FPs. We considered but declined to adopt several evidentiary standards that demanded that agents, brokers, and web-brokers subject to enforcement action under § 155.220(g)(1) through (3) meet a higher evidentiary bar, and we decided that the preponderance of the evidence standard is appropriate in our termination for cause framework under § 155.220(g)(1) through (3) because it is the standard used in most Federal civil cases and administrative proceedings.

In addition, as we explained previously in this final rule, our adoption of the "preponderance of the evidence" standard will enhance transparency for agents, brokers, and web-brokers and enhance public trust in the FFEs and SBE-FPs, which in turn may spur consumers to enroll in coverage through the FFEs and SBE-FPs with the assistance of agents, brokers, and web-brokers. We believe that this increased transparency for agents, brokers, and web-brokers and improved public trust are likely to encourage agents, brokers, and web-brokers to continue assisting consumers with enrollment through the FFEs and SBE-FPs.

Comments: Some commenters suggested that applying a "preponderance of the evidence" standard will increase the cost of healthcare, limit availability for vulnerable populations, and

increase discrimination against consumers. Commenters also suggested that States should have sole jurisdiction to agent, broker, and web-broker oversight.

Response: We disagree with comments asserting that applying a preponderance of the evidence standard in the context of enforcement actions under § 155.220(g)(1) through (3) will increase the cost of healthcare, limit availability for vulnerable consumers, or increase discrimination. The proposed "preponderance of the evidence" standard will have no direct effect on the pricing or availability of health insurance available to consumers in FFE and SBE-FP States. [75]If commenters intended to suggest that use of the "preponderance of the evidence" standard will deter agents, brokers, and web-brokers from assisting consumers with enrollment through the FFEs and SBE-FPs and thereby reduce healthcare accessibility and affordability and increase discrimination, we refer commenters to previous discussion in this section of this final rule explaining our belief that adopting the "preponderance of the evidence" standard in enforcement actions under § 155.220(g)(1) through (3) is likely to encourage agents, brokers, and web-brokers to continue assisting consumers with enrollment through the FFEs and SBE-FPs.

We remind commenters that section 1312(e) of the ACA states the Secretary shall establish procedures under which a State may allow agents or brokers (1) to enroll individuals and employers in any QHPs in the individual or small group market as soon as the plan is offered through an Exchange in the State; and (2) to assist individuals in applying for premium tax credits and cost-sharing reductions for plans sold through an Exchange. Section 1321(a)(1) of the ACA authorizes the Secretary to promulgate regulations for meeting the requirements of Title I of the ACA (which includes section 1312 of the ACA) with respect to the establishment and operation of Exchanges, the offering of QHPs through such Exchanges, and such other

[75] *See* § 156.255(b).

requirements as the Secretary determines appropriate. Finally, Section 1313(a)(5)(A) of the ACA directs the Secretary to provide for the efficient and non-discriminatory administration of Exchange activities and implement any measure or procedure the Secretary determines is appropriate to reduce fraud and abuse in the administration of Title I of the ACA.

After consideration of comments received, we are finalizing as proposed our proposal to permanently revise § 155.220(g)(2) to apply a "preponderance of the evidence" standard of proof for terminations for cause by HHS of an agent's, broker's, or web-broker's Exchange agreements under § 155.220(g)(1) through (3), and our proposal to add a definition of "preponderance of the evidence" to § 155.20.

3. Annual Eligibility Redetermination (§ 155.335)

In the 2025 Marketplace Integrity and Affordability proposed rule (90 FR 12969 through 12973), we proposed an amendment to the annual eligibility redetermination regulation by adding § 155.335(a)(3) and (n) to prevent enrollees from being automatically re-enrolled in coverage with APTC that fully covers their premium without taking an action to confirm their eligibility information. Specifically, we proposed under our authority in section 1411(f)(1)(B) of the ACA, which directs the Secretary to establish procedures by which the Secretary redetermines eligibility on a periodic basis, to require at § 155.335(a)(3) and (n) that when an enrollee does not submit an application for an updated eligibility determination on or before the last day to select a plan for January 1 coverage, in accordance with the effective dates specified in § 155.410(f) and 155.420(b), as applicable, and the enrollee's portion of the premium for the entire policy would be zero dollar after application of APTC through the Exchange's annual redetermination process (hereafter "fully-subsidized enrollees" for purposes of this section), all Exchanges must decrease the amount of the APTC applied to the policy such that the remaining monthly premium owed by the enrollee for the entire policy equals $5 for the first month and for every following month that the enrollee does not confirm or update the eligibility determination.

Consistent with §§ 155.310(c) and (f), enrollees automatically re-enrolled with a $5 monthly premium after APTC under this policy would be able to submit an application at any point to confirm eligibility for APTC that covers the entire monthly premium, and re-confirm their plan to thereby reinstate the full amount of APTC for which the enrollee is eligible on a prospective basis.

We proposed at new § 155.335(n)(1) that the FFEs and the SBE-FPs must implement this change starting with annual redeterminations for benefit year 2026. We proposed at new § 155.335(n)(2) that the State Exchanges must implement it starting with annual redeterminations for benefit year 2027. We are finalizing this proposal with modifications.

In the proposed rule (90 FR 12969), we stated that we recognize that $5 may not provide a meaningful enough incentive for individuals to re-confirm their income and plan and, as such, sought comment on other options available to us to ensure program integrity in re-enrollments. As discussed in the proposed rule and this preamble, we stated that we are increasingly concerned about the level of improper enrollments in QHPs and believe that automatic re-enrollment of consumers into zero premium plans poses a significant risk to continuing high levels of improper payments of the APTC. We sought comment on the appropriate dollar amount individuals could be required to pay under the proposed policy such that they would be meaningfully incentivized to re-confirm their income and desired plan after being automatically re-enrolled. We also sought comment on whether any APTC payments should be made on behalf of individuals with fully-subsidized plans who have been automatically re-enrolled without confirming their plan and income consistent with the limitation on annual redeterminations when an Exchange does not have authorization to obtain tax data as part of the redetermination process. Additionally, we sought comment on if the program integrity concerns with automatic re-enrollments outweigh any potential benefit of allowing Exchanges to automatically re-enroll

consumers without the consumer taking any action to affirmatively consent to continuing coverage for the following plan year.

Previously in the proposed rule and this final rule, we discussed the dramatic increase in the number of improper enrollments in QHPs with APTC through the FFEs and SBE-FPs. Among the most concerning problems are situations where an agent, broker, or web-broker improperly enrolls a consumer in a fully-subsidized QHP without their knowledge. Because these enrollees do not receive a monthly premium bill requiring action on their part, they may not be aware they are enrolled. This lack of awareness allows agents, brokers, and web-brokers to continue earning monthly commission payments from issuers for these enrollments. Improper enrollments present the most concerning situation, but the availability of fully-subsidized QHPs that require no action on the part of enrollees also leads to situations where enrollees inadvertently and improperly remain enrolled after obtaining other coverage. As a result of either of these scenarios, the enrollee is at risk of accumulating surprise tax liabilities and the financial stress of resolving these liabilities. Ultimately, the financial cost of consumers unknowingly or inadvertently remaining enrolled in fully-subsidized QHPs would fall almost entirely on the Federal Government as Federal law limits repayments of the PTC for certain consumers,[76] and the Federal Government only recoups APTC payments from issuers for enrollments that are cancelled after a consumer or other third party, such as an issuer, discovers an improper enrollment and reports it to the Exchanges.

The expansion of tax credits under the ARP[77] and IRA,[78] significantly increased the number of enrollees who initially enrolled in a fully-subsidized QHP. As a result, this significantly increased the number of enrollees who remained enrolled in fully-subsidized QHPs

[76] Section 1401 of the ACA; Sec. 36B(f)(2)(B) of the Code.
[77] Pub. L. 117-2.
[78] Pub. L. 117-169.

through the automatic re-enrollment process. For the Exchanges on the Federal platform, 2.68 million enrollees were automatically re-enrolled for benefit year 2025 with APTC that fully covered their premium, compared to 270,000 for benefit year 2019 (84 FR 229). The enhanced tax credits are set to expire at the end of benefit year 2025, which means there will be fewer enrollees who initially enroll in a fully-subsidized QHP and fewer enrollees who remain enrolled in fully-subsidized QHPs through the automatic re-enrollment process. However, as demonstrated in Table 14, there are millions of people improperly enrolled in fully-subsidized QHPs, and therefore temporary action to ensure these individuals are properly enrolled in a QHP that they are eligible for is a necessary consumer protection.

That said, the expiration of the enhanced premium tax credits will dramatically reduce the number of individuals eligible for fully-subsidized plans and anyone being automatically re-enrolled into a silver plan will almost assuredly be required to pay a premium once the enhanced tax credits expire. While one-time action to ensure fully-subsidized automatic re-enrollees update or confirm their application information or else pay a $5 monthly premium is necessary to shed improper and fraudulent enrollments, we do not believe the ongoing burden associated with this policy is justified by its benefits if fully-subsidized benchmark plans are not widely available. Therefore, we are finalizing this policy for Exchanges on the Federal platform for PY 2026 only.

In the 2021 Payment Notice proposed rule (85 FR 7088), we sought comment on a proposal to modify the automatic re-enrollment process such that any enrollee who would be automatically re-enrolled with APTC that would cover the enrollee's entire premium would instead be automatically re-enrolled without APTC. This would ensure that any enrollee in this situation would need to return to the Exchange and obtain an updated eligibility determination prior to having any APTC paid on the consumer’s behalf for the upcoming benefit year. We also requested comments on a variation on this approach, in which APTC for this population would be reduced to a level that would result in an enrollee premium that is greater than zero dollar but

not eliminated entirely. Both approaches elicit, to varying degrees, a consumer's active involvement in re-enrollment because any enrollment in a plan with an enrollee premium that is greater than zero would require the enrollee to take an action by making a premium payment to maintain coverage or else face eventual termination of coverage for non-payment.

All but one commenter opposed modifying the automatic re-enrollment process in these ways. Many believed that adopting the proposed changes could disadvantage the lowest income group of Exchange enrollees by taking away financial assistance for which they are eligible without evidence that they are at greater risk of incurring overpayments of APTC. Some commenters were specifically opposed to any requirement that State Exchanges modify their automatic re-enrollment processes because it would require costly IT system reconfigurations, consumer noticing changes, and additional investments to support increased Exchange customer service capacity that would be necessary to address consumer confusion caused by the change.

Most commenters supported the current automatic re-enrollment process, citing benefits such as the stabilization of the risk pool due to the retention of lower risk enrollees who are least likely to actively re-enroll, the increased efficiencies and reduced administrative costs for issuers, the reduction of the numbers of uninsured, lower premiums, and promotion of continuity of coverage. Many commenters also believed that existing processes, including annual eligibility redetermination, periodic data matching, and APTC reconciliation, sufficiently safeguard against potential eligibility errors and increased Federal spending. As a result, we did not finalize any changes to the automatic re-enrollment process in the 2021 Payment Notice (85 FR 29164), citing our belief that existing safeguards against APTC overpayments were sufficient.

Given the heightened urgency of program integrity concerns with enhanced APTCs, fully-subsidized plans, and automatic re-enrollments, as previously outlined in the proposed rule (90 FR 12970), we sought comment on these proposals once again. We also stated that we would consider whether other methods – such as outreach – could sufficiently prompt fully-subsidized

enrollees to update or confirm their eligibility information and actively re-enroll in coverage. Current outreach methods for the FFEs and SBE-FPs, such as notices, emails, texts, and advertising, before and during the OEP are extensive and already successfully prompt over half of re-enrollees to actively confirm or update their information and actively select a plan. Most enrollees on the FFEs and the SBE-FPs actively re-enroll by the applicable deadlines for January 1 coverage. Based on our experience operating the Exchanges on the Federal platform, we stated in the proposed rule that we do not believe additional or different notifications would prompt action from fully--subsidized enrollees who choose not to submit an application for an updated eligibility determination and actively re-enroll. However, we sought comment on this idea.

Instead, we stated in the proposed rule (90 FR 12970) that we believe that it is necessary to prompt an affirmative action by enrollees who would otherwise be fully subsidized through the automatic re-enrollment process, whether such action be through a premium payment or re-confirming their plan choice altogether. We stated that we are again considering whether to automatically re-enroll these enrollees without any APTC, which would require them to return to the Exchange and obtain an updated eligibility determination prior to having any APTC paid on their behalf for the upcoming year, or else be charged for the full-price premium during automatic re-enrollment. As described in the proposed rule, we proposed to permit issuers to attribute past-due premium amounts they are owed to the initial premium the enrollee pays to effectuate new coverage. Removing all APTC during automatic re-enrollment for fully-subsidized enrollees is likely to create a significant debt to the issuer, since the enrollee is unlikely to be able to pay the full gross premium, which would harm the enrollee financially and could impact their ability to effectuate new QHP coverage. We therefore stated in the proposed rule that we believe that this approach would create undue financial hardship for these enrollees and act as a significant barrier to accessing health coverage. We also stated that we believe this approach could result in the loss of lower-risk enrollees, who are least likely to actively re-enroll

due to an inability to pay, which could destabilize the market risk pool and increase premiums and the uninsured rate. We sought comment on this idea and whether it would more sufficiently mitigate the program integrity concerns we have described.

We then considered what enrollee portion of premium amount greater than zero but less than the full price of the QHP would avoid consumer harm but still achieve active participation by the enrollee. We proposed an amount of $5, which we stated in the proposed rule (90 FR 12970) that we believe would sufficiently balance the need to require an enrollee to take action, without substantially increasing the risk of undue financial hardship, such as termination for non-payment of premiums, that a greater amount could cause.

Additionally, we stated in the proposed rule (90 FR 12970) that we believe that the $5 would still achieve the desired effect of requiring an enrollee's active participation even if their issuer has adopted a net percentage-based premium payment threshold, under which enrollees must always pay at least 95 percent of the enrollee-responsible portion of the premium. We stated that if issuers adopt such a threshold, enrollees who have a $5 premium payment due to this amendment to the annual redetermination process would be required to pay at least $4.75 or else be placed in a grace period.

We stated in the proposed rule (90 FR 12970) that we believe our proposal, which decreases the amount of the APTC applied to the policy such that the remaining premium owed by the enrollee for the entire policy equals $5, strikes an appropriate balance between encouraging active confirmation of eligibility information and enrollment decision making and ensuring market stability.

We sought comment on this proposal. Specifically, we sought comment on whether an amount other than $5 would better address the program integrity concerns we have described. In addition, we sought comment on whether there are different policies or program measures that

would help to reduce eligibility errors and potential Federal Government misspending, without adding additional burden for consumers.

A comparison of QHP enrollments to estimates of consumer-reported QHP enrollments from national health insurance coverage surveys strongly suggests there has been a large increase in the number of people unknowingly enrolled in subsidized QHPs. Researchers regularly track and study the "Medicaid undercount" which represents the difference in actual Medicaid enrollments to what people report on Census surveys.[79] This research finds that U.S. Census Bureau surveys undercount actual Medicaid enrollments, mostly due to people misreporting that they do not have Medicaid and found an increase in the Medicaid undercount between 2019 and 2022. At least part of such undercounts may be attributable to consumer misunderstanding when responding to surveys – for example a Medicaid enrollee may erroneously report not being enrolled in Medicaid due to the enrollee's familiarity with the program under a different, State-specific name (for example, Medicaid is called DenaliCare in the State of Alaska). We undertook a similar analysis to assess whether there is a similar undercount for subsidized coverage through the Exchanges. The comparison of actual subsidized QHP enrollments to QHP enrollments reported on Census surveys confirms this undercount exists and has grown substantially since 2021. As Table 1 shows, the Current Population Survey (CPS) undercount for enrollment in a QHP with APTC grew from 25 percent in 2021 to 50 percent in 2024. The undercount is even

[79] *See* Peter Nelson, What the Medicaid Undercount reveals about the Medicaid 'Unwinding' (Center of the American Experiment May 2024); Robert Hest, Elizabeth Lukanen, and Lynn Blewett, Medicaid Undercount Doubles, Likely Tied to Enrollee Misreporting of Coverage (SHADAC December 2022), available at https://www.shadac.org/publications/medicaid-undercount-doubles-20-21; State Health Access Data Assistance Center, Phase VI Research Results: Estimating the Medicaid Undercount in the Medical Expenditure Panel Survey Household Component (MEPS-HC) (January 2010), available at https://www.shadac.org/publications/snacc-phasevi-report; State Health Access Data Assistance Center, Phase IV Research Results: Estimating the Medicaid Undercount in the National Health Interview Survey (NHIS) and Comparing False-Negative Medicaid Reporting in NHIS to the Current Population Survey (CPS) (May 2009), available at https://www.shadac.org/publications/snaccphase-iv-report; and State Health Access Data Assistance Center, Phase II Research Results: Examining Discrepancies between the National Medicaid Statistical Information System (MSIS) and the Current Population Survey (CPS) Annual Social and Economic Supplement (ASEC) (March 2008), available at https://www.shadac.org/publications/snacc-phase-ii-report.

larger for consumers with incomes less than 250 percent of the FPL who likely qualify for CSRs. The undercount for these consumers grew from 33 percent in 2021 to 57 percent in 2024.

TABLE 1: CPS Undercount of CSR and APTC Subsidized Coverage

	CPS Current Subsidized Exchange Coverage (March Supplement)		CMS Effectuated Enrollment (February)		CSR and APTC Undercount	
	Subsidized <250% of the FPL	Subsidized Total	Feb CSR	Feb APTC	CSR	APTC
2019	3,750,261	7,055,972	5,468,004	9,250,243	-31%	-24%
2020	2,896,282	6,292,926	5,348,201	9,232,225	-46%	-32%
2021	3,663,155	7,335,480	5,449,070	9,722,533	-33%	-25%
2022	3,693,063	7,652,083	6,788,231	12,483,707	-46%	-39%
2023	3,799,900	7,789,723	7,566,232	14,295,339	-50%	-46%
2024	4,441,847	9,562,392	10,395,544	19,306,162	-57%	-50%

Methodology: This table reports subsidized Exchange enrollment estimates from the U.S. Census CPS, including coverage estimates for people with incomes less than 250 percent of the FPL who are more likely to be eligible for CSR subsidies. The CPS is generally completed in March which provides a point in time estimate of insurance coverage. The final two columns report the CPS undercount of the actual CSR and APTC enrollment which equals the CPS estimate minus effectuated enrollment divided by effectuated enrollment.
Sources: CMS, Effectuated Enrollment; and U.S. Census, Current Population Survey Annual Social and Economic Supplement.

Table 2 draws a similar comparison between the reported level of Exchange coverage on the National Health Interview Survey (NHIS)[80] and total effectuated enrollment through the Exchanges. Prior to the enhanced PTC becoming law in 2021, the NHIS coverage estimates roughly matched the actual effectuated QHP enrollment counts. But in 2022, the NHIS undercounted effectuated QHP enrollment through Exchanges by 14.1 percent. This undercount increased to 19.3 percent in 2023 and edged up to 20.2 percent in the first quarter of 2024.

[80] OMB Control Number 0920-0214.

TABLE 2: NHIS Coverage Undercount (in Millions)

	People Reporting QHP Coverage at Time of Interview	Average Monthly Effectuated Enrollment	Undercount
2019	10	9.8	2.0%
2020	10.1	10.3	-1.9%
2021	11.6	11.7	-0.9%
2022	11.6	13.5	-14.1%
2023	13	16.1	-19.3%
2024 (1st Qtr)	16.6	20.8*	-20.2%

* February effectuated enrollment.
Sources: CMS, Effectuated Enrollment; and Centers for Disease Control and Prevention, National Health Interview Survey.

The research on the Medicaid undercount referenced previously links people with Medicaid coverage to their Census survey responses, which shows most people who misreport not being enrolled in Medicaid report having another form of coverage. Among this group, the largest portion reports having employer coverage, followed by Medicare coverage, and then Exchange coverage.[81] Some of these people may have confused their Medicaid coverage for Medicare or Exchange coverage. But these findings suggest that many people who misreport not having Medicaid unknowingly retained multiple forms of coverage after assuming they lost Medicaid coverage when they enrolled in new private coverage or aged into Medicare.

Similar to the experience with the Medicaid undercount, the increase in the undercount of people with APTC-subsidized coverage is likely due to the increase in people with multiple forms of coverage. CBO estimates that in 2023, approximately 28.7 million people[82] had multiple types of coverage, up from 27.7 million people in 2022[83] and 18 million in 2021.[84]

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[81] Blewett, Lynn A. et al. State Health Data Assistance Center, (2022, December) Medicaid Undercount Doubles, Likely Tied to Enrollee Misreporting of Coverage. Available at https://www.shadac.org/publications/medicaid-undercount-doubles-20-21.
[82] Congressional Budget Office, (2024, June) Health Insurance and Its Federal Subsidies: CBO and JCT's June 2024 Baseline Projections. Available at https://www.cbo.gov/system/files/2024-06/51298-2024-06-healthinsurance.pdf.
[83] Congressional Budget Office, (2003, May) Health Insurance and Its Federal Subsidies: CBO and JCT's May 2023 Baseline Projections. Available at https://www.cbo.gov/system/files/2023-09/51298-2023-09-healthinsurance.pdf.
[84] Congressional Budget Office, (2002, May) Federal Subsidies for Health Insurance Coverage for People Under Age 65: CBO and JCT's May 2022 Baseline Projections. Available at https://www.cbo.gov/system/files/2022-06/51298-2022-06-healthinsurance.pdf.

Considering that research identifies response errors from survey participants as the main reason for the Medicaid undercount, it is reasonable to assume the same is true for the Exchange undercount. Both Medicaid managed care plans and subsidized QHPs – as a result of the enhanced premium tax credits – can have very low to no premium, can go unused by healthier people, can be confused for other types of coverage, and are available through the Exchanges. In addition, subsidized QHP enrollees tend to share similar characteristics with Medicaid enrollees who misreport at higher rates. This includes Medicaid enrollees who are adults,[85] employed,[86] at higher income levels overlapping with APTC income eligibility levels,[87] and qualify for automatic re-enrollment.[88] The fully-subsidized nature of this group, under the enhanced premium tax credits, furthers these comparisons. Therefore, the dramatic increase in the Exchange undercount after 2021 in both the CPS and NHIS strongly suggests a substantial increase in the number of individuals with subsidized Exchange coverage who misreport not having such coverage on surveys. People may misreport coverage for various reasons, but the most likely reason for the increase in this level of misreporting in 2022 is the statutory change in 2021 expanding access to fully-subsidized QHPs.[89] Research on the increase in the Medicaid undercount links the increase to the Medicaid continuous coverage condition under the COVID-

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[85] Davern M, Klerman JA, Baugh DK, Call KT, Greenberg GD. An examination of the Medicaid undercount in the current population survey: preliminary results from record linking. Health Serv Res. 2009 Jun;44(3):965-87. doi: 10.1111/j.1475-6773.2008.00941.x. Epub 2009 Jan 28. PMID: 19187185; PMCID: PMC2699917. Available at *https://pmc.ncbi.nlm.nih.gov/articles/PMC2699917/.*

[86] Boudreaux MH, Call KT, Turner J, Fried B, O'Hara B. Measurement Error in Public Health Insurance Reporting in the American Community Survey: Evidence from Record Linkage. Health Serv Res. 2015 Dec;50(6):1973-95. doi: 10.1111/1475-6773.12308. Epub 2015 Apr 12. PMID: 25865628; PMCID: PMC4693849. Available at *https://pmc.ncbi.nlm.nih.gov/articles/PMC4693849/.*

[87] Davern M, Klerman JA, Baugh DK, Call KT, Greenberg GD. An examination of the Medicaid undercount in the current population survey: preliminary results from record linking. Health Serv Res. 2009 Jun;44(3):965-87. doi: 10.1111/j.1475-6773.2008.00941.x. Epub 2009 Jan 28. PMID: 19187185; PMCID: PMC2699917. Available at *https://pmc.ncbi.nlm.nih.gov/articles/PMC2699917/*; and Boudreaux MH, Call KT, Turner J, Fried B, O'Hara B. Measurement Error in Public Health Insurance Reporting in the American Community Survey: Evidence from Record Linkage. Health Serv Res. 2015 Dec;50(6):1973-95. doi: 10.1111/1475-6773.12308. Epub 2015 Apr 12. PMID: 25865628; PMCID: PMC4693849. Available at *https://pmc.ncbi.nlm.nih.gov/articles/PMC4693849/.*

[88] Kincheloe, Jennifer, et al. Health Affairs (2006), GrantWatch: Report Can We Trust Population Surveys To Count Medicaid Enrollees And The Uninsured? Volume 25, Number 4. Available at *https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.25.4.1163.*

[89] Pub. L. 117-2.

19 PHE that kept people unknowingly covered after they obtained other coverage.[90] Similar to the Medicaid continuous coverage condition, Federal policy regarding subsidized QHP coverage changed in response to the COVID-19 PHE in a manner that increased the risk of people remaining enrolled in fully-subsidized QHP without their knowledge. The expansion of eligibility to a fully-subsidized QHP in combination with the current Exchange annual eligibility redetermination process substantially increased the number of people with a fully-subsidized QHP able to remain continuously enrolled in a QHP from year to year without taking any action.[91] The 2022 OEP was the first year where people with fully--subsidized QHPs provided under the ARP entered the annual redetermination process. Other policy changes and factors may have contributed to the dramatic change in the Exchange undercount in 2022. However, based on the similar experience with the Medicaid undercount, we stated in the proposed rule (90 FR 12971) that we believe the ARP's expansion of fully-subsidized QHP coverage in combination with the existing annual eligibility redetermination process that does not require the enrollees' acknowledgement or active participation, increases the risk that ineligible consumers without knowledge of their enrollments will remain enrolled, improperly increases Federal APTC expenditures.

As the data discussed previously shows, individuals with Exchange coverage appear increasingly less likely to accurately report their coverage in survey data. Recent APTC changes that increased the availability of fully-subsidized coverage likely enabled more people to stay enrolled in Exchange coverage without their knowledge, which we stated in the proposed rule (90 FR 12971) is clearly a program integrity issue. To address this issue, we stated that we

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[90] Robert Hest, Elizabeth Lukanen, and Lynn Blewett, Medicaid Undercount Doubles, Likely Tied to Enrollee Misreporting of Coverage (SHADAC December 2022), available at *https://www.shadac.org/publications/medicaid-undercount-doubles-20-21.*

[91] Note that existing procedures under § 155.335 prohibit the indefinite continuation of APTC through auto re-enrollment in various circumstances, including for tax filers who do not comply with the failure to file and reconcile rules or whose authorization for the Exchange to obtain tax data from the IRS has expired (which is limited to 5 years).

believe it is important to require qualified enrollees who are redetermined to be eligible for APTC that fully subsidizes their premium to take an active step to confirm their eligibility information before continuing with fully--subsidized coverage.

We sought comment on this proposal.

After consideration of comments and for the reasons outlined in the proposed rule and this final rule, including our responses to comments, we are finalizing this policy for Exchanges on the Federal platform for PY 2026. We think this policy represents an important program integrity measure to help the Exchanges on the Federal platform shed improper and fraudulent enrollments in the currently fully-subsidized QHP cohort of enrollees, which is highly concentrated in Exchanges on the Federal platform. Given the appreciably smaller estimates of improper enrollments on State Exchanges, coupled with our belief that this policy will help Exchanges shed holdover improper and fraudulent enrollments associated with fully-subsidized QHPs, we are not finalizing a parallel requirement for State Exchanges. After further evaluation and considering public comments on this proposal discussed later in this section, the Department has determined the burden this policy would have imposed on State Exchanges would not be worth it given that State Exchanges could not implement the policy before PY 2027, long after the expiration of the enhanced premium tax credits. For these reasons, we are finalizing this policy for PY 2026 only for Exchanges on the Federal platform, with a reversion to the previous policy for PY 2027 and beyond.

We also clarify this policy applies when an applicable enrollee does not submit an application for an updated eligibility determination specifically for the immediately forthcoming coverage year by the deadline to select a plan for January 1, 2026, coverage specified only at § 155.410(f) (and not at § 155.420(b) as proposed). Therefore, we are finalizing the following: When an enrollee does not submit an application for an updated eligibility determination for the immediately forthcoming coverage year (2026) by the last day to select a plan for January 1,

2026, coverage, and the enrollee's portion of the premium for the entire policy would be zero dollars after application of APTC, Exchanges on the Federal platform must decrease the amount of the APTC applied to the policy, such that the remaining monthly premium owed by the enrollee for the entire policy equals $5 for the first month and for every following month until the enrollee confirms or updates the information relevant to their annual redetermination of eligibility. Consistent with § 155.310(c) and (f), enrollees automatically re-enrolled with a $5 monthly premium after APTC under this policy would be able to update their application at any point to confirm information relevant to their annual redetermination for APTC and confirm their plan to reinstate the full amount of APTC for which they are eligible on a prospective basis.

We sought comment on whether the $5 amount would provide enough incentive for fully-subsidized individuals to confirm their information and whether fully-subsidized individuals should be re-enrolled without any APTC. We sought comment on other options available to us to ensure program integrity in re-enrollments. We sought comment on whether program integrity concerns outweigh the benefit of permitting Exchanges to automatically re-enroll consumers at all.

We summarize and respond to public comments received on this proposed annual redetermination policy below.

Comment: Some commenters generally supported this proposal. Many of these commenters stated that this proposal would require fully-subsidized enrollees to confirm their information, which would incentivize these enrollees to actively enroll, receive updated eligibility determinations, and discourage improper and fraudulent enrollments that undermine program integrity. Some commenters stated that this proposal would help protect consumers from APTC repayment by requiring their confirmation or updated eligibility information. However, several of these commenters proposed additional recommendations: delay the effective date to PY 2027 to ensure Exchanges and issuers have sufficient time to educate enrollees and

develop, test, and implement necessary changes; and preserve an OEP from November 1 to January 15 so that individuals impacted by this proposal have sufficient time to actively re-enroll.

Response: We appreciate these comments in support of the proposal and acknowledge commenters' concerns regarding the proposed change. We note that an effective date in PY 2026 provides sufficient time for Exchanges on the Federal platform to educate enrollees through updated notices (for example, Marketplace Open Enrollment Notice and Marketplace Automatic Enrollment Confirmation Message),[92] which are sent before and during Open Enrollment. Exchanges on the Federal platform will also provide robust training and technical assistance to interested parties, including agents, brokers, assisters, navigators, and issuers, so they can assist enrollees in understanding the proposed change.

For reasons stated in this final rule, the proposal to shorten the OEP at III.B.7. is finalized with modifications. The changes to the OEP will take effect beginning with the OEP for PY 2027 and the rule will provide flexibility for Exchanges within set parameters. Because the proposal to shorten the OEP will not be implemented in PY 2026, and this policy at 45 CFR 155.335 (a)(3) and (n) will only be effective for PY 2026, enrollees and other interested parties will have sufficient time to take the required action to avoid the $5 monthly premium.

Comment: Most commenters opposed the proposal. Many of these commenters stated the proposal is likely to cause a decrease in enrollment as some low-income enrollees will be terminated due to non-payment of the $5 premium. Generally, commenters believed the proposal would compromise the Exchange risk pool because younger and healthier individuals are most likely to lose coverage, which will ultimately discourage carrier participation and lead to higher premiums. Some cited data showing that a nominal monthly payment causes coverage losses

[87] Samples of PY 2025 notices can be found here https://www.cms.gov/marketplace/in-person-assisters/applications-forms-notices/notices. CMS will revise this page with updated samples for PY 2026.

specifically for younger enrollees.[93] [94] A few commenters cited research on Massachusetts' pre-ACA exchange, which found that consumers who were passively enrolled into fully-subsidized plans were younger and healthier (44 percent lower medical spending per month).[95] [96] A few commenters opposed the proposal because they do not believe it achieves the stated objective of reducing improper enrollments. These commenters stated that an agent or broker could update the application by the applicable deadlines to continue an improper fully-subsidized premium enrollment. Many commenters cited other program integrity measures that they believe are sufficient to safeguard against errors in Federal spending without undue risk of coverage losses, such as the 1-year FTR policy in the proposed rule, income verification, periodic data matching, and APTC reconciliation. Some of these commenters believe HHS should directly address agent and broker fraud in the Exchanges on the Federal platform rather than imposing this requirement on consumers.

Response: We acknowledge these comments in opposition to the proposal. While other program integrity measures also safeguard against errors in Federal spending, we maintain that this policy change is necessary in 2026 to ensure the fully-subsidized population confirms or updates their information, which will help lower the currently high level of improper enrollments and dual enrollment in the Exchanges on the Federal platform with financial assistance and other minimum essential coverage, such as Medicaid or employer sponsored coverage, that persist through the annual redetermination and re-enrollment specifically. After considering these

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[93] The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings. Samantha Artiga, Petry Ubri, and Julia Zur. Kaiser Family Foundation. https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-94?.

[94] McIntyre A, Shepard M, Layton TJ. Small Marketplace Premiums Pose Financial and Administrative Burdens: Evidence from Massachusetts, 2016–17. Health Affairs. Published online January 8, 2024.

[95] Automatic Insurance Policies — Important Tools for Preventing Coverage Loss, Adrianna McIntyre, Ph.D., M.P.H., M.P.P., and Mark Shepard, Ph.D. https://www.nejm.org/doi/full/10.1056/NEJMp2114189.

[96] Do Ordeals Work for Selection Markets? Evidence from Health Insurance Auto-Enrollment by Mark Shepard and Myles Wagner, June 7, 2024. https://scholar.harvard.edu/files/mshepard/files/shepard_wagner_autoenrollment.pdf.

comments, we believe that an ongoing requirement is likely unnecessary as once the level of improper enrollments is reduced and the amount of fully-subsidized plans has decreased, the incentive and opportunity for ongoing improper and fraudulent enrollments is substantially lower, and the burdens associated with this policy are not justified by its benefits. Therefore, we are finalizing this policy for PY 2026 only.

With respect to the amount, we believe $5 is a nominal amount that sufficiently balances requiring action by the enrollee without the risk of undue financial hardship that a greater amount could cause. These enrollees will be incentivized to return to an Exchange, evaluate available coverage options and premiums, and make an active enrollment decision. We therefore anticipate that this policy will lead to better matches between consumers' coverage preferences and available coverage offerings in the individual market.

We do not anticipate the Exchange risk pool will be compromised as this policy retains automatic re-enrollment while introducing a nominal premium amount to encourage active consumer engagement for the fully-subsidized population. We believe $5 does not risk undue financial hardship and that fully-subsidized enrollees will be incentivized to actively enroll or make a refundable $5 payment, rather than be dropped from Marketplace coverage, due to this policy.

Exchanges on the Federal platform will educate enrollees through updated notices (for example, Marketplace Open Enrollment Notice and Marketplace Automatic Enrollment Confirmation Message),[97] and issuers can update their discontinuation and renewal notices with information about this change. Exchanges on the Federal platform will also provide robust training and technical assistance to interested parties, including agents, brokers, assisters,

[97] Samples of PY 2025 notices can be found here *https://www.cms.gov/marketplace/in-person-assisters/applications-forms-notices/notices*. CMS will revise this page with updated samples for PY 2026.

navigators, and issuers, so they can assist enrollees in understanding the proposed change and continue coverage as needed.

We note that § 155.220(j)(2)(iii) and (l) require agents, brokers, and web-brokers who are assisting with consumer enrollments through the Exchanges on the Federal platform to obtain and document consumer consent before making an application or enrollment update on behalf of the consumer, a measure intended to ensure that consumer information is accurate. We also established procedures under § 155.220(g) for HHS to suspend or terminate an agent's, broker's, or web-broker's Exchange agreement(s) in circumstances that involve certain fraudulent or abusive conduct or where there are sufficiently severe findings of non-compliance. We also established other standards of conduct under § 155.220(j) for agents, brokers, and web-brokers that assist consumers with enrolling in coverage through the FFEs to, protect consumers and ensure the proper administration of the FFEs, and under § 155.220(l) we extended this standard to agents, brokers, and web-brokers who assist consumers with enrollment through the SBE-FPs. CMS will continue to monitor and take enforcement action in response to any agent, broker, or web-broker activity that is deemed to be non-compliant under § 155.220(g)(2).

Comment: Several commenters opposed the proposal because they believe the $5 amount would be insufficient to incentivize individuals to confirm their eligibility information and that agents would pay the $5 premium on behalf of the enrollee or offer inducements to the enrollee such that the enrollee pays the $5. One commenter also opposed the proposal because they believe that fraud is not limited to fully-subsidized plans.

Response: Data supports the conclusion that lower income enrollees who may be eligible for zero-dollar premium plans after application of APTC are price sensitive.[98] We cannot be

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[98] *See, e.g.,* The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings. Samantha Artiga, Petry Ubri, and Julia Zur. Kaiser Family Foundation. https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-

certain that $5 is the best amount to produce the desired outcome. However, after consideration of higher and lower amounts, we concluded $5 was a reasonable amount to encourage most low-income enrollees to act without being cost prohibitive such that it prevents their action. In other words, low-income enrollees who are price sensitive may interpret an invoice with a larger premium payment as insurmountable and choose not to take action to update their information to see if they can lower the bill nor pay the bill because they can't afford it. Therefore, we finalize this $5 amount to prompt enrollees to act while also balancing debt consideration for low-income enrollees if they don't act. We are finalizing this provision for Exchanges on the Federal platform for PY 2026 only.

Additionally, our experience investigating improper enrollments by agents, brokers, and web-brokers does not suggest that these entities commonly enroll consumers in non-zero plans by paying premiums on their behalf. Doing so would reduce the profit available to the agent, broker, or web-broker from commissions, as well as increase the risk of being discovered as engaging in unauthorized activity (for example, because an issuer could identify if payment was made using a check or credit card belonging to the agent, broker, or web-broker). Rather, improper enrollments typically involve agents, brokers, or web-brokers enrolling consumers in fully-subsidized plans without their knowledge or consent. Therefore, we believe it is appropriate to target this proposal to fully-subsidized enrollments, where we know unauthorized activity by agents, brokers, and web-brokers is most likely.

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updated-review-of-research-findings/view/footnotes/#footnote-220856-94?. McIntyre A, Shepard M, Layton TJ. Small Marketplace Premiums Pose Financial and Administrative Burdens: Evidence from Massachusetts, 2016–17. Health Affairs. Published online January 8, 2024. Automatic Insurance Policies — Important Tools for Preventing Coverage Loss, Adrianna McIntyre, Ph.D., M.P.H., M.P.P., and Mark Shepard, Ph.D. https://www.nejm.org/doi/full/10.1056/NEJMp2114189. Do Ordeals Work for Selection Markets? Evidence from Health Insurance Auto-Enrollment by Mark Shepard and Myles Wagner, June 7, 2024. https://scholar.harvard.edu/files/mshepard/files/shepard_wagner_autoenrollment.pdf.

Comment: Many commenters requested that State Exchanges be excluded from this proposal because State Exchanges are less likely to have fraudulent and improper enrollment compared to Exchanges on the Federal platform and because they believe States are best positioned to evaluate whether updates to the redetermination process are necessary for their Exchange. Many of these commenters stated that State Exchanges have sufficient verification safeguards in place due to State-specific data for eligibility verification and closer oversight, and a few commenters stated that State Exchanges have more robust system controls to prevent fraudulent activity than the Exchanges on the Federal platform, all of which they stated contributes to low instances of fraud and improper enrollment. Commenters requested that States retain flexibility to implement alternative policies and procedures to improve consumer awareness of their options for renewal. Commenters stated that State Exchange operations related to this proposal would be costly and some could not implement the proposal based on the proposed timeline. One State Exchange commented that all of the enrollees in their State already have a non-zero premium after their full APTC amount is applied. We received three comments from State Exchanges noting the numerous program integrity safeguards they currently have in place as part of their annual redetermination and re-enrollment processes that minimize their risks for unauthorized enrollments, such as their use of approved state-based data sources, which supplement the required Federal data sources to verify consumer eligibility, and the timing and specificity of their redetermination and re-enrollment notices.

Response: We appreciate these comments. As described above, we are not finalizing these requirements for State Exchanges. Much of the concerning improper and fraudulent enrollment is concentrated on Exchanges on the Federal platform. Given the temporary nature of the policy and burdens this requirement would put on State Exchanges, we are exempting them from the requirement.

Comment: Many commenters requested that HHS delay implementation to PY 2027 or later to evaluate whether the policy is necessary after implementing other program integrity measures in this rule and after expiration of the enhanced PTC. Some commenters stated this proposal is not worth the cost to implement if the enhanced PTCs expire because relatively few enrollees will qualify for a zero-dollar premium. One commenter asked HHS to collaborate with issuers to design an implementation that avoids administrative costs and minimizes consumer confusion.

Response: We appreciate these comments and are only finalizing this requirement for PY 2026 for Exchanges on the Federal platform. We understand there will be fewer consumers eligible for fully-subsidized QHPs after the expiration of the enhanced PTCs than are eligible for fully-subsidized QHPs now and, as such, do not believe that the ongoing burden associated with this policy is justified by its benefits once the Exchanges shed the improper enrollments associated with fully-subsidized QHPs.

Comment: Many commenters questioned the statutory authority Exchanges have to reduce the amount of APTC used toward an enrollee's coverage. These commenters believe the ACA does not provide any construct for Exchanges to take independent action to adjust the tax credit based on policy preferences and expressed concern that Exchanges may arbitrarily interfere with qualified individuals' access to the full amount of the APTC. Many of these commenters stated that the Exchange must permit a qualified individual to use their tax credit in advance and must act as a facilitator of the tax credit once the qualified individual is determined eligible based on statutory criteria. Commenters believed that section 36B of the Code defines the criteria for APTC and HHS did not consider necessary modifications to that part of the law.

Some commenters believed that after an individual is determined as qualifying for APTC under section 1411 of the ACA, section 1412 compels the Federal government to pay APTC

using the calculation of PTC rules in section 36B of the Code. They argued this means it is mandatory to pay the full amount of APTC for which the individual qualifies.

A few commenters believed that section 1411(f)(1)(B) of the ACA does not give HHS the authority to withhold APTC it is legally obligated to pay on behalf of every individual who is automatically re-enrolled without a redetermination finding that they are not entitled to the full APTC amount. The commenters believed that withholding payment is not a procedure to redetermine eligibility, and therefore, this proposal exceeds statutory authority.

One commenter stated that the proposal conditioning re-enrollment on the $5 enrollee premium contravenes guaranteed availability established by Vermont State law.

Another commenter stated this policy will be subject to litigation and will result in wasteful government spending that could be avoided by not finalizing the policy.

Response: We believe we have authority under the ACA to implement this provision. Section 1411(f)(1)(B) directs the Secretary to establish procedures by which it "redetermines eligibility on a periodic basis in appropriate circumstances." We believe that recent history of improper enrollments in unsubsidized plans is an appropriate circumstance to temporarily require that the amount of PTC paid in advanced to be reduced by $5, unless and until an enrollee verifies their eligibility for a fully-subsidized premium. We emphasize that 45 CFR 155.335(n) would not independently reduce the amount of PTC an enrollee is eligible for under section 36B of the Code, but rather would reduce the amount of PTC paid in advance.

Comment: A few commenters shared that this proposal would result in additional administrative steps for agents and brokers, resulting in slower transaction times by agents and brokers and increased demand for their services in a condensed period of time if the OEP is shortened to November 1 through December 15.

Response: We acknowledge commenters' feedback. As stated above, we are finalizing this policy for Exchanges on the Federal platform for PY 2026 only, and the changes to the OEP

at III.B.7. do not take effect until PY 2027. Therefore, agents and brokers will have sufficient time to help enrollees take the required action to avoid the $5 monthly premium.

Comment: A few commenters stated that consumer outreach is essential and that they would like more information from HHS about how enrollees will be informed of their individual responsibility amount.

Response: We agree with the commenters and will provide more information about consumer outreach through existing interested party forums, which include assister, agent and broker, navigator and issuer trainings.

Comment: Commenters offered the following operational suggestions if this policy is finalized as proposed: simplify the annual renewal process by allowing enrollees to confirm their eligibility information without having to recomplete the entire application; permit EDE partners to offer new features to support the active renewal process; provide information about re-enrollees to EDE partners so EDE partners and their agent and broker users can assist in outreach to enrollees who have a new financial obligation as a result of this proposal; and ensure income updates are effective on the first of the following month to limit the financial impact for enrollees subject to this proposal.

Response: We appreciate these suggestions and will consider them as we develop IT changes for this policy. We note that some EDE partners already simplify the annual renewal process by allowing agents and brokers to confirm an enrollee's eligibility information without having to click through the entire application. EDE partners may be approved by CMS to offer new features to support the active renewal process; EDE partners already have information about how to submit proposed features for CMS review and approval. We will evaluate whether more information about re-enrollment can be provided to EDE partners and their agent and broker users for their outreach purposes. We will ensure interested parties understand applicable effective dates for changes submitted by consumers.

Comment: A commenter recommended that HHS encourage State Exchanges to implement EDE. EDE is predominantly a pathway to service agents and brokers who assist consumers with Exchange enrollment, so this commenter is recommending HHS encourage State Exchanges to implement EDE, thereby increasing their agent and broker service capabilities to meet increased consumer support needs resulting from this policy.

Response: State Exchanges presently have the option to implement EDE (*see* 45 CFR 155.221(j)) and may make the decision to do so based on the needs of consumers in their State. HHS currently provides technical assistance to State Exchanges interested in the EDE model. State Exchanges are exempt from the requirement being finalized at 45 CFR 155.335(a)(3) and (n).

Comment: Commenters recommended HHS finalize different premium amounts other than the proposed $5. A few commenters suggested that if HHS moves forward with the proposal, it should be less than $5, such as $1. A few commenters suggested that if HHS moves forward with the proposal, it should be more than $5 but did not specify an amount. One commenter believed the amount should be similar to issuers' commission payments to agents and brokers – such as $25 for the first plan member and $20 for each additional plan member – to remove the incentive for third parties to pay the premium amount for the enrollee. However, this commenter recommended ending APTC altogether for the fully-subsidized population or for all enrollees who qualify for any amount of APTC because they believed those proposals would do the most to ensure the Federal government does not pay excess APTC, and they believed automatic re-enrollment is detrimental to the quality and price of health insurance.

Response: As described earlier, our experience investigating improper enrollments by agents, brokers, and web-brokers does not suggest that they commonly pay premiums on behalf of enrollees to secure enrollment. For the reasons described above, we believe $5 sufficiently

balances requiring action by the enrollee without the risk of undue financial hardship a greater amount could cause while the market adapts to the changing subsidy environment.

Comment: Almost all commenters strongly opposed other ideas we solicited comments on, such as ending APTC during automatic re-enrollment for enrollees who would otherwise be fully subsidized, and they robustly supported continuing to permit Exchanges to automatically re-enroll consumers altogether. These commenters believed automatic re-enrollment is critical to supporting a strong risk pool and preventing premium increases. Many commenters believed alternatives such as removing all APTC or not renewing their coverage at all for individuals who do not verify their eligibility for full-subsidized coverage would cause widespread loss of legitimate enrollments that support a healthy risk pool. Many commenters believed automatic re-enrollment promotes continuity of coverage and removes unnecessary burden for enrollees who are satisfied with their health coverage and note it is a standard practice in the industry. As described above, a few commenters cited research on Massachusetts' pre-ACA exchange, which found that consumers who were passively enrolled into fully-subsidized plans were younger and healthier (44 percent lower medical spending per month) and that eliminating auto-enrollment for health insurance reduced enrollment by 33 percent and differentially excluded young, healthy, and economically disadvantaged people.

Response: We appreciate these comments. We are not finalizing the alternative proposals to modify the automatic re-enrollment process such that any enrollee who would be automatically re-enrolled with APTC that would cover the enrollee's entire premium would instead be automatically re-enrolled without APTC, or to prohibit Exchanges from automatically re-enrolling consumers. Similar to the commenters, we believe that these proposals present too great a risk of widespread coverage loss to legitimate enrollments. To minimize the risk of disruption while taking a necessary step to shed excess improper enrollments, we are finalizing this policy for PY 2026 for Exchanges on the Federal platform only.

4. Annual Eligibility Redetermination (§ 155.335(j))

In the 2025 Marketplace Integrity and Affordability proposed rule (90 FR 12973 through 12974), we proposed to amend the automatic re-enrollment hierarchy by removing § 155.335(j)(4), which currently allows Exchanges to move a CSR-eligible enrollee from a bronze QHP and re-enroll them into a silver QHP for an upcoming plan year, if a silver QHP is available in the same product with the same provider network and with a lower or equivalent net premium after the application of APTC as the bronze plan into which the enrollee would otherwise have been re-enrolled. In effect, this current policy allows Exchanges to terminate an enrollee's coverage through a bronze QHP without the enrollee's active participation. These proposals would leave in place the requirements for Exchanges to take into account network similarity to the enrollee's current year plan when re-enrolling enrollees whose current year plans are no longer available, but would remove the re-enrollment hierarchy policy at § 155.335(j)(4) that allows Exchanges to move a CSR-eligible enrollee from a bronze QHP and re-enroll them into a silver QHP for an upcoming plan year, if a silver QHP is available in the same product with the same provider network and with a lower or equivalent net premium after the application of APTC as the bronze plan into which the enrollee would otherwise have been re-enrolled.

We sought comment on this proposal, and after consideration of comments, we are finalizing this policy as proposed. Based on certain public comments as further discussed below, we also clarify the flexibility that State Exchanges have regarding the re-enrollment hierarchy at the discretion of the Secretary per § 155.335(a)(2)(iii). As the re-enrollment hierarchy policy is an important policy to honor consumer choice, and is not addressing enhanced-subsidy related improper enrollment, we are finalizing this policy to be effective for PY 2026 and beyond. We summarize and respond to public comments below.

Comment: Some commenters supported the proposal and agreed that removing the option at § 155.335(j)(4) for Exchanges to re-enroll CSR eligible bronze enrollees into a silver QHP

when certain conditions are met would help preserve consumer choice. Some of these commenters further stated that consumers select plans for a variety of reasons, such as affordability, provider network, or health savings account (HSA) eligibility, and that it is not appropriate to re-enroll them into a different plan when their current plan remains available in the coming year, even if the different plan provides higher actuarial value and the plan change would not result in a change to the consumer's product or provider network. Several of these commenters also agreed that removing § 155.335(j)(4) would reduce the risk of unexpected tax liabilities for bronze enrollees who appear, based on their most recent household income attestation, to be CSR eligible.[99] Several commenters who supported the proposal stated that removing § 155.335(j)(4) would help reduce consumer confusion. A few of these cited past experiences of consumers' mistaken belief that their health insurance agent changed their coverage when, in fact, the change was due to a re-enrollment pursuant to the reenrollment hierarchy at § 155.335(j). Based on these experiences, these commenters believed that allowing enrollees to stay in the same plan if it continues to be available unless they actively choose a different option would significantly reduce complaints and improve transparency. One commenter who supported the proposal asked that HHS consider delaying this change to PY 2027 to allow for issuers to incorporate this change into their product planning and filings.

Response: We agree with commenters that amending the re-enrollment hierarchy to remove the option for Exchanges to auto re-enroll bronze enrollees into a silver plan even when their same bronze plan remains available helps preserve consumer choice. We also agree with the commenter who emphasized the role that this final policy will play in helping reduce consumer confusion, as it aligns with an approach of preserving consumer choice whenever possible. We strongly agree with commenters who stated that removing this policy would reduce the risk of

[99] *See* discussion in the 2024 Payment Notice (88 FR 25823), regarding this potential risk in cases where APTC amount is determined based on inaccurate household income for the future year.

unexpected tax liabilities for bronze enrollees who appear, based on their most recent household income attestation, to be CSR eligible, and with those who cited HSA eligibility as a potential factor in bronze plan selection. Finally, we will not delay this change because, as noted in the proposed rule (90 FR 13015), we do not anticipate that it would result in significant burden to issuers, given that, as discussed in the 2024 Payment Notice (88 FR 25822), Exchanges were primarily responsible for the policy's implementation.

Comment: Several commenters who supported the proposal also emphasized the importance of decision support tools to help consumers select the best plan for themselves and their family's needs. These commenters stated that enhancing consumer decision support tools could help consumers understand all aspects of cost-sharing, including premiums, deductibles, out-of-pocket costs, and become more familiar with how health insurance coverage works in general. Commenters recommended developing more personalized tools to illustrate individuals' expected health care utilization or prescription drug needs and to help them use that information to choose a plan that is best suited to their needs. They also noted that focused training for navigators, agents, and brokers could boost take-up of silver plans among those eligible for CSRs.

Response: We agree with honoring and supporting consumer choice instead of re-directing enrollment on behalf of consumers when their current plan remains available in the following coverage year. Providing consumers with the information they need to make informed choices, and then honoring consumer choices, is a matter of trust. As we stated in the proposed rule (90 FR 12974), we believe the policy at § 155.335(j)(4) unnecessarily risked undermining this trust, and we will continue to explore and work to improve upon strategies that help consumers to make decisions that are best for themselves and their families based on their financial situations and health care needs. We agree with commenters who advocated for more robust decision support tools, and over the past several years we have made enhancements to the

HealthCare.gov application and plan selection platforms to help income-based CSR eligible consumers understand the financial benefits of selecting a silver plan. For example, when they begin their plan selection process, these CSR eligible consumers view language explaining that they qualify for extra savings on out-of-pocket costs with a silver plan, and are offered the option to see silver plans only. Silver plans have "Extra Savings" tags, and consumers who qualify for CSRs of 94 percent or 87 percent and select a non-silver plan see a pop-up that encourages them to choose a silver plan instead. We believe that these changes, implemented over the past 5 years, have made a meaningful difference in these consumers' ability to make an informed choice about their coverage, though we will continue exploring ways to best provide consumers with information they need.

Comment: Many commenters opposed the proposal to remove § 155.335(j)(4) from the auto re-enrollment hierarchy based on their belief that the policy improved access to higher actuarial value coverage for enrollees who did not previously realize that such coverage was available to them. These commenters cited concerns that consumers are largely confused about their health insurance plan options and how to choose the plan that meets their health care and financial needs, and provided studies and other references to support this concern. These commenters cited factors including the high volume of plans to choose from in certain areas, resulting in choice overload; cuts to HHS Navigator grantee funding that decreases the in-person assistance available to potential enrollees; and the lack of data or other evidence to support the assertion that confusion had decreased. One commenter who stated the policy led to better outcomes for enrollees said that consumers should not be required to have a robust understanding of actuarial values, cost-sharing, co-payments, and deductibles. Multiple commenters stated that this policy would result in a family with a household income up to two times the FPL being re-enrolled in a plan with a $21,200 maximum out-of-pocket limit rather than a plan with a $7,000 out-of-pocket limit. One commenter who opposed the proposal asked that we wait until 2027 to

consider this policy based on whether Congress would renew the enhanced PTC. Another commenter said that given this policy has only been in place for two plan years, it is not yet possible to determine whether it has been successful.

Response: We disagree that many consumers remain confused or unaware about their health insurance plan options and available cost savings and strongly disagree that consumers should not need to understand how generous a plan is in terms of the percentage of benefit costs that enrollees generally must pay (*i.e.*, actuarial value) and other aspects of health insurance coverage in order to make their own decisions regarding their health insurance coverage. When we proposed this policy in 2024 Payment Notice proposed rule (87 FR 78259), we highlighted that some CSR eligible bronze enrollees may have been initially enrolled before the more generous APTC became available with the passage of the ARP as extended by the IRA,[100] may not have been initially income-based CSR-eligible when they first enrolled, or may have been helped by an agent, broker, web-broker, or Navigator who did not adequately explain the benefits of silver enrollment for CSR-eligible enrollees.

In contrast, as of the start of the OEP for 2026 Exchange health insurance coverage, these enhanced subsidies will have been available to Exchange enrollees for a full five years. During this time, potential Exchange enrollees have had the chance to benefit from outreach and education services provided in part by tens of millions of dollars in Federal funding for HHS Navigator grantees, and enrollment increased significantly. Additionally, as discussed earlier, over the past five years we have made a number of enhancements to the HealthCare.gov application and plan selection platforms to help income-based CSR eligible consumers understand the financial benefits of selecting a silver plan. Therefore, as we stated in the proposed rule (90 FR 12974), we believe consumers and the agents, brokers, web-brokers, and

[100] With the passage of the IRA, these enhanced subsidies were extended for an additional 3 years (through 2025).

Navigators who help them are largely aware of the more generous subsidies.[101] Further, we disagree that it makes sense to delay this policy until PY 2027 because, regardless of whether Congress continues the enhanced subsidies under the IRA, these investments and resulting increase in consumer awareness will persist. Finally, we also disagree that the removal of the policy at § 155.335(j)(4) will definitively result in auto re-enrollment of CSR eligible individuals and families into a particular bronze plan, because during the OEP, such individuals can actively choose to enroll in a silver plan.

Comment: A number of commenters who opposed the proposal asked if State Exchanges would continue to have flexibility to design their re-enrollment hierarchies.

A few commenters cited examples of State Exchanges' success in reducing inadvertent forfeiture of CSRs and ensuring better access to health care for those with access to a plan with a higher actuarial value with the same or similar benefit design and provider network as the lower actuarial value plan that they had actively selected. For example, a commenter described Covered California's practice since 2022 of re-enrolling CSR eligible enrollees into silver coverage, targeting individuals with incomes below 250 percent of the FPL with access to the same benefits and providers with equal or better value at the same or lower premium. This commenter emphasized that the Exchange informs these enrollees of the change and provides sufficient time to opt out of the change. The commenter also described other auto re-enrollment policies Covered California adopted that reportedly had strong approval ratings, did not cause consumer confusion, and led to 34,000 consumers enrolled in a higher-value plan at a lower cost for PY 2024, and noted that platinum and gold crosswalks to silver plans could result in lower PTC expenditures for the Federal Government in cases where the applicable silver plan is the

[101] For example, *see* the January 2025 Marketplace 2025 Open Enrollment Period Report: National Snapshot (https://www.cms.gov/newsroom/fact-sheets/marketplace-2025-open-enrollment-period-report-national-snapshot-2) and informational materials such as those available on HealthCare.gov: https://www.healthcare.gov/more-savings/.

lowest cost silver plan. The commenter strongly recommended that CMS continue to allow States the freedom to adopt these innovative policies that make it easier for consumers to obtain the best coverage, value, and affordability for them. A few commenters raised concerns about the time and cost associated with requiring State Exchanges to implement changes to their systems, including to their re-enrollment processes.

Response: For reasons discussed earlier in this preamble, we are finalizing this policy as proposed. While we appreciate that some State Exchanges have had success with modifying their approaches to auto re-enrollment and have not received consumer complaints, based on our experience operating the Federal Exchange and Exchanges on the Federal platform, we believe that the potential consumer harm related to this policy outweighs these potential benefits. In particular, we discussed several comments earlier in this preamble that described confusion consumers in Exchanges on the Federal platform have experienced related to this policy, including a few that cited examples of consumers who assumed that their health insurance agent had re-enrolled them in a different plan against their wishes. In the 2024 Covered California Member survey, the sample size of over 2,000 auto re-enrolled people drops to under 500 when restricted to those who reported being "Aware that their Plan Changed,"[102] suggesting many enrollees did not understand the Exchange's change to their plan. Additionally, commenters did not address the risk that switching enrollees to a higher actuarial value plan without their knowledge could increase these enrollees' risk of tax liability.[103] We believe that this potential negative impact, combined with consumer confusion, presents sufficient risk to outweigh the potential benefits that these commenters cite. Even bronze enrollees who are aware that they have been auto re-enrolled into a silver plan and who voiced support for this change according to

[102] NORC at the University of Chicago and Covered California. (2024, Nov. 21). Covered California's 2024 Member Survey. https://hbex.coveredca.com/dataresearch/library/Member_Survey_2024_Public_Report.pdf.
[103] *See* discussion in the 2024 Payment Notice (88 FR 25823) regarding this potential risk in cases where APTC amount is determined based on inaccurate household income for the future year.

Covered California's 2024 Member Survey might not be aware of potential implications to their tax liability, and those who are not aware of the change are even more at risk for incurring tax liability without realizing it.

Finally, in response to requests for clarification on flexibility for State Exchanges in this area, we clarify that Exchanges can request flexibility regarding the annual redetermination processes described in § 155.335(b) through (m), which include the auto re-enrollment hierarchy, per § 155.335(a)(2)(iii). That is, § 155.335(a)(2) provides Exchanges with three options to conduct annual redeterminations: under § 155.335(a)(2)(i), an Exchange can apply the procedures described in paragraphs (b) through (m) of this section, and under (a)(2)(ii), an Exchange can apply alternative procedures specified by the Secretary for the applicable benefit year. Section 155.335(a)(2)(iii) allows Exchanges to apply alternative procedures approved by the Secretary based on certain criteria. In the 2025 Payment Notice (89 FR 26313), we explained that State Exchanges that cannot implement or choose not to implement the re-enrollment hierarchy at § 155.335(j) may seek approval from the Secretary to conduct their own annual eligibility redetermination process as described in § 155.335(a)(2)(iii). We already approve State Exchanges' requests for flexibility in this area on an annual basis, as part of their submission of their eligibility re-determination and re-enrollment plans, both in order to mitigate burden and to permit innovation that allows Exchanges to best serve their enrollees.

Specifically, regulations at §§ 155.1200 and 155.1210 outline HHS's authority to oversee the Exchanges after their establishment. In 2014, HHS developed the State Marketplace Annual Reporting Tool (SMART) to facilitate State Exchanges' reporting to HHS on how they are meeting Federal program and operational requirements, including compliance with Federal eligibility and enrollment program requirements under 45 CFR part 155.[104] On an annual basis,

[104] The SMART is currently approved under OMB control number: 0938-1244 (CMS-10507).

HHS gathers information about State Exchanges' Open Enrollment readiness and practices. Alongside this process, HHS also collects information on State Exchange plans for auto re-enrollment implementation, and conducts follow up discussion of any related questions or concerns prior to providing approval. During years where there have been regulatory changes that impact the Exchange functions this review covers, we provide technical assistance and targeted support for State Exchanges that have questions, and as needed, conduct further follow-up during Open Enrollment to ensure their operations were successful.

5. Verification Process Related to Income Eligibility for Insurance Affordability Programs (§§ 155.305, 155.315, and 155.320)

The ACA provides Federal subsidies to reduce premium and cost sharing payments for lower-income households who purchase QHPs through the Exchanges. To guard against fraud and abuse, the ACA establishes a set of standards and processes to verify that consumers meet the eligibility requirements for APTC and CSR subsidies. In the 2025 Marketplace Integrity and Affordability proposed rule (90 FR 12956 through 12968), we proposed several changes to the processes specifically related to verifying income eligibility for APTC and CSR subsidies.

Under the statutory framework, HHS is responsible for verifying and determining income eligibility. The ACA further directs HHS to establish compatible electronic information exchange systems for enrollment applications and eligibility verification and determination. This creates a clear expectation for HHS to develop a robust data matching program between Federal agencies, State Exchanges, and other trusted data sources to determine APTC payments using the most accurate income estimates. Giving a Federal agency like HHS primary responsibility for verifying and determining APTC eligibility follows from the fact that APTC payments are Federal expenditures.

Exchanges operate as the intermediary between HHS and the applicant. They provide the applicant's information to HHS and then HHS has the primary responsibility for verifying the

information. However, when the IRS cannot verify the income information, HHS may delegate its responsibility to verify household income to the Exchanges. Still, HHS retains authority to regulate and guide how Exchanges verify this household income information, as well as responsibility for the data matching program used to establish, verify and update income eligibility. As the intermediary, the Exchanges must also make the final connection with the applicant to resolve any outstanding income inconsistencies. The Exchanges' role here is to provide notice to the applicant, collect any documentary evidence from the applicant, and facilitate any final effort to resolve the inconsistency with the IRS or other trusted data sources.

Applicants also bear important responsibilities in this process. This primarily includes a responsibility to file Federal income taxes for any year that they receive APTC and, if they have had a change in circumstances or were not required to file taxes, to report and attest to accurate income information. The ACA, however, requires verification of applicants' attestations of household income under section 1411(c) or (d), as referenced in section 1411(e)(4) of the ACA. If the applicant's household income cannot be verified, the applicant is responsible for providing satisfactory documentary evidence or taking further steps to resolve the inconsistency with the Federal information sources. If the applicant fails to resolve the inconsistency, the APTC amount must be based on the income data from Federal sources provided to HHS under section 1411(c) of the ACA.

There is a critical balance HHS must achieve between assuring responsible stewardship of taxpayer dollars with protecting access to Federal program for those who qualify for them. In circumstances presenting higher-than-normal risks, it is appropriate for the agency to take greater-than-normal precautions against waste, fraud, and abuse while balancing access to Federal benefits over the long-term.

With that as background, we proposed the following changes to the processes in place related to verifying income eligibility for APTC and CSR subsidies.

a. Failure to File Taxes and Reconcile APTC Process (§ 155.305(f)(4))

i. Delay of FTR Process until after 2 consecutive years of FTR removed

In the 2025 Marketplace Integrity and Affordability proposed rule (90 FR 12958 through 12961), we proposed to amend paragraph § 155.305(f)(4) to reinstate the previous policy that an Exchange may not determine a tax filer or their enrollee eligible for APTC if: (1) HHS notifies the Exchange that APTC were paid on behalf of the tax filer, or their spouse if the tax filer is a married couple, for a year for which tax data would be utilized for verification of household and family size, and (2) the tax filer did not comply with the requirement to file a Federal income tax return and reconcile APTC for that year.

In the 2024 Payment Notice (88 FR 25814), we amended the FTR process to restrict an Exchange from determining a tax filer ineligible for APTC until they have failed to file a Federal income tax return and reconcile APTC for 2 consecutive tax years. We made this change to address operational challenges that required Exchanges to determine someone ineligible for APTC without having up-to-date information on the tax filing status of tax filers, to help consumers who may be confused or may have received inadequate education on the requirement to file and reconcile, to promote continuity of coverage for consumers who may not be aware of the requirement to file and reconcile, and to reduce the administrative burden on HHS.

When we adopted this 2-tax year FTR process, we acknowledged it could place consumers at risk of increased tax liability. To mitigate this concern, in the 2025 Payment Notice (89 FR 26298 through 26299), we required Exchanges to issue FTR warning notices for enrollees in Exchanges on the Federal platform who have not filed and reconciled for 1-tax year. We also acknowledged the risk for improper enrollment by consumers who know they can ignore their FTR status for an additional year, but concluded these instances would be limited as the majority of enrollees comply with FTR. Despite the potential for large tax liabilities and the risk of improper enrollment, we concluded that this policy would have a positive impact on

consumers, while still ensuring program integrity as it would provide better continuity of coverage for consumers who may not be aware of the requirement to file and reconcile. We noted that we would continue to monitor the implementation of this new policy, including whether certain populations continue to experience large tax liabilities, and would consider whether additional guidance, or any additional policy changes in future rulemaking, are necessary.

Upon further analysis of enrollment data, as we previously stated in the proposed rule (90 FR 12959), we believe the 2-year FTR process places a substantially higher number of tax filers at a greater risk of accumulating increased tax liabilities.[105] We also stated that we believe this is because the current FTR process could incentivize tax filers to not file and reconcile because they are allowed to keep APTC eligibility for an additional year without filing their Federal income tax return and reconciling APTC. If tax filers do not file and reconcile for 2 consecutive tax years, they could have an increasing tax liability due to APTC that is not reconciled on the tax return. For example, if a tax filer had projected their household income to be less than 200 percent of the FPL but had household income over 400 percent of the FPL when filing their Federal income tax return, the requirement to repay their excess APTC could constitute a major tax liability. Average APTC per month for those receiving it is $548 for OEP 2024.[106]

Considering new evidence regarding unauthorized enrollments, it became apparent that the 2-year FTR process established under the 2024 Payment Notice could impede Exchange efforts to mitigate unauthorized enrollments. At the time, we did not estimate the number of people with an FTR status who entered the OEP and either disenrolled, actively reenrolled without APTC, or resolved their FTR status and reenrolled with APTC. Due to concerns related to the safeguarding of Federal Taxpayer Information (FTI), the Exchanges on the Federal

[105] Marketplace Open Enrollment Period Public Use Files, https://www.cms.gov/data-research/statistics-trends-reports/marketplace-products/2024-marketplace-open-enrollment-period-public-use-files.
[106] Ibid.

platform are unable to track specifically how many consumers originally identified as FTR prior to the OEP ultimately resolved their FTR status. This kind of information would have helped us fully understand the population that might take advantage of the current FTR process. Nor did we attempt to estimate the portion of people with FTR status who were likely ineligible for APTC. Rather, we assumed continuity of coverage with APTC was appropriate for everyone with an FTR status.

Moreover, we did not consider how changing the notice to reflect the new FTR process would impact enrollment decisions. The prior FTR direct notice (for PY 2020 and earlier) gave notice that access to APTC would end if tax filers failed to file and reconcile for 1-tax year, while the current 1-tax year FTR direct notice for PY 2025 provides notice for tax filers identified as having a 1-tax year FTR status that they *may* lose their APTC in the future if they do not file and reconcile their APTC. Tax filers with a 1-tax year FTR status or their enrollees are directed to file their Federal income tax returns and reconcile their APTC as soon as possible in the current 1-tax year FTR direct notice. Indirect notices for tax filers in both the 1-tax year and 2-tax year FTR status cannot directly tell an enrollee that they need to file their Federal income tax return but encourage doing so in order to ensure that they remain eligible for APTC, along with other reasons why they may be at risk of losing APTC to mask FTI.

Upon further analysis of enrollment and tax filing data, we believe that Exchanges on the Federal platform currently have a substantially higher than normal number of enrollees who have not filed and reconciled as compared to the previous 1-year FTR process. We also stated that we revisited the enrollment and tax filing data from the OEP for PY 2020, as well as more recent enrollment data. During OEP 2025, the initial year in which FTR was resumed, the data shows that approximately 356,000 potential reenrollments entered OEP 2025 with a 2-tax year FTR status and approximately 1,500,000 potential reenrollments entered OEP 2025 with either a 1-tax year FTR status, an extension of the deadline to file their Federal income taxes, or had filed their

Federal income taxes but had not attached IRS Form 8962 to reconcile their APTC. Under the current 2-year policy for PY 2025, enrollees with a 2-tax year FTR status could have actively reenrolled (but not auto-reenrolled) and attested to having filed and reconciled while IRS data still shows them as not having filed taxes for the 2022 or 2023 tax years, and the enrollees with a 1-tax year FTR status could have either actively or automatically reenrolled in an Exchange QHP without meeting the requirement to file taxes for the 2023 tax year. Historically, internal analysis of agency data has shown that, under the 1-tax year FTR process, between 15 percent and 20 percent of consumers originally identified at OEP as FTR end up losing their APTC due to the FTR Recheck process.

As of February 2025, we did not have information on the number of consumers who were identified as having a 2-tax year FTR status before the OEP and who have filed and reconciled in order to remain eligible for APTC. We stated in the proposed rule that it is probable that due to the increase in enrollment under the 2-tax year FTR policy, the number of consumers who would remain covered into the second year would be greater than the 81,600 we previously estimated (90 FR 12960). Since publishing the proposed rule, we are updating our initial data projections as we initiated FTR Recheck operations in March 2025. Of the approximate 1,500,000 potential re-enrollments who entered OEP 2025 with either a 1-tax year FTR status, a valid tax filing extension from IRS, or had filed their Federal income taxes but had not attached IRS Form 8962 to reconcile their APTC (non-reconcilers), approximately 400,000 enrollees with either a 1-tax year FTR status or a non-reconciler status were identified during FTR Recheck. This represents a drop of 73 percent of the initially identified FTR population, suggesting that the 1-year notices sent during the OEP were relatively effective and also followed historical trends observed by HHS. The 2-year FTR status population decreased from 356,000 to approximately 270,000, a decrease of 24 percent. This suggests that the 2-year population is less responsive to notices than the 1-year population.

Furthermore, in the proposed rule (90 FR 12960), we stated that we believe the proposed 1-tax year FTR process can serve as a backstop to improper enrollments. The Paragon Health Institute provided evidence that lead generation companies associated with noncompliant agents, brokers, and web-brokers are misleading enrollees with the promise of free coverage and other enticements.[107] In these cases, some people are likely not aware they are enrolled in QHP coverage with APTC because, in response to misleading advertisements promising cash or gift cards, they provided enough personal information for agents, brokers, and web-brokers to improperly enroll them in such coverage with APTC without their knowledge.[108] These schemes tend to target low-income people, many of whom likely have a projected annual household income of less than 100 percent of the FPL. Under these schemes, some agents, brokers, or web-brokers improperly enroll people in QHP coverage with APTC who would not otherwise qualify. Individuals who were improperly enrolled may not realize they are enrolled in Exchange coverage until they receive a Form 1095-A. These individuals can obtain a voided Form 1095-A and avoid improper tax liabilities, but the process is burdensome and could lead to delays or errors in tax filing. Improvements have been made to the Unauthorized Enrollment (UE) casework process to reduce consumer burden; in addition, CMS and IRS have several resources about what a consumer should do if they believe they were enrolled in a UE and they need a voided Form 1095-A.[109] In the proposed rule we stated that we believe that FTR status may provide a strong indicator that a current enrollee entering the OEP has income that makes the household ineligible for APTC. Generally, people with lower incomes do not need to file taxes unless their income is over the filing requirement. Because the income filing requirement for a single filer with no self-employment income aligns with the eligibility threshold for APTC—

[107] Blase, B; Kalisz, G. (2024, August). Unpacking The Great Obamacare Enrollment Fraud. Paragon Health Institute. https://paragoninstitute.org/private-health/unpacking-the-great-obamacare-enrollment-fraud/.
[108] Ibid.
[109] Resource on reporting UE to Marketplace Call Center: https://www.cms.gov/files/document/agent-broker-infographic-2024-final.pdf.

$14,600 for 2024 tax filing compared to $14,580 for 2024 APTC eligibility—people who inflate their income to qualify for APTC will often have an income low enough to, absent the receipt of APTC, not require them to file taxes. In this case, the FTR status likely reflects a lack of understanding of the need to file taxes based on the receipt of APTC which, if they still think they do not meet the filing requirement based on their income, means they are likely to have an income too low to meet the APTC eligibility threshold.

We established the current 2-tax year FTR process at the end of the COVID-19 Public Health Emergency (PHE). At that time, we had paused the removal of APTC under the FTR process because the pandemic severely impacted the IRS's ability to process tax returns for the 2019, 2020, and 2021 tax years.[110] Continuing the FTR process during that time would have removed APTC from substantial number of eligible enrollees who timely filed tax returns but had not had their tax returns processed yet.

While many enrollees did in fact file their Federal income taxes and reconcile APTC while FTR was paused during the COVID-19 PHE, in light of the substantial increase in improper enrollments HHS observed during PY 2024, we stated in the proposed rule (90 FR 12960) that we believe that reverting back to the pre-existing FTR policy in place before the COVID-19 PHE, is a critical program integrity measure that could further protect Exchanges and enrollees from improper enrollments. Specifically, we stated that we are concerned that the current policy of pausing removal of APTC due to an FTR status for an additional year could potentially let improperly enrolled enrollees stay enrolled for another year undetected. If an improper enrollment is not detected by the other methods that the Exchange has implemented, the proposed 1-tax year FTR process should act as a backstop to ensure that an enrollee who is improperly enrolled loses APTC after 1 year of failing to file and reconcile instead of 2 years of

[110] CMS. (2022, July 18). Failure to File and Reconcile (FTR) Operations Flexibilities for PY 2023. https://www.cms.gov/cciio/resources/regulations-and-guidance/ftr-flexibilities-2023.pdf.

failing to file and reconcile. For example, under the 1-tax year FTR process, people received a notice that they would lose their eligibility for APTC unless they met the requirement to file and reconcile. Whereas under the current 2-tax year FTR process, enrollees do not receive notification that they are imminently at risk of losing their APTC until they have had an FTR status for 2 years. As background, under the current process, Exchanges can choose to send (1) a direct notice to tax filers, (2) an indirect notice to enrollees, or (3) both a direct and indirect notice to enrollees with either 1-tax year and 2-tax year FTR status.[111] Enrollees with a 1-tax year FTR status can receive either a direct notice that they must file and reconcile, but they are not at risk for losing APTC for the current plan year if otherwise eligible, or an indirect notice that indirectly tells the enrollee to ensure they have done all the actions necessary to keep their APTC eligibility, including filing their Federal tax return and reconciling their APTC. It is not until an enrollee receives an FTR notice for the second tax year that they are instructed to file and reconcile as soon as possible to avoid losing APTC for the applicable plan year.

After reviewing the tax filing data, we stated in the proposed rule (90 FR 12960) that we remain concerned that enrollees are accumulating tax liabilities due to misestimating their income. Before the COVID-19 PHE, over 50 percent of people who filed tax returns and reconciled APTC received excess APTC for the 2016, 2017, 2018, and 2019 tax years.[112] For those who filed their taxes and reconciled their APTC, the accumulation of any tax liability is limited to a single year. In 2022, excess liability represented 11.5 percent of total APTC payments reported on tax returns.[113] This tax liability, if not paid by the taxpayer, will continue to be an outstanding debt to the IRS and may accrue interest and penalties. To mitigate any

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[111] Direct notices contain Federal tax information (FTI) and are sent to tax filers, while indirect notices do not contain FTI and can be sent to enrollees who may not be their tax household's tax filer.
[112] IRS. (2024, Dec. 30). SOI Tax Stats - Individual Income Tax Returns Line Item Estimates (Publications 4801 and 5385). Dep't of Treasury. *https://www.irs.gov/statistics/soi-tax-stats-individual-income-tax-returns-line-item-estimates-publications-4801-and-5385*.
[113] https://www.irs.gov/pub/irs-pdf/p4801.pdf.

accumulation of liability, the longstanding FTR process had disenrolled people from APTC after giving them over 6 months to resolve their FTR status after initial notification. The current process could potentially provide up to 18 months after an initial FTR notice is received for a tax filer to comply with the requirement to file and reconcile their APTC. We stated in the proposed rule (90 FR 12961) that we no longer believe this provides reasonable protection against accumulating tax liabilities.

Furthermore, in the current environment, as Exchanges on the Federal platform attempt to ensure that unauthorized enrollments are removed from QHP coverage and have APTC ended, we believe that there are still a large number of ineligible enrollees, which is increasing the burden on taxpayers because, due to repayment limitations discussed previously, not all ineligible enrollees who receive APTC are required to fully repay any APTC improperly received. Those unpaid liabilities add to Federal APTC expenditures. We did not previously estimate the Federal cost of the current FTR process due to providing coverage and APTC continuity to enrollees who were ineligible for APTC and not liable for repaying the full excess of their APTC. In the proposed rule (90 FR 12961), we stated that we estimate up to 18.5 percent[114] of people currently in FTR status may be ineligible for APTC based on the overall growth in the 100 to 150 percent of the FPL population of the Exchanges on the Federal platform between 2019 and 2024, if the growth is due to noncompliant agents, brokers, and web-brokers enrolling enrollees who are actually below the 100 percent of the FPL threshold. However, we stated in the proposed rule that this population would also be impacted by numerous other proposals in the proposed rule as well as other actions that HHS has taken over the past year to protect the Exchanges, and we are unable to isolate the proposed impact of changing the FTR policy.

[114] Figure derived from CCIIO analysis of internal agency data.

Overall, we stated in the proposed rule (90 FR 12961) that this new analysis of the enrollment and tax filing status suggests a large number of people with FTR status are ineligible for APTC and that pausing removal of APTC due to an FTR status allows ineligible enrollees to accumulate tax liabilities. These additional liabilities create a substantial financial burden for enrollees who must repay the excess APTC and increase the Federal APTC expenditures. Moreover, we stated our view in the proposed rule that the ACA does not allow HHS to determine someone eligible for APTC if they failed to meet the requirement to file a tax return. Therefore, to align regulations with the ACA, protect people from accumulating additional Federal tax liabilities, and reduce the Federal expenditures associated with APTC expenditures for ineligible enrollees, we proposed to reinstate the FTR process that requires Exchanges to determine enrollees ineligible for APTC when HHS notifies the Exchange that a taxpayer has failed to file a Federal income tax return and reconcile their past APTC for a year for which their tax data would be utilized to verify their eligibility.

We proposed to implement the proposed 1-year FTR process beginning with OEP 2026 in the fall of 2025. This would allow enrollees currently in a 1-tax year FTR status to receive appropriate noticing informing them of the urgent need to file their Federal income tax return and reconcile APTC in order to remain eligible for APTC.

We sought comment on this proposal.

After consideration of comments and for the reasons outlined in the proposed rule and this final rule, including our responses to comments, we are finalizing a modified policy under which all Exchanges will be required to deny APTC once an applicant has failed to file and reconcile APTC for 1 year, but only through the end of PY 2026. Thereafter, the 2-year FTR policy in effect today that allows an Exchange to deny APTC only once an applicant has failed to file and reconcile APTC for 2 consecutive years, will spring back into effect. While the 1-year FTR policy is needed right now to reduce the number of improper APTC payments in Exchanges

on the Federal platform, its utility is less apparent in the context of the expiration of the expanded subsidies and fully-subsidized benchmark plans, which removes much of the incentive for unscrupulous agents and brokers to fraudulently enroll consumers into Exchange coverage who then may not know they need to file Federal income taxes and reconcile APTC. Commenters also expressed concern that the 1-year FTR may result in coverage losses because the tax filing process is complex, and many consumers are not fully aware of the requirements to file and reconcile. Commenters suggested that this could especially be true for young persons, which might result in a less healthy risk pool. Commenters also expressed concern that low-income consumers would be negatively affected by proposals requiring household income verification because persons in this group have a much more difficult time predicting and verifying income due to unpredictable nature of their income.

Therefore, to balance competing concerns, this policy will sunset automatically after the completion of one new coverage year, PY 2026, on December 31, 2026. The two-year FTR policy will be in effect for PY 2027 and beyond, beginning with Open Enrollment for PY 2027. As such, we are adding a new special rule at § 155.305(f)(4)(iii), which states that for PY 2026, Exchanges must follow the 1-year FTR policy and 1-year FTR notice requirements.

Comment: Many commenters opposed the proposed policy change to revert to the 1-year FTR policy stating that the two-year policy strikes a better balance between ensuring that enrollees file their Federal income taxes and reconcile APTC, while also allowing for the fact that the IRS data is often delayed due to long processing times, especially for paper filers and amended income tax returns.

Response: While we agree that long IRS processing times of Federal income tax returns, especially for those filing paper and amended tax returns, may impact an Exchange's FTR operations, we believe this is unlikely a sufficient reason to maintain the current two-year FTR process for 1 year while addressing the imminent program integrity concerns. Further, we

attempt to mitigate the long IRS processing times with the FTR Recheck process, which allows for enrollees who have filed by the October 15 extended filing date to attest to doing so, while maintaining eligibility for APTC for the following coverage year. FTR status is rechecked early in the coverage year to compare attestations with more recently updated FTR data. If a consumer is still showing as FTR after FTR Recheck, then the consumer receives a notification before a final check of FTR status before the Exchange terminates eligibility for APTC. Consumers who believe they have erroneously been found ineligible for APTC should contact the Marketplace Appeals Center.[115]

Comment: Many commenters expressed concern over the short time frame for implementing the 1-year FTR policy and asked to extend the implementation date until OEP 2027. They noted that many of their plans for OEP 2026 are already being finalized, and their time and State budgets have already been committed to different projects, which will prevent State Exchanges from completing the necessary IT infrastructure and eligibility logic changes to revert to a 1-year FTR policy.

Response: We understand these concerns, however, we believe that implementing this policy as soon as practicable and implementing the 1-year FTR policy during PY 2026 is most appropriate to address imminent improper enrollment concerns associated with fully-subsidized plans and the expanded subsidies generally. As we explain earlier in this section, under the 1-year FTR policy, consumers are more likely to discover their improper enrollments after 1 year, instead of 2 years, lessening their risk of increased tax liability due to premium subsidies paid on their behalf. That said, we understand that once the excess improper enrollments have been shed and the expanded subsidies are no longer shielding enrollees from all costs associated with coverage, the efficiency of maintaining the 1-year FTR policy is less clear. Thus, we are

[115] The Marketplace Appeals Center can be contacted at 1-855-231-1751.

finalizing this policy as proposed, but with a modification that Exchanges will be required to implement the 1-year FTR policy through the conclusion of PY 2026 on December 31, 2026.

Comment: Many commenters expressed concern that the proposed 1-year policy would increase coverage loss, especially among those who are lower-income individuals and homeless as they would no longer be able to afford their monthly Exchange premium after APTC is terminated, as well as having a negative impact on the risk pool. Relatedly, many commenters expressed concern about the potential increase in IRS delays and the impact that delayed data could have on the 1-year process.

Response: We thank these commenters for their concern. We share commenters' concerns about the risk of coverage losses among lower-income individuals. However, we believe that imminent program integrity concerns merit the need for a temporary policy. As the Department is concerned with potentially unwarranted coverage loss, we are finalizing this policy for PY 2026 only, with a reversion to the previous 2-year policy for PY 2027 and beyond. This approach allows us to balance ensuring that consumers who have not filed their Federal income taxes and reconciled APTC due to improper enrollment, do not retain unwanted or unneeded coverage as well as preventing the loss of coverage by enrollees who have complied with tax filing requirements over the long-term. We also note that, if an enrollee believes that they lost APTC erroneously due to FTR, they can file an appeal with the Marketplace Appeals Center.

Comment: A few commenters stated that the change in the FTR policy does not meet the Administrative Procedure Act (APA) requirements for reasoned decision-making because they believe that HHS has failed to provide the public with adequate data to adequately comment on the proposed rule.

Response: In the proposed rule (90 FR 12959 through 12961), we provided historical data for the 1-tax year FTR process as well as data estimates provided in the 2024 Payment Notice for the 2-tax year FTR process to represent the FTR population prior to the publishing of the

proposed rule. This data showed that more consumers would have an FTR status (either 1 year or 2 year) as compared to the prior 1-tax year process, which would increase Federal expenditures. In addition, we provided tax filing status data that supported the current 2-year FTR process placing a substantially higher number of consumers at risk of accumulating increased tax liabilities than compared to a 1-year FTR process. We believe that this data supports the need for and the reasonableness of the FTR policy change while providing adequate notice to the public to comment on this policy change.

As we explained in the proposed rule (90 FR 12959), the Initial FTR Recheck data from the 2-year policy was not available at the time of publishing the proposed rule. We have provided updated data in preamble of this final rule about the FTR population following the FTR Recheck process and is current as of April 2025. We believe this data further supports the need for this near-term policy change after which we can closely monitor its impacts. HHS is of the view that the best way forward is to act now to guard against improper payments of APTC and the potential for increased tax liability by finalizing the 1-year policy for all Exchanges effective for the 2026 coverage year.

We also note that some commenters may believe that we have additional data regarding the FTR population. We reiterate that due to FTI privacy concerns, we have a limited set of data regarding the FTR population and to protect FTI, the data generally, does not trace how an enrollee moves through the FTR process in order to protect FTI. Instead, we examined the overall population level data that shows how the FTR population decreases as tax filers either file and reconcile or lose eligibility for APTC or QHP coverage for other, non-FTR related reasons.

Comment: Commenters expressed concern that the change could increase coverage loss, as well as negatively impact the risk pool because healthy individuals are less likely to jump through administrative hurdles to keep their coverage. They also expressed concern that many

people will forgo their health coverage, thereby leading to lower levels of community health and increased incidence of communicable disease, potentially even increasing diseases such as HIV/AIDS if they are not well controlled due to lack of insurance and ability to purchase medications.

Response: We appreciate and share commenter concerns about the potential for increased coverage loss and potential negative impacts on the risk pools. For this reason and others outlined in section III.B of this final rule, we think it is prudent to closely monitor the effects of the implementation of this policy for a year to measure the impacts of the change in the FTR policy on the number of enrollees who lose coverage due to FTR. Finally, as mentioned above, consumers may submit an appeal to the Marketplace Appeals Center if they believe that they lost APTC erroneously due to FTR.

Comment: Many commenters expressed concern that the tax filing process is complex, and many consumers are not fully aware of the requirements to file and reconcile, especially for the population that is more transient, as well as those not as financially or technologically literate. They noted that many of these consumers are simply unaware of how the tax system works, and consumers are not trying to purposefully game it and potentially incur criminal penalties from not filing Federal income taxes. They recommended States partner with providers who serve those who are experiencing homelessness to ensure consumers are aware of the need to file and reconcile.

Response: We appreciate these concerns, but also note that HHS does not have authority over the Federal income tax rules in the Internal Revenue Code. We note that the IRS's Volunteer Income Tax Assistance (VITA) curriculum includes information on the requirement to file and reconcile and that through VITA, IRS-certified volunteers are available to help individuals who need assistance in preparing their own tax returns, including people who make $67,000 or less, persons with disabilities, and limited English-speaking taxpayers. We will continue to educate

consumers about the requirement to file and reconcile using notices throughout the FTR process and also encourage State Exchanges to work with homeless service providers in their States to ensure consumers are aware of the need to file and reconcile.

Comment: A few commenters expressed support for the 1-year FTR policy and noted that the proposed changes would save taxpayer money by reducing APTC payments on behalf of ineligible enrollees or consumers who were unaware of their enrollment. One commenter agreed with HHS' concern for preventing accumulating balances of back taxes on behalf of consumers.

Response: We agree with the commenters and note that reverting back to a 1-year FTR policy will help mitigate the risk of improper enrollment in the Exchanges, while also protecting consumers from incurring large tax liabilities due to failing to file and reconcile APTC. Finalizing this policy for 2026 allows us to balance these imminent concerns with longer-term desires to streamline enrollment processes.

Comment: A State Exchange noted that only 1 percent of their enrollees failed to file a tax return for 2 consecutive tax years when they ran FTR Recheck this year.

Response: Due to IRS data constraints, if State Exchanges used the Hub service to call IRS for their consumers' FTR statuses between December 8, 2024 and March 29, 2025, it is highly likely that a consumer with a 2-year FTR status would return a 1-year FTR response from the IRS. Unfortunately, this error was not discovered until Exchanges on the Federal platform started FTR Recheck operations in January 2025. While we understand that many State Exchanges' FTR populations do not mirror the Exchanges on the Federal platform for a variety of reasons, it seems likely that the State Exchanges that had such low 2-year FTR rates may have called the IRS Hub service while the IRS's data was not being correctly reported. We understand that many State Exchanges did not perform FTR Recheck operations until later in the coverage year.

Comment: Many State Exchanges recommended that they should retain flexibility regarding their notices because they need to meet both Federal and State requirements and forced alignment with requirements for Exchanges on the Federal platform could open States to burdensome requirements and possible litigation. Other State Exchanges noted that they only provide enrollment options through their Exchange website and their Navigators work with their enrollees to help project their income and educate them on the need to file and reconcile.

Response: We acknowledge State Exchanges' request to retain flexibility in their notice requirements. HHS has retained the current flexibility regarding FTR notices allowed to State Exchanges in the finalized rule and these flexibilities would remain in place whether Exchanges are required to use a 1-year or 2-year FTR policy.

Comment: A few commenters stated that HHS should fully repeal FTR processes because there is no statutory authority for it.

Response: We disagree with commenters that there is no statutory authority for Exchanges to conduct FTR. Consumers who receive APTC are required to file income taxes pursuant to section 6011(a) of the Code and regulations prescribed by the Secretary of Treasury. Section 36B(f) of the Code requires taxpayers to reconcile their APTC under section 1412 of the ACA with their PTC allowed under section 36B of the Code. FTR regulations, implemented pursuant to the Secretary of HHS' general rulemaking authority under section 1321(a) of the ACA, facilitate compliance with those requirements and were implemented as part of the original Exchange Establishment Rule.

ii. Conforming Change to Notice Requirements

To conform with this proposed FTR process, in the 2025 Marketplace Integrity and Affordability proposed rule (90 FR 12961 through 12962), we proposed to revise the notice requirement at § 155.305(f)(4)(i) and remove the notice requirement at § 155.305(f)(4)(ii). When we finalized the current FTR process for PY 2025 in the 2024 Payment Notice (88 FR 25814) to

require Exchanges to wait to discontinue APTC until the tax filer has failed to file a tax return and reconcile their past APTC for 2 consecutive tax years, we did not impose a requirement for Exchanges to notify such enrollee during the first year that they failed to file and reconcile. We then amended § 155.305(f)(4) in the 2025 Payment Notice (89 FR 26298 through 26299) to require that all Exchanges send one of two notices to tax filers or enrollees with an FTR status for 1 year, and again in the 2026 Payment Notice (90 FR 4472 through 4473) to require that all Exchanges send one of two notices to tax filers or enrollees with an FTR status for 2 consecutive tax years. Accordingly, for both an enrollee's first and second year with an FTR status, all Exchanges must have either (1) notified the tax filer directly of their FTR status and educate them of the need to file and reconcile or risk being determined ineligible for APTC if they fail to file and reconcile for a second consecutive year, or (2) sent an indirect notification to either the tax filer or their enrollee that informs them they are at risk of being determined ineligible for APTC in the future. The indirect notice must do so without indicating that the tax filer has failed to file and reconcile their APTC for both the first year and the second year that they have been found not to have done so in order to protect FTI.

Because we proposed to amend § 155.305(f)(4) to require Exchanges to determine people ineligible for APTC after one tax year of FTR status rather than 2 consecutive tax years, the current notice requirement aimed at tax filers in a 2-tax year FTR status would no longer apply. Therefore, we proposed to revise the notice requirement at § 155.305(f)(4)(i) and remove the notice requirement at § 155.305(f)(4)(ii). We invited comment on this proposal.

To ensure tax filers and enrollees receive advanced notice of their FTR status and the risk for being determined ineligible for APTC after removing this notice requirement, we proposed to reinstate the notice procedures that existed before we established the current FTR process for Exchanges on the Federal platform. See Table 3 for summary of notices sent.

TABLE 3: FTR Recheck Notices and Timing

Notices	Timing
Enrollees with FTR status receive Marketplace Open Enrollment Notice (MOEN) with FTR language & tax filers receive OE FTR direct notice	Fall (prior to OEP beginning)
Tax filers receive FTR Recheck direct notice and enrollees receive FTR Recheck Indirect Notice upon completion of FTR Recheck	Early winter (shortly after OEP ends)
Upon final recheck, enrollees losing APTC receive updated Eligibility Determination Notice (EDN) and tax filers receive Stop APTC direct notice	Spring

If enrollees have attested to filing and reconciling, enrollees would be discontinued from APTC only after the IRS checks and rechecks their FTR status four times. We stated in the proposed rule (90 FR 12962) that we believe this gives ample notice to enrollees who may have been confused about the requirement to file and reconcile and provides the IRS enough time to process tax returns for enrollees who complied. We also stated that we believe this procedure ensures that enrollees who are eligible for coverage continue to receive coverage. Under this proposed requirement at §155.305(f)(4)(i)(B), State Exchanges would be responsible for administering their own notice procedure with flexibility to send either direct notices containing FTI, or indirect notices which do not contain any protected FTI, or both.

We sought further comment on whether State Exchanges should be required to align with Exchanges on the Federal platform on this consumer noticing and recheck process.

After consideration of comments and for the reasons outlined in the proposed rule, final rule, and our responses to comments, including the reasons outlined in Section III.B of this final rule, we are finalizing the addition of § 155.305(f)(4)(iii) for all Exchanges. Once these policies sunset at the end of PY 2026, the 2-year FTR policy will apply to all Exchanges, as well as the requirements to send FTR notices under the currently effective versions of §§ 155.305(f)(4)(i)(B) and (f)(4)(ii). We summarize and respond to public comments received on the proposed FTR notice policy below.

Comment: Several commenters were concerned with ensuring that enrollees receive adequate notice of appeal and extension rights if there is a mistake in the FTR process.

Response: We agree with commenters that enrollees should receive adequate notice about the requirement to file their Federal income taxes and reconcile APTC, which is why the Exchanges on the Federal platform exceed the requirements of this rule in notifying tax filers and/or their enrollees. Exchanges on the Federal platform provide a direct notification to the tax filer and an indirect notification that does not disclose FTI to the enrollee before the OEP, at the time of FTR Recheck, as well as when an enrollee's APTC is terminated. HHS includes instructions in both the APTC termination notice to the tax filer after removal of APTC as well as the enrollee's updated Eligibility Determination Notice on how to contact the Marketplace Appeals Center to appeal their FTR status if a consumer believes they have filed and reconciled.[116] We recommend that State Exchanges also include this information in their notices to enrollees and/or tax filers.

Comment: Many commenters expressed concern that the 1-year FTR process would not provide sufficient notice and would be insufficient to meet due process requirements because the notices are spread out over a year, and because the indirect notice does not explain in sufficient detail why the individual is losing APTC or what they could do to remediate the issue and be successful in appeal. They believed the current 2-year process, including the associated notices, should remain in place.

Response: While we appreciate the commenters' concern, we believe the 1-year FTR process would provide sufficient notice. A consumer would receive their first FTR notice approximately six months before losing their eligibility for APTC for failing to file their income taxes and reconcile their APTC. While an indirect notice may not specifically state that a

[116] https://www.cms.gov/marketplace/in-person-assisters/applications-forms-notices/notices.

consumer has been identified as failing to file their Federal income tax returns and reconcile, it should say that a consumer needs to file their Federal income tax return and reconcile APTC to remain eligible for APTC. We note that the notice policies that we finalize in this rule describe the minimum requirements for these notices, and States are free to provide a direct notice to the tax filer as well. We have provided guidance to State Exchanges to ensure the notice content is adequate.[117]

b. 60-Day Extension to Resolve Income Inconsistency (§ 155.315)

In the 2025 Marketplace Integrity and Affordability proposed rule (90 FR 12962 through 12963), we proposed to remove § 155.315(f)(7) which requires Exchanges to provide an automatic 60-day extension in addition to the 90 days currently provided by § 155.315(f)(2)(ii) to allow applicants additional time to provide documentation to verify household income.

According to section 1411(e)(4)(A) of the ACA, part of the process to verify the accuracy of information provided on applications requires Exchanges to provide applicants an opportunity to correct an inconsistency with HHS or other trusted data sources when the inconsistency or inability to verify the information is not resolved by the Exchange. This requires Exchanges to give applicants notice of the inability to resolve the inconsistency and verify the information. Exchanges must also provide the applicant an opportunity to either present satisfactory documentary evidence or resolve the inconsistency with HHS or other trusted data sources during the 90-day period beginning on the date on which the notice is sent to the applicant. Section 1411(e)(4)(A) of the ACA also states HHS may extend the 90-day period for enrollments occurring during 2014.

When we explained the legal basis for a 60-day extension in the 2024 Payment Notice (88 FR 25819), we stated the proposal aligns with current § 155.315(f)(3), which provides

[117] OMB Control No. 0938-1207.

extensions to applicants beyond the existing 90 days if the applicant demonstrates that a good faith effort has been made to obtain the required documentation during the period. We noted that it is also consistent with the flexibility under section 1411(c)(4)(B) of the ACA to modify methods for verification of the information where we determined such modifications would reduce the administrative costs and burdens on the applicant. However, as discussed previously, section 1411(c)(4)(B) of the ACA specifically limits modifications on how information is exchanged and verified between HHS and trusted data sources and does not extend to other aspects of the verification process. Therefore, section 1411(c)(4)(B) of the ACA does not provide a statutory basis to modify the length of the 90-day response period.

Section 1411(e)(4)(A) of the ACA also limits modifications to the 90-day response period. This language allows HHS to extend the 90-day period in 2014. This flexibility was clearly intended to accommodate any issues that might arise during the first year HHS administered eligibility determinations for premium and cost-sharing subsidies. By expressly including this specific allowance to extend the 90-day period for 2014, the language strongly suggests Congress did not intend to allow any further extensions to the 90-day period. Therefore, we do not believe § 155.315(f)(7) conforms with the statute.

Based on this reading of the statute, we stated in the proposed rule (90 FR 12963) that we question whether the extension of the 90-day period when an applicant demonstrates a good faith effort to obtain documentation during the period under § 155.315(f)(3) conforms with the statute. Due to the *ad hoc* nature of this good faith effort extension, we stated that we believe this is likely an appropriate use of our authority. In contrast, the automatic 60-day extension, in effect, categorically suspends the 90-day period and replaces it with a 150-day period which we believe falls well outside our authority.

We stated in the proposed rule (90 FR 12963), that even if the statute allowed an automatic 60-day extension, our review of how applicants used the 60-day extension shows that

the benefits we previously anticipated have not materialized. When we adopted the 60-day extension in the 2024 Payment Notice (88 FR 25819 through 25820), we determined the change would ensure consumers are treated equitably, ensure continuous coverage, and strengthen the risk pool. However, we stated in the proposed rule (90 FR 12963) that upon further review of the prior experience and the current experience using the 60-day extension, we find the 60-day extension largely does not deliver the benefits anticipated. Instead, we stated that we find the change weakened program integrity.

As we stated in the proposed rule (90 FR 12963), we previously determined that 90 days is often an insufficient amount of time for many applicants to provide income documentation, since it can require multiple documents from various household members along with an explanation of seasonal employment or self-employment, including multiple jobs. The previous review of income DMI data indicated that when consumers receive additional time, they are more likely to successfully provide documentation to verify their projected household income. We stated that between 2018 and 2021, over one third of consumers who resolved their DMIs on the Exchange did so in more than 90 days.

We further stated in the proposed rule (90 FR 12963) that while we previously found one-third of consumers who resolve income DMIs used an extension between 2018 and 2021, our review from 2024 shows that applicants who successfully used the extension represented 55 percent of the total income DMIs. We also found that the percent of all applicants with an income DMI who used an extension represented 60 percent of total income DMIs. We noted that after implementing the 60-day extension, we did not see that the extension improved these statistics. Of those who successfully resolved their income DMI in 2024, 58 percent used the extension which is about the same as before in 2022. This suggests that, before the automatic 60-day extension, anyone who needed a 60-day extension was granted one under § 155.315(f)(3), and the automatic 60-day extension only served to keep people who were able to provide

documentation within 60 days (instead of 120 days) covered for a longer period. Additionally, we estimated this increased APTC expenditures by $170 million in 2024. Therefore, we determined that the automatic 60-day extension did not provide a meaningful benefit to consumers and weakened program integrity.

We sought comment on this topic and suggestions to alleviate this concern.

As we discussed in other aspects of the proposed rule, there are often countervailing impacts on the risk pool and program integrity from the policy decisions we make. In this case, we stated in the 2024 Payment Notice (88 FR 25820) that consumers in the 25–35 age group were most likely to lose their APTC eligibility due to an income DMI, resulting in a loss of a population that, on average, has a lower health risk, thereby negatively impacting the risk pool. Therefore, we concluded that adding the automatic 60-day extension would improve the risk pool by making it easier for younger and healthier populations to enroll.

In the proposed rule (90 FR 12963), we stated that we must weigh this potential positive impact on the risk pool against the substantial increase in APTC expenditures that we identified from ineligible people who stay enrolled and receive APTC for an additional 60 days. We stated that we believe the cost to taxpayers and decline in program integrity outweigh any possible benefit to the risk pool.

We stated in the proposed rule (90 FR 12963) that providing a 60-day extension for households with income DMIs only serves to increase APTC payments and tax liabilities for ineligible enrollees during the extension. Therefore, we stated that we believe the cost of the extension outweighs the benefits.

As stated previously and in the proposed rule, we now believe that the automatic 60-day extension falls outside of our authority and therefore statutory language compels us to make this change. As such, we must make this change permanent.

We sought comment on this proposal.

After consideration of comments and for the reasons outlined in the proposed rule and this final rule, including our responses to comments, we are finalizing, as proposed, the removal of 155.315(f)(7). This amendment will be applicable as of the effective date of this rule. We summarize and respond below to public comments received on the proposed removal of the 60-day extension for households to resolve income DMIs.

Comment: Some commenters supported the proposal, most of whom were advocacy groups or large issuers who supported the proposal's focus on addressing fraud. One supportive commenter referenced surprise tax bills as an additional benefit of updated verification requirements.

Response: We acknowledge and appreciate the commenters' support for this proposal, which we believe will reduce fraud in Exchanges.

Comment: Many commenters expressed concern that the proposed policy would disproportionately impact some consumer groups and present barriers to enrollment. Specific groups referenced included, among others, low-income people, rural individuals, persons with disabilities, people of color, Tribal communities, and seniors.

Response: We acknowledge commenters' concern. While we do not believe the 60-day automatic extension is consistent with our statutory authority under the ACA, as discussed in the proposed rule (90 FR 12962 through 12963), consumers with difficulties resolving their data matching issues remain eligible for the extension outlined in § 155.315(f)(3). We will continue to evaluate program performance to identify inconsistency resolution trends among all groups and the impact of these operational changes on identified groups.

Comment: Many commenters expressed concerns that proposed policy would adversely affect consumers who are employed in the gig economy or seasonal work.

Response: We recognize that consumers with multiple streams of income information experience more complex income DMI verification processes and may encounter increased

administrative burden in providing the documentation to resolve their DMIs. We believe that the policy we are finalizing in this rule still provides sufficient time for consumers to provide documentation for verification because a review of income inconsistency resolution data before and after the implementation of the extension did not demonstrate a significant increase in resolution with the additional 90 days, indicating under most conditions consumers across all income data matching issue scenarios, including gig workers, can verify their data matching issues in the provided timeframe. Furthermore, we want to emphasize that this change does not prevent consumers from receiving an extension as outlined in § 155.315(f)(3) should they meet the applicable criteria.

Comment: Some State Exchanges noted that the payment integrity data CMS proposed is inconsistent with their data and requested additional flexibilities in extensions for their distinct populations. The particulars of the inconsistencies noted by these State Exchanges varied by State, however, the Massachusetts Commonwealth Health Insurance Connector Authority provided an example, stating "the Health Connector does not experience those challenges that CMS describes as occurring within the FFM." Specific concerns raised by States included, among others, a lack of analysis of Medicaid expansion vs non-expansion States and the lack of analysis in the proposed rule of which States utilize third party agents and brokers.

Response: We acknowledge that State Exchanges have nuances in their demographics and payment integrity data, however, we believe that this change is necessary given that the requirement to automatically provide a 60-day extension at § 155.315(f)(7) is inconsistent with our statutory authority. Because this is a statute-driven change, we believe that this change must be implemented across all Exchanges, regardless of the data matching dynamics in the particular context of implementation. Furthermore, we believe that consumers should have sufficient time to submit documentation to verify their projected household income within the inconsistency period without the automatic 60-day extension given that the income inconsistency resolution

data before and after the 60-day extension as referenced in the proposed rule (90 FR 12963), indicating that this change is not anticipated to unreasonably adversely impact consumers in State Exchanges. Finally, we note that § 155.315(f)(3) already allows State Exchanges to extend the 90-day period in § 155.315(f)(2)(ii) when an applicant demonstrates that a good faith effort has been made to obtain the required documentation during the period. This finalized change removes the requirement for all Exchanges to provide an automatic, general 60-day extension, but it does not restrict a State Exchange's flexibility on exercising its extension authority on a case-by-case basis.

Comment: Some commenters, particularly individual advocacy groups, stated that CMS should evaluate the inclusion of other data sources into income verification processes rather than removing the 60-day extension in order to support program efficiency and integrity.

Response: We may continue to evaluate data sources which may be more appropriate for income verification procedures, however, we are making this change to fulfill our responsibility to align policy with statutory authority which is independent of considerations for additional verification methods. We believe that additional data sources could complement the changes we are finalizing to the automatic extension, however, their inclusion would not substitute for the necessity of making this change. We take the position that ultimately this change will improve program integrity, and believe that consumers should still have sufficient time to submit documentation to verify their projected household income within their inconsistency period with or without additional changes to the utilization of trusted data sources.

Comment: Commenters expressed concern with the data referenced in the proposed rule to support this proposal, reporting that they were not satisfied that the reported metrics sufficiently demonstrated evidence of widespread fraudulent behavior. Specifically, some commenters questioned the data findings referenced in the proposed rule, including the data limitations and exclusions, and the limited data regarding enrollment trends changing around the

COVID-19 PHE. Others noted that the data referenced was not representative of State Exchange data dynamics.

Response: We acknowledge the need to collect and report on high quality metrics to evaluate and monitor program integrity across the Exchange. While this change is determined to be necessary on the grounds of statutory alignment and thus is independent of the identified data concerns, we will continue to evaluate data on income verification operations on an ongoing basis to assess the impact of this operational change and continue to evaluate opportunities to strengthen program integrity and efficiency.

Comment: Many commenters opposed this proposal, citing concerns that these administrative changes would create consumer and bureaucratic burden which could in turn destabilize the risk pool.

Response: We acknowledge commenters' concerns around administrative burden. However, as discussed in the proposed rule (90 FR 12963), this change is necessary given that the current 60-day extension is inconsistent with the statute, necessitating implementation of this change across the Exchanges. Ultimately, after an analysis of program data, we believe that the positive impact to program integrity will outweigh any negative impacts to the risk pool.

c. Income Verification When Data Sources Indicate Income Less Than 100 Percent of the FPL (§ 155.320(c)(3)(iii))

In the 2025 Marketplace Integrity and Affordability proposed rule (90 FR 12963 through 12967), we proposed to revise § 155.320(c)(3)(iii) to require Exchanges to generate annual household income inconsistencies in certain circumstances when a tax filer's attested projected annual household income is equal to or greater than 100 percent of the FPL and no more than 400 percent of the FPL, while the income amounts returned by the IRS, the SSA, and current income data sources is less than 100 percent of the FPL. This change would re-codify a provision the Department finalized in the 2019 Payment Notice (83 FR 16985), that was later vacated by

the United States District Court for the District of Maryland in *City of Columbus v. Cochran*, 523 F. Supp. 3d 731 (D. Md. 2021), finding there was insufficient evidence of prevalent fraudulent behavior justifying the administrative burden and corresponding coverage impacts. In the proposed rule, we stated that though we believe we had a clear legal basis for finalizing the provisions in the 2019 Payment Notice, we also believe circumstances have changed substantially since the court vacated the prior rulemaking. The Department, in the proposed rule and this final rule, has provided a reasoned justification to reinstate the policy, supported by data and related estimates documenting the consumer harm and significant losses of taxpayer dollars illustrating the reasons this income DMI is necessary. While we previously acknowledged in the 2019 Payment Notice that we did not have firm data on the number of applicants who might be inflating their income to gain APTC eligibility, there is now clear evidence from enrollment data that shows potentially millions of applicants are inflating their incomes or having applications submitted on their behalf with inflated incomes.[118] Additionally, while concerns were raised in *City of Columbus v. Cochran* about consumers who may project a higher income than they receive due to the nature of low-wage work making it difficult to predict their annual household income, we stated that we believe enough consumers – and the agents, brokers, and web-brokers helping them apply – are intentionally inflating their incomes to qualify for fully-subsidized plans that justifies the creation of this income DMI type, as data shows below.

Section 155.320(c)(3)(iii) sets forth the verification process when household income attestations on applications increase from the prior tax year or are higher than trusted data sources indicate. Generally, if income data from our electronic data sources indicate a tax filer's attested projected annual household income is *more than* the household income amount

[118] *See* Hopkins, B.; Banthin, J.; and Minicozzi, A. (2024, Dec. 19). How Did Take Up of Marketplace Plans Vary with Price, Income, and Gender? *American Journal of Health Economics, 1(11*). *https://www.journals.uchicago.edu/doi/10.1086/727785*.

represented by income data returned by the IRS and the SSA and current income data sources, § 155.320(c)(3)(iii) requires the Exchange to accept the attestation without further verification. Currently, Exchanges are generally not permitted to create inconsistencies for consumers when the consumers' attested household income is greater than the amount represented by income data returned by IRS and the SSA and other trusted data sources.

However, in the 2019 Payment Notice (83 FR 16985), we concluded that where electronic data sources reflect household income under 100 percent of the FPL and a consumer attests to household income between 100 percent of the FPL and 400 percent of the FPL and where the attested household income exceeds the income reflected in trusted data sources by more than a reasonable threshold, it would be reasonable to request additional documentation to protect against overpayment of APTC because the consumer's attested household income could make the consumer eligible for APTC when income data from electronic data sources suggest otherwise. Additionally, consumers who have attested household income higher than 100 percent of the FPL, but data sources show income below 100 percent of the FPL, may be motivated to overestimate their income to gain eligibility for APTC where they would not be eligible otherwise, especially in non-Medicaid expansion States. In contrast, consumers who have higher attested annual household income than trusted data sources reflect, but where both the attested and income from data sources is above 100 percent of the FPL, are not motivated to overestimate their income as they would simply receive less APTC. Still today, the risk of APTC overpayments under these circumstances is true because tax filers may be eligible for PTC with household income below 100 percent of the FPL if APTC was paid based on the tax filer having estimated household income of at least 100 percent of the FPL.[119] Barring other changes in circumstance, these tax filers will not have to repay any APTC. That taxpayers are not required

[119] *See* 26 CFR 1.36B-2(b)(6)(i). This rule does not apply if the taxpayer, with intentional or reckless disregard for the facts, provided incorrect information to the Exchange for the year of coverage. *See* 26 CFR 1.36B-2(b)(6)(ii).

to repay APTC in this situation magnifies the need for Exchanges to take additional reasonable steps to verify the household incomes of persons for whom Federal trusted data services report household income of less than 100 percent of the FPL.

In the 2019 Payment Notice (83 FR 16985), we concluded it would be reasonable to request additional documentation to protect against overpayment of APTC despite not having firm data on the number of applicants that might be inflating their income. We viewed this policy as a critical program integrity measure to address the findings from a U.S. Government Accountability Office (GAO) study on improper payments that determined our control activities related to the accuracy of APTC calculations were not properly designed.[120] Specifically, this study found that "CMS does not check for potentially overstated income amounts, despite the risk that individuals may do so in order to qualify for advance PTC."[121]

Based on this finding, the GAO recommended that HHS direct the CMS Administrator to take the following action: "Design and implement procedures for verifying with IRS (1) household incomes, when attested income amounts significantly exceed income amounts reported by IRS or other third-party sources, and (2) family sizes." To support this recommendation, the GAO cited its own testing of 93 applications which found 11 applications for individuals residing in States that did not expand Medicaid where IRS data provided to CMS during application review indicated incomes less than 100 percent of the FPL.[122] After citing these GAO findings and recommendations, we concluded in the 2019 Payment Notice (83 FR 16986) that, particularly to the extent funds paid for APTC cannot be recouped through the tax reconciliation process, it is important to ensure these funds are not paid out inappropriately in the first instance.

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[120] U.S. Government Accountability Office (2017, July). Improper Payments: Improvements Needed in CMS and IRS Controls over Health Insurance Premium Tax Credit. P. 36. https://www.gao.gov/assets/d17467.pdf.
[121] Ibid.
[122] Ibid. at 37.

Though we cited evidence from the GAO study in the 2019 Payment Notice (83 FR 16986), the United States District Court for the District of Maryland in *City of Columbus v. Cochran* stated that HHS "failed to point to any actual or anecdotal evidence indicating fraud in the record."[123] The court went on to conclude that "HHS's decision to prioritize a hypothetical risk of fraud over the substantiated risk that its decision result in immense administrative burdens at best, and a loss of coverage for eligible individuals at worst, defies logic." With this final rule, we believe we have addressed concerns raised in this case through new data illustrating the findings raised in the GAO study.

After the court vacated HHS' income verification requirements, we reviewed data from a recent study analyzing the time period before the original income verification requirement was implemented and found data support that applicants inflated their income. A recent study analyzing CMS enrollment data for the 39 States that used *HealthCare.gov* between 2015 and 2017 found that many people with household incomes too low to qualify for APTC in States that did not expand Medicaid have a strong incentive to attest to income just above the eligibility threshold to obtain APTC.[124] While the data in the study predates the 2019 Payment Notice (83 FR 16986), the study was published in 2024, and identifies vulnerabilities that still exist today following the court's vacatur of the income verification requirement. The study's authors found far higher numbers of enrollees who reported household income just above the income threshold in non-Medicaid expansion States versus Medicaid expansion States. We stated in the proposed rule (90 FR 12964) that we believe this data is a strong indicator that increased enrollment volume since 2021 has exacerbated the vulnerabilities the study identified as existing between 2015 and 2017.

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[123] 523 F. Supp. 3d 731, 762 (D. Md. 2021).
[124] Hopkins, B.; Banthin, J.; and Minicozzi, A. (2024, Dec. 19). How Did Take-Up of Marketplace Plans Vary with Price, Income, and Gender? American Journal of Health Economics, 1 (11). https://www.journals.uchicago.edu/doi/10.1086/727785.

In addition, the study identified that enrollees attested to very precise household incomes that suggested they were aware of the income thresholds to gain eligibility for APTC.[125] This finding is consistent with applicants who did not provide their best household income estimate but instead provided an estimate to maximize the premium and CSR subsidies they receive or were assisted in their applications by entities who were aware of these thresholds and who could profit from their enrollment. In the proposed rule (90 FR 12964 through 12965), we stated that this led us to believe that while some consumers may have difficulty estimating their annual household income due to the uncertainty present in low wage work, many consumers are intentionally inflating their incomes. The study's authors then compared actual enrollment on *HealthCare.gov* for enrollees who reported household income just above the eligibility threshold from $11,760 to $12,500 to estimated potential enrollment from Census surveys and found actual enrollment was 136 percent higher than the total population of potential enrollments.[126]

A more recent analysis of 2024 open enrollment data shows plan selections on *HealthCare.gov* among people ages 19-64 who reported household income between 100 percent and 150 percent of the FPL in non-Medicaid expansion States were 70 percent higher than potential enrollments estimated from Census data at that same income level.[127] Based on this mismatch between enrollment and the eligible population, this study estimates four to five million people improperly enrolled in QHP coverage with APTC in 2024 at a cost of $15 to $20 billion.[128] These data provide substantial evidence that applicants with household incomes below the APTC income eligibility threshold are strategically inflating their household incomes—or, based on evidence described elsewhere in this rule, are getting assistance from agents, brokers, or web-brokers who have a financial incentive to misstate enrollee income to secure

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[125] Ibid.
[126] Ibid.
[127] Blase, B.; Gonshorowski, D. (2024, June). The Great Obamacare Enrollment Fraud. Paragon Health Institute. https://paragoninstitute.org/private-health/the-great-obamacare-enrollment-fraud.
[128] Ibid.

commissions from enrollments of consumers who, absent financial assistance, would not enroll—when they apply for APTC.[129] These individuals are then often being enrolled in fully-subsidized QHPs. We stated in the proposed rule (90 FR 12965) that we believe the scale of actual enrollments in excess of potential enrollments eligible for financial assistance in certain States suggests evidence of improper enrollments, some by agents and brokers.[130] In these cases, enrollees may not even know they are enrolled, and agents, brokers, and web-brokers strategically enroll them at income levels just above the income eligibility threshold so they qualify for fully-subsidized plans. Enrollees never need to pay a premium which would otherwise alert the enrollee to the improper enrollment.[131] Therefore, to strengthen program integrity and reduce the burden of APTC expenditures on taxpayers, we proposed to require all Exchanges to generate annual household income inconsistencies in certain circumstances when applicants report a household income that is *greater than* the income amount represented by income data returned by the IRS and the SSA and current income data sources.

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[129] We note that in the proposed rule (90 FR 12965), we included a table which showed a substantial increase in the percent of returns with APTC that report excess APTC at lower household income levels between 2019 and 2022. We concluded this suggests a substantial increase in people who earn less than the eligibility threshold for PTC who incorrectly report higher incomes and then qualify for APTC, which, in turn, provides further evidence that applicants with household incomes below the APTC income eligibility threshold are strategically inflating their household incomes to qualify for APTC. After reviewing comments and a closer examination of what is driving the increase in the percent of returns reporting excess APTC at lower income levels, we no longer believe these data provide additional evidence that people are strategically inflating their income. While the evidence presented in this final rule continues to strongly support the conclusion that people are inflating their incomes to qualify for APTC after access to fully-subsidized QHPs expanded, we now understand this expanded access to fully-subsidized plans in 2021 led to the increase in the percent of returns with excess APTC at lower income levels for a different reason. The reason stems from a discrepancy in how Exchanges on the Federal platform report the premium for the benchmark plan used to determine the APTC. The premium for the benchmark plan is generally reported as the full amount in dollars and cents while the APTC is rounded to the nearest dollar amount. This reporting discrepancy was generally not an issue before 2021 because everyone was subject to a required contribution percentage greater than zero. Where a required contribution percentage is set at zero, APTC that is rounded up creates excess APTC.

[130] *See* Ibid.

[131] For example, from January 2024 through August 2024, CMS received 183,553 complaints that consumers were enrolled in coverage through an Exchange on the Federal platform without their consent (also known as an "unauthorized enrollment"). Additionally, from June 2024 through October 2024, CMS suspended 850 agents and brokers' Exchange agreements for reasonable suspicion of fraudulent or abusive conduct related to unauthorized enrollments or unauthorized plan switches. CMS (2024, October). CMS Update on Action to Prevent Unauthorized Agent and Broker Marketplace Activity. https://www.cms.gov/newsroom/press-releases/cms-update-actions-prevent-unauthorized-agent-and-broker-marketplace-activity.

Section 155.320(c)(3)(iii)(A) generally requires the Exchange to accept a consumer's attestation to projected annual household income when the attestation reflects a higher household income than what is indicated in data from the IRS and SSA. This approach makes sense from a program integrity perspective when both the attestation and data from trusted data sources are over 100 percent of the FPL, since an attestation that is higher than data from trusted data sources in that situation would reflect a lower APTC than would be provided if the information from trusted data were used instead. However, where electronic data sources reflect income under 100 percent of the FPL, a consumer attests to household income between 100 percent of the FPL and 400 percent of the FPL, and the attested household income exceeds the income reflected in trusted data sources by more than some reasonable threshold, we stated in the proposed rule (90 FR 12966) that we believe it would be reasonable, prudent, and even necessary in light of the program integrity weaknesses just outlined to request additional documentation, since the consumer's attested household income could make the consumer eligible for APTC that would not be available using income data from electronic data sources. In cases where a consumer receives this DMI, but they do legitimately have annual household income above 100 percent of the FPL, we stated that we believe that the existing DMI process and corresponding time frame provides them plenty of time and opportunities to confirm their annual household income with minimal burden.

Sections 1411 through 1414 of the ACA establish the framework for verifying and determining income eligibility for APTC and CSR subsidies. Requiring further documentation for verification when there is an income inconsistency between the household income provided on the application and the income indicated by the IRS and other data sources makes sense within this statutory framework. The statute compels HHS to, at a minimum, submit the income information provided by applicants to the IRS for verification without exception. Without additional documentation or other supporting evidence, HHS would generally deny eligibility for

APTC and CSR subsidies based on the inconsistency with IRS data. When the IRS cannot verify an applicant's income, the statute requires HHS to take additional steps to verify income, thus providing HHS clear discretion to use additional trusted data sources. To support these verifications, section 1413 of the ACA further requires HHS to establish data matching arrangements to verify eligibility through reliable, third-party data sources. However, HHS must also weigh the administrative and other costs of a data matching program against its expected gains in accuracy, efficiency, and program participation, such as when an applicant reports higher household income than reported by trusted data sources and both household income amounts are above 100 percent of the FPL, illustrating no financial incentive for inflating household income. In addition to the program integrity weaknesses discussed previously, we stated in the proposed rule (90 FR 12966) that we believe this statutory framework compels HHS to request additional documentation when applicants attest to household income above 100 percent of the FPL, but trusted data sources show income below 100 percent of the FPL. We requested comments on whether adding these additional data matching issue requirements will outweigh its expected gains as described above.

Accordingly, we proposed to modify § 155.320(c)(3)(iii)(D) and (c)(3)(vi)(C)(2) to specify that Exchanges on the Federal platform would follow the procedures in § 155.315(f)(1) through (4) to create an annual income DMI for consumers if: (1) The consumer attested to projected annual household income that is greater than or equal to 100 percent but not more than 400 percent of the FPL (2) the Exchange has data from IRS and SSA that indicates household income is below 100 percent of the FPL; (3) the Exchange has not assessed or determined the consumer to have income within the Medicaid or CHIP eligibility standard; and (4) the consumer's attested projected annual household income exceeds the income reflected in the data available from electronic data sources by a reasonable threshold established by the Exchange and approved by HHS. We proposed that a reasonable threshold must not be less than 10 percent and

can also include a threshold dollar amount.[132] We sought comments on this proposed reasonable threshold, especially comments that furnish data that could help us ensure that it is properly calibrated to maximize program integrity while minimizing unnecessary administrative burden. Additionally, we stated that this requirement would not apply if an applicant is a non-citizen who is lawfully present and ineligible for Medicaid by reason of immigration status. In accordance with the existing process in § 155.315(f)(1) through (4), if the applicant fails to provide documentation verifying their household income attestation, we stated that the Exchange would redetermine the applicant's eligibility for APTC and CSRs based on available IRS data, which under this proposal would typically result in discontinuing APTC and CSR as required in § 155.320(c)(3)(vi)(G). We further stated that the adjustment and notification process would work like other inconsistency adjustments laid out in § 155.320(c)(3)(vi)(F). We also proposed to modify § 155.320(c)(3)(iii)(A) to add a cross-reference to paragraph § 155.320(c)(3)(iii)(D).

Finally, in the proposed rule (90 FR 12966), we stated that we estimate that answering verification questions and submitting supporting documents would take consumers approximately 1 hour. We stated that we believe such a burden is minimal and is significantly outweighed by the benefit of APTCs for those individuals found to be eligible for them as well as the benefits of reducing improper enrollment. Additionally, even if consumers end up needing longer than the 1-hour estimation due to difficulty in obtaining documentation that may be present, we stated that we believe that the period given to resolve this DMI gives them enough time, and if a consumer ends up needing more time, they are able to request an extension in certain circumstances as described in 45 CFR 155.315(f)(3).

We sought comment on this proposal.

[132] This 10 percent threshold aligns with Annual Income Threshold Adjustment FAQ guidance which was published on 10/22/21 here: https://www.cms.gov/cciio/resources/regulations-and-guidance/income-threshold-faq.pdf

After consideration of comments and for the reasons outlined in the proposed rule and this final rule, including our responses to comments, we are finalizing this policy as of the effective date of this final rule, but with a modification under which the policy and related requirements will sunset for all Exchanges at the end of PY 2026 with a reversion to the previous policy in PY 2027. Like other policies within this rule, we believe it is critical to addressing imminent concerns with improper enrollments related to fully-subsidized plans. As discussed, there is ample evidence of strategic behavior whereby predatory agents, brokers, and web brokers are enrolling people, often without their knowledge, into fully-subsidized plans and, because these individuals often are shielded from ever repaying subsidies, the taxpayer is on the hook for 100% of improperly paid APTCs on their behalf.

We respect the fraught history of this specific policy, however, and understand the importance of targeting it appropriately towards clear and demonstrable fraud concerns. We understand with the expiration of the enhanced subsidies the same concerns may not exist. Thus, we believe this policy should run through the remainder of PY 2025 after the rule is effective and all of PY 2026 to help the Exchanges shed excess improper enrollments and, once the market has readjusted to the changing subsidy environment in PY 2027, the policy will no longer be effective as concerns about holdover improper enrollments from fully-subsidized plans will likely have abetted. This means that, beginning in PY 2027, Exchanges will instead be required to consider an annual household income attestation verified if IRS returns tax data indicating that the household's annual income is less than the application's attestation of annual household income, even if that IRS data is below 100 percent of the FPL in scenarios where the attested projected annual household income would qualify the tax payer as an applicable taxpayer per 26 CFR 1.36B-2(b). As we explain in this section and in section III.B of this final rule, HHS is of the view that implementing this income verification policy in instances where a consumer is attesting to annual household income above 100 percent of the FPL, but IRS data shows income

below 100 percent of the FPL, is a reasonable and necessary step to ensure accurate eligibility determinations based on projected household income during this time of clearly high levels of improper enrollments. However, in consideration of comments, we are finalizing this policy to be applicable only temporarily through the end of PY 2026. Additionally, while in the proposed rule we connected this to the statutory framework, and while it is clear this is allowed by statute, we recognize the statute includes in 1411(c)(4)(B) the provision to weigh the administrative and other costs of a data matching program against its expected gains in accuracy, efficiency, and program participation.

Additionally, independent of comments, we are including a minor modification to remove the reference to 400 percent of the FPL as the maximum to account for possibilities of subsidy eligibility beyond those at 400 percent of the FPL or below. Instead, we are stating that this income DMI is generated in circumstances where the attested projected annual household income would qualify the taxpayer as an applicable taxpayer per 26 CFR 1.36B-2(b). This change also better aligns with existing regulatory text. We summarize and respond to public comments received on the proposed policy to require Exchanges to generate annual household income inconsistencies when a tax filer's attested projected annual household income is equal to or greater than 100 percent of the FPL and no more than 400 percent of the FPL below but income from the IRS shows annual household income below under 100 FPL.

Comment: Some commenters supported the proposal, stating it would improve program integrity, especially as incorrect income estimations threaten program integrity. One commenter stated that the proposal will help address the increase in improper and fraudulent enrollments. Multiple commenters mentioned this will help stop the “backdoor” of getting ineligible people coverage in non-Medicaid expansion States.

Response: We agree that this policy will improve program integrity in response to urgent concerns. Given the large amount of improper behavior cited in the proposed rule and in this

final rule, we agree that this policy may help limit associated improper enrollments largely resulting from fully-subsidized plans. We acknowledge that this is particularly impactful in non-Medicaid expansion States.

Comment: Some commenters expressed support for how the proposal could help the income verification process and the resulting positive effects of that. Multiple commenters believe that this proposal's improved income verification process could help with correct APTC determinations, with one commenter stating they believe these changes would help result in a more stable and affordable marketplace.

Response: We agree that this policy will help with the income verification process by ensuring income verification occurs when consumers may have an incentive to overestimate their income. Implementing this policy may help ensure accurate income amounts and corresponding APTC determinations and we believe that the improvement to the income verification process outweighs any temporary disruptions as the temporary policy assists Exchanges in reducing the current high levels of improper enrollment.

Comment: Some commenters supported our proposal but believed that CMS needs to take further actions to address program integrity issues such as eliminating or limiting the "safe harbor" provision in 26 CFR 1.36B-2(b)(6)(1) or making enrollment pending during the income DMI process rather than allowing for preliminary eligibility.

Response: We appreciate the concerns for program integrity from commenters. We note that HHS does not have regulatory authority over 26 CFR 1.36B-2(b)(6)(1) as this is an IRS regulation. We believe, however, that this policy is the best way to address the specific concern around overestimation of income for these individuals while balancing long-term need to ensure enrollment processes are as efficient as possible. It is not permissible under 1411(e)(4)(B) of the Affordable Care Act to prevent consumers from using their coverage until they submit documents to resolve their income DMIs. Additionally, we maintain that it is important to

balance program integrity with ensuring access to coverage and believe this temporary policy maintains that balance.

Comment: Many commenters expressed concerns that this proposal would negatively impact consumers' ability to enroll in affordable coverage and recommended CMS not finalize the proposal. Specifically, commenters mentioned that the policy would result in a decrease of enrollment and would be a barrier to enrolling in the first place, in part due to the administrative burden of submitting documents to resolve their income inconsistency. Additionally, commenters mentioned expiration of an annual income DMI would typically lead to a loss of APTC, which means consumers would be forced to either drop coverage or pay unaffordable premiums, including if they are in process of appealing their DMI expiration. One commenter mentioned how many sick consumers end up having to take on debt or skip essential bills to pay for coverage after losing their financial assistance.

Response: We understand that some consumers may temporarily end up having their financial assistance reduced or removed, resulting in coverage loss and financial burden. However, the income DMI process allows 90 days[133] to submit documentation, including submitting new documents if their previously submitted documents were deemed insufficient to resolve, and we previously estimated that submitting documentation will only take 1 hour, so we believe that the administrative burden of submitting documents is minimal. Additionally, if consumers need more time to resolve their income inconsistency, they are able to request an extension to the 90-day period on a case-by-case basis. We also emphasize that it is important that consumers receive accurate APTC eligibility to help protect taxpayer spending on APTC, which is why we believe it is important to have this income DMI in place even if some

[133] In section III.A.3.b of this final rule, § 155.315(f)(7) is being removed. This regulation currently requires Exchanges to give an automatic 60-day extension to the 90-day income DMI period if the income DMI has not yet resolved after those 90 days.

consumers are unintentionally harmed through loss of APTC. We acknowledge the concern on how the continued loss of APTC occurs even during the appeals process but emphasize that it is important for consumers to resolve their income DMI before it expires to maintain continuous financial assistance and not end up having to go through an appeal. It is important to note that these are temporary measures enacted in response to unprecedented concerns over improper enrollments.

Comment: Many commenters stated that loss of coverage and financial barriers would result in poor health outcomes for many consumers, such as relying more on emergency services and threatening the ability of consumers to make timely, informed, and autonomous decisions about their health, in particular related to pregnancy. Many of these commenters stated these negative health outcomes would be compounded for those who are already experiencing difficulties in accessing health care. Additionally, nearly all community health centers that commented on this proposal stated that this would disproportionally affect consumers who use their services, resulting in negative health outcomes for them. Given this, these commenters did not recommend we finalize this proposal.

Response: While we understand the concerns of the commenters, we want to emphasize that many of these annual household income attestations are inaccurate and are made by agents, brokers, and web-brokers without consumers' knowledge as a part of other potentially inappropriate activity such as unauthorized enrollments, which can lead to consumers experiencing hardship when they go to use health coverage and find out they are enrolled in a plan they were unaware of. These are largely functions of the incentives and opportunities created by the existence of fully-subsidized plans and these outcomes in themselves represent consumer harms that we also must attempt to mitigate. By making this policy temporary to address these imminent concerns while Exchanges shed excess improper enrollment, we believe we strike the right balance of program integrity with long-term enrollment policy efficiencies.

Comment: Many commenters stated they are concerned that low-income consumers who would be more affected by this proposed policy have a much more difficult time than other consumers in predicting and verifying income due to unpredictable income. They stated this is compounded by the fact that Exchange eligibility is based on future income, rather than previous years' income, and therefore tax data is typically not able to accurately predict and verify their expected future annual household income. Additionally, some commenters pointed out that these lower income consumers typically are not required to file taxes, so they are more likely to not have tax data available to verify their income. Many commenters also listed reasons why a consumer may have unpredictable income— such as starting a new job or losing a job, pay raises, plans to work more in the future—and stated that consumers should not be penalized for these changes by losing APTC eligibility after DMI expiration.

Response: We acknowledge that consumers with more unpredictable income may have a more difficult time estimating their income. We have made improvements over the years to account for this concern, including creating an income calculator tool that we recommend consumers use if they are having difficulty estimating their income.[134] Additionally, we understand that income can change throughout the year and highly recommend that consumers update their Marketplace application when their household income changes to ensure they are receiving the most accurate eligibility determination. We also emphasize that in scenarios where new consumers to the Exchange may not have tax data available because they were not previously required to file tax returns, they would not receive the type of income DMI described in this policy, as this policy specifically generates an income DMI in scenarios where IRS returns data under 100 percent of the FPL but consumers attest to annual household income above 100 percent of the FPL. Without having filed taxes, they would not have IRS data returned for them

[134] https://www.healthcare.gov/income-calculator/.

and would therefore not generate the type of income DMI described in this policy, though they may be impacted by other income verification policies in this rule such as the one described in section III.B.3.d. Finally, even if a consumer would normally not be required to file a tax return due to their income, notifications include language to remind consumers that once they have received APTC, they are required to file a tax return to reconcile their APTC. As these policies are temporary, we believe they strike the right balance between urgent program integrity concerns and long-term enrollment efficiencies.

Comment: Many commenters stated how it is more difficult for low-income consumers to submit documents to resolve their DMIs. Specifically, they stated it can be more challenging to find documents that show their predicted annual household income because common documents such as tax documents and paystubs are either inaccurate or not available. One commenter requested that we add to this final rule what documentation CMS would accept for this new income DMI to prove anticipated income.

Response: We provide a robust list of acceptable documents that households can submit to resolve their income DMIs, many of which clearly can convey future year income and including potential documents self-employed consumers can submit, and include this list in multiple consumer notices and on CMS' website.[135] We recommend that consumers who cannot obtain tax forms or paystubs that reflect their projected household income submit other suggested income documents that may be more available and accurate.

Comment: Many commenters specifically noted the challenges that gig workers would face with this proposal. Commenters mentioned how this type of work has grown substantially since the ACA was passed, and recommended that CMS reconsider how this proposal and general verification processes account for the realities of the gig economy. One commenter stated

[135] https://www.healthcare.gov/help/how-do-i-resolve-an-inconsistency/#household-income.

that nearly a third of all gig workers are uninsured, and that 48 percent believe their work status has made it more difficult to access health insurance. One commenter suggested that CMS needs to do additional research around economic and employment trends since the ACA passed, with a particular focus on gig workers, and consider flexible updates related to that.

Response: We appreciate the concern for gig workers. We are aware of how gig workers may have a more difficult time verifying their income and we have made operational changes over the past few years to improve how our systems and processes better account for the types of documents gig workers may use to verify their income. Regarding what documents gig workers should submit to verify their annual household income, we recommend they submit a self-employment ledger that outlines whose income it includes, where the income is from, the start date of the income, either the frequency (such as biweekly) of the income or the end date, and the specific income amounts. This can include documents from employers that employ gig workers or from online services that outline this information. We are open to additional changes and improvements to better assist consumers working in the gig economy on getting and staying in coverage. However, we do not believe that this policy is especially burdensome for consumers with legitimate income attestations and will help prevent fraudulent attestations from continuing to receive improper financial assistance. That said, by making this policy temporary, we believe we strike the right balance of program integrity with long-term enrollment efficiencies.

Comment: Many commenters expressed concerns about how this policy would impact the risk pool. Specifically, commenters stated that younger consumers, who are also typically healthier, tend to have lower and less predictable streams of income. Commenters also mentioned that healthier consumers are less motivated to get insurance, particularly when they encounter administrative burdens such as additional required paperwork, while sick consumers are often more motivated to overcome administrative barriers to coverage. Commenters stated that all of this results in fewer young and healthy consumers entering the risk pool, which would

result in increased premiums for everyone, leading to a decrease in enrollment and increased health care costs for everyone.

Response: We disagree that requiring additional documents is a large administrative burden that will result in young, healthier, less motivated consumers not getting insurance. The 90 days Congress provided under the statute gives consumers sufficient time to identify documents and resolve their income DMI, and we estimate that identifying and submitting documentation for an income DMI typically takes consumers only 1 hour. The Department is of the view that younger individuals generally are accustomed to requirements to prove their eligibility for a variety of benefits and activities, including proving their identities and incomes, such that dedicating a single hour to verification activities is unlikely to lead to significant numbers of young persons abandoning their insurance applications once the process is started. Additionally, we are finalizing this policy temporarily to help the Exchange address urgently high levels of improper enrollments while balancing long-term enrollment efficiencies. This limited period of effectiveness will mitigate any adverse impacts on the risk pool that might result if this policy dissuades younger, healthier persons to abandon their applications for insurance.

Comment: Many commenters expressed concerns about the costs and burdens for this proposal on Exchanges. Commenters mentioned that they believe the proposal would increase administrative costs and be operationally challenging for Exchanges to implement, and that Federal funds would be better spent elsewhere. Many also said that State Exchanges do not currently have appropriated funds or other financial resources to implement this change by the applicability date of 60 days after this rule's finalization, with one State Exchange unsure if they can implement it at all due to their State's limits on how they can use Federal tax information. Finally, one commenter stated it was unclear that money would be saved through unspent APTC.

Response: We acknowledge the costs associated with implementing this proposal. We are confident that the Exchanges on the Federal platform can implement this proposal by the rule's effective date and are not concerned with implementation operations. Additionally, we believe that the costs associated with implementing and operating this policy are justified, as this is a critical program integrity measure to ensure consumers who may not be eligible for APTC are not erroneously receiving APTC throughout the entire plan year. Because of that, while we understand State Exchanges are concerned about the implementation and ongoing costs, we believe that the program integrity gains outweigh the potential costs to State Exchanges. Additionally, by requiring Exchanges to sunset this proposal starting in PY 2027, operational costs for Exchanges will only occur for the remainder of PY 2025 after this rule's effective date and all of PY 2026, resulting in lower costs to Exchanges for operations over time. As illustrated later in the regulatory impact analysis section of this rule, we estimate that APTC savings will be greater than operational costs.

Comment: Some commenters expressed concerns about potential administrative and cost burdens to other interested parties such as issuers and health care professionals who help consumers enroll. Commenters mentioned how historical data has illustrated that administrative complexity and uncertainty result in an increase in operational and administrative costs for issuers, particularly for smaller issuers and those serving in rural communities, which typically results in those costs being passed on to consumers.

Response: As outlined in the regulatory impact analysis section of this rule, the administrative and cost burden is minimal in comparison to the APTC savings. We will ensure that information on this policy, how it affects consumers and other interested parties, and best steps to address and easily resolve income DMIs are readily available to issuers and other interested parties. We will make sure this is made available on HHS' public-facing website within 60 days of the effective date of this rule to help all interested parties be prepared to

address this policy with their clients and, therefore, minimize potential burden. Additionally, we believe benefits on program integrity likely outweigh potential minimum administrative or cost burdens on issuers, especially due to the temporary nature of the provisions to address program integrity while Exchanges adapt to the changing subsidy environment, as the primary concern is related to fully-subsidized plans, which are due to dramatically decrease in PY 2026 prior to the provisions sunsetting in PY 2027. We reiterate our commitment to helping interested parties understand and account for changes in this rule.

Comment: Many commenters did not agree with the assertion that numerous consumers are intentionally overestimating their income. These commenters did not believe we provided enough evidence of such behavior being widespread. Additionally, many commenters stated that these discrepancies between attestation and final annual household income are due to consumers honestly projecting their annual household income to be above 100 percent of the FPL but instead finishing the year with their actual annual household income below it, such as due to working less than anticipated or because of the difficulty of estimating future year income. A few commenters also pointed towards the enhanced subsidies causing more people to enroll in the Exchange and as a result, simply having more discrepancies. As a conclusion, many commenters believed that this proposal would not improve program integrity, with many stating that nothing has changed since this DMI type was vacated by the court in *City of Columbus v. Cochran*, and therefore recommended against finalizing the policy as proposed.

Response: We acknowledge that many consumers may be estimating their household income accurately based on the best information available to them at the time. However, we have also identified data suggesting that consumers—or agents, brokers, or web-brokers assisting them—may be intentionally misestimating income. As laid out in the proposed rule, one study illustrated that many consumers attested to very precise annual household income amounts,

suggesting that they knew the exact income thresholds to gain eligibility for APTC[136]. For people who attested to those precise thresholds, this same study found that enrollment in corresponding plans was 136 percent higher than the total population of potential enrollments. These numbers, combined with other data sources that are cited and discussed earlier in this section III.A.3.c of the preamble, show clear indications of some consumers intentionally attesting to annual household income just above 100 percent of the FPL to gain APTC eligibility they may not have been eligible for with a more accurate annual household income attestation.

While we believe this was also the case during the time that the 2019 Payment Notice originally implemented this proposal, we did not have clear data available to outline in the 2019 Payment Notice illustrating this, something that is mentioned in *Columbus v Cochran* as a reason why this policy was originally struck down. However, given the data we now have now as set forth in the proposed rule, higher enrollment data illustrates that this problem is much more prevalent than it was prior to 2021. We respect the concerns many have with this proposal and, as such, are finalizing a temporary policy targeted at the most demonstrable program integrity concern – fully-subsidized plans and the holdover improper enrollment that data suggests will persist temporarily following the expiration of the expanded subsidies. After allowing this policy to work to right-size enrollment to ensure those receiving subsidies are eligible for such subsidies, this policy will sunset as the reduction in fully-subsidized plans reduces the urgency of its program integrity features.

Comment: Some commenters, while they agreed with the widespread problem of improper payment of APTC caused by overinflating incomes above 100 percent of the FPL, did not believe that this proposal is the best way to address it. Most of these commenters believed that CMS should focus on improving agent, broker, and web-broker enforcement rules, as many

[136] Blase, B.; Gonshorowski, D. (2024, June). The Great Obamacare Enrollment Fraud. Paragon Health Institute. *https://paragoninstitute.org/private-health/the-great-obamacare-enrollment-fraud*.

commenters believed they primarily are driving this fraudulent behavior. Some commenters also expressed concerns with the Exchanges on the Federal platform's usage of Enhanced Direct Enrollment (EDE) platforms, claiming that having third parties host the eligibility and enrollment platform allowed agents, brokers, and web-brokers to more easily engage in fraud or improper behavior.

Response: We acknowledge commenters' concerns that some agents, brokers, and web-brokers are fraudulently attesting to household income on behalf of consumers, oftentimes without their knowledge, and that this is often done through direct enrollment pathways. Both States and the Federal Government are taking steps to address agents, brokers, and web-brokers participating in actions or schemes that result in improper enrollments. We have increased program integrity measures aimed at non-compliant agents, brokers, and web-brokers, including, for example, requiring agents, brokers, and web-brokers to perform a three-way call with their client and the HealthCare.gov call center to effect certain changes to some consumers' applications or coverage. We also work closely with EDE partners on program integrity issues. Improving program integrity may require multiple approaches, and we believe this policy will work well in partnership with agent, broker, and web-broker enforcement actions to help prevent this type of improper behavior.

Comment: Many commenters expressed concerns with the data and studies the proposed rule cited as proof of program integrity concerns. These commenters cited concerns related to studies' methodology and analytical approach, limitations and usage of data, inconsistent income definitions, and that they did not account for other factors at the same time such as the COVID-19 PHE and Medicaid disenrollment. Many commenters stated that the estimation of 4-5 million fraudulently enrolled consumers is inaccurate and an overestimation. One commenter also stated that CMS should gather more data to see how program integrity changes made in 2024 have

affected this fraudulent behavior and wait to implement this proposal until that is available to show the impact of those policies.

Response: We disagree with the commenters' concerns on the validity of data sources utilized in the proposed rule to support the proposal. We believe the various data sources cited suggest that households are fraudulently attesting to income directly above the FPL. Notwithstanding, in light of commenters' concerns and as explained in section V.C.18 of this final rule, we are finalizing this policy so that it will be applicable only for PY 2026, providing further opportunities to monitor this policy's effects instead of codifying it to be applicable indefinitely. We clarify that consumers will have the opportunity in the DMI process to show through documents that their attestation of estimated household income is accurate. We will continue to monitor and collect data regarding DMIs and how changes, such as those made in 2024 and this final rule, have impacted enrollment.

Comment: A handful of commenters mentioned that CMS should address better how Medicaid and CHIP eligibility intersects with the population of consumers who may overestimate their income for Exchange coverage. They state that some consumers may be eligible for Medicaid or CHIP one month but not the next, meaning that it is possible they could be eligible for Exchange coverage in those months they are not Medicaid/CHIP eligible. Some commenters pointed out how many State Exchanges have more robust integration with Medicaid and CHIP eligibility systems, resulting in more accurate and timely eligibility determinations. One commenter also sought clarification on why the Exchanges on the Federal platform would fail to determine if someone is Medicaid or CHIP eligible.

Response: We acknowledge commenters' concerns regarding the intersection of the Medicaid and CHIP population and the Exchange population. We continue to improve on our integration with State Medicaid and CHIP agencies to facilitate Medicaid and CHIP eligibility determinations, but we do not currently have the same capabilities as State Exchanges. However,

we do collect both monthly and annual projected income as a part of the application process for the Federal Exchange, and we base Medicaid eligibility on monthly, not annual, income. Exchanges on the Federal platform determines or assesses eligibility for Medicaid and CHIP based on State rules for eligibility. If a consumer was previously determined eligible for Medicaid or CHIP, but their income has changed such that they believe they will no longer be eligible for Medicaid or CHIP coverage, we encourage them to return to the Exchange to update their income and receive an updated eligibility determination.

Comment: All State Exchanges, as well as many other commenters, expressed concerns related to the proposed requirement for State Exchanges to implement this proposal. Most commented that State Exchanges do not have the type of fraudulent behavior this proposal attempts to address because nearly all State Exchanges have expanded Medicaid. States also said they are not seeing any indication of agents, brokers, or web-brokers purposefully overestimate income to be above 100 percent of the FPL in their State. Some also commented that they do not have agents, brokers, web-brokers or EDE partners in their Exchange, which they attribute in part for the lack of this type of program integrity concern. Additionally, some commenters mentioned that many State Exchanges have more robust and cost-effective income verification processes, and that implementing this new requirement would stifle innovation.

Response: We appreciate that State Exchanges may not have experienced the same challenges of agents, brokers, and web-brokers improperly overestimating income resulting in improper payment of APTC. We also acknowledge that many State Exchanges have robust income verification processes and can integrate well with additional data sources and their State's Medicaid and CHIP programs and appreciate that State Exchanges continue to ensure accurate income eligibility determinations. However, the persistently high levels of fraud associated with fully-subsidized plans, which are widely available on both Federal and State Exchanges, lead us to still believe this is a vital program integrity policy that is important for all

Exchanges, including State Exchanges, to implement. Specifically, data illustrated in this section of the preamble shows that all States, including State Exchanges in non-Medicaid expansion States, experience some instances of consumers overestimating their annual household income. Even in States where this may occur in lower numbers, we still believe it is vital to have this policy in place to ensure that these consumers' annual household income is fully verified and they are receiving the correct eligibility determinations. However, given these concerns by State Exchanges, we believe that instituting the requirement that all Exchanges sunset this proposal after PY 2026 will balance the need for program integrity with overall costs to Exchanges. This modification is also intended to be responsive to State Exchange comments noting that this measure may not be necessary to ensure program integrity in these State Exchanges in the long term. We also acknowledge that while we have found that agents, brokers, and web-brokers intentionally overestimate income, consumers also often intentionally overestimate their annual household income without the assistance of an agent, broker, or web-broker, so we believe this is still necessary in State Exchanges that choose not to allow agents, brokers, or web-brokers on their Exchange. As this is primarily a function of the incentive and opportunity created by the expanded subsidies, we believe it to be necessary to implement on all Exchanges until excess improper enrollment levels have abetted. We reiterate that State Exchanges will continue to be able to check additional income data sources after IRS to attempt to verify a household's income which may minimize the burden of reviewing paper documents submitted for verification.

Comment: Some commenters believed that, in addition to making this proposal optional for State Exchanges, CMS should only implement this proposal for States that have not expanded Medicaid. Commenters recommended this because consumers in non-expansion States with annual household incomes below 100 percent of the FPL may fall in a "coverage gap" because they do not meet the income requirements for Medicaid in their State or for APTC. Such consumers typically do not have another affordable option for coverage available. Given this,

those consumers are potentially motivated to intentionally overestimate their income in order to gain eligibility for APTC. In contrast, consumers in expansion States do not fall into this "coverage gap" and therefore have less reason to intentionally overestimate their income since they likely will be eligible for Medicaid or CHIP if their income is below 100 percent of the FPL and they meet all other eligibility criteria.

Response: We understand commenters' concerns that consumers in Medicaid expansion States may have less motivation to intentionally overestimate their annual household income than those in non-expansion States. In order to balance urgent program integrity concerns with long-term operation costs and enrollment efficiencies, we are sunsetting this policy after PY 2026. We do want to emphasize that agents, brokers, and web-brokers who are intentionally misrepresenting a household's annual household income attestation are motivated to do so regardless of Medicaid expansion status, as any commissions they are trying to receive that are tied to those enrollments would occur regardless. We also note the potential selection issues that may exist among people who reside in Medicaid expansion States with State Exchanges who may take advantage of the lack of income verifications to select coverage through State Exchanges with APTC over Medicaid based on their health status. To the extent coverage through State Exchanges provides better access to providers or other benefits to people with higher health care needs compared to Medicaid, the lack of income verification could harm the individual market risk pool.

Comment: A few commenters requested that CMS delay the implementation of this proposed rule, with the earliest timeline suggested being the beginning of PY 2026 rather than 60 days from the effective date of the final rule, given concerns about operational challenges and administrative burdens, especially for issuers.

Response: We do not believe that a delay in implementing this rule is necessary or appropriate given it is a temporary policy designed to address urgent program integrity concerns.

Exchanges on the Federal platform are able to implement this policy by the final rule's effective date, and, given the minimal implementation burden on the Federal Exchange, we believe State Exchanges should similarly be able to implement this policy by the rule's effective date. With respect to concerns about burden on issuers, CMS will ensure that issuers are informed of the change in policy and what they should do to help enrollees, both current and new, prepare for potentially receiving a DMI ahead of the policy's implementation. Additionally, since consumers will still receive the full time period to resolve their income DMI and receive temporary eligibility during that period as is the case for other DMI types, we believe issuers will have enough time to help their enrollees determine documents to submit to resolve their DMI before clients' DMIs would potentially expire and result in loss of APTC. Given that the time frame of when this type of DMI could actually expire and affect an enrollee's coverage is at least 150 days from the rule's effective date (accounting for this policy's implementation of 60 days after the rule's effective date and the 90 days households have to resolve this type of DMI), as well as our plans to inform and prepare issuers for this change, we believe that this implementation timeline is feasible for issuers.

Comment: Some commenters suggested other types of improvements to the income verification processes. Many of these commenters encouraged Exchanges on the Federal platform to use other data sources to verify income, such as the State Wage Information Collection Agency; data from State agencies that have unemployment or human service programs; and the National Directory of New Hires. They suggested that using such additional data sources would reduce the reliance on Federal tax data, align better with State Exchanges that use some of these data sources, and help the APTC verification process become more streamlined and accessible. One commenter said that Exchanges should be required to leverage income data through the Verify Current Income Hub, as this would help reduce improper enrollments and better direct consumers to the correct coverage pathway, and that the data's

accuracy and efficiency outweighs the cost of using the service. One commenter suggested that Exchanges on the Federal platform should implement a "facilitated enrollment" program. Some commenters suggested changes to how APTC and PTC work, including basing APTC on prior year income and working with Congress on legislation changes on APTC recoupment rules.

Response: We appreciate the comments with additional ways in which Exchanges on the Federal platform can improve the income verification process. We continue to explore utilizing additional data sources to verify income as well as other innovations and improvements. However, additional data checks would take additional time and resources to set up and integrate with existing processes, and some of the data sources State Exchanges utilize are unavailable on the Federal level. As outlined in 155.320 (c)(3)(vi)(A), the Federal Exchange must weigh whether the available data will provide sufficiently accurate income information for enough consumers to justify the costs of both connecting to these data sources and continuing to pay for the data. Additionally, we do not believe that those would replace the need for this policy, as even with additional trusted data sources available to potentially verify household income above 100 percent of the FPL, there will still be consumers for whom the Exchange is unable to verify household income. We would like to clarify that we currently use the Verify Current Income Hub that one commenter suggested but continue to allow State Exchanges flexibility in what additional data sources they use beyond IRS.

Comment: One commenter stated that because this policy was originally vacated in *City of Columbus v. Cochran*, the proper place to contest this is in court rather than through this rule.

Response: We believe that the proposed and final rule address the concerns raised in *City of Columbus v. Cochran* and therefore reinstating this policy via rulemaking is appropriate. Specifically, we have provided additional data demonstrating that consumers overestimate their income so it is above 100 percent of the FPL when IRS data sources show their income is below 100 percent of the FPL in order to be determined eligible for APTC. Additionally, circumstances

have changed since the original proposal in the 2019 Payment Notice with many more consumers being aided by agents, brokers, or web-brokers, some of whom have used this gap in the income verification process to enroll consumers with subsidies without their knowledge, making setting income DMIs for this population even more needed than it was in the original 2019 Payment Notice proposal.

Comment: One commenter expressed concerns that that the proposed language could allow a State to perform Periodic Data Matching (PDM) more than twice a year, resulting in consumers erroneously losing their coverage without any legitimate increase in program integrity.

Response: We clarify that this proposal does not relate to PDM. This proposal only refers to the process that occurs when a consumer applies for coverage or updates their Marketplace application, and does not involve Exchange-initiated verification of income.

Comment: Some commenters expressed concern that we are denying APTC to low-income consumers if they do not immediately verify with tax data.

Response: We clarify that if tax data from the IRS does not verify an applicant's attestation of annual household income, we then check other available income data sources and, if those do not verify their attested annual household income, the household would be given an income DMI. The applicant would be given 90 days[137] to submit documentation to verify their projected annual household income, during which time the applicant would be given temporary eligibility for financial assistance based on their application attestation allowing them to use APTC to enroll in coverage. It is only after that 90-day period has passed that the household, if they had not yet verified their income DMI, would have their APTC decreased based on tax data,

[137] In section III.A.3.b of this final rule, § 155.315(f)(7) is being removed. This regulation currently requires Exchanges to give an automatic 60-day extension to the 90-day income DMI period if the income DMI has not yet resolved after those 90 days.

potentially to zero if IRS data indicates they would be ineligible for APTC altogether. Given this, we highly recommend consumers submit documents to verify their income during that 90-day period to ensure they maintain their financial assistance and health coverage, and, if they need more time beyond that 90-day period, they can request additional time on a case-by-case basis.

Comment: We requested comments on our proposal's minimum income threshold of 10 percent for all Exchanges, and the inclusion of an optional dollar amount. This minimum income threshold is utilized by Exchanges to compare an applicant's attested annual household income with income amounts provided from trusted data sources or documents submitted by the applicant. This information allows the Exchange to determine whether applicant's attested annual household income is within a reasonable threshold of the income reported from a trusted data source or documents, such that the Exchange can consider the applicant's attested annual household income verified. Comments on the threshold proposal were mixed. Most commenters believed that 10 percent is not a generous enough threshold as it does not account for variability in projected annual household income from documents, but there was no consensus on whether 20, 25, or 50 percent was the correct percentage. One commenter cautioned CMS against having too generous of a threshold, as they believed this could lead to income being verified despite substantial variation between attested annual household income and income from trusted data sources or documents, but they did not suggest an alternative threshold. None of these commenters mentioned the inclusion of an optional dollar amount.

Response: We appreciate the comments on the proposed minimum threshold amount and would like to clarify that this is simply a minimum, and not a maximum, threshold level that all Exchanges must have. Because Exchanges may have a threshold higher than the one specified in regulation, no commenters requested a threshold lower than the 10 percent threshold or recommended against including an optional dollar amount as considered in the proposed rule, and because no comments were received expressing concerns with the ability to include an

optional dollar amount in addition to the percentage difference, we are finalizing this as proposed, and will not specify a specific threshold dollar amount or provide flexibility for Exchanges to adopt one.

d. Income Verification When Tax Data is Unavailable (§ 155.320(c)(5))

In the 2025 Marketplace Integrity and Affordability proposed rule (90 FR 12967 through 12968), we proposed to remove § 155.320(c)(5), which requires Exchanges to accept an applicant's or enrollee's self-attestation of projected annual household income when the Exchange requests tax return data from the IRS to verify attested projected annual household income, but the IRS confirms there is no such tax return data available. This requirement currently operates as an exception to the requirement to verify household income with other trusted data sources under § 155.320(c)(1)(ii) and the alternative verification process under § 155.320(c)(3)(vi). These provisions generally require that, in the event the IRS and other trusted data sources cannot resolve a DMI, applicants must submit documentary evidence or otherwise resolve the DMI with the inconsistent information source. Therefore, by removing this exception, this proposal would require Exchanges to verify household income with other trusted data sources when tax return data is unavailable and follow the full alternative verification process.

As we detailed previously in this preamble, there is a growing body of evidence that shows a substantial number of improper enrollments on the Exchanges. Some agents, brokers, and web-brokers and applicants are taking advantage of weaknesses in the Exchanges' eligibility framework to enroll consumers in coverage with APTC subsidies without their knowledge and when consumers are not eligible. We believe the recent change in the 2024 Payment Notice (88 FR 25818 through 25820) to allow applicants to self-attest to income when IRS data is unavailable may have contributed to weakening the Exchange eligibility system.

We made the change to accept attestation when HHS successfully contacted the IRS but IRS data was unavailable because we believed that the standard alternative verification process was overly punitive to consumers and burdensome to Exchanges when IRS data is unavailable. To explain the punishing aspects of the prior alternative verification process, we itemized the legitimate reasons for a tax return to be unavailable aside from a consumer's failure to file a tax return, including tax household composition changes (such as birth, marriage, and divorce), name changes, or other demographic updates or mismatches. We then concluded the consequence of receiving an income DMI and being unable to provide sufficient documentation to verify projected household income outweighs program integrity risks as, under § 155.320(c)(3)(vi)(G), consumers are determined completely ineligible for APTC and CSRs.

After revisiting this issue, we stated in the proposed rule (90 FR 12967) that we no longer believe the prior alternative verification process was overly punitive. We stated that our use of the term punitive to characterize the process improperly suggests the process involved a punishment when the process solely involved establishing eligibility to receive a government benefit and did not involve a judgment to mete out consequences of bad behavior. Instead, the process focused on ensuring that applicants are eligible for APTC to both protect against making improper payments and to protect the applicant from accumulating unnecessary tax liabilities. In the proposed rule, we stated that as we reassess the current verification process, we note that the existence of legitimate reasons for tax return data to be unavailable does not diminish the need to have an accurate estimate of income. As discussed previously, an accurate household income estimate is a critical program integrity element of the ACA's framework for verifying and determining eligibility for APTC.

In making our reassessment, we investigated the difficulty of providing documentation to verify household income and believe eligible applicants can meet the requirement with relative ease. People with legitimate reasons for not having tax data available like marriage, the birth of

child, name changes, and other demographic updates would have the opportunity to be verified through other trusted data sources. However, if other trusted data sources cannot verify the household income and applicants must provide documentation, we previously estimated (88 FR 25893) that consumers would take 1 hour to submit documentation on average. We sought comment on the accuracy of this estimate of administrative burden. We stated in the proposed rule (90 FR 12967) that we believe eligible applicants would likely have documentation to verify their household income as readily available to them as the standard tax filer without an income DMI.

For these people, prior to the implementation of the 2024 Payment Notice, we found that half of all resolved income DMIs generated when IRS income data was unavailable were resolved within 90 days. Therefore, to the extent applicants failed to resolve their income DMI, we believe this largely reflects how the prior process successfully stopped ineligible people from enrolling.

Regarding the burden on Exchanges, we previously estimated the administrative task under the prior policy accounts for approximately 300,000 hours of labor annually on the Federal platform. We concluded this was proportionally mirrored by State Exchanges, which may also access approved State specific data sources to verify income data. We expect APTC subsidized enrollment to be lower in the coming years.

Considering the amount of improper enrollments under the current policy, we stated in the proposed (90 FR 12967) rule that we believe this administrative burden of requiring people with an income DMI due to unavailable IRS data to provide documentation to verify income is more than offset by the program integrity benefits.

In addition to the policy concerns mentioned above, we stated in the proposed rule (90 FR 12967) that the Department now believes this policy violates statutory requirements for verifying income under section 1411(d) of the ACA and addressing income inconsistencies under

section 1411(e)(4)(A) of the ACA, including by restricting Exchanges from using the process under § 155.315(f)(1) through (4), as well as 1411(c)(4)(B) and 1412(b)(2). We previously stated in the 2024 Payment Notice that the requirements for Exchanges under § 155.320(c)(5) complied with section 1411(c)(4)(B) of the ACA and section 1412(b)(2) of the ACA, but stated in the proposed rule (90 FR 12967), that we believe our previous statutory justifications for this policy were mistaken and inconsistent with Congress' intent.

Therefore, to strengthen the program integrity of the eligibility determination process for APTC, we proposed to remove § 155.320(c)(5).

We sought comment on this proposal.

After consideration of comments and for the reasons outlined in the proposed rule, this final rule, and our responses to comments, we are finalizing this policy as proposed, but with a modification under which the policy and related requirements will sunset for all Exchanges at the end of PY 2026. Beginning in PY 2027, the income verification policy under § 155.320(c)(5), which was in effect prior to the finalization of this rule, will become effective again. As we explain in this section and in section III.B of this final rule, HHS is of the view that the best way to address program integrity concerns created by the proliferation of fully-subsidized plans policy is to require further verification when the IRS reports no tax return data is available for a tax-filer. Notwithstanding, we share concerns related to the risk of coverage loss by low-income persons. For this reason, we will codify this policy to be applicable only from this rule's effective date until the end of PY 2026 to balance these concerns.

We summarize and respond to public comments received on the proposed policy below.

Comment: Many commenters supported the proposal, including many advocacy groups and issuers who stated the proposal would reduce fraud. Additionally, one professional association and one advocacy group supported the proposal because it would protect enrollees against surprise tax bills by verifying attested information.

Response: We appreciate the commenter's support and agree that this proposal will help mitigate currently high levels of fraud in Exchanges. An accurate annual household income estimate is a critical program integrity element for verifying and determining eligibility for APTC. We believe that verifying annual household income with other trusted data sources and then following the alternative verification process when a tax return is unavailable will strengthen program integrity.

We also agree with the commenters who stated that removing this exception to verification of annual household income may protect consumers from incurring large tax liabilities, due to incorrect income information. Once these provisions have helped reduce holdover fraud from the expansion of subsidies, they will go away.

Comment: Some commenters supported the proposal but provided recommendations such as: providing exceptions for certain situations, providing State Exchanges with implementation flexibility, ensuring Exchanges are prepared to implement this proposal without undue harm to consumers, requiring Exchanges to check additional data sources when tax data is unavailable, obtaining new data sources for income verification (such as the National Database for New Hires), and delaying implementation.

Response: We appreciate the commenters' recommendations on additional ways to improve the income verification process. We do not agree that exceptions to the verification process should be provided because the policy is temporary in nature and that would not align with our goal of addressing urgent program integrity concerns. Once these policies sunset at the end of PY 2026, the requirement for Exchanges to accept an applicant's or enrollee's self-attestation of projected annual household income when the Exchange requests tax return data from the IRS to verify attested projected annual household income, but the IRS confirms there is no such tax return data available will once again apply to all Exchanges.

Comment: Most professional associations, provider groups, and advocacy groups opposed this proposal, stating that it would create barriers for vulnerable consumers, increase administrative costs, and destabilize the risk pool because these changes could increase adverse selection because sicker individuals have greater incentive to put in the time and effort necessary to resolve income verification issues.

Response: We acknowledge commenters' concerns around administrative burdens like cost and potential extra verifications steps and risk pool impacts. Reintroducing income verification for applicants for whom no tax return data is available would increase burden on some applicants, but the currently high level of improper enrollments, which we believe to be driven by the incentives and opportunities created by the expanded subsidy regime, call for immediate action to improve program integrity. That said, we understand that reactions to crisis levels of improper enrollments may not strike the right balance with proper enrollment access over the long term and, as such, are making this policy temporary. Additionally, while in the proposed rule we connected the need to use alternative income verification methods when the IRS returns no data to the statutory framework, and while the proposal is allowed by statute, we recognize the statute includes in section 1411(c)(4)(B) the provision to weigh the administrative and other costs of a data matching program against its expected gains in accuracy, efficiency, and program participation. In response to comments detailed later in this section related to consumer and State Exchange burden and risk pool concerns, and as explained in section III.B. and elsewhere in this final rule, we are finalizing this policy to be effective only through the end of the PY 2026. This will allow this policy, as well as the other policies in this rule, to reduce the high levels of holdover improper enrollments while mitigating long-term burden.

Comment: Some providers, provider groups, and organizations expressed concern that it could take vulnerable enrollees longer than 1 hour to submit documentation related to this income verification requirement.

Response: We recognize that it may take certain consumers longer than 1 hour to submit documentation related to this income verification requirement, and note that the 1-hour estimate is an average. However, there are no data to support an alternative estimate of the time it would take a consumer to submit income verification documentation.

Comment: Many commenters who opposed the proposal believed that when self-attestation does not match trusted data sources, this is not indicative of fraud, but rather people whose income fluctuates often or dramatically enough that their projected household annual income would not match records for previous years.

Response: We acknowledge the commenters' concern about the variable nature of consumer income. We proposed to require Exchanges verify household income when data from the IRS is unavailable. This is different from when a consumer's attestation does not match trusted data sources. If the additional verification processes result in the consumer's attestation not matching the trusted data sources, the Exchange would generate an income DMI. We acknowledge that many income DMIs are created by eligible consumers and during the income DMI resolution process, eligible consumers have the opportunity to verify their income using a list of acceptable documents. Nevertheless, based on the data set forth in this rule, we maintain our concern that agents, brokers, and web-brokers may make improper attestations without consumers' knowledge leading to unauthorized enrollments, and that further income verification is needed to protect consumers from the resulting harm.

Comment: Many State Exchanges opposed this proposal, stating that it would cause unnecessary income DMIs and significantly increase administrative burdens for applicants and members and lead to coverage erosion that would adversely affect the States' risk pool since younger people are more likely to not have IRS data available.

Response: We acknowledge the increase in DMIs that may result from finalization of this proposal. We believe that the increases in program integrity outweigh the increased

administrative burdens that may be encountered and believe that it is necessary to ensure accurate projected household income attestations and eligibility determinations. Although reintroducing income verification for applicants with no tax return data would increase the burden on some applicants, we do not anticipate this burden would deter many eligible people from enrolling. This is because eligible applicants would likely have documentation other than tax information, such as pay stubs, to verify their household income as readily available to them as the standard tax filer who is verified through the IRS. Because of the availability of these documents to verify annual household income, the removal of § 155.320(c)(5) would not deter many eligible people from enrolling and will not destabilize the risk pool, especially given the provision's temporary nature

Comment: Multiple States stated that State Exchanges should retain flexibility to determine the income verification processes and procedures necessary and appropriate to meet program integrity standards when determining eligibility for coverage and financial assistance. Some States also opposed implementing this policy on the grounds that the problem it would address is not present on their State Exchanges according to internal State analysis.

Response: We appreciate the various comments highlighting how this program integrity risk looks different for State Exchanges and the recommendation to allow State Exchanges to retain flexibility to determine income verification operations. We acknowledge that many State Exchanges have robust income verification processes and can integrate well with additional data sources and their State's Medicaid and CHIP programs and appreciate the State Exchanges continue to ensure accurate income eligibility determinations. States have existing flexibilities, such as the option to call other data sources if the IRS does not have data available when verifying income, therefore we do not believe that additional flexibilities in implementing this rule are necessary. For this reason and others outlined in section III.B of this final rule, we think the temporary nature of this sunset modification is also intended to be responsive to State

Exchange comments noting that this measure may not be necessary to ensure program integrity in these State Exchanges in the long term.

Comment: Two Tribal organizations opposed this proposal because it would create barriers to enrollment for American Indian and Alaskan Native people who are not required to file taxes. They stated that the proposal would complicate enrollment, delay access to care, and increase administrative strain on Exchanges.

Response: We acknowledge that there are cases where consumers, including Tribal members, are exempt from filing Federal income taxes and thus the IRS may have no tax data upon which to verify the consumer's household income. Tax data, however, is not the only way for Exchange applicants to verify annual household income. When tax return data is unavailable to immediately verify a consumer's attestation of annual household income, the Exchange would trigger the rest of the verification and data matching process. Specifically, an Exchange can check other available income data sources and, if those do not verify the annual household income, the household would be given an income DMI. During the 90-day period, they would be given temporary eligibility for financial assistance based on their application attestation and can use that APTC to enroll in and start coverage. It is only after that 90-day period has passed that the applicant or tax-filer, if they had not yet resolved their income DMI, would have their APTC decreased based on available tax data. The Department is of the view that this 90-day period provided under statute provides ample time for applicants to provide proof of their household income before their APTC is reduced. While we understand this may result in negative outcomes for some consumers and increased administrative burden on the Exchanges, we believe implementing this policy is necessary due to the program integrity benefits and protection of consumers enrolled without their knowledge. The temporary nature of this policy strikes the right balance between urgent program integrity concerns and long-term enrollment efficiencies.

Comment: Some commenters expressed concern that APTC would be denied to consumers if they do not have IRS data available to verify their income.

Response: We clarify that when tax return data is unavailable to immediately verify a consumer's attestation of annual household income, they would go through the rest of the verification and data matching process. Specifically, we then check other available income data sources and, if those do not verify the annual household income, the household would be given an income DMI. During the 90-day period, they would be given temporary eligibility for financial assistance based on their application attestation and can use that APTC to enroll in and start coverage. It is only after that 90-day period has passed that the household, if they had not yet verified their income DMI, would have their APTC decreased based on tax data, potentially to zero. Given this, we highly recommend consumers submit documents to verify their income during that 90-day period to ensure they maintain their financial assistance and health coverage.

6. Premium Payment Threshold (§ 155.400)

In the 2025 Marketplace Integrity and Affordability proposed rule (90 FR 12974 through 12976), we proposed to modify § 155.400(g) to remove paragraphs (2) and (3), which establish an option for issuers to implement a fixed-dollar and gross percentage-based premium payment threshold (if the issuer has not also adopted a net percentage-based premium threshold), and modify 155.400(g) to reflect the removal of paragraphs (2) and (3). Under these provisions, issuers on the Exchanges can implement (1) a percentage-based premium payment threshold policy; and (2) a fixed-dollar premium payment threshold policy. However, to preserve the integrity of the Exchanges, we stated in the proposed rule that we believe it is important to ensure that enrollees do not remain enrolled in coverage for extended periods of time without paying at least some of the premium owed, and therefore proposed to limit issuers to the net percentage-based premium payment threshold established in the 2017 Payment Notice (81 FR 12271), and modified in the 2026 Payment Notice (90 FR 4475 through 4478) to allow issuers to

set at 95 percent of the net premium or higher. We are finalizing these changes as proposed with the following modification: the removal of the fixed-dollar and gross-premium threshold flexibilities will sunset after the completion of one new coverage year, PY 2026, on December 31, 2026.

In the 2026 Payment Notice (90 FR 4475 through 4478), we implemented an option for issuers to establish a fixed-dollar premium payment threshold policy, under which issuers can consider enrollees to have paid all amounts due during the following circumstance: the enrollees pay an amount that is less than the total premium owed and the unpaid remainder of which is equal to or less than a fixed-dollar amount of $10 or less, adjusted for inflation, as prescribed by the issuer. In addition, we implemented a gross percentage-based premium payment threshold policy, under which issuers can consider enrollees to have paid all amounts due when the enrollee pays an amount that is equal to or greater than 98 percent of the gross premium, including payments of APTC, as prescribed by the issuer. If an enrollee satisfies the fixed-dollar or gross percentage-based premium payment threshold policy, the issuer may avoid triggering a grace period for non-payment of premium or avoid terminating the enrollment for non-payment of premium. However, these premium payment thresholds may not be applied to the binder payment.

As we noted in the proposed rule (90 FR 12975), we have compiled data regarding enrollments effectuated during the OEP. Those data reflect a continuing increase in improper enrollments on the Exchanges. For example, in December 2024 HHS received 7,134 consumer complaints of improper enrollments, an increase from the 5,032 complaints received in December 2023. We stated in the proposed rule (90 FR 12975) that although these numbers

represent a decrease from the high of 39,985 complaints received in February 2024,[138] the fact that the number of complaints for 2024 remains substantially higher than for 2023 demonstrates that previous program integrity measures[139] have not resulted in a decrease in improper enrollments, and additional measures are necessary to prevent rampant waste and abuse of Federal funds and protect consumers from surprise tax liabilities and other negative impacts that may flow when consumers are enrolled in coverage without their knowledge. We further stated that this has caused us to reconsider the need for additional program integrity measures, as reflected throughout this proposed rule, and in particular whether the new premium threshold provisions appropriately safeguard program integrity and whether the value of the new premium threshold provisions outweighs the potential harms to program integrity. We also explained that given the increased need to protect program integrity reflected in the enrollment data, and the limited probability that any issuer has implemented one of the new types of available premium threshold policies, we believe the burden of eliminating these policies on issuers and consumers is outweighed by the potential increase in program integrity.

We stated in the proposed rule that under both the fixed-dollar and gross percentage-based thresholds, it is possible for enrollees in certain circumstances to avoid paying premium for multiple months before entering delinquency or losing coverage. For example, an enrollee whose premium after the application of APTC was $1 (and where the issuer had adopted a $10 premium threshold policy) could, after paying binder, not pay any premium for the next 9 months before they would enter delinquency, and due to the APTC grace period would not have

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[138] From internal HHS data, using the most recent numbers available. HHS has previously published data on consumer complaints of unauthorized enrollments, such as in the update published in October 2024. CMS (2024, October). CMS Update on Action to Prevent Unauthorized Agent and Broker Marketplace Activity. *https://www.cms.gov/newsroom/press-releases/cms-update-actions-prevent-unauthorized-agent-and-broker-marketplace-activity.*

[139] Measures such as those announced in our update from October 2024 on preventing unauthorized agent and broker activity. CMS (2024, October). CMS Update on Action to Prevent Unauthorized Agent and Broker Marketplace Activity. *https://www.cms.gov/newsroom/press-releases/cms-update-actions-prevent-unauthorized-agent-and-broker-marketplace-activity*.

coverage terminated for an additional 3 months (though the termination would be effective the last day of the first month of grace). In instances where an issuer implemented a gross premium threshold of 98 percent, an enrollee's gross premium might be $600, making their threshold $12; if the consumer owed $2 after application of APTC, they could, after paying binder, not pay any premium for the next 6 months before they would enter delinquency, and due to the APTC grace period would not have coverage terminated for an additional 3 months (though the termination would be effective the last day of the first month of grace). We stated in the proposed rule (90 FR 12975) that this policy therefore increases the risk that improper enrollments remain undetected, since the enrollee is less likely to receive invoices, and a delinquency[140] or termination notice alerting them to the improper enrollment in the case that the individual or entity submitting the improper enrollment used false contact information. In addition, we stated that an enrollee who stops paying premiums in the belief that this would lead to termination of coverage may instead find that the coverage has continued for several months due to the issuer having implemented a fixed-dollar or gross percentage-based premium threshold, with the additional risk that the enrollee has accumulated a large amount of debt if the issuer has adopted a gross premium percentage-based threshold and the enrollee's pre-APTC premium is much higher than the de minimis $10 fixed-dollar threshold. We noted that, in contrast, this is not the case with the long-established net percentage-based threshold, under which enrollees must always pay at least some premium to avoid delinquency or loss of coverage (in cases where the premium is not covered 100 percent by APTC).

As we explained in the proposed rule (90 FR 12976), because of these program integrity concerns, we remain concerned that these policies allow enrollees to unknowingly remain in

[140] Per § 156.270(f), if an enrollee is delinquent on premium payment, the QHP issuer must provide the enrollee with notice of such payment delinquency. Issuers offering QHPs in Exchanges on the Federal platform must provide such notices promptly and without undue delay, within 10-business days of the date the issuer should have discovered the delinquency.

coverage they did not consent to be enrolled in or remain in coverage that they no longer need or are utilizing, if a third party or agent, broker, or web-broker paid the enrollee's binder payment on their behalf in order to effectuate enrollment. In the October 10, 2024 **Federal Register** (89 FR 82366 through 82369), we provided an analysis of Exchange data for PY 2023, where we found that there were 184,111 total policies terminated for non-payment in which $10 or less was owed by the enrollee, representing approximately 12.25 percent of the total number of policies terminated for non-payment that year. As such, in the proposed rule, we estimated that, if finalized, the proposed rule would likely result in about 184,111 policy terminations after application of the available grace period. We noted that this would likely be representative of both enrollees who desired coverage but failed to take the necessary action, and enrollees who were unaware of their coverage either because they had intended for it to terminate due to nonpayment, or because they were improperly enrolled by agents, brokers, or web-brokers.

In the proposed rule (90 FR 12976), we stated that we have also become aware of instances in which consumers who are enrolled in Medicaid are, without their knowledge or consent, enrolled into unwanted QHP coverage with APTC for which they are not eligible. In 2024, we received 44,151 complaints alleging that Medicaid beneficiaries were enrolled without their consent into QHP plans, of which 12,954 were deemed medically urgent.[141] These cases have caused disruptions in coverage for consumers, due to Medicaid's refusal to pay for services[142] when the consumer is enrolled in a QHP, and has also caused delays in payments to health care providers. As noted previously, we stated that we expect that the removal of these premium threshold options would make it more difficult for some agents, brokers, and web-brokers to keep consumers enrolled without their knowledge or consent, and thereby reduce the potential for these kinds of disruptions in coverage.

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[141] *See* § 156.1010(e)

[142] As required by section 1902(a)(25) of the Social Security Act, Medicaid is the payer of last resort.

We refer readers to the proposed rule (90 FR 12974 through 12976) for a more detailed discussion of our proposal.

We sought comment on this proposal.

After consideration of comments and for the reasons outlined in the proposed rule and this final rule, including our responses to comments, we are finalizing this policy as proposed for all Exchanges, with the following modification: the removal of the fixed-dollar and gross-premium threshold flexibilities will sunset after the completion of one new coverage year, PY 2026, on December 31, 2026. This will address the urgent improper enrollment concerns previously noted, and allow the Department to collect additional data on the effects of this policy. Thereafter, the FFE and SBE-FPs will, and State Exchanges may, offer issuers the flexibility to implement the premium payment thresholds outlined in the 2026 Payment Notice (90 FR 4424). We summarize and respond to public comments received on the proposed modifications to the premium payment thresholds below.

Comment: Most commenters opposed the proposal because removing premium payment thresholds could create barriers to coverage for low-income enrollees who struggle to pay full premiums. For example, many commenters stated that health center patients are disproportionately financially strained compared to other patients, and that 61 percent have incomes below 200 percent of the FPL.

Response: We recognize that it may be more difficult for low-income consumers to pay premiums but believe that the urgent concern of addressing the high level of improper enrollments driven in part by individuals not paying any premium outweighs, at least temporarily, the burdens associated with enrollees being terminated for failure to pay a portion of their premium. Once the high levels of improper enrollment have been addressed, those concerns may no longer persist. The Department also acknowledges that collection of additional data, as well as gaps or losses in coverage due to this provision would be possible under a more

permanent policy, and in response to comments, the Department is finalizing this policy so that it addresses the urgent program integrity concerns in PY 2026 without ongoing effects after PY 2026.

Comment: Some commenters opposed the proposal because it could disproportionately impact vulnerable populations, increase the uninsured rate, and destabilize insurance markets. Commenters stated that consumers with chronic conditions might be able to utilize either the gross-premium percentage-based or fixed-dollar thresholds to avoid coverage gaps. Commenters also stated that the resulting loss of coverage could lead to poorer outcomes and increased healthcare costs. Many commenters stated that the additional thresholds allow issuers to focus on collecting most of the premium rather than pursuing small outstanding amounts that might lead to coverage loss.

Response: We agree that it is in the best interest of all enrollees to remain in steady coverage that they desired to obtain. However, under a fixed-dollar or gross premium percentage-based threshold, a consumer could unknowingly remain in unwanted coverage for a longer period of time than under the net premium percentage-based threshold before entering delinquency, while also accumulating debt, a dynamic that has been exacerbated by the currently high levels of improper enrollment.

Comment: Many commenters stated that removing the fixed-dollar and gross premium percentage-based thresholds would not address program integrity concerns, since both require the enrollee to pay their binder in full before such thresholds would apply. One commenter recommended that HHS increase efforts to monitor third party premium payments so that agents and brokers are not paying binder payments or subsequent premiums, and noted that some issuers have seen increased third party payment activity in recent months, and would appreciate the Exchange's increased vigilance to monitor third party premium payments, particularly as these payments do not fall under the exceptions at § 156.1250.

Response: We disagree that rescinding the fixed-dollar and gross premium percentage-based thresholds would not address program integrity concerns, because although payment of binder is required, both policies permit issuers to keep consumers enrolled in coverage for multiple months without making any payments or otherwise indicating they are aware of the coverage they are enrolled in. This policy balances the urgent need for program integrity with the long-term desire for flexibility and enrollment efficiencies.

Comment: Many commenters stated that the proposed rule did not provide sufficient evidence that agent and broker fraud has anything to do with premium payment thresholds or that these flexibilities have been abused by anyone. In addition, commenters stated that the data on unauthorized enrollments from PYs 2023 – 2024 did not reflect the effect that new premium payment policies would have on improper enrollments because these provisions did not take effect until January 15, 2025. Commenters recommended instead that CMS wait to rescind these thresholds until there has been sufficient time to gather and analyze data on the impacts of these new premium payment thresholds and continue to prohibit fixed-dollar thresholds for binder payments.

Response: As we noted previously, CMS continues to observe a high level of unauthorized enrollments, which we attribute largely to the proliferation of fully-subsidized plans. Although the fixed-dollar and gross percentage-based premium thresholds have only been in place for a short amount of time, the Department believes that allowing the use of fixed-dollar and gross percentage-based premium payment thresholds by issuers at this time is likely to exacerbate this problem at a critical period. In order to protect consumers from fraudulent enrollments and ensure that they are only enrolled in healthcare coverage that they want and need, rather than in coverage that they are unaware of and do not want, we believe it is important to safeguard against potential vulnerabilities added to this dynamic by the fixed-dollar and gross-premium thresholds. As with other policies, this addresses the imminent program integrity

concerns while reverting back to the previous policy once the market has had a year to address the lack of expanded subsidies.

Comment: One commenter stated that CMS is inappropriately prioritizing concerns about enrollees' future tax liabilities over the potential for future health care liabilities.

Response: We disagree that we are prioritizing concerns about enrollees' future tax liabilities over the potential future health care liabilities. This temporary policy balances urgent program integrity concerns with the long-term desire for flexibility and enrollment efficiencies.

Comment: One commenter stated that if enhanced PTCs expire at the end of 2025, many more people will be enrolled in plans with nominal premiums (rather than fully-subsidized premiums) in future years, exacerbating the risk of disenrollment due to nonpayment of small premium amounts.

Response: Although expiration of the enhanced subsidies may lead to an increase in the number of enrollees whose coverage is terminated for non-payment, including non-payment of small amounts of premium, it is also important to ensure that consumers are protected from improper enrollment. Temporarily eliminating the fixed-dollar and gross percentage premium thresholds, while maintaining the net premium thresholds, appropriately strikes a balance between ensuring that Exchange enrollees do not lose coverage for owing only a small percent of their net premium, while ensuring they do not remain enrolled in coverage for extended periods of time without paying any premium. After allowing the temporary program integrity policies in this rule to help the Exchanges shed the currently high levels of improper enrollment, our policies revert back to those in effect prior to this rule, balancing urgent program integrity needs with long-term desire for flexibility and enrollment efficiencies.

Comment: Several commenters stated that disruptions due to non-payment terminations may mean a loss for providers of anticipated reimbursement revenue and an increase in

uncompensated care—further challenging the financial health of health centers, which will lead to less access to care for patients.

Response: We recognize that temporary interruptions in care may mean a temporary loss of revenue for providers and increase uncompensated care. However, since issuers have not yet implemented either the fixed-dollar or gross premium percentage-based thresholds, the risk of lost revenue is minimal as a result of this temporary policy.

Comment: Several State Exchanges and State-specific advocacy organizations stated that this provision would limit the ability of their State to manage their own unique health insurance market, where most State Exchanges already see lower rates of fraud.

Response: We appreciate these comments and concerns raised by State Exchanges, but we maintain that the policy proposals above are an appropriate balance of temporary measures to address urgent program integrity concerns with long-term flexibility for State Exchanges. The temporary actions are necessary to protect consumers from accruing large tax liabilities and ensure program integrity, but the rule reverts back to existing policy once immediate concerns have been addressed, and State Exchanges regain the flexibility those policies created. Given our expectation that the expiration of enhanced subsidies will substantially decrease improper enrollments, the Department believes it is reasonable to adopt certain policies temporarily in response to commenter concerns.

Comment: Several commenters stated that issuers have historically managed payment thresholds and are best positioned to implement these thresholds due to their deep understanding of enrollee needs and local market dynamics.

Response: While issuers have insight into payment habits of their enrollees, Exchanges must provide guardrails to ensure the integrity and affordability of their markets.

Comment: Several commenters stated that many issuers may have already made substantial investments to implement the new thresholds. Reversing course now could render

those investments as sunk costs and could exert modest upward pressure on premiums. Commenters also stated that promoting continuous coverage contributes to a more stable and balanced risk pool, and in turn reduces premiums.

Response: We recognize that some issuers may have begun implementation of one or both of these premium payment thresholds. However, we believe that the urgent program integrity concerns outlined in this final rule outweigh the costs that may be associated with issuers modifying their systems to eliminate the fixed-dollar and gross percentage-based premium payment thresholds. Further, these measures are temporary and work to implement these premium payment thresholds will be relevant once again as issuers prepare for PY 2027.

Comment: A few commenters supported the proposal because of its intention to address existing program integrity concerns.

Response: We agree that eliminating the fixed-dollar and gross percentage-based premium payment threshold will address program integrity concerns, as it will ensure that consumers must always pay some amount of their monthly premium (at least 95 percent) and will prevent consumers, especially those who are victims of unauthorized enrollments, from accruing significant premium debts. We believe finalizing these proposals through PY 2026 strikes the right balance in addressing urgent program integrity concerns with long-term desires for flexibility and enrollment efficiencies.

Comment: One commenter stated that the grace period for premium payments would be shortened with the finalization of this rule.

Response: We clarify that this final rule does not modify the grace period for enrollees receiving the benefit of APTC described in § 156.270(d).

Comment: One commenter stated that the net premium threshold amount (which must be at least 95 percent of net premium) was being modified with this proposal.

Response: We clarify that this final rule does not modify the net percentage-based premium payment threshold described in § 155.400(g)(1).

7. Annual Open Enrollment Period (§ 155.410)

In the 2025 Marketplace Integrity and Affordability proposed rule (90 FR 12976 through 12979), we proposed to amend § 155.410(e), which provides the dates for the annual individual market Exchange OEP in which qualified individuals and enrollees may apply for or change coverage in a QHP. Specifically, we proposed to add § 155.410(e)(5) and (f)(4) to change the OEP for benefit years starting January 1, 2026, and beyond so that it begins on November 1 and runs through December 15 of the calendar year preceding the benefit year and to set an effective date of January 1 for QHP selections received by the Exchange on or before this December 15 OEP end date. The Exchange OEP is extended by cross-reference to non-grandfathered individual health insurance coverage, both inside and outside of an Exchange, under the guaranteed availability regulations at § 147.104(b)(1)(ii). We also proposed conforming revisions to § 155.410(e)(4) and (f)(3).

In previous rulemaking, we have adjusted the length of the OEP to account for various circumstances impacting the stability of the risk pool, Exchange operations, and the consumer experience (see Table 4). In setting the OEP, as we explained when we set the initial enrollment period in the Exchange Establishment Rule (77 FR 18387), we attempt to balance the risk of adverse selection—a situation where individuals with higher risk are more likely to select coverage than healthy individuals—with the need to ensure that consumers have adequate opportunity to enroll in QHPs through an Exchange.

TABLE 4: Summary of Open Enrollment Period Length for Exchanges on the Federal Platform (PY 2014-2027)

Plan Year	OEP Start Date	OEP End Date	Duration (Days)	Notes
2014	10/1/2013	3/31/2014	182	Lengthy first enrollment period to allow time for consumers to explore new options and to raise awareness.
2015	11/15/2014	2/15/2015	93	Planned OEP for PY 2015 was October 15 to December 7, but challenges and delays meant the OEP was extended.
2016	11/1/2015	1/31/2016	92	Proposed a shorter OEP but finalized more modest change primarily to limit the burden of a shift on Exchanges still experiencing implementation challenges.
2017	11/1/2016	1/31/2017	92	
2018	11/1/2017	12/15/2017	45	Cleanup for late Exchange activity[143] occurred between December 16, 2017 and December 23, 2017 for the 39 States that used *HealthCare.gov*.
2019	11/1/2018	12/15/2018	45	Cleanup for late Exchange activity[144] occurred between December 16, 2018 and December 22, 2018 for the 39 States that used *HealthCare.gov*.
2020	11/1/2019	12/15/2019	45	Cleanup for late Exchange activity[145] occurred between December 16, 2019 and December 21, 2019, which included the additional time from December 16-18 provided to consumers who were unable to enroll by the original deadline.
2021	11/1/2020	12/15/2020	45	Cleanup for late Exchange activity[146] occurred between December 16, 2020 and December 21, 2020 for the 36 States that used *HealthCare.gov*.
2022	11/1/2021	1/15/2022	76	
2023	11/1/2022	1/15/2023	76	
2024	11/1/2023	1/16/2024	77	In 2024, January 15 was a Federal holiday; accordingly, consumers had until midnight on Tuesday, January 16 (5 a.m. EST on January 17) to enroll in coverage.
2025	11/1/2024	1/15/2025	76	
2026	11/1/2025	1/15/2026	76	
2027	11/1/2026	12/15/2026	45	

Sources: Marketplace Open Enrollment Period Public Use Files and Marketplace Open Enrollment Fact Sheets

Consistent with our original policy establishing a December OEP end date for PY 2015 that promotes a full year of coverage, we maintained an OEP set to November 1 to December 15 for PYs 2018, 2019, 2020, and 2021. During this time, we observed several benefits from a 45-day OEP that ends on December 15 for coverage starting January 1 compared to OEPs ending on

[143] *See* CMS (2018). Public Use Files: FAQs, *https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/marketplace-products/downloads/2018_public_use_file_faqs.pdf*.
[144] *See* CMS (2019). Public Use Files: FAQs. *https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/marketplace-products/downloads/2019publicusefilesfaqs.pdf*.
[145] *See* CMS (2020). Public Use Files: FAQs. *https://www.cms.gov/files/document/2020-public-use-files-faqs.pdf*.
[146] *See* CMS (2021). Public Use Files: FAQs. *https://www.cms.gov/files/document/2021-public-use-files-faqs.pdf*.

February 15 for benefit year 2015 and January 31 for benefit years 2016 and 2017. As discussed in the 2022 Payment Notice proposed rule (86 FR 35167 through 35168), prior enrollment data suggested that the majority of new consumers to the Exchange selected plans prior to December 15 so they had coverage beginning January 1. We stated in the proposed rule (90 FR 12978) that we believe this data shows consumers became accustomed to the deadline. Also, we stated that it reduces consumer confusion by aligning more closely with the open enrollment dates for other coverage for many employer-based health plans. We also observed that consumer casework volumes related to coverage start dates and inadvertent dual enrollment decreased in the years after the December 15 end date was adopted, suggesting that the consumer experience, as well as program integrity, was improved by having a singular deadline of December 15 to enroll in coverage for the upcoming plan year. We noted how confusion over the deadline could cause someone to wait until January 15 and miss out on a whole month of coverage. In addition, the extended OEP requires enrollment assisters to stretch budget resources over an additional month.

In the 2022 Payment Notice proposed rule (86 FR 35168), we also identified negative impacts from a 45-day OEP that ends on December 15. In particular, we observed that consumers who receive financial assistance, who do not actively update their applications during the OEP, and who are automatically re-enrolled into a plan are subject to unexpected plan cost increases if they live in areas where the second lowest-cost silver plan has dropped in price relative to other available plans. In this situation, consumers would experience a reduction in their allocation of APTC based on the second lowest-cost silver plan price but are often unaware of their increased plan liabilities until they receive a bill from the issuer in early January, after the OEP has concluded. We noted that extending the OEP end date to January 15 would allow these consumers the opportunity to change plans after receiving updated plan cost information from their issuer and to select a new plan that is more affordable to them. We also noted concerns from some Navigators, certified application counselors (CACs), agents, and brokers regarding a lack

of time to fully assist all interested Exchange applicants with comparing their different plan choices. In light of these negative impacts, we sought comment on whether an extended OEP would provide a balanced approach to provide consumers additional time to make informed choices and increase access to health coverage, while mitigating risks of adverse selection, consumer confusion, and issuer and Exchange operational burden. While some commenters expressed substantial concern over these risks, we concluded the experience from State Exchanges that extend their OEP suggested an extension in January does result in increased enrollments and would not introduce adverse selection into the market. Therefore, we concluded the negative impacts of an OEP ending in December justified extending the OEP to end on January 15 for PY 2022 and beyond. This extension to the OEP has now been in place for PYs 2022, 2023, 2024, and 2025. We refer readers to Table 4 for a summary of OEPs in effect from PY 2014 to PY 2025.

We noted in the proposed rule that with our experience implementing this extended OEP over the past 4 years, we have had the opportunity to more closely assess whether this extension achieves the right balance between an adequate opportunity to enroll in a QHP and the added risk for adverse selection, consumer confusion, and unnecessary burden on issuers and Exchanges. This assessment reveals that only a small number of consumers took advantage of the additional time to switch to a lower-cost plan after receiving a bill from their issuer in January with higher plan costs. During the most recent OEP, fewer than 3 percent of enrollees (470,000 individuals) ended their FFE or SBE-FP coverage between December 15, 2024, and January 15, 2025, including those enrollees who switched to other plans as well as those who did not. We also compared the enrollment growth for Exchanges on the Federal platform to State Exchanges under the previous December 15 end date. While most State Exchanges (12 out of 20) use the same enrollment schedule as Exchanges on the Federal platform, 7 State Exchanges use

enrollment windows past January 15.[147] For the best comparison, we focused on enrollment among people enrolled in APTC subsidized plans without CSRs. This controlled for the variable of whether States expanded Medicaid or not.[148] From 2017 (the year before the end date changed to December 15) to 2021 (the last year of the December 15 end date), we found that Exchanges on the Federal Platform experienced a larger (47 percent) growth in enrollment among people who enrolled in coverage with only APTC compared to 28 percent growth among people enrolled with only APTC through State Exchanges. This suggests the change to the December 15 OEP end date did not compromise access to coverage for people selecting plans through the Exchanges on the Federal platform. Some of these people may have switched to a more affordable plan after receiving a bill in January with unexpected plan costs. However, we stated in the proposed rule (90 FR 12978) that we expect that upon finalizing the proposed addition of §155.335(n), a higher proportion of enrollees will actively re-enroll and compare their plan options prior to December 15, reducing the need for changes after December 15. To the extent people are switching coverage during the extended period, this may also be due, in part, to improper plan switching. In the 2024 OEP for Exchanges on the Federal platform, 1,490,000 consumers were added to coverage between 12/15 and 1/15. Overall, this is about 9 percent of all consumers (~16.4 million) who selected coverage in the entire 2024 OEP. After implementation of a shorter OEP, we expect some portion of these 1,490,000 consumers will adjust their behavior and enroll earlier, some portion will acquire coverage through another means, and the remainder will miss the opportunity to enroll due to this change to the OEP duration.

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[147] *See* CMS. (2024, Oct. 17). State-based Marketplaces: 2025 Open Enrollment. *https://www.cms.gov/files/document/state-exchange-oe-chart-py-2025.pdf*.

[148] Whether or not a State expanded Medicaid affects the lower end of the CSR eligibility income range. In States that have expanded Medicaid, the lower income threshold for CSR eligibility is 138 percent of the FPL, while in non-expansion States it is 100 percent of the FPL. As a result, whether or not a State has expanded Medicaid can have a substantial impact on enrollment differences between States.

As we have noted elsewhere, we recently began receiving substantially more consumer complaints alleging improper enrollments by agents and brokers who switch enrollees to new QHPs offered on the Exchange or update enrollees' current policies without their knowledge, to capture commissions.[149] However, in the proposed rule, we also noted that when the enhanced subsidies made available under the ARP and IRA expire at the end of 2025, plan costs for the majority of Exchange enrollees will increase, so there may be an increase in the proportion of enrollees seeking to drop coverage or change plans for PY 2026 after December 15, 2025. Due to changing plan costs, enrollees may need more time to make their PY 2026 plan selections. We sought comment on whether to delay the effective date for the proposal to update the OEP end date until the OEP preceding PY 2027, given the special circumstances for PY 2026 financial assistance.

Based on the foregoing analysis, we stated in the proposed rule (90 FR 12979) that we do not anticipate that changing the OEP end date from January 15 to December 15 would have a negative impact on a consumer's opportunity to enroll in QHPs through an Exchange. We sought comment on how changing the OEP end date to December 15 would impact QHP enrollment opportunities, consumer confusion, and burden.

In making this proposal, we stated in the proposed rule (90 FR 12979) that the OEP plays a crucial role in protecting the stability of the individual market risk pool within the structure of the ACA. Adverse selection remains a serious concern under the ACA's guaranteed availability and modified community rating requirements. The average plan liability risk score in the individual market remains substantially higher than the small group market, showing that higher-than-average risks continue to select into the individual market. This higher risk leads to higher premiums for those who purchase coverage through the individual market.

[149] Based on internal CMS data, in the first 3 months of 2024, we received 50,000 complaints of improper enrollments and 40,000 complaints of improper plan switches attributed to agent or broker noncompliant behavior.

We understood there was still an ongoing risk of adverse selection when we decided to extend the OEP end date to January 15. However, we concluded this risk of adverse selection was outweighed by the benefits of increased consumer enrollments and opportunities to switch plans for consumers with unexpected plan costs.

In the proposed rule (90 FR 12979), we stated that our new analysis of this experience extending the OEP to end January 15 suggests that these benefits did not materialize. Accordingly, without any clear benefit, we stated that we no longer believe the benefits of the OEP extension outweigh the risk of adverse selection. We sought comment on whether the risk of adverse selection supports changing the OEP end date to December 15.

We anticipated in the proposed rule (90 FR 12979) that if an OEP end date of December 15 were finalized, this change would apply to all Exchanges, including State Exchanges, for the 2026 coverage year and beyond.

Given our proposal to adopt a standard OEP, we sought comment on whether we should also prohibit Exchanges from extending an OEP through application of a blanket SEP. Where available, we requested that comments include data demonstrating the impact of the OEP end date on enrollment and adverse selection. Additionally, we sought comment on the overall effects and impacts of OEP duration and OEP placement within the calendar year, including suggestions regarding the ideal duration and placement to minimize adverse selection and maximize consumer choice.

We sought comment on this proposal.

After consideration of comments and for the reasons outlined in the proposed rule and this final rule, including our responses to comments, we are finalizing this policy with the following modifications: the changes to the OEP period will take effect beginning with the OEP for PY 2027 and the rule will provide flexibility for all Exchanges within set parameters. Newly added § 155.410(e)(5)(i) states that the OEP must begin by November 1 of the year preceding the

coverage year and must end by December 31 of the year preceding the coverage year. Newly added § 155.410(e)(5)(ii) limits all Exchange OEPs to a maximum of nine weeks in duration. Each State's Exchange OEP is also extended by cross-reference to non-grandfathered individual health insurance coverage outside of the Exchange per § 147.104(b)(1)(ii). Thus, beginning with the OEP for PY 2027, the dates of the OEP each year for Exchanges operating on the Federal platform will be November 1 through December 15 of the preceding year; however, the final rule provides flexibility for all Exchanges, including those on the Federal platform, to adjust OEP dates, within the outlined parameters, in future years as operational processes evolve.

For example, in some cases the timelines and operations established by Exchanges for premium rate filings and consumer noticing may currently preclude beginning the OEP earlier than November 1. In addition, while some Exchanges already have a December 31 cutoff date for January 1 coverage, many Exchanges, including the Exchanges on the Federal platform, have generally made coverage effective on February 1 when a plan selection is made between December 16 and December 31. Per § 155.410(f)(4), as finalized in this rule, all plan selections made during the OEP must be effective as of January 1 of the plan year. Therefore, in order to elect a December 31 end date to the OEP, the Exchange and its issuers must be capable of making coverage effective the very next day following a December 31 plan selection. Under this final rule, Exchanges may adopt any start date on or before November 1, and may adopt an end date as late as December 31, as long as operational processes allow for meeting all other Exchange requirements associated with the OEP. As we believe the open enrollment period length is largely independent of subsidy levels set by Congress and the current high levels of improper enrollment we are attempting to mitigate, we are finalizing these changes for PY 2027 and beyond. We summarize and respond to public comments received on the proposed change in OEP dates below. and respond to public comments received on the proposed change in OEP dates below.

Comment: Almost all commenters expressed support for delaying implementation of a shorter OEP, if finalized as proposed. Most commenters cited the sunset of enhanced PTC as a potential cause for consumer confusion during the upcoming OEP, which will require additional consumer support and staffing on the part of issuers, agents, brokers, web-brokers and Exchanges. Commenters expressed concern that these dynamics would be exacerbated by a shorter OEP. Many issuers asserted that shortening the OEP in a year when consumers most need additional time to assess and change plans has the potential to create market instability. Some stated that there is not adequate time to incorporate this change into premium rate filings for PY 2026.

Several organizations stated that there is insufficient time to notify consumers and conduct educational outreach about this provision prior to the OEP for PY 2026, and decreased Navigator enrollment support funding for PY 2026[150] may contribute to consumer confusion. Some commenters said that technical modifications and testing were already underway for PY 2026 OEP, so adding modifications would be challenging and costly for Exchanges and their issuers to incorporate.

Response: We recognize that finalizing a rule that changes the OEP dates only a few months prior to the start of an OEP for a plan year during which nearly all enrollees receiving financial assistance will experience changes in their APTC eligibility or amount has the potential to be challenging for consumers, Exchanges, and issuers. In light of these concerns, we are modifying the effective date for the OEP change to begin for the PY 2027 OEP rather than the PY 2026 OEP.

Comment: Commenters addressing the proposal to amend § 155.410(e) to shorten the annual OEP in all individual market Exchanges, including State Exchanges, all expressed

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[150] *See* CMS (2025, Feb 14). Press Releases: CMS Announcement on Federal Navigator Program Funding. *https://www.cms.gov/newsroom/press-releases/cms-announcement-federal-navigator-program-funding.*

support for States to retain flexibility to set their own OEP dates. Issuers and issuer associations that supported the proposal for a shorter OEP for the FFEs recommended that CMS permit State Exchanges to continue setting their own OEP dates. All State Exchanges that submitted comments also supported giving State Exchanges flexibility to set their own OEP, primarily stating that States better understand local market conditions, such as consumer demographics, enrollment patterns, fraud, risk, and adverse selection, and therefore are better positioned to decide the length of OEP that will work best for their residents. These commenters also noted the need for flexibility in case of natural disasters.

Response: After consideration of the comments received, we are modifying our proposal to provide flexibility for States to set their own OEP dates, with the condition that, beginning with the OEP for PY 2027, the end date is no later than December 31 of the preceding year and all Exchange OEPs have a maximum length of 9 weeks. We specify the 9-week duration because it will allow most Exchanges to maintain their OEP start date of November 1 and extend their OEPs through the latest allowed end date of December 31. If an Exchange preferred to start the OEP earlier, such as on October 15, the 9-week durational limit would ensure that the Exchange's OEP length does not place excessive burden on issuers and enrollment partners. We believe that a 9-week OEP provides more than sufficient time for consumers to submit an application, compare their plan options, and enroll in advance of the new year. During the PY 2025 OEP, 97 percent of all Exchange enrollments occurred by the end of the ninth week. The latest allowable OEP end date of December 31, coupled with the finalized effective date rules in § 155.410(f) will ensure that all OEP enrollees have full year coverage effective January 1 of the plan year for which they are enrolling. We also note that throughout the year, Special Enrollment Periods are available for consumers who live in areas that are experiencing a natural disaster (or other national or State-level emergency) when it is designated a Federal Emergency Management Agency (FEMA) incident.

Comment: Several commenters supported shortening the annual OEP as proposed, beginning with PY 2027 or later. One commenter cited consistency across Exchanges to help consumers remember key dates and reduce confusion from having two deadlines for two different coverage start dates. Two commenters opined that the shorter OEP would reduce adverse selection and ensure the stability of the individual market. One commenter noted that an OEP that ends before the start of the next calendar year begins allows health plans to better predict risk and pricing models.

Response: We agree with these comments and are finalizing the policy to end the annual OEP for all Exchanges no later than December 31 of the calendar year preceding the applicable benefit year, beginning with PY 2027. This approach balances State flexibility with consistency, because beginning with the PY 2027 OEP all Exchange OEP enrollments across the country will have a January 1 effective date. The single effective date ensures that consumers have only one deadline. Ending the OEP before the plan year begins will mitigate adverse selection because consumers will not be able to switch plans in January based on emergent health needs or delay enrollment by forgoing January coverage with the option of enrolling later instead. The December 31 end date and the 9-week durational limit will shorten the OEP for all Exchanges once effective for the PY 2027 OEP.

Comment: Many interested parties expressed concerns about the proposed revision to the annual OEP. Commenters noted that a shorter OEP would have potential for reduced enrollment and an increase in the uninsured population. Some commenters commented on the importance of the OEP providing enough time to support consumer choice and informed decisions about coverage, noting in particular that vulnerable populations, including those in rural areas with limited digital access, those with language barriers, and those with disabilities, may need additional time and assistance to enroll. Many commenters also noted that some consumers need enough time to switch plans.

Response: We agree that the OEP must provide sufficient time for all entities involved in the annual open enrollment process to conduct outreach, provide assistance, and enroll in coverage. We intend to conduct outreach to consumers in States with Exchanges operating on the Federal platform to ensure that they are aware of the newly shortened OEP are prepared to enroll or re-enroll in 2027 coverage. By providing flexibility to State Exchanges to set their OEP dates within set parameters, we anticipate that Exchanges can time their OEP period to best accommodate the needs of the specific populations in their States, including vulnerable populations. By delaying the effective date until PY 2027, Exchanges can increase outreach to vulnerable populations or consider tactics other than an extended OEP to promote their participation.

Comment: Many commenters said that a shortened enrollment period would strain agents, brokers, enrollment assisters, and call center capacity as they would be supporting the same number of people in a shorter timeframe. Some commenters noted that the reduction in Federal funding for Navigators compounds the capacity concerns regarding consumer assistance.

Response: A shorter enrollment period may require agents, brokers, web-brokers, enrollment assisters, and the Marketplace call center to assist the same number of people over a shorter timeframe. As noted above, during the PY 2025 OEP, 97 percent of all Exchange enrollments occurred by the end of the ninth week. The final rule provides States flexibility to set their OEPs up to nine weeks in length. We encourage Exchanges to work with the enrollment support interested parties in their States to establish the OEP dates that best align with their capacity.

Comment: Several commenters shared data from California, New York, Massachusetts and Virginia State Exchanges showing that those who enroll later in the OEP may on average be younger, healthier, and therefore less costly consumers. Commenters worried that if some such consumers miss the shortened deadline, it could destabilize the risk pool and increase premiums.

Many said that long-term effects would lead to higher uninsurance rates, uncompensated care, and clinician burnout that could strain the health care ecosystem.

Response: We noted the crucial role that the OEP plays in protecting the stability of the individual market risk pool within the structure of the ACA. Adverse selection remains a serious concern when a longer OEP allows consumers to wait until the coverage year begins before deciding whether to enroll. Enrollment periods are one of the few tools established by the ACA to mitigate adverse selection and contribute to a more stable, affordable market. Under the final rule, beginning in PY 2027, consumers will have one clear and consistent deadline for January 1 coverage within their Exchange that will not differ from the end date of the OEP. By delaying the effective date until PY 2027, Exchanges have sufficient time to message the clearer OEP end date to consumers, especially the younger and healthier consumers who may tend to enroll later in the OEP. While we cannot foresee to what extent younger and healthier consumers will enroll before the updated deadline, we do believe consumers are deadline-driven. Given that State Exchange markets may experience unique patterns of enrollment and have State-specific history of OEP dates and enrollment outcomes, we are maintaining flexibility for State Exchanges to set their own OEP dates in this final rule within set parameters. Moreover, we believe that addressing adverse selection through all the provisions of this rule will lead to lower premiums that will do more to encourage younger and healthier consumers to enroll than additional time does today. Therefore, we believe that the adjusted OEP period will not lead to negative long-term consequences.

Comment: A few commenters responded to our request about the overall effects and impacts of OEP placement within the calendar year. Several commenters recommended that if CMS moves up the OEP end date to December 15, the Exchanges should also move up the OEP start date to October 15 to ensure consumers have sufficient time to enroll while still maintaining a deadline for a January 1 coverage start. Others suggested that December 31 be the last date of

OEP for coverage effective January 1. Several also mentioned that the OEP falls during a busy holiday season, which brings its own time constraints and financial challenges for consumers and business owners.

Response: We appreciate the comments noting potential benefits of an OEP start date prior to November 1st. Therefore, the final regulation at § 155.410(e)(5) allows all Exchanges to set an earlier start date for their OEP if desired. This change provides additional flexibility to States as compared to the previous policy at § 155.410(e)(4)(iii) which did not allow an Exchange to set a start date for their OEP earlier than November 1 unless that earlier start date was already in place as of November 1, 2023. The rule does not require any Exchange to establish an earlier OEP start date given that the timing for issuer rate filings may make it difficult to a start OEP prior to November 1. We agree that an end date of December 31 or earlier coupled with the effective date rules at § 155.410(f) will ensure that all effective dates (other than those pursuant to a SEP) will be on the same day (January 1 of the coverage year).

Comment: A commenter noted that that many brokers write both Medicare and individual market business, and a shorter OEP would reduce agents' ability to balance these overlapping enrollment periods. Some commenters worried that the overlap of the Exchange OEP with the Medicare Advantage OEP may confuse consumers or strain the capacity of agents and brokers.

Response: Ending the Exchange OEP prior to January will align more closely with enrollment periods for other coverage such as employer coverage which benefits consumers because it allows consumers to compare their options within the same timeframe when they need to switch from one coverage type to another at the end of the plan year. In addition, each year since 2010 the Medicare Annual Enrollment Period has run from October 15 to December 7, and this rule provides flexibility for Exchanges to partially align their OEP with that period. However, given the capacity concerns voiced by agents and brokers and associated organizations, the final OEP policy strikes a balance between goals of consistency with other

OEPs and not straining the capacity of enrollment assistance entities. We note that the Medicare Advantage OEP occurs annually from January 1 to March 31, so the Exchange OEP, with its last possible end date of December 31, will not overlap.

Comment: Some commenters noted that future Medicaid changes could cause more consumers to be eligible for Exchange coverage and therefore the OEP would need to be long enough to ensure an opportunity for them to enroll.

Response: We are not aware at this time of Medicaid eligibility changes that would disrupt Exchange enrollment expectations. Consumers who lose eligibility for Medicaid or CHIP qualify for a Special Enrollment period under § 155.420 and thus would not be limited to the annual OEP for Exchange enrollment.

Comment: Some commenters noted that an OEP that extends beyond January 1 allows a valuable "free look" period during which consumers can change plans. One commenter noted that Exchange enrollees who are automatically re-enrolled into a plan may not learn of cost increases until after they receive their first bill in January. Another commenter noted that an enrollee may discover their plan's clinician directory included inaccurate information only after the enrollment period begins.

Response: We provide notice in advance of the OEP to consumers about the importance of updating information for the future plan year and actively comparing plan options and prices. We note that section 2799A–5 of the Public Health Service Act requires issuers to verify and update their provider directories on a regular basis. They are required to verify that their provider directories are accurate at least once every 90 days and to update the directory within 2 business days of provider or facility notice of network agreement termination. Additionally, if a plan participant receives information from the issuer's provider directory that a provider or facility is in-network when the provider or facility is in fact not in network, the issuer may not charge a

cost-sharing amount greater than the cost-sharing amount that would apply to the item or service if the provider or facility was in-network.

8. Monthly Special Enrollment Period for APTC-Eligible Qualified Individuals with a Projected Household Income at or Below 150 Percent of the Federal Poverty Level (§ 155.420)

In the 2025 Marketplace Integrity and Affordability proposed rule (90 FR 12979 through 12982), we proposed to remove § 155.420(d)(16) to repeal the monthly SEP for APTC-eligible qualified individuals with a projected annual household income at or below 150 percent of the FPL, which we refer to as the "150 percent FPL SEP." To conform existing regulations to the repeal of this SEP, we also proposed to remove § 155.420(a)(4)(ii)(D) (which adds plan category limitations and permits eligible enrollees and their dependents to use the 150 percent FPL SEP to change to a silver level plan) and § 155.420(b)(2)(vii) (regarding when coverage is effective for this SEP), and § 147.104(b)(2)(i)(G) (as discussed in section III.A.1 of this final rule). We also proposed to amend the introductory text of § 155.420(a)(4)(iii) to remove reference to paragraph (d)(16). Finally, we also proposed to revise paragraphs (a)(4)(ii)(B) and (a)(4)(ii)(C) to move the placement of the word "or" for clarity given the proposed removal of paragraph (a)(4)(ii)(D).

We created the 150 percent FPL SEP to provide additional opportunities for low-income consumers to take advantage of free or low-cost coverage that section 9661 of the ARP made available on a temporary basis during the COVID-19 PHE. When we first finalized this SEP and then made it permanent in the 2025 Payment Notice (89 FR 26320), we projected that it would increase premiums due to adverse selection and, as a result, increase both the financial hardship on consumers who pay the full premium and the Federal cost of APTC. While we previously concluded the enrollment benefits of this SEP outweighed these costs and risks for adverse selection, we now believe that the SEP in combination with the widespread availability of zero-dollar premium plans has increased opportunities and incentives to conduct improper enrollments, as well as increased the risk for adverse selection, as the 150 percent FPL SEP

incentivizes consumers to wait until they are sick to enroll in Exchange coverage. In the proposed rule (90 FR 12979), we encouraged commenters and other interested parties to provide comments on whether and how the 150 percent FPL SEP has exacerbated these issues. Finally, we stated that we believe that the single, best interpretation of the statute is that it does not authorize the Secretary to add the 150 percent FPL SEP to the list of SEPs enumerated at sections 1311(c)(6)(C) and (D) of the ACA.

As background, section 9661 of the ARP amended section 36B(b)(3)(A) of the Code to decrease the applicable percentages used to calculate the amount of household income a taxpayer is required to contribute to their second lowest cost silver plan for tax years 2021 and 2022.[151] For those with household incomes at or below 150 percent of the FPL, the new applicable percentage is zero. The IRA extended this provision to the end of PY 2025. As a result of these changes, many low-income consumers whose QHP coverage can be fully subsidized by the APTC have one or more options to enroll in a silver-level plan without needing to pay a premium after the application of APTC.

To provide certain low-income individuals with additional opportunities to newly enroll in this fully-subsidized or low-cost coverage, in part 3 of the 2022 Payment Notice (86 FR 53429 through 53432), we finalized, at the option of the Exchange, a new monthly SEP for APTC-eligible qualified individuals with projected household income at or below 150 percent of the FPL. We also finalized a provision stating that this SEP is available only during periods of time when a taxpayer's applicable percentage, which is used to calculate the amount of household income a tax filer is required to contribute to their second lowest cost silver plan, is set at zero, such as during tax years 2021 through 2025, as provided by section 9661 of the ARP and extended by the IRA. As background, the applicable percentages are used in combination with

[151] Pub. L. 117-2.

other factors, including annual household income and the cost of the benchmark plan, to determine the PTC amount for which a taxpayer can qualify to help pay for a QHP on an Exchange for themselves and their dependents. These decreased percentages generally result in increased PTC for PTC-eligible tax filers.

In the 2025 Payment Notice (89 FR 26320), we removed the limitation that the 150 percent FPL SEP is available only during periods of time when the applicable percentage is set to zero. However, given concerns regarding the growth of improper enrollments using this SEP, we proposed that this SEP would end as of the effective date of the final rule, and not in December 2025, when the provisions extended by the IRA sunset. We stated in the proposed rule (90 FR 12980) that we believe ending the 150 percent FPL SEP across all Exchanges immediately is necessary due to the rise in improper enrollments, as the 150 percent FPL SEP was one of the primary mechanisms that certain agents, brokers, and web-brokers used to conduct unauthorized enrollments to improperly enroll consumers in fully-subsidized Exchange plans.

We stated in the proposed rule (90 FR 12980) that while we previously concluded that the benefits of increased access outweighed the risk of premium increases, new information suggests the expanded availability of fully-subsidized plans (referred to as zero-dollar plans in previous rulemaking),[152] combined with easier access to these fully-subsidized plans through the 150 percent FPL SEP, led to a substantial increase in improper enrollments. We stated that the existence of fully-subsidized plans by itself creates an opportunity for some agents, brokers, and web-brokers to conduct improper enrollments of consumers in Exchange coverage without them knowing, because without a premium, there is no ongoing need for consumer engagement following completed enrollment in an Exchange plan. We noted that based on our own analysis,

[152] In previous rulemaking, we referred to fully-subsidized plans as zero-dollar plans. This former characterization suggested there is no premium. But health issuers do receive a full premium for every plan they sell. For people with incomes between 100 and 150 percent of the FPL, this premium is fully subsidized by the Federal taxpayer.

we have identified various mechanisms that some agents, brokers, and web-brokers have exploited to conduct unauthorized enrollments to improperly enroll consumers in Exchange coverage without their consent. For example, an agent, broker, or web-broker can enroll a consumer without the consumer's knowledge and earn a commission for each consumer enrolled. An agent, broker, or web-broker can also change the agent of record for an existing enrollee and take the commission from the existing agent, broker, or web-broker. An agent, broker, or web-broker can switch an enrollee to a new health plan without the consumer's consent to capture the new commission. An agent, broker, or web-broker can also split up a household and enroll them in multiple plans to capture multiple commissions.

We noted that this pattern of agents, brokers, and web-brokers targeting low-income individuals with deceptive practices to entice enrollment in fully-subsidized plans is illustrated in multiple indictments recently pursued by the Department of Justice (DOJ). In one case, an insurance brokerage firm allegedly schemed to maximize commission payments by preying on vulnerable, low-income individuals, using deceptive practices to improperly inflate the incomes of consumers projected to earn no income.[153] In another case, a different insurance brokerage executive pleaded guilty to deceptive marketing practices and fraudulently enrolling ineligible consumers into fully-subsidized ACA plans by inflating their incomes.[154]

Because of these practices, in 2024, we implemented various system and logic changes to prevent some improper agent, broker, and web-broker behavior and we have observed some improvements. However, we stated in the proposed rule (90 FR 12980) that we believe that so long as there is no premium cost for the consumer, these enrollments can continue to go unnoticed until an enrollee tries to use a health plan that has been improperly cancelled by an

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[153] Press Release, Department of Justice *https://www.justice.gov/opa/pr/president-insurance-brokerage-firm-and-ceo-marketing-company-charged-161m-affordable-care#:~:text=The%20indictment%20alleges%20that%20Lloyd,initially%20projected%20having%20no%20income.*

[154] Press Release, Department of Justice, *https://www.justice.gov/opa/pr/executive-vice-president-insurance-brokerage-pleads-guilty-133m-affordable-care-act-fraud.*

agent, broker, or web-broker, or eventually learns they must reconcile APTC when they file their Federal income tax return.

In December 2024 the FFE received 7,134 consumer complaints of improper enrollments, an increase from the 5,032 complaints received in December 2023. Although these numbers represent a decrease from the high of 39,985 complaints received in February 2024, the fact that the number of complaints for 2024 remains substantially higher than for 2023 demonstrates that previous program integrity measures have not resulted in a decrease in potential improper enrollments such that additional measures are not necessary. We stated in the proposed rule (90 FR 12980) that this has caused us to reconsider the 150 percent FPL SEP, as it continues to serve as a mechanism for some agents, brokers, and web-brokers to circumvent the protections that we have put into place, and even reverse some of the gains we have made in mitigating agent, broker, and web-broker improper enrollments.

On April 12, 2024, a class of plaintiffs, including Exchange consumers and insurance agents, filed a complaint against certain agents and marketing companies alleging a conspiracy to conduct unauthorized enrollments and change enrollments to improperly capture commissions.[155] The complaint alleges that the false ads created by the defendants "resulted in hundreds of thousands of enrollments by class members."[156] We noted in the proposed rule (90 FR 126980) that enrollment data for the 2024 OEP suggest improper enrollments may be significantly more widespread than the parties involved in this case. A comparison of plan selections during the 2024 OEP and U.S. Census Bureau population estimates show the number of plan selections among people reporting household incomes between 100 and 150 percent of the FPL exceeded the number of potential enrollees within this FPL range in nine States.[157] This

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[155] Complaint, *Turner v. Enhance Health, LLC*, No. 24-cv-60591-MD. (S.D. Fla. Apr. 12, 2024).
[156] Id. at 56.
[157] Blase, B.; Gonshorowski, D. (2024, June). The Great Obamacare Enrollment Fraud. Paragon Health Institute. *https://paragoninstitute.org/private-health/the-great-obamacare-enrollment-fraud.*

analysis estimates between 4 to 5 million improper enrollments in 2024 at a cost of $15 to $26 billion in improper PTC payments.[158]

We stated in the proposed rule (90 FR 12980) that our own analysis confirms the number of plan selections for people with household incomes between 100 and 150 percent of the FPL exceeds the population of people at that income level based on U.S. Census Bureau surveys. At the extreme, 2.7 million Floridians claimed a household income between 100 and 150 percent of the FPL and selected plans through *HealthCare.gov* during the 2024 OEP. Yet, 2022 Census surveys estimated that only 1.5 million people who live in Florida fell within that income level.[159] We stated that this disparity between the number of plan selections and Census population estimates suggests there were likely over 1 million improper enrollments in Florida alone. We noted that several other States have similar patterns of more enrollees reporting household income between 100 and 150 percent of the FPL than people who would be eligible in the State for Exchange coverage with income in that category.[160] A detailed discussion of the limitations of this data analysis can be found in section V.C.18 of this final rule. In the proposed rule, we encouraged commenters and other interested parties to share their experiences in their respective States, including the extent of improper enrollments and other data disparities.

We stated in the proposed rule (90 FR 12981) that the 150 percent FPL SEP expands the opportunities for some agents, brokers, and web-brokers to conduct unauthorized enrollments for people in fully-subsidized plans at any time during the year. We noted that by design, anyone who reports a projected household income at or below 150 percent of the FPL on their application can enroll in a QHP or change from one QHP to another at any time during the year. We stated that this allows agents, brokers, and web-brokers to conduct unauthorized enrollments

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[158] Ibid.
[159] U.S. Census Bureau (2022). American Community Survey. Dep't of Commerce. *https://www.census.gov/programs-surveys/acs/data.html.*
[160] Ibid.

or enrollment changes any time during the year when they gain access to the personally identifiable information that allows them to falsely represent someone. Before the implementation of the 150 percent FPL SEP, we received a handful of complaints from consumers about improper enrollments or plan switching. In contrast, in the first 3 months of 2024, we received 50,000 complaints of improper enrollments and 40,000 complaints of unauthorized plan switches attributed due to agent or broker noncompliant conduct and improper enrollments. For these reasons, in the proposed rule (90 FR 12981) we stated that by immediately ending this SEP as of the effective date of the final rule, Exchanges would be protecting consumers by preventing improper enrollments in addition to working to mitigate the negative effects of adverse selection on the risk pool, thus moving towards a more stable individual market risk pool.

In addition to concerns over improper enrollments, we stated in the proposed rule (90 FR 12981) that we remain concerned over the ability of consumers at or below 150 percent of the FPL to wait to enroll until they need health care services, resulting in adverse selection. We stated that additional research is necessary to accurately quantify the negative impacts of this behavior to the risk pool, and we sought comment on this issue from the public. With respect to improper enrollments, we recognized the need to revise the Federal platform process for pre-enrollment verification for SEPs and to reinforce that process so that SEPs are not being misused. In the proposed rule, we stated that this reinforcement of pre-enrollment verification for SEPs would strengthen program integrity measures, deter agents, brokers, and web-brokers from engaging in improper enrollments and enrolling unsuspecting consumers in QHP coverage through the Exchanges without their knowledge or consent, and stabilize the individual market risk pool. We proposed changes to pre-enrollment verification for SEPs at § 155.420(g).

In the proposed rule (90 FR 12981), we stated our concern that the risk of people waiting to enroll until sick is substantially heightened by the flexibility consumers, as well as agents,

brokers, and web-brokers acting on behalf of consumers, receive when estimating their annual household income on their application, along with the limits on how much low-income individuals must pay to reconcile any misestimate on their taxes. We noted that while a tax filer would need to reconcile a poor income estimate on their taxes, under statute, some tax filers need only repay a small portion of excess APTC. This is referred to as the excess APTC repayment limit. For single filers with household incomes less than 200 percent of the FPL, the amount they must pay back was limited to $375 in 2024.[161] The limit is $950 for single filers with household incomes from 200 to less than 300 percent of the FPL and $1,575 for single filers with household incomes from 300 to less than 400 percent of the FPL. We stated in the proposed rule that with wide flexibility in estimating household income and minimal penalties for misestimates, the 150 percent FPL SEP is an ideal enrollment loophole for some agents, brokers, and web-brokers seeking to increase enrollment commissions. Additionally, we noted that it can result in a large portion of people who fail to enroll in coverage until they incur significant health care expenses, introducing high adverse selection risks for issuers, which are then reflected in higher premiums and associated Federal spending on premium subsidies. We further noted that this SEP has certainly been abused by some agents, brokers, and web-brokers, who are aware of the excess APTC repayment limits and who have inappropriately marketed "free" plans to enrollees.[162,163]

We stated in the proposed rule (90 FR 12981) that this wide flexibility in estimating income may also be open to misuse by Navigators and Certified Application Counselors (CACs). We noted that while Navigators and CACs may not receive a direct financial incentive for improper enrollments, they may still have incentives to encourage or allow applicants to

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[161] IRS (n.d.) Rev. Proc. 2023-34. Dep't of Treasury. https://www.irs.gov/pub/irs-drop/rp-23-34.pdf.
[162] Appleby, J. (2024, April 8). Rising Complaints of Unauthorized Obamacare Plan-Switching and Sign-Ups Trigger Concern. KFF Health News. *https://kffhealthnews.org/news/article/aca-unauthorized-obamacare-plan-switching-concern/.*
[163] Chang, D. (2023, June 12). Florida Homeless People Duped into Affordable Care Act Plans They Can't Afford. Tampa Bay Times. *https://www.tampabay.com/news/florida-politics/2023/06/12/florida-homeless-people-duped-into-affordable-care-act-plans-they-cant-afford/.*

underestimate their income to take advantage of fully-subsidized plans outside of the OEP. Navigators and CACs, for example, still have incentives to hit and exceed enrollment targets. The number of consumers assisted with enrollment or re-enrollment in a QHP is one of the project goals we list in the Navigator grant application.[164] Navigators must provide progress reports to CMS and future grant funding levels are based in part on progress toward this goal.[165] Navigators and CACs may even believe it is appropriate to encourage applicants to understate their income to gain more affordable coverage. We sought comment on this issue and the proposal generally.

We stated in the proposed rule (90 FR 12981) that we are working hard to address the increase in improper enrollments to ensure only eligible people enroll in all plans, but especially fully-subsidized plans. While we stated that we believe stronger enforcement measures can substantially reduce improper enrollments, we also stated that we believe improper enrollments would continue to be a problem so long as there is access to fully-subsidized plans combined with even easier access through the 150 percent FPL SEP. We noted that even if we were able to reduce the problem of some agents, brokers, and web-brokers enrolling consumers in Exchange coverage without their knowledge or consent, substantial issues remain with consumers taking advantage of the 150 percent FPL SEP by falsely representing their household income on their Exchange applications. Because of this, we stated that we believe that ending the 150 percent FPL SEP remains one of the most critical ways to mitigate this risk of improper enrollments and protect the individual risk pool. We also stated that we believe that the loopholes and incentives created by the 150 percent FPL SEP are too large to simply police retrospectively.

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[164] Centers for Medicaid and Medicare Services, Cooperative Agreement to Support Navigators in Federally Facilitated Exchanges, CMS NAV 001, June 7, 2024, at 33. OMB 0938-1215.
[165] Id. at 32.

In the 2025 Payment Notice (89 FR 26321), we reviewed the enrollment experience and found that the percent of Exchange enrollees on the Federal platform who had projected annual household income of less than 150 percent of the FPL increased from 41.8 percent in 2022 to 46.9 percent in 2023, after the implementation of the 150 percent FPL SEP. At the time, we concluded this suggested the policy was successful. We also analyzed the availability of fully-subsidized plans in 2020 before enhanced subsidies became temporarily available under the ARP and IRA. We found 77 percent of the consumer population at or below 150 percent of the FPL had access to fully-subsidized bronze plans and 16 percent had access to fully-subsidized silver plans. Based on this finding, we concluded the risk of adverse selection was mitigated by the broad access to fully-subsidized plans because consumers with fully-subsidized plans would not have a financial incentive to drop their Exchange plan when healthy and resume coverage when sick. Nevertheless, we still projected the 150 percent FPL SEP would increase premiums by 3 to 4 percent (89 FR 26405).

In the proposed rule (90 FR 12982), we stated that these conclusions no longer seem valid considering the recent *Turner v. Enhance Health, LLC* litigation, higher numbers of consumer complaints about unauthorized plan switching and improper enrollments, and a sharp increase in enrollment relative to the population with household income under 150 percent of the FPL in PY 2024. We noted that this new information suggests the increase in the proportion of Exchange enrollees who report household incomes under 150 percent of the FPL is driven by improper enrollments. In addition, we explained that it highlights how the adverse selection issue for the 150 percent FPL SEP does not primarily involve concerns over consumers dropping coverage when healthy and resuming coverage when sick. We stated that people already enrolled in fully-subsidized plans clearly have little incentive to drop their plan. We further stated that the adverse selection issue surfaces from people who do not enroll in a fully-subsidized plan during the OEP and, instead, wait to enroll when sick. We noted that people who wait can avoid

enrollment if they never become sick and, therefore, avoid contributing when healthy. We further noted that many consumers can also wait and know, if they do become sick, they would qualify for the 150 percent FPL SEP, due to the widespread evidence that millions of people have enrolled at this income level who do not have such household income and are subject to limitations on repayments of excess tax credits.

Based on this analysis, we stated in the proposed rule (90 FR 12982) that we believe the impact of the 150 percent FPL SEP on premiums absent IRA subsidies is less than the 3 to 4 percent we previously projected in the 2025 Payment Notice. We stated in the proposed rule that after fully accounting for the impact of people not enrolling during the OEP and waiting to enroll until sick, we projected the premium impact of the current policy would be between 0.5 to 3.6 percent. In this final rule, we have revised this estimate. We now estimate that removing the current monthly SEP for people with incomes below 150 percent of the FPL will result in premiums being 3 to 4 percent lower than they would be if the SEP were to remain in place.[166] A point estimate of 3.4 percent is used in the RIA, and an explanation of this estimate can be found in section V.C.12 of this rule.

Based on the premium increase and the increase in improper enrollments which was exacerbated by our previous SEP policy, we also stated that we do not believe that the benefits of increased access to coverage for low-income consumers outweighs the risk of higher premiums and improper enrollments. In fact, we stated that we believe that the costs may exceed the benefits and we encouraged commenters and other interested parties to provide comments on the cost impact of the 150 percent FPL SEP.

[166] Based on internal CMS Office of the Actuary analysis, removing this provision is expected to reduce premiums within the range of 3 to 4 percent, and we use the point estimate of 3.4 percent to estimate expected claims impact and the shift in average months of enrollment.

In the proposed rule (90 FR 12982), we noted that improper enrollments resulting from the 150 percent FPL SEP may mitigate premium increases caused by adverse selection from this SEP. Individuals who are unknowingly enrolled through the 150 percent FPL SEP would not file insurance claims and, therefore, would improve the risk pool. We stated that while these negative impacts from the 150 percent FPL SEP are related, we account for them separately in our consideration. We explained that the ACA authorizes the Secretary only to require an Exchange to provide for the SEPs listed at sections 1311(c)(6)(C) and (D) of the ACA, and nothing more. We also explained that where a statute such as sections 1311(c)(6)(C) and (D) of the ACA provides a list, the "specific and comprehensive statutory list necessarily controls over the [Secretary's] general authorization,"[167] such as the one in in sections 1321(a)(1)(A), (B), and (C) of the ACA, which authorizes the Secretary to "issue regulations setting standards for meeting the requirements … with respect to" the establishment and operation of Exchanges, the offering of qualified health plans through Exchanges, and "such other requirements as the Secretary determines appropriate."

Section 1311(c)(6)(C) of the ACA mandates that the Secretary require an Exchange to provide for "special enrollment periods specified in section 9801 of the Code of 1986 and other special enrollment periods under circumstances similar to such periods under part D of title XVIII of the Act." We noted in the proposed rule (90 FR 12982) that the circumstances underlying the 150 percent FPL SEP are dissimilar to the circumstances for Medicare Part D SEPs under section 1860D-1(b)(3) of the Act, which are: involuntary loss of creditable prescription drug coverage; errors in enrollment; exceptional conditions; Medicaid coverage; and discontinuance of a Medicare Advantage Prescription Drug (MA-PD) election during the first

[167] *Texas Med. Ass'n v. U.S. Dep't of Health & Hum. Servs.*, 110 F.4th 762, 775 (5th Cir. 2024) (citing *Nat'l Pork Producers Council v. EPA*, 635 F.3d 738, 753 (5th Cir. 2011); *Texas v. United States*, 809 F.3d 134, 179, 186 (5th Cir. 2015), aff'd by an equally divided court, 579 U.S. 547 (2016)).

year of eligibility. We stated that the 150 percent FPL SEP is likewise not one of the SEPs specified in section 9801 of the Code, nor similar to such SEPs.

We stated in the proposed rule (90 FR 12982) that this interpretation aligns with our overall experience regarding the role that enrollment periods play in mitigating adverse selection within the structure of the ACA. We stated that we have thoroughly considered our experience with the program before and after the implementation of the 150 percent FPL SEP and assessed the fit between the rationale for this SEP and the policy consequences that flow from it. Based on this expanded body of experience, we also stated that we believed that Congress was correct to provide the Secretary with a comprehensive statutory list of SEPs that omitted the 150 percent FPL SEP. We sought comments on this proposal.

We stated in the proposed rule (90 FR 12982) that a commenter on the 2025 Payment Notice (89 FR 26323) also questioned whether it was lawful for HHS to implement the 150 percent FPL SEP. We noted that the statute requires a specific set of SEPs that focus on giving people an opportunity to enroll mid-year if they experience a change in their life circumstances, such as a move or the loss of job. We further noted that, in contrast, the 150 percent FPL SEP allows people to enroll at any time during the year based on their existing income, not a change in their income. We requested further comment on this proposal.

After careful consideration of comments and for the reasons outlined in this final rule, we are finalizing this policy with a modification under which the policy and related requirements will sunset for all Exchanges at the end of PY 2026. Thereafter, the 150 percent FPL SEP that was available at the option of the Exchange prior to the finalization of this rule will become available again. As mentioned throughout this proposed rule, there are currently high levels of improper enrollment in the 100 to 150 percent of the FPL cohort as a result of the fully-subsidized benchmark plans available to them. Despite the expiration of the fully-subsidized benchmark plans, we expect there to be significant numbers of improperly enrolled individuals in

this income cohort that remain enrolled and receiving APTC for which they are ineligible for some time before markets normalize. That said, we received significant comments in opposition to our proposal to end the 150 percent FPL SEP with commenters raising significant concerns over its impacts on low-income Americans that properly utilize this pathway to receive coverage.

While we agree that low-income Americans properly seeking coverage should not be locked out of it, the 150 percent FPL SEP for individuals with fully-subsidized premiums – as a result of the expanded subsidies – has enabled significant improper enrollment. That said, once the expanded subsidies expire and individuals are exposed to greater premium costs, the ability of individuals or actors on behalf of individuals to improperly enroll in plans that the 100 to 150 percent of the FPL cohort are eligible for is significantly diminished. In order to address the currently high rate of improper enrollments, we believe it to be necessary to pause the 150 percent FPL SEP temporarily. Coupled with the other temporary policies in this rule and the expiration of fully-subsidized plans, we expect the level of improper enrollments to come down drastically in PY 2026, diminishing the need for ongoing crisis-level program integrity policies. This dynamic, combined with the significant concerns raised by commenters on our proposal, has led us to finalize a pause on the 150 percent FPL SEP thorough PY 2026, with a reversion to the previous policy for PY 2027 and beyond.

We summarize and respond to public comments received on the proposed repeal of the 150 percent FPL SEP below.

Comment: Some commenters supported the proposed repeal of the 150 percent FPL SEP, including issuers and advocacy groups. Commenters acknowledged that the 150 percent FPL SEP was created to accommodate individuals losing Medicaid while States worked to "unwind" from the Families First Coronavirus Response Act (FFCRA) continuous enrollment condition and to return to regular eligibility and enrollment processes in Medicaid and CHIP. However, now that State Medicaid Agencies have generally completed unwinding activities, commenters

stated that consumers should utilize other SEPs based on qualifying life events to enroll into coverage outside of the OEP. Commenters expressed that with numerous existing pathways to coverage, income level alone is not a compelling reason to offer a SEP, and that the 150 percent FPL SEP departed from the ACA's structure to reserve SEPs for those experiencing life events necessitating a coverage change.

Response: We appreciate the commenters' support for our proposal. That said, given the substantial uncertainty over the future of the Exchanges and individual health insurance market, we don't believe a permanent repeal is appropriate, and as explained previously, we are finalizing a pause to best balance the urgent need for program integrity with the long-term desire for enrollment efficiencies.

Comment: Some actuaries, community advocacy organizations, and issuers supported the repeal of the 150 percent FPL SEP, as the SEP contributes to adverse selection. Commenters wrote that the SEP introduces volatility, making it challenging for issuers to distribute enrollee risk and gauge the market, resulting in higher premiums. Commenters cited CMS data showing that five million enrollees have utilized the SEP since it was implemented. They further noted that, in PY 2024, nearly half of Exchange enrollees had incomes below 150 percent of the FPL, and the sheer volume of the SEP contributed to the challenges issuers faced gauging the market. Commenters also noted that they expect the risk of adverse selection through this SEP to significantly increase once the enhanced IRA subsidies expire. One commenter indicated that they expected the removal of the 150 percent FPL SEP, in concert with the other policies listed in the rule, would improve the risk pool and reduce premiums.

Response: We appreciate the commenters sharing their insights on how they believe this SEP affected the market. That said, once the enhanced IRA subsidies expire, fewer consumers with income below 150 percent FPL will have fully-subsidized QHPs available to them, making it less likely that the SEP can be abused for inappropriate enrollment. We believe the pause best

balances the need for urgent program integrity measures with the long-term desire to promote enrollment efficiencies.

Comment: Some issuers and advocacy groups agreed that removing the 150 percent FPL SEP would reduce opportunities for noncompliant agents, brokers, web-brokers to perform improper enrollments. Commenters stated that removing this SEP would reduce taxpayer costs in the form of improper APTC outlays and would protect low-income individuals from unauthorized enrollments and plan switching. Commenters noted the many ways in which unauthorized enrollments and plan switches harm consumers, who may face disruptions in care, inability to fill needed prescriptions, or tax liabilities as a result. One commenter estimated that this SEP led to billions of dollars in fraudulent subsidy expenditures, based on analysis of HHS reports of 50,000 complaints of unauthorized enrollment and 40,000 complaints of unauthorized plan switches in the first three months of 2024.

Response: We appreciate these comments highlighting that this policy will have the desired effect of increasing program integrity and addressing fraud in Exchanges on the Federal platform. We believe the pause best balances the urgent program integrity concerns with the long-term desire to promote enrollment efficiencies.

Comment: One commenter said they supported repealing the 150 percent FPL SEP because it allows individuals with income below 100 percent of the FPL, who would not otherwise be eligible for APTC, to gain access to APTC.

Response: We clarify that the 150 percent FPL SEP does not have any bearing on whether an individual is eligible for APTC. Individuals with income below 100 percent of the FPL who are not otherwise eligible for APTC are not made eligible for APTC by the 150 percent FPL SEP.

Comment: Some individuals, local and national advocacy groups, and healthcare providers opposed the repeal of the 150 percent FPL SEP. Commenters stated that the 150 percent FPL SEP provides an important pathway into coverage, acting as a safety net for

uninsured individuals who may face barriers enrolling during the annual OEP or other SEPs. Commenters noted many populations to whom this SEP is particularly valuable, including individuals who experience income fluctuations throughout the year, individuals who move in-and-out of Medicaid coverage frequently, and individuals who reside in States that have not expanded Medicaid coverage to adults. Commenters further expressed that this SEP is helpful for individuals who may face barriers to navigating enrollment during the annual OEP or other SEPs, including individuals with low health literacy, limited English proficiency, disabilities, or high health care needs. Commenters expressed concern that more individuals may face administrative challenges related to enrollment during the annual OEP or other SEPs due to recent cuts to Navigator funding, as well as the proposals in this rule to instate new SEP verification requirements and to shorten the annual OEP.

Response: We acknowledge commenters' concerns. However, pausing the 150 percent FPL SEP simply provides a year to allow the market to shed excess levels of improper enrollments while allowing the market to adjust to the expiration of the expanded subsidies that enabled such high levels in the first place. After PY 2026, the SEP will return to a market without fully-subsidized premiums and exposure to premium costs should mitigate the fraud that previously proliferated under the expanded subsidies. We believe that the pause best balances the need to address urgent program integrity concern with the long-term desire to promote enrollment efficiencies.

We acknowledge commenters' concerns about the number of consumers that may be served by Navigators due to changes in funding, but do not believe that that is a compelling reason not to pursue this proposal.

Comment: Some issuers and advocacy groups agreed that removing the 150 percent FPL SEP would reduce opportunities for noncompliant agents, brokers, and web-brokers to perform improper enrollments. Commenters stated that removing this SEP would reduce taxpayer costs in

the form of improper APTC outlays and would protect low-income individuals from unauthorized enrollments and plan switching. Commenters noted the many ways in which unauthorized enrollments and plan switches harm consumers, who may face disruptions in care, inability to fill needed prescriptions, or tax liabilities as a result. One commenter estimated that this SEP led to billions of dollars in fraudulent subsidy expenditures, based on analysis of HHS reports of 50,000 complaints of unauthorized enrollment and 40,000 complaints of unauthorized plan switches in the first three months of 2024.

Response: We appreciate these comments highlighting that this policy will have the desired effect of increasing program integrity and addressing fraud in Exchanges on the Federal platform. While noncompliant agents, brokers, and web-brokers contributed to these issues, we want to acknowledge that most comply with CMS rules and regulations and act in good faith. The expiration of the enhanced subsidies will diminish the incentive and opportunity for improper enrollments.

Comment: Commenters anticipated that this policy change could result in more individuals having longer periods of uninsurance, resulting in decreased access to care, worse health outcomes, and increased financial instability for impacted individuals. Commenters noted that in addition to impacting individual health outcomes, increased uninsurance would also have a negative impact on community and public health, and on businesses that rely on a healthy workforce. Commenters expressed concerns that care would shift from primary and preventive care settings to more costly urgent and emergency care settings, and that increased uncompensated care costs would negatively impact hospitals, community health centers, issuers, municipalities, and States. Commenters anticipated that increased risks of uninsurance would disproportionately impact vulnerable populations, including individuals with substance use disorders, individuals at risk of or living with HIV, individuals with cancer, individuals with multiple sclerosis, and individuals recently released from incarceration. One commenter noted

that repealing this SEP without modifying existing limits on Short-Term Limited Duration Insurance (STLDI) would result in coverage gaps for low-income individuals. One commenter raised concerns that consumers who become uninsured due to the proposed the repeal of this SEP would instead need to utilize Medicaid if they have a medical emergency.

Response: We acknowledge commenters' concerns and note that we are simply finalizing a 1-year pause to the 150 percent FPL SEP to address urgent program integrity concerns. At the beginning of PY 2027, the 150 percent FPL SEP will begin again.

We appreciate the commenter's analysis of the intersection between STLDI and the repeal of this SEP and acknowledge the commenter's suggestions for future changes to STLDI policy. We agree that STLDI coverage may be a valuable option for uninsured individuals who are not able to enroll in Exchange coverage through an SEP, given that STLDI policies generally offer year-round enrollment.[168]

We disagree with the commenter who expressed concerns about individuals who would have otherwise used this SEP during the pause needing to rely on Medicaid instead. The 150 percent FPL SEP is only available to individuals who are eligible for APTC, meaning that they are not eligible for Medicaid. Therefore, individuals who would have otherwise used the 150 percent FPL SEP during the pause are generally not otherwise eligible for Medicaid. Individuals who are eligible for Medicaid can and should continue to utilize Medicaid's year-round enrollment.

Comment: Comments from States, individuals, and advocacy groups opposed the repeal of the 150 percent FPL SEP and expressed their view that it is not a major driver of adverse selection, as claimed in the proposed rule. Commenters asserted that people do not wait until they are sick to enroll in coverage as they have no incentive to wait when their monthly

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[168] *https://www.cato.org/policy-analysis/biden-short-term-health-plans-rule-creates-gaps-coverage#short-term-limited-duration-insurance.*

premiums are zero or nearly zero dollars. Commenters further noted that it is not prudent for individuals to wait until they are sick to enroll in coverage through this SEP because their plan effective date and their access to care are not instantaneous.

Some commenters stated that even if individuals wait until sick to enroll into coverage, the opportunity to enroll via the 150 percent FPL SEP should be made available as it could result in a net positive impact because it promotes continuous coverage in the future. One commenter cited a study showing that even if there is some evidence of adverse selection amongst SEP enrollees, most care that was sought was "nondiscretionary". One State Exchange cited data showing that 85 percent of the 150 percent FPL SEP enrollees remained enrolled throughout the rest of the plan year, claiming that this shows the SEP supports continuous coverage. One organization noted that in 2024, only half of Coloradans who qualified for subsidized coverage enrolled in coverage, demonstrating that not everyone who is eligible enrolls into coverage regardless of their health needs. The organization also stated that in prior rulemaking we found that the risk of adverse selection associated with this SEP was lower than anticipated.

Response: We appreciate commenters' analysis of the extent to which the 150 percent FPL SEP may contribute to adverse selection and we acknowledge commenters' concerns. While we are not able to quantify the extent to which the 150 percent FPL SEP may drive adverse selection, we still believe it is reasonable to conclude that this SEP creates a risk of adverse selection.

We are committed to ensuring that consumers have continuous coverage, however, and we believe that finalizing the pause of the 150 percent FPL best balances the need to address urgent program integrity concerns with the long-term desire to promote enrollment efficiencies. We will continue to evaluate adverse selection in the marketplace after the enhanced subsidies expire.

Comment: Commenters from States, individuals, and advocacy groups opposed the repeal of the 150 percent FPL SEP by stating that removing the 150 percent FPL SEP could deter young and healthy people from enrolling in coverage and destabilize the risk pool, given that healthy individuals may be more easily deterred by administrative hurdles to coverage. State Exchanges cited their own research and researchers cited State Exchange data showing that the per member per month claims costs associated with SEP enrollees were lower than costs for non-SEP enrollments. One commenter referenced actuarial research specific to the State of New York suggesting that lower-income APTC enrollees had better risk than their higher income counterparts. Commenters additionally cited studies demonstrating that States that offered broad, continuous SEPs during the COVID-19 PHE saw greater decreases in consumers' prospective risk scores, indicating a healthier enrollee population, than States that did not. One commenter shared an analysis conducted by industry pricing actuaries showing that premiums could increase after the repeal of 150 percent FPL SEP, based on data demonstrating that loss ratios for SEP enrollees as compared to OEP enrollees have improved since the 150 percent FPL SEP was introduced. Commenters encouraged HHS to include data in this rulemaking regarding the claims costs, loss ratios, or risk profiles of individuals who utilized the 150 percent FPL SEP to enroll in coverage through the FFM, and one commenter suggested that failing to do so constituted a violation of the APA.

Response: We appreciate commenters' narrative on how repealing the 150 percent FPL SEP along with the administrative barriers to enrollment may disproportionately deter individuals who are healthy from enrolling in coverage. As explained in this rule, we are not repealing the 150 percent FPL SEP, we are pausing it through PY 2026 to address the surge in improper enrollments for ineligible consumers as the expanded subsidies expire.

Comment: Commenters also disagreed with the agency's claim that the 150 percent FPL SEP is a major driver of fraud and stated that efforts to address improper enrollments, while

laudable, should be more focused on preventing abuses by agents and brokers instead of limiting enrollment pathways. Many commenters expressed their belief that HHS' estimate of improper enrollments was flawed and noted that HHS' analysis of Census data in Florida to Exchange data was an "apples-to-oranges" comparison and was not generalizable nationwide. One State Exchange highlighted that they performed a similar analysis of Census data in their State and found that they had fewer enrollees with incomes at or below 150 percent of the FPL than were reported in Census data. Some asserted that increased enrollment among low-income enrollees could be explained by Medicaid Unwinding, improved messaging and outreach, enhanced premiums subsidies. and other factors.

Many commenters responded to our concerns that, in addition to well-documented instances of improper agent and broker behavior, Navigators and Certified Application Counselor (CACs) may encourage individuals to underreport their income so that they qualify for the 150 percent FPL SEP. Commenters noted that enrollment assisters are subject to strict integrity guardrails and that, if anything, assisters tend to encourage consumers to overestimate their income to reduce risk of tax liability. One commenter pointed out that Navigators and CACs were instrumental in sounding the alarm about increases in fraudulent agent and broker behavior in 2023 and 2024, including by participating in meetings with CMS to relay the experiences of their clients. They noted that Navigators and CACs often spend significant time working to resolve issues for clients who have experienced unauthorized enrollments or plan switches performed by agents and brokers, and that there have been no media reports or Department of Justice investigations related to Navigators or CAC misconduct.

Response: Our conclusion that the 150 percent FPL SEP was a source of improper enrollments and plan switches for fully-subsidized enrollees was informed by our work responding to the influx of consumer complaints; these complaints included detailed narratives that often implicated the 150 percent FPL SEP as a pathway for unauthorized behavior. The

Department of Justice (DOJ) has recently initiated action against several brokers alleging that they have inflated consumers' income levels to make them appear eligible and enroll in coverage they do not qualify for, resulting in improper payments of APTC and improper commissions for agents, brokers, and web-brokers.

We acknowledge that with the expiration of the expanded subsidies there is diminished incentive and opportunity for fraud and improper enrollment. That said, the current rates of such improper enrollment are exceedingly high and necessitate some action as the subsidy environment normalizes. Pausing the 150 percent FPL SEP will help the Exchanges shed the excess levels of improper enrollments they are currently experiencing in PY 2026 before reverting back to current policy in PY 2027.

We further acknowledge commenters' appreciation for navigators and CACs. However, we also note that commenters did not provide any data supporting the assertion that navigators and CACs are not contributing to improper enrollments.

Comment: Commenters offered other policy and operational solutions to curb the adverse selection and program integrity concerns that we expressed in the rule, including limiting the SEP to new enrollments, limiting consumers to one enrollment or plan change through the SEP every three months, limiting consumers to one enrollment or plan change through the SEP per year, and requiring that consumers' income be verified in order to utilize the SEP. Some commenters proposed alternative approaches to protecting consumers from unauthorized enrollments and plan switches, including requiring two-factor authentication, requiring verbal authorization from a consumer before certain changes can be made, better monitoring of DE/EDE pathways, additional monitoring requirements for agents and brokers with fully-subsidized clients, new penalties for agents and brokers, and more resources for State Departments of Insurance to investigate fraud.

Response: We appreciate the suggestions to focus on alternative methods to enhance program integrity and to explore other solutions to curb fraudulent activities. We agree that these issues require a multi-faceted approach, and we have already been taking actions to address fraud, safeguard the consumers from fraud and harm, and reduce improper payments of APTC. This rule takes a holistic approach to improving integrity and affordability in the individual market through a series of temporary policies designed to address urgent integrity issues and permanent policies designed to improve affordability. We are continuing to explore additional operational solutions to further curb improper enrollments, including two-factor verification. We believe that at least temporarily pausing the 150 percent FPL SEP is an important step to curb improper enrollments while the subsidy environment normalizes. This policy will sunset after the end of PY 2026 and Exchanges will again be permitted to offer 150 percent FPL SEPs.

Comment: Some commenters pointed out that the ACA directs HHS to establish SEPs in circumstances similar to those in Medicare Part D and that Part D has a similar low-income SEP that allows individuals with low incomes to change plans once per month. Commenters also expressed that HHS has a broad legal authority under section 1321(a) and that 1311(c)(6)(C) of the ACA to offer Exceptional Circumstances SEPs as it sees fit.

Response: Section 1311(c)(6)(C) of the ACA states that the HHS Secretary shall require Exchanges to provide SEPs "under circumstances similar to such periods under part D of title XVIII of the Social Security Act," which prescribes SEPs for Medicare Part D coverage. The Medicare Part D SEPs enumerated in title XVIII of the Act primarily include changes in circumstance that necessitate a change in coverage, such as involuntary coverage loss. While we acknowledge that Medicare Part D offers a low-income SEP in regulation at 42 CFR 423.38(c)(4),[169] section 1311 of the ACA only requires that Exchanges provide SEPs similar to

[169] Social Security Act § 1860D-01(b)(3)(A).

those established in title XVIII of the Act, and title XVIII of the Act does not include income-based SEPs. Therefore, the Department is of the view that the best reading of section 1311 of the ACA is that it does not require CMS to allow Exchanges to offer income-based SEPs. That said, after evaluating comments we have decided that pausing the income-based SEP is the best course of action to balance urgent program integrity needs with long-term desires to promote enrollment efficiencies. The pause will honor commenter concerns that additional data is necessary to discern the causes of improper enrollments.

We further agree with commenters that, since SEPs for exceptional circumstances are allowed under title XVIII of the Act, that Exchanges are required by statute to offer exceptional circumstance SEPs. This requirement is also reflected in Exchange regulations at § 155.420(d)(9). While both the statute and Exchange regulations do not define what constitutes an exceptional circumstance, we believe that a plain understanding of the term compels the conclusion that simply having a low income is not an exceptional circumstance. This interpretation is further supported by longstanding FFE sub-regulatory guidance, which notes that exceptional circumstance SEPs are generally granted on a case-by-case basis.[170]

Comment: Commenters stated that nearly all State Exchanges currently offer the 150 percent FPL SEP or income-based SEPs with higher income thresholds. Many State Exchanges that offer income-based SEPs indicate that they are aware of zero reports of unauthorized plan switching or enrollments in their Exchanges, due to factors including more stringent security measures as compared to the FFM's DE and EDE pathways. One State Exchange noted it has an integrated eligibility and enrollment system that prevents Medicaid-eligible consumers from utilizing this SEP and experiences limited utilization of the SEP, along with no program integrity issues. As such, commenters pointed out that State Exchanges should be able to maintain the

[170] *See* Section 5.8 of the FFE Enrollment Manual: https://regtap.cms.gov/reg_librarye.php?i=5507.

flexibility to design their Exchanges to meet local needs. Commenters also stated that Federal law specifies required SEPs, but does not preclude States from establishing additional SEPs. One State Exchange expressed concerns that the proposal reverses standing deference to State authority regarding the establishment of SEPs. They also stated that the effective date to repeal the 150 percent FPL SEP imposes major costs on State Exchanges which were not accounted for in the proposed rule.

Response: While we appreciate commenters' concerns, we feel it is critical to pause this SEP pathway as soon as possible and for all Exchanges, due to its potential to drive improper enrollments in the fully-subsidized QHP policy environment. We also believe that there will be residual improper enrollments extending into PY 2026, necessitating a pause through the end of PY 2026, at which time the 150 percent FPL SEP will resume. We acknowledge that State Exchanges, unlike the FFE, have not experienced high rates of unauthorized enrollments or unauthorized plan switches driven by noncompliant agents, brokers, and web-brokers. However, as discussed in detail in section V.C.18. of this final rule, improper enrollments also include individuals with incomes below 100 percent of the FPL who intentionally overstate their incomes in order to qualify for subsidized Exchange coverage, as well as for the 150 percent FPL SEP. We believe that pausing the 150 percent FPL SEP best balances the need to address urgent program integrity concerns with the long-term desire to promote enrollment efficiencies. This modification is intended to be responsive to State Exchange comments noting that this measure may not be necessary to ensure program integrity in these State Exchanges in the long term. We further note that Exchange regulations at § 155.410(a)(2) require that all Exchanges, including State Exchanges, only permit individuals to enroll in or change their QHP during OEP or during a special enrollment period described in § 155.420.

We acknowledge that we did not fully account for State Exchanges' implementation costs in the proposed rule and have updated section V.C.12. of this final rule to include an estimate of such costs.

Comment: Some commenters expressed concerns with the proposal's effective date and asked that the effective date be delayed until PY 2026 or PY 2027 to give State Exchanges more time to make IT changes and to give consumer-facing organizations time to update education and outreach strategies.

Response: Because of concerns regarding improper enrollment and in order to protect the integrity of all Exchanges, we are maintaining our proposed effective date. Due to the primary concerns of fraudulent enrollments, unauthorized plan switching, and the 150 percent FPL SEP's overall impact on the risk pool, the provisions in this section will be effective 60 days following the effective date of this rule. In response to concerns, however, we are simply pausing the 150 percent FPL SEP through PY 2026, at which time Exchanges will be permitted to begin offering the SEP again.

Comment: Some commenters expressed concerns related to the proposed change at § 147.104(b)(2), stating that they opposed changes to eliminate the 150 percent FPL SEP for all group and individual market coverage.

Response: We clarify that the conforming amendment to § 147.104(b)(2) does not substantively impact group or individual market SEP availability. Rather, the change to § 147.104(b)(2) pauses the 150 percent FPL SEP from a list of SEPs that issuers are not required to provide for individual market coverage offered outside of the Exchange through PY 2026.

Comment: One commenter expressed concern about the impact of the proposed removal of the 150 percent FPL SEP on the monthly SEP available to members of a Federally recognized Tribe.

Response: We clarify that the proposal to pause the 150 percent FPL SEP does not

impact the monthly SEP for members of Federally recognized Tribes under 45 CFR 155.420(d)(8).

Comment: One commenter, a State Insurance Commissioner, noted that they opposed the proposed repeal of the 150 percent FPL SEP but did not have adequate time to fully analyze the impact of the proposed change due to the limited comment window and requested that interested parties be granted additional time.

Response: We acknowledge the commenter's concerns and have accounted for them by finalizing a pause to the 150 percent FPL SEP to best balance urgent program integrity concerns with a long-term desire to promote enrollment efficiencies.

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

In the 2025 Marketplace Integrity and Affordability proposed rule (90 FR 12982 through 12985), we proposed to amend § 155.420(g) to reinstate (with modifications) the requirement that Exchanges on the Federal platform must conduct pre-enrollment verification of eligibility of applicants for other categories of individual market SEPs in line with operations prior to the implementation of the 2023 Payment Notice and to eliminate the provision that states that Exchanges on the Federal platform will conduct pre-enrollment special enrollment verification of eligibility only for SEPs under paragraph (d)(1) of this section.[171] We proposed to further amend § 155.420(g) to require all Exchanges to conduct pre-enrollment verification of eligibility for at least 75 percent of new enrollments through SEPs.

In the 2018 Payment Notice proposed rule (81 FR 61456, 61502), we expressed a commitment to making sure that SEPs are available to those who are eligible for them and equally committed to avoiding any misuse or abuse of SEPs. To avoid misuse and abuse, we

[171] Currently, § 155.420(g) provides that Exchanges on the Federal platform will conduct pre-enrollment special enrollment verification of eligibility only for SEPs for loss of minimum essential coverage. Prior to the implementation of the 2023 Payment Notice, Exchanges on the Federal platform conducted manual verification for five SEPs: marriage, adoption, moving to a new coverage area, loss of minimum essential coverage, and Medicaid/CHIP Denial.

implemented verification processes for SEPs in the Market Stabilization Rule (82 FR 18357 through 18358). In setting these processes, we acknowledged in the Market Stabilization Rule (82 FR 18357 through 18358) competing concerns over how verification can impact the individual market risk pool and, in turn, impact premium affordability.

Verification protects the risk pool from ineligible individuals enrolling only after they become sick or otherwise need expensive health care services or medical products/equipment. However, verification can also undermine the risk pool by imposing a barrier to eligible enrollees, which may deter healthier, less motivated individuals from enrolling. After analyzing enrollment and risk pool data against these competing concerns, we stated in the proposed rule (90 FR 12983) that we believe the current SEP verification requirements do not provide enough protection against misuse and abuse. This negatively impacts both the risk pool and program integrity around determining eligibility for APTC and CSR subsidies. We stated that we believe the positive impact of verification on the risk pool far exceeds the potential negative impact on the risk pool. Therefore, we proposed to amend § 155.420(g) to remove the provision that limits Exchanges on the Federal platform from conducting pre-enrollment verification for only the loss of minimum essential coverage SEP, which would allow us to reinstate pre-enrollment verification for other SEPs on Exchanges on the Federal platform. We further proposed to amend § 155.420(g) to require all Exchanges to conduct pre-enrollment eligibility verification for SEPs.

Section 1311(c)(6) of the ACA requires that Exchanges establish enrollment periods, including SEPs for qualified individuals, for enrollment in QHPs. Section 1311(c)(6)(C) of the ACA directs the Secretary to require Exchanges to provide for the SEPs specified in section 9801 of the Code and other SEPs under circumstances similar to such periods under part D of title XVIII of the Act. Section 2702(b)(2) of the PHS Act also directs issuers in the individual and group market to establish SEPs for qualifying events under section 603 of the Employee Retirement Income Security Act of 1974. Section 1321(a)(1)(A) of the ACA and section

2792(b)(3) of the PHS Act directs the Secretary to issue regulations with respect to these requirements.

Prior to June 2016, we largely permitted individuals seeking coverage through the Exchanges to self-attest to their eligibility for most SEPs and to enroll in coverage without further verification of their eligibility or without submitting proof of prior coverage. After a GAO undercover testing study of SEPs observed that self-attestation could allow applicants to obtain subsidized coverage they would otherwise not qualify for and then found 9 of 12 of GAO's fictitious applicants were approved for coverage on the Federal and selected State Exchanges, we began implementing policies to curb potential abuses of SEPs.[172] In 2016 we added warnings on *HealthCare.gov* regarding inappropriate use of SEPs. We also eliminated several SEPs and tightened certain eligibility rules.[173] Also in 2016, we announced retrospective audits of a random sampling of enrollments through SEPs for loss of minimum essential coverage and permanent move, two commonly used SEPs. Additionally, we created the Special Enrollment Confirmation Process under which consumers enrolling through common SEPs were directed to provide documentation to confirm their eligibility.[174] Finally, we proposed to implement (beginning in June 2017) a pilot program for conducting pre-enrollment verification of eligibility for certain SEPs.[175]

In response to the deteriorating stability of the individual health insurance market leading into PY 2017, we implemented the Market Stabilization Rule (82 FR 18355 through 18356) in 2017 which sidestepped the pilot program and, instead, took quick action to require pre-enrollment verification for most SEPs. Understanding the potential for verifications to deter

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[172] GAO. (2016 Nov.). Patient Protection and Affordable Care Act: Results of Enrollment Testing for the 2016 Special Enrollment Period, GAO-17-78. *https://www.gao.gov/products/gao-17-78.*
[173] CMS. (2016, Feb. 24). Fact Sheet: Special Enrollment Confirmation Process. *https://www.cms.gov/newsroom/fact-sheets/fact-sheet-special-enrollment-confirmation-process.*
[174] Ibid.
[175] CMS. (n.d.). Pre-Enrollment Verification for Special Enrollment Periods. *https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/downloads/pre-enrollment-sep-fact-sheet-final.pdf.*

eligible people from enrolling, we studied the initial consumer experience with this pre-enrollment verification process and published our findings in 2018.[176] For PY 2017, this report showed that we averaged a response time of 1-to-3 days to review consumer-submitted documents. In addition, the vast majority (over 90 percent) of SEP applicants who made a plan selection and were required to submit documents to complete enrollment were able to successfully verify their eligibility for the SEP. We conducted additional research for the following plan years through 2021. Based on data from PY 2019, the last year prior to the PHE which greatly impacted SEPV processing, the majority of consumers (73 percent) were able to submit documents within 14 days of their SEP verification issue (SVI) being generated. Also, we found that the majority of consumers (63 percent) were able to fully resolve their SVI within 14 days of it being generated. That resolution percentage increases to 86 percent by 30 days.[177] We also found that for PY 2019, only approximately 14 percent or 75,500 individuals were unable to resolve their SVI out of the total population of SEP consumers who received an SVI.

In the 2023 Payment Notice (87 FR 27278), we noted that pre-enrollment verification can also negatively impact the risk pool. At that time, we did not analyze the experience of people applying for SEPs to assess the impact on the risk pool. Rather, it was our perception that the extra step required by verification can deter eligible consumers from enrolling in coverage through an SEP, which in turn, can negatively impact the risk pool because younger, often healthier, consumers submit acceptable documentation to verify their SEP eligibility at much lower rates than older consumers. To mitigate this potential negative impact on the risk pool and streamline the consumer experience, we then scaled back pre-enrollment verification for every

[176] CMS. (2018, July 2). The Exchanges Trends Report. https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/2018-07-02-Trends-Report-3.pdf.
[177] Consumers who resolve an SVI in more than 30 days are able to do so through extensions they are eligible to receive.

SEP type, with the exception of the SEP for new consumers who attest to losing minimum essential coverage.

Since the implementation of pre-enrollment verification for SEPs in the Market Stabilization Rule, we continue to monitor pre-enrollment verification to determine its impact, including on enrollments by different groups of individuals affected by the process. After 3 years of experience applying pre-enrollment verification to only the SEP for losing minimum essential coverage, we reviewed whether this policy achieves the right balance between reducing enrollment barriers and protecting against abuse and misuse of SEPs. This review shows the prior use of pre-enrollment verification for all SEPs achieved the better balance. As noted previously in this section, our initial review of pre-enrollment verification during PY 2017 did not find any substantial enrollment barrier. We applied this same analysis to PY 2018 and PY 2019 before the COVID-19 PHE changed patterns of SEP use and found pre-enrollment verification continued to not present any substantial enrollment barrier. We also compared the use of SEPs before and after the implementation of pre-enrollment verification for PY 2017. This comparison revealed a substantial shift to SEPs that were not subject to pre-enrollment verification that required consumers to submit documentation, suggesting agents, brokers, and people had been previously abusing SEPs and shifted to special enrollment that did not require document submissions to continue this potential abuse of SEPs.

When we sought feedback on the proposal to reduce pre-enrollment verification for SEPs in PY 2023 in the 2023 Payment Notice (88 FR 27278 through 27279), one commenter pointed out that data from the HHS-operated risk adjustment model, specifically the factors related to partial-year enrollments, showed a significant decrease in the negative impact of these enrollments on the overall risk pool from 2017 to 2022.[178] This suggests that individuals who

[178] Comment ID CMS-2021-0196-0196, 01/27/2022 available at *https://www.regulations.gov/comment/CMS-2021-0196-0196.*

enroll for only part of the year—who are more likely to use SEPs—now pose a smaller risk to the insurance pool than they did in the past. The commenter concluded that a likely factor is that fewer people are abusing SEPs to wait to get coverage until they need care due to pre-enrollment SEP verification. Another commenter noted how loss ratios for SEP enrollments, as compared to OEP enrollments, increased after pre-enrollment verifications were relaxed during the COVID-19 public health emergency.[179] We reviewed enrollment patterns and found there was a substantial increase in the enrollment duration after the implementation of pre-enrollment verification for all SEPs, which adds another data point suggesting pre-enrollment verification helped encourage continuous enrollment by making it more difficult to engage in strategic enrollment and disenrollment. Consistent with the comment to the 2023 Payment Notice, partial year enrollment factors did improve after PY 2017. Issuer-level enrollment data similarly shows a decline in the percent of disenrollments as a percent of total enrollments from about 20 percent in PY 2017 to about 12 percent in PY 2019.[180] After we reduced pre-enrollment verification for SEPs for PY 2023, the average number of months enrolled per consumer declined from 4.5 months in PY 2022 to 4.3 months in PY 2023.[181] While this decline may be due, in part, to an increase in mid-year enrollments from people being disenrolled from Medicaid after the Medicaid continuous enrollment condition ended on April 1, 2023, it may also be linked to the reduction in pre-enrollment verification for SEPs.

In the proposed rule (90 FR 12984), we stated that we acknowledge pre-enrollment verification can deter eligible consumers from enrolling in coverage through an SEP because of the burden of document verification. However, as noted previously, our prior analyses show the verification process does not impose a substantial burden and therefore should not be a barrier to

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[179] Comment ID CMS-2021-0196-0222, 01/27/2022 available at *https://www.regulations.gov/comment/CMS-2021-0196-0222.*
[180] Derived from issuer enrollment data, CMS. (2024, Sept. 10). Issuer Enrollment Data. *https://www.cms.gov/marketplace/resources/data/issuer-level-enrollment-data.*
[181] Ibid.

enrollment. We also stated that documentation to verify SEPs is generally easy for applicants to access and provide to Exchanges. Applicants should have ready access to official documents acknowledging employer separations, loss of minimum essential coverage, marriage, divorce, births, adoptions, death, gaining lawful presence or citizenship certificates, a new address, or a release from incarceration. Pre-Enrollment SEP verification takes place simultaneously with the consumer's SEP timeline on the Federal platform currently. This means that Pre-Enrollment SEP verification takes place while the consumer's SEP timeline is running.[182] Typically, the SEP window on the Exchanges on the Federal platform is 60 days from when a consumer experiences a qualifying event, and a Special Enrollment Period Verification Issue (SVI) is triggered when a consumer selects a plan during that timeframe.

In addition, we previously found younger people submit acceptable documentation to verify their SEP eligibility at lower rates than older consumers, which can negatively impact the risk pool as younger consumers use less health care on average.[183] While successful submission rates might be lower for younger people, the overall effect on the risk pool is minimal because it is a very small number of younger enrollees relative to older enrollees. This small impact on the total enrollment among younger people from SEPs would not lead to a meaningful increase in the proportion of young people enrolled and, as a result, not lead to a meaningful improvement to the risk pool. Therefore, in the proposed rule (90 FR 12984), we stated that we expect any negative impact on the risk pool would be minimal and substantially outweighed by the reductions in people misusing and abusing SEPs.

The weight of the data analysis presented here shows how the implementation of pre-enrollment verification for applicable SEPs reduced misuse and abuse of SEPs without deterring eligible people from enrolling in coverage in a measurable way. This improves the risk pool by

[182] Descriptions and information on the length of SEPs can be found at § 155.420(c).
[183] This statistic is based on SEPV resolution data from PY 2019.

restricting people from gaming SEPs to wait to enroll until they need health care services. An improved risk pool lowers premiums which, in turn, makes health coverage more affordable for unsubsidized enrollees and lowers the average APTC by lowering the average premium for the benchmark plan used to set APTC. Moreover, pre-enrollment verification for SEPs strengthens program integrity by denying ineligible enrollments and discouraging ineligible enrollees who know they cannot meet verification standards from attempting to enroll which, in turn, reduces Federal subsidies to ineligible consumers who would otherwise enroll and receive APTC and CSR subsidies. Consequently, we stated in the proposed rule (90 FR 12984) that this proposal would reduce Federal expenditures by both lowering the average APTC paid due to a reduction in the benchmark plan premium used to calculate APTC and reducing the number of ineligible people who would otherwise improperly enroll in APTC- and CSR-subsidized coverage. Therefore, we proposed to amend § 155.420(g) to remove the limitation on Exchanges on the Federal platform to conduct pre-enrollment verification for only the loss of minimum essential coverage special enrollment and also reinstate (with modifications) pre-enrollment verification requirement for other categories of SEPs.

In implementing pre-enrollment verifications for SEPs in the Market Stabilization Rule (82 FR at 18356), HHS did not require that all Exchanges conduct SEP verifications, to allow State Exchanges to determine the most appropriate way to ensure the integrity of the SEPs. Currently, all State Exchanges have flexibility under § 155.420(g) to conduct pre-enrollment verification of SEPs. Based on our analysis of the data showing how SEP verifications successfully encouraged continuous enrollment on Exchanges on the Federal platform, we stated in the proposed rule (90 FR 12985) that we believe State Exchange enrollments would benefit from implementing a similar policy.

In the proposed rule (90 FR 12985), we stated that we also believe State Exchanges now have more experience with conducting SEP verifications, which would make broader

implementation less burdensome than before. We sought comments regarding this proposal including State Exchanges' expectations regarding the time and expense needed to comply. Currently, all but four State Exchanges conduct either pre- or post-enrollment verification of at least one special enrollment type, and most State Exchanges had previously implemented a process to verify the vast majority of SEPs requested by consumers. Therefore, we proposed to amend § 155.420(g) to require all Exchanges to conduct eligibility verification for SEPs.

We also proposed to require that Exchanges, including all State Exchanges, conduct SEP verification for at least 75 percent of new enrollments through SEPs for consumers not already enrolled in coverage through the applicable Exchange. We proposed that Exchanges must verify at least 75 percent of such new enrollments based on the current volume of SEP verification by Exchanges. In the proposed rule (90 FR 12985), we stated that the 75 percent threshold was chosen since we believe that most States would be able to meet this threshold by verifying at least their two or three largest SEP types based on current SEP volumes. If the Exchange is unable to verify the consumer's eligibility for enrollment through the SEP, then we stated that the consumer is not eligible for enrollment through the Exchange under that SEP, and any plan selection under that SEP would have to be canceled. Should an enrollment under an SEP for which eligibility cannot be verified become effectuated, the enrollment through the Exchange may be terminated in accordance with § 155.430(b)(2)(i). If an Exchange chooses to pend a plan selection prior to enrollment, and the Exchange cannot verify eligibility for the SEP, then the consumer would be found ineligible for the SEP, and the plan selection would not result in an enrollment. We stated in the proposed rule that the determination of how many enrollments would constitute 75 percent would be required to be based on enrollment through all SEPs. We stated that this would provide Exchanges with implementation flexibility so they can continue to decide which special enrollment types to verify and the best way to conduct that verification. Exchanges would not be required to verify eligibility for all SEPs, since the cost to verify

eligibility for SEP triggering events with very low volumes could be greater than the benefit of verifying eligibility for them.

While we proposed to eliminate the current flexibility Exchanges have under § 155.420(g) to provide exceptions to SEP verification processes, we stated in the proposed rule (90 FR 12985) that we are continuing certain flexibilities that State Exchanges currently have to design eligibility verification processes that are appropriate for their market and Exchange consumers, such that State Exchanges may have such flexibility in their approaches for meeting the requirement proposed at § 155.420(g) to verify eligibility for an SEP. Specifically, under § 155.315(h), State Exchanges have the flexibility to propose alternative methods for conducting required verifications to determine eligibility for enrollment in a QHP under subpart D, such that the alternative methods proposed reduce the administrative costs and burdens on individuals while maintaining accuracy and minimizing delay. We proposed to use the existing authority at § 155.315(h) to allow State Exchanges to request HHS approval for use of alternative processes for verifying eligibility for SEPs as part of determining eligibility for SEPs under § 155.305(b).[184] We stated that this would allow, for instance, the State Exchanges that have administrative burden and cost concerns the option to coordinate with HHS to devise and agree upon the best approach for SEP verification for their specific population. We also stated that we recognize that State Exchanges may vary in their approach and technical capabilities relating to verification of SEPs and may need additional time to implement this requirement. Therefore, we proposed to allow Exchanges until PY 2026 to implement SEP verification. We sought comment on this topic and suggestions to alleviate this concern.

We sought comment on these proposals. With respect to SEP verification, we sought comment from States about the 75 percent verification threshold and whether it should be based

[184] Such requests would be made through the State-based Marketplace Annual Reporting Tool (SMART; OMB Control Number 0938-1244).

on past year SEP enrollments or some other appropriate metric such as future year projections understanding that unforeseen events may occur that may drive up or down enrollments from year-to-year. In the proposed rule (90 FR 12985), we stated that we also understand that State Exchanges have matured and that even smaller State Exchanges may find applying pre-verification to all new enrollments through SEPs less burdensome than the first time we proposed this policy. Therefore, we also invited comment on whether State Exchanges believe it to be feasible to apply pre-enrollment verification to enrollments through SEPs beyond the stated 75 percent in alignment with our proposed goal for Exchanges on the Federal platform.

After careful consideration of public comments, we have decided to finalize and implement these policies with a significant modification – for Exchanges on the Federal platform, each of the rules outlined in this section will automatically sunset at the end of PY 2026, on December 31, 2026. As with other policies in this rule and as discussed in the Executive Summary and section III.B. earlier in this final rule, we recognize that the imminent program integrity concerns are being driven by the existence of fully-subsidized plans. The expiration of the enhanced subsidies coupled with the temporary program integrity requirements enacted by this rule will right-size marketplace enrollment in PY 2026 and should obviate the need for ongoing higher levels of program integrity policies. As the excess levels of improper enrollments are taken down in 2026, we expect the lower subsidy levels to appropriately deter future levels of improper enrollments from ever growing so high again, diminishing the returns of the temporary policies we are enacting in this rule. In other words, the burden of continuing such policies will reach a point at which they outweigh any benefits. For these reasons, we are finalizing this policy for PY 2026 only, with a reversion to the previous policy for PY 2027 and beyond.

Further, we are declining to finalize these provisions for State Exchanges. As discussed in great detail in this rule, the program integrity issues are largely concentrated in Exchanges utilizing the Federal platform. Given the lower levels of improper enrollment in States, we don’t

believe the burden that would be imposed by implementing these requirements for PY 2026 would be worth the benefits.

We summarize and respond to public comments received on the proposed adjustments to pre-enrollment SEP verification below.

Comment: The majority of commenters, including general advocacy groups, disease advocacy groups, providers, State agencies, State Exchanges, agents and brokers, and one health insurance issuer, noted that the increased SEP verification requirements would pose an additional burden to consumers and increase barriers to coverage for qualified individuals. These commenters also noted that these increased burdens and barriers would result in decreased enrollment and worse health outcomes for those impacted.

Response: We acknowledge commenters' concerns. However, we believe that the additional burden is not significant enough to outweigh the merits of SEP verification and the increases in program integrity that it provides, especially since we are only finalizing the requirement for a single year. We also note that the SEP verification policy we are proposing for the Exchanges on the Federal platform is not wholly new and is partially a return to the previous policy. When SEP verification was active for most SEP types prior to the changes implemented in the 2023 Payment Notice, most consumers who received SEP Verification Issues were able to resolve them in a timely manner as noted previously in this preamble.

Comment: Many commenters, particularly advocacy groups, individuals, labor groups, and State Exchanges, noted concerns that SEP verification negatively impacts younger consumers in particular who have lower resolutions rates than other generations of consumers. These commenters noted that younger individuals improve the risk pool and help to lower premiums. On average, increased verification tends to deter younger individuals from enrolling, which could have the effect of raising enrollee premiums.

Response: We appreciate the concerns raised. As noted previously in this preamble, we acknowledge that younger consumers do resolve their SEP verification issues at a lower rate than older consumers. While we acknowledge that this policy can have the effect of deterring some young people from enrolling in coverage, we do not think that it outweighs the benefits of preventing improper enrollments in Exchanges on the Federal platform. Further, finalizing the policy for a single year is unlikely to have demonstrable effects on the risk pool over any longer term. This policy balances the need to address urgent program integrity concerns with the long-term desire to promote enrollment efficiencies.

Comment: Several commenters, which included health insurance issuers, providers, advocacy groups, and individuals, expressed support for this proposal. These comments cited concerns around fraud in the marketplace and how they believe that increased SEP verification would reduce or eliminate fraud related to SEPs. Several commenters, in particular, noted that increased verification would help to prevent agent, broker, and web-broker fraud. Overall, these commenters agreed that the SEP verification provision would have the desired effect of increasing program integrity on the Exchanges.

Response: We appreciate these comments highlighting that this policy will have the desired effect of increasing program integrity and addressing improper enrollments in the marketplace during its temporary implementation in PY 2026. While we do acknowledge that most agents, brokers, and web-brokers seek to comply with HHS rules in good bad faith, we also believe that increased verification requirements for SEPs will deter agents, brokers, web-brokers, and consumers from completing enrollments when a consumer is not eligible. We believe that implementing SEP verification policy will ensure only qualified consumers are enrolling through SEPs and, as expressed previously, we anticipate benefits similar to those we experienced when SEP verification was first implemented as a result of the 2017 Market Stabilization Rule. This temporary policy will help stabilize the marketplace in PY 2026 as the subsidy environment

normalizes and the high levels of improper enrollments are reduced before reverting back in PY 2027.

Comment: Many commenters, particularly State Exchanges, advocacy groups, providers, and individuals, noted concerns around the increased financial and administrative burdens the rule would have on State Exchanges and the Exchanges on the Federal platform. They also noted concern around a decrease in flexibility for State Exchanges to determine what verification methods work best for their States. Many State Exchanges expressed that they do not see any indications of SEPs being used fraudulently on their Exchange and believe that the proposed rule would place additional costs and burdens on them with no real benefit. Other State Exchanges did note that they were not concerned because they are already in compliance with this proposal.

Response: We appreciate commenters' concerns. We recognize that there is a great deal of variance between States in terms of levels of SEP verification and whether it is conducted pre or post enrollment. After careful consideration of public comments, we have decided we will not be finalizing these proposals for State Exchanges in an effort to address concerns around increased burdens and costs. Additionally, we have decided to finalize and implement the proposed policy with a significant modification – for Exchanges on the Federal platform, each of the rules outlined in this section will sunset by their terms after the completion of one new coverage year, PY 2026, on December 31, 2026. Sunsetting these rules after PY 2026 will allow the policy to achieve its desired effect of program integrity.

Comment: Several commenters, which included providers, advocacy groups, one State Exchange, one EDE partner, one health insurance issuer, and individuals, expressed that Exchanges should pursue alternate verification methods or focus on improving the current system as opposed to increasing SEP verifications for consumers. Some of these commenters noted that HHS should focus more on regulating agents and brokers and less on increasing consumer verifications.

Response: We appreciate the suggestions related to alternate methods of verification and system improvements to improve program integrity. While we will continue to identify and consider effective methods of verifying eligibility, we believe that solely focusing on agents, brokers, and web-brokers to the exclusion of adopting effective verification processes is not the best policy because it ignores identified weaknesses in Exchange verification processes as well as our responsibility to comply with the ACA. We acknowledge that improper enrollments are not conducted solely by agents, brokers, and web-brokers, and that most are compliant with HHS rules, and operate in good faith. We have already taken action to address improper enrollments by agents, brokers, and web-brokers as outlined elsewhere in this rule. We are committed to continuing to address those issues. We believe the temporary policies in this rule, including SEP verification, will help to directly address improper enrollments committed by agents, brokers, and web-brokers, while promoting flexibility and efficiencies in enrollment processes over the long-term.

C. Part 156 —Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges

1. Prohibition on Coverage of Specified Sex-trait Modification Procedures as an EHB (§§ 156.115(d) and 156.400)

In the 2025 Marketplace Integrity and Affordability proposed rule (90 FR 12985 through 12987), we proposed to amend § 156.115(d) to provide that issuers of non-grandfathered individual and small group market health insurance coverage – that is, issuers of coverage subject to EHB requirements – may not provide coverage for sex-trait modification as an EHB beginning with PY 2026.

Section 1302(a) of the ACA provides for the establishment of an EHB package that includes coverage of EHB (as defined by the HHS Secretary), cost-sharing limits, and AV requirements. Among other things, the law directs that the scope of the EHB be equal in scope to

the benefits provided under a typical employer plan and that they include at least the 10 general categories outlined in the statute and the items and services covered within those categories.[185]

Section 156.115(d) currently provides that for plan years beginning on or before January 1, 2026, an issuer of a plan offering EHB may not include routine non-pediatric dental services, routine non-pediatric eye exam services, long-term/custodial nursing home care benefits, or non-medically necessary orthodontia as EHB; and, for plan years beginning on or after January 1, 2027, an issuer of a plan offering EHB may not include routine non-pediatric eye exam services, long-term/custodial nursing home care benefits, or non-medically necessary orthodontia as EHB. In the EHB Rule (78 FR 12845), we stated that routine non-pediatric dental services are not typically included in the medical plans offered by employers and are often provided as excepted benefits by the employer. We accordingly proposed and finalized the rule prohibiting issuers from covering these services as EHB.[186]

Because the scope of EHB must be equal in scope to the benefits provided under a typical employer plan, and coverage of sex-trait modification is not typically included in employer-sponsored plans, in the proposed rule (90 FR 12986), we proposed to add "sex-trait modification" to the list of items and services that may not be covered as EHB beginning in PY 2026. As noted in the proposed rule (90 FR 12986), such procedures sometimes are referred to as "gender affirming care," and were referred to in the proposed rule as "sex-trait modification." The proposed rule (90 FR 12986) stated that the term "sex" is defined as a person's immutable biological classification as either male or female; the term "female" is a person of the sex

[185] *See* section 1302(b)(2)(A) of the ACA. *See also* section 1302(b)(1) of the ACA, delineating the 10 general categories of EHB: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

[186] In the 2025 Payment Notice (89 FR 26343), we finalized the removal of the regulatory prohibition at § 156.115(d) on issuers from including non-pediatric dental services as EHB for plan years beginning on or after January 1, 2027.

characterized by a reproductive system with the biological function of producing eggs (ova); and the term "male" is a person of the sex characterized by a reproductive system with the biological function of producing sperm.[187]

In the proposed rule (90 FR 12986), we stated that although the fact that sex-trait modification is not typically included in employer-sponsored plans is an independent, sufficient, and legally compelling reason for our proposal, we acknowledged recent executive orders[188] that have been subject to preliminary injunctions. We stated that the agency made this proposal independently of the executive orders because sex-trait modification is not typically included in employer health plans and therefore cannot legally be covered as EHB. The agency acknowledged in the proposed rule that two courts have issued preliminary injunctions relating to the executive orders described above and stated that it did not rely on the enjoined sections of the executive orders in making this proposal.

In particular, we noted in the proposed rule (90 FR 12986) that the United States District Court for the Western District of Washington has issued a preliminary injunction that enjoined defendant agencies "from enforcing or implementing section 4 of Executive Order 14187 within the Plaintiff States," as well as "sections 3(e) or 3(g) of Executive Order 14168 to condition or withhold Federal funding based on the fact that a health care entity or health professional provides gender-affirming care within the Plaintiff States." *Washington v. Trump*, No. 2:25-CV-00244-LK, 2025 WL 659057, at *28 (W.D. Wash. Feb. 28, 2025), appeal docketed, No. 25-1922 (9th Cir. Mar. 24, 2025). The United States District Court for the District of Maryland has issued a preliminary injunction that enjoins the Federal defendants in that case "from conditioning,

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[187] *See also*, Section 2 of E.O. 14168 and Office of Women's Health (2025, Feb. 19). Sex-Based Definitions. Dep't of Health and Human Services. Retrieved March 6, 2025, from *https://womenshealth.gov/article/sex-based-definitions.*

[188] Executive Order 14168, "Defending Women From Gender Ideology Extremism and Restoring Biological Truth to the Federal Government" (E.O. 14168); Executive Order 14187, "Protecting Children From Chemical and Surgical Mutilation" (E.O. 14187).

withholding, or terminating Federal funding under section 3(g) of Executive Order 14168 and section 4 of Executive Order 14187, based on the fact that a healthcare entity or health professional provides gender-affirming medical care to a patient under the age of nineteen" and required a written notice "instruct[ing] the aforementioned groups that Defendants may not take any steps to implement, give effect to, or reinstate under a different name the directives in section 3(g) of Executive Order 14168 or section 4 of Executive Order 14187 that condition or withhold Federal funding based on the fact that a healthcare entity or health professional provides gender-affirming medical care to a patient under the age of nineteen." *PFLAG, Inc. v. Trump*, No. CV 25-337-BAH, 2025 WL 685124, at *33 (D. Md. Mar. 4, 2025), appeal docketed, No. 25-1279 (4th Cir. Mar. 24, 2025). We stated in the proposed rule that if our proposal were finalized, it would not conflict with those preliminary injunctions because, among other things, it would be based on independent legal authority and reasons and not the enjoined sections of the executive orders. We further stated that any final rule on this issue would not be effective until PY 2026, and would not be implemented, made effective, or enforced in contravention of any court orders. [189]

In the proposed rule (90 FR 12986), we noted that with regard to whether sex-trait modification is typically included in employer-sponsored plans, we are aware that employer-sponsored plans often exclude coverage for some or all sex-trait modification, and it is our understanding that these exclusions may include use of puberty blockers, sex hormones, and surgical procedures identified in E.O. 14187. We stated that this includes many small group plans that do not cover such services and noted that 42 States chose or defaulted to small group plans as their EHB-benchmark plan selections in 2014 and 2017.[190] In addition, we stated that, of those

[189] HHS intends to notify the courts in both cases about this rule after it has been published in the Federal Register.
[190] CMS. (2016, April 8). Final List of BMPs. *https://www.cms.gov/cciio/resources/data-resources/downloads/final-list-of-bmps_4816.pdf.*

employer-sponsored plans that do cover sex-trait modification, these EHB-benchmark plan documents would indicate that there is inconsistency nationwide with respect to the scope of benefits included. We noted that the infrequent and inconsistent coverage of such benefits is also apparent in the treatment of sex-trait modification by the States and territories, which provides further support that coverage of these benefits is not typical, and we stated our understanding that the majority of States and territories do not include coverage for sex-trait modification in State employee health benefit plans or mandate its coverage in private health insurance coverage.[191] In addition, we noted that 12 States and 5 territories do not mention or have no clear policy regarding sex-trait modification in their employee health benefit plans, and 14 States explicitly exclude sex-trait modification from their State employee health benefit plans.[192]

As explained in the proposed rule (90 FR 12986 through 12987), we believe that coverage of sex-trait modification may be sparse among typical employer plans because the rate of individuals utilizing sex-trait modification is very low; less than 1 percent of the U.S. population seeks forms of sex-trait modification,[193] and this low utilization is apparent in the External Data Gathering Environment (EDGE) limited data set.[194] In this data set, which encompasses the majority of health insurance enrollees covered outside of large group plans,

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[191] Movement Advancement Project. 2025. "Equality Maps: Healthcare Laws and Policies." *https://www.mapresearch.org/equality-maps/healthcare_laws_and_policies. Accessed Feb. 23, 2025.*
[192] Ibid.
[193] *See* Hughes, L.; Charlton, B.; Berzansky, I.; et al. (2025, Jan. 6). Gender-Affirming Medications Among Transgender Adolescents in the US, 2018-2022. *JAMA Pediatr. 179*(3):342-344. *https://jamanetwork.com/journals/jamapediatrics/fullarticle/2828427*; *see also*, Dai, D.; Charlton, B.; Boskey, E.; et. al. (2024, June 27). Prevalence of Gender-Affirming Surgical Procedures Among Minors and Adults in the US. *JAMA Netw Open. 7(6*):e2418814. *https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2820437*.
[194] The EDGE limited data set contains certain masked enrollment and claims data for on- and off-Exchange enrollees in risk adjustment covered plans in the individual and small group (including merged) markets, in States where HHS operated the risk adjustment program required by section 1343 of the ACA, and is derived from the data collected and used for the HHS-operated risk adjustment program.

approximately 0.11 percent of enrollees in non-grandfathered individual and small group market plans utilized sex-trait modification during PYs 2022 and 2023.[195]

We noted that nothing in this proposal would prohibit health plans from voluntarily covering sex-trait modification as a non-EHB consistent with applicable State law, nor would it prohibit States from requiring the coverage of sex-trait modification, subject to the rules related to State-mandated benefits at § 155.170.

We stated in the proposed rule (90 FR 12987) that we are also aware that some interested parties do not believe that sex-trait modification services fit into any of the 10 categories of EHB and, therefore, do not fit within the EHB framework even if some employers cover such services. As discussed in the proposed rule (90 FR 12987), the items and services that comprise sex-trait modification are performed to align or transform an individual's physical appearance with an identity that differs from his or her sex. We stated that we are also concerned about the scientific integrity of claims made to support their use in health care settings. As such, we sought comment on whether it would be appropriate to exclude sex-trait modification as an EHB.

Consistent with the other listed benefits that issuers must not cover as an EHB at § 156.115(d), we did not propose a definition of "sex-trait modification." However, we sought comment on whether we should adopt a formal definition of "sex-trait modification," whether there are current issuer standards with regards to what is considered "sex-trait modification"; and how such a definition could best account for the items and services currently covered or excluded as sex-trait modification by plans subject to the EHB requirement.

We also recognized in the proposed rule (90 FR 12987) that there are some medical conditions, such as precocious puberty, or therapy subsequent to a traumatic injury, where items

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[195] *See https://www.cms.gov/data-research/files-order/limited-data-set-lds-files/enrollee-level-external-data-gathering-environment-edge-limited-data-set-lds*. To request the EDGE limited data set, refer to the instructions at *https://www.cms.gov/data-research/files-for-order/limited-data-set-lds-files.*

and services that are also used for sex-trait modification may be appropriate. We sought comments regarding whether we should define explicit exceptions to permit the coverage of such items and services as EHB for other medical conditions, and what those conditions are, for potential inclusion in finalizing as part of this rule.

We noted in the proposed rule (90 FR 12987) that pursuant to § 155.170(a)(2), a covered benefit in a State's EHB-benchmark plan is considered an EHB. There is no obligation for the State to defray the cost of a State mandate enacted after December 31, 2011, that requires coverage of a benefit covered in the State's EHB-benchmark plan. If a State mandates coverage of a benefit that is in its EHB-benchmark plan, the benefit will continue to be considered EHB and the State will not have to defray the costs of that mandate. However, if at a future date the State updates its EHB-benchmark plan under § 156.111 and removes the mandated benefit from its EHB-benchmark plan, the State may have to defray the costs of the benefit under the factors set forth at § 155.170 as it will no longer be an EHB after its removal from the EHB-benchmark plan.

In the proposed rule (90 FR 12987), we also noted that there are some State EHB-benchmark plans that currently cover sex-trait modification as an EHB. Other State EHB-benchmark plans provide coverage for sex-trait modification, but do not explicitly mention sex-trait modification or any similar term.[196] We stated that if this proposal were finalized as proposed, health insurance issuers would be prohibited from providing coverage for sex-trait modification as an EHB in any State beginning in PY 2026. We further stated that if any State separately mandates coverage for sex-trait modification outside of its EHB-benchmark plan, the State would be required to defray the cost of that State mandated benefit as it would be

[196] The EHB-benchmark plans for California, Colorado, New Mexico, Vermont, and Washington specifically include coverage of some sex-trait modification. The EHB-benchmark plans of six other States do not expressly include or exclude coverage of sex-trait modification. The EHB-benchmark plans of 40 States include language that excludes coverage of sex-trait modification.

considered in addition to EHB pursuant to § 155.170. We explained, however, that if any such State does not separately mandate coverage of sex-trait modification outside of its EHB-benchmark plan, there would be no defrayal obligation. We noted that States may consider mandating coverage of sex-trait modification in the future, in which case defrayal obligations at § 155.170 would apply, and CMS would enforce the defrayal obligations appropriately. Further, we explained that issuers in States in which sex-trait modification is currently an EHB would also be prohibited from covering it as an EHB beginning in PY 2026. However, we explained that they may opt to continue covering sex-trait modification consistent with applicable State law, but not as an EHB. We sought comment on whether additional program integrity measures would be necessary to ensure Federal subsidies do not continue to fund sex-trait modification if this proposal is finalized.

Lastly, we sought comment on the proposed effective date of this proposal. We proposed PY 2026 as the effective date for when issuers subject to EHB requirements would be prohibited from covering sex-trait modification as an EHB. We sought comment specifically on the impact that this proposal would have, if finalized, on health insurance coverage in the individual, small group, and large group markets for PY 2026, or whether an earlier or later effective date is justified.

After consideration of comments and for the reasons outlined in the proposed rule and this final rule, including our responses to comments, we are finalizing this policy with the following modification. In response to comments, we are finalizing at § 156.400 the addition of a definition of "specified sex-trait modification procedure," which means any pharmaceutical or surgical intervention that is provided for the purpose of attempting to align an individual's physical appearance or body with an asserted identity that differs from the individual's sex either by: (1) intentionally disrupting or suppressing the normal development of natural biological functions, including primary or secondary sex-based traits; or (2) intentionally altering an

individual's physical appearance or body, including amputating, minimizing or destroying primary or secondary sex-based traits such as the sexual and reproductive organs. Such term does not include procedures undertaken (1) to treat a person with a medically verifiable disorder of sexual development, or (2) for purposes other than attempting to align an individual's physical appearance or body with an asserted identity that differs from the individual's sex. This policy is applicable for PY 2026 and beyond.

We summarize and respond below to public comments received on our proposal to prohibit issuers subject to EHB requirements from covering sex-trait modification as an EHB beginning with PY 2026.

Comment: Many commenters disagreed with the proposition that coverage for sex-trait modification is not included under a typical employer plan. These commenters cited various reports, including a report from Marsh McLennan,[197] a major employee benefit services company, to dispute this proposition. Many commenters raised as evidence that in the 2025 Corporate Equality Index,[198] the Human Rights Campaign Foundation found that 72 percent of Fortune 500 businesses, and 91 percent of businesses listed on the Corporate Equality Index, offer coverage of treatment for gender dysphoria. These commenters noted that, as a result, over 1,300 major employers nationwide cover this care, 28 times as many businesses as in 2009. These commenters further stated that coverage for gender dysphoria is widespread among State employee plans (24 States and D.C.), Medicaid (27 States, Puerto Rico, and D.C.), and QHPs offered on the Exchanges (55 percent of QHPs across all 50 States covered this care in PY 2025) and that many States prohibit exclusions of coverage for gender dysphoria (24 States and

[197] Umland, B; Hifer, E. Health benefits that matter to the LGBTQ+ community: By the numbers. US Health News, Marsh McLennan, available at https*://www.mercer.com/en-us/insights/us-health-news/health-benefits-that-matter-to-the-lgbtq-community/*.

[198] Human Rights Campaign Foundation. "Corporate Equality Index 2025" available at *https://reports.hrc.org/corporate-equality-index-2025.*

D.C.).[199] Many of these same commenters stated that the KFF 2024 Employer Health Benefit Survey found that only one-third of employers with 200 or more employees responded that they did not offer coverage for sex-trait modification hormone therapy. These commenters further stated that the survey found that the largest firms in the country (5,000 or more employees) employ 43 percent of people with job-based coverage and were significantly more likely to report covering hormone therapy in relation to sex-trait modification in their largest plan by enrollment. Another commenter pointed to a study by Out2Enroll of 2025 silver plans in all 50 States and D.C., which found that 92.9 percent of the 2,138 silver plans did not exclude certain services for transgender-identifying people and that over half of all reviewed plans (54.6 percent) included affirmative language indicating that medically necessary care is covered.

Some commenters opined that CMS failed to include evidence in the proposed rule that coverage for sex-trait modification is not typically included in employer-sponsored coverage.

One commenter disagreed with the proposed rule's reliance on the Movement Advice Project (MAP) report to support the claim that sex-trait modification generally is not covered under typical employer-sponsored plans for treatment of gender dysphoria. This commenter stated that the MAP report conflicts with several studies, HHS did not include portions of the report that did not support its conclusions, and that the MAP report conflates States' transgender-identifying population numbers with an analysis of how many employers categorically exclude from coverage sex-trait modification services as treatment for gender dysphoria.

One commenter disagreed that the fact that some States that do not mention or have no clear policy on coverage of sex-trait modification services is evidence that sex-trait modification is not covered in typical employer plans. This commenter stated that this lack of clarity is likely

[199] Movement Advancement Project. "Equality Maps: Healthcare Laws and Policies" available at *https://www.lgbtmap.org/equality-maps/healthcare_laws_and_policies*. Accessed 05/28/2025.
https://www.lgbtmap.org/equality-maps/healthcare_laws_and_policies. Accessed 05/28/2025.

because sex-trait modification encompasses a wide array of services that are also used to treat other health conditions, in addition to treatment for gender dysphoria, so coverage of such services for sex-trait modification purposes may not explicitly be stated in some health plans.

Response: We disagree with commenters' assertion that sex-trait modification is covered under typical employer-sponsored plans. In fact, according to the KFF 2024 Employer Health Benefits Survey, which was cited by many commenters, only 24 percent of employers with 200 or more employees responded that they cover gender-affirming hormone therapy[200]; and an additional 45 percent of such employers were unable to confirm whether they offer coverage for such services. It is also reasonable to assume that, compared to gender-affirming hormone therapy coverage rates, an even lower percentage of the employers surveyed by KFF cover more invasive, higher cost sex-trait modification surgeries. We believe this evidence substantiates the claim that typical employer plans are not covering specified sex-trait modification procedures, as defined in this rule.

Additionally, we disagree with the commenter who took issue with the MAP report as a basis for this policy change. The Department is of the view that we appropriately relied on and represented the materials, and that they represent a sound statistical basis to inform our final policy. This is consistent with the statutory requirement that EHB align with the coverage provided by a typical employer plan,[201] and CMS history of excluding by regulation such services from EHB.[202]

We acknowledge that very large employers that represent a larger share of employees may be more likely to cover the specified sex-trait modification procedures that are the focus of this policy. However, in the Department's experience, this mainly reflects the fact that larger

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[200] Claxton, G. Et al. (2024, October 9). Employer Health Benefits. KFF. *https://www.kff.org/health-costs/report/2024-employer-health-benefits-survey/.*
[201] 42 U.S.C. 18022(b)(2).
[202] 45 CFR 156.115(d).

employers tend to have more financial resources to provide a more generous benefit set. The statute specifically references the typical employer and not the typical employee, which acts to restrain the EHB from reflecting the more generous and costly health plans offered by very large employers. Moreover, very large employers also receive more pressure from advocacy organizations to cover sex-trait modification procedures and, therefore, likely do not represent the typical employer to the degree a portion respond to this pressure. In regard to the Human Rights Foundation Corporate Equality Index findings, we note that the employers referenced in this report volunteered to participate in the advocacy organization's program and such voluntary participation suggests these employers do not represent the typical employer and, instead, align with the advocacy organization's views.

Comment: Some commenters stated that the argument that typicality is equivalent to a benefit's utilization rate is flawed, and that no one would argue against coverage for people with rare cancers that affect few people, or heart transplants, for example. Some commenters also stated that the utilization data cited in the proposed rule did not support CMS' claims regarding typical employer coverage because they: (1) spoke to actual utilization and not available coverage, and (2) reflect consumer experience for consumers participating in Exchange rather than employer-sponsored insurance. Other commenters raised concerns that the observed low utilization of sex-trait modification services may reflect the relative rarity of gender dysphoria as a diagnosis, rather than low levels of coverage for such services under Exchange or employer-sponsored coverage.

Response: We continue to believe that utilization data from the EDGE limited data set offers a useful picture of the coverage offered by a typical employer. While commenters raised concerns that the observed low utilization of sex-trait modification services may reflect the relative rarity of gender dysphoria as a diagnosis, rather than low levels of coverage for such services under Exchange or employer-sponsored coverage, low utilization, as evidenced by

EDGE data, also supports the contention that specified sex-trait modification procedures, as defined in this final rule, are not covered by typical employer plans. Specifically, we believe these data reflect the coverage experiences of consumers receiving coverage through the small business health options program (SHOP), which we believe to be more reflective of the coverage typically provided by the majority of employers, which are significantly smaller[203] than those employers surveyed by, for example, the Corporate Equity Index or KFF. We disagree with commenters' concern that utilization, as measured through the EDGE database, does not accurately reflect the level of coverage available to the enrollees receiving employer-sponsored coverage, given that all plans available to Exchange consumers (those upon whom EDGE data are based), must adhere to the requirements for EHB, which are themselves closely tied to typical employer-sponsored coverage.

Comment: One commenter noted that gaps in coverage or ambiguity regarding coverage because the issuer's plan documents do not reference sex-trait modification often means issuers will adjudicate medical necessity on a case-by-case basis and do not justify a claim that sex-trait modification is not typically covered by employer plans. Another commenter suggested that the typicality standard should be understood only as setting a guideline for minimum benchmark coverage and that typical employer plans have historically excluded coverage for the same services that the EHB provision was intended to expand. This commenter therefore suggested that CMS should not take the requirement that EHBs be equal in scope to a typical employer plan to mean that 1) EHB-benchmark plans cannot or should not be more generous than a typical employer plan, nor that 2) just because a particular service is not commonly covered by typical employer plans, that that should automatically exclude those services from being EHB.

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[203] Bureau of Labor Statistics data (available at: https://www.bls.gov/charts/county-employment-and-wages/employment-by-size.htm) suggest that approximately 58% of U.S. employers employ 99 or fewer employees – substantially fewer than the employers surveyed by KFF or the Corporate Equity Index.

Other commenters stated that the proposal conflicts with CMS' regulations on typicality for EHB-benchmark plans, which allow States to require coverage beyond what is covered in a typical employer plan, so long as the scope of benefits is not more generous than the scope of benefits in the most generous plan in the State. Other commenters urged that the appropriate analysis regarding the typical employer plan per CMS' own regulations is not whether most other States include sex-trait modification in their EHB-benchmark plans or the number of enrollees utilizing this care nationwide, but instead whether such care is covered by typical employer plans in the State selecting it as EHB. These commenters emphasized that a requirement that States exclude sex-trait modification from their State EHB-benchmark plans would be inconsistent with typical employer plans in their respective States.

Response: We disagree with commenters' position that the statutory requirement that EHB be equal in scope to the benefits provided by a typical employer plan was intended to close gaps in coverage by setting a floor for coverage. We further disagree that sex-trait modification procedures, if not covered by typical employer plans, are required to be covered as an EHB to correct gaps in coverage. The position that EHB be defined in a manner that addresses gaps in coverage must conform to the typicality requirement.

Comment: Some commenters stated that CMS should consider in its analysis of typical employer plan coverage for sex-trait modification that half of all States have interpreted Federal and State laws to prohibit discrimination based on sexual orientation and gender identity, which extends to most public and private health insurance plans.

Response: We acknowledge that several States have interpreted Federal and State laws to prohibit discrimination against sexual orientation and gender identity, which may influence employer coverage of sex-trait modification services. We have considered this and have found that, despite such State efforts, coverage of sex-trait modification in employer-sponsored plans remains atypical. After finalizing the section 1557 nondiscrimination rules in 2016 that added a

definition of sex discrimination to incorporate discrimination on the basis of gender identity, some State departments of insurance issued policy bulletins making clear that exclusion of such types of coverage are discriminatory based on section 1557.[204] Immediately after our amendment to section 1557 nondiscrimination regulations in 2020 (amending the 2016 definition of sex discrimination to incorporate discrimination on the basis of gender identity), an advocacy organization that tracks coverage of sex-trait modification procedures on the Exchanges found "the number of insurers using transgender-specific exclusions...more than doubled."[205] Since 2021, over half of States have taken action to restrict sex-trait modification procedures for minors.[206] We believe these swings in State and Federal policy reflect the relatively recent emergence and ongoing controversy over coverage of the specified sex-trait modification procedures we address in this final rule, which supports the conclusion that such procedures are not typically covered by employer-plans.

Comment: One opposing commenter stated that HHS provided no evidence in the proposed rule that treatment for gender dysphoria has ever been offered by issuers under an excepted benefit plan and noted that treatment for gender dysphoria is therefore dissimilar to the other benefits in § 156.115(d) that are excluded from being covered as EHB. This same commenter stated that the other benefits at § 156.115(d) are excluded as EHB by general designation (eye exam services, home care benefits, and non-medically necessary orthodontia), but that here HHS seeks to categorically prohibit specific medical services used by a specific population (people diagnosed with gender dysphoria) even when they are medically necessary.

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[204] *See, e.g.,* Oregon Department of Consumer and Business Services, Division of Financial Regulation. Bulletin DFR 2016-1 (September 7, 2016), available at https://dfr.oregon.gov/laws-rules/Documents/Bulletins/bulletin2016-01.pdf.; State of Vermont, Department of Financial Regulation. Insurance Bulletin 174 (rev. June 12, 2019), available at *https://dfr.vermont.gov/sites/finreg/files/regbul/dfr-bulletin-insurance-174-gender-dysphoria-surgery.pdf* ; Pennsylvania Bureau of Life, Accident and Health, Office of Insurance Product Regulation. Notice Regarding Nondiscrimination; Notice 2016-05 (April 30, 2016), available at *https://www.pacodeandbulletin.gov/Display/pabull?file=/secure/pabulletin/data/vol46/46-18/762.html.*

[205] AGLY v. USDHHS, 557 F. Supp. 3d 224, at 239 (internal citations omitted).

[206] *https://www.lgbtmap.org/equality-maps/healthcare_youth_medical_care_bans.*

Many commenters raised concerns that this could be a slippery slope to excluding other medically necessary benefits as EHB.

Some opposing commenters urged CMS to preserve the framework that allows States to adopt an EHB-benchmark plan that best fits their unique market dynamics. Such commenters stated that this proposal would be a significant departure from the existing EHB-benchmark plan framework because it would prohibit coverage of services as EHB at a more granular level than before and that this could restrict the ability of States to respond to local needs, increase the price of coverage, limit plan and provider innovation, and hinder flexibility for issuers to respond to changes in scientific evidence and clinical practice. Many commenters noted that the impact of the proposal on individuals without gender dysphoria seeking care will also lead to higher out-of-pocket costs and access issues throughout the U.S.

Response: We disagree that the prohibition on coverage of specified sex-trait modification procedures as EHB, as finalized in this rule, is likely to create a slippery slope towards additional coverage exclusions. We acknowledge commenters' concern that other services are excluded from coverage as EHB on the grounds that they are excepted benefits and that specified sex-trait modification procedures are not generally covered as excepted benefits. However, the contention underlying the prohibition of other services (for example, routine adult vision) is the same as that at issue with respect to specified sex-trait modification procedures – that they *are not* typically covered by employer-sponsored plans. Specifically, specified sex-trait modification procedures *have not* typically been provided by employers *through any coverage vehicle,* be that an excepted benefit plan or otherwise. As such, we are not concerned that prohibiting coverage of specified sex-trait modification procedures as EHB is likely to curtail the coverage of other services, given that nothing in this prohibition is intended to place limitations on services deemed EHB, so long as those services are in accordance with the statutory requirement that EHB be equal in scope to the benefits provided under atypical employer plan.

Additionally, while we are largely supportive of State flexibility with regard to establishing EHB, we take seriously the responsibility to ensure consistency with the parameters on EHB enumerated in the statute. As such, we have engaged in rulemaking on a number of occasions to refine our interpretation of the typicality standard. We believe the policy we are finalizing is neither a departure from our previous posture on prohibited benefits, in which we have considered whether such benefits are included in a typical employer plan, nor an action that exceeds the authority explicitly articulated in statute. Rather, we rely on the Secretary's broad regulatory authority to define EHB and the statutory requirement that EHB be equal in scope to the benefits provided under a typical employer plan.

Finally, we do not believe there is merit to commenters' concerns regarding unreasonable increases in out-of-pocket costs for consumers utilizing sex-trait modification services that do not meet the definition of specified sex-trait modification procedures finalized in this rule, or negative impacts to care based on alleged ambiguities introduced by this policy change. We believe that issuers have the appropriate flexibility to ensure that services that *may* or *must* remain covered as EHB retain such coverage, and that services that *may not* be covered as EHB will no longer be covered as such without disrupting enrollees' receipt of appropriate care. And, to the extent that out-of-pocket costs do increase for some consumers utilizing specified sex-trait modification procedures as defined in this rule, whose cost-sharing may increase as a result of such services no longer qualifying as EHB, we believe that will align with the degree of out-of-pocket costs for such services experienced by consumers covered by employer-sponsored plans.

Comment: Some commenters disagreed with the proposal to prohibit coverage of sex-trait modification as an EHB on the basis that numerous leading medical professional organizations, including the American Medical Association, American Academy of Pediatrics, American College of Obstetricians, and Pediatric Endocrine Society, and medical journal articles have found sex-trait modification to be medically necessary and that people who have received

sex-trait modification services rarely regret those services. Many commenters stated that sex-trait modification is the standard of care for gender dysphoria and provided copies of or links to peer-reviewed journal articles in support of this assertion.

Other commenters supported the proposal and referenced peer-reviewed studies and medical evidence or anecdotal scenarios in support of the policy. For example, some commenters stated that patients, especially children, may feel regret after utilizing sex-trait modification services and may suffer negative effects on their future fertility and sexual function.

One commenter opined that use of puberty blockers to suppress puberty could possibly further gender dysphoria symptoms, and that those symptoms, but for the puberty blockers, might have otherwise naturally subsided over time. Some commenters stated that sex-trait modification treatment is "experimental" and "dangerous," especially for children, and that it can lead to sexual dysfunction and/or sterility and place people at higher risk of other conditions such as obesity, diabetes, and cardiovascular disease. Some commenters argued that many States have prohibited sex-trait modification interventions for children and that this is evidence that science supporting such services is medically unsound.

Response: CMS understands the lack of consensus regarding the efficacy and necessity of sex-trait modification services for people with gender dysphoria, and especially children, as evidenced by the comments received and published peer-reviewed studies.[207] Likewise, on June

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[207] *See* Treatment for Pediatric Gender Dysphoria, May 1, 2025, Department of Health and Human Services. ("The umbrella review found that the overall quality of evidence concerning the effects of any intervention on psychological outcomes, quality of life, regret, or long-term health, is very low… The risks of pediatric medical transition include infertility/sterility, sexual dysfunction, impaired bone density accrual, adverse cognitive impacts, cardiovascular disease and metabolic disorders, psychiatric disorders, surgical complications, and regret.") *https://opa.hhs.gov/gender-dysphoria-report*. Straub, J.J., Paul K.K., Bothwell, L.G., Deshazo, S.J., Golovko, G., Miller, M.S., & Jehle, D.V. (2024). Risk of Suicide and Self-Harm Following Gender-Affirmation Surgery. Cureus, 16(4):e57472. doi: 10.7759/cureus.57472. ("There is ongoing controversy surrounding the benefits of gender-affirmation surgery on mental health. This controversy reflects diverse perspectives within the medical and research communities, emphasizing the need for a more comprehensive understanding of the psychological outcomes of gender-affirming procedures."); Surendran, S., Toh, H.J., Voo, T.C., De Foo, C., & Dunn, M. (2025). A scoping review of the ethical issues in gender-affirming care for transgender and gender-diverse individuals. BMC Med Ethics 26, 54. *https://doi.org/10.1186/s12910-025-01216-2* ("Despite extensive discussion, there remains significant

18, 2025, the Supreme Court upheld a State's ban on certain medical treatments for transgender minors, acknowledging that the dispute regarding these treatments "carries with it the weight of fierce scientific and policy debates about the safety, efficacy, and propriety of medical treatments in an evolving field."[208] We carefully read each comment submitted and appreciate that commenters shared a myriad of opinions and personal stories, both in support of and against the proposal. However, we are not persuaded that the existence of journal articles and clinical guidelines supporting the use of sex-trait modification services for the treatment of gender dysphoria should require that specified sex-trait modification procedures be covered as an EHB. In fact, such a stance would be a departure from the current EHB framework which, with the very limited exceptions of the preventive services and prohibition on discrimination at § 156.125(a), makes no reference to clinical bases as a justification for whether something is EHB or not.

The basis for prohibiting the coverage of specified sex-trait modification procedures as an EHB, as previously stated in the proposed rule and in this final rule, is that such benefits are not covered under typical employer plans. Section 1302(a)(1) of the ACA gives the Secretary broad latitude to define EHB, subject to ensuring that EHB is equal in scope to the benefits provided under a typical employer plan pursuant to section 1302(b)(2) of the ACA and meets the other

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disagreement and a lack of resolution on … ethical issues [related to sex-trait modification procedures]."); Effects of gender affirming therapies in people with gender dysphoria: evaluation of the best available evidence. Dr. Romina Brignardello-Petersen and Dr. Wojtek Wiercioch; Main report; May 16, 2022 ("[I]t is unknown whether people with gender dysphoria who use puberty blockers experience more improvement in gender dysphoria, depression, anxiety, and quality of life than those with gender dysphoria who do not use them. There is very low certainty about the effects of puberty blockers on suicidal ideation."); Ludvigsson JF, Adolfsson J, Höistad M, Rydelius PA, Kriström B, Landén M. A systematic review of hormone treatment for children with gender dysphoria and recommendations for research. Acta Paediatr. 2023 Nov;112(11):2279-2292. doi: 10.1111/apa.16791. Epub 2023 May 1. PMID: 37069492 (this systematic literature review concluded that the long-term effects of treatment of gender dysphoria in children below 18 years old with gonadotropin-releasing hormone analogues (GnRHa) are unknown and that "GnRHa treatment in children with gender dysphoria should be considered experimental treatment of individual cases rather than standard procedure); Straub J J, Paul K K, Bothwell L G, et al. (April 02, 2024) Risk of Suicide and Self-Harm Following Gender-Affirmation Surgery. Cureus 16(4): e57472. doi:10.7759/cureus.57472 ("The results of this study indicate that patients who have undergone gender affirmation surgery are associated with significantly higher risks of suicide, self-harm, and PTSD compared to general population control groups in this real-world database.").

[208] *See United States v. Skrmetti et al.,* No. 23-477 slip op. at *24 (U.S. June 18, 2025), available at *https://www.supremecourt.gov/opinions/24pdf/23-477_2cp3.pdf*.

limitations enumerated in section 1302(b) of the ACA. We understand that EHB cannot include all possible items and services for all possible diagnoses, simply by the plain language of section 1302 of the ACA, such as the requirement that benefits be "essential," limited to at least the 10 enumerated categories, and equal in scope to the benefits provided under a typical employer plan.

The Department has also examined these issues elsewhere, including in a commissioned review of evidence and best practices[209] regarding pediatric gender dysphoria. The report echoes some of the concerns commenters raised, however the report was distributed solely for the purpose of pre-dissemination peer review under applicable information quality guidelines. It has not been formally disseminated by the Department, therefore it does not represent and should not be construed to represent agency determination or policy. The report will undergo formal post-publication peer review involving interested parties with different perspectives according to the Information Quality Bulletin for Peer Review.

Comment: Numerous commenters commented on the need to specifically define what sex-trait modification is, so that issuers have certainty as to what they can cover as EHB and consumers can have certainty as to what their plans cover. Some commenters raised concerns with the use of the term sex-trait modification and stated that the proposed rule lacked clarity regarding what specific sex-trait modification services would be prohibited from being covered as EHB.

Commenters also provided numerous examples of services they believe should fall under the definition of sex-trait modification. One commenter urged CMS to provide examples of services that would be prohibited from being covered as EHB under the term sex-trait

[209] HHS (2025, May 1). Treatment for Pediatric Gender Dysphoria. Office of Population Affairs, Office of the Assistant Secretary for Health, available at *https://opa.hhs.gov/sites/default/files/2025-05/gender-dysphoria-report.pdf*

modification, including the following: puberty blockers; hormone therapy; genital surgery (amputation, building replica cross-sex organs); non-genital cosmetic surgeries (mastectomy, breast construction, cheek/chin implants, rhinoplasty, feminization surgeries, liposuction, voice surgery, hair removal, and "Adam's Apple" reduction), and "erroneous" sex-trait modification psycho-social interventions. One commenter suggested that issuers be required to cover as EHB services to reverse the effects of sex-trait modification.

Other opposing commenters noted that sex-trait modification is not the clinically appropriate terminology when referring to treatment of individuals with gender dysphoria, citing to medical professional organizations, such as the American College of Obstetricians and Gynecologists, the American Medical Association, the American Academy of Family Physicians, and the American Psychiatric Association, which recommend the use of the term "gender-affirming care." Several commenters opposing the proposal raised concerns that the proposal is too broad and could lead to inappropriate exclusions of treatments that are clinically distinct from sex-trait modification services for gender dysphoria. Many commenters stated that while sex-trait modification services can be used to affirm an individual's physical appearance or body with an asserted identity that differs from the individual's sex, sex-trait modification services are not used most commonly for gender transition purposes (for example, a biological female receiving hormone therapy for symptoms of menopause). Numerous commenters expressed that most people will use at least one service that could be used for sex-trait modification purposes in their lifetime. They expressed concern that without clarification, numerous services and drugs could be excluded for people who do not have gender dysphoria but who need them to treat other conditions.

Commenters opposing the proposal listed the following as some of the treatments and conditions unrelated to gender dysphoria that may be implicated by the broad scope of the proposal: precocious puberty; hormone replacement therapy to mitigate symptoms of vaginal

atrophy and menopause; hysterectomies and mastectomies for cancer treatment or prevention; birth control; endocrine disorders; facial reconstruction; hair removal; hair implants; speech therapy; counseling; oophorectomy; sexual organ removal due to cancer; treatment for endometriosis, polycystic ovary syndrome, and other gynecological conditions; treatment for intersex conditions; and other reconstructive procedures (such as for trauma victims or cancer patients). Many commenters opposing the proposal noted that several of these interventions may involve modifying secondary sex characteristics, but are clearly not related to gender transition, and that CMS should either remove the term "sex-trait modification" from the final rule or define it narrowly and with specificity, consistent with accepted medical usage, to allow exceptions for unrelated and medically necessary treatments.

A few commenters who supported the proposal also requested clarification regarding the scope of services that are included in the term sex-trait modification. These commenters supported the proposal, but requested that CMS define what sex-trait modification means and specify the precise exclusions from the proposed prohibition on coverage of sex-trait modification as EHB, emphasizing the importance of these clarifications for enforceability of the proposal. One commenter suggested that coverage of EHB include services to assess the origins of a person's gender dysphoria.

One commenter supporting the proposal stated that sex-trait modification should mean services that reinforce an erroneous identity inconsistent with one's sex but should exclude from the definition of sex-trait modification any services that are routine or medically necessary to maintain physiological integrity or organ functioning or that are aimed at restoring or reconstructing form and function consistent with one's sex. One commenter supported coverage of diagnostic testing of newborns with congenital anomalies such as ambiguous genitalia, ostensibly to determine if the newborn has a disorder of sexual development.

One commenter opposing the proposal stated that CMS should not define explicit exceptions to the proposal for conditions other than gender dysphoria, such as cancer or precocious puberty, as doing so would discriminate on the basis of health conditions as well as transgender status. Many commenters expressed concern that patient conditions could worsen if their access to drugs or services were disrupted abruptly after losing coverage for a service due to ambiguity as to what is considered sex-trait modification. Another opposing commenter urged CMS to refrain from defining "sex-trait modification," stating that attempting to codify a definition risks oversimplifying the range of medical treatments that could fall under this term. One commenter suggested that coverage of EHB include services to assess the origins of a person's gender dysphoria, while another commenter opposing the proposal disagreed with how the proposed rule defined sex because the commenter believed the policy would exclude individuals who identify with their sex assigned at birth, but who have medical conditions that make them unable to reproduce. Many commenters opposing the policy expressed specific concern regarding how the proposal would apply to intersex people. These comments asserted that persons with disorders of sexual development may have variations in chromosomes, external genitalia, hormones, and reproductive organs, among other characteristics, that make them neither "male" nor "female."

Response: We acknowledge concerns raised by commenters regarding the ambiguity of the term "sex-trait modification" as used in the proposed rule. As discussed elsewhere in this final rule, we are finalizing the addition of a definition of "specified sex-trait modification procedure" at § 156.400 to ensure greater clarity regarding what procedures related to sex-trait modifications may and may not be covered as EHB. Additionally, we acknowledge that issuers may not categorize some benefits as sex-trait modification services, because they may instead adjudicate claims for such care based on determinations of medical necessity and the specific condition the service in question is intended to treat. We note that this policy change will not

prohibit issuers from covering specified sex-trait modification procedures when deemed medically necessary. This is both because 1) this prohibition does not prohibit issuers from covering any types or forms of care; the prohibition is only on covering specified sex-trait modification procedures *as EHB,* and 2) this prohibition only prohibits issuers from covering specified sex-trait modification procedures as EHB *if* they meet the definition we are finalizing at § 156.400.

We agree with commenters that providing a definition of the services implicated by this policy would provide issuers, consumers, health care providers, and other interested parties with greater certainty. Accordingly, after considering comments, we are finalizing the addition of a definition of "specified sex-trait modification procedure" at § 156.400. Specifically, the term "specified sex-trait modification procedure" means any pharmaceutical or surgical intervention that is provided for the purpose of attempting to align an individual's physical appearance or body with an asserted identity that differs from the individual's sex either by: (1) intentionally disrupting or suppressing the normal development of natural biological functions, including primary or secondary sex-based traits; or (2) intentionally altering an individual's physical appearance or body, including amputating, minimizing, or destroying primary or secondary sex-based traits such as the sexual and reproductive organs. Such term does not include procedures undertaken (1) to treat a person with a medically verifiable disorder of sexual development, or (2) for purposes other than attempting to align an individual's physical appearance or body with an asserted identity that differs from the individual's sex.

After closely reviewing public comments, we believe this definition of "specified sex-trait modification procedure" addresses commenters' concerns that regulated entities may be confused regarding the scope of services subject to the policy, as well as concerns that people be able to access benefits as EHB when provided for purposes other than attempting to align an individual's physical appearance or body with an asserted identity that differs from the

individual's sex, as discussed further below. For example, this final rule would not prevent an issuer from covering as EHB mastectomies or breast reconstruction after a mastectomy for women with breast cancer or hormone therapy for a person with precocious puberty, cancer, or infertility, if those services are otherwise covered.

In response to comments received regarding the applicability of the term "sex-trait modification" versus the term "gender-affirming care", we have adopted a narrowly tailored definition of "specified sex-trait modification procedures," in part, because of commenter concerns that the term "gender-affirming care" generally encompasses a broader set of medical services, such as mental health services. For example, hormone replacement therapy may or may not be prohibited from coverage as EHB under our final policy, depending on whether or not that therapy is being provided in an attempt "to align an individual's physical appearance or body with an asserted identity that differs from the individual's sex," among other defined considerations.

Although some commenters suggested including certain other services in the definition of sex-trait modification services, we decline to adopt an exhaustive list. We believe that the definition we are finalizing in this rule provides an appropriate and actionable degree of certainty and clarity for consumers, issuers, providers, and other interested parties, while also maintaining flexibility to accommodate changes in medical science and standards of care.

We agree with commenters that services or procedures that would constitute sex-trait modification procedures if provided for the purpose of "attempting to align an individual's physical appearance or body with an asserted identity that differs from the individual's sex" do not constitute specified sex-trait modification procedures if provided for a different purpose. Specifically, the definition of a specified sex-trait modification procedure categorically excludes procedures undertaken: (1) to treat a person with a medically verifiable disorder of sexual development, and (2) for purposes other than attempting to align an individual's physical

appearance or body with an asserted identity that differs from the individual's sex. We believe these exclusions are fully responsive to commenters' concerns that sex-trait modification be narrowly defined. These exclusions will ensure that services that may be employed to effectuate sex-trait modification are not categorically excluded from coverage as EHB for other purposes.

We note, for example, that this definition will allow people with medically verifiable disorders of sexual development to receive surgical services as EHB, if otherwise covered by the plan. Similarly, those needing hormone therapy for cancer, menopause, or other conditions will still be able to receive that therapy as an EHB, if otherwise covered by the plan, as this is for purposes other than attempting to align an individual's physical appearance or body with an asserted identity that differs from the individual's sex. These are examples and not an exhaustive list. Additionally, services to reverse the effects of specified sex-trait modification procedures and to treat conditions caused by specified sex-trait modification procedures, such as testing, medication, and care for iatrogenic hypogonadism, osteoporosis, osteopenia, and low testosterone, are still covered as EHB if otherwise included by the State's EHB-benchmark plan. Further, nothing in this rule precludes coverage of testing to determine disorders of sexual development, including for newborns, from being an EHB, nor is coverage of diagnostic treatment to determine the psychological and/or physiological origin of an individual's gender dysphoria diagnosis precluded from being covered as EHB by this rule, should such treatment exist.

Comment: Several commenters raised different issues regarding costs. One commenter stated that an issuer's ongoing implementation costs by virtue of, for example, having to modify its claims processes and systems, would be higher than what the issuer would reimburse providers for the sex-trait modification services themselves, if these services were covered benefits, and that such implementation costs are not minuscule. This commenter noted that the policy would disproportionately affect smaller issuers and those issuers that primarily cater to

low-income and medically underserved populations. Other commenters noted that covering sex-trait modification services in insurance plans is cost-neutral or cost-saving as there is no actuarial basis to price sex-trait modification surgeries separately from any other type of surgery.

Many commenters noted their belief that issuers dropping coverage of sex-trait modification services due to this proposal would increase out-of-pocket consumer costs, as the cost of care would be shifted to consumers. Numerous commenters also expressed concerns that this proposal would block consumers from accessing sex-trait modification services with the same cost-sharing and benefit design protections as the same services covered for non-sex-trait modification still included in the EHB package, and that users of these services are more likely to be low-income and economically vulnerable.

Many commenters expressed concern that the proposal would increase overall health care costs by shifting current treatment costs for sex-trait modification to hospitals and State and local governments. Other commenters opposing the proposal stated that this proposal could lead to States with budget concerns removing State coverage requirements for sex-trait modification services because they would otherwise be forced to defray the cost of requiring such coverage. Some commenters stated that they believed that if sex-trait modification is not covered as an EHB, there will be an increased prevalence of more costly conditions, like severe depression or osteoporosis. Other commenters noted concern that individuals will seek sex-trait modification procedures through unregulated and unofficial channels if issuers stop covering it entirely which could lead to downstream health issues. Commenters noted that uncompensated care would likely increase; these commenters also noted concerns with the proposal leading to increased risk of psychiatric symptoms leading to more utilization of psychiatric services, including psychiatric hospitalizations for these patients if current treatments were no longer covered. One commenter believed that the proposal would have a destabilizing effect on insurance markets where sex-trait modification services were previously covered.

Response: We realize that smaller issuers often have outsized costs when new requirements are put into place that apply to all issuers, simply because they lack economies of scale that some of their larger, nationwide counterparts may have. However, we also believe that this final rule does not require issuers to undergo complex system builds or process changes in order to implement this policy and are not persuaded that the burden of any changes to processes and systems is a compelling basis for not finalizing this proposal. Specifically, issuers are already required to ensure that benefits that are not EHB are appropriately designated as such in the Plans & Benefits Template completed as part of the QHP certification application and that the percentage of premium attributable to EHB is accurately reflected, so that APTC does not erroneously subsidize non-EHB. Although under this final rule, there could be services that can or cannot be covered as EHB depending on diagnosis, we believe that issuers should already have the capability to differentiate between these claims since they already have to make these distinctions today. For example, currently, issuers must ensure that benefits that can never be EHB, such as routine non-pediatric eye exam services or non-medically necessary orthodontia pursuant to § 156.115(d), are not erroneously noted as EHB in plan filings and claims processing. We believe that what an issuer is required to do under this final policy to exclude coverage for specified sex-trait modification procedures as EHB is similar to how issuers currently handle coverage for other claims. Additionally, while issuers may not be currently differentiating claims for specified sex-trait modification procedures in this manner, in any State there exists the possibility of State mandated benefits changing the manner in which the issuer designates discrete covered services as either EHB or non-EHB -- as such, we believe issuers have this capability for any benefit.

We do not believe that whether a benefit is cost-neutral from an actuarial perspective has bearing on whether it should be an EHB. A benefits package is comprised of numerous benefits, some of which are cost-neutral or even cost-saving, and some of which are not. If issuers seek to

voluntarily cover specified sex-trait modification procedures as non-EHB, they would need to price the services accordingly.

We agree with commenters that for those States that wish to mandate coverage of specified sex-trait modification procedures, they will be responsible for defraying this cost pursuant to § 155.170(b). However, there is nothing inherently unique about specified sex-trait modification procedures as related to the overall defrayal policy; if a State wishes to mandate a benefit that is not EHB, it must defray the cost of that benefit, regardless of what that benefit is. This is a longstanding EHB policy and furthers State flexibility to regulate their own markets and ensure coverage of benefits that are most critical in their State.

We also understand concerns that there may be some people enrolled in plans that must cover EHB who seek specified sex-trait modification procedures who will now need to pay for the full cost out-of-pocket, unless the coverage is State-mandated or an issuer voluntarily offers such coverage. However, this is the case with any benefit that is not EHB. The framework for EHB as established in section 1302(b)(2) of the ACA requires EHB to be "equal to the scope of benefits provided under a typical employer plan." There will necessarily be some benefits that are not EHB. This final rule better aligns coverage with the statutory requirements. In response to concerns that people seeking sex-trait modification services are often medically underserved, lower-income, and more economically vulnerable than the general population, we note that in defining the EHB, we have attempted to balance coverage generosity and affordability, with the realization that what makes coverage more affordable for some, may in turn make certain benefits less affordable for others.

In addition, while some commenters expressed concerns about costs being shifted to local governments and hospital uncompensated care, we emphasize that nothing in this final rule requires States or hospitals to develop programs to fund specified sex-trait modification procedures. This policy is not likely to result in additional uncompensated care for mental health

services because it does nothing to change the status of mental health services as EHB. We reiterate that mental health services will continue to be available, including for persons with gender dysphoria and those seeking specified sex-trait modification procedures, within their respective healthcare plans. We also expect that covered services for purposes other than attempting to align an individual's physical appearance or body with an asserted identity that differs from the individual's sex will continue to be available. Additionally, to the extent they are presently covered as EHB, services that become necessary due to discontinuation of specified sex-trait modification procedures, such as treatment for bone mineral density loss, will continue to be covered as EHB.

We disagree that prohibiting coverage of specified sex-trait modification procedures as EHB in States that previously required such coverage would be destabilizing for the insurance market. First, States have the option of requiring this coverage as long as they defray the cost pursuant to § 155.170. Second, the current EHB-benchmark plan framework at § 156.111(a) and substitution policy at § 156.115(b) allow benefits to change as long as they comply with other requirements related to EHB.

We also acknowledge commenters' concern that gender dysphoria is often associated with severe depression and individuals could seek specified sex-trait modification procedures through unregulated and unofficial channels. As we have noted, pursuant to 1302(b)(2) of the ACA, EHB must be "equal to the scope of benefits provided under a typical employer plan", and thus, not all benefits will fall under the definition of EHB. Just as States and issuers are not prohibited from covering specified sex-trait modification procedures as a non-EHB consistent with applicable State law, individuals have the ability to identify health care plans that provide coverage related to their conditions and health issues in an appropriate manner.

We also clarify that if an issuer were to voluntarily cover specified sex-trait modification procedures, as defined in this rule, as non-EHB, those services would not be subject to EHB

protections such as the prohibition on discrimination at § 156.125, the prohibition on annual and lifetime dollar limits at § 147.126, and the requirement to accrue enrollee cost sharing towards the annual limitation on cost sharing at § 156.130. We note that because the premium attributable to these procedures would not be for an EHB, the portion of the premium attributable to specified sex-trait modification procedures would not be eligible for PTC or CSR, and the enrollee would be responsible for the cost of any associated premium and cost sharing. Similarly, if a State were to mandate coverage of specified sex-trait modification procedures, those procedures would not be EHB, and not subject to the prohibition on discrimination or annual and lifetime dollar limits applicable to EHBs. However, in such a case, the State would bear the cost of the portion of premium attributable to these procedures, though the enrollee would still be responsible for any applicable cost sharing.

Comment: Several commenters expressed concern with the proposal being effective for PY 2026, citing concerns about interruption of care as well as Federal and State filing deadlines. They noted they believed that the effective date was too soon and would be disruptive to issuers' plan filings for PY 2026, since that process generally began prior to the publication and the effective date of this rule. One commenter noted that some States have an April 25, 2025 QHP application filing deadline for PY 2026, and many others have QHP application filing deadlines of May 15. Another commenter opined that EHB-benchmark plans for PY 2026 have already been finalized, and that any EHB-benchmark plans that include sex-trait modification should be permitted to keep those benefits as EHB for PY 2026. Some commenters explained that issuers will need to make changes to claims systems and utilization management policies and processes as a result of this policy, which takes time. Other commenters stated that such quick finalization for PY 2026 could create market instability and disproportionately affect smaller safety net plans that are predominantly community-based, and local issuers that primarily serve lower-income consumers. Some commenters suggested that the policy be effective for fiscal year 2026, as

opposed to PY 2026. Others suggested delaying the effective date of the proposal until calendar year 2027 and one commenter suggested delaying the effective date until no earlier than PY 2028. As support for requesting a later effective date, some commenters noted that when States make updates to their EHB-benchmark plans under § 156.111, States must submit their EHB-benchmark plan application 2 years in advance of the plan year for which the new EHB-benchmark plan will be effective.

Response: We are finalizing an effective date of PY 2026 for this policy. Although we acknowledge that issuers may need to alter their plan filings to ensure specified sex-trait modification procedures are either not covered at all or covered but as non-EHB, we believe this rule will be finalized with sufficient time for issuers to make such changes and ask that States permit changes to rate filings as appropriate to reflect such changes. Specifically, this rule will be finalized prior to the conclusion of QHP certification for PY 2026, such that we believe issuers will have time to adjust their plan offerings in accordance with this rule, regardless of the size, location, or resources of the issuer. We also reiterate that we do not believe issuers will be required to undergo complex system builds or process changes in order to implement this policy, as discussed in more detail above. We believe that finalizing this policy without delay, for PY 2026, is important to align issuer coverage of EHBs with section 1302 of the ACA. Additionally, we do not believe that this change is analogous to the changes States make to their EHB-benchmark plans (for which we require that changes are finalized well in advance of the applicable plan year). Rather, we believe that this change affects rarely utilized coverage, and will be uniformly applied across States, making this change easier for issuers to make for the upcoming plan year.

Comment: Many commenters presented a variety of legal arguments in support of their opposition to the proposal. Many commenters opposing the policy argued that the proposal violates the Supreme Court's holding in *Bostock v. Clayton County*, 590 U.S. 644 (2020), which

held that discrimination based on transgender status constitutes sex discrimination under Title VII. Many commenters stated that this policy would violate Title IX and section 1557 which also prohibit discrimination on the basis of sex, and that the reasoning in *Bostock* has since been extended to Title IX and Section 1557 in a growing body of Federal case law holding that discrimination on the basis of gender identity and transgender status is prohibited sex discrimination. Many objecting commenters also stated the proposal would prohibit EHB coverage for a protected group on the basis of animus. Many commenters also raised that denying EHB coverage of sex-trait modification procedures such as hormone replacement therapy only to individuals with gender dysphoria while permitting the exact same treatments to be covered as EHB for individuals without gender dysphoria is overtly discriminatory on the basis of sex in violation of section 1557 of the ACA. Many commenters further stated that the proposal discriminates on the basis of sex by reinforcing sex stereotypes and punishing gender nonconformity.

One commenter supporting the proposed policy stated it would not violate nondiscrimination requirements in the ACA or other applicable Federal nondiscrimination laws, because such laws do not support claims that exclusions for coverage of sex-trait modification are discriminatory.

Response: We disagree with comments questioning HHS's legal authority to make these policy changes. Section 1557 of the ACA prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs or activities. We disagree that the policy in the proposed rule, and as revised in this final rule, constitutes sex discrimination in violation of section 1557 of the ACA. On May 6, 2024, we finalized the Nondiscrimination in Health Programs and Activities final rule, issued in the **Federal Register** on May 6, 2024 ("2024 Section 1557 final rule") (89 FR 37522), which expanded the definition of prohibited discrimination on the basis of sex to include, inter alia, discrimination on the basis of sex

characteristics, including intersex traits, gender identity, and sex stereotypes. Several district courts stayed or preliminarily enjoined HHS from enforcing certain portions of the 2024 Section 1557 final rule—primarily those prohibiting discrimination on the basis of gender identity. *See Florida. v. Dep't of Health & Hum. Servs*., 739 F. Supp. 3d 1091 (M.D. Fla. 2024); *Tennessee v. Becerra*, 739 F. Supp. 3d 467 (S.D. Miss. 2024); *Texas v. Becerra*, No. 6:24-CV-211-JDK, 2024 WL 4490621 (E.D. Tex. Aug. 30, 2024). Although the Secretary filed appeals in these cases, the United States Court of Appeals for the Fifth and Eleventh Circuits subsequently dismissed all appeals pursuant to motions filed after the change in administration, and HHS remains enjoined from enforcing the 2024 Section 1557 final rule's expanded interpretation of sex discrimination.[210] According to the reasoning in these cases, section 1557 of the ACA does not create an obligation to provide or extend coverage to specified sex-trait modification procedures.[211]

We also disagree that this policy would violate the ruling in *Bostock*. The Supreme Court's holding in *Bostock* applied to discriminatory employment decisions under Title VII of the Civil Rights Act of 1964. We reject the notion that *Bostock* would have any bearing on the prohibition of coverage of sex-trait modification as an EHB. Such an application would be outside the scope of the *Bostock* decision. As the United States District Court for the Southern District of Mississippi stated in the order granting a preliminary injunction on enforcement of the

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[210] In *Florida v. Department of Health and Human Services*, 739 F. Supp. 3d 1091 (M.D. Fla. 2024), the court stayed 45 CFR 92.101(a)(2)(iv), 92.206(b), 92.207(b)(3)-(5), and 42 CFR 438.3(d)(4), in Florida. OCR also may not enforce the interpretation of discrimination "on the basis of sex" in 45 CFR 92.101(a)(2)(iv), 92.206(b), or 92.207(b)(3)-(5) in Florida. In *Tennessee v. Becerra*, 739 F. Supp. 3d 467 (S.D. Miss. 2024), the court stayed nationwide the following regulations to the extent they "extend discrimination on the basis of sex to include discrimination on the basis of gender identity": 42 CFR 438.3, 438.206, 440.262, 460.98, 460.112; 45 CFR 92.5, 92.6, 92.7, 92.8, 92.9, 92.10, 92.101, 92.206-211, 92.301, 92.303, 92.304; and enjoined HHS from enforcing the 2024 Section 1557 final rule "to the extent that the final rule provides that 'sex' discrimination encompasses gender identity." In *Texas v. Becerra*, No. 6:24-CV-211-JDK, 2024 WL 4490621 (E.D. Tex. Aug. 30, 2024), the court stayed nationwide the following regulations: 42 CFR 438.3(d)(4), 438.206(c)(2), 440.262, 460.98(b)(3), 460.112(a); 45 CFR 92.101(a)(2) (and all references to this subsection), 92.206(b), 92.207(b)(3)–(5).

[211] Office of Women's Health (2025, Feb. 19). Sex-Based Definitions. Dep't of Health and Human Services. Retrieved March 6, 2025, from https://womenshealth.gov/article/sex-based-definitions.

2024 Section 1557 final rule, "[T]he Court has found no basis for applying *Bostock*'s Title VII analysis to section 1557's incorporation of Title IX. HHS acted unreasonably when it relied on Bostock's analysis in order to conflate the phrase 'on the basis of sex' with the phrase 'on the basis of gender identity.' Specifically, the Bostock holding did not 'sweep beyond Title VII to other Federal or State laws that prohibit sex discrimination."' *See Tennessee v. Becerra*, 739 F. Supp. 3d 467, 482 (S.D. Miss. 2024). Further, the Supreme Court in *Bostock* made the intended limited application to Title VII claims clear when it stated, "[N]one of these other [sex discrimination] laws are before us; we have not had the benefit of adversarial testing about the meaning of their terms, and we do not prejudge any such question today..." *See Bostock*, 590 U.S. at 681, 140 S.Ct. 1731.

On June 18, 2025, the Supreme Court concluded that *Bostock* "does not alter our analysis" when they upheld a State ban on certain medical treatments for transgender minors.[212] In *Bostock*, the Supreme Court specifically "held that an employer who fires an employee for being gay or transgender violates Title VII's prohibition on discharging an individual 'because of" their sex" after "incorporat[ing] the traditional but-for causation standard" to determine but-for cause.[213] Applying the *Bostock* reasoning to an example of a transgender boy who is restricted from receiving testosterone to treat gender dysphoria under the State law, the Supreme Court concluded "neither his sex nor his transgender status is the but-for cause of his inability to obtain testosterone."[214] Consistent with this conclusion, neither an individual's sex nor transgender status is the but-for cause of their inability to obtain certain sex trait modification

[212] United States v. Skrmetti et al., No. 23-477 slip op. at *18 (U.S. June 18, 2025)
[213] Ibid.
[214] Ibid. at *19.

procedures as an EHB. Therefore, we likewise conclude the *Bostock* reasoning does not apply here.[215]

Comment: Commenters opposing the proposal also argued that it violates the authority granted to the Secretary to define EHB under section 1302 of the ACA because the proposal does not take into account health needs of diverse segments of the population. One commenter stated that because gender dysphoria is recognized by experts as a disability, this policy would be directly contrary to the plain language and intent of the ACA to provide patient protection and access to care. Some opposing commenters also claimed that the proposal conflicts with the EHB nondiscrimination standards at § 156.125 because the proposal creates discriminatory benefit designs that are not clinically based. Several commenters also stated that this proposal would violate § 156.125 because it discriminates on the basis of sex characteristics, which includes but is not limited to intersex traits, pregnancy or related conditions, sexual orientation, gender identity, and sex stereotypes, which is prohibited under § 156.125(b). Many commenters objecting to the proposal stated that prohibiting coverage as EHB for medical care for individuals with gender dysphoria, while expressly proposing to create exceptions to cover these same services for other indications, is discriminatory.

Many opposing commenters also expressed concern that the proposal is at odds with the State EHB benchmark approach at § 156.111 which relies on the States to address specific gaps in coverage affecting their populations. Some commenters also stated that the proposal exceeds the Secretary's EHB authority by imposing condition-based exclusions on health plans, providers, or enrollees. Many objecting commenters also stated it is unclear how § 156.110, which requires that an EHB-benchmark plan provide coverage for mental health and substance

[215] The Supreme Court declined to rule on whether the *Bostock* reasoning applies outside the context of Title VII because, under the State law at issue in the case, neither a person's sex nor their transgender status would be the but-for cause of their inability to obtain the services banned under the law. Ibid.

use disorder services, does not conflict with the removal of sex-trait modification as EHB, since care for gender dysphoria falls under the definition of mental health and substance use disorder services in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

Response: We disagree with commenters who stated that this policy violates EHB nondiscrimination rules at § 156.125. That regulation applies only to services that are covered as EHB under a plan. As finalized at § 156.115, specified sex-trait modification procedures will be prohibited from being covered as EHB. Therefore, the nondiscrimination requirements at § 156.125 will not apply to such procedures.

We also disagree with commenters who stated that this policy violates section 1302(b)(4)(C) of the ACA, which requires that in defining the EHB the Secretary take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups. Section 1302(b)(2)(A) of the ACA requires the Secretary to ensure that the scope of EHB be equal in scope to the benefits provided under a typical employer plan. We read these provisions together so that they do not conflict with one another. Therefore, although the Secretary must take into account the health care needs of diverse segments of the population, the Secretary must only do so insofar as it does not conflict with the requirement that the scope of the EHB be equal to the scope of the benefits provided under a typical employer plan. Because specified sex-trait modification procedures are not typically covered by employer plans, specified sex-trait modification procedures are not among the benefits the Secretary is required to consider under section 1302(b)(4)(C) of the ACA.

Similarly, we disagree with commenters that asserted that the proposed policy would violate the State benchmark-based approach. Although this approach provides States with flexibility in determining which benefits will be EHB in the State, such flexibility is not without limitations. States selecting EHB-benchmark plans must do so in accordance with § 156.111, which requires that the EHB-benchmark plan provide a scope of benefits equal to the scope of

benefits provided under a typical employer plan. As explained, specified sex-trait modification procedures are not typically included in employer-sponsored plans. Therefore, this policy change aligns with the plain language and intent of section 1302 of the ACA.

We also disagree with commenters that the policy creates discriminatory circumstances under which individuals would be denied coverage of medical care for gender dysphoria as EHB, while others could receive the same services as EHB for other indications. This is not the case. We clarify that nothing in this rule prohibits issuers from providing coverage beyond the defined exceptions for specified sex-trait modification procedures as non-EHB.

We believe that the amendments we are finalizing to add a definition for specified sex-trait modification procedure at § 156.400 resolve commenters' concerns that an EHB-benchmark plan provide coverage for mental health and substance use disorder services, as the finalized definition at § 156.400 will permit non-pharmaceutical and non-surgical mental health and substance use disorder services to treat gender dysphoria to be covered as EHB.

Comment: Some commenters opposing the policy also argued that the proposal violates the Americans with Disabilities Act (ADA) and section 504 of the Rehabilitation Act. Commenters raising ADA concerns cited as support *Williams v. Kincaid*, 45 F.4th 759, 766–74 (4th Cir. 2022), which held that gender dysphoria is a covered disability for purposes of the ADA.

Response: We disagree with concerns that the policy violates the Americans with Disabilities Act or section 504 of the Rehabilitation Act; the final policy does not explicitly single out treatment for gender dysphoria or any particular medical condition for exclusion or prohibit any issuer's coverage of specified sex-trait modification procedures, but instead excludes specified sex-trait modification procedures from being covered as an EHB.

Comment: Many commenters opposing the proposal asserted that it violates the APA, with many of these commenters stating that the proposal is arbitrary and capricious because it

fails to consider important facts, including the widespread coverage of sex-trait modification procedures by large employer-based health plans and the established clinical evidence that these services are medically necessary and considerably improve the lives and health outcomes for its recipients. Other commenters argued the proposal is an agency action that exceeds statutory authority in violation of the APA because the policy would discriminate on the basis of sex in violation of section 1557 of the ACA. Many commenters objecting to the proposal also stated that the proposal constitutes unlawful discrimination in violation of the Equal Protection Clause and several court opinions finding that medically unsupported exclusions of specific treatments for beneficiaries with gender dysphoria could constitute discrimination in violation of Federal law. Many opposing commenters raising Equal Protection Clause arguments noted that because they believe this policy discriminates against a protected class, the policy would trigger heightened scrutiny review, and stated that they believe HHS offers no legitimate justification showing that the proposal serves important governmental objectives or that the discriminatory means employed are substantially related to the achievement of those objectives. Such commenters argued that the justification provided—that sex-trait modification procedures are not typically included in employer-sponsored plans—lacks sufficient evidence or analysis and is readily disproven. These commenters also stated that the proposed rule suggested that part of the reasoning for the proposal is that the Secretary is concerned about the scientific integrity of claims made to support the use of sex-trait modification procedures in health care settings, but that the proposed rule did not cite any evidence to support this claim and, in failing to do so, cannot articulate a satisfactory explanation for its action.

One commenter supporting the proposal asserted that whether gender identity qualifies as a protected class under the Equal Protection Clause is not settled law. The commenter also argued that, even if it were a protected class, the proposed policy would not need to survive heightened constitutional scrutiny if reviewed by courts. As support, this commenter cited to the

Supreme Court's decision in *Geduldig v. Aiello,* 417 U.S. 484 (1974), which found that "[t]he regulation of a medical procedure" specific to a protected class "does not trigger heightened constitutional scrutiny" absent "invidious discrimination." This commenter also stated that the proposed policy lacks invidious discrimination because the proposed change is required by law as most employer health plans do not cover sex-trait modifications.

Another commenter objecting to the proposal noted that the proposal conflicts with State law, because according to the commenter, half of all States have interpreted their State health laws to bar discrimination against people with gender dysphoria. Commenters objecting to the proposal also raised Federalism concerns, noting that the proposal goes against the premise that States determine the best way to enable and regulate health insurance within their borders. Commenters also raised concerns that the proposal contravenes section 1554 of the ACA, which prohibits the Secretary from promulgating a regulation that "creates any unreasonable barriers to the ability of individuals to obtain appropriate medical care." One commenter explained it would violate section 1554 of the ACA because prohibiting coverage of sex-trait modification procedures as EHB in turn means removing important EHB protections for such services, such as requiring cost-sharing for EHBs to accrue towards the annual limitation on cost sharing and prohibitions on annual and lifetime dollar limits on EHBs.

Response: We disagree that the policy would violate the Equal Protection Clause, which provides that no State shall "deny to any person within its jurisdiction the equal protection of the laws," because the policy applies equally to coverage for all persons, including both sexes. The policy also does not discriminate on the basis of transgender status, because it turns on the purpose and effect of the procedures at issue, not the status of the patient. Moreover, transgender persons do not exhibit "obvious, immutable, or distinguishing characteristics that define them as a discrete group" sufficient to make them a protected class under the Supreme Court's equal protection jurisprudence. *Bowen v. Gilliard*, 483 U.S. 587, 602 (1987). Additionally, on June 18,

2025, the Supreme Court upheld a State's ban on the provision of puberty blockers and hormones for minors to treat gender dysphoria, gender identity disorder, or gender incongruence for minors, concluding that the ban did not violate the Equal Protection Clause because the State only prohibited healthcare providers from administering puberty blockers or hormones to minors for certain medical uses, regardless of a minor's sex.[216] In any event, the policy would pass constitutional muster even under heightened equal protection scrutiny because it serves the important governmental interest of complying with the law governing the scope of EHBs under the ACA and is substantially related to achievement of that objective. The Department also agrees that the law is far from settled with regard to whether persons diagnosed with gender dysphoria or other identity-related conditions fit within the class of persons protected from discrimination under the Equal Protection Clause.

In response to comments arguing this policy violates conflicting State laws, we note that the policy we are finalizing does not prohibit health plans from voluntarily covering specified sex-trait modification procedures as non-EHB consistent with applicable State law, nor does it prohibit States from requiring the coverage of specified sex-trait modification procedures, subject to the rules related to State-mandated benefits at § 155.170. Likewise, we disagree with commenters' assertions that this policy would violate section 1554 of the ACA which prohibits the Secretary from promulgating a regulation that "creates any unreasonable barriers to the ability of individuals to obtain appropriate medical care," as the finalized policy only prohibits coverage for specified sex-trait modification procedures as EHB but otherwise permits such coverage to continue, so long as it is not EHB.

In response to comments suggesting that part of the reasoning for the proposal is that the Secretary is concerned about the scientific integrity of claims made to support the use of sex-trait

[216] *See United States v. Skrmetti et al.,* No. 23-477 slip op. at *10 (U.S. June 18, 2025), available at *https://www.supremecourt.gov/opinions/24pdf/23-477_2cp3.pdf.*

modification procedures in health care settings but that the proposed rule did not cite any evidence to support this concern, we note that concern about the scientific integrity of claims made to support the use of specified sex-trait modification procedures in health care settings supports our rationale that specific sex-trait modification procedures are not typically covered under employer-sponsored plans. As we stated and reiterated in the proposed rule and earlier in this final rule, specified sex-trait modification procedures are not typically included in employer-sponsored plans, which is an independent, legally-sufficient basis for adoption of this policy.

For the reasons cited in a previous response to comments addressing section 1557 of the ACA, we disagree with commenters that the policy proposed in the proposed rule, and as revised in this final rule, exceeds statutory authority in violation of the APA because it constitutes sex discrimination in violation of section 1557 of the ACA. We refer readers to our discussion of section 1557 of the ACA in the respective response above.

Further, commenter concerns regarding Federalism or the APA are misguided. The ACA expressly authorizes and provides broad flexibility to the Secretary to define the EHB under section 1302 of the ACA. While the ACA outlines 10 general categories that EHBs must include, the Secretary has the authority to determine the specific services and items within those categories. As discussed elsewhere in this final rule, there is ample data suggesting that the specified sex-trait modification procedures, as defined in this rule, are not benefits covered under a typical employer plan. Therefore, we disagree that this policy, as finalized, is arbitrary and capricious and exceeds statutory authority in violation of the APA.

Comment: Many commenters opposing the proposal also stated that the proposal conflicts with the preliminary injunctions on the executive orders cited in support of the proposal in the proposed rule (E.O. 14168 and E.O. 14187). Some commenters objecting to the policy stated it is premature in light of ongoing litigation and urged CMS to postpone consideration of finalizing this policy until the various lawsuits enjoining application of the executive orders are resolved.

Another opposing commenter stated that E.O. 14187 is limited to sex-trait modification procedures for minors, whereas the proposal applies more broadly to both minors and adults. Two commenters supportive of the proposal stated that they do not believe the existing injunctions on the executive orders should preclude finalizing this policy as proposed, with one commenter noting that the proposal does not rely on the enjoined executive orders but also arguing that the injunctions rely on incorrect legal reasoning. One commenter noted support for the proposal because they noted it protects the rights of employers and enrollees who object to covering services or paying premiums that violate their deeply held religious or moral beliefs.

Response: We agree with commenters supporting the proposed policy in spite of the injunctions on the executive orders. As we stated in the proposed rule (90 FR 12986), we made this proposal independently of the executive orders because specified sex-trait modification procedures are not typically included in employer health plans and therefore cannot legally be covered as EHB. We acknowledge that two courts have issued preliminary injunctions relating to the E.Os described above, and we do not rely on the enjoined sections of the executive orders in making this proposal. The finalized policy does not conflict with those preliminary injunctions because, among other things, it is based on independent legal authority and reasons and not the enjoined sections of the executive orders. Further, this policy as finalized will not be effective until PY 2026, and will not be implemented, made effective, or enforced in contravention of any court orders.[217]

Comment: Numerous commenters opposed the proposal on the basis that it would lead to adverse mental health outcomes and increase suicide risk, though commenters both for and against the proposal universally supported mental health treatment for gender dysphoria. Many commenters who did not support the proposal noted that medical evidence indicates lack of

[217] HHS intends to notify the courts in both cases about this Rule after it has been published in the Federal Register.

access to services for sex-trait modification procedures, and especially hormone therapy, will lead to an overall increase in suicidality and self-harm and create or exacerbate mental health conditions. Many commenters noted that people with gender dysphoria and other identity-related conditions experience higher rates of violence, discrimination, and harassment, which often compounds mental health symptoms. One commenter expressed concern that their treatment would be stopped midstream if the proposal were finalized, and that this would put them at continued risk of violence.

Numerous commenters opposing the proposal also argued that, due to discrimination and stigma, suicide rates are four times higher for individuals with gender dysphoria than the general population, with one commenter stating this rate is even higher among people of color with gender dysphoria. Commenters stated this proposal would result in the denial of medically necessary care that has proven associations with lowering suicidal ideation and that denial of this care would subsequently lead to worse mental health outcomes for persons with gender dysphoria, including higher rates of depression, anxiety, suicide, and suicidal ideation. These commenters cited to multiple studies demonstrating that access to sex-trait modification procedures is associated with lower odds in both children and adults of depression, self-harm, and suicidal thoughts compared to individuals not receiving these services. Commenters opposing the proposal noted particular concern with the mental health impact of this proposal on youth with gender dysphoria.

Commenters opposing the proposal also expressed concern that inability to access certain care as a result of the proposal would exacerbate other conditions. One commenter opposing the proposal stated this would be particularly true for health care services that require risk assessment or consistent engagement with a provider. For example, this commenter noted that receiving a prescription for hormone therapy for sex-trait modification is associated with lower rates of acquiring HIV and increased rates of HIV viral suppression among patients with gender

dysphoria and that limiting access to sex-trait modification services for Exchange enrollees will only exacerbate the HIV epidemic given the disproportionate impact of HIV among individuals with gender dysphoria. Other commenters opposing the proposal noted specific concerns regarding increased substance use in the absence of access to sex-trait modification procedures, as substance use may be used as a coping mechanism.

One commenter that supported the proposal stated that although deaths by suicide are higher than average among the population of persons with gender dysphoria there is no evidence supporting the claim that sex-trait modification procedures reduce this risk. One commenter supporting the proposal stated that there is no scientifically valid evidence that suicide risk among persons with gender dysphoria increases in the absence of sex-trait modification and that puberty blockers are associated with depression. This commenter stated that transition may exacerbate psychological distress, which could lead to suicide, and that persons with gender dysphoria would benefit from mental health services shown to be useful in treating other body dysphoria disorders such as anorexia nervosa, as well as counseling or other treatment for depression and anxiety.

Response: The Department agrees with commenters that mental health services are a critical part of treating gender dysphoria, and we are committed to improving the quality of, and access to, mental health care services.[218] As discussed earlier in this final rule, mental health services will continue to be covered as an EHB as required by section 1302(b)(1)(E) of the ACA, including for those who seek or undergo specified sex-trait modification procedures or are diagnosed with gender dysphoria. We note that the definition of "specified sex-trait modification procedure" we adopt in this rule places no prohibition on coverage of mental health services as EHB. Specifically, the definition neither prohibits coverage for mental health treatment for

[218] Behavioral Health, CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.cms.gov/about-cms/what-we-do/behavioral-health (last visited May 13, 2025).

specific conditions as EHB (for example, for mental health treatment for gender dysphoria), nor prohibits coverage for mental health treatment for any specific populations as EHB (for example, mental health treatment for consumers with gender dysphoria).

Comment: Several commenters opposing the proposal also raised concerns that the proposal would conflict with the Mental Health Parity and Addiction Equity Act (MHPAEA). One such commenter stated that the prohibition of coverage for sex-trait modification is contrary to the MHPAEA prohibition on group health plans and health insurance issuers from imposing less favorable benefit limitations on mental health and substance abuse benefits as compared to medical/surgical benefits, as gender dysphoria is a mental health condition defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR) as a serious medical condition characterized by distress due to incongruence between the patient's gender identity (that is, the innate sense of one's own gender) and sex. These commenters noted concern that complying with this proposal would put group health plans and issuers out of compliance with MHPAEA.

Response: On May 15, 2025, the Departments of Labor, HHS, and the Treasury (the Departments) announced that the Departments will not enforce the September 23, 2024 final rule "Requirements Related to the Mental Health Parity and Addiction Equity Act," 89 FR 77586 (2024 MHPAEA Final Rule) or otherwise pursue enforcement actions based on a failure to comply with the 2024 MHPAEA Final Rule that occur prior to a final decision in ongoing litigation regarding the 2024 MHPAEA Final Rule, plus an additional 18 months.[219] The Departments also announced their intention to reconsider the 2024 MHPAEA Final Rule, including whether to issue a notice of proposed rulemaking rescinding or modifying the

[219] Statement of U.S. Departments of Labor, Health and Human Services, and the Treasury regarding enforcement of the final rule on requirements related to the Mental Health Parity and Addiction Equity Act, May 15, 2025, available at *https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-parity/statement-regarding-enforcement-of-the-final-rule-on-requirements-related-to-mhpaea*.

regulation through notice and comment rulemaking. Further, the Departments announced that they will undertake a broader reexamination of each Department's respective enforcement approach under MHPAEA. Nothing in this final rule prevents a plan or issuer from providing benefits for treatment for gender dysphoria; the benefits simply would not be considered EHB if they fall under the definition of specified sex-trait modification procedures we are finalizing at § 156.400. Additionally, we reiterate that the definition of "specified sex-trait modification procedure" neither prohibits coverage for mental health treatment for specific conditions as EHB (for example, for mental health treatment for gender dysphoria), nor prohibits coverage for mental health treatment for any specific populations as EHB (for example, mental health treatment for consumers with gender dysphoria).

Comment: Many commenters objected to the proposal in general or did not state a basis for the objection. Some commenters stated that the proposal is motivated by animus against transgender-identified people and intended to cause harm to a specific group of people and others stated that the proposal would target individuals already at significantly higher risk for negative health and mental health outcomes. Some commenters stated they believed that the proposal is contrary to HHS' role in protecting the vulnerable, the Make America Healthy Again movement, and pro-life beliefs given the increased risk of suicide among persons with gender dysphoria. Other commenters opined that the proposal creates a double standard through which persons without gender dysphoria may continue to receive sex-trait modification services as EHB but persons with gender dysphoria cannot. Several commenters opined that a prohibition on coverage of sex-trait modification services as EHB is tantamount to eugenics or genocide and a crime against humanity. Other commenters stated that if the proposed rule were finalized as proposed, it would have downstream psychological effects on the friends and family of persons with gender dysphoria who had been seeking sex-trait modification services. Some comments were out of the scope of this rule.

Response: We share commenters' concern for vulnerable groups and individuals. However, we disagree with commenters that prohibiting coverage of specified sex-trait modification procedures as EHB is discriminatory or will be damaging to the health and wellbeing of the nation. Specifically, we disagree with commenters that finalization of the proposal would mean persons without gender dysphoria will have access to specified sex-trait modification procedures while persons with gender dysphoria will not. All people will be able to access covered items and services as EHB, so long as the items and services do not meet the definition of "specified sex-trait modification procedures," in that they are not, in a given instance, surgical or pharmaceutical interventions being provided for the purpose of attempting to align an individual's physical appearance or body with an asserted identity that differs from the individual's sex, or they otherwise fall within an exception. Additionally, we emphasize that we are not prohibiting any consumers from accessing specified sex-trait modification procedures when paid for out of pocket, or prohibiting issuers on the Exchanges from providing coverage for such services as non-EHB. We are only prohibiting the coverage of specified sex-trait modification procedures specifically as EHB, given that they are not within the scope of benefits provided by a typical employer plan, as directed in statute.

2. Premium Adjustment Percentage (§ 156.130(e))

In the 2025 Marketplace Integrity and Affordability proposed rule (90 FR 12987 through 12995), we proposed to update the premium adjustment percentage methodology to establish a premium growth measure that captures premium changes in the individual market in addition to ESI premiums for PY 2026 and beyond. In addition, based on this proposed updated methodology, we proposed values for the PY 2026 premium adjustment percentage, maximum annual limitation on cost sharing, reduced maximum annual limitations on cost sharing, and required contribution percentage.

Section 1302(c)(4) of the ACA directs the Secretary to determine an annual premium adjustment percentage, the measure of premium growth that is used to set the rate of increase for the following three parameters: (1) the maximum annual limitation on cost sharing (defined at § 156.130(a)); (2) the required contribution percentage used to determine eligibility for certain exemptions under section 5000A of the Code (defined at § 155.605(d)(2)(iii)); and (3) the employer shared responsibility payment amounts under section 4980H(a) and (b) of the Code (see section 4980H(c)(5) of the Code). Section 1302(c)(4) of the ACA and § 156.130(e) provide that the premium adjustment percentage is the percentage (if any) by which the average per capita premium for health insurance coverage for the preceding calendar year exceeds such average per capita premium for health insurance for 2013.

The 2015 Payment Notice (79 FR 13744) and 2015 Market Standards Rule (79 FR 30240) established a methodology for estimating the average per capita premium for purposes of calculating the premium adjustment percentage for PY 2015 and beyond. Beginning with PY 2015, the premium adjustment percentage was calculated based on the estimates and projections of average per enrollee ESI premiums from the NHEA, which are calculated by the CMS Office of the Actuary. In the 2015 Payment Notice proposed rule (78 FR 72359 through 72361), we proposed that the premium adjustment percentage be calculated based on the projections of average per enrollee private health insurance premiums from the NHEA. Based on comments received, we finalized in the 2015 Payment Notice (79 FR 13801 through 13804) use of per enrollee ESI premiums from the NHEA in the premium adjustment percentage methodology. We finalized use of per enrollee ESI premiums because these premiums reflected trends in health care costs without being skewed by individual market premium fluctuations resulting from the early years of implementation of the ACA market rules. However, recognizing that ESI premiums did not comprehensively reflect premiums for the entire market, we noted in the 2015

Payment Notice (79 FR 13801 through 13804) that we may change our methodology after the initial years of implementation of the market rules, once the premium trend is more stable.

In the 2020 Payment Notice proposed rule (84 FR 285 through 289), we noted that we believed the premium trend in the individual market had stabilized and, therefore, proposed to change the premium adjustment percentage methodology to comprehensively reflect premium changes across all affected markets as we had suggested in the 2015 Payment Notice (79 FR 13801 through 13804). As such, in the 2020 Payment Notice (84 FR 17537 through 17541), we finalized the use of per enrollee private health insurance premiums from the NHEA (excluding Medigap and property and casualty insurance) in the premium adjustment percentage calculation.

In the 2022 Payment Notice proposed rule (85 FR 78633 through 78635), we proposed a premium adjustment percentage using the methodology adopted in the 2020 Payment Notice (84 FR 17537 through 17541). In addition, we proposed to amend § 156.130(e) to, beginning with PY 2023, set the premium adjustment percentage in guidance separate from the annual notice of benefit and payment parameters, unless we were to propose a change to the methodology for calculating the parameters, in which case, we would do so through notice-and-comment rulemaking. We finalized this latter proposal (the amendment to § 156.130(e)) in part 2 of the 2022 Payment Notice (86 FR 24237 through 24238). Although we did not propose to change the methodology for calculating the premium adjustment percentage in the 2022 Payment Notice proposed rule (85 FR 78633 through 78635), we finalized a new methodology in part 2 of the 2022 Payment Notice (86 FR 24233 through 24237) that readopted the measure of premium growth for PY 2022 and beyond using the NHEA projections of average per enrollee ESI premium in response to comments requesting that we revert to the use of the NHEA ESI premium measure to estimate premium growth, which was the methodology used for PY 2015 through PY 2019. We finalized this change after concluding it was consistent with the will and

interest of interested parties and would mitigate the uncertainty regarding premium growth during the COVID-19 PHE.

Because the COVID-19 PHE has ended and should no longer impact the premium adjustment percentage, and because evidence described in the proposed rule now suggests that the COVID-19 PHE did not impact premiums as we anticipated in part 2 of the 2022 Payment Notice (86 FR 24233 through 24237), in the proposed rule (90 FR 12987 through 12993), we proposed to revert to the methodology for calculating the premium adjustment percentage that we established in the 2020 Payment Notice (84 FR 17537 through 17541). Specifically, we proposed to calculate the premium adjustment percentage for PY 2026 and beyond using an adjusted private individual and group market health insurance premium measure, which is similar to NHEA's private health insurance premium measure.[220] NHEA's private health insurance premium measure includes premiums for ESI, "direct purchase insurance," which includes individual market health insurance purchased directly by consumers from health insurance issuers, both on and off the Exchanges, Medigap insurance, and the medical portion of accident insurance ("property and casualty" insurance). The measure we proposed to use includes NHEA estimates and projections of ESI and direct purchase insurance premiums but would exclude premiums for Medigap and property and casualty insurance (we refer to the proposed measure as "private health insurance (excluding Medigap and property and casualty insurance),") consistent with the approach finalized in the 2020 Payment Notice (84 FR 17537 through 17541).

We proposed to exclude Medigap and property and casualty insurance from the premium measure since these types of coverage are not considered primary medical coverage for

[220] *See* Table 17 of the "NHE Projections - Tables (ZIP)" link available at *https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/projected.*

individuals who elect to enroll.[221] For example, Medigap coverage supplements Original Medicare[222] coverage by helping to pay certain out-of-pocket costs not covered by Original Medicare such as co-payments, coinsurance, and deductibles. Specifically, we stated in the proposed rule that to calculate the premium adjustment percentage for PY 2026, the measures for 2013 and 2025 would be calculated as private health insurance premiums minus premiums paid for Medigap insurance and property and casualty insurance, divided by the unrounded number of unique private health insurance enrollees with comprehensive coverage (that is, excluding supplemental coverage such as Medigap and property and casualty insurance from the count of enrollees in the denominator). We stated that these results would then be rounded to the nearest $1 followed by a division of the 2025 figure by the 2013 figure rounded to 10 significant digits. We explained that the proposed premium measure would reflect cumulative, historic growth in premiums for private health insurance markets (excluding Medigap and property and casualty insurance) from 2013 onwards.

In addition to the proposal to use the private health insurance premium measure data (excluding Medigap and property and casualty insurance) to measure premium growth for the PY 2026 and beyond, in the proposed rule (90 FR 12991 through 12992), we also proposed the premium adjustment percentage value for PY 2026. Specifically, we proposed that the premium adjustment percentage for PY 2026 be the percentage (if any) by which the most recent NHEA projection of per enrollee premiums for private health insurance (excluding Medigap and property and casualty insurance) for 2025 ($7,885) exceeds the most recent NHEA estimate of

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[221] Section 1302(c)(4) of the ACA refers to "the average per capita premium for health insurance coverage in the United States." The term "health insurance coverage" is defined in 42 U.S.C. 300gg–91(b)(1) as "benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer."

[222] Original Medicare includes Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) and covers services such as inpatient hospital care, outpatient services and office visits, tests, and preventive services. *see*, for example, CMS. (n.d.). What Original Medicare Covers. *https://www.medicare.gov/providers-services/original-medicare.*

per enrollee premiums for private health insurance (excluding Medigap and property and casualty insurance) for 2013 ($4,714).[223] Using this formula, in the proposed rule (90 FR 12992), we proposed a premium adjustment percentage for 2026 of 1.6726771319 ($7,885/$4,714). We stated in the proposed rule that this would represent an increase in private health insurance premiums (excluding Medigap and property and casualty insurance) of approximately 67.3 percent over the period from 2013 to 2025 and would reflect an overall growth rate for this period that is approximately 7.2 percentage points higher than the overall growth rate reflected by the previously published PY 2026 premium adjustment percentage (1.6002042901).[224]

We refer readers to the proposed rule (90 FR 12987 through 12997) for a more detailed discussion of our proposed methodology, including further information regarding the background, rationale, and expected impacts of this proposal.

Based on the proposed PY 2026 premium adjustment percentage, we proposed the cost-sharing parameters for PY 2026, including the maximum annual limitation on cost sharing, the reduced maximum annual limitations on cost sharing, and the required contribution percentage as further described in the following subsections.

a. Maximum Annual Limitation on Cost Sharing for PY 2026

Under § 156.130(a)(2)(i), for PY 2026, cost sharing for self-only coverage may not exceed the dollar limit for calendar year 2014 increased by an amount equal to the product of that amount and the premium adjustment percentage for PY 2026. Under § 156.130(a)(2)(ii), for

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[223] The 2013 and 2025 premiums used for this calculation reflect the latest NHEA data. The series used in the determinations of the adjustment percentages can be found in Tables 1 and 17 on the CMS website, which can be accessed by clicking the "NHE Projections 2023-2032—Tables" link located in the Downloads section at https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/projected. A detailed description of the NHE projection methodology is available at CMS. (2024, June 12). Projections of National Health Expenditures and Health Insurance Enrollment: Methodology and Model Specification. *https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/downloads/projectionsmethodology.pdf.*

[224] *See* CMS. (2024, Oct. 8). Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing, Reduced Maximum Annual Limitation on Cost Sharing, and Required Contribution Percentage for the 2026 Benefit Year. *https://www.cms.gov/files/document/2026-papi-parameters-guidance-2024-10-08.pdf.*

other than self-only coverage, the limit is twice the dollar limit for self-only coverage. Under § 156.130(d), these amounts must be rounded down to the next lowest multiple of $50. Using the proposed premium adjustment percentage of 1.6726771319 for PY 2026, and the 2014 maximum annual limitation on cost sharing of $6,350 for self-only coverage, which was published by the IRS on May 2, 2013,[225] in the proposed rule (90 FR 12993), we proposed that the PY 2026 maximum annual limitation on cost sharing would be $10,600 for self-only coverage and $21,200 for other than self-only coverage. We stated in the proposed rule that this represents approximately a 15.2 percent increase from the PY 2025 parameters of $9,200 for self-only coverage and $18,400 for other than self-only coverage, and approximately a 4.4 percent increase from the previously published PY 2026 parameters of $10,150 for self-only coverage and $20,300 for other than self-only coverage.[226]

b. Reduced Maximum Annual Limitation on Cost Sharing for PY 2026

The reduced maximum annual limitations on cost sharing for cost-sharing plan variations are determined using the methodology we established in the 2014 Payment Notice (78 FR 15410). In the 2014 Payment Notice, we established standards related to the provision of these cost-sharing reductions (CSRs). Specifically, in 45 CFR part 156, subpart E, we specified that QHP issuers must provide CSRs by developing plan variations, which are separate cost-sharing structures for each eligibility category that change how the cost sharing required under the QHP is to be shared between the enrollee and the Federal Government.[227] At § 156.420(a), we detailed the structure of these plan variations and specified that QHP issuers must ensure that each silver

[225] *See* IRS. (n.d.) Rev. Proc. 2013-25. Dep't of Treasury. *http://www.irs.gov/pub/irs-drop/rp-13-25.pdf.*
[226] CMS. (2024, Oct. 8). Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing, Reduced Maximum Annual Limitation on Cost Sharing, and Required Contribution Percentage for the 2026 Benefit Year. *https://www.cms.gov/files/document/2026-papi-parameters-guidance-2024-10-08.pdf.*
[227] On October 12, 2017, the Attorney General issued a legal opinion that HHS did not have a Congressional appropriation with which to make CSR payments. Sessions III, J. (2017, Oct. 11). Legal Opinion Re: Payments to Issuers for Cost-Sharing Reductions (CSRs). Office of Attorney General. *https://www.hhs.gov/sites/default/files/csr-payment-memo.pdf.*

plan variation has an annual limitation on cost sharing no greater than the applicable reduced maximum annual limitation on cost sharing specified in the annual HHS guidance or HHS notice of benefit and payment parameters. We noted in the proposed rule (90 FR 12993) that although the amount of the reduction in the maximum annual limitation on cost sharing is specified in section 1402(c)(1)(A) of the ACA, section 1402(c)(1)(B)(ii) of the ACA states that the Secretary may adjust the cost sharing limits to ensure that the resulting limits do not cause the AV of the health plans to exceed the levels specified in section 1402(c)(1)(B)(i) of the ACA (that is, 70 percent, 73 percent, 87 percent, or 94 percent, depending on the income of the enrollee).

As indicated in Table 8 of the proposed rule (90 FR 12994), we proposed the values of the PY 2026 reduced maximum annual limitation on cost sharing for self-only coverage at $3,500 for enrollees with household income greater than or equal to 100 percent of the FPL and less than or equal to 150 percent of the FPL, $3,500 for enrollees with household income greater than 150 percent of the FPL and less than or equal to 200 percent of the FPL, and $8,450 for enrollees with household income greater than 200 and less than or equal to 250 percent of the FPL, as calculated using the proposed PY 2026 premium adjustment percentage and proposed PY 2026 maximum annual limitation on cost sharing. We stated that these proposed values reflect 4.3 to 4.5 percent increases relative to the previously published PY 2026 parameters.[228]

We refer readers to the proposed rule (90 FR 12993 through 12995) for a more detailed discussion of the proposed values of the PY 2026 reduced maximum annual limitation on cost sharing, including further information regarding the background, rationale, and expected impacts of these proposed values. Table 5 outlines the final values for the PY 2026 reduced maximum

[228] *See* CMS. (2024, Oct. 8). Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing, Reduced Maximum Annual Limitation on Cost Sharing, and Required Contribution Percentage for the 2026 Benefit Year. *https://www.cms.gov/files/document/2026-papi-parameters-guidance-2024-10-08.pdf.*

annual limitation on cost sharing, as calculated using the final PY 2026 premium adjustment percentage and final PY 2026 maximum annual limitation on cost sharing.

TABLE 5: Final Reductions in Maximum Annual Limitation on Cost Sharing for PY 2026

Eligibility Category	Reduced Maximum Annual Limitation on Cost Sharing for Self-only Coverage for BY 2026	Reduced Maximum Annual Limitation on Cost Sharing for Other than Self-only Coverage for BY 2026
Silver 94% AV* CSR Plan Variant: Individuals eligible for CSRs under § 155.305(g)(2)(i) (household income greater than or equal to 100 and less than or equal to 150 percent of the FPL)	$3,500	$7,000
Silver 87% AV* CSR Plan Variant: Individuals eligible for CSRs under § 155.305(g)(2)(ii) (household income greater than 150 and less than or equal to 200 percent of the FPL)	$3,500	$7,000
Silver 73% AV* CSR Plan Variant: Individuals eligible for CSRs under § 155.305(g)(2)(iii) (household income greater than 200 and less than or equal to 250 percent of the FPL)	$8,450	$16,900

*Under section 1402(d) of the ACA, American Indian/Alaska Native (AI/AN) enrollees with incomes under 300 percent of the FPL are eligible for Zero Cost Sharing plan variants. Additionally, all AI/AN QHP enrollees are eligible for no cost sharing for items and services provided by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services. Under § 155.305(g)(1)(ii), all other enrollees must be enrolled in a silver plan variant to be eligible for CSRs.

c. Required Contribution Percentage at § 155.605(d)(2) for PY 2026

We calculate the required contribution percentage for each plan year using the most recent projections and estimates of premium growth and income growth over the period from 2013 to the preceding calendar year (that is, the 2025 calendar year, in the case of PY 2026 required contribution percentage). Accordingly, in the proposed rule (90 FR 12995), we proposed the required contribution percentage for PY 2026, calculated using income and premium growth data for the 2013 and 2025 calendar years.

Section 5000A of the Code imposes an individual shared responsibility payment on non-exempt individuals who do not have MEC for each month. Under § 155.605(d)(2), an individual is allowed a coverage exemption (the affordability exemption) for months in which the amount the individual would pay for MEC exceeds a percentage, called the required contribution

percentage, of the individual's household income. Although the Tax Cuts and Jobs Act[229] reduced the individual shared responsibility payment to $0 for months beginning after December 31, 2018, the required contribution percentage is still used to determine whether individuals ages 30 and above qualify for an affordability exemption that would enable them to enroll in catastrophic coverage under § 155.305(h).

The initial 2014 required contribution percentage under section 5000A of the Code was 8 percent. For plan years after 2014, section 5000A(e)(1)(D) of the Code and Treasury regulations at 26 CFR 1.5000A-3(e)(2)(ii) provide that the required contribution percentage is the percentage determined by the Secretary that reflects the excess of the rate of premium growth between the preceding calendar year and 2013, over the rate of income growth for that period.

As the measure of income growth for a calendar year, we established in the 2017 Payment Notice (81 FR 12281 through 12282) that we would use NHEA projections of per capita personal income (PI). The rate of income growth for PY 2026 is the percentage (if any) by which the NHEA Projections 2023–2032 value for per capita PI for the preceding calendar year ($74,083 for 2025) exceeds the NHEA Projections 2023–2032 value for per capita PI for 2013 ($44,559), carried out to ten significant digits. The rate of income growth from 2013 to 2025 is therefore 1.6625821944 ($74,083/$44,559). Using the proposed PY 2026 premium adjustment percentage, we stated in the proposed rule (90 FR 12995) that the excess of the rate of premium growth over the rate of income growth for 2013 to 2025 would be 1.6726771319 ÷ 1.6625821944, or 1.0060718427. We determined that this results in the proposed PY 2026 required contribution percentage under section 5000A of the Code of 8.00 × 1.0060718427 or 8.05 percent, when rounded to the nearest one-hundredth of 1 percent, an increase of approximately 0.77 percentage points above the 2025 value (7.28 percent) and an increase of

[229] Pub. L. 115-97, 131 Stat, 2054.

approximately 0.35 percentage points above the previously published PY 2026 value[230] (7.70 percent).

We noted that these proposals do not alter the policy established in the 2022 Payment Notice (86 FR 24237 through 24238) that we will publish the premium adjustment percentage, along with the maximum annual limitation on cost sharing, the reduced maximum annual limitation on cost sharing, and the required contribution percentage, in guidance by January of the year preceding the applicable plan year, unless we are amending the methodology to calculate these parameters, in which case we would amend the methodology and publish the parameters through notice-and-comment rulemaking.

We stated in the proposed rule that if finalized as proposed, the values for the PY 2026 premium adjustment percentage, maximum annual limitation on cost sharing, reduced maximum annual limitations on cost sharing, and required contribution percentage proposed in the proposed rule would supersede the values published in the October 2024 PAPI Guidance.[231]

We sought comment on the proposal to revert to the premium adjustment percentage methodology finalized in the 2020 Payment Notice (84 FR 17537 through 17541) using private health insurance premiums (excluding Medigap and property and casualty insurance premiums) to estimate the growth in premiums for PY 2026 and beyond. We also sought comment on the resulting proposed values for the PY 2026 premium adjustment percentage, maximum annual limitation on cost sharing, reduced maximum annual limitations on cost sharing, and required contribution percentage.

After consideration of comments and for the reasons outlined in the proposed rule and this final rule, including our responses to comments, we are finalizing the use of private health

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[230] *See* CMS. (2024, Oct. 8). Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing, Reduced Maximum Annual Limitation on Cost Sharing, and Required Contribution Percentage for the 2026 Benefit Year. *https://www.cms.gov/files/document/2026-papi-parameters-guidance-2024-10-08.pdf.*
[231] Ibid.

insurance premiums (excluding Medigap and property and casualty insurance premiums) to estimate the growth in premiums for PY 2026 and beyond. We are also finalizing the values for the PY 2026 premium adjustment percentage, maximum annual limitation on cost sharing, reduced maximum annual limitations on cost sharing, and required contribution percentage as proposed. Table 6 provides the final premium adjustment percentage index and related payment parameters for PY 2026:

TABLE 6: Final Premium Adjustment Percentage Index and Related Payment Parameters for the PY 2026

Area	Metric	Value
Premium Adjustment Percentage	NHEA Projections 2023-2032 value[(a)] for per enrollee Private Health Insurance premiums (excluding Medigap and property and casualty insurance) for 2013	$4,714
	NHEA Projections 2023-2032 value[(a)] for per enrollee Private Health Insurance premiums (excluding Medigap and property and casualty insurance) for 2025	$7,885
	2026 Premium Adjustment Percentage	1.6726771319
Required Contribution	NHEA Projections 2023-2032 value[(a)] for of per capita personal income for 2013	$44,559
	NHEA Projections 2023-2032 value[(a)] for of per capita personal income for 2025	$74,083
	Income Growth	1.6625821944
	Premium Growth over Income Growth Index	1.0060718427
	2026 Required Contribution Percentage	8.05%
Maximum Annual Limitation on Cost Sharing – Self Only[(b)]	2026 Maximum Annual Limitation on Cost Sharing	$10,600
	2026 Reduced Maximum Annual Limitation on Cost Sharing – household income greater than or equal to 100 percent and less than or equal to 150 percent of the FPL	$3,500
	2026 Reduced Maximum Annual Limitation on Cost Sharing – household income greater than 150 percent and less than or equal to 200 percent of the FPL	$3,500
	2026 Reduced Maximum Annual Limitation on Cost Sharing – household income greater than 200 percent and less than or equal to 250 percent of the FPL	$8,450

[(a)] For the calculation of the PY 2026 premium adjustment percentage, maximum annual limitation on cost sharing, reduced maximum annual limitation on cost sharing, and required contribution percentage, we are using the NHEA Projections 2023-2032 (published June 12, 2024), which were the most recent projections that had been released as of the publication of the proposed rule.[232]

[(b)] The maximum annual limitation on cost sharing and reduced maximum annual limitations on cost sharing for other than self-only coverage is twice the dollar limit for self-only coverage. *See* 45 CFR 156.130(a)(2)(ii). For example, for the PY 2026, the maximum annual limitation on cost sharing for other than self-only coverage is $21,200.

We summarize and respond below to public comments received on the proposed premium adjustment percentage methodology for the 2026 benefit year and beyond and the resulting proposed values for the PY 2026 premium adjustment percentage, maximum annual

[232] In the 2021 Payment Notice (85 FR 29228), we finalized a policy that we would calculate final payment parameters that depend on NHEA data based on the data that are available as of the publication of the proposed rule for that benefit year to increase the predictability of benefit design.

limitation on cost sharing, reduced maximum annual limitations on cost sharing, and required contribution percentage.

Comment: A few commenters supported the proposed change to the premium adjustment percentage methodology, stating that the proposed methodology would better align with the plain language of section 1302(c)(4) of the ACA, which directs the Secretary to determine the premium adjustment percentage for any calendar year based on the "average per capita premium for health insurance in the United States."[233] These commenters also noted that basing the premium adjustment percentage on a more comprehensive measure of premiums in the market would provide issuers with more flexibility to design innovative plans that better meet consumer needs.

However, many other commenters expressed opposition to or concerns about the proposed change to the premium adjustment percentage methodology and the related proposed PY 2026 parameters. Many of these commenters indicated HHS should continue to use the current measure, ESI premiums, to measure premium growth because ESI premiums presently result in a lower premium adjustment percentage, maximum annual limitation on cost sharing, and reduced annual limitations on cost sharing than the proposed values using all private health insurance premiums (excluding Medigap and property and casualty insurance).

Additionally, several of these commenters noted that, because the IRS has historically adopted the same measure of premium growth as HHS for indexing under Section 36B(b) and (c) of the Code, the proposed change to the premium adjustment percentage methodology will likely impact the coverage "affordability" percentages that IRS releases annually, which are used by applicable employers to determine the affordability of their offers of coverage for purposes of the

[233] *See* Section 1302(c)(4) of the ACA.

employer shared responsibility provisions, resulting in increased net premiums for enrollees who receive health insurance coverage through their employers.

Many commenters also expressed concerns about the impact of the proposal on the health insurance market and individuals and families, citing HHS' estimates of the impacts in the Regulatory Impact Analysis section of the proposed rule, including a decrease in enrollment and increase in net premiums, under the assumption that the IRS will adopt HHS' premium indexing methodology for the applicable percentage table, as it has historically done.

Among commenters who expressed concern that the increase in net premiums would lead to a decrease in health insurance enrollment, a few commenters noted that an increase in individuals without health insurance coverage would also lead to an increase in medical debt. Furthermore, many commenters expressed concerns about the impact of the higher proposed premium adjustment percentage on the maximum annual limitation on cost sharing and reduced maximum annual limitations on cost sharing, which they noted would increase out-of-pocket costs for consumers. Many of these commenters expressed concerns that the increased limits on cost sharing would disproportionately impact older enrollees, individuals with chronic health conditions, and other individuals who have a higher likelihood of incurring high medical costs. These commenters expressed concerns that the higher costs would lead to these enrollees choosing to forgo care to manage their conditions, leading to higher rates of complications and lower levels of overall health in the population. A few of these commenters noted that many people with chronic or serious health conditions have non-covered or out-of-network costs that are not subject to their plans' annual limitation on cost sharing and that the increase in the maximum annual limitation on cost sharing would compound the financial burden of these enrollees.

Several commenters also noted that the increase in net premiums is likely to have a disproportionate impact on enrollment in rural and low-income communities. Many of these

commenters expressed concern that hospitals, community health clinics, and other providers that serve these low-income communities would see an increase in patients without insurance or who cannot afford the out-of-pocket costs of care, causing providers to be unable to cover their expenses and to close, increasing burdens on the health system and decreasing health care access. Additionally, several commenters expressed concern that the impact of the increase in net premiums would be further compounded when the expanded PTC subsidies made available under the American Rescue Plan Act of 2021 (ARPA) (and extended under the Inflation Reduction Act of 2022 (IRA) until the end of 2025) expire. One commenter requested more detailed modelling of the impact of the proposed change to the premium adjustment percentage methodology before implementation, stating that projections of the impacts on various income and demographic groups are necessary to ensure that interested parties can offer thoroughly informed feedback.

Regarding the impact on low-income consumers, some commenters stated the justification provided by HHS for this proposed change is inadequate and contrary to the legislative intent of the financial assistance structure of the ACA. A few commenters noted that the primary purpose of providing PTC to Exchange enrollees is so the Federal Government, rather than low-income individuals and families, bears the burden of any premium increases in the individual market.

Additionally, several commenters expressed concern that healthier enrollees are more likely to choose not to enroll in health insurance plans in response to higher net premiums than sicker enrollees, therefore increasing the average risk in the risk pool, prompting issuers to increase premiums across the entire risk pool.

Response: We appreciate the comments in support of the proposed change to the premium adjustment percentage methodology and are finalizing the change, as proposed, to use per enrollee private health insurance premiums (excluding Medigap and property and casualty

insurance) as the premium growth measure for purposes of calculating the premium adjustment percentage because we agree that this approach allows us to better achieve the statutory and regulatory goals of adopting a more comprehensive and accurate measure of premium costs across the private health insurance market. Specifically, section 1302(c)(4) of the ACA and § 156.130(e) provide that the premium adjustment percentage is the percentage (if any) by which the average per capita premium for health insurance coverage for the preceding calendar year exceeds such average per capita premium for health insurance for 2013. As the purpose of this index is to measure growth in premiums, we believe it is appropriate to use a premium measure that comprehensively reflects the actual growth in premiums in the related insurance markets. We also agree that a measure of premium that more comprehensively includes plans from both the individual and employer-sponsored market is better aligned with the language of the ACA and that the resulting higher maximum annual limitation on cost sharing will provide issuers with more flexibility to set other cost sharing parameters to better meet consumer needs.

We acknowledge commenters' concerns about the assumption noted in the proposed rule (90 FR 13018) that the IRS will adopt the same premium growth indexing methodology as HHS, as it has historically done. IRS utilizes HHS' methodology for indexing the applicable percentage table that determines PTC payments and "affordability percentages" used by applicable employers to determine the affordability of their coverage offerings for the employer shared responsibility provisions. As we did in the proposed rule, we also acknowledge that these changes will increase net premiums for enrollees under 400 percent of the FPL, consistent with section 36B(b)(3) of the Code, potentially decreasing enrollment through the Exchange as noted in the Regulatory Impact Analysis section of this final rule and that the change may also lead to enrollees in ESI being required to pay more of their income towards their health insurance premiums, consistent with section 36B(c)(2)(C) of the Code.

Because the projected decrease in Exchange enrollment is driven by decreased PTC resulting in increased net premiums for lower income enrollees, we do not disagree with the commenters' statement that low-income enrollees are more likely to be impacted by this policy change. It is also reasonable to assume that providers who serve a disproportionate number of low-income patients, which may include providers in rural communities, may experience downstream impacts of the policy change and its impact on low-income consumers in the form of increased provision of unpaid care and reduced utilization by consumers. Specifically, we stated in the proposed rule (90 FR 13019) that the proposal may increase the number of uninsured, and that this may increase Federal and State uncompensated care costs and contribute to negative public health outcomes.[234]

Furthermore, we recognize commenters' concerns about the burden that an increase in the maximum annual limitation on cost sharing places on consumers who meet the annual limit for the plan in which they have enrolled. The proposed change will raise the cap on the dollar value an issuer may set for a plan's annual limitation on cost sharing, leading to higher out-of-pocket costs for enrollees who use enough medical services to reach the limit for their plan.

With the impacts on premiums, enrollment, and out-of-pocket costs in mind, to the extent that lack of coverage or higher out-of-pocket costs are correlated to medical debt, it is also reasonable to believe that rates of medical debt may increase for those enrollees who choose not to enroll due to higher net premiums or who cannot afford out-of-pocket costs associated with medical care. Likewise, it is reasonable to believe that some individuals, including those with chronic conditions, may choose to forgo care due to higher-out-of-pocket costs or lack of coverage, which may in turn worsen the state of overall health for those individuals.

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[234] *See*, for example, Goldin, J., Lurie, I.Z., & McCubbin, J. (2021). Health Insurance and Mortality: Experimental Evidence from Taxpayer Outreach. The Quarterly Journal of Economics, 136(1), 1-49.

Although we recognize commenters' concerns on these matters, we believe that the scope of the impacts on enrollee cost sharing and medical debt will be relatively limited. As we noted in the proposed rule (90 FR 13019), those plans that are required to comply with the maximum annual limitation on cost sharing are generally required to comply with AV (or with minimum value) requirements, constraining the range of cost-sharing parameter values that issuers can offer for those plans, regardless of the maximum annual limitation on cost sharing. This proposal allows issuers to set higher annual limitations on cost sharing for their plans, but higher annual limitations on cost sharing would generally also require lower deductibles, coinsurance, or copayment parameters for a plan to be able to meet AV requirements. As such, this proposal gives issuers additional flexibility to set cost-sharing parameters that meet their populations' needs without impacting the overall value of coverage.

Furthermore, we continue to believe the definition of the premium adjustment percentage in section 1302(c)(4) of the ACA as growth in the "average per capita premium for health insurance coverage in the United States" suggests that the measure of growth was intended to be comprehensive. Therefore, a premium growth measure should reflect premium growth in all affected markets and should not be limited to ESI premium growth. In effect, this change is a correction for measuring premium growth, as the previous exclusion of individual market data was not the most comprehensive method of premium growth measurement, but was deemed necessary as a result of the premium instability in the individual market immediately following implementation of the ACA market reforms (79 FR 13801 through 13804) and then again as a result of anticipated premium instability in the individual market during the COVID-19 PHE (86 FR 24233 through 24237). In both of these cases, our decision to exclude individual market premiums from the measure of premium growth was primarily intended to account for short-term market distortions and the impact of those potential distortions on various parameters, rather than to provide relief for specific groups of consumers or other interested parties. Moreover, as

described in the proposed rule (90 FR 12988 through 12991), the COVID-19 PHE did not impact the individual market as we originally anticipated and conversely appears to have increased premiums in the employer-sponsored market more than in the individual market during this period, suggesting in hindsight that the primary justification for reverting to using only employer-sponsored premiums to calculate the premium adjustment percentage was unfounded.

Although the ACA does contain financial assistance provisions that shift costs from consumers to the Federal Government as noted by some commenters, increasing access to health insurance coverage and care for low-income communities, the indexing methodology of the premium adjustment percentage is not in itself one of those provisions. Instead, the premium adjustment percentage reflects the intent of Congress to appropriately index financial assistance provision related-parameters which were initially determined at the time of passage of the ACA. Because the role of the premium adjustment percentage is to appropriately index various parameters defined in the ACA, the primary consideration for setting the value of the premium adjustment percentage should be whether it accurately and comprehensively captures the rate of premium growth in the United States rather than the impact of the indexing methodology on net premiums, enrollment, access to health care, health outcomes, or out-of-pocket costs for those who receive non-covered or out-of-network care. Considering these other impacts when setting the premium adjustment percentage may result in a measure of premium growth that does not accurately reflect actual premium growth in the United States, artificially inflating the generosity of provisions of the ACA beyond the intent of Congress. Likewise, in response to the comments expressing concern that the impact of the change in the premium adjustment percentage methodology on net premiums would be further compounded when the expanded PTC subsidies made available under the ARPA and extended by the IRA expire, it would be beyond the intent of Congress as expressed in the ACA, ARPA, or IRA to take into account the expiring enhanced subsidies in setting the premium adjustment percentage indexing methodology.

As such, we believe that the measure of premium growth should aim to be comprehensive and accurate to best satisfy the statutory requirement that the premium adjustment percentage reflect growth in the "average per capita premium for health insurance coverage in the United States," regardless of the impacts of a given premium adjustment methodology on specific groups of consumers, including rural and low-income consumers and consumers with chronic or severe conditions. Again, we note that we shifted away from utilization of a more comprehensive measure in Part 2 of the 2022 Payment Notice (86 FR 24233 through 24237) primarily due to concern that anticipated market distortions related to the COVID-19 PHE would distort the indexing set by the premium adjustment percentage. Because evidence appears to demonstrate that this anticipated distortion among private health insurance (excluding Medigap and property and casualty insurance) did not occur, we do not consider the continued exclusion of these premiums from the index to be appropriate. With these considerations, we do not think the premium adjustment percentage methodology in this rulemaking is contrary to the legislative intent of the financial assistance structure of the ACA because the Federal Government will continue to provide appropriately indexed premium assistance for enrollees with incomes less than 400 percent of the FPL and will continue to set appropriately indexed limitations on cost sharing and employer responsibility requirements. We also believe the premium adjustment percentage finalized in this rule is more consistent with the intent of the indexing provisions of the ACA than the previous premium adjustment percentage methodology. Because appropriately aligning with the intent of Congress is our primary consideration in setting the premium adjustment percentage methodology to include all private health insurance premiums (excluding Medigap and property and casualty insurance), we do not see the need to delay this change for the purposes of analyzing impacts on various income and demographic groups, as suggested by one commenter. Furthermore, we believe that section 1302(c)(4) of the ACA provides the Secretary with the authority to update and modify the

premium adjustment percentage and premium growth rate measure as appropriate, and that our policy is within this authority.

Finally, we acknowledge commenters' concern that healthy enrollees may be less likely to enroll due to the higher net premiums that result from the change in the premium adjustment methodology, to the extent that consumers consider the costs and benefits of enrolling in health insurance coverage. However, as with the other concerns discussed above, we believe the consideration of the impact of this proposal on the risk pool to be outside the scope of the indexing provisions of the ACA because the purpose of the premium adjustment percentage is to accurately index program parameters against the growth in premiums, not to control the growth of those premiums. Nevertheless, we believe the impact of the change in the premium adjustment percentage methodology on enrollment, and likewise, the impact on the risk pool and overall premiums, will be relatively limited. As noted in the Regulatory Impact Analysis sections of the proposed rule and this final rule, the decrease in enrollment for PY 2026 due to the premium adjustment percentage change is estimated to be 80,000 Exchange enrollees, approximately 0.3 percent of the number of individuals who selected coverage in the Exchange during the PY 2025 OEP.[235] Also, we estimated the impact of this proposal on gross premiums to be negligible, reflecting the limited impact of the change in the premium adjustment percentage methodology on the average risk in the risk pool.

Based on these considerations, we are finalizing the premium adjustment percentage, maximum annual limitation on cost sharing, reduced maximum annual limitations on cost

[235] *See* the CMS press release "Over 24 Million Consumers Selected Affordable Health Coverage in ACA Marketplace for 2025" (January 17, 2025), available at: *https://www.cms.gov/newsroom/press-releases/over-24-million-consumers-selected-affordable-health-coverage-aca-marketplace-2025.*

sharing, and required contribution percentage as proposed, effective for PY 2026, and these values will supersede the PY 2026 values published in the October 2024 PAPI Guidance.[236]

Comment: A few commenters noted that because the premium adjustment percentage is a cumulative measure, including individual market premiums in the definition of premium growth implicitly incorporates the impact on premiums of the significant enhancement of benefits in the individual market as a result of the ACA's market reforms. As such, the commenters stated that individual market premiums should not be used to measure premium growth since 2013 because premiums in the early years of ACA were volatile, even in comparison to the growth in employer-sponsored premiums during the COVID-19 PHE that we cited in the proposed rule. Due to the cumulative nature of the premium adjustment percentage, these commenters stated that the early years of ACA implementation will continue to impact the premium adjustment percentage if individual market premiums are included in the measure. One of these commenters recommended HHS use a benchmark year no earlier than 2018 (rather than 2013) to avoid inclusion of premium increases resulting from the ACA market reforms and other Federal policy and legislative decisions such as the cessation of Federal funding for CSRs and the elimination of the individual mandate penalty. This commenter also suggested that individual market premiums may be impacted by the expansion of section 1332 waivers since the implementation of the ACA.

Response: As stated in the 2015 Payment Notice (79 FR 13801 through 13804), we previously excluded premiums from the individual market because they were most affected by the significant changes in benefit design and market composition in the early years of implementation of the ACA market rules and were most likely to be subject to risk premium

[236] *See* CMS. (2024, Oct. 8). Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing, Reduced Maximum Annual Limitation on Cost Sharing, and Required Contribution Percentage for the 2026 Benefit Year. *https://www.cms.gov/files/document/2026-papi-parameters-guidance-2024-10-08.pdf.*

pricing. Likewise, in part 2 of the 2022 Payment Notice (86 FR 24233 through 24237), we excluded premiums from the individual market because, at the time, we anticipated that these premiums would be more volatile in response to the COVID-19 PHE than employer-sponsored premiums. As noted in the 2020 Payment Notice (84 FR 17537 through 17541), the rule in which we first adopted a premium adjustment percentage methodology that incorporated all private health insurance (excluding Medigap and property and casualty insurance), the ACA is now past the initial years of implementation and issuers have had the opportunity to collect data on the risk composition of the individual market and adjust pricing accordingly. Additionally, as noted in the proposed rule (90 FR 12990 through 12991), premiums in the employer-sponsored market increased more rapidly than premiums in the individual market during the COVID-19 PHE, the impact of which has led to a decreasing gap in premium growth between the individual market and employer-sponsored market. As such, we believe that a comprehensive measure incorporating both individual market and employer-sponsored premiums will more accurately reflect true premium growth going forward. Therefore, we are finalizing our proposal to measure growth of premiums issuers charged enrollees more comprehensively by once more including individual market premiums. We acknowledge that the premium adjustment percentage is a cumulative measure and, as such, the market fluctuations in the early years of ACA implementation are included in the calculation when using private health insurance premiums (excluding Medigap and property and casualty insurance) as the data source for indexing. However, because it is a cumulative measure, the impact of these early years decreases as more time elapses between the applicable plan year and the benchmark year (2013). For example, for PY 2018, PY 2014 was 1 of 4 years of growth included in the premium adjustment percentage measure and therefore the weight of PY 2014 premium growth was approximately one quarter of the overall measure. For PY 2026, PY 2014 is 1 of 12 years of growth included in the measure. Therefore, for PY 2026, the weight of PY 2014 is only one twelfth of the overall measure. As

such, the greater time between the benchmark year and the applicable plan year reduces the impacts of any individual year, even if the premium growth in that year is unusual.

Furthermore, as we have said in response to other comments on this proposal, the premium adjustment percentage reflects the intent of the Congress to appropriately index parameters which were initially determined at the time of passage of the ACA. Because the role of the premium adjustment percentage is to appropriately index various parameters defined in the ACA, the primary consideration for setting the value of the premium adjustment percentage should be whether it accurately and comprehensively captures the rate of premium growth in the United States. With the reduced impact over time of any individual year of premium growth, continuing to exclude individual market premiums from this measure because they may be impacted by States' approved section 1332 waivers or other policy actions could result in parameters that are indexed inaccurately relative to the actual rate of premium growth in the United States, contrary to the intent of Congress.

With respect to the comment requesting we use a different benchmark year, we did not propose and are not finalizing the use of a different benchmark year for individual market premiums. Moreover, the applicable statute, section 1302(c)(4) of the ACA, requires the Secretary to establish a premium adjustment percentage that measures premium growth between the preceding calendar year (2025, in this case) and 2013. Without legislative action, it is not permissible to change the benchmark year to any year other than 2013.

Comment: One commenter expressed concern about the evidence we presented in the proposed rule to support the assertion that individual market premiums remained stable during the COVID-19 PHE due to the commenter's perception that the predictions regarding the anticipated impacts of the COVID-19 PHE premiums were inaccurate.

Response: The analysis of the trends in premium growth during the COVID-19 PHE that we presented in the proposed rule were not based on predicted values but were based on the

CMS Office of the Actuary's NHEA historical data,[237] which included data through the 2023 calendar year, encompassing the entirety of the COVID-19 PHE.[238] As described in the methodology documents for the NHEA historical data,[239] major data sources for the historical data include annual and quarterly Census Bureau surveys and annual American Hospital Association surveys. As such, these data represent point-in-time estimates (rather than projections) from calendar years impacted by the COVID-19 PHE. Given this, we are confident that the NHEA historical data accurately reflect the growth in premiums in the individual and employer-sponsored markets during the COVID-19 PHE and that employer-sponsored market premiums grew more rapidly than individual market premiums during this period.

Comment: A few commenters suggested that HHS delay adoption of this change to the premium adjustment percentage methodology until PY 2027 due to issuer and various States' timing constraints for rate setting. A few commenters recommended that HHS consider a more delayed or gradual phase-in of individual market premiums over several years.

Response: In finalizing these values for PY 2026, we recognize that some States have rate filing deadlines in April and May and that this rule may not be finalized in time for issuers in these States to adjust plan parameters and rates to take advantage of the additional flexibility afforded by the increased maximum annual limitation on cost sharing and reduced maximum annual limitations on cost sharing. However, because the values finalized in this final rule resulted in a higher maximum annual limitation on cost sharing than was previously released in guidance,[240] the vast majority of plans that met maximum annual limitation on cost sharing

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[237] Available at *https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/historical.*
[238] *See* "National Health Expenditure Accounts: Methodology Paper, 2023: Definitions, Sources, and Methods" available at *https://www.hhs.gov/coronavirus/covid-19-public-health-emergency/index.html*.
[239] *See https://www.cms.gov/files/document/definitions-sources-and-methods.pdf*.
[240] *See* CMS. (2024, Oct. 8). Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing, Reduced Maximum Annual Limitation on Cost Sharing, and Required Contribution Percentage for the 2026 Benefit Year. *https://www.cms.gov/files/document/2026-papi-parameters-guidance-2024-10-08.pdf*.

requirements under the previously released PY 2026 premium adjustment percentage methodology will also meet the maximum annual limitation on cost sharing requirements under the premium adjustment percentage methodology for PY 2026 as finalized in this rule. Therefore, issuers would not be required to modify all of their plans as a result of the methodology finalized in this final rule if those plans were already compliant with the values previously released in guidance.[241] Additionally, to aid in rate setting for issuers, CMS released an updated version of the AV calculator in March 2025 that reflected the proposed higher maximum annual limitation on cost sharing.[242]

Lastly, we note that we did not propose, and are not finalizing, a phased-in approach to using private health insurance premiums (excluding Medigap and property and casualty insurance) in defining the premium adjustment methodology for PY 2026. We do not believe that further delay meets the statutory and regulatory goals of using a comprehensive measure of premium growth. Additionally, as stated in the proposed rule (90 FR 12987 through 12991), we believe that the individual market is now sufficiently stable to justify the immediate inclusion of individual market premium growth in the indexing measure going forward. As such, we believe it is appropriate to prioritize better achieving the goals of comprehensiveness and accuracy of the premium adjustment percentage methodology over the limited effect on mitigating impacts that implementing our proposal using a phased-in approach would be likely to have. This also aligns with our previous approaches to implementing changes to the premium adjustment percentage methodology where we have not implemented a phased-in approach regardless of the premium adjustment percentage amount and whether the rate was increasing or decreasing.[243]

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

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[241] Id.
[242] Available at *https://www.cms.gov/files/document/revised-final-2026-av-calculator.xlsm.*
[243] *See* the 2020 Payment Notice (84 FR 17537 through 17541) and part 2 of the 2022 Payment Notice (86 FR 24233 through 24237).

In the 2025 Marketplace Integrity and Affordability proposed rule (90 FR 12995 through 12997), we proposed to change the de minimis ranges at § 156.140(c) beginning in PY 2026 to +2/-4 percentage points for all individual and small group market plans subject to the actuarial value (AV) requirements under the EHB package, other than for expanded bronze plans, for which we proposed a de minimis range of +5/-4 percentage points. We also proposed to revise § 156.200(b)(3) to remove from the conditions of QHP certification the de minimis range of +2/0 percentage points for individual market silver QHPs. We also proposed to amend the definition of "de minimis variation for a silver plan variation" in § 156.400 to specify a de minimis range of +1/-1 percentage points for income-based silver CSR plan variations.

Section 2707(a) of the PHS Act and section 1302 of the ACA direct issuers of non-grandfathered individual and small group health insurance plans (including QHPs) to ensure that these plans adhere to the levels of coverage specified in section 1302(d)(1) of the ACA. Section 1302(d)(2) of the ACA provides that a level of coverage of a plan, or its AV, is determined based on its coverage of the EHB for a standard population. Section 1302(d)(1)(A)-(D) of the ACA requires a bronze plan to have an AV of 60 percent, a silver plan to have an AV of 70 percent, a gold plan to have an AV of 80 percent, and a platinum plan to have an AV of 90 percent. Section 1302(d)(2) of the ACA directs the Secretary to issue regulations on the calculation of AV and its application to the levels of coverage. Section 1302(d)(3) of the ACA authorizes the Secretary to develop guidelines to provide for a de minimis variation in the AVs used in determining the level of coverage of a plan to account for differences in actuarial estimates.

In the EHB Rule (78 FR 12834), we established at § 156.140(c) that the allowable de minimis variation in the AV of a health plan that does not result in a material difference in the true dollar value of the health plan was +2/-2 percentage points. In the 2018 Payment Notice, we revised § 156.140(c) to permit a de minimis variation of +5/-2 percentage points for bronze plans that either cover and pay for at least one major service other than preventive services before the

deductible or meet the requirements to be a high deductible health plan within the meaning of section 223(c)(2) of the Code.

In the 2017 Market Stabilization Rule, effective beginning in PY 2018, we expanded the de minimis range for standard bronze, silver, gold, and platinum plans to +2/-4 percentage points.[244] In that final rule (82 FR 18368), we stated that we believed that flexibility was needed for the AV de minimis range for metal levels to help issuers design new plans for future plan years, thereby promoting competition in the market. In addition, we noted that changing the de minimis range would allow more plans to keep their cost sharing the same as well as provide additional flexibility for issuers to make adjustments to their plans within the same metal level. We stated our view that a de minimis range of +2/-4 percentage points would provide the flexibility necessary for issuers to design new plans while ensuring comparability of plans within each metal level.

In the 2023 Payment Notice (87 FR 27306 through 27308), effective beginning in PY 2023, we narrowed the de minimis range for standard bronze, silver, gold, and platinum plans to +2/-2 percentage points, narrowed the de minimis range for expanded bronze plans to +5/-2 percentage points, and narrowed the de minimis range for income-based silver CSR plan variations to +1/0 percentage points. We also established, as a condition of QHP certification, that individual market silver QHPs must have an AV of 70 percent with a de minimis allowable AV variation of +2/0 percentage points. As discussed in the 2023 Payment Notice (87 FR 27307), we made these changes due to concerns that a wider de minimis range jeopardized the meaningful comparison of plans between the silver and bronze levels of coverage. In that rule

[244] We did not in that rule modify the de minimis range for the income-based silver CSR plan variations (the plans with an AV of 73, 87 and 94 percent) under §§ 156.400 and 156.420. The de minimis variation for an income-based silver CSR plan variation is a single percentage point. In the Actuarial Value and Cost-Sharing Reductions Bulletin (2012 Bulletin) issued on February 24, 2012, available at: *https://www.cms.gov/cciio/resources/files/downloads/av-csr-bulletin.pdf*, we explained why we did not intend to require issuers to offer a silver CSR plan variation with an AV of 70 percent; to align with this change, we also modified the de minimis range for expanded bronze plans from +5/-2 to +5/-4.

(87 FR 27307), we also narrowed the de minimis range for individual market silver QHPs in order to maximize PTC and APTC for subsidized enrollees, noting that narrowing the de minimis range of individual market silver QHPs would influence the generosity of the second lowest cost silver plan (SLCSP), the benchmark plan for calculating PTC and APTC.

In the proposed rule (90 FR 12996), we explained that since we finalized these de minimis ranges in the 2023 Payment Notice, we have received considerable feedback from issuers that indicates narrower de minimis ranges substantially reduce issuer flexibility in establishing plan cost sharing. We noted that these issuers have expressed that any benefit to consumers that result from improvements to the comparability between the levels of coverage is outweighed by the harm to consumers caused by reduced issuer flexibility in setting non-standardized cost-sharing parameters, and as a result, harm to the health of the overall risk pool. We further noted that due to these effects, issuers have also voiced concern about their ability to continue to participate in the market generally. We stated that sustained, robust issuer participation in the market is key to ensuring overall market stability and keeping costs down.

Based on this feedback, we proposed to change the de minimis ranges at § 156.140(c) beginning in PY 2026 to +2/-4 percentage points for all individual and small group market plans subject to the AV requirement, other than for expanded bronze plans,[245] for which we proposed a de minimis range of +5/-4 percentage points. We stated that we believe reverting to the de minimis ranges in effect from PYs 2018 to 2022 offers the best balance between comparability between the levels of coverage and issuer flexibility in establishing competitive cost-sharing designs that appeal to wide segments of the population. With this proposal, we noted that an expansion of the universe of permissible plan AVs would not preclude issuers from continuing to

[245] Expanded bronze plans are bronze plans currently referenced in § 156.140(c) that cover and pay for at least one major service, other than preventive services, before the deductible or meet the requirements to be a high deductible health plan within the meaning of section 223(c)(2) of the Code.

design plans with an AV that is closer to the middle of the applicable de minimis ranges instead of plans at the outer limits. We stated that to the extent that issuers believe that plan designs that have a higher AV would attract enrollment, they would remain free to do so under this proposal.

We also proposed, through the authority granted to HHS in sections 1311(c) and 1321(a) of the ACA to establish minimum requirements for QHP certification, to revise § 156.200(b)(3) to remove from the conditions of QHP certification the de minimis range of +2/0 percentage points for individual market silver QHPs. We stated that under this proposal, we would amend § 156.200(b)(3) to revert to the original regulatory text finalized in the 2012 Exchange Establishment rule (77 FR 18469), which stated that, as a condition of QHP certification, issuers must "[e]nsure that each QHP complies with benefit design standards, as defined in § 156.20." We stated that we believe the removal of this QHP certification requirement is justified because we are no longer of the view that this certification requirement, which was finalized in the 2023 Payment Notice, is in the best interests of the overall risk pool.

In the 2012 Exchange Establishment rule, we explained narrowing the de minimis range of individual market silver QHPs would influence the generosity of the SLCSP, the benchmark plan for calculating PTC and APTC for subsidized consumers. We noted in the proposed rule (90 FR 12996 through 12997) that while narrowing the de minimis range in this way has such an effect on PTC and APTC to improve affordability for subsidized consumers, it comes at the expense of affordability for unsubsidized consumers. We stated that we believe attracting these unsubsidized consumers to participate in the risk pool may help to drive down overall costs by expanding the risk pool. In turn, we stated that we believe premiums for all consumers in the risk pool may be lower.

As explained in the proposed rule (90 FR 12997), maximizing PTC with a +2/0 percentage point de minimis range for individual market silver QHPs created imbalance between access and affordability for all consumers, particularly for unsubsidized ones. We stated that we

believe this certification requirement can have the effect of damaging the overall health of the risk pool, which in turn may make coverage less affordable overall than it could have been as healthier, unsubsidized enrollees are priced out of the market. We explained that while pushing for increased subsidies may make coverage more affordable for certain consumers in the very short term, this is a short-sighted approach to regulating the AV de minimis ranges. We stated that we believe that lower AVs would lead to lower premiums, and in turn potentially improve the risk pool as coverage becomes more affordable for generally healthy people who currently may opt to forgo coverage altogether. We noted that although this may mean that those eligible for APTCs receive less money in tax credits, we believe that in the long term there would be a sufficient choice of affordable plans. We stated that we also believe reverting the de minimis range of individual market silver QHPs back to +2/-4 percentage points is the best method for balancing the affordability of health plans for all segments of the population enrolled in non-grandfathered individual and small group market plans with the long-term viability of the overall risk pool.

Finally, we proposed to revise the definition of "de minimis variation for a silver plan variation" at § 156.400 to change the de minimis variation for individual market income-based silver CSR plan variations from +1/0 percentage points to +1/-1 percentage points. We explained that similar to the removal of the de minimis certification requirement for individual market silver QHPs, this proposal would deliver further balance between affordability and market stabilization. We did not propose edits to the minimum AV differential in § 156.420(f) for silver QHPs and 73 percent income-based plan variations, where the AVs must differ by at least 2 percentage points. We noted for issuers that, similar to the current de minimis ranges, standard silver QHPs with plan AVs between 71 and 72 percent would require the corresponding 73 percent income-based plan variation AV to be at least 2 percentage points above the standard plan's AV.

We sought comment on these proposals.

After consideration of comments and for the reasons outlined in the proposed rule and this final rule, including our responses to comments, we are finalizing these policies as proposed. We summarize and respond to public comments received on the proposed changes to the de minimis ranges below.

Comment: Many commenters supported the proposal, noting that they agreed with the rationale provided in the proposed rule that wider de minimis ranges would improve issuer flexibility in plan design. These commenters explained that increased flexibility would allow issuers to better design plans that meet the needs of their enrollees.

Response: We agree that wider de minimis ranges will significantly improve issuer flexibility in plan design and are finalizing this proposal as proposed. As we noted in the proposed rule, issuers have indicated that narrower de minimis ranges substantially reduce issuer flexibility in establishing plan cost sharing, and that any benefits from improved comparability between coverage levels due to wider variation in metal levels are outweighed by the reduced flexibility in setting non-standardized cost-sharing parameters.

The wider de minimis ranges of +2/-4 percentage points (and +5/-4 percentage points for expanded bronze plans) offer several important benefits to the market.

First, these expanded ranges allow issuers to design plans that better promote competition in the market. With greater flexibility in adjusting actuarial values, issuers can create more differentiated combinations of premiums and cost-sharing structures. This enables issuers to develop innovative plan designs targeting specific consumer needs and respond more dynamically to competitor offerings without being constrained by overly narrow AV requirements.

Second, the wider ranges provide flexibility for issuers to make adjustments to their plans within the same metal level. This practical benefit allows issuers to implement year-to-year

modifications based on changing healthcare costs, utilization patterns, and claims experience while maintaining their metal tier classification. Issuers can respond to provider network changes or drug formulary updates without disrupting their established metal level offerings, ensuring greater continuity for consumers.

Third, these expanded ranges help maintain robust issuer participation, which is important for overall market stability. By reducing compliance burdens that might otherwise drive issuers to exit markets, particularly those with challenging risk profiles, the wider ranges make market participation more attractive to a broader range of issuers. This helps prevent overly restrictive pricing and ensures consumers have multiple options to choose from, which is fundamental to a healthy, competitive marketplace. This is a particularly important considering that several issuers have publicly announced their intent to end participation in the Exchange in PY 2026.

We note that this increased flexibility does not prevent issuers from designing plans with AVs closer to the middle of the applicable de minimis ranges. Issuers will retain the ability to offer plans with higher AVs if they believe such designs would better attract enrollment.

Comment: Some commenters supported the proposal because it would maintain uniform AV standards for plans on- and off-Exchange.

Response: We agree that standardizing the de minimis ranges for plans on- and off-Exchange is important. As we stated in the proposed rule (90 FR 12997), while specifying different de minimis ranges for individual market silver QHPs pushed for increased subsidies in the very short term, it was a short-sighted approach to regulating the AV de minimis ranges that damaged the overall health of the risk pool long-term. Subjecting on- and off-Exchange plans to the same de minimis ranges will correct this short-sighted approach because it will help to ensure better balance between access and affordability for all consumers, particularly for those enrolling in off-Exchange plans.

Comment: Many commenters, both those in support of and in opposition to the proposal, recommended that, if the proposed de minimis variations are finalized, implementation of the proposal be delayed until PY 2027 instead of PY 2026. These commenters noted that it may be difficult for some issuers to take advantage of wider de minimis ranges for PY 2026 given the timing of the proposal and State rate submission deadlines.

Response: We decline to delay implementation of these wider de minimis ranges until PY 2027. By definition, wider de minimis ranges do not require issuers or States to take any additional action to revise existing plan designs. Issuers may choose not to take any action to revise their existing plan designs for PY 2026 and will still be compliant with these wider de minimis ranges. We recognize that some issuers in some States will not be able to modify plan designs in time to meet State-specific filing deadlines. However, making these wider de minimis ranges available as soon as possible will maximize the extent to which issuers are able to take advantage of them to create a wider array of benefit designs that appeal to a wider array of consumers. We therefore believe that finalizing these wider de minimis ranges beginning in PY 2026 is justified.

Comment: Many commenters did not support the proposal. These commenters primarily expressed concern that wider de minimis ranges would result in lower overall plan AVs. These commenters explained that this would lead to increased out-of-pocket consumer costs as plan cost-sharing generosity decreases and higher overall premiums for some consumers given a potential impact on the generosity of the SLCSP, the benchmark plan used to determine an individual's PTC.

Response: We acknowledge commenters' concerns regarding a decrease in plan cost-sharing generosity to the extent that plans utilize the lower end of the wider de minimis ranges, the impact on PTCs if the AV of the applicable SLCSP is lower than in previous years, and the burden that increased cost-sharing and decreased PTCs may have on enrollees in the short-term.

However, this change is essential to restoring greater balance between access and affordability in the long term. As we explained in the proposed rule (90 FR 12997), we believe that the overall benefits to the risk pool as a result of this change will better incentivize unsubsidized enrollees to enroll in coverage, which we expect to lower overall costs and further drive down premiums as the risk pool improves.

Comment: Other commenters opposing the proposal expressed concern that wider de minimis ranges would undermine the ability of consumers to meaningfully compare plans. These commenters were concerned that a silver plan at the lower end of the de minimis range (with a 66 percent AV) could be closer in AV to a bronze plan at the higher end of the expanded de minimis range (with a 65 percent AV) than it would be to another silver plan at the higher end of the de minimis range (with a 72 percent AV).

Response: We do not agree with the premise that consumers currently typically rely on material differences in AV percentages to compare plans. Communicating material differences between plan cost-sharing for plans of the same metal tier and plans of different metal tiers has always been essential to ensure that consumers make informed decisions about their plan selections, which includes deprioritizing AV as a comparison tool. This was the case with narrower de minimis ranges as well, when a bronze plan could have an AV at the higher end of the expanded de minimis range (with a 65 percent AV) and a silver plan could have an AV at the lower end of a -2 percentage point de minimis range (with a 68 percent AV). To consumers comparing plans, the difference in cost sharing is immaterial for a 3-percentage point separation between a 65 percent AV bronze plan and a 68 percent AV silver plan or a 1 percentage point separation between a 65 percent AV bronze plan and a 66 percent AV silver plan. Exchanges use an array of strategies to effectively communicate the meaningful differences between plans in terms that consumers – in addition to agents, brokers, web-brokers, Navigators, and other

assisters – can understand and appreciate. Therefore, we are not concerned about material changes in the comparability between plan AVs with this change.

Comment: A few commenters noted the proposal's impact on silver loading. These commenters explained that if the relativity between the standard QHP silver plan and the CSR plan variations expands, there is potential for the "silver load" to increase. Commenters stated that where the "silver load" is applied only to silver QHPs, this would offset some portion of the potential silver premium decrease. Commenters also stated that where the "silver load" is applied to all plans, it would similarly offset premium decreases for other metal tiers as well.

Response: We acknowledge the commenters' observations regarding the potential impact of wider de minimis ranges on silver loading. The relationship between standard silver QHP AVs and CSR plan variation AVs could affect the magnitude of silver loading. The wider de minimis range (+2/-4 percentage points) for standard silver QHPs, combined with the +1/-1 percentage point range for CSR variations, could increase the relative difference between standard silver plans and CSR variations. This increased differential could result in higher silver loading amounts to account for the cost of CSR benefits.

We expect any impact on premiums would manifest differently depending on how issuers implement their loading strategy. In markets where silver loading is applied exclusively to silver QHPs, any potential premium decreases from lower AVs in silver plans may be partially offset by the increased loading amount. In markets where broad loading is implemented across all metal levels, the loading effects could moderate premium decreases throughout the entire market.

Despite these potential effects, we maintain that the wider de minimis ranges represent a necessary rebalancing of market dynamics. While silver loading may partially counteract some premium reductions, the broader benefits of this policy—including enhanced issuer flexibility, improved market stability, and potential risk pool improvements—remain compelling factors in our decision-making process.

Comment: A few commenters asserted that the proposal could weaken the risk pool because healthier people are more likely to drop coverage when net premiums rise. Other commenters asserted the proposal can help bring more stability to the risk pool by attracting more unsubsidized individuals who otherwise might choose to go uninsured.

Response: We acknowledge the differing viewpoints regarding the proposal's potential impacts on the risk pool. As explained above, after careful consideration of the evidence and interested parties' feedback, we believe that while there may be some initial weakening of the risk pool as some commenters note, the long-term benefits of wider de minimis ranges are likely to strengthen overall market stability.

Comment: A few commenters requested clarification on the applicability of uniform modification standards under § 147.106(e) to the proposal to widen the de minimis ranges.

Response: Under the exceptions to guaranteed renewability for uniform modification of coverage under § 147.106(e), an issuer may, only at the time of coverage renewal, modify the health insurance coverage for a product offered in the individual market or small group market if the modification is consistent with State law and is effective uniformly for all individuals or group health plans with that product. To be considered a uniform modification of coverage, among other things, each plan within the product that has been modified must have the same cost-sharing structure as before the modification, except for any variation in cost sharing solely related to changes in cost and utilization of medical care or to maintain the same metal tier level described in sections 1302(d) and (e) of the ACA. States have flexibility to broaden what cost-sharing changes are considered within the scope of a uniform modification of coverage and may, for example, consider uniform cost-sharing changes that result in plans having the same metal level based on the expanded de minimis range to be uniform modifications.

We note that under § 147.106(e)(2), modifications made uniformly and solely pursuant to applicable Federal or State requirements are considered uniform modifications if such

modification is directly related to the imposition or modification of the Federal or State requirement and made within a reasonable time period after the imposition or modification of the Federal or State requirement. However, given that the de minimis ranges are being widened, an issuer is not required to modify a plan's cost-sharing structure as a result of this provision of the final rule. Therefore, changes to cost-sharing to take advantage of the wider de minimis ranges under this final rule would not be considered to have been "made solely pursuant to a Federal requirement." Such a modification would have to meet the other criteria in § 147.106(e)(3) to be considered a uniform modification of coverage.[246]

Comment: Some commenters asserted that lower overall AVs could result in a reduction in the quality of provider networks.

Response: We disagree with this claim. In the proposed rule, we recognized that wider de minimis ranges may lower the generosity of plan cost sharing, and that this would result in lower premiums. However, plan cost sharing is only one of many factors involved with plan rate setting. Provider network quality can also be reflected in plan rate setting, and by allowing for lower AVs, plans can reallocate funds to improving network quality.

Comment: Some commenters requested clarification on whether the proposal would impact the standardized plan options finalized in the 2026 Payment Notice and whether issuers are required to offer these plans for PY 2026.

Response: For PY 2024 and beyond, § 156.201(b) requires QHP issuers in a FFE or SBE-FP to offer at least one standardized QHP option at every product network type, at every metal level (except the non-expanded bronze metal level), and throughout every service area that it also

[246] *See* Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond, Final rule (79 FR 30240, 30249) ("For example, if State legislation newly requires a minimum level of benefits (for example, imposing a new minimum visit limit on specific benefits) reducing covered benefits to meet the minimum requirement would not be directly related to the new requirement because the lesser coverage of the benefit coverage was previously permissible, and the modification did not have to be made in order for the issuer to comply with the State law. Accordingly, the modification would not be considered to have been 'made solely pursuant to' the new requirement.").

offers non-standardized QHP options (including, for silver plans, for the income-based cost-sharing reduction plan variations, as provided for at § 156.420(a)). We finalized the standardized QHP options required under § 156.201(b) for PY 2026 in the 2026 Payment Notice (90 FR 4493). We confirm that the widening of the de minimis ranges finalized in this final rule does not impact the plan designs for the standardized plan options finalized in the 2026 Payment Notice, nor does it impact the broader requirement for issuers to offer these plans for PY 2026 under § 156.201(b).

For PY 2025 and beyond, § 156.202(b) allows QHP issuers in an FFE or SBE-FP to offer two non-standardized plan options per product network type, metal level (excluding catastrophic plans), and inclusion of adult dental benefit coverage, pediatric dental benefit coverage, and adult vision benefit coverage (as defined in paragraphs § 156.202(c)(1) through (3)), in any service area. We confirm that QHP issuers in a FFE or SBE-FP may utilize the wider de minimis ranges finalized in this final rule to adjust the cost sharing of their non-standardized plan options under § 156.202(b), subject to uniform modification requirements at § 147.106(e) and the requirements under the definition of "plan" at § 144.103.

D. Applicability Dates

In the 2025 Marketplace Integrity and Affordability proposed rule, we proposed that some policies, if finalized, would become applicable for plan years beginning on or after January 1, 2026. We noted that these policies would include the proposed provisions requiring Exchanges on the Federal platform to conduct pre-enrollment verification of eligibility for individual market SEPs and to verify at least 75 percent of new enrollments through SEPs, as well as the proposed prohibition on issuers of coverage subject to EHB requirements from covering sex-trait modification as EHB. We also noted that for State Exchanges, the provisions requiring all Exchanges to conduct pre-enrollment verification of eligibility for Exchange SEPs and to verify at least 75 percent of new enrollments through SEPs would be applicable starting PY 2027. Also,

the policies to update the premium adjustment percentage methodology and AV de minimis ranges would apply beginning with PY 2026. We noted that the policy to prevent re-enrollees from receiving APTC that fully covers their premium without taking an action to confirm their eligibility information would be applicable for Exchanges on the Federal platform starting with annual redeterminations for PY 2026, and State Exchanges would be required to implement the same policy or a comparable policy starting with annual redeterminations for PY 2027. We noted in the proposed rule that we believe these applicability dates provide issuers and Exchanges ample time to prepare for these changes. However, we noted that we understand that different States and issuers face different resource issues and implementation hurdles. We therefore sought comment on whether regulated entities would require additional time to comply with these proposals. We also sought comment on any operational considerations or other issues that may impede compliance with the proposed applicability dates.

In the proposed rule, we discussed that the remaining policies in that proposed rule would become applicable upon the effective date of the final rule. We stated that these proposals included, among others, the provision to pause the monthly SEP for APTC-eligible qualified individuals with a projected annual household income at or below 150 percent of the FPL. We noted that our experience with this SEP suggests it has substantially increased the level of improper enrollments, as well as increased the risk for adverse selection. We further stated that the remaining proposals in the proposed rule aimed to increase the program integrity of the Exchange and protect Federal tax dollars. We therefore stated in the proposed rule that we believed it would be appropriate for these policies to become applicable immediately upon the effective date of the final rule.

After consideration of comments and for the reasons outlined in the proposed rule and this final rule, including our responses to comments, we are finalizing the applicability dates with the following modifications as provided in Table 7. We note that all rules are effective 60 days

after publication in the **Federal Register**, and we provide further specificity where applicability dates of certain provisions may vary.

TABLE 7: Applicability Dates of Finalized Provisions

Provision	Proposed Applicability Date	Finalized Applicability Date	Sunset at the End of PY 2026?
Coverage Denials for Failure to Pay Premiums for Prior Coverage (§ 147.104(i))	Effective date of this rule	Effective date of this rule	No
Deferred Action for Childhood Arrivals (DACA) (§ 155.20)	Effective date of this rule	Effective date of this rule	No
Standards for Termination of an Agent's, Broker's, or Web-broker's Exchange Agreements for Cause (§ 155.220(g)(2))	Effective date of this rule	Effective date of this rule	No
Failure to File Taxes and Reconcile APTC Process (§ 155.305(f)(4))	PY 2026	PY 2026	Yes
60-Day Extension to Resolve Income Inconsistency (§ 155.315)	Effective date of this rule	Effective date of this rule	No
Income Verification When Data Sources Indicate Income Less Than 100 Percent Federal Poverty Level (§ 155.320(c)(3)(iii))	Effective date of this rule	Effective date of this rule	Yes
Income Verification When Tax Data is Unavailable (§ 155.320(c)(5))	Effective date of this rule	Effective date of this rule	Yes
Annual Eligibility Redetermination (§ 155.335(a), (n))	Exchanges on Federal Platform: PY 2026 State Exchanges: PY 2027	Exchanges on Federal Platform: PY 2026 State Exchanges: Not Finalized	Yes
Annual Eligibility Redetermination (Automatic Re-enrollment Hierarchy) (§ 155.335(j))	PY 2026	PY 2026	No
Gross Premium Percentage-based and Fixed-dollar Premium Payment Thresholds (§ 155.400(g))	Effective date of this rule	Effective date of this rule	Yes
Annual Open Enrollment Period (OEP) (§ 155.410)	PY 2026 OEP	PY 2027 OEP	No
Monthly Special Enrollment Period for APTC-Eligible Qualified Individuals with a Household Income at or Below 150 Percent of the Federal Poverty Level (§ 155.420)	Effective date of this rule	Effective date of this rule	Yes
All Exchanges Conducting Eligibility Verification	PY 2026	Exchanges on Federal Platform:	Yes

Provision	Proposed Applicability Date	Finalized Applicability Date	Sunset at the End of PY 2026?
for SEPs (§ 155.420(g))		PY 2026 State Exchanges: Not finalized	
All Exchanges Conducting Eligibility Verification for 75 Percent of New Enrollments through SEPs (§ 155.420(g))	PY 2026	Exchanges on Federal Platform: PY 2026 State Exchanges: Not finalized	Yes
Prohibition on Coverage of Specified Sex-Trait Modification Procedures as an EHB (§§ 156.115(d) and 156.400)	PY 2026	PY 2026	No
Premium Adjustment Percentage Index (PAPI) (§ 156.130(e))	PY 2026	PY 2026	No
Levels of Coverage (Actuarial Value) (§§ 156.140, 156.200, 156.400)	PY 2026	PY 2026	No

We summarize and respond to public comments received on the proposed applicability dates below. Public comments regarding the applicability date of individual provisions as well as our responses to these comments can be found in the respective provisions' sections of this final rule.

Comment: Many commenters expressed concerns about the proposed implementation timeline for the rule holistically. Some commenters noted their concern about the proposed rule's immediate and near-term changes adding to existing Exchange uncertainty in PY 2026, which includes the scheduled expiration of expanded PTC under the ARPA and IRA at the end of 2025 and possible Congressional action related to health programs like Medicaid. Several commenters noted several proposed policies (such as those that impact rates and plan designs like the premium adjustment percentage methodology) may not be compatible with existing processes and timelines, which creates financial and operational burdens for regulators, State Exchanges, issuers, agents, brokers, web-brokers and consumers. These commenters specifically cited

needing time to analyze impact, implement, and test changes including administrative and IT operations, consumer education and assistance, marketing and outreach, staffing, and other mitigation strategies that address operational challenges, coverage loss, and consumer confusion. One commenter cited that there could be a disproportionate impact of uncertainty on safety-net or other smaller plans that are unable to make sweeping changes in short order. Moreover, these commenters noted that the implementation changes may not have been budgeted for in calendar year 2025. Many commenters recommended delaying implementation with the earliest applicability date being PY 2027 to allow States to fully adopt and be compliant with these changes. One commenter suggested effective dates should begin with the following plan year, at minimum, instead of the effective date of the final rule or mid-year. In consideration of provisions that impact PY 2026 plan design or rates, many commenters supported delaying implementation while a few recommended the final rule be published as soon as possible (including within a few weeks of the public comment deadline) to minimize regulatory uncertainty and timely finalize products.

Response: While we acknowledge the commenters' feedback regarding the general implementation timeline of the final rule and the issues associated with meeting the applicability dates of various provisions finalized as part of this final rule, we are generally finalizing the applicability dates as proposed. Specifically, the provisions in this rulemaking are intended to promote program integrity and prevent improper Exchange enrollments and given the pervasiveness of this issue,[247] we do not believe that a delay in implementation of these provisions is appropriate. That said, we acknowledge the concerns raised by commenters about the need to consider the effects of the expiring expanded subsidies. As such, we are finalizing a

[247] As documented in a CMS press release from 2024, we received and resolved over 180,000 unauthorized enrollment complaints from January to August 2024. CMS (2024, October). CMS Update on Action to Prevent Unauthorized Agent and Broker Marketplace Activity. *https://www.cms.gov/newsroom/press-releases/cms-update-actions-prevent-unauthorized-agent-and-broker-marketplace-activity*.

number of the policies associated with the improper enrollments associated with fully-subsidized plans through PY 2026, which provides the policies with enough time to work to shed improper enrollments without burdening the Exchanges over the long term. Further, where appropriate in this final rule, we are changing the implementation dates of certain provisions, as described in Table 7 in this section.

E. Comments Regarding Public Comment Period

Many commenters expressed concerns about the 2025 Marketplace Integrity and Affordability proposed rule's 30-day public comment period. We summarize and respond to the public comments received regarding the length of the public comment period below.

Comment: Several commenters expressed concerns about the comment period being shorter than 30 days given that the rule was issued in the **Federal Register** on March 19, 2025 (90 FR 12942) and the comment period closed on April 11, 2025. These commenters suggested that such a window limits public comment and prevents interested parties from fully engaging with the proposed rule's reasoning in violation of the APA. Several commenters also expressed concerns about the scope and complexity of the proposed rule and requested the comment period be extended to 60 or 90 days to allow interested parties (including issuers, State Exchanges, providers, and consumers) additional time to analyze and respond to the impact of the proposed rule. These commenters cited the ruling in *National Lifeline Ass'n v. FCC*, 921 F.3d 1102, 1117-18 (D.C. Cir. 2019), which noted that a 30-day comment period is generally considered the shortest time period for interested persons to "meaningfully review a proposed rule and provide informed comment."

A commenter cited that HHS historically has provided substantially more time for public comments, stating that the comment periods for the 2025 and 2024 Payment Notice proposed rules were 45 and 41 days, respectively.

Response: We disagree with commenters that stated that we did not provide a 30-day comment period on the proposed rule, in violation of the APA. The proposed rule was displayed for public inspection at the **Federal Register** on March 12, 2025, with an opportunity to submit public comment electronically on *https://www.regulations.gov* or by regular, express, or overnight mail. Under 44 U.S.C. 1507, unless otherwise specifically provided by statute, filing of a document required or authorized to be published by 44 U.S.C. 1505,[248] except in cases where notice by publication is insufficient in law, is sufficient to give notice of the contents of the document to a person subject to or affected by it. Thus, consistent with 44 U.S.C. 1507, display of the proposed rule at the **Federal Register** on March 12, 2025 constituted public notice of the proposed rule on that date, and the 30-day comment period was held between March 12, 2025 and April 11, 2025. We note that we did in fact receive public comments between March 12, 2025 and March 19, 2025 (the date the proposed rule appeared in the **Federal Register**), demonstrating that the public had notice of the proposed rule on March 12, 2025.

We also disagree with the comments requesting that we extend the comment period to 60 or 90 days. If we were to do this, the publication of the final rule would be delayed, which would impact rate setting and plan finalization for PY 2026 that depend on the finalization of the policies set forth in this final rule (such as the changes to the premium adjustment percentage and the AV de minimis ranges). To provide individual and small group market issuers sufficient time to develop and price plan offerings for PY 2026, we will not be extending the comment period to 60 or 90 days.

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[248] *See* 44 U.S.C. 1505(a) (providing that there shall be published in the Federal Register— (1) Presidential proclamations and Executive orders, except those not having general applicability and legal effect or effective only against Federal agencies or persons in their capacity as officers, agents, or employees thereof; (2) documents or classes of documents that the President may determine from time to time have general applicability and legal effect; and (3) documents or classes of documents that may be required so to be published by Act of Congress) and 44 U.S.C. 1505(b) (providing that, in addition to the foregoing there shall also be published in the **Federal Register** other documents or classes of documents authorized to be published by regulations prescribed under this chapter with the approval of the President, but comments or news items of any character may not be published in the Federal Register).

F. Severability

As demonstrated by the number of distinct programs addressed in this rulemaking and the structure of this final rule in addressing them independently, HHS generally intends the rule's provisions as finalized to be severable from each other. For example, the final rule refines the interpretation of "lawfully present" for purposes of determining eligibility to enroll in a QHP offered on an Exchange or a BHP in States that elect to operate a BHP and eligibility for PTC, APTC, and CSRs. It also outlines the discontinuation of the SEP for individuals with an income less than 150 percent of the FPL and makes a change in the calculation of the premium adjustment percentage. It also updates the Exchange automatic re-enrollment hierarchy and changes the process of income verification where tax return data is unavailable. We believe that these provisions are generally capable of functioning sensibly on an independent basis. It is our intent that if any provision of this final rule is held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, the other provisions in the final rule shall be construed so as to continue to give maximum effect as permitted by law, unless the holding shall be one of utter invalidity or unenforceability. In the event a provision is found to be utterly invalid or unenforceable, we intend that provision to be severable.

We sought comment on the severability of these provisions in the proposed rule.

After consideration of comments and for the reasons outlined in the proposed rule and this final rule, including our responses to comments, we are finalizing the severability provision as proposed. We summarize and respond to public comments received on this provision below.

Comment: A few commenters supported the severability approach discussed in the proposed rule.

Response: We thank commenters for their support and are finalizing this approach as proposed such that it is HHS' position if any provision of this final rule is held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, the other provisions in

the final rule shall be construed so as to continue to give maximum effect as permitted by law, unless the holding shall be one of utter invalidity or unenforceability. In the event a provision is found to be utterly invalid or unenforceable, that provision is severable.

IV. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA), we are required to provide a 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. To fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comments on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of the agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We solicited public comment on each of these issues for the following sections of this document that contain information collection requests (ICRs).

A. Wage Estimates

To derive wage estimates, we generally use data from the Bureau of Labor Statistics to derive labor costs (including a 100 percent increase for the cost of fringe benefits and overhead) for estimating the burden associated with the ICRs.[249] Table 8 presents the median hourly wage, the cost of fringe benefits and overhead, and the adjusted hourly wage. These estimates were

[249] *See* U.S. Bureau of Labor Statistics (n.d.). Occupational Employment and Wage Statistics, May 2024 Occupation Profiles. Dep't. of Labor. *https://www.bls.gov/oes/current/oes_stru.htm.*

updated from the estimates used in the 2025 Marketplace Integrity and Affordability proposed rule due to the availability of more recent data between the publication of the proposed and final rules. The proposed rule estimates may be found at 90 FR 12998.

As indicated, employee hourly wage estimates have been adjusted by a factor of 100 percent. This is necessarily a rough adjustment, both because fringe benefits and overhead costs vary significantly across employers, and because methods of estimating these costs vary widely across studies. Nonetheless, there is no practical alternative, and we believe that doubling the hourly wage to estimate total cost is a reasonably accurate estimation method.

TABLE 8: Adjusted Hourly Wages Used in Burden Estimates

Occupation Title	Occupational Code	Median Hourly Wage ($/hr.)	Fringe Benefits and Overhead ($/hr.)	Adjusted Hourly Wage ($/hr.)
Database and Network Administrators and Architects	15-1240	51.67	51.67	103.34
Computer Programmers	15-1251	47.44	47.44	94.88
Eligibility Interviewers, Government Programs	43-4061	24.76	24.76	49.52

We adopt an hourly value of time based on after-tax wages to quantify the opportunity cost of changes in time use for unpaid activities. This approach matches the default assumptions for valuing changes in time use for individuals undertaking administrative and other tasks on their own time, which are outlined in an Assistant Secretary for Planning and Evaluation (ASPE) report on "Valuing Time in U.S. Department of Health and Human Services Regulatory Impact Analyses: Conceptual Framework and Best Practices."[250] We started with a measurement of the

[250] Office of the Assistant Secretary for Planning and Evaluation. (2017, Sept. 17). Valuing Time in U.S. Department of Health and Human Services Regulatory Impact Analyses: Conceptual Framework and Best Practices. Dep't of HHS. *https://aspe.hhs.gov/reports/valuing-time-us-department-health-human-services-regulatory-impact-analyses-conceptual-framework*.

usual weekly earnings of wage and salary workers of $1,159.[251] We divided this weekly rate by 40 hours to calculate an hourly pre-tax wage rate of approximately $28.98. We adjusted this hourly rate downwards by an estimate of the effective tax rate for median income households of about 17 percent, resulting in a post-tax hourly wage rate of approximately $24.05. We adopt this as our estimate of the hourly value of time for changes in time use for unpaid activities.

We sought comment on the estimates and assumptions in the proposed rule.

We did not receive any comments in response to the proposed rule estimates and assumptions. We are using revised estimates as presented above as a result of more recent data being available at the time of this final rule.

B. ICRs Regarding Deferred Action for Childhood Arrivals

1. Basic Health Program (42 CFR 600.5)

The following changes will be submitted for review under OMB Control Number 0938-1218 (CMS-10510).

The changes in this final rule to 42 CFR 600.5 will again exclude DACA recipients from the definition of "lawfully present" used to determine eligibility for a BHP in those States that elect to operate the program, if otherwise eligible. A discussion of the proposed ICRs for this policy may be found in the 2025 Marketplace Integrity and Affordability proposed rule (90 FR 12998). We are updating the ICRs for this policy in this final rule to account for updated wage rates available after the publication of the proposed rule.

The impact of this change will be with regards to the two States that currently operate a BHP—Minnesota and Oregon. We assume for the purposes of this estimate that both States have completed the updates from the 2024 DACA Rule. We estimate that it will take each State 100

[251] U.S. Bureau of Labor Statistics. Employed full time: Median usual weekly nominal earnings (second quartile): Wage and salary workers: 16 years and over [LEU0252881500A], retrieved from FRED, Federal Reserve Bank of St. Louis. *https://fred.stlouisfed.org/series/LES1252881500Q. Annual Estimate, 2024*.

hours to develop and code the changes to its BHP eligibility and verification system to correctly evaluate eligibility under the revised definition of "lawfully present" to once again exclude DACA recipients as outlined in section III.B.1. of this final rule. To be conservative in our estimates, we are assuming 100 hours per State, but it is important to note that it may take each State less than 100 hours given that the work required to implement this rule for Minnesota's and Oregon's State Exchange systems may also be able to be leveraged for its BHPs.

Of those 100 hours, we estimate it will take a database and network administrator and architect 25 hours at $103.34 per hour and a computer programmer 75 hours at $94.88 per hour.[252] In the aggregate, we estimate a one-time burden of 200 hours (2 States × 100 hours) at a cost of $19,399 (2 States × [(25 hours × $103.34 per hour) + (75 hours × $94.88 per hour)]) for completing the necessary system updates to the application for BHP coverage, including any associated terminations for DACA recipients currently enrolled in BHP coverage.

These changes will reduce costs on States related to the decrease in applications for individuals who would have applied for coverage if not for this change. Those impacts are accounted for under OMB Control Number 0938-1191 (Data Collection to Support Eligibility Determinations for Insurance Affordability Programs and Enrollment through Health Insurance Marketplaces, Medicaid and Children's Health Insurance Program Agencies (CMS-10440)), discussed in section IV.B.3. of this final rule, which pertains to the streamlined application.

We sought comment on the estimates and assumptions in the proposed rule.

We did not receive any comments in response to the proposed burden estimates for this policy. For the reasons outlined in this final rule, we are finalizing these estimates, with updated wage rates, as proposed.

2. Exchanges and Processing Streamlined Applications (§ 155.20)

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[252] *See* U.S. Bureau of Labor Statistics (n.d.). Occupational Employment and Wage Statistics, May 2024 Occupation Profiles. Dep't. of Labor. *https://www.bls.gov/oes/current/oes_stru.htm.*

The following changes will be submitted for review under OMB Control Number 0938-1191 (CMS-10440).

As discussed previously, we are finalizing modifications to the definition of "lawfully present" at § 155.20 to exclude DACA recipients from the definition of "lawfully present" that is used to determine eligibility to enroll in a QHP through an Exchange, for PTC, APTC, and CSRs, and to enroll in a BHP in States that elect to operate a BHP. This change will apply to the 20 State Exchanges, as well as Exchanges on the Federal platform. A discussion of the proposed ICRs for this policy may be found in the 2025 Marketplace Integrity and Affordability proposed rule (90 FR 12999 through 13000). We are updating the ICRs for this policy in this final rule to account for updated wage rates available after the publication of the proposed rule.

On December 9, 2024, the United States District Court for the District of North Dakota issued a preliminary injunction in *Kansas v. United States*, Case No. 1:24-cv-00150, 2024 WL 5220178 (D.N.D. Dec. 9, 2024). Per the district court's ruling, the 2024 DACA Rule is enjoined in three States that operate State Exchanges – Kentucky, Idaho, and Virginia. Even though DACA recipients are not currently eligible for Exchange coverage in these three States, we are still estimating that these State Exchanges may still need to make eligibility system changes in order to correctly implement this rule. This is because these State Exchanges may need to make changes in order to correctly re-implement the clarifying and technical changes to the definition of "lawfully present" that were included in the 2024 DACA Rule, and that are not altered by this final rule, but that are currently blocked in these three State Exchanges due to the court's injunction. We estimate that it will take the Federal Government and each of the State Exchanges 1,000 hours in 2025 to develop and code changes to their eligibility systems to correctly evaluate and verify eligibility under the revised definition of "lawfully present," such that DACA recipients are no longer considered lawfully present for purposes of enrolling in a QHP offered through an Exchange, APTC, PTC, CSRs, or BHP coverage in States that elect to operate a BHP,

as outlined in section III.B.1. of this final rule. This estimate is informed by the FFE's prior experience implementing similar system changes. Of those 1,000 hours, we estimate it will take a database and network administrator and architect 250 hours at $103.34 per hour and a computer programmer 750 hours at $94.88 per hour. In aggregate for the States, we estimate a one-time burden in 2025 of 20,000 hours (20 State Exchanges × 1,000 hours) at a cost of $1,939,900 (20 States × [(250 hours × $103.34 per hour) + (750 hours × $94.88 per hour)]) for completing the necessary updates to State Exchange eligibility systems.[253] For the Federal Government, we estimate a one-time burden in 2025 of 1,000 hours at a cost of $96,995 ([250 hours × $103.34 per hour] + [750 hours × $94.88 per hour]). In total, the burden associated with all system updates will be 21,000 hours at a cost of $2,036,895.

Next, we estimate costs associated with termination operations to end Exchange coverage for any DACA recipients who are already enrolled. This work will need to be done by the Federal Government, which will take steps to end coverage for DACA recipients enrolled in States with FFEs and SBE-FPs and ensure that DACA recipients are not renewed for future coverage years. Additionally, we anticipate that termination operations will occur in the 17 States that operate State Exchanges where the 2024 DACA Rule is not currently enjoined. We assume that in the three States that operate State Exchanges where the 2024 DACA Rule is enjoined, the States have already undertaken the work necessary to end coverage for DACA recipients and therefore will not need to perform additional work as a result of this rule.

[253] On December 9, 2024, the United States District Court for the District of North Dakota issued a preliminary injunction in *Kansas v. United States*, Case No. 1:24-cv-00150, 2024 WL 5220178 (D.N.D. Dec. 9, 2024). Per the district court's ruling, DACA recipients in three State Exchanges – Kentucky, Idaho, and Virginia – are not eligible to enroll in Exchange coverage. As a result, these three States may have already incorporated the necessary changes to their eligibility system and mailed any required notices to impacted consumers.

We estimate that it will take the Federal Government and each of the 17 State Exchanges 1,000 hours in 2025 to terminate Exchange coverage for DACA recipients.[254,255] This estimate is informed by the FFE's prior experience implementing similar system changes. Of those 1,000 hours, we estimate it will take a database and network administrator and architect 250 hours at $103.34 per hour and a computer programmer 750 hours at $94.88 per hour. In aggregate for the States, we estimate a one-time burden in 2025 of 17,000 hours at a cost of $1,648,915 (17 States × [(250 hours × $103.34 per hour) + (750 hours × $94.88 per hour)]) in 2025 for all termination operations. For the Federal Government, we estimate a one-time burden in 2025 of 1,000 hours at a cost of $96,995 ([250 hours × $103.34 per hour] + [750 hours × $94.88 per hour]). Collectively, we estimate that it will take the Federal Government and each of the State Exchanges 18,000 hours at an associated cost of $1,745,910 to end coverage for DACA recipients. We sought comments on these burden estimates, including regarding additional costs and benefits anticipated as a result of this proposal.

"Data Collection to Support Eligibility Determinations for Insurance Affordability Programs and Enrollment through Health Benefits Exchanges, Medicaid and CHIP Agencies," OMB Control Number 0938-1191 (CMS-10440) accounts for burdens associated with the streamlined application for enrollment in the programs impacted by this rule. As such, the following information collection addresses the burden of processing applications and assisting enrollees with BHP and Exchange QHP enrollment, and those impacts are not reflected in the ICRs for BHP, discussed in section IV.B.1. of this final rule.

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[254] Section 155.310(g).

[255] On December 9, 2024, the United States District Court for the District of North Dakota issued a preliminary injunction in *Kansas v. United States*, Case No. 1:24-cv-00150, 2024 WL 5220178 (D.N.D. Dec. 9, 2024). In compliance with the Court's order, CMS terminated enrollments for PY 2025 for DACA recipients in 16 States that are served by the Federal platform. All impacted consumers received notices regarding their ineligibility for Exchange coverage. These States are Alabama, Arkansas, Florida, Indiana, Iowa, Kansas, Missouri, Montana, Nebraska, New Hampshire, North Dakota, Ohio, South Carolina, South Dakota, Tennessee, and Texas.

For assisting eligible enrollees and processing their applications, we estimate this will take a government programs eligibility interviewer 10 minutes (0.17 hours) per application at a rate of $49.52 per hour, for a cost of approximately $8.42 per application. This estimate is based on past experience with similar application changes. As outlined further in section IV.B.3. of this final rule, we anticipate that approximately 11,000 fewer individuals impacted by this change will complete the application annually. Therefore, the total application processing burden associated with this policy will be reduced by 1,870 hours (0.17 hours × 11,000 applications) for a total cost savings of $92,602 (1,870 hours × $49.52 per hour). As discussed further in this section, we anticipate an overall reduction in application processing burden for States and the Federal Government.

As outlined in section VI.C.1. of this final rule, we estimate that as a result of this policy, 10,000 fewer individuals will enroll in QHP coverage and 1,000 fewer individuals will enroll in a BHP on average each year, including redeterminations and re-enrollments.

The entire information collection savings associated with changes to BHPs falls on the two States that currently operate a BHP—Minnesota and Oregon.[256] As such, we assume 100 percent of the BHP application processing savings will fall on these two States. Using the per-application processing burden of 10 minutes (0.17 hours) per application at a rate of $49.52 per hour, and the estimate that 1,000 fewer individuals will apply for BHP, we anticipate a burden reduction of 170 hours with an associated cost savings of $8,418, for States to process BHP applications.

For the Exchanges, we use data from the 2024 OEP to estimate the proportion of applications that are processed by States compared to the Federal Government, and we determined that 49 percent of Exchange applications were submitted to FFEs/SBE-FPs, and are

[256] Minnesota's BHP began January 1, 2015. Oregon's BHP began July 1, 2024. For more information, *see* CMS. (n.d.) Basic Health Program. *https://www.medicaid.gov/basic-health-program/index.html.*

therefore processed by the Federal Government, while 51 percent were submitted to and processed by the 20 State Exchanges.[257] As such, we anticipate that 49 percent of Exchange application processing savings will be attributed to the Federal Government and 51 percent of Exchange application processing savings will be attributed to States using their own eligibility and enrollment platforms.

For the Exchanges, if we estimate 10,000 fewer applications will be processed, 51 percent of those (5,100) will no longer be processed by State Exchanges and 49 percent (4,900) will no longer be processed by the Federal Government. Using the per-application processing burden of 10 minutes (0.17 hours) per application at a rate of $49.52 per hour, we anticipate cost savings of $42,934 or a reduction by 867 hours for State Exchanges to process applications. Additionally, we estimate cost savings of $41,250 or a reduction by 833 hours for the Federal Government to process applications at a rate of $49.52 per hour. Therefore, the total burden on State Exchanges to assist eligible beneficiaries and process their applications will be reduced by 1,037 hours annually beginning in 2025 (170 hours for BHP + 867 hours for State Exchanges) with a net cost reduction of $51,352. The total burden on the Federal Government will be reduced by 833 hours annually beginning in 2025 (entirely for Exchanges), with a net cost reduction of $41,250.

In addition, Exchanges would have required individuals completing the application to submit supporting documentation to confirm their lawful presence if it was unable to be verified electronically through a data match with DHS via the Hub using DHS' Systematic Alien Verification for Entitlements (SAVE) system.[258] An applicant's lawful presence may not be able to be verified if, for example, the applicant opts to not include information about their

[257] CMS. (2024, March 27). Health Insurance Markets 2024 Open Enrollment Report. https://www.cms.gov/files/document/health-insurance-exchanges-2024-open-enrollment-report-final.pdf.
[258] 45 CFR § 155.315(f).

immigration documentation such as their alien number or employment authorization document (EAD) number when they fill out the application. Therefore, we anticipate cost savings for Exchanges due to the reduction in lawful presence inconsistencies for DACA recipients who were not able to have their immigration status verified electronically during the application process.

Of the 10,000 fewer DACA recipients who will apply for Exchange coverage as a result of this rule, we estimate that 20 percent, or 2,000, will have generated an immigration status inconsistency.[259] Of these 2,000 inconsistencies, we assume that 51 percent of those (1,020) will no longer be processed by State Exchanges and 49 percent (980) will no longer be processed by the Federal Government.[260] To adjudicate an inconsistency, we estimate that it would have taken an eligibility support worker (BLS occupation code 43–4061) 12 minutes, or 0.2 hours, at an hourly rate of $49.52 to review submitted documentation. Therefore, for State Exchanges, we anticipate a net burden reduction of 204 hours (0.2 hours × 1,020 inconsistencies) with an equivalent cost savings of $10,102 (204 hours × $49.52 per hour). For the Federal Government, we anticipate a net burden reduction of 196 hours (0.2 hours × 980 inconsistencies), with an equivalent cost savings of $9,706 (196 hours × $49.52 per hour). In sum, we expect a burden reduction due to processing fewer immigration status inconsistencies of 400 hours (204 hours + 196 hours), with cost savings of $19,808 (400 hours × $49.52 per hour).

We sought comment on the estimates and the methodology and assumptions used to calculate them in the proposed rule. We are using revised estimates as presented above as a result of more recent data being available at the time of this final rule.

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[259] Estimates are based on internal CMS data comparing the number of immigration DMIs generated to the number of noncitizen enrollees during similar time periods during 2024, rounded to the nearest 5 percent.
[260] CMS. (2024, March 27). Health Insurance Markets 2024 Open Enrollment Report. *https://www.cms.gov/files/document/health-insurance-exchanges-2024-open-enrollment-report-final.pdf.*

Comment: Many commenters are concerned that the finalization of this rule would require considerable burden on State Exchanges, States that operate a BHP, and FFE States, including requiring them to reverse current processes and change their systems in the middle of the year in order to terminate coverage for existing enrollees and halt future enrollment for DACA recipients. Commenters stated that estimates included in the proposed rule regarding the impact on all the States and Exchanges do not take into account expenditures related to customer outreach and education, changing call center scripts and website copy, and training for call center workers and consumer assisters.

Response: We appreciate these commenters' concerns. The burden estimates included in this section are informed by the FFE's past experience conducting similar systems changes. We believe these estimates should allow Exchanges and States that operate a BHP to plan for any additional expenditures caused by the finalization of this rule. We note that due to differing State systems and processes, we cannot include estimates related to customer outreach, education, and website updates.

Comment: Many State Exchanges, BHP agencies, and SBE-FPs, and other commenters noted concerns about being able to implement these changes upon finalization of the rule. A few commenters requested a detailed implementation plan to assist impacted Exchanges.

Response: We understand that State Exchanges, States that elect to operate a BHP, SBE-FPs, and the FFE will need to make changes to their eligibility and enrollment systems to correctly determine eligibility for DACA recipients as of the applicability date. We are committed to providing all Exchanges and State agencies that operate a BHP with technical assistance and any additional support needed to ensure that States are able to correctly determine eligibility for DACA recipients impacted by this final rule's effective date. We are also committed to working with all Exchanges and State agencies that operate a BHP to identify any potential manual workarounds that may be needed to correctly determine eligibility prior to full

systems changes being in place. For the reasons outlined in this final rule, we are finalizing these estimates as they appear in this section.

3. Application Process for Applicants

The following proposed changes will be submitted for review under OMB Control Number 0938-1191 (CMS-10440).

As required by the ACA, there is one application through which individuals may apply for health coverage in a QHP through an Exchange and for other insurance affordability programs like Medicaid, CHIP, and a BHP in a State that chooses to operate a BHP.[261] We note that we proposed no changes to the eligibility application for Medicaid and CHIP. Hence, this section only includes data on the burden associated with completing an application and submitting additional information to verify lawful presence, if necessary, for health coverage in a QHP through an Exchange and for BHP coverage.[262] A discussion of the proposed ICRs for this policy may be found in the 2025 Marketplace Integrity and Affordability proposed rule (90 FR 13000 through 13001). We are updating the ICRs for this policy in this final rule and removing the potential cost savings associated with these ICRs upon further analysis and reflection in finalizing these provisions.

We sought comment on the estimates and assumptions in the proposed rule.

We did not receive any comments in response to the burden estimates for this policy in the proposed rule. We are using revised assumptions as presented above as a result of additional analysis conducted at the time of this final rule. For the reasons outlined in the final rule, we are finalizing these assumptions as presented earlier in this section.

C. ICRs Regarding Failure to File and Reconcile (§ 155.305(f)(4))

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[261] 42 U.S.C. 18083.

[262] We assume that the burden of completing an application is essentially the same regardless of whether the individual applies directly with the State agency responsible for administering the BHP or with an Exchange.

We are finalizing an amendment to the current regulation at § 155.305(f)(4), under which an Exchange may not find an enrollee eligible for APTC where an enrollee or their tax filer has failed to file a Federal income tax return reconciling their APTC for 2 consecutive tax years, to increase the program integrity of the Exchange. We are finalizing the requirement for Exchanges to find enrollees ineligible for APTC after they or their tax filer has failed to file and reconcile their APTC for 1-tax year for coverage year 2026. However, the 1-year policy would sunset on December 31, 2026 and Exchanges would revert back to the current 2-year policy in coverage year 2027 that allows an Exchange to not find an enrollee eligible for APTC when an enrollee or their tax filer has failed to file a Federal income tax return reconciling their APTC for 2 consecutive tax years. This allows Exchanges to collect data on the 1-year policy. We will consider these data to determine whether to make permanent the 1-year FTR policy or to revert back to the 2-year FTR policy that was in place in coverage year 2025. For Exchanges on the Federal platform, the FTR process will otherwise be conducted similarly to the previous iterations of FTR prior to the 2024 Payment Notice, except that those identified as being in a 1-tax year FTR status will be at risk for removal of APTC and there will no longer be a 2-tax year FTR status population. Minimal changes to the language of the Exchange application questions will be necessary to obtain relevant information; as such, we anticipate that the amendment finalized in this rule will not impact the information collection burden for consumers. We anticipate that there will no longer be a 2 year FTR population for coverage year 2026, and thus the notices sent to the FTR population will be similar to the current 2-tax year FTR notices in inciting an urgency to act, but that all consumers with an FTR status will be in a 1-tax year FTR status for coverage year 2026. Due to this, we do not anticipate PRA impacts related to noticing requirements.

We sought comment on the proposed assumptions and any information collection burdens not identified in this section.

We did not receive any comments in response to the proposed assumptions for this policy. For the reasons outlined in the final rule, we are finalizing these assumptions as proposed.

D. ICRs Regarding Income Verification When Data Sources Indicate Income Less Than 100 Percent of the FPL (§ 155.320(c)(3)(iii))

The following changes will be submitted for review under OMB Control Number 0938-1191 (CMS-10440).

We are finalizing amendments to § 155.320(c)(3)(iii) to specify that all Exchanges must generate annual income inconsistencies when a tax filer's attested projected annual income would qualify the taxpayer as an applicable taxpayer according to 26 CFR 1.36B-2(b) and trusted data sources indicate that projected income is under 100 percent of the FPL. This policy will be effective upon the effective date of this rule, but with a modification under which the policy and related requirements will be sunset for all Exchanges at the end of PY 2026. Thereafter, this policy will no longer be effective. A discussion of the proposed ICRs for this policy may be found in the proposed rule (90 FR 13001 through 13002). We are updating the ICRs for this policy in this final rule to account for updated wage rates available after the publication of the proposed rule.

We anticipate that adding this income verification requirement will result in approximately 1 hour of time spent by consumers to complete associated questions in the application, or to submit supporting documentation. Based on historical data from the FFE, we estimate that approximately 340,000 inconsistencies will be generated at the household level for the Exchanges on the Federal platform. On the State Exchanges, we estimate this figure to be 208,000 inconsistencies. Therefore, adding these inconsistencies will increase burden on consumers by approximately 548,000 hours across all Exchanges. Using the estimate of the hourly value of time for changes in time use for unpaid activities calculated at $24.05 per hour in section IV.A. of this final rule, we estimate that the increase in cost for each consumer in 2026

will be approximately $24.05, and the cost increase for all consumers who will generate this income inconsistency in 2026 will be approximately $13,179,400 (548,000 hours x $24.05 cost of unpaid activities).

Additionally, we estimate that adding this income verification requirement will result in an increase in burden on the Exchanges on the Federal platform. Based on historical FFE data, we anticipate that approximately 340,000 inconsistencies will be generated at the household level for Exchanges using the Federal platform, and 208,000 in State Exchanges. Once households have submitted the required verification documents, we estimate that it will take approximately 1 hour and 12 minutes for an eligibility support staff person (Eligibility Interviewers, Government Programs – BLS occupation code 43–4061), at an hourly cost of $49.52, to receive, review, and verify submitted verification documents as well as conduct outreach and determine DMI outcomes. Therefore, adding these inconsistencies will result in an increase in burden on the Federal Government of 408,000 hours (340,000 verifications x 1.2 hours per verification) at a cost of $20,204,160 (408,000 hours x $49.52 per hour) in 2026, and an increase in burden on the State Exchanges of 249,600 hours (208,000 verifications x 1.2 hours per verification) at a cost of $12,360,192 in 2026.

Finally, we estimate that adding this income requirement will require costs related to updating the technical systems, including the eligibility system. We estimate that it will take the Exchanges on the Federal platform and each State Exchange 8,000 hours in 2025 to make these updates. Of those 8,000 hours, we estimate it will take a database and network administrator and architect 2,000 hours at $103.34 per hour and a computer programmer 6,000 hours at $94.88 per hour. Given this, we estimate that Exchanges on the Federal platform will incur a one-time burden in 2025 of $775,960 (2,000 x $103.34 + 6,000 x $94.88) to make these eligibility system updates. State Exchanges will incur a one-time burden of $14,743,240 (2,000 x $103.34 + 6,000 x $94.88 x 19). We also estimate that the Exchanges would incur the same burdens in 2026 in

order to sunset the policy at the end of that year. Therefore, we estimate that Exchanges on the Federal platform will incur a one-time burden in 2026 of $775,960 (2,000 x $103.34 + 6,000 x $94.88) to make these eligibility system updates. State Exchanges will incur a one-time burden of $14,743,240 (2,000 x $103.34 + 6,000 x $94.88 x 19).

We sought comment on the proposed estimates and assumptions.

After consideration of comments and for the reasons outlined in the proposed rule and this final rule, including our responses to comments, we are finalizing these burden estimates for this policy with modifications to account for updated general occupational cost estimations and the sunsetting of this policy following the completion of PY 2026. These updated estimates are reflected in the cost estimates already laid out in this section of the final rule. We summarize and respond to public comments received on the original proposed estimates below.

Comment: Some providers and provider groups and organizations expressed concern that it could take vulnerable enrollees longer than 1 hour to submit documentation related to this income verification requirement.

Response: We acknowledge commenters' concerns and emphasize that 1 hour is an average. These consumers will still have 90 days to submit documentation to verify their annual household income. We provide a robust list of acceptable documents that households can submit to resolve their Income DMIs, and this list is included in multiple consumer notices and on the CMS website. We recommend that consumers for whom more common documents like paystubs and tax forms are either not available or are inaccurate submit other suggested income documents that may be more available and accurate.

E. ICRs Regarding Income Verification When Tax Data is Unavailable (§ 155.320(c)(5))

The following changes will be submitted for review under OMB Control Number 0938-1191 (CMS-10440).

We are finalizing amendments to remove § 155.320(c)(5) which currently requires Exchanges to accept attestations, and not set an Income DMI, when the Exchange requests tax return data from the IRS to verify attested projected annual household income, but the IRS confirms there is no such tax return data available**.** We are finalizing this with a modification under § 155.320(c)(5): this final provision removes this policy upon the effective date of this rule and will be reinstated for all Exchanges at the end of PY 2026. A discussion of the proposed ICRs for this policy may be found in the 2025 Marketplace Integrity and Affordability proposed rule (90 FR 13002). We are updating the ICRs for this policy in this final rule to account for updated wage rates available after the publication of the proposed rule.

Based on internal historical DMI data, we estimate that approximately 1,722,000 inconsistencies will be generated at the household level for Exchanges using the Federal platform, and 1,056,000 will be generated at the household level for State Exchanges due to this final policy. Once households have submitted the required verification documents, we estimate that it will take approximately 1 hour and 12 minutes for an eligibility support staff person (BLS occupation code 43–4061), at an hourly cost of $49.52, to receive, review, and verify submitted verification documents as well as conduct outreach and determine DMI outcomes. Therefore, the removal of § 155.320(c)(5) will result in an increase in burden for the Federal Government of 2,066,400 hours (1,722,000 verifications x 1.2 hours per verification) at a cost of $102,328,128 (2,066,400 hours x $49.52 per hour) in 2026 and an increase in burden on State Exchanges of 1,267,200 hours (1,056,000 verifications x 1.2 hours per verification) at a cost of $62,751,744 (1,267,200 hours x $49.52 per hour) in 2026.

In addition to the increased administrative burden on Exchanges, this change will increase the number of consumers who are required to submit documentation to verify their income. We estimate that consumers will each spend 1 hour to answer the associated question, or to submit documentation. Based on historical data from the FFE, we estimate that approximately

2,777,000 inconsistencies will be generated at the household level across all Exchanges. Using the estimate of the hourly value of time for changes in time use for unpaid activities calculated at $24.05 per hour in section IV.A. of this final rule, we estimate that the increase in cost for each consumer in 2026 will be approximately $24.05 and that the proposed change will increase burden on consumers by 2,777,000 hours per year at an associated cost of $66,786,850 (2,777,000 hours x $24.05 per hour).

Finally, we estimate that removing the current process of verifying income attestations when IRS returns no data will require costs related to updating the eligibility system. We estimate that it will take Exchanges on the Federal platform and each State Exchange 9,000 hours in 2025 to make these updates. Of those 9,000 hours, we estimate it will take a database and network administrator and architect 2,250 hours at $103.34 per hour and a computer programmer 6,750 hours at $94.88 per hour. Given this, we estimate that the Federal Government will incur a one-time burden of $872,955 (2,250 x $103.34 + 6,750 x $94.88) to make these eligibility system updates. State Exchanges will incur a one-time burden total in 2025 of $16,586,145 ($872,955 x 19) associated with a total of 171,000 (9,000 x 19) burden hours**.** We also estimate that the Exchanges would incur the same burdens in 2026 in order to sunset the policy at the end of that year. Therefore, we estimate that Exchanges on the Federal platform will incur a one-time burden in 2026 of $872,955 (2,250 x $103.34 + 6,750 x $94.88) to make these eligibility system updates. State Exchanges will incur a one-time burden total in 2026 of $16,586,145 ($872,955 x 19) associated with a total of 171,000 (9,000 x 19) burden hours.

We sought comment on the proposed impacts and assumptions.

After consideration of comments and for the reasons outlined in the proposed rule and this final rule, including our responses to comments, we are finalizing these burden estimates for this policy with modifications to account for updated general occupational cost estimations. These updated estimates are reflected in the cost estimates already laid out in this section of the

final rule. We summarize and respond to public comments received on the original proposed estimates below.

Comment: Some providers and provider groups and organizations expressed concern that it could take vulnerable enrollees longer than 1 hour to submit documentation related to this income verification requirement.

Response: We acknowledge commenters' concerns and emphasize that 1 hour is an average. These consumers will still have 90 days to submit documentation to verify their annual household income, and may be eligible for extensions granted by the Exchanges on the Federal platform or State Exchanges under § 155.315(f)(3). In order to assist consumers in a wide variety of circumstances, we provide a robust list of acceptable documents that households can submit to resolve their Income DMIs, and this list is included in multiple consumer notices and on the CMS website. We recommend that consumers for whom more common documents like paystubs and tax forms are either not available or are inaccurate submit other suggested income documents that may be more available and accurate.

F. ICRs Regarding Annual Eligibility Redetermination (§ 155.335)

Under § 147.106(c) and (f), health insurance issuers that discontinue or renew non-grandfathered coverage under a product in the individual market (including coverage offered through the Exchanges) (including a renewal with uniform modifications), or that non-renew or terminate coverage under a product in the individual market (including coverage offered through the Exchanges) based on movement of all enrollees in a plan or policy outside the product's service area, are required to provide written notices to enrollees, in a form and manner specified by the Secretary.[263] Under § 156.1255, QHP issuers in the individual market must include certain

[263] The requirement to provide notices of renewal applies to issuers in the individual or small group market. The requirement to provide notices of product discontinuation and notices of non-renewal or termination based on enrollees' movement outside the service area applies to issuers in the individual or group market. *See* section 2703 of the PHS Act and 45 CFR 147.106. These requirements also apply with respect to grandfathered coverage pursuant to sections 2712 (former) and 2742 of the PHS Act and §§ 146.152 and 148.122.

information in the applicable renewal and discontinuation notices.[264] To satisfy these notice requirements, issuers in the individual market must use Federal standard notices, unless a State develops and requires the use of a different form consistent with CMS guidance.

This final rule amends the automatic re-enrollment hierarchy by removing § 155.335(j)(4), which allowed Exchanges to direct re-enrollment for enrollees who are eligible for CSRs from a bronze QHP to a silver QHP in the same product if the silver QHP has a lower or equivalent net premium after the application of APTC, and if the silver QHP has the same provider network as the bronze plan into which the enrollee would otherwise have been re-enrolled. To align with this change, we remove language related to the bronze to silver crosswalk from the Federal standard notices.

This final rule also requires enrollees who would otherwise be automatically re-enrolled in a QHP with a zero-dollar premium after application of APTC ("fully-subsidized") by the Exchanges on the Federal platform to instead be automatically re-enrolled with APTC applied to the policy reduced such that the enrollee owes a $5 premium in PY 2026. This policy sunsets after PY 2026 and reverts back to current policy. We updated the Federal standard notices to include language related to this requirement.

The burden to issuers related to sending the Federal standard notices is currently approved under OMB Control Number 0938-1254 (CMS-10527).[265] The information collection has been revised to incorporate the necessary language modifications in the Federal standard notices due to the changes in this final rule. However, we do not anticipate any change in burden to issuers.

G. ICRs Regarding Pre-Enrollment Verification for Special Enrollment Periods (§ 155.420)

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[264] Section 156.1255(a) through (d).

[265] OMB Control Number 0938-1254 (CMS-10527, Annual Eligibility Redetermination, Product Discontinuation and Renewal Notices).

The following changes will be submitted for review under OMB Control Number 0938-1191 (CMS-10440).

We are temporarily finalizing amendments to § 155.420(g) to require all Exchanges to conduct eligibility verification for SEPs. Specifically, are finalizing removal of the limit on Exchanges on the Federal platform to conducting pre-enrollment verifications for only the loss of minimum essential coverage SEP. With this limitation removed, we are finalizing the requirement to conduct pre-enrollment verifications for most categories of SEPs for Exchanges on the Federal platform in line with operations prior to the implementation of the 2023 Payment Notice. At this time, we are finalizing this policy for PY 2026 only, with a reversion to the previous policy for PY 2027 and beyond.

We are also temporarily finalizing that Exchanges must conduct SEP verification for at least 75 percent of new enrollments through SEPs for consumers not already enrolled in coverage through the applicable Exchange. We are finalizing that Exchanges must verify at least 75 percent of such new enrollments based on the current implementation of SEP verification by Exchanges. At this time, we are finalizing this policy for PY 2026 only, with a reversion to the previous policy for PY 2027 and beyond. A discussion of the proposed ICRs for this policy may be found in the 2025 Marketplace Integrity and Affordability proposed rule (90 FR 13003). We are updating the ICRs for this policy in this final rule to account for updated wage rates available after the publication of the proposed rule.

We anticipate that adding this expansion of pre-enrollment verification for SEPs will result in approximately 1 hour of time spent by consumers to complete associated questions in the application or submit supporting documentation. Based on historical data from the FFE, we estimate that approximately 293,073 new SEP verification issues will be generated at the household level for Exchanges on the Federal platform. Therefore, adding these inconsistencies will increase burden on consumers by approximately 293,073 hours. Using the estimate of the

hourly value of time for changes in time use for unpaid activities calculated at $24.05 per hour in section IV.A. of this final rule, we estimate that the increase in cost for each consumer will be approximately $24.05 in 2026, and the cost increase for all consumers who generate this income inconsistency will be approximately $7,048,406 in 2026.

Additionally, we estimate that expanding pre-enrollment verification for SEPs will result in an increase in burden on Exchanges using the Federal platform and State Exchanges. Based on historical FFE data, we anticipate that approximately 293,073 inconsistencies will be generated at the household level for Exchanges using the Federal platform, and 179,625 inconsistencies will be generated at the household level for Exchanges not using the Federal platform. Once households have submitted the required verification documents, we estimate that it will take approximately 12 minutes for an eligibility support staff person (BLS occupation code 43–4061), at an hourly cost of $49.52, to review and verify submitted verification documents. Therefore, expanding verification will result in an increase in burden on Exchanges using the Federal platform of 58,615 hours (293,073 verifications x 0.2 hours per verification) at a cost of $2,902,615 (58,615 hours x $49.52 per hour) in 2026.

We sought comment on the proposed estimates and assumptions.

As discussed, after careful consideration of public comments, we have decided to finalize and implement these policies with a significant modification – for Exchanges on the Federal platform, each of the rules outlined in this section will sunset by their terms after the completion of one new coverage year, PY 2026, on December 31, 2026. We are declining to finalize these proposals for State Exchanges. We have also added the one-time development cost estimate to this section.

Comment: States, providers, actuaries, labor groups, general advocacy groups, individuals, and one health insurance issuer raised general concern about the administrative

burden and cost on States of implementing pre-enrollment SEP verification and expressed that States do not experience the same level of fraud cited for Exchanges on the Federal platform.

Response: We acknowledge commenters' concerns. However, after careful consideration of public comments, we have decided to finalize and implement the proposed policy with a significant modification – for all Exchanges, each of the rules outlined in this section will sunset by their terms after the completion of one new coverage year, PY 2026, on December 31, 2026 with a reversion to the previous policy for PY 2027 and beyond. We will not be finalizing these proposals for State Exchanges in an effort to address concerns around increased burdens and costs.

H. Summary of Annual Burden Estimates for Finalized Requirements

TABLE 9: Finalized Annual Recordkeeping and Reporting Requirements

Regulation Section(s)	OMB Control Number	Number of Respondents	Number of Responses	Burden per Response (hours)	Total Annual Burden (hours)	Labor Cost of Reporting ($)	Total Cost ($)
155.20 (Exchange)	0938-1191	-11,000	-11,000	0.17	-1,870	-$92,602	-$92,602
TOTAL					**-1,870**		**-$92,602**

I. Submission of PRA-Related Comments

We have submitted a copy of this final rule to OMB for its review of the rule's information collection and recordkeeping requirements. These requirements are not effective until they have been approved by OMB.

To obtain copies of the supporting statement and any related forms for the collections discussed above, please visit CMS' website at *www.cms.hhs.gov/PaperworkReductionActof1995,* or call the Reports Clearance Office at 410-786-1326.

V. Regulatory Impact Analysis

A. Statement of Need

We are finalizing the exclusion of DACA recipients from the definitions of "lawfully present" that are used to determine eligibility to enroll in a QHP through an Exchange, for PTC, APTC, and CSRs, and to enroll in a BHP in States that elect to operate a BHP, which will be applicable as of the effective date of this rule and beyond. This rule also finalizes the policy contained in the proposed rule to reverse the policy restricting an issuer from denying coverage due to an individual's or employer's failure to pay premiums owed for prior coverage, including by attributing payment of premium for new coverage to past-due premiums from prior coverage, which will be applicable as of the effective date of this rule and beyond. Additionally, we are finalizing temporary revisions to the FTR process at § 155.305(f)(4) to reinstate the policy that Exchanges must determine enrollees ineligible for APTC when HHS notifies the Exchange that they or their tax filer has failed to file a Federal income tax return and reconcile their past APTC for a year for which their tax data would be utilized to verify their eligibility. This policy is effective for PY 2026, and we are sunsetting this policy at the end of PY 2026 with a reversion to the previous policy for PY 2027 and beyond. We also are finalizing policies to strengthen the verification process around annual household income, which will be applicable as of the effective date of this rule, and we are sunsetting these policies pertaining to income verification when data sources indicate income less than 100 percent of the FPL and income verification when tax data is unavailable for State Exchanges at the end of PY 2026 with a reversion to the previous policies for PY 2027 and beyond. We are further finalizing a temporary requirement for Exchanges on the Federal platform that enrollees who would otherwise be automatically re-enrolled in a QHP with a zero dollar premium after application of APTC ("fully-subsidized") will instead be automatically re-enrolled with APTC applied to the policy reduced such that the enrollees owe a 5-dollar premium if they do not submit an application for an updated eligibility determination to the Exchanges on the Federal platform. This requirement is being finalized as effective for PY 2026 only, with a reversion to the previous policy for PY 2027 and beyond. We

also are finalizing an amendment to the automatic reenrollment hierarchy by removing § 155.335(j)(4) which currently allows Exchanges to move an enrollee from a bronze QHP to a silver QHP if the silver QHP has a lower or equivalent net premium after the application of APTC, and if the silver QHP is in the same product and has the same provider network as the bronze plan into which the enrollee would otherwise have been re-enrolled. We are finalizing this policy to be effective for PY 2026 and beyond. We also are finalizing a temporary removal of the fixed-dollar and gross percentage-based premium payment thresholds at § 155.400(g), which will be applicable as of the effective date of this rule and we are sunsetting this policy at the end of PY 2026 with a reversion to the previous policy for PY 2027 and beyond. We are finalizing changing the annual OEP for coverage through all individual market Exchanges beginning with the PY 2027 OEP. We are finalizing flexibility for Exchanges to set their own OEP as long as: the start date is no later than November 1, the end date is no later than December 31, the OEP does not exceed 9 weeks, and all coverage pursuant to enrollments during the OEP begins January 1. Additionally, we are finalizing a pause of § 155.420(d)(16) and making conforming changes to repeal the monthly SEP for qualified individuals or enrollees, or the dependents of a qualified individual or enrollee, who are eligible for APTC, and whose projected household income is at or below 150 percent of the FPL. This finalized policy will be applicable as of the effective date of this rule, and we are sunsetting this policy at the end of PY 2026 with a reversion to the previous policy for PY 2027 and beyond. We also are finalizing an amendment to § 155.420(g) to enable HHS to temporarily reinstate (with modifications) pre-enrollment verification of eligibility of applicants for all categories of individual market SEPs. This policy is effective for PY 2026, and we are sunsetting this policy at the end of PY 2026 with a reversion to the previous policy for PY 2027 and beyond. Additionally, we are finalizing a prohibition on covering specified sex-trait modification procedures as an EHB and adding a definition of "specified sex-trait modification procedure," which will be effective for PY 2026 and beyond.

Finally, we are finalizing a change to the premium adjustment percentage methodology to establish a premium growth measure that comprehensively reflects premium growth in all affected markets, and we are finalizing revised AV de minimis ranges. These finalized policies will be effective for PY 2026 and beyond.

B. Overall Impact

We have examined the impacts of this rule as required by Executive Order 12866, "Regulatory Planning and Review Executive Order 13132, "Federalism"; Executive Order 13563, "Improving Regulation and Regulatory Review"; the Regulatory Flexibility Act (RFA) (Pub. L. 96-354); section 1102(b) of the Social Security Act; section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104-4); and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select those regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety, and other advantages; distributive impacts). Section 3(f) of Executive Order 12866 defines a "significant regulatory action" as any regulatory action that is likely to result in a rule that may: (1) have an annual effect on the economy of $100 million or more or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or Tribal governments or communities; (2) create a serious inconsistency or otherwise interfere with an action taken or planned by another agency; (3) materially alter the budgetary impact of entitlements, grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raise novel legal or policy issues arising out of legal mandates, or the President's priorities.

A regulatory impact analysis (RIA) must be prepared for a regulatory action that is significant under Executive Order 12866. Based on our estimates, OMB's Office of Information

and Regulatory Affairs (OIRA) has determined this rulemaking is significant under section 3(f)(1). Pursuant to Subtitle E of the Small Business Regulatory Enforcement Fairness Act of 1996 (also known as the Congressional Review Act), OIRA has also determined that this is a rule as defined under 5 U.S.C. 804(2).

C. Impact Estimates of the Final Individual Market Program Integrity Provisions and Accounting Table

Consistent with OMB Circular A-4,[266] we have prepared an accounting statement in Table 10 showing the classification of the impact associated with the provisions of this final rule. We have included the undiscounted annual impacts in Table 11.

This final rule implements standards for programs that will have numerous effects, including supporting program integrity, reducing the impact of adverse selection, and stabilizing premiums in the individual and small group health insurance markets and in Exchanges. We are unable to quantify and monetize all the benefits and costs of this final rule. The effects in Table 10 reflect qualitative assessment of impacts and estimated direct monetary costs and transfers resulting from the provisions of this final rule for Exchanges, health insurance issuers, and consumers. The individual effects of each provision in this final rule are presented separately in Table 10 and collectively in Table 11, but we anticipate these estimates may overlap, as some individuals could be impacted by multiple provisions. Therefore, in section V.C.18. of this final rule, we present overall impact estimates of all provisions considered jointly. Due to the sunsetting of certain provisions, there is a risk that some improper enrollment returns with an adverse impact on the risk pool. This level of risk is not certain and difficult to estimate, but we have accounted for this uncertainty by providing a range of estimates in this analysis.

TABLE 10: Accounting Table

[266] Available at *https://trumpwhitehouse.archives.gov/sites/whitehouse.gov/files/omb/circulars/A4/a-4.pdf.*

Benefits:	Estimate	Year Dollar	Discount Rate	Period Covered
Annualized Monetized ($/year)	$0.2 million	2025	7 percent	2025-2029
Annualized Monetized ($/year)	$0.2 million	2025	3 percent	2025-2029

Quantified:

- Annual reduction in costs starting in 2025 of $41,250 in application processing savings for the Federal Government and $51,352 total for State Exchanges and States that choose to operate BHPs as a result of fewer individuals applying for coverage associated with the policy regarding the definition of "lawfully present."
- Annual reduction in costs starting in 2025 of $10,102 total for State Exchanges and $9,706 for the Federal Government as a result of fewer individuals generating immigration status inconsistencies associated with the policy regarding the definition of "lawfully present."
- One-time reduction in costs in 2026 of $92,400 total for States and $292,000 for the Federal Government as a result of not sending an additional 2-tax year notice to consumers found as failing to file and reconcile.

Non-quantified:

- Reduction in the risk of adverse selection associated with the policy to permit attribution of payment for new coverage to past-due premium amounts.
- Reduction in outstanding premium debt amount for enrollees resulting in potential improvement in their financial standing over time and a reduced likelihood of any debt being placed into collections associated with the policy to permit attribution of payment for new coverage to past-due premium amounts.
- Improved continuous coverage for enrollees and premium collection rates and reduced administrative costs for issuers associated with the policy to permit attribution of payment for new coverage to past-due premium amounts.
- Increased transparency for agents, brokers, and web-brokers by establishing an evidentiary standard to be used during investigations of agent, broker, or web-broker noncompliance under § 155.220(g)(1)-(3).
- Reduced potential for APTC recipients to incur large tax liabilities in 2026 as a result of the policies regarding FTR and income verification in this final rule.
- Simplified operational processes for issuers and the Exchanges associated with the policy regarding the annual OEP length.
- Improved continuous coverage for the full year and improved risk pool associated with the policy regarding the annual OEP length.
- Increased issuer participation and improved coverage options, resulting in an improved overall risk pool and reduced overall costs associated with the policy to revise the AV de minimis ranges.
- Better matches between consumers' coverage preferences and available coverage offerings and a reduction in financial burden due to improper enrollment associated with the policies in this rule.
- Reduction in improper enrollments of fully-subsidized enrollees by agents, brokers, and web-brokers associated with the policies in this rule.

Costs:	Estimate	Year Dollar	Discount Rate	Period Covered
Annualized Monetized ($/year)	$132.0 million	2025	7 percent	2025-2029
Annualized Monetized ($/year)	$125.6 million	2025	3 percent	2025-2029

Quantified:

- One-time costs in 2025 of $1,959,299 total for State Exchanges and States operating BHPs and $96,995 for the Federal Government to make changes to eligibility systems regarding the definition of "lawfully present" finalized in this rule.
- One-time costs in 2025 of $1,648,915 total for State Exchanges and $96,995 for the Federal Government to end QHP coverage for individuals no longer considered "lawfully present" due to policies in this final rule.
- One-time costs in 2025 of $969,950 for the Federal Government and $19,399,000 total for State Exchanges to develop and code changes to the eligibility systems to evaluate and verify FTR status under the revised FTR process finalized in this rule, plus an additional cost of $1,939,900 for two additional States that plan to transition to State Exchanges to complete system builds for FTR.
- One-time costs in 2026 of $969,950 for the Federal Government and $19,399,000 total for State Exchanges

to develop and code changes to the eligibility systems to evaluate and verify FTR status under the 2-year process that this rule would sunset back to.

- One-time costs in 2025 of approximately $14.7 million total for State Exchanges and $775,960 for the Federal Government to complete the necessary system changes and other technical changes to implement the policy regarding creating annual income DMIs when applicants attest to income that would qualify the taxpayer as an applicable taxpayer per 26 CFR 1.36B-2(b) but trusted data sources show income below 100 percent of the FPL.
- One-time costs in 2026 of approximately $14.7 million total for State Exchanges and $775,960 for the Federal Government to complete the necessary system changes and other technical changes to sunset the policy regarding creating annual income DMIs when applicants attest to income that would qualify the taxpayer as an applicable taxpayer per 26 CFR 1.36B-2(b) but trusted data sources show income below 100 percent of the FPL.
- One-time operating costs of approximately $20.2 million for the Federal Government and approximately $12.4 million total for State Exchanges in 2026 to review and verify submitted documents, communicate with consumers, and process DMIs for applicants with incomes below 100 percent of the FPL.
- Increase in burden of $13,179,400 in 2026 for consumers with incomes below 100 percent of the FPL to fulfill income verification requirements addressing DMIs.
- One-time costs in 2025 of approximately $16.6 million total for State Exchanges and approximately $873,000 for the Federal Government to complete the necessary system changes and other technical changes to implement the policy to no longer permit Exchanges to accept an applicant's income attestation without further verification when tax return data is unavailable.
- One-time costs in 2026 of approximately $16.6 million total for State Exchanges and approximately $873,000 for the Federal Government to complete the necessary system changes and other technical changes to reimplement the policy to require Exchanges to accept an applicant's income attestation without further verification when tax return data is unavailable.
- Increase in burden of approximately $102.3 million for the Federal Government and approximately $62.8 million total for State Exchanges in 2026 to review and verify submitted documents, communicate with consumers, and process DMIs for applicants whose tax return data is unavailable.
- Increase in burden of $66.8 million in 2026 for consumers whose tax return data is unavailable to fulfill income verification requirements addressing DMIs.
- One-time costs in 2025 of approximately $9,500,000 total for State Exchanges and approximately $500,000 for the Federal Government to complete the necessary changes to implement the policy to remove the automatic 60-day extension to resolve income DMIs.
- One-time costs in 2025 of $969,950 for the Federal Government to complete the necessary system changes and other technical changes for Exchanges on the Federal platform associated with the temporary amendment to the annual eligibility redetermination regulation.
- One-time costs in 2026 of $969,950 for the Federal Government to complete the necessary system changes and other technical changes for Exchanges on the Federal platform associated with the sunsetting of the temporary amendment to the annual eligibility redetermination regulation.
- One-time costs in 2026 of $387,980 for the Federal Government and $7,371,620 total for State Exchanges associated with the policy to shorten the OEP.
- One-time costs in 2025 of approximately $390,000 for the Federal Government and approximately $7 million total for State Exchanges to pause the functionality to grant the 150 percent FPL SEP and make any necessary updates to Exchange eligibility logic systems.
- One-time cost in 2026 of approximately $390,000 for the Federal Government and approximately $7 million total for State Exchanges to re-add functionality to grant the 150 percent FPL SEP and make any necessary updates to Exchange eligibility logic systems in accordance with sunsetting the policy to pause this SEP until the end of 2026.
- One-time processing cost in 2026 of approximately $11,675,000 for Exchanges on the Federal platform to comply with finalized pre-enrollment verification requirements.
- One-time labor cost increase for the Federal Government of $2,902,615 in 2026 associated with the policies regarding SEP verification.
- One-time cost increase for consumers of approximately $7,048,406 in 2026 associated with the policies regarding SEP verification.
- One-time cost in 2025 of $2,973,300 to the Federal Government to develop and code changes associated with the policies regarding SEP verification.
- Regulatory review costs of $15,493,869 for interested parties to review and analyze this final rule in 2025.

Non-quantified:

- Total reduced annual enrollment between 725,000 and 1,800,000 individuals in PY 2026, including:
  - Reduced annual QHP enrollment of 10,000 and annual BHP enrollment of 1,000 associated with the policy to exclude DACA recipients from the definition of "lawfully present" used to determine eligibility for enrollment in a QHP through an Exchange, for APTC and CSRs, and for a BHP in States that operate BHPs.
  - Potential increase in the number of people who owe past-due premiums who may be deterred from enrolling in new coverage due to a higher initial premium payment associated with the policy to permit attribution of payment for new coverage to past-due premium amounts.
  - Potential loss of coverage for PY 2026 only due to non-payment of premiums for some automatically re-enrolled, fully-subsidized enrollees associated with the annual eligibility redetermination provision, if these enrollees do not submit an application for an updated eligibility determination and subsequently experience a decrease in the amount of APTC applied to their policy such that the remaining monthly premium owed by the enrollee for the entire policy equals $5 for the first month and for every following month that the enrollee does not confirm or update the eligibility determination, and fail to make payment of the premium amount due.
  - Reduced annual enrollment by 80,000 beginning in 2026 due to decreases in PTC subsidies for enrollees, based on an assumption that the Department of the Treasury and the IRS will adopt the use of the same premium measure finalized for the calculation of the premium adjustment percentage in this rule for purposes of calculating the indexing of the PTC applicable percentage and the required contribution percentage under section 36B of the Code.
- Small negative impact on the individual market risk pool associated with the policy to exclude DACA recipients from the definition of "lawfully present" for purposes of enrolling in a QHP offered through an Exchange, APTC, PTC, CSRs, or BHP coverage in States that elect to operate a BHP, as well as the return to the FTR 1-year policy for QHPs offered on an Exchange, which is likely offset by the improvement in the risk pool as a result of the reduced premiums anticipated to result from this final rule.
- Potential costs to the Federal Government and to States to provide limited Medicaid coverage for the treatment of an emergency medical condition for DACA recipients who have an emergency medical condition and meet all other Medicaid eligibility requirements in their State, applicable to those DACA recipients who would become uninsured due to the policy regarding the definition of "lawfully present."
- Potential increase in costs and medical debt for individuals who are deterred from enrolling due to a higher initial premium payment, which could in turn lead to increased costs incurred by hospitals and municipalities associated with the policy to permit attribution of payment for new coverage to past-due premium amount.
- Potential costs to State governments and private hospitals in the form of charity care for individuals who become uninsured as a result of the policies in this final rule.
- Potential increase in Federal and State Medicaid expenditures by enrolling more people in Medicaid who would otherwise have enrolled in APTC-subsidized QHP coverage due to the policy regarding income verification for individuals with incomes below 100 percent of the FPL.
- Time costs to enrollees who would be automatically re-enrolled in their QHP with a $0 premium after application of APTC to submit an application for an updated eligibility determination to the Exchanges on the Federal platform associated with the annual eligibility redetermination provision for PY 2026 only.
- Costs to the Federal Government, State Exchanges, and issuers for outreach activities associated with the shortened OEP.
- Enrollment for 293,073 enrollees potentially delayed for 1-3 days for SEP verification.

Transfers:	Low	High	Year Dollar	Discount Rate	Period Covered
Annualized Monetized ($/year)	-$3.8 billion	-$3.9 billion	2025	7 percent	2025-2029
Annualized Monetized ($/year)	-$3.7 billion	-$3.8 billion	2025	3 percent	2025-2029

Quantified:

- Reduced annual transfers from the Federal Government to issuers[267] of $34 million in APTC payments and

[267] Regarding references to APTC transfers from the Federal Government to issuers in this table and Accounting Table 11 in the proposed rule (90 FR 13006 through 13009), the Department notes that some of these dollars

$3.2 million in BHP payments associated with the policy to exclude DACA recipients from the definition of "lawfully present" for purposes of enrolling in a QHP offered through an Exchange, APTC, PTC, CSRs, or BHP coverage in States that elect to operate a BHP, beginning in 2026. • Reduced one-time APTC transfers from the Federal Government to issuers of up to $1.28 billion associated with the policies regarding FTR in 2026. • Annual reduction in APTC transfers from the Federal Government to issuers of $266 million beginning in 2025 for households across all Exchanges who receive fewer months of APTC due to no longer receiving an automatic 60 days of additional time to resolve their income DMI. • Reduction in APTC transfers from the Federal Government to issuers of $191 million in 2026 for consumers across all Exchanges who receive fewer months of APTC due to reinstatement of DMIs where households attest to income that would qualify the tax payer as an applicable taxpayer per 26 CFR 1.36B-2(b) and data sources show income below 100 percent of the FPL. • Reduction in APTC transfers from the Federal Government to issuers of $957 million in 2026 for households across all Exchanges who receive fewer months of APTC due to reinstatement of DMIs when IRS data is not available. • One-time reduction in APTC transfers from the Federal Government to issuers of $817,571,843 in 2026 associated with the policy regarding premium payment thresholds. • Reduction in APTC transfers from the Federal Government to issuers of approximately $3.4 billion in 2026 associated with the policy to pause the 150 percent FPL SEP, which is anticipated to reduce premiums by 3 to 4 percent. • Reduction in APTC transfers from the Federal Government to issuers of approximately $105.4 million in 2026 associated with the policy to revise pre-enrollment verification requirements for SEPs, associated with a reduction in premiums of approximately 0.5-1.0 percent for PY. • Reduced annual transfers from the Federal Government to issuers of between $1.27 billion and $1.55 billion in APTC payments beginning in 2026, assuming that the Department of the Treasury and the IRS will adopt the use of the same premium measure finalized for the calculation of the premium adjustment percentage in this rule for purposes of calculating the indexing of the PTC applicable percentage and the required contribution percentage under section 36B of the Code. • Increased annual transfers from large employers to the Federal Government of between $3 million and $20 million in Employer Shared Responsibility Payments annually over the period of 2028 to 2030, based on an assumption that the Department of the Treasury and the IRS will adopt the use of the same premium measure finalized for the calculation of the premium adjustment percentage in this rule for purposes of calculating the indexing of the PTC applicable percentage and the required contribution percentage under section 36B of the Code. • Reduced annual APTC transfers from the Federal Government to issuers of approximately $1.22 billion in 2026, $1.28 billion in 2027, $1.33 billion in 2028, and $1.40 billion in 2029 associated with an estimated 1 percent premium decrease on average for individuals eligible for PTC due to the policy to require individual market silver QHPs to provide an AV between 66-72 percent and associated income-based CSR plan variations to follow a de minimis range of +1/-1.
Non-quantified: • Reduction in net Federal PTC spending associated with policy terminations during PY 2026 if enrollees do not pay their portion of the premium and a reduction in improper enrollments occurs due to the temporary annual eligibility redetermination provision. • Reduced premiums and APTC cost to the Federal Government associated with the policy regarding the annual OEP length. • Decreased premiums for plans that do not cover specified sex-trait modification procedures as an EHB as a result of this final rule. • Reduction in commission payments from issuers to agents, brokers, and web-brokers associated with a reduction in improper enrollments of fully-subsidized enrollees by agents, brokers, and web-brokers due to the policies in this final rule.

ultimately flow from issuers to other entities like providers and jurisdictions that reimburse uncompensated care, as referenced earlier in this table where we discuss potential costs to State governments and private hospitals in the form of charity care for individuals who become uninsured as a result of policies in this final rule.

TABLE 11: Summary of Undiscounted Annual Impacts Reported in Accounting Table

	2025	2026	2027	2028	2029
Benefits	$0.1 million	$0.5 million	$0.1 million	$0.1 million	$0.1 million
Costs	$234.7 million	$368.7 million	$0	$0	$0
Transfers – Low	$0	-$10.3 billion	-$3.8 billion	-$2.1 billion	-$2.2 billion
Transfers – High	$0	-$12.4 billion	-$3.6 billion	-$1.4 billion	-$1.5 billion

1. Coverage Denials for Failure to Pay Premiums for Prior Coverage (§ 147.104(i))

This final rule revises § 147.104(i) to reverse the policy prohibiting an issuer from denying coverage due to an individual's or employer's failure to pay premiums owed for prior coverage, including by attributing payment of premium for new coverage to past-due premiums from prior coverage. The final rule allows an issuer, to the extent permitted by applicable State law, to establish terms of coverage that add past-due premium amounts owed to the issuer (or owed to another issuer in the same controlled group) to the initial premium the applicant must pay to effectuate new coverage and to refuse to effectuate new coverage if the initial and past-due premium amounts are not paid in full. An issuer adopting this policy must apply its past-due premium payment policy uniformly to all individuals or employers in similar circumstances in the applicable market and State regardless of health status, and consistent with applicable nondiscrimination requirements, and not condition the effectuation of new coverage on payment of past-due premiums by any individual other than the person contractually responsible for the payment of premium. The amount of the past-due premium an issuer may require for this purpose is subject to any premium payment threshold the issuer has adopted pursuant to 45 CFR 155.400(g).

This policy aims to promote continuous coverage while providing issuers with an additional mechanism for past-due premium collection. The policy may help reduce outstanding premium debt amounts for enrollees, potentially benefiting their financial standing over time and reducing the likelihood of any debt being placed into collections. Additionally, this final rule may

potentially improve premium collection rates and reduce administrative costs associated with repeated enrollment-termination cycles and other collection methods.

The comments and our responses are summarized below.

Comment: Some commenters highlighted important operational considerations, including the cost-benefit analysis issuers must undertake when implementing collection practices, and noted that some issuers may find that the implementation costs outweigh potential revenue from collections, particularly for nominal amounts.

Response: We acknowledge and recognize that, should the State in which an issuer operates allow issuers to collect past-due premiums to effectuate coverage, the final business decision will remain at the discretion of individual issuers and what they feel is in their best interest.

Comment: Some commenters expressed their support for the proposed policy. One commenter specifically identified positive aspects of the policy, notably its potential to reduce administrative burden and address adverse selection.

Response: We recognize that the ability to require past-due premium payments to effectuate new coverage can assist in maintaining stable risk pools by promoting continuous coverage and, consequently, help to moderate premium costs for all enrollees.

Past-due premiums can influence both issuer operations and market dynamics. This can occur if enrollees choose to move in and out of coverage based on anticipated health care needs by taking advantage of certain features in the insurance system, such as the regulatory grace period provisions, and allowing coverage to lapse without addressing premium obligations even when seeking to enroll in new coverage. By addressing these circumstances, this policy encourages continuous coverage and reduces the burden on issuers to collect past-due premiums in other ways. This policy reduces the risk of adverse selection by consumers.

Comment: Many commenters raised concerns about the potential impacts on coverage access, particularly in markets with limited competition where there may be a limited number of issuers serving that geographic area, and noted the potential for varying effects in different market contexts.

Response: We note that this policy provides States flexibility to address adverse selection based on their specific market conditions and allows for appropriate market-specific solutions that recognize the differences between competitive and less competitive regions. We believe this flexible approach strikes an appropriate balance between preserving consumer access to coverage and accounting for varying market conditions across regions.

This policy may also increase enrollment by encouraging enrollees to maintain continuous coverage. These enrollment gains may be partially offset by people who owe past-due premiums and who may be deterred from enrolling in new coverage due to a higher initial premium payment. Some enrollees, particularly those facing financial constraints, may need to adjust their household budgets to maintain coverage or, if they are not able to, become uninsured. Depending on the circumstances, these enrollees, if they become uninsured, may face higher costs for care and medical debt if care is needed. These costs may, in turn, be incurred by hospitals and municipalities in the form of uncompensated care. While some consumers may face challenges paying past-due premiums and may become or remain uninsured, the longer-term effects can include more stable risk pools and potentially more moderate premium trends.

Comment: Many commenters expressed concerns about the potential impacts on vulnerable populations and healthcare access, particularly for low-income individuals, rural communities, and those facing unexpected financial hardships. These commenters highlighted specific challenges faced by individuals who miss payments due to unexpected life circumstances, economic hardship, or administrative confusion.

Response: We acknowledge the range of concerns noted by commenters related to barriers to coverage for those experiencing financial difficulties, potential impacts on rural communities with limited issuer competition, and effects on young and healthy enrollees who contribute to a stable risk pool. However, after reviewing the comments, we are finalizing this policy contained in the proposal by codifying it in regulation text. This decision reflects our assessment that the policy provides necessary tools for maintaining market stability within the existing framework. This policy aims to balance multiple objectives, including promoting continuous coverage, maintaining stable risk pools, addressing concerns about adverse selection, and respecting States' ability to regulate their insurance markets. We recognize that some enrollees may face challenges in maintaining continuous coverage or addressing past-due premium obligations. However, this policy's flexible framework allows States and issuers to make market-specific decisions about implementation based on their understanding of local conditions and population needs. This flexibility also enables issuers to balance past-due premium practices with member retention goals and market stability considerations.

There is some uncertainty regarding the net enrollment effects of this policy—that is, whether the coverage gains from moderate premium trends and promoting continuous coverage will be higher than coverage losses due to allowing issuers to require payment of past-due premiums to effectuate new coverage. We anticipate any discouragement from enrolling will be minimal. As discussed earlier in this preamble, when a similar policy was previously in place, the percentage of enrollees in Exchanges using the Federal platform who had their coverage terminated for non-payment of premiums dropped substantially. While the data analysis did not indicate any specific reason for this reduction, it is possible that the policy may have successfully encouraged more people to maintain continuous coverage. This likely reduced the number of people with past-due premium debt and lowered costs to issuers related to the collection of those past-due premiums. We expect this policy will result in similar benefits. While we lack data to

quantify these effects, we believe that these effects will collectively contribute to more stable market conditions over time.

Comment: Several commenters noted their concern over the data limitations and the empirical basis for the proposed policy on past-due premium collection.

Response: We acknowledge commenters' concerns. While acknowledging these data limitations, based on our understanding of market dynamics and previous experience, we have decided to finalize the policy contained in the proposal. Although we cannot definitively quantify all effects, we have observed patterns suggesting that allowing issuers to condition the sale of new coverage on payment of past-due premiums can contribute to market stability. Additionally, as discussed in section III.A.2 of this final rule, States may choose whether to allow issuers to attribute the initial premium payment to past-due premiums and to refuse to effectuate new coverage until both amounts are paid. We believe States will make these determinations based on their specific markets, demographics, and anticipated outcomes for their constituents.

Finally, in terms of PTCs, given that this policy aims to encourage continuous coverage, we recognize that there could be varying effects in net Federal PTC spending. While some individuals might have their policies terminated due to non-payment, potentially reducing PTC spending, others might be encouraged by this policy to maintain coverage they would otherwise have dropped due to past-due premium issues, resulting in increased PTC spending for those months the individuals would otherwise not have maintained coverage. However, we do not anticipate any significant impact on PTCs.

2. Definitions; Deferred Action for Childhood Arrivals (§ 155.20)

We are finalizing modifications to the definition of "lawfully present" currently articulated at § 155.20 and used for the purpose of determining whether a consumer is eligible to enroll in a QHP through an Exchange and to enroll in a BHP in States that elect to operate a BHP. This change will exclude DACA recipients from the definition of "lawfully present" that is

used to determine eligibility to enroll in a QHP through an Exchange, for PTC, APTC, and CSRs, and for BHP coverage. We have updated the RIA for this policy due to revised wage rates and other data estimates available between the time of the proposed and final rule publication dates. The proposed 2025 Marketplace Integrity and Affordability RIA for this policy may be found at 90 FR 13010 through 13011.

We anticipate excluding DACA recipients from the definition of "lawfully present" will reduce annual QHP enrollment through the Exchanges by 10,000 and annual BHP enrollment by 1,000 in 2025. We project this decline in enrollment in QHP enrollment through the Exchanges will reduce annual APTC expenditures by $34.0 million and the decline in enrollment in BHP will reduce annual BHP expenditures by $3.2 million beginning in 2026.

While initial estimates under the ACA expansion to DACA recipients estimated 100,000 DACA recipients would receive coverage, actual Exchange enrollment of DACA recipients has been much lower. Comparing CMS internal data for participating FFE States to the count of active DACA recipients from U.S. Citizenship and Immigration Services (USCIS)[268] showed an enrollment rate of 2 percent among DACA recipients; however, 1.3 percent of enrollment was in States that received an injunction preventing enrollment in coverage. With this new information, we have updated our DACA enrollee assumptions to 10,000 Exchange enrollees and 1,000 BHP enrollees. With the average age of DACA recipients being 30.6, we assume an APTC amount of $283 per month, leading to an expected approximately $34 million reduction in APTC expenditures through the Exchange (10,000 x $283 x 12 months = $33,960,000). Similarly, we expect approximately $3.2 million in lower BHP expenditures (1,000 x $283 x 0.95 x 12 months = $3,226,200) in States that choose to operate BHPs.

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[268] U.S. Citizenship and Immigration Services. (n.d.) Immigration and Citizenship Data. Dep't of Homeland Security. *https://www.uscis.gov/tools/reports-and-studies/immigration-and-citizenship-data?topic_id%5B%5D=33602&ddt_mon=12&ddt_yr=2024&query=approximate+active+daca&items_per_page=10.*

Because DACA recipients are young,[269] they generally tend to be healthier. We therefore anticipate that excluding DACA recipients from individual market QHP coverage offered through the Exchanges will have a small negative impact on the individual market risk pool. Some DACA recipients who lose Exchange or BHP coverage may be able to enroll in non-Exchange coverage. However, we anticipate the majority who lose Exchange or BHP coverage will become uninsured. This may result in costs to the Federal Government and to States to provide limited Medicaid coverage for the treatment of an emergency medical condition to DACA recipients who have a qualifying medical emergency and who become uninsured as a result of this rule.

We also anticipate that this change will result in costs to State Exchanges and the Federal Government to update eligibility systems in accordance with this policy. As discussed further in section IV.B. of this final rule, in aggregate for the States, we estimate a one-time cost in 2025 of $1,959,299 total ($1,939,900 for State Exchanges + $19,399 for BHPs) total and $96,995 for the Federal Government. We also estimate a one-time cost in 2025 for termination operations of $1,648,915 total for State Exchanges and $96,995 for the Federal Government, as discussed further in section IV.B.2. of this final rule. In addition, we estimate cost savings annually beginning in 2025 for State Exchanges and States that operate BHPs of $51,352 total and for the Federal Government of $41,250 associated with assisting fewer eligible beneficiaries and processing their applications as a result of this policy. We also estimate cost savings annually beginning in 2025 for State Exchanges of $10,102 in total and for the Federal Government of $9,706 associated with processing fewer immigration state inconsistencies.

We sought comment on the proposed impact estimates and assumptions, the details of

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[269] Per USCIS data, the average age of DACA recipients is 30 years old. Count of Active DACA Recipients by Month of Current DACA Expiration as of September 30, 2024. U.S. Citizenship and Immigration Services. (2024, Sept. 30). Count of Active DACA Recipients by Month of Current DACA Expiration as of September 30, 2024. Dep't of Homeland Security. *https://www.uscis.gov/sites/default/files/document/data/active_daca_recipients_fy2024_q4.xlsx.*

which may be found in section IV.B. of the proposed rule.

Comment: Many commenters stated that CMS underestimated how many DACA recipients would apply in the next open enrollment. They stated that DACA recipient enrollment would increase over time as awareness of the coverage option grew. They further stated that enrollment was limited for PY 2025 because we published the 2024 DACA rule (89 FR 39424) only 6 months before open enrollment creating a short window for outreach campaigns, and because we cancelled 2025 enrollment for DACA recipients in 19 States to comply with *Kansas v. United States*.

Furthermore, one commenter stated that the estimates in the 2025 Marketplace Integrity and Affordability proposed rule, or even the estimates from the 2024 Final Rule (89 FR 39424) of 100,000 DACA recipients enrolled in the Exchanges and 1,000 enrolled in BHPs, sum to less than $345 million, which is far less than what DACA recipients contribute annually to Federal programs in taxes which is estimated at $2.1 billion. As such, this commenter believed DACA recipients should continue to remain eligible for Exchange or BHP coverage.

Response: We appreciate these commenters' concerns regarding the estimate of 11,000 DACA recipients enrolled in QHP plans or BHPs. However, our estimate of 10,000 applicants enrolling in a QHP and 1,000 applicants enrolling in a BHP are based on data from the 2024 Open Enrollment Period. We believe data from the 2024 OEP provides a reasonable estimate of DACA recipient enrollees, as that is when the majority of eligible consumers enroll in coverage. While consumers can continue to enroll throughout the year, they will need to qualify for an SEP to enroll in coverage outside of the Open Enrollment Period – this results in fewer DACA recipients who are eligible to enroll outside of OEP. As mentioned in Section IV.B.2. and outlined by commenters, DACA recipients continue to be ineligible for coverage in nineteen

states due to a preliminary injunction in Kansas v. United States,[270] thus reducing the total number of DACA recipients enrolled in Exchange or BHP coverage. Collectively, we believe these numbers provide the most accurate representation of enrollment estimates for DACA recipients. We acknowledge that DACA recipients have valid work authorization and therefore pay taxes that fund Federal benefit programs. However, this does not impact our position that the best reading of the ACA compels us to exclude DACA recipients from the definition of lawfully present used to determine eligibility for QHP or BHP coverage.

Comment: Additionally, commenters provided detailed analysis of the negative impacts they expected this rule would have if finalized. These impacts, discussed in detail in section II.B.1. of this final rule, include decreased access to care, worsened health outcomes, increased disparities, increased reliance on uncompensated care and emergency department care, and worsened local economies. Many commenters pointed out how the provisions of this rule may negatively impact not only DACA recipients, but their families and communities as well. Commenters further noted that this rule would worsen individual market Exchange risk pools, due to DACA recipients' age and health status as compared to current Exchange enrollees, and that a weaker risk pool could result in cost increases for health insurance issuers, cost increases for hospitals, and cost increases for individuals throughout the Exchanges in the form of higher health insurance premiums.

Response: We acknowledge that these are potential negative impacts of the policy finalized in this rule. We appreciate the insight from commenters that the policy in this rule will also negatively impact the families and communities of the DACA recipients impacted by the

[270] On December 9, 2024, the United States District Court for the District of North Dakota issued a preliminary injunction in *Kansas v. United States*, Case No. 1:24-cv-00150, 2024 WL 5220178 (D.N.D. Dec. 9, 2024). As a result, DACA recipients are ineligible for Exchange or BHP coverage in nineteen states. These states are: Alabama, Arkansas, Florida, Idaho, Indiana, Iowa, Kansas, Kentucky, Missouri, Montana, Nebraska, New Hampshire, North Dakota, Ohio, South Carolina, South Dakota, Tennessee, Texas, and Virginia. All of those states except Idaho, Kentucky, and Virginia are served by the Federal Marketplace platform.

rule. We agree that it is possible that this rule could weaken the Exchange risk pools, which could result in cost increases for issuers and individuals due to higher claims costs and premiums. We are not able to quantify these potential impacts.

Comment: Commenters expressed concern that the burden estimates did not account for the economic burden the 11,000 currently enrolled DACA recipients will place on the health care system in the future without having health insurance.

Response: We acknowledge these concerns, but are not able to quantify these potential impacts.

After consideration of public comments, we are finalizing these estimates using the methodology as proposed without modifications.

3. Standards for Termination for Cause from the FFE (§ 155.220(g)(2))

As discussed in the preamble to this proposal, we are finalizing improvements to the transparency in the process for holding agents, brokers, and web-brokers accountable for noncompliance with applicable law, regulatory requirements, and the terms and conditions of their Exchange agreements. Specifically, we are finalizing the addition of text to § 155.220(g)(2) that clearly sets forth that HHS would apply a "preponderance of the evidence" standard of proof to assess potential noncompliance under § 155.220(g)(1) and to make a determination there was a specific finding or pattern of noncompliance that is sufficiently severe. Our regulatory change will put all agents, brokers, and web-brokers assisting consumers with enrollment on the FFEs and SBE-FPs on notice of the evidentiary standard we will use in leveraging our enforcement authority under § 155.220(g)(1) through (3). We believe this update will make the regulations easier to follow and more clearly articulate our enforcement process, improving transparency for agents, brokers, and web-brokers, consumers, and other interested parties.

We believe our change will have positive impacts on agents, brokers, and web-brokers. Codifying the evidentiary standard will provide agents, brokers, and web-brokers under

investigation for noncompliant behavior more transparency in the process for holding agents, brokers, and web-brokers accountable for noncompliance with applicable law, regulatory requirements, and the terms and conditions of their Exchange agreements. We anticipate agents, brokers, and web-brokers will react positively to knowing more about our enforcement processes and how we determine regulatory compliance.

We do not anticipate any impact or burdens on agents, brokers, or web-brokers stemming from our policies as we did not expand the bases under which HHS may find them noncompliant under § 155.220(g)(1) through (3) or otherwise require more from agents, brokers, and web-brokers as part of this enforcement framework; rather, we finalized clarifications to an evidentiary standard that is not explicit at present.

We sought comment on these proposed impacts and assumptions.

We did not receive any comments in response to the proposed impact estimates for this policy. For the reasons outlined in the proposed and in this final rule, we are finalizing these estimates as proposed.

4. Annual Eligibility Redetermination (§ 155.335)

We are finalizing the temporary amendment to the annual eligibility redetermination regulation to prevent enrollees from being automatically re-enrolled in coverage with APTC that fully covers their premium without taking an action to confirm their eligibility information for Exchanges on the Federal platform. Specifically, when an enrollee does not submit an application for an updated eligibility determination for the immediately forthcoming coverage year (2026) by the last day to select a plan for January 1, 2026 coverage, in accordance with the effective dates specified in § 155.410(f), and the enrollee's portion of the premium for the entire policy would be zero dollars after application of APTC through the annual redetermination process, Exchanges on the Federal platform must decrease the amount of the APTC applied to the policy, consistent with § 155.340(f), such that the remaining monthly premium owed by the

enrollee for the entire policy equals $5 for the first month and for every following month until the enrollee confirms or updates the eligibility determination. Consistent with §§ 155.310(c) and (f), enrollees automatically re-enrolled with a $5 monthly premium after APTC under this policy will be able to update their Exchange application at any point to confirm eligibility for APTC that covers the entire monthly premium, if eligible, and re-confirm their plan to thereby reinstate the full amount of APTC for which the enrollee is eligible on a prospective basis.

We require that Exchanges on the Federal platform must implement this change for annual redeterminations for benefit year 2026, with a reversion to the previous policy for benefit year 2027 and beyond. We are not finalizing this policy for State Exchanges for the reasons discussed in section III.B.3 of this preamble.

For Exchanges on the Federal platform, we estimate that 2.68 million enrollees were automatically re-enrolled in a QHP for benefit year 2025 with APTC that fully covered their premium. Given that the expanded PTC structure under the ARP and IRA expires at the end of 2025 and the number of Exchange enrollees, as well as the number of Exchange enrollees with APTC that fully covers their premium, is expected to decrease as a result,[271] we view this figure to be an upper-bound estimate of the number of enrollees with coverage through Exchanges on the Federal platform who may be affected by this temporary policy.

Regarding the benefits associated with this policy, we believe this change may lead to increased price sensitivity to premiums and premium changes among enrollees whose premiums are fully subsidized and who would be automatically re-enrolled. This is because these enrollees will now pay $5 more in net premiums per month if they do not submit an application for an updated eligibility determination from an Exchange. These enrollees will therefore be

[271] Baseline enrollment projections are presented in Tables 15 and 16 in section V.C.18. of this final rule. Enrollment among those with APTC that fully covers their premium was not projected separately but is expected to decline following the expiration of the expanded PTC structure.

incentivized to return to an Exchange, evaluate available coverage options and premiums, and make an active enrollment decision. We therefore anticipate that this policy will lead to better matches between consumers' coverage preferences and available coverage offerings in the individual market.

Comment: We received many comments expressing strong support for automatic re-enrollment as a valuable tool for maintaining continuous coverage and market stability. One commenter specifically noted that automatically re-enrolled consumers in the Washington Exchange maintain their coverage for an average of 10.3 months, compared to 9.5 months for new enrollees, demonstrating the policy's contribution to a stable risk pool.

Response: We want to reiterate that this policy maintains automatic re-enrollment while introducing a modest premium requirement to encourage active consumer engagement and participation for a specific population.

Comment: Several commenters expressed concerns about the policy's effectiveness in preventing fraud and the possibility of third-party premium payments.

Response: As noted earlier in the preamble, we are aware that some consumers have been improperly enrolled in a fully-subsidized QHP without their knowledge or consent and other consumers have remained enrolled in a fully-subsidized QHP after obtaining other coverage. This policy, as finalized (with modification), will contribute to reducing the financial stress that ineligible enrollees may experience by protecting them from accumulating surprise tax liabilities.[272]

As described earlier in this rule, § 155.220(j)(2)(iii) and (l) requires agents, brokers, and web-brokers who are assisting with consumer enrollments through the Exchanges on the Federal platform to obtain and document consumer consent before making an application or enrollment

[272] Currently, the Exchanges on the Federal platform collaborate with the IRS to prevent surprise tax liabilities when Exchanges on the Federal platform receive reports from consumers who have been improperly enrolled.

update on behalf of the consumer. Additionally, our experience investigating fraudulent or improper enrollments by agents, brokers, and web-brokers does not suggest that these entities fraudulently enrolling consumers in non-zero premium plans by paying premiums on behalf of enrollees is a common occurrence. Doing so would reduce the profit available to the agent, broker, or web-broker for the fraudulent activity, as well as increase the risk that it would be identified as fraudulent activity (for example, because an issuer could identify if payment was made using a check or credit card belonging to the agent, broker, or web-broker). Rather, improper enrollments typically involve agents, brokers, or web-brokers enrolling consumers in fully-subsidized plans without their knowledge or consent. Therefore, we believe it is appropriate to target this proposal to fully-subsidized enrollments, where we know fraudulent activity by agents, brokers, and web-brokers is most likely.

Comment: We received comments from several State Exchanges reporting different experiences with improper enrollments compared to the Exchanges on the Federal platform.

Response: We acknowledge that State Exchanges report varying experiences with improper enrollments compared to the Exchanges on the Federal platform. In recognition of these differences and the need for State flexibility, as well as the appreciably smaller estimates of improper enrollments on State Exchanges, we are not finalizing this policy for State Exchanges.

Comment: One commenter noted that it is the consumer's responsibility for managing duplicate coverage and associated tax liabilities.

Response: We agree that consumers have a responsibility to report coverage changes and to ensure they avoid excess tax liabilities upon filing their annual taxes; however, we believe implementing measures that encourage active eligibility confirmation serves both the consumer protection and program integrity goals.

Comment: Many commenters expressed concerns about potential coverage impacts and market stability.

Response: We believe the small premium requirement, combined with clear communication about how to maintain full subsidies, if eligible, will help mitigate these concerns while achieving the policy's objectives of reducing improper enrollments and protecting consumers from unexpected tax liabilities.

Regarding the potential costs associated with this policy, if some enrollees with fully-subsidized premiums are unaware of the APTC adjustments that will be made and the premium amounts that will be due because they have not submitted an application for an updated eligibility determination or decide not to pay the $5 per month premium amount, this policy, as finalized, may lead some enrollees to have their coverage terminated due to non-payment of premiums. This, in turn, can lead to adverse health outcomes for those enrollees who experience loss of coverage and a coverage gap. However, we expect the number of fully-subsidized enrollees who ultimately have their coverage terminated due to non-payment of premiums as a result of this policy will be low given the nominal expense associated with the proposed APTC adjustments and the expected reduction in enrollment associated with the expiration of the PTC eligibility expansions under the IRA.

Comment: Many commenters provided evidence about premium sensitivity among Exchange enrollees, including research showing that even nominal premium increases can affect enrollment decisions, with one commenter citing a study that indicated a 14-percent attrition rate when enrollees transition from zero-dollar to positive premiums. These commenters stated that auto-enrollment plays a significant role in maintaining a balanced risk pool. Another commenter referenced a study by the National Bureau of Economic Research that found that eliminating auto-enrollment reduced coverage by 33 percent, particularly among young, healthy, and economically disadvantaged individuals. Another commenter referenced research from the Massachusetts Exchange showing that auto-enrolled individuals typically have medical costs 44 percent below average.

Response: We acknowledge the research cited by commenters regarding premium sensitivity and its potential impact on enrollment decisions. While we previously determined that a $5 premium would be nominal enough to minimize coverage disruption, we recognize and acknowledge the evidence suggesting even small premium increases may affect enrollment patterns and risk pool composition and the potential effects this could have on enrollees and enrollment. We are finalizing the policy, with modifications described in section III.B.3 of this preamble, to achieve our program integrity objectives and believe the $5 premium will prompt enrollees to act without being cost prohibitive and balances debt consideration for low-income enrollees.

Comment: Some commenters expressed concerns regarding the potential impact on uncompensated care in the healthcare system, noting that coverage disruptions may result in increased uncompensated care, particularly as individuals who lose coverage may still require medical services but lack the means to pay for them.

Response: We acknowledge commenters' concerns. While we understand these concerns, we believe the policy's design—including clear communication about maintaining full subsidies and minimal premium requirements—will help minimize coverage disruptions. Additionally, the ability for consumers to reinstate full APTC, if still eligible, by confirming eligibility at any time provides an important safeguard against prolonged coverage gaps that could lead to uncompensated care.

Enrollees who otherwise would not have obtained an updated eligibility determination will also incur time costs associated with the need to submit an application to the Exchanges on the Federal platform to obtain an updated eligibility determination notice and confirm their plan in order to obtain a $0 premium, if they are still eligible for one.

Comment: Some commenters noted the administrative burden and potential barriers associated with requiring consumers to submit updated eligibility determinations. These

commenters raised concerns about the practical challenges consumers may face in completing this process. They noted specific barriers including limited access to technology and internet services and consumer confusion, to name a few.

Response: We acknowledge commenters' concerns. However, we would like to note that enrollees will continue to be able to update this information through the call center for Exchanges on the Federal platform. Because consumers have various ways in which they can update their eligibility information, we believe this policy will balance program integrity objectives with maintaining accessible coverage.

In the 2025 Marketplace Integrity and Affordability proposed rule, we estimated that Exchanges would incur costs to comply with this policy. Specifically, we estimated that Exchanges would need to make changes to their IT systems to be able to identify enrollees who will be automatically re-enrolled with a zero-dollar premium after annual redetermination procedures and decrease the amount of APTC applied to the policy such that the remaining premium owed by the enrollee equals $5, if the enrollee does not submit an application for an updated eligibility determination to the Exchange. We estimated that it would take the Federal Government and each of the State Exchanges 10,000 hours to develop and code the changes to their IT systems. Of those 10,000 hours, we estimated it would take a database and network administrator and architect 2,500 hours (at $103.34 per hour) and a computer programmer 7,500 hours (at $94.88 per hour). These estimates were based on past experience with similar system changes. However, as noted earlier in this preamble, we are only finalizing this policy for Exchanges on the Federal platform, and only for benefit year 2026.

We therefore estimate a burden to the Federal Government, in 2025, of 10,000 hours with an estimated cost of $969,950 ((2,500 hours × $103.34 per hour) + (7,500 hours × $94.88 per hour)). Because there will be a reversion to the previous policy for PY 2027 and beyond, the Federal Government will also incur a burden in 2026 to reverse the IT systems changes and other

technical changes made in support of this temporary policy. We expect that the burden to reverse these changes will be comparable to the burden to initiate them. Relying on the same assumptions, we therefore estimate a burden to the Federal Government in 2026 of 10,000 hours, with an estimated cost of $969,950.

We recognized the burden the proposed policy would place on State Exchanges and sought comment on the impact of this burden estimated in the proposed rule.

Comment: No comments were received specifically related to our cost estimate above; however, many commenters identified several additional implementation components to State Exchange IT systems as a result of this policy. These include new APTC calculation logic development, billing process modifications, batch auto-renewal coding changes, and enrollment reconciliation system updates.

Response: As discussed previously in this preamble, we are not finalizing this policy for State Exchanges.

Comment: We received numerous comments related to additional costs associated with customer service, outreach, and education to implement this policy. Many commenters raised concerns about operational impacts across multiple interested parties and potential downstream effects on consumer experience. Specifically, many commenters noted the potential impacts to customer service, including the increased call center volume, the need for enhanced customer service capacity, and additional staffing and training requirements. Other commenters noted challenges related to education and outreach, specifically the substantial consumer education needs, resource constraints (especially regarding Navigator funding), and complex messaging requirements across multiple interested parties. Additional administrative burden concerns focused on new notification requirements and process changes for issuers and Exchanges.

Response: We acknowledge the commenters' concerns. As discussed previously in this preamble, we are not finalizing this policy for State Exchanges. We recognize that depending on

the level of customer service, outreach, and education efforts, this policy could result in increased costs to Exchanges on the Federal platform.

Regarding the potential economic transfers associated with this policy, this policy is expected to reduce net Federal PTC spending if an enrollee's policy is terminated because the enrollee does not pay their portion of the premium.[273] The need for fully-subsidized enrollees to actively re-enroll in QHP coverage to continue with fully-subsidized coverage may also reduce improper enrollments that are not reported to CMS by consumers and reduce the likelihood that an enrollee who obtained other coverage errantly retains their current fully-subsidized QHP, which will also reduce net Federal PTC spending. These reductions represent transfers from consumers or other payers (such as providers of charity care) who would have directly or indirectly received improper APTC from the Federal Government. Lastly, this policy will reduce commission payments from issuers to agents, brokers, and web-brokers due to the expected reduction in improper enrollments of fully-subsidized enrollees by agents, brokers, and web-brokers. This represents a transfer from agents, brokers, and web-brokers to issuers. These transfer effects will be realized for PY 2026 only.

Comment: One commenter noted that the implementation requirements create additional connections between regulatory effects, as issuers must redirect resources to cover system updates, notification requirements, and premium collection processes. These administrative costs represent an indirect link from issuers to various service providers and operational entities, all of which must be managed within existing MLR requirements. The commenter argues that this effectively shifts resources from other issuer activities to administrative functions. While the $5 premium appears to be a direct transfer from PTC to direct consumer payment, the

[273] In the regulatory impact analysis, a transfer is a shift in resources from one party (for example, the government) to another (for example, individuals) for which the quantification does not reflect a change in use of resources (such as goods or services).

administrative costs create a net negative effect for issuers, as they must redirect resources to implement and maintain these new requirements without receiving offsetting revenue, which may be offset by increased premiums paid for by consumers (and potential APTC increases).

Response: We acknowledge the commenter's concerns. We understand that administrative costs create additional financial implications for issuers operating under MLR requirements. We believe that any potential broad increases in premiums and PTCs will be minimal and will be offset by the provisions of this final rule.

5. Annual Eligibility Redetermination (§ 155.335(j)(4))

We are finalizing an amendment to the automatic reenrollment hierarchy by removing § 155.335(j)(4) which currently allows Exchanges to move a CSR-eligible enrollee from a bronze QHP and re-enroll them into a silver QHP for an upcoming plan year, if a silver QHP is available in the same product, with the same provider network, and with a lower or equivalent net premium after the application of APTC as the bronze plan into which the enrollee would otherwise have been re-enrolled. These amendments will leave in place the policy to require Exchanges to take into account network similarity to current year plan when re-enrolling enrollees whose current year plans are no longer available, but would remove the re-enrollment hierarchy standards at § 155.335(j)(4) that allows Exchanges to move a CSR-eligible enrollee from a bronze QHP and re-enroll them into a silver QHP for an upcoming plan year, if a silver QHP is available in the same product with the same provider network and with a lower or equivalent net premium after the application of APTC as the bronze plan into which the enrollee would otherwise have been re-enrolled. We believe this change will improve the consumer experience by retaining consumer choice and reducing consumer confusion. In the 2025 Marketplace Integrity and Affordability proposed rule, we explained that we believe the removal of the bronze to silver crosswalk criteria in the Federal hierarchy for re-enrollment will result in some burden for Exchanges that have already implemented this policy, including for CMS as the

operator of Exchanges on the Federal platform, because it will require operational and system changes to reverse the policy including related consumer outreach. We do not anticipate that these changes will result in significant burden to issuers, because, as discussed in the 2024 Payment Notice (88 FR 25822), Exchanges were primarily responsible for the policy's implementation, though we solicited comment on that assumption.

By retaining consumer choice, we also anticipated that this policy would lead to fewer low-income bronze enrollees being switched to silver QHPs. Because these silver QHPs have higher premiums than bronze QHPs and indirectly fund CSR subsidies, they require higher APTC subsidies. Therefore, we anticipate the reduction in people being switched to silver QHPs will reduce APTC expenditures. We are not able to quantify the reduction in APTC expenditures because we do not expect the current policy would have led to a substantial number of people switching from a bronze QHP to a silver QHP during the 2026 OEP. Therefore, we anticipate only a small reduction in APTC expenditures.

We sought comment on the proposed impacts and assumptions, and we received some comments citing concerns about persisting consumer confusion, which are further discussed in the preamble. After consideration of comments and for the reasons outlined in the proposed rule and this final rule, including our responses to comments, we are finalizing these impact estimates for this policy as proposed.

6. Failure to File and Reconcile (§ 155.305(f)(4))

We are finalizing the proposed amendments to the FTR process at § 155.305(f)(4) with a modification under which the amendments will only be effective through PY 2026. Under this modified policy, all Exchanges are required to determine a tax filer ineligible for APTC if HHS notifies the Exchange that the tax filer failed to file a Federal income tax return and reconcile APTC for any year for which tax data would be used to verify APTC eligibility for coverage year 2026 only. For PY 2027 onward, the current rule that requires Exchanges to disallow APTC

eligibility when an enrollee or their tax filer has failed to file a Federal income tax return reconciling their APTC for 2 consecutive tax years will apply. Putting the 1-year policy in place through PY 2026 only will allow Exchanges to collect data on the 1-year FTR policy. This policy will remove the current flexibility that gives tax filers 2 consecutive tax years to file and reconcile before removing APTC for coverage year 2026, while allowing for data collection to determine the correct FTR policy for coverage year 2027 and beyond. To conform with this policy, we are finalizing amending the notice requirement at § 155.305(f)(4)(i) aimed at addressing the gap in notice from giving tax filers a second consecutive tax year to comply with the requirement to file Federal income taxes and reconcile APTC received under the current policy and to remove the notice requirement at § 155.305(f)(4)(ii) that requires notification for enrollees and tax filers that are found to be in a 2-tax year FTR status for coverage year 2026, while allowing for flexibility in coverage years 2027 and beyond. We have updated the RIA for this policy due to revised wage rate and other data estimates available between the time of the 2025 Marketplace Integrity and Affordability proposed and final rule publication dates. The proposed RIA for this policy may be found at 90 FR 13011 through 13012.

Previously, we estimated the cost of giving enrollees 2 consecutive tax years to meet the requirement to file and reconcile would increase APTC expenditures by approximately $373 million per year beginning in PY 2025 for those enrollees who have not filed and reconciled for only 1 tax year and retain their APTC eligibility. In 2024, we implemented various system and logic changes to decrease and/or prevent certain agent, broker, and web-broker noncompliant conduct in an effort to mitigate unauthorized enrollments, and we have observed some improvements. Due to these recent safeguards, as well as the fact that FTR notices were provided in the Fall 2024, it is likely that the FTR population identified prior to OEP 2025 represents a peak in the FTR population. In addition, it is likely that if enhanced subsidies are not extended, the total Exchange population would most likely drop, thereby also decreasing the FTR

population. Due to these competing influences, it is difficult to determine the overall impact that this policy will have on APTC expenditures. While the current 2-tax year FTR process may inadvertently shield some unauthorized enrollments during PY 2025 for consumers who may have enrolled in Exchange coverage in PY 2023 (as most Exchange activity to mitigate unauthorized enrollments was implemented in PY 2024), the 2-tax year FTR process will catch those fraudulently enrolled consumers for PY 2026, as will this change to the FTR process. Therefore, it is likely that the APTC savings resulting from this policy change will not be derived from the enrollees who lose their APTC eligibility after being found as failing to file their income taxes and reconcile their APTC, but rather from the decrease in unauthorized enrollments that will result from other provisions of this rule that we are finalizing. Taking all of these considerations into account, we still anticipate that APTC expenditures will decrease by more than what we previously estimated due to the increase in the overall Exchange population. While we initially sent out almost 1.8 million FTR notices (both the 1-year and 2-year notices) prior to OEP 2025, our run of FTR Recheck in March 2025 has reduced this number to approximately 670,000 households that we provided notices to this spring.

Approximately 270,000 households had a 2-year FTR status after FTR Recheck, which is a decrease from the OEP of approximately 85,000 households. In addition, the total 1-year FTR population of non-filers, non-reconcilers, and extension tax-filers dropped from almost 1,500,000 prior to the OEP to less than 420,000 during FTR Recheck, a decline of over seventy percent. While a significant percentage of that population was due to the number of households whose extension to file their Federal income tax expired, both 1-year non-filers and non-reconcilers also saw significant drops in the number of households.

It is difficult to draw historically similar comparisons for multiple reasons: FTR had been inactive for three consecutive plan years prior to PY 2025 due to the COVID-19 PHE, the increase in improper enrollments, and the newly implemented 2-tax year FTR process. However,

historically, between removal of APTC at OEP and the FTR Recheck process, the overall population of enrollees that lose APTC has ranged from 18 percent to 43 percent from 2016 to 2020. On average, 30 percent of enrollees lost their APTC due to FTR between OEP and FTR Recheck. After accounting for a portion of the 420,000 households with a 1- year FTR status during FTR Recheck this year whose extension to file their Federal income tax has not expired, we estimate that approximately 210,000 current households with a 1-year FTR status will lose APTC due to FTR when Exchanges on the Federal platform revert back to a 1-year FTR policy for the 2026 coverage year. The average APTC received per consumer per month for 2024 among those receiving APTC is $548, and the average household has 1.4 consumers. Removing APTC after FTR Recheck can save up to 8 months of APTC. Therefore, it is possible that the average Federal APTC savings could be as much as $1.28 billion in 2026 (210,000 x $548 x 1.4 x 8); however, this policy change is not occurring on its own and this estimate is most likely an overstatement of the possible savings available in future years. This is due to the negative impact on enrollment of implementing the program integrity measures in the Exchange in response to unauthorized enrollment as well as the resumption of FTR noticing and termination of APTC eligibility for PY 2025. There are also other sections of this rule that will likely negatively impact the enrollment of the same population that is affected by the finalized 1-year FTR policy for coverage year 2026, as discussed further in section V.C.18. of this final rule.

This policy will support compliance with the filing and reconciling requirement under 36B(f) of the Code and its implementing regulations at 26 CFR 1.36B-4(a)(1)(i) and (a)(1)(ii)(A). By supporting greater compliance, this policy will also minimize the potential for APTC recipients to incur large tax liabilities for coverage year 2026.

Using the final notice policy for 2026 that is similar to our prior notice procedure before FTR was paused, we anticipate eligible enrollees will respond and take appropriate action to file and reconcile to maintain continuous coverage. To the extent enrollees are not aware of or

confused by the requirement to file and reconcile, enrollees would receive an indirect notice that protects FTI prior to the OEP as well as a notice at the time of FTR Recheck. The tax filer (and enrollee if they are the same person) will also receive a direct notice prior to the OEP as well as a direct notice at the time of FTR Recheck. Enrollees whose APTC is terminated as a result of the FTR process would receive an updated eligibility determination notice that contains a full explanation of appeal rights. Enrollees who appeal may request to continue receiving financial assistance during the appeal, consistent with § 155.525. We believe the notices and appeal rights protect continuity of coverage for eligible enrollees that have complied with their requirement to file an income tax return and reconcile APTC and, therefore, anticipate the proposal would continue to avoid situations where eligible enrollees become uninsured when their APTC is terminated. Because the policy will discontinue APTC for a larger number of enrollees who are not eligible, we anticipate a portion of those enrollees would drop coverage and become uninsured. This may result in costs to State and county governments and private hospitals in the form of charity care for individuals who become uninsured because of this rule and have medical emergencies.

Currently, Exchanges must send separate notices to people with 1-tax year FTR status and 2 tax years of FTR status. This policy conforms the notice process to the finalized policy by eliminating the separate notice for enrollees in their second year of FTR status for 2026. Therefore, we anticipate this policy will also reduce the burden of providing notice to enrollees with an FTR status in 2026. In the 2026 Payment Notice (90 FR 4524), we estimated that sending 2-year notices would cost the Federal Government approximately $292,000 and cost State Exchanges approximately $92,400 (cost of $0.84 per notice for FY 2025 which is based on the cost for the Exchanges on the Federal platform to send an average notice x 110,000 FTR notices) annually through 2029. With respect to costs to the Federal Government, we are not publishing specific future contract estimates in this rule because publishing those contract

estimates could undermine future contract procurements. For example, if we were to publish the projected future cost of the contracts used to provide print notifications, the Federal Government would be meaningfully disadvantaged in future contract negotiations related to Federal notice printing activities, as bidders would know how much we anticipate such a future contract being worth. We noted that this estimate could decrease specifically depending on the overall population size of the Exchange in response to whether increased subsidies are continued or not. By removing the additional year of APTC eligibility for FTR consumers in 2026, we will remove at least some of the associated noticing requirements and corresponding 2-tax year FTR population, yielding a cost savings that will provide a benefit to the Federal Government and State Exchanges for 2026.

We estimate that it will take the Federal Government and each State Exchange approximately 10,000 hours in 2025 to develop and code changes to the eligibility systems to evaluate and verify FTR status under the revised FTR process, such that enrollees are found to be FTR after 1-tax year of failing to file and reconcile their APTC. Of those approximately 10,000 hours, we estimate it would take a database and network administrator and architect 2,500 hours at $103.34 per hour and a computer programmer 7,500 hours at $94.88 per hour based on our prior experience with system changes. In aggregate for the State Exchanges, we estimate a one-time burden in 2025 of 200,000 hours (20 State Exchanges × 10,000 hours) at a cost of $19,399,000 (20 States × [(50,000 hours × $103.34 per hour) + (150,000 hours × $94.88 per hour)]) for completing the necessary updates to State Exchange eligibility systems. We are aware of one additional State that is planning to transition to a State Exchange in 2026. If they do finalize their transition, we estimate that their cost would be an additional $969,950 in 2025. For the Federal Government, we estimate a one-time burden in 2025 of 10,000 hours at a cost of $969,950 ((2,500 hours × $103.34 per hour) + (7,500 hours × $94.88 per hour)). However, Exchanges would need to revert this cost in 2026 as the provision sunsets for 2027, and we

assume the same estimates as 2025 would also apply in 2026.

We recognize the burden this policy may place on State Exchanges, and sought comment in the proposed rule on the impact of this burden and potential less burdensome alternatives that would still further the program integrity goals of this policy. The majority of State Exchanges expressed in comments that they could not make the technological changes to revert back to a 1-year FTR policy in time for OEP 2026. However, we are finalizing the effective date of the FTR policy so that all Exchanges must impose a 1-year FTR requirement beginning for PY 2026 to gather data from this plan year.

After consideration of comments and for the reasons outlined in the proposed rule and this final rule, including our responses to comments, we are finalizing these impact estimates for this policy. We summarize and respond to public comments received on the proposed estimates below.

Comment: Many State Exchanges expressed concern that implementing the 1-year policy after just switching to the 2-year policy would be costly and burdensome. They also expressed the fact that their planning for this year has already commenced, and it would be very hard to make the technical changes needed at this point for PY 2026. In addition, many State Exchanges noted that they have much lower incidences of fraud as compared to Exchanges on the Federal platform, so the return on their investment for the technical changes would not be as impactful.

Response: We appreciate the concern from these commenters. While we appreciate that State Exchanges do not currently have the levels of fraudulent activity that Exchanges on the Federal platform do, we believe that the 1-year FTR policy will also help to ensure that there is less of a risk of fraud in coverage year 2026. As mentioned above, we believe that the potential costs of paying APTC to those who have not filed and reconciled for a second consecutive tax year outweigh the benefits for State Exchanges.

7. 60-Day Extension to Resolve Income Inconsistency (§155.315(f)(7))

We are finalizing the removal of § 155.315(f)(7) which requires that applicants must receive an automatic 60-day extension in addition to the 90 days currently provided by § 155.315(f)(2)(ii) to allow applicants sufficient time to provide documentation to verify any DMI, including income inconsistencies. Using previous costs associated with implementing this policy and similar policies, we anticipate that taking out this extension will result in a one-time cost of approximately $500,000 to Exchanges. For the 19 State Exchanges, we anticipate this will be a total cost of approximately $9,500,000 ($500,000 x 19). We recognize the burden this policy may place on State Exchanges and sought comment in the 2025 Marketplace Integrity and Affordability proposed rule on the impact of this burden and potential less burdensome alternatives that would still further the program integrity goals of this policy.

By reducing the period to provide documentation to verify income from 150 days to 90 days, we anticipate households using the Exchanges on the Federal platform to experience a reduction in the number of months they receive APTC, and that, using our internal analysis of historical enrollment and DMI data, approximately 140,000 enrollees will lose APTC eligibility. For State Exchanges, we also anticipate households may experience a reduction in the number of months they receive APTC, resulting in approximately 86,000 enrollees losing APTC eligibility. In total, using the average monthly APTC amount of $588.07 and 2 months reduced APTC, this will result in approximately $266 million (140,000 x $588.07 x 2 + 86,000 x $588.07 x 2) less APTC expenditures annually across all Exchanges.

In the proposed rule, we sought comments on whether this number may be slightly less because of potential decreased enrollment if the enhanced PTC are no longer in effect.

We did not receive any comments in response to the proposed impact estimates for this policy. For the reasons outlined in the final rule, we are finalizing these estimates as proposed.

8. Income Verification When Data Sources Indicate Income Less Than 100 Percent of the FPL (§ 155.320(c)(3)(iii))

This final rule amends § 155.320(c)(3)(iii) to create annual income DMIs when applicants attest to income that would qualify the taxpayer as an applicable taxpayer per 26 CFR 1.36B-2(b), but trusted data sources show income below 100 percent of the FPL. We are finalizing this policy to become effective on the effective date of this rule, but with a modification under which the policy and related requirements will sunset for all Exchanges at the end of PY 2026. Thereafter, this policy will no longer be effective. We have updated the RIA for this policy due to revised wage rate and other data estimates available between the time of the proposed and final rule publication dates. The proposed 2025 Marketplace Integrity and Affordability RIA for this policy may be found at 90 FR 13013.

As discussed further in section IV.D. of this proposed and the final rule, we estimate an approximate increase in burden costs of $20.2 million for the Federal Government and $12.4 million in 2026 for State Exchanges to receive, review, and verify submitted verification documents as well as conduct outreach and determine DMI outcomes for applicants below 100 percent of the FPL, as well as approximate one-time costs in 2025 to update the eligibility systems and perform other technical updates for this change of $775,960 for the Federal Government and $14,743,240 for State Exchanges. Exchanges would incur the same one-time costs at the time of sunsetting this policy at the end of 2026, resulting in a one-time burden of $775,960 to the Federal Government and $14,743,240 to State Exchanges in 2026 as well. Finally, as also discussed further in section IV.D. of this final rule, we estimate an increase in burden of $13,179,400 across all Exchanges in 2026 for consumers to submit documentation to fulfill income verification requirements. We recognize the burden this policy may place on State Exchanges and sought comment in the proposed rule on the impact of this burden and potential less burdensome alternatives that would still further the program integrity goals of this policy.

By reducing the number of applicants who inflate income to qualify for APTC and the opportunities for improper enrollments, we anticipate this policy will substantially reduce

Federal APTC expenditures. Based on our analysis of enrollment data from DMI generation numbers from when this DMI was previously in place, we estimate creating DMIs that require additional verification will reduce the number of people who receive APTC by 50,000 for Exchanges on the Federal platform. We estimate the reduction of people who receive APTC in the State Exchanges to be 31,000. Using an estimated average four months reduced APTC and an average monthly APTC rate of $588.07 per person, we estimate total APTC expenditures will be reduced by approximately $191 million in 2026 (50,000 x $588.07 x 4 + 31,000 x $588.07 x 4).

We also anticipate that stronger income verification standards will increase Federal and State Medicaid expenditures by enrolling more people in Medicaid who, by intentionally or unintentionally overestimating their annual household income and being unable to verify that overestimated income, would otherwise have enrolled in APTC subsidized coverage. We do not have the data necessary to provide specific estimates on the increase in Medicaid expenditures and sought comment in the proposed rule on the data sources we could use to further this analysis.

We anticipate the stronger income verification standards would have only a minimal impact on the number of eligible tax filers who enroll in APTC subsidized coverage. Although we acknowledge that income verification can be more challenging for lower-income tax filers due to less consistent employment, our experience with income verifications suggests the process does not impose a substantial burden. Moreover, the generosity of the subsidy for lower-income households creates a strong incentive for applicants to follow through and meet the verification requirements.

We sought comment on the proposed impacts and assumptions.

After consideration of comments and for the reasons outlined in the proposed rule and this final rule, including our responses to comments, we are finalizing this policy to become effective upon the effective date of this rule, but with a modification under which the policy and

related requirements will be sunset for all Exchanges at the end of PY 2026. Thereafter, this policy will no longer be effective. We also made modifications to account for general updated occupational costs in this rule. We summarize and respond to public comments received on the proposed estimates below.

Comment: Many State Exchanges, as well as other commenters, expressed concerns with the burden this would place on their Exchanges. They emphasized that the program integrity gains that may justify this burden would be extremely minimal to non-existent, given that they have identified improper income estimates to the same extent as Exchanges on the Federal platform. Many State Exchanges pointed out that they already have implemented robust additional income verification processes, including leveraging additional income data sources, that make real-time verification of income much more effective. Finally, some State Exchanges stated they simply do not have the resources to implement and maintain this policy currently. Given this, State Exchanges and other commenters requested that we make this policy optional for State Exchanges.

Response: We acknowledge the commenters' concerns. However, we believe the program integrity concerns, which, while potentially less in number, are still present in State Exchanges including those that have expanded Medicaid, that this policy attempts to address outweigh the cost and burdens to Exchanges. Additionally, because this policy will sunset after PY 2026, the costs and benefits outlined in this rule will only occur for the reminder of PY 2025 after this rule's effective date and for PY 2026.

9. Income Verification When Tax Data is Unavailable (§ 155.320(c)(5))

We are finalizing the removal of § 155.320(c)(5) which requires Exchanges to accept an applicant's income attestation without further verification when tax return data is unavailable. We are finalizing this with a modification under which § 155.320(c)(5), which this final policy is removing upon the effective date of this rule, will be reinstated for all Exchanges at the end of

PY 2026. As further discussed in section IV.E. of the proposed and this final rule, we estimate an increase in burden costs of approximately $102.3 million for the Federal Government and approximately $62.8 million total for State Exchanges in 2026 to receive, review, and verify submitted verification documents as well as conduct outreach and determine DMI outcomes for applicants whose tax return data is unavailable, as well as approximate one-time costs to update the eligibility systems and perform other technical updates for this change of approximately $872,955 for the Federal Government and approximately $16.6 million total for State Exchanges in 2025. These costs would also be incurred at the sunset of this program at the end of 2026, resulting in a one-time burden of $872,955 to the Federal Government and approximately $16.6 million total State Exchanges in 2026 as well. As also further discussed in section IV.E. of this proposed and this final rule, we also estimate an increase in burden of $66,778,850 for consumers in 2026 to submit documentation to fulfill income verification requirements associated with this proposal. We recognize the burden this policy may place on State Exchanges, and in the proposed rule sought comment on the impact of this burden and potential less burdensome alternatives that would still further the program integrity goals of this policy.

The prior alternative verification process for applicants without tax return data in place from 2013 to 2023 provided a basic, frontline protection against improper APTC payments. Based on our analysis of enrollment data from DMI generation numbers from when this DMI was previously in place, as well as historical enrollment data, we estimate creating DMIs that require additional verification will result in a decrease in APTC, potentially to zero, for 252,000 enrollees for Exchanges on the Federal platform and 155,000 enrollees on State Exchanges. Using an estimated average 4 months reduced APTC and with an average monthly APTC rate of $588.07 per person, we anticipate that this change could result in a reduction of $957 million (252,000 x $588.07 x 4 + 155,000 x $588.07 x 4) in APTC expenditures in 2026. We accept

comments on whether this number may be slightly less because of potential decreased enrollment if the enhanced PTC are no longer in effect.

Although reintroducing income verification for applicants with no tax return data will increase the burden on some applicants, we do not anticipate this burden will deter many eligible people from enrolling.

We sought comment on the proposed impacts and assumptions.

We did not receive any comments in response to the proposed impact estimates for this policy. We are finalizing these estimates with modifications as noted earlier in this section related to updated general occupational estimated costs as well as reinstating the policy as outlined in § 155.320(c)(5) for all Exchanges after the completion of PY 2026 on December 31, 2026.

10. Premium Payment Threshold (§ 155.400(g))

We are finalizing modifications to § 155.400(g) to remove paragraphs (2) and (3), which establish an option for issuers to implement a fixed-dollar and/or gross percentage-based premium payment threshold (if the issuer has not also adopted a net percentage-based premium threshold), and modify § 155.400(g) to reflect the removal of paragraphs (2) and (3), with the following modification: the removal of the fixed-dollar and gross-premium threshold flexibilities will sunset after the completion of one new coverage year, PY 2026, on December 31, 2026. Thereafter, the FFE and SBE-FPs will, and State Exchanges may, offer issuers the flexibility to implement the premium payment thresholds outlined in the 2026 Payment Notice (90 FR 4424). Removing the options for issuers to implement either a fixed-dollar and/or gross percentage will help address program integrity concerns by ensuring that enrollees cannot remain enrolled in coverage for extended periods of time without paying any premium, increasing the likelihood that consumers who were improperly enrolled become aware of their enrollment.

We anticipate that there will be some costs for issuers in PY 2026 who had already implemented a fixed-dollar or gross premium percentage-based threshold and will have to

remove those policies or replace them with the remaining net premium percentage-based thresholds.

Since these threshold policies are optional, we do not know how many issuers adopted them. In the 2026 Payment Notice, we estimated that based on a fixed-dollar threshold of $10 or less, utilizing PY 2023 counts of 135,185 QHP policies terminated for non-payment where the enrollee had a member responsibility amount of $0.01-$10.00, with an average monthly APTC of $604.78 per enrollee (for PY 2023), that would at most result in a one-time APTC payment of $817,571,843 in 2026 for 10 months that excludes the binder payment and first month of the grace period (for which the issuer already received APTC and would not have to return it) that issuers would retain, rather than being returned to the Federal Government. We now estimate that this cost will not be incurred in 2026 with the removal of the fixed-dollar and gross premium percentage-based thresholds.

We sought comment on the proposed impacts and assumptions.

We did not receive any comments in response to the proposed impact estimates for this policy. For the reasons outlined in the final rule, we are finalizing these estimates as proposed.

11. Annual Open Enrollment Period (§ 155.410(e) and (f))

We are finalizing amendments to § 155.410(e)(5) with a modification to change the annual OEP for PY 2027 and beyond to begin no later than November 1 and end no later than December 31 of the calendar year preceding the benefit year. Additionally, paragraph (e)(5)(ii) specifies that the Exchange OEP has a maximum length of 9 weeks. Newly added paragraph (f)(4) ensures that all OEP enrollees have full year coverage effective January 1 of the plan year beginning in benefit year 2027. This is expected to have a positive impact on the risk pool by reducing the risk of adverse selection. Although we cannot quantify Federal savings, by reducing adverse selection, we expect premiums will decline and, in turn, reduce the cost of PTC to the Federal Government. Lower premiums may also increase enrollment among unsubsidized

consumers and help lower the uninsured rate. In addition, we expect a higher proportion of Exchange enrollees to be covered continuously for the full year beginning in January.

While the final rule does provide flexibility for Exchanges, 19 of 20 of the State Exchanges would need to shorten their OEP because their OEPs for PY 2025 either extended past December 31 or exceeded 9 weeks in duration. We estimated in the 2025 Marketplace Integrity and Affordability proposed rule that it would take the Federal Government and each impacted State Exchange 4,000 hours to develop and code the changes to their IT systems. Of those 4,000 hours, we estimated it would take a database and network administrator and architect 1,000 hours and a computer programmer 3,000 hours. The median wage rates used in the proposed rule were $101.66 per hour for a database and network administrator and architect and $95.88 per hour for a computer programmer. The median wage rates used for our estimates were updated after the proposed rule was published to reflect the latest available rates. In this final rule, we use the updated median wages of $103.34 per hour for a database and network administrator and architect and $94.88 per hour for a computer programmer for the final rule as discussed in section IV.A. of this final rule. We did not expect States operating SBE-FPs to incur any implementation costs. These estimates were based on past experience with similar system changes.

For the Federal Government, we estimate a one-time burden in 2026 of 4,000 hours at a cost of $387,980 (1,000 hours × $103.34 per hour) + (3,000 hours × $94.88 per hour), which is a decrease from the proposed rule's estimate of $389,300. In aggregate, for State Exchanges, we estimate a one-time burden in 2026 of 76,000 hours (19 State Exchanges × 4,000) at a cost of $7,371,620 (19 States × [(1,000 hours × $103.34 per hour) + (3,000 hours × $94.88 per hour)]), which is a decrease from the proposed rule's estimate of $7,786,000. In total, the burden associated with all system updates would be 80,000 hours at a cost of $7,759,600, which is a decrease from the proposed rule's estimate of $8,175,580. We recognized the burden that the

proposed policy would have placed on State Exchanges and modified the policy while keeping intact its impact on program integrity.

We did not anticipate that the change to the OEP end date would have a negative impact on enrollment or the consumer experience due to the maturity of the enrollment systems. This change is expected to simplify operational processes for the Exchanges by eliminating the burden of supporting an extra month of open enrollment and addressing consumer confusion related to administering two enrollment deadlines. Lower administrative costs may also contribute to lower premiums, but we noted that there also may be administrative costs for issuers and Exchanges associated with an increase in SEP casework. Consumers will benefit from clearer enrollment rules that will encourage all annual enrollment activities to be complete by a December OE end date and therefore ensure coverage for the month of January. The Federal Government, State Exchanges, and issuers may incur costs if additional consumer outreach is needed to educate people on the new policy. However, this should be temporary and largely offset by the elimination of the ongoing outreach necessary to educate people on the second January 15 deadline.

We sought comment on the proposed impacts and assumptions. After consideration of comments and for the reasons outlined in the proposed rule and this final rule, including our responses to comments, we are finalizing these impact estimates for this policy with the following modifications. As stated above, the new OEP dates will apply for PY 2027 instead of PY 2026, and we are allowing Exchanges to adopt their preferred OEP dates subject to timing and durational parameters. This delay and flexibility is aimed at mitigating the operational burden and consumer experience and timeline concerns expressed by commenters, including State Exchanges. Because comments on these estimates were combined with general comments on this policy, we summarize and respond to public comments received on the proposed estimates in section III.B.7. of this final rule.

12. Monthly SEP for APTC-Eligible Qualified Individuals with a Projected Annual Household Income at or Below 150 Percent of the Federal Poverty Level (§ 155.420(d)(16))

We are finalizing the removal of § 155.420(d)(16) and pausing the 150 percent FPL SEP for all Exchanges only until the end of PY 2026. This includes making conforming changes to regulations established to support this SEP, including removing §§ 147.104(b)(2)(i)(G), 155.420(a)(4)(ii)(D), and 155.420(b)(2)(vii), as well as amending § 155.420(a)(4)(iii) introductory text.

As discussed in this final rule, the expanded availability of fully-subsidized plans combined with easier access to these fully-subsidized plans through the 150 percent FPL SEP (which allows people to enroll in fully-subsidized plans at any time during the year) opened substantial opportunities for improper enrollments. As discussed earlier in preamble, recent litigation from April 2024, *Turner v. Enhance Health, LLC,* higher numbers of consumer complaints, and a sharp increase in enrollment relative to the eligible population with household income under 150 percent of the FPL in PY 2024 all suggest a substantial increase in improper enrollments among consumers reporting incomes between 100 and 150 percent of the FPL on their application. We are working hard to reduce the level of improper enrollments, and we believe that these efforts necessitate repealing the 150 percent FPL SEP. However, we acknowledge that it is challenging to predict the level of improper enrollments in future years, as we are still in the process of taking enforcement actions to reduce the initial spike in improper enrollments that occurred after we established the 150 percent FPL SEP.

We believe that pausing the 150 percent FPL SEP will reduce adverse selection and, as a result, reduce premiums. Previous rulemaking projected the 150 percent FPL SEP would increase premiums by 0.5 to 2 percent with enhanced premium subsidies in place and projected the SEP would increase premiums from 3 to 4 percent if the enhanced premium subsidies expire. Based on our analysis of recent enrollment data, we believe these previous estimates underestimated the

premium impact and overestimated the enrollment impact of the 150 percent FPL SEP. As discussed in the preamble, we believe that the 150 FPL SEP has substantially increased the level of improper enrollments, as well as increased the risk for adverse selection as this SEP incentivizes consumers to wait until they are sick to enroll in Exchange coverage. Unknown factors continue to make these impacts difficult to estimate, including the utilization of this SEP by healthy and unhealthy enrollees and the impact to the average duration of coverage for enrollees. However, we estimate pausing this SEP could decrease premiums by 3 to 4 percent compared to baseline premiums, and therefore decrease annual APTC outlays by approximately $3.4 billion in 2026. In the proposed rule, we sought comment on how this policy would impact premiums and APTC/PTC outlays.

However, quantifying the impact of the 150 percent FPL SEP on enrollment remains difficult to estimate. Although we can quantify the number of people who enroll through this SEP, the enrollment impact is likely less than the number of people who use the SEP. Some people may use this SEP as an alternative to an SEP they would have otherwise used. Without this SEP, consumers may have otherwise enrolled through the OEP. The substantial level of improper enrollments associated with fully-subsidized plans also obscures the number of eligible individuals who used the SEP.

For these reasons, and for the reasons outlined in section III.B.8. of this final rule, we are finalizing that this SEP will be paused through the end of PY 2026.

To repeal the monthly 150 percent FPL SEP, we estimated a one-time cost of approximately $387,980 to pause the functionality to grant the 150 percent FPL SEP and make any necessary updates to eligibility logic systems for Exchanges on the Federal platform. This is based on our estimate that it will take the Federal Government 4,000 hours in 2025 to remove the SEP. Here, we are assuming that 25 percent of the hours needed to end the 150 percent FPL SEP are being performed by a database and network administrator (hourly wage of $103.34) and 75

percent of the work is being performed by a computer programmer (hourly wage of $94.88). This estimate was informed by our experience with past system changes.

We sought comment on this proposed impact.

Because we are sunsetting the repeal of the 150 FPL SEP after PY 2026, we estimate a new additional one-time cost of $387,980 for Exchanges on the Federal platform to reinstate the 150 percent FPL SEP for years after PY 2026. This is based on our estimate that it will take the Federal Government 4,000 hours in 2026 to reinstate the SEP. Here, we are assuming that 25 percent of the hours needed to end the 150 percent FPL SEP are being performed by a database and network administrator (hourly wage of $103.34) and 75 percent of the work is being performed by a computer programmer (hourly wage of $94.88). This estimate was informed by our experience with past system changes.

We estimate a new one-time cost for State Exchanges that operate their own eligibility and enrollment systems and currently offer the 150 percent FPL SEP to pause the SEP. Based on public comments received, we believe that 18 State Exchanges are currently offering the 150 percent FPL SEP or other income-based SEPs that would need to be discontinued. We estimate a one-time cost in 2025 of approximately $387,980 for each of these 18 State Exchanges to pause the functionality granting the 150 percent FPL SEP and make any necessary updates to State Exchange eligibility logic systems. This results in a total cost of $6,983,640 for State Exchanges to pause the 150 percent FPL SEP in 2025. This is based on our estimate that it will take each State Exchange 4,000 hours in 2025 to pause the SEP. Here, we are assuming that 25 percent of the hours needed to end the 150 percent FPL SEP are being performed by a database and network administrator (hourly wage of $103.34) and 75 percent of the work is being performed by a computer programmer (hourly wage of $94.88). This estimate was informed by our experience with past system changes.

We also estimate a new one-time cost for State Exchanges that operate their own eligibility and enrollment systems and currently offer the 150 percent FPL SEP to reinstate the SEP after PY 2026. We assume that all 18 State Exchanges that currently offer the 150 percent FPL SEP will elect to reinstate it once the pause of this SEP sunsets at the end of 2026. We estimate a one-time cost in 2026 of approximately $387,980 for each of the 18 State Exchanges currently offering the SEP to reinstate their functionality to grant the 150 percent FPL SEP and make any necessary updates to State Exchange eligibility logic systems. This results in a total cost of $6,983,640 for State Exchanges to reinstate the 150 percent FPL SEP. This is based on our estimate that it will take each State Exchange 4,000 hours in 2026 to reinstate the SEP. Here, we are assuming that 25 percent of the hours needed to end the 150 percent FPL SEP are being performed by a database and network administrator (hourly wage of $103.34) and 75 percent of the work is being performed by a computer programmer (hourly wage of $94.88). This estimate was informed by our experience with past system changes.

After consideration of comments and for the reasons outlined in the proposed rule and this final rule, including our responses to comments, we are finalizing these impact estimates for this policy with the addition of SEP reinstatement costs and State Exchange costs. We summarize and respond to public comments received on our proposed estimates below.

Comment: Commenters from local and State governments expressed that nearly all State Exchanges currently offer the 150 percent FPL SEP or income-based SEPs with higher income thresholds. The commenter expressed concerns about the resources needed for IT and messaging campaign changes for State Exchanges to dismantle these SEPs. They stated that requiring State Exchanges to terminate the 150 percent FPL SEP within 60 days of the final rule would impose major costs, and failure to account for these costs makes the proposal arbitrary and capricious under the APA.

Response: We appreciate the commenters' concerns regarding the repeal of the 150 percent FPL SEP and the timeline for Exchanges to implement this policy change, however, we are finalizing to pause the availability of 150 percent FPL SEP for PY 2026. We believe that this policy change and timeline are critical to protect all Exchanges from fraudulent activity and to ensure that only consumers who are eligible to receive APTC continue to do so. We also wish to reiterate that we do not consider having a low income to meet the definition of an exceptional circumstance per § 155.420(d)(9); therefore, State Exchanges are not permitted to use exceptional circumstances SEP authority to continue to offer a 150 percent FPL-like SEP, or any SEPs based on income for that matter. In response to not accounting for the full costs for State Exchanges, we have updated the estimates in this proposal.

Comment: One commenter expressed specific concerns regarding the methodology that HHS used to estimate the premium impacts of the proposal to rescind the 150 percent FPL SEP. The commenter expressed confusion about how HHS arrived at the assumption that removing the current monthly SEP for people with incomes below 150 percent of the FPL would reduce premiums by 3.4 percent. The commenter stated that in the preamble of the proposed rule, HHS referenced a prior estimate that the monthly SEP policy would result in premium increases of 3 to 4 percent in the absence of the IRA subsidies, then provided a revised range of 0.5 to 3.6 percent based on more recent data. Then, however, in the regulatory impact analysis, HHS reverted to the discarded 3 to 4 percent estimate, before adopting 3.4 percent as a point estimate. The commenter asked for clarification as to how HHS arrived at this point estimate.

Response: We appreciate the commenter bringing this discrepancy to our attention, and we would like to clarify we believe pausing the current monthly SEP for people with incomes below 150 percent of the FPL will result in premiums being 3 to 4 percent lower than they would be if the SEP were to remain in place. A point estimate of 3.4 percent is used in the RIA. With the expiration of enhanced subsidies, enrollees at this income level will see an increase in net

premiums for the same coverage they can receive currently at $0 net premium. The ability to enroll in Exchange coverage every month creates an incentive for healthy enrollees to forego health insurance coverage and wait to enroll when they believe they will need coverage. We estimated the SEP would decrease the average number of months of enrollment from 10 months to around 9 months with minimal reduction in program costs, since these enrollees would be enrolled when they needed coverage. Overall, the expected claims impact and shift in average months of enrollment is estimated at 3.4 percent of premium. Pausing this provision is expected to have the opposite impact and reduce premiums by 3.4 percent for 2026. We believe this premium reduction will wear off with the sunset of this provision and have accounted for this in the RIA.

13. Pre-Enrollment Verification for Special Enrollment Periods (§ 155.420)

We are finalizing amendments to § 155.420(g) to require Exchanges on the Federal platform to conduct pre-enrollment eligibility verification for SEPs. Specifically, we are finalizing the removal of the limit on Exchanges on the Federal platform to conducting pre-enrollment verifications for only the loss of minimum essential coverage SEP. With this limitation removed, we are finalizing conducting pre-enrollment verifications for most categories of SEPs for Exchanges on the Federal platform in line with operations prior to the implementation of the 2023 Payment Notice.

We are also finalizing the requirement that Exchanges on the Federal platform conduct pre-enrollment SEP verification for at least 75 percent of new enrollments through SEPs for consumers not already enrolled in coverage through the applicable Exchange. We are finalizing that Exchanges must verify at least 75 percent of such new enrollments based on the current implementation of SEP verification by Exchanges. We have updated the RIA for this policy due to revised wage rates and other data estimates available between the time of the proposed and final rule publication dates. The proposed RIA for this policy may be found at 90 FR 13016

through 13017.

Both of the proposals outlined in this section will sunset by their terms after the completion of one new coverage year, PY 2026, on December 31, 2026. We are declining to finalize these provisions for State Exchanges.

We anticipate that revisions to § 155.420 will have a positive impact on program integrity by verifying eligibility for SEPs. Increasing program integrity through this policy will reduce improper subsidy payments and could contribute to keeping premiums low and therefore, further protecting taxpayer dollars. This policy may deter enrollments among younger people at higher rates, which could worsen the risk pool and increase premiums. However, we expect any such deterrence will impact a very small number of young people and, therefore, have only a minimal impact on the risk pool and premiums. We estimate that the net effect of pre-enrollment verification will reduce premiums by approximately 0.5-1.0 percent for PY 2026 and will reduce APTC spending by approximately $105.4 million.[274]

We anticipate this policy will moderately increase the regulatory burden on Exchanges using the Federal platform. Based on past experience, we estimate that the expansion in pre-enrollment verification to most individuals seeking to enroll in coverage through all applicable SEPs offered through Exchanges on the Federal platform will result in an additional 293,073 individuals having their enrollment delayed or "pended" annually until eligibility verification is completed, although for the vast majority of individuals the delays would be less than 1-3 days. As discussed further in section IV.G. of this final rule, we anticipate that the expansion of SEP verification will result in increased income inconsistencies, with an associated cost increase for consumers of approximately $7,048,406 in 2026. There will also be an increase in ongoing costs

[274] The reduction in APTC was calculated by multiplying the estimated new SVIs by the previous SVI expiration rate (293,073 x .137 = 40,151) and then multiplying that number by the estimated annual APTC amount per SEP consumer (40,151 x $2,625 = $105,396,375).

for Exchanges on the Federal platform due to an increase in the number of SEP enrollments for which they must conduct verification. We estimate that the total increase in ongoing processing costs to comply with this requirement for the FFE will be approximately $11.7 million for PY 2026. Furthermore, as discussed in section IV.G. of this final rule, we anticipate that expanding verification will result in an increase in annual burden in labor costs on Exchanges using the Federal platform at a cost of $2,902,615 for PY 2026.

Additionally, we anticipate that the expansion of SEP verification will have a one-time development cost in 2025 for Exchanges using the Federal platform of $2,973,300 (30,000 hours x $99.11). This assumes that 25 percent of the hours needed to expand SEP verification are being performed by a database and network administrator (hourly wage $103.34) and 75 percent of the work is being performed by a computer programmer (hourly wage $94.88). This allocation of work between network administrator and computer programmer was informed by our experience with past system changes. We do not anticipate this policy will increase regulatory burden or costs on issuers. We sought comment on the proposed impacts and assumptions.

After careful consideration of public comments, we have decided to finalize and implement these policies with a significant modification – for Exchanges on the Federal platform, each of the rules outlined in this section will sunset by their terms after the completion of one new coverage year, PY 2026, on December 31, 2026. We are declining to finalize these provisions for State Exchanges. We summarize and respond to public comments received on the proposed adjustments to pre-enrollment SEP verification below.

Comment: States, providers, actuaries, labor groups, general advocacy groups, individuals, and one health insurance issuer expressed general concern about the burden and cost on States of implementing pre-enrollment SEP verification and expressed that States do not experience the same level of fraud cited for Exchanges on the Federal platform.

Response: We acknowledge the commenters' concerns. After careful consideration of public comments, for Exchanges on the Federal platform, each of the rules outlined in this section will sunset by their terms after the completion of one new coverage year, PY 2026, on December 31, 2026. We are declining to finalize these provisions for State Exchanges.

14. Prohibition on Covering Specified Sex-trait Modification Procedures as an EHB (§§156.115(d) and 156.400)

We are finalizing an amendment to § 156.115(d) to provide that an issuer of a plan subject to EHB requirements may not provide coverage for specified sex-trait modification procedures as an EHB beginning with PY 2026 and are finalizing the addition of a definition of "specific sex-trait modification procedure" at § 156.400. Finalization of this policy will mean that beginning with PY 2026, issuers of plans subject to EHB requirements may not provide coverage for specified sex-trait modification procedures that fall within the definition at § 156.400 as EHB. The EHB are subject to various protections under the ACA, including the prohibition on annual and lifetime dollar limits and the requirement to accrue enrollee cost sharing towards the annual limitation on cost sharing. As finalized, the prohibition on annual and lifetime dollar limits and requirement to accrue enrollee cost sharing towards the annual limitation on cost sharing will not apply to specified sex-trait modification procedures to the extent such care is included in health plans as non-EHB, including in large group market and self-insured group health plans. This includes a prohibition on covering specified sex-trait modification procedures as an EHB in the five States that currently include coverage for sex-trait modification services in their EHB-benchmark plans, as well as in States that do not have such coverage expressly mentioned in the State's EHB-benchmark plan.[275]

[275] California, Colorado, New Mexico, Vermont, and Washington EHB-benchmark plans specifically include coverage of some sex-trait modification services. Six other States do not expressly include or exclude coverage of sex-trait modification services in EHB-benchmark plans. Forty States include language that excludes coverage of sex-trait modification services in EHB-benchmark plans.

As we noted in the 2025 Marketplace Integrity and Affordability proposed rule, utilization of sex-trait modification services is low; therefore, the impact of this policy will be limited. As we noted, approximately 0.11 percent of enrollees in the EDGE data set gathered from issuers as part of the HHS-operated risk adjustment program utilized specified sex-trait modification procedures between PYs 2022 and 2023. In the aggregate, the total allowed cost of specified sex-trait modification procedures amounts to 0.08 to 0.09 percent of all claims in the EDGE data set for these years. Although EDGE does not distinguish between whether a benefit is EHB, we believe that a substantial majority of such claims are being covered as EHB by issuers submitting claims data to the EDGE server.

Given that a QHP's percentage of premium attributable to the EHB is used to determine the amount of available tax credits under the ACA, we expect an impact on the amount of available PTC. We believe, however, that finalizing a definition of specified sex-trait modification procedure at § 156.400 will help to further minimize premium impacts, since the definition adds needed clarity to what procedures cannot be covered as EHB and there will therefore be less opportunity for issuers to price for any uncertainty. Under our final policy, plans that stop covering specified sex-trait modification procedures as EHB will see premiums and PTC decrease as the generosity of plan benefit coverage decreases. Plans that decide to cover specified sex-trait modification procedures as non-EHB will see premiums rise or stay the same to account for this benefit generosity, but will see any existing PTC decrease as the benefits will no longer be covered as EHB. States that choose to mandate such coverage as a benefit in addition to the EHB will be required to defray its cost pursuant to § 155.170; in this circumstance, we expect premiums and PTCs to decrease to account for the State's defrayal obligations.

We sought comment on these proposed impacts and assumptions.

After consideration of comments and for the reasons outlined in the proposed rule and this final rule, including our responses to comments, we are finalizing these impact estimates for this policy as proposed. We summarize and respond to public comments received on the proposed estimates below.

Comment: Some commenters supported a prohibition on coverage of sex-trait modification services as an EHB because they stated it will prevent tax credits from applying to medical procedures they believe are dangerous or cosmetic in nature. One commenter incorrectly noted that costs associated with sex-trait modification services would not be borne by States if they mandate coverage. One commenter stated that an issuer's ongoing implementation costs by virtue of, for example, having to modify its claims processes and systems, will be more costly than what the issuer would reimburse providers for the sex-trait modification services themselves, if these services were covered benefits, and that such implementation costs are not minuscule.

Response: This final rule will ensure that Federal tax credits are not used to pay for services that fall under the definition of "specified sex-trait modification procedure" at § 156.400. This will better align the statutory requirement that EHB be equal in scope to those benefits provided in a typical employer plan. If a State mandates coverage of specified sex-trait modification procedures, then it will need to defray that cost to the issuer or the enrollee pursuant to § 155.170(b). Though we recognize comments that stated costs associated with specified sex-trait modification procedures are relatively minor, which aligns with the data we provided in this rule, we are not persuaded that costs associated with implementation of this policy are costlier than paying for those services themselves. Issuers offering QHPs are required to ensure that benefits that are not EHB are appropriately designated as such in their plan filings as part of QHP certification. Based on this, there is good indication issuers internally have the capability of

determining which benefits are not EHB, as evidenced by current requirements for issuers to note which benefits, if any, are not EHB, and will vary from issuer to issuer.

Regardless, we are required to adhere to the statute and believe that the policy finalized in this rule better aligns with the plain language of section 1302(b)(2)(A) of the ACA.

Comment: Several commenters opposing the proposal stated that it will increase overall healthcare costs for States and local governments, issuers, providers, and consumers as further detailed below. One commenter noted increased out-of-pocket consumer costs due to issuers dropping this coverage entirely as a result of this proposal and therefore shifting the cost for care to consumers. Other commenters noted that covering sex-trait modification services in insurance plans is cost-neutral or cost-saving as there is no actuarial basis to price sex-trait modification surgeries separately from any other type of surgery. Commenters also expressed concerns that this proposal would block consumers from accessing sex-trait modification services with the same cost-sharing and benefit design protections as the same services covered for non-sex-trait modification still included in the EHB package. Commenters also expressed concern that costs would shift to States or local governments if they want to continue to ensure sex-trait modification services are covered. Another commenter expressed concern that the proposal would increase overall costs by shifting current treatment from the community to the hospital and uncompensated care, with increased prevalence of more costly conditions, like severe depression or osteoporosis. This commenter also stated concerns that the proposal could lead to increased risk of psychiatric symptoms leading to more utilization of psychiatric services, including psychiatric hospitalizations for these patients if current treatments were no longer affordable.

Response: We acknowledge commenters' concerns that smaller issuers often have outsized costs when new requirements are put into place that apply to all issuers, because they lack economies of scale that some of their larger, nationwide counterparts may have. However,

as we have noted in other parts of the finalized rule, we believe that this final rule does not require issuers to undergo complex system builds or process changes to implement it and are not persuaded that the burden of any changes to processes and systems is a basis for not finalizing this proposal. Specifically, issuers are already required to ensure that benefits that are not EHB are appropriately designated as such in the Plans & Benefits Template completed as part of the QHP certification application and that the percentage of premium attributable to EHB is accurately reflected, so that APTC does not erroneously subsidize non-EHB. Although under this final rule, there could be services that can be covered as EHB or not as EHB depending on diagnosis, we believe that issuers should already have the capability to differentiate between these claims since they already have to make these distinctions today. For example, currently issuers must ensure that benefits that can never be EHB, such as routine non-pediatric eye exam services or non-medically necessary orthodontia pursuant to § 156.115(d), are not erroneously noted as EHB in plan filings and claims processing. We believe that what an issuer is required to do under this final policy to exclude coverage for specified sex-trait modification procedures as EHB is similar to how issuers currently handle coverage for other claims.

We do not believe that whether a benefit is neutral from an actuarial perspective has bearing on whether it should be an EHB. A benefits package is comprised of numerous benefits, some of which are neutral or even cost-saving, and some of which are not. If issuers seek to voluntarily cover specified sex-trait modification procedures as non-EHB, they would need to price the services accordingly.

We agree with commenters that for those States that wish to mandate coverage of specified sex-trait modification procedures, they will be responsible for defraying this cost pursuant to § 155.170(b). We appreciate the concerns commenters, including States, raised. However, there is nothing inherently unique about sex-trait modification services as related to the overall defrayal policy; if a State wishes to mandate a benefit that is not EHB, it must defray

the cost of that benefit, regardless of what that benefit is. This is longstanding EHB policy and furthers State flexibility to regulate their own markets and ensure coverage of benefits that are most critical in their State.

We also agree that there may be some people enrolled in plans that must cover EHB who seek specified sex-trait modification procedures who will now need to pay for the full cost out-of-pocket, unless the coverage is State-mandated or an issuer voluntarily offers such coverage. We understand that this is not what many commenters advocated for. However, this is the case with any benefit that is not EHB. The framework for EHB as established in section 1302(b)(2) of the ACA requires EHB to be "equal to the scope of benefits provided under a typical employer plan." There will necessarily be some benefits that are not EHB. This final rule better aligns coverage with the statutory requirements. We understand commenters' concerns that people seeking sex-trait modification services are often lower-income and more economically vulnerable than the general population. In defining the EHB, we have attempted to balance coverage generosity and affordability, with the realization that what makes coverage more affordable for some may in turn make certain benefits less affordable for others

We also appreciate comments that expressed concerns about costs being shifted to local governments and hospital uncompensated care. Nothing in this final rule prohibits local governments or hospitals from voluntarily funding specified sex-trait modification procedures. However, nothing in this final rule requires States or hospitals to develop programs to fund specified sex-trait modification procedures. We think that additional uncompensated care for mental health services will be minimal if any, and we reiterate that mental health services will continue to be available, including for persons with gender dysphoria and those seeking specified sex-trait modification procedures.

Comment: Several commenters objecting to the proposal agreed that utilization of sex-trait modification services procedures is low, given the small size of the population with gender

dysphoria and the fact that individual medical needs will vary. Other commenters objecting to the proposal agreed that the cost of providing sex-trait modification services is minimal in light of such low utilization. One commenter noted as evidence that some States added sex-trait modification services to their EHB-benchmark plans without exceeding the actuarial limitations imposed by HHS and that the addition of such services had negligible impact on premiums. One supporting commenter stated that the proposal would reduce overall coverage by issuers for sex-trait modification procedures, reducing complications stemming from such procedures that could still be covered as EHB, and that this would lead to a small reduction in both premiums and premium tax credits and well as improvements in the health of these enrollees.

Response: We agree with commenters that utilization of specified sex-trait modification procedures is low. As we stated in the proposed rule, less than 1 percent of the U.S. population seeks forms of sex-trait modification[276] and this low utilization is also apparent in the EDGE limited data set.[277] We agree with commenters that, as result of this low utilization, we anticipate the premium impact of this policy will be minimal. This includes only minimal cost effects to the extent this policy results in decreased complications requiring care due to fewer sex-trait modification procedures.

15. Premium Adjustment Percentage Index (§ 156.130(e))

We are finalizing a premium adjustment percentage of 1.6726771319 for PY 2026 based on the change to the premium measure for calculating the premium adjustment percentage that we are finalizing in this rule. Under § 156.130(e), we are finalizing the use of average per

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[276] *See*, Hughes, L.; Charlton, B.; Berzansky, I.; et. al. (2025, Jan. 6). Gender-Affirming Medications Among Transgender Adolescents in the US, 2018– 2022. JAMA Pediatr. 179(3):342–344. *https://jamanetwork.com/journals/jamapediatrics/fullarticle/2828427*; *see also*, Dai, D.; Charlton, B.; Boskey, E.; et. al. (2024, June 27). Prevalence of Gender-Affirming Surgical Procedures Among Minors and Adults in the US. JAMA Netw Open. 7(6):e2418814. *https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2820437*.

[277] The EDGE limited data set contains certain masked enrollment and claims data for on- and off- Exchange enrollees in risk adjustment covered plans in the individual and small group (including merged) markets, in States where HHS operated the risk adjustment program required by section 1343 of the ACA, and is derived from the data collected and used for the HHS-operated risk adjustment program.

enrollee private health insurance premiums (excluding Medigap and property and casualty insurance), instead of ESI premiums, which were used in the calculation since PY 2022, for purposes of calculating the premium adjustment percentage for PY 2026 and beyond. The annual premium adjustment percentage sets the rate of change for several parameters detailed in the ACA, including the annual limitation on cost sharing (defined at § 156.130(a)); the reduced annual limitations on cost sharing; the required contribution percentage used to determine eligibility for certain exemptions under section 5000A of the Code (defined at § 155.605(d)(2)); and the employer shared responsibility payments under sections 4980H(a) and 4980H(b) of the Code.

As explained in the 2025 Marketplace Integrity and Affordability proposed rule, our policy to use private health insurance premiums (excluding Medigap and property and casualty insurance) in the premium adjustment percentage calculation will result in a higher overall premium growth rate measure than if we continued to use ESI premiums as was used for prior plan years and in the October 2024 PAPI Guidance.[278] To further elaborate on the potential impacts of this policy change, in § 155.605(d)(2), we are finalizing a required contribution of 8.05 percent for PY 2026 using the finalized premium adjustment percentage in § 156.130 to supersede the previous required contribution of 7.70 percent for PY 2026 calculated from ESI premiums previously published in the October 2024 PAPI Guidance.[279] Pursuant to § 156.130(a)(2), we are finalizing a maximum annual limitation on cost sharing of $10,600 for self-only coverage for PY 2026 to supersede the maximum annual limitation on cost sharing of $10,150 for self-only coverage for PY 2026 calculated from ESI premiums previously published in the October 2024 PAPI Guidance.[280] The CMS Office of the Actuary estimates that the change

[278] CMS. (2024, Oct. 8). Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing, Reduced Maximum Annual Limitation on Cost Sharing, and Required Contribution Percentage for the 2026 Benefit Year. *https://www.cms.gov/files/document/2026-papi-parameters-guidance-2024-10-08.pdf*.
[279] Ibid.
[280] Ibid.

in methodology for the calculation of the premium adjustment percentage may have the following impacts between PY 2026 and PY 2030:[281]

TABLE 12: Impacts of Final Modifications to the Premium Adjustment Percentage Methodology, PYs 2026-2030

Calendar year	2026	2027	2028	2029	2030
Exchange Enrollment Impact (enrollees, thousands)	−80	−80	−80	−80	−80
Premium Impacts:					
Gross Premium Impact (%)	0%	0%	0%	0%	0%
Net Premium Impact (%)	2%	2%	2%	2%	2%
Federal Impacts:					
PTC (million, $)	−1,270	−1,340	−1,410	−1,480	−1,550
Employer Shared Responsibility Payment (million, $)	0	0	3	11	20
Total Federal Impact (million, $) *	−1,270	−1,340	−1,413	−1,491	−1,570

* Note: While the PTC impact figures are negative to signify reductions in Federal outlays, and the employer shared responsibility payment figures are positive to signify increased revenue to the Federal Government, they are totaled together to indicate savings for the Federal Government.

As noted in Table 12, we expect that the change in measure of premium growth used to calculate the premium adjustment percentage for PY 2026 may result in:

- Net premium increases of approximately $530 million per year for PY 2026 through PY 2030, which is approximately 2 percent of PY 2024 net premiums. Net premiums are calculated for Exchange enrollees as premium charged by issuers minus APTC.

- A decrease in Federal PTC spending of between $1.27 billion and $1.55 billion annually from 2026 to 2030, due to an increase in the PTC applicable percentage and a decline in Exchange enrollment of approximately 80,000 individuals in PY 2026, based on an assumption that the Department of the Treasury and the IRS will adopt the use of the same premium measure finalized for the calculation of the premium adjustment percentage in this final rule for purposes of calculating the indexing of the PTC applicable percentage and the required contribution percentage under section 36B of the Code. We anticipate that enrollment may decline by 80,000

[281] CMS Office of the Actuary's estimates are based on their health reform model, which is an amalgam of various estimation approaches involving Federal programs, ESI, and individual insurance choice models that ensure consistent estimates of coverage and spending in considering legislative changes to current law.

individuals in PY 2026, and enrollment will remain lower by 80,000 individuals in each year between 2026 and 2030 than it would if there were no change in premium measure for the premium adjustment percentage for PY 2026 and beyond.

- Increased Employer Shared Responsibility Payments of $3 to $20 million each year between 2028 and 2030.

The small increase in net premiums will reduce the number of people who qualify for fully-subsidized plans through the Exchanges. Therefore, by reducing the number of people who qualify for fully-subsidized plans, we anticipate this premium measure will reduce enrollments in APTC coverage and, in turn, reduce APTC expenditures.

Some of the 80,000 individuals estimated to not enroll in Exchange coverage as a result of the change in the measure of premium growth used to calculate the premium adjustment percentage may purchase short-term, limited-duration insurance, catastrophic coverage, or join a spouse's health plan, though some will become uninsured. Any of these transitions may result in greater exposure to health care costs, which previous research suggests reduces utilization of health care services, including unnecessary or counterproductive services.[282] However, some individuals who transition into short-term plans, catastrophic health plans, or who join their spouses' coverage may also experience an increase in health utilization because the provider

[282] Manning, W.G., Newhouse, J.P., Duan, N., Keeler, E.B., & Leibowitz, A. (1987). Health insurance and the demand for medical care: evidence from a randomized experiment. The American economic review, 251-277; Keeler, E.B., & Rolph, J.E. (1988). The demand for episodes of treatment in the health insurance experiment. Journal of health economics, 7(4), 337-367; Buntin, M.B., Haviland, A., McDevitt, R. & Stood, N. (2011). Healthcare Spending and Preventive Care in High-Deductible and Consumer-Directed Health Plans. The American Journal of Managed Care, 17(3), 222-230; Finkelstein, A., et al. (2012). The Oregon health insurance experiment: evidence from the first year. The Quarterly journal of economics, 127(3), 1057-1106; Brot-Goldberg, Z.C., Chandra, A., Handel, B.R., & Kolstad, J.T. (2017). What does a Deductible Do? The Impact of Cost-Sharing on Health Care Prices, Quantities, and Spending Dynamics. The Quarterly Journal of Economics, 132(3). 1261-1318.

networks for such plans tend to be more expansive than plans on the individual market.[283,284] This means that such individuals may be able to better access providers who can address their specific health needs. However, the increased number of uninsured may increase Federal and State uncompensated care costs and may contribute to negative public health outcomes.[285] We sought feedback from interested parties about these impacts and the magnitude of these changes in the proposed rule.

As noted previously in this final rule, the premium adjustment percentage is the measure of premium growth that is used to set the rate of increase for the maximum annual limitation on cost sharing, defined at § 156.130(a). Pursuant to § 156.130(a)(2), we finalized a maximum annual limitation on cost sharing of $10,600 for self-only coverage for PY 2026. Additionally, we finalized reductions in the maximum annual limitation on cost sharing for silver plan variations (Table 5 in section III.C.2.b. of this final rule).

We sought comment on these proposed impact estimates and assumptions related to the proposed change to the premium measure for calculating the premium adjustment percentage for PY 2026 and beyond.

After consideration of comments and for the reasons outlined in the proposed rule and this final rule, including our responses to comments, we are finalizing these impact estimates for this policy as proposed. Because comments on these estimates were combined with general comments on this policy, we summarize and respond to public comments received on these proposed estimates in section III.C.2. of this final rule.

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[283] Burns, A. et. al. (2019, Jan.) How CBO and JCT Analyzed Coverage Effects of New Rules for Association Health Plans and Short-Term Plans. Congressional Budget Office. p. 6. *https://www.cbo.gov/system/files/2019-01/54915-New_Rules_for_AHPs_STPs.pdf.*

[284] Cruz, D; Fann, G. (2024, Sept.). It's Not Just the Prices: ACA Plans Have Declined in Quality Over the Past Decade. Paragon Health Institute. *https://paragoninstitute.org/private-health/its-not-just-the-prices-aca-plans-have-declined-in-quality-over-the-past-decade/.*

[285] *See*, for example, Goldin, J., Lurie, I.Z., & McCubbin, J. (2021). Health Insurance and Mortality: Experimental Evidence from Taxpayer Outreach. The Quarterly Journal of Economics, 136(1), 1-49.

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

We are finalizing changing the de minimis ranges at § 156.140(c) beginning in PY 2026 to +2/-4 percentage points for all individual and small group market plans subject to the AV requirements under the EHB package, other than for expanded bronze plans,[286] for which we are finalizing a de minimis range of +5/-4 percentage points. We are also finalizing revisions to § 156.200(b)(3) to remove from the conditions of QHP certification the de minimis range of +2/0 percentage points for individual market silver QHPs. We are also finalizing amendments to the definition of "de minimis variation for a silver plan variation" in § 156.400 to specify a de minimis range of +1/-1 percentage points for income-based silver CSR plan variations.

As noted in the 2025 Marketplace Integrity and Affordability proposed rule, we believe that changing the de minimis ranges for standard metal level plans (except for individual market silver QHPs) will not generate a transfer of costs for consumers overall. Wider de minimis ranges will allow issuers to design plans with a lower AV than is possible currently, which will reduce the generosity in health plan coverage for out-of-pocket costs. However, we expect that issuers will, in turn, lower overall premiums. We estimate the premiums could decrease approximately 1.0 percent on average because of benefit changes issuers will make with a wider de minimis range. Lower overall premiums will have positive effects for consumers over the longer term as issuer participation increases and coverage options improved, which will attract more young and healthy enrollees into health plans, improving the overall risk pool and reducing overall costs that could mitigate any increase in consumer out-of-pocket costs.

As shown in Table 13, the policy to widen the de minimis range for individual market silver QHPs to +2/-4 percentage points will generate a transfer of costs in the short-term from

[286] Expanded bronze plans are bronze plans currently referenced in § 156.140(c) that cover and pay for at least one major service, other than preventive services, before the deductible or meet the requirements to be a high deductible health plan within the meaning of section 223(c)(2) of the Code.

consumers to the government and issuers in the form of decreased APTC, because widening the de minimis range for silver plans can affect the generosity of the SLCSP. The SLCSP is the benchmark plan used to determine an individual's PTC. A subsidized enrollee in any county that has a SLCSP that is currently at or above 70 percent AV will see the generosity of their current SLCSP decrease, resulting in a decrease in PTC.

TABLE 13: PTC Impact of +2/-4 Silver De Minimis Plan AVs, 2026-2029

Calendar Year	**2026**	**2027**	**2028**	**2029**
Change in PTC	-$1.22 billion	-$1.28 billion	-$1.33 billion	-$1.40 billion
Fiscal Year	**2026**	**2027**	**2028**	**2029**
Change in PTC	-$0.92 billion	-$1.27 billion	-$1.32 billion	-$1.38 billion

This policy, by itself, would not invalidate the cost-sharing design of any health plan an issuer currently plans to offer in PY 2026. As explained above, this policy only expands the universe of permissible plan AVs and will not preclude issuers from continuing to design plans with an AV that is closer to the middle of the applicable de minimis ranges instead of plans at the outer limits. To the extent that issuers believe that plan designs that have a particular AV will attract more enrollment, they will remain free to do so under this policy.

In addition, changing the de minimis range for standard silver plans will impact Individual Coverage Health Reimbursement Arrangements (ICHRAs), which use the Lowest Cost Silver Plan (LCSP) as the benchmark to determine whether an ICHRA is considered affordable to an employee. Under this policy, as premiums decrease, an employer will have to contribute less to an ICHRA to have it be considered affordable. This could encourage large employer use of ICHRAs because large employers need to offer affordable coverage to satisfy the employer shared responsibility provisions.

We sought comment on the proposed impact estimates and assumptions, as well as any timing considerations with its proposed implementation.

After consideration of comments and for the reasons outlined in the proposed rule and this final rule, including our responses to comments, we are finalizing these impact estimates for this policy as proposed. We summarize and respond to public comments received on the proposed estimates below.

Comment: A few commenters estimated that PTCs would decrease between $327 and $714 per year for a typical family of four as a result of this proposal.

Response: We thank these commenters for their estimates, and do not find these estimates to be incomparable to the PTC impact estimates in Table 13. Therefore, we have taken these estimates into account in deciding to finalize the widened de minimis ranges as proposed.

17. Regulatory Review Cost Estimation

Due to the uncertainty involved with accurately quantifying the number of entities that will review the rule, we assume that the total number of unique commenters on the 2025 Marketplace Integrity and Affordability proposed rule will be the number of reviewers of this final rule. We acknowledge that this assumption may understate or overstate the costs of reviewing this rule. It is possible that not all commenters reviewed the proposed rule in detail, and it is also possible that some reviewers chose not to comment on the proposed rule. For these reasons, we believe that the number of commenters to the proposed rule would be a fair estimate of the number of reviewers of this rule. We welcomed any public comments on the approach in estimating the number of entities that would review the proposed rule. We did not receive any public comments specific to our solicitation.

We also recognize that different types of entities are in many cases affected by mutually exclusive sections of this proposed rule, and therefore for the purposes of our estimate, we assume that each reviewer reads approximately 50 percent of the rule. We sought public

comments on this assumption. We did not receive any public comments specific to our solicitation.

Using the wage information from the BLS for medical and health service managers (Code 11-9111), we estimate that the cost of reviewing this final rule is $113.42 per hour, including overhead and fringe benefits.[287] Assuming an average reading speed of 250 words per minute, we estimate that it would take approximately 5.25 hours for the staff to review half of this final rule. For each entity that reviews the rule, the estimated cost is approximately $595.46 (5.25 hours x $113.42). Therefore, we estimate that the total cost of reviewing this regulation is approximately $15,493,869 ($595.46 x 26,020 reviewers).

We sought comment on the analysis in the proposed rule.

We did not receive any comments in response to the analysis in the proposed rule. Therefore, we are finalizing this analysis as presented in the preceding paragraphs.

18. Overall Impact of the Final Individual Market Program Integrity Provisions

In the regulatory impact analysis of this final rule, we include impact analyses and estimates for each policy separately, as we intend for each provision to be severable from the rest. Please see section III.F. of this final rule for a more detailed discussion on the severability of the provisions of this rule. However, we anticipate that the provisions of this final rule, while severable, may work in concert with each other and affect many of the same individuals seeking coverage through the individual health insurance market. Therefore, the overall impact of this final rule will likely be less than the simple accumulation of the individual provisions' impact analyses. To the best of our ability, we provide overall impact estimates of these provisions with respect to enrollment, premiums, and APTC, that minimize the overlap of individuals affected. These estimates use a baseline of current law such that a reduction in enrollment attributable to

[287] U.S. Bureau of Labor Statistics. (n.d.). Occupational Employment and Wage Statistics. Dep't. of Labor. *https://www.bls.gov/oes/current/oes_nat.htm.*

the expiration of enhanced PTCs in the IRA on December 31, 2025, is generally accounted for separately from these estimates, as such a reduction would not be due to the provisions in this final rule. These estimates consider the enrollment, premium, and APTC impact solely due to the provisions in this final rule, compared to what would occur if these provisions were not finalized. We have updated this analysis due to revised policies in this final rule compared to the proposals in the 2025 Marketplace Integrity and Affordability proposed rule. The proposed analysis may be found at 90 FR 13020 through 13026.

As this updated analysis shows, we expect the provisions of this final rule that sunset after PY 2026 will work to more quickly remove improper enrollments that exploited the availability of fully-subsidized coverage. The Department acknowledges, however, that there are numerous uncertainties regarding how the expiration of enhanced subsidies and the policies in this final rule will affect market conditions and coverage, especially following the sunset of certain policies finalized in this rule. Although there is data available from which we can draw reasonable conclusions regarding the causes of improper enrollments over recent years, there are many unknowns. As the Department and commenters agree, it is not possible to know with certainty which $0 premium plan enrollments were for persons who improperly took advantage of enhanced subsidies and the availability of $0 premium plans, and which represent improper exploitation of those benefits. The inability to trace the causes of potentially millions of unauthorized enrollments is exacerbated by data collection challenges and infrastructure gaps caused and identified after March 2020 when the COVID-19 public health emergency started and today when various temporary policies are still in the process of being ended and their impact understood. For instance, under the Medicaid continuous coverage requirements, States were required to maintain Medicaid enrollment for beneficiaries (who may have been otherwise eligible for Exchange coverage) and were prohibited from disenrolling consumers in limited circumstances. This policy potentially increased dual enrollments in both Medicaid and

Exchanges in prior years while the continuous coverage requirement was in place. The end of the continuous coverage requirement reasonably could have caused spikes in enrollment in $0 premium plans. These circumstances have led the Department to conclude that it is reasonable to codifying certain policies through the end of PY 2026 in response to commenter concerns. The estimates presented in this section consider the increased instability of the health care and insurance markets that resulted from these changes and the massive amounts of improper Exchange enrollments.

The estimates we present were calculated as follows. CMS Marketplace Open Enrollment Period (OEP) Public Use Files (PUFs) contain data on individual Marketplace activity, including the demographic characteristics of consumers who made a plan selection. The Integrated Public Use Microdata Series (IPUMS) USA data provides access to samples of the American population drawn from sixteen Federal censuses, including the U.S. Census Bureau's American Community Survey (ACS). A 2024 study published in the American Journal of Health Economics (AJHE) estimated and analyzed the take-up rate of Marketplace insurance in the 39 States that used Healthcare.gov by comparing confidential microdata on all FFE enrollees who selected a plan during an open or SEP and effectuated their enrollment between 2015 and 2017 with the ACS 5-year public-use microdata sample for 2013-2017.[288] This methodology was adapted in a 2024 paper by the Paragon Health Institute to calculate erroneous and improper enrollments for 2024 by comparing CMS Marketplace OEP PUF data with ACS 1-year microdata.[289] Both of these approaches use ACS data to identify the non-elderly adult population that is potentially eligible for Exchange coverage and exclude individuals who are enrolled in Medicare or Medicaid. The AJHE study additionally excludes individuals receiving health insurance through an employer or

[288] Hopkins, B. et al. (2024). How Did Take-Up of Marketplace Plans Vary with Price, Income, and Gender? American Journal of Health Economics, 11(1 winter 2025). Retrieved from *https://doi.org/10.1086/727785.*
[289] Blase, B. & Gonshorowski, D. (n.d.). The Great Obamacare Enrollment Fraud. Retrieved from *https://paragoninstitute.org/private-health/the-great-obamacare-enrollment-fraud/.*

TRICARE. There are also methodological differences between the two studies in how income eligibility for subsidized Exchange coverage is determined with the AJHE study estimating and imputing modified adjusted gross income (MAGI) for ACS survey respondents. We have carefully considered both these sources and used the Paragon Health Institute methodology in the following analysis as a way to quantify erroneous and improper enrollments using CMS Marketplace OEP PUFs data and IPUMS USA data using the best available data.

The analysis in Table 14 below compares sign-ups during the OEP for people with expected income between 100 and 150 percent of the FPL by State to the number of State residents in this income range who are eligible for Exchange coverage for the years 2019, 2023, and 2024. The number of plan selections on the Exchanges among people with expected incomes between 100 and 150 percent of the FPL are from the CMS Marketplace OEP PUFs data.[290] This information is based on the consumer's attestation of income for those who actively submitted an application for coverage for the specified plan year. For PYs 2023 and 2024, it reflects verified data on the prior year's income for those consumers who were auto re-enrolled without actively submitting an application for the current plan year.[291] The number of State residents in the 100 to 150 percent of the FPL income range who are potentially eligible for Exchange coverage in each year is estimated using the 2019 and 2023 1-year ACS files from IPUMS USA.[292] State residents ages 19-64 with household incomes between 100 and 150 percent of the FPL who are not enrolled in Medicaid or Medicare are considered potentially eligible for Exchange coverage. This follows a methodology used in prior research and excludes children age 18 and under who are eligible for Medicaid or the Children's Health Insurance Program (CHIP) if their incomes are in

[290] Marketplace Products. (n.d.). Retrieved from https://www.cms.gov/data-research/statistics-trends-and-reports/marketplace-products.
[291] Public Use Files: Definitions. (2024). Retrieved from *https://www.cms.gov/files/document/2024-public-use-files-definitions.pdf*; *https://www.cms.gov/files/document/2023-public-use-files-definitions.pdf.*
[292] Ruggles, S., et al. (2023). IPUMS USA: Version 15.0 [dataset]. Retrieved from *https://www.ipums.org/projects/ipums-usa/d010.V15.0*.

this range,[293] as well as adults ages 65 and older who are likely eligible for Medicare.[294] Because the 2024 ACS microdata is not yet available, the number of individuals potentially eligible for Exchange coverage in this income range for each State during 2024 was estimated by applying State-level estimates of population change from 2023 to 2024 from the United States Census Bureau to the 2023 ACS estimates.[295] This adjustment assumes that changes in population within the 100 to 150 percent of the FPL range are similar to those within the State and ignores any potential distributional changes. Minnesota, New York,[296] and Oregon were excluded from the analysis due the presence of a BHP for low-income residents during at least part of the analysis period.[297] The District of Columbia was excluded from the analysis due to insufficient income information available in the OEP PUF. In addition, a 2019 estimate for Idaho is not reported due to unavailable income information in the OEP PUF for this year.[298]

The comparisons presented in Table 14 include columns that calculate the take-up of Exchange coverage by dividing Exchange enrollment for each State by the corresponding estimate of eligible State residents from the ACS and multiplying by 100. While these estimates are useful for understanding trends in Exchange enrollment over time and different patterns of enrollment across States, they should not be interpreted as precise measures of take-up of Exchange coverage for several reasons. First, this methodology relies on 1-year samples of the ACS to estimate eligible State populations, which provides a current portrait of residents meeting

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[293] Medicaid/CHIP Upper Income Eligibility Limits for Children, 2000-2024. (n.d.). Retrieved from *https://www.kff.org/medicaid/state-indicator/medicaidchip-upper-income-eligibility-limits-for-children/.*
[294] Blase, B. & Gonshorowski, D. (n.d.). The Great Obamacare Enrollment Fraud. Retrieved from *https://paragoninstitute.org/private-health/the-great-obamacare-enrollment-fraud/.*
[295] State Population Totals and Components of Change: 2023-2024[Vintage 2024]. *https://www.census.gov/data/tables/time-series/demo/popest/2020s-state-total.html#v2024.*
[296] New York operated a BHP from April 1, 2015, through April 1, 2024. *See https://www.medicaid.gov/basic-health-program.*
[297] Basic Health Program. (n.d.). Retrieved from *https://www.medicaid.gov/basic-health-program/index.html.*
[298] Public Use Files: Definitions. Retrieved from *https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/marketplace-products/downloads/2019publicusefilesdefinitions-.pdf*; *https://www.cms.gov/data-research/statistics-trends-and-reports/marketplace-products/2019-marketplace-open-enrollment-period-public-use-files.*

the 100 to 150 percent of the FPL criteria in each year but leads to less precise estimates than the use of multi-year ACS samples with larger sample sizes.[299] Second, it uses the Census definition of poverty to identify residents with family incomes between 100 to 150 percent of the FPL, which differs from the MAGI relative to poverty measure that is used to determine eligibility for PTC on the Exchanges and reported in the OEP PUFs.[300] There are differences in both the sources of income that are included in the definition of income, as well as which household members are included in the calculation.[301] In addition, the ACS is fielded throughout the calendar year and asks about income during the previous 12 months,[302] meaning that this survey measure does not align with income during the calendar/plan year. Third, there is a tendency for income to be underreported in survey data, including in the ACS.[303] Fourth, the eligible population estimated using the ACS includes certain individuals who would not be eligible for subsidized Exchange coverage, including those with access to affordable employer-based coverage,[304] those with Medicaid coverage that they did not report on the survey,[305] immigrants who are not lawfully present,[306] and people enrolled in Department of Veteran Affairs (VA) health care. Finally, the eligible population estimated using the ACS does not include certain

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[299] Using 1-Year or 5-Year American Community Survey Data. (2020). Retrieved from *https://www.census.gov/programs-surveys/acs/guidance/estimates.html.*

[300] What's Included as Income. (n.d.). Retrieved from *www.healthcare.gov/income-and-household-information/income/.*

[301] State Health Access Data Assistance Center. (2023). Defining Family for Studies of Health Insurance Coverage. Retrieved from *https://shadac-pdf-files.s3.us-east-2.amazonaws.com/s3fs-public/publications/2023%20Defining%20families%20brief.pdf.*

[302] Rothbaum, J. L. (2015). Comparing Income Aggregates: How do the CPS and ACS Match the National Income and Product Accounts, 2007-2012. Retrieved from *https://www.census.gov/content/dam/Census/library/working-papers/2015/demo/SEHSD-WP2015-01.pdf.*

[303] About Income. (n.d.). Retrieved from *https://www.census.gov/topics/income-poverty/income/about.htmlhttps://www.census.gov/content/dam/Census/library/working-papers/2015/demo/SEHSD-WP2015-01.pdf.*

[304] People with coverage through a job. (n.d.) *Retrieved from https://www.healthcare.gov/have-job-based-coverage/options/.*

[305] O'Hara, Brett. (2009). Is there an undercount of Medicaid participants in the ACS Content Test? Retrieved from *https://www.census.gov/content/dam/Census/library/working-papers/2009/adrm/medicaid-participants-acs-content-test.pdf.*

[306] Coverage for lawfully present immigrants. (n.d.). Retrieved from *https://www.healthcare.gov/immigrants/lawfully-present-immigrants/.*

individuals who are eligible for Exchange coverage and are included in the enrollment counts in the OEP PUFs, such as people aged 65 or older who do not qualify for premium-free Medicare.[307] We acknowledge these limitations and sought comment in the proposed rule on ways to improve these analyses in the final rule. For instance, possible revisions to this analysis could include the use of multi-year ACS samples or the refinement of the measures of income and family unit used in the ACS to more closely align with Exchange PTC eligibility determination.

Table 14 shows there is large variation in the take-up of Exchange coverage among potential enrollees across States. It also indicates that there has been a substantial increase in take-up from the estimated 43.8 percent of potential enrollees in this set of States who enrolled in Exchange coverage for PY 2019. The estimates for 2023 and 2024 are 94.2 percent and 143.9 percent, respectively. These overall take-up estimates by year exclude Idaho given the lack of income information available for this State in 2019.

Nine States have take-up rates that exceed 100 percent for PY 2024, indicating that there are a larger number of Exchange enrollees reporting incomes of between 100 and 150 percent of the FPL than residents reporting incomes in this range on the ACS. While estimates slightly above 100 percent could potentially be attributed to imprecision in population estimates or differences in the measurement of income as described above, these explanations seem less likely for take-up estimates that greatly exceed 100 percent, such as the 438 percent observed for Florida in 2024. Other possible explanations for such a high take-up rate include people misestimating their income for the plan year at the time of open enrollment, as sign-ups typically occurring in the fall prior to the plan year and individuals may earn more or less than they

[307] FAQs: Health Insurance Marketplace and the ACA. I am turning 65 years old next month, but I am not entitled to Medicare without having to pay a premium for Part A because I have not worked long enough to qualify. Can I sign up for a Marketplace plan? (n.d.). Retrieved from *https://www.kff.org/faqs/faqs-health-insurance-marketplace-and-the-aca/i-am-turning-65-years-old-next-month-but-i-am-not-entitled-to-medicare-without-having-to-pay-a-premium-for-part-a-because-i-have-not-worked-long-enough-to-qualify-can-i-sign-up-for-a-marketplace-pla/.*

expected, or people not updating their income information if auto re-enrolled with the prior year's income data in 2023 and 2024. These would constitute errors. To the extent that people with incomes below 100 percent of the FPL intentionally overstate their income in order to qualify for subsidized Exchange coverage or are counseled to do so by an agent, broker, or web-broker, or if people outside this income range are unknowingly enrolled by an agent, broker, or web-broker who claim their income at 100 to 150 percent of the FPL, these types of improper enrollments would also contribute to a take-up rate that exceeds 100 percent. Of note, 7 of the 9 States with take-up rates above 100 percent in 2024 are States that have not implemented ACA Medicaid expansions.[308] Medicaid eligibility for non-elderly and non-disabled adults in these States is limited to parents who meet a median income eligibility threshold of 27 percent of the FPL.[309] Previous research presents evidence suggesting that many people with incomes that exceed the Medicaid eligibility limit in non-ACA Medicaid expansion States, especially in Florida, obtain subsidized Exchange coverage by reporting income just above the FPL at enrollment.[310]

One approach to estimate the possible reduction in erroneous and improper enrollments under the changes in this rule is to sum the total number of enrollments in 2024 that exceed 100 percent of potential enrollees in Table 14. This calculation suggests that there are as many as 4.4 million erroneous or improper enrollments. This is expected to be an upper bound estimate of the scale of erroneous and improper enrollments. PY 2024 Exchange enrollments occurred prior to

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[308] Status of State Medicaid Expansion Decisions. (2025, February 12). Retrieved from *https://www.kff.org/status-of-state-medicaid-expansion-decisions/.*

[309] Medicaid Income Eligibility Limits for Adults as a Percent of the Federal Poverty Level. (2024, 1 May). Retrieved from *https://www.kff.org/affordable-care-act/state-indicator/medicaid-income-eligibility-limits-for-adults-as-a-percent-of-the-federal-poverty-*level/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D. Parental income eligibility limits for parents in a family of three as of May 1, 2024 for each of the 7 States are 18 percent of the FPL in Alabama, 27 percent of the FPL in Florida, 30 percent of the FPL in Georgia, 27 percent of the FPL in Mississippi, 67 percent of the FPL in South Carolina, 105 percent of the FPL in Tennessee, and 15 percent of the FPL in Texas. Other adults are not eligible.

[310] Hopkins, B. et al. (2024). How Did Take-Up of Marketplace Plans Vary with Price, Income, and Gender? American Journal of Health Economics, 11(1 winter 2025). Retrieved from https://doi.org/10.1086/727785.

recent HHS actions to improve program integrity, which were expected to reduce the number of improper and erroneous enrollments prior to the implementation of the provisions in this final rule. Additionally, this estimate fully attributes excess enrollments to error and improper enrollments and does not adjust for the presence of general uncertainty around expected income among enrollees, which is not expected to change as a result of the provisions, nor does it take into account the imprecision inherent in the use of survey data to identify and measure the population eligible for Exchange coverage. However, despite HHS actions to improve program integrity, there was still a substantial increase in plan selections during the PY 2025 OEP, suggesting the possibility that erroneous and improper enrollments may have increased further this year. In addition, the excess enrollment estimate ignores the potential presence of erroneous and improper enrollments in States with take-up rates below 100 percent and, in this way, could underestimate the potential impact of the provisions. For all of these reasons, there is uncertainty present regarding the estimate derived from this analysis. We acknowledge this uncertainty and sought comment in the proposed rule on how we may improve this estimate in final rulemaking.

TABLE 14: Exchange Sign-Ups Compared to Potential Enrollees at 100-150 Percent of the FPL Income, by State and Year

	2019			2023			2024		
	Exchange Sign-Ups	Potential Enrollees	Take-Up Rate (%)	Exchange Sign-Ups	Potential Enrollees	Take-Up Rate (%)	Exchange Sign-Ups	Potential Enrollees	Take-Up Rate (%)
Alabama	70,951	162,156	43.8	119,737	161,318	74.2	228,883	162,580	140.8
Alaska	1,896	16,161	11.7	2,050	11,860	17.3	2,317	11,918	19.4
Arizona	20,565	177,646	11.6	49,204	153,762	32.0	114,197	156,012	73.2
Arkansas	11,893	106,418	11.2	23,680	90,011	26.3	56,640	90,565	62.5
California	242,016	758,412	31.9	274,117	630,793	43.5	278,204	634,536	43.8
Colorado	15,222	104,067	14.6	14,327	85,286	16.8	14,786	86,098	17.2
Connecticut	8,292	51,747	16.0	8,315	46,834	17.8	12,991	47,246	27.5
Delaware	2,886	16,730	17.3	3,584	13,723	26.1	8,374	13,928	60.1
Florida	981,323	742,425	132.2	1,961,049	608,549	322.2	2,718,501	620,966	437.8
Georgia	219,261	362,003	60.6	496,628	326,102	152.3	834,058	329,534	253.1
Hawaii	2,352	20,557	11.4	2,571	24,026	10.7	3,006	24,105	12.5
Idaho	NR	NR	NR	4,768	43,826	10.9	8,193	44,504	18.4

	2019			2023			2024		
	Exchange Sign-Ups	Potential Enrollees	Take-Up Rate (%)	Exchange Sign-Ups	Potential Enrollees	Take-Up Rate (%)	Exchange Sign-Ups	Potential Enrollees	Take-Up Rate (%)
Illinois	52,000	255,798	20.3	78,590	198,726	39.5	111,131	199,793	55.6
Indiana	19,172	173,981	11.0	41,719	131,311	31.8	112,127	132,154	84.8
Iowa	6,334	53,568	11.8	12,580	49,928	25.2	23,908	50,286	47.5
Kansas	28,266	88,955	31.8	47,693	83,239	57.3	82,256	83,778	98.2
Kentucky	10,401	94,295	11.0	4,748	83,064	5.7	8,534	83,754	10.2
Louisiana	19,207	114,770	16.7	36,199	97,572	37.1	93,833	97,778	96.0
Maine	15,854	28,318	56.0	4,312	22,190	19.4	4,581	22,275	20.6
Maryland	19,450	77,124	25.2	18,522	89,654	20.7	21,599	90,320	23.9
Massachusetts	37,759	66,807	56.5	17,045	67,287	25.3	30,595	67,950	45.0
Michigan	43,286	201,320	21.5	64,618	171,546	37.7	122,597	172,517	71.1
Mississippi	53,009	116,614	45.5	124,404	110,202	112.9	210,749	110,197	191.2
Missouri	83,499	195,867	42.6	90,907	159,071	57.1	154,459	160,030	96.5
Montana	4,924	25,305	19.5	4,296	23,278	18.5	8,522	23,400	36.4
Nebraska	22,677	53,748	42.2	15,563	36,846	42.2	25,158	37,172	67.7
Nevada	15,548	85,249	18.2	21,208	76,288	27.8	22,471	77,548	29.0
New Hampshire	5,077	19,425	26.1	5,238	13,681	38.3	8,484	13,748	61.7
New Jersey	37,653	142,831	26.4	53,173	135,983	39.1	69,867	137,740	50.7
New Mexico	5,744	42,939	13.4	4,016	45,821	8.8	6,747	46,017	14.7
North Carolina	186,358	357,623	52.1	347,551	278,562	124.8	507,098	282,782	179.3
North Dakota	2,149	16,765	12.8	3,019	10,854	27.8	3,770	10,957	34.4
Ohio	24,792	226,871	10.9	60,101	195,405	30.8	166,814	196,385	84.9
Oklahoma	51,744	144,964	35.7	70,349	124,195	56.6	120,013	125,158	95.9
Pennsylvania	63,304	213,444	29.7	62,303	187,117	33.3	81,714	187,994	43.5
Rhode Island	6,449	14,631	44.1	4,453	14,798	30.1	6,117	14,917	41.0
South Carolina	79,543	163,892	48.5	168,217	156,016	107.8	301,553	158,651	190.1
South Dakota	7,752	23,691	32.7	9,898	24,736	40.0	8,821	24,907	35.4
Tennessee	73,392	215,288	34.1	158,033	180,654	87.5	310,781	182,662	170.1
Texas	474,670	1,115,085	42.6	1,360,433	1,037,034	131.2	2,133,460	1,056,033	202.0
Utah	56,561	92,491	61.2	87,196	74,704	116.7	133,065	76,014	175.1
Vermont	2,326	5,584	41.7	1,626	6,076	26.8	2,227	6,074	36.7
Virginia	91,810	181,345	50.6	80,751	146,563	55.1	110,912	147,847	75.0
Washington	20,704	122,440	16.9	16,092	112,052	14.4	21,588	113,490	19.0
West Virginia	3,168	41,262	7.7	5,516	34,229	16.1	17,243	34,219	50.4
Wisconsin	46,353	119,818	38.7	39,856	104,583	38.1	64,398	105,122	61.3
Wyoming	5,317	16,606	32.0	6,767	18,034	37.5	8,054	18,113	44.5
TOTAL (excluding Idaho)	3,252,909	7,427,036	43.8	6,082,254	6,453,563	94.2	9,387,203	6,525,270	143.9

Sources: 2019, 2023, and 2024 CMS Marketplace Open Enrollment Period Public Use Files (OEP PUF); 2019 and 2023 1-year American Community Survey (ACS) files from IPUMS USA. NR = Not reported.

Notes: Potential enrollees by State are estimated using the ACS as State residents ages 19-64 who are not enrolled in Medicaid or Medicare. The 2024 estimates are calculated by applying a State population growth rate to the 2023 estimates. Minnesota, New York, and Oregon are excluded due to the presence of a BHP during at least some portion of the analysis period. The District of Columbia is excluded due to the unavailability of income information in the OEP PUF.

Furthermore, we anticipate that IRA subsidies expiring after PY 2025 will reduce the availability of fully-subsidized plans and, therefore, is expected to also reduce the occurrence of improper enrollments that exploited the availability of enhanced subsidies. That reduction in improper enrollments is not attributable to the policies in this rule, but rather by current law causing IRA subsidies to expire after PY 2025. However, there is uncertainty regarding how many improper enrollments will be reduced by the expiration of IRA subsidies compared to the policies in this rule. Moreover, in response to commenters' concerns, we finalize certain verification requirements to sunset at the end of PY 2026, creating additional uncertainty related to the level of improper enrollments in PY 2027 and beyond. We believe that coverage in connection with the majority of improper enrollments will end as a result of the enhanced subsidies; therefore, in the proposed rule, we assumed a range of approximately 750,000 to 2,000,000 fewer individuals will enroll in QHP coverage in 2026 as a result of the policies in the proposed rule. In the proposed rule, we sought comment on the estimate and assumptions and respond to such comments later in this analysis.

Based on comments and revised analysis resulting from some policy changes between the proposed and final rules, as discussed previously in this final rule, we now assume a range of approximately 725,000 to 1,800,000 fewer individuals will enroll in QHP coverage in 2026 as a result of the policies in this final rule. We use this range moving forward in this analysis. The full proposed rule analysis may be found at 90 FR 13020 through 13026.

Starting with internal CMS data of enrollment by month, premiums, and APTCs, we summarize the data using average monthly amounts. These monthly averages are projected throughout the year using historical monthly patterns during a similar environment. For future

years, the enrollment is trended by the projected growth in the under age 65 population. Spending amounts are trended using projected growth in NHEA less Medicare. With the expiration of enhanced subsidies, we assume approximately 42 percent of recent enrollment growth will discontinue coverage. We believe the discontinuing enrollees are likely to be healthier than those remaining in the risk pool, leading to higher overall premiums on a per member per month (PMPM) basis ($614.44 PMPM in 2025 increasing to $662.13 PMPM in 2026). Based on the analysis presented thus far in this section, we expect average enrollment for 2026 to decrease by approximately 725,000 to 1,800,000 enrollees compared to baseline estimates. Some enrollees dropping coverage will likely be healthier than those remaining in the risk pool, while other enrollees losing coverage due to improper enrollments could potentially be less healthy, so we estimated the claims impact to the risk pool to potentially range from -0.5 percent to +4 percent. The claims changes were then combined with the estimated 3.4 percent decrease for the expected impact of removing the monthly 150 percent FPL SEP, a 0.5 percent decrease for SEP verification, and 1 percent decrease for the de minimis AV change. The 2026 baseline claims per member was decreased by 5.4 percent for the 725,000 reduced enrollment scenario and 0.9 percent for the 1,800,000 reduced enrollment scenario. The revised premium was calculated assuming issuers will price to an average 84 percent loss ratio, yielding a revised PMPM of $626.37 for the 725,000 reduced enrollment scenario and $656.17 for the 1,800,000 reduced enrollment scenario for 2026 as a result of these jointly finalized policies. Estimated APTCs were assumed to be 88.8 percent of the premium PMPM ($626.37 x 0.888 = $556.22 and $656.17 x 0.888 = $582.68), and APTC enrollment was estimated to be 90.6 percent of total enrollment for 2026. For future years under this rule, we assume premium growth of 3.9 percent for 2027 and 2028 and 1.9 percent for 2029. Enrollment growth is estimated at 1.1 percent for 2027, 1.5 percent for 2028, and 3 percent for 2029. We assume the enrollment and claims impacts from the sunsetting policies wear off over 2027 and 2028, with 80 percent of the wear-

off occurring in 2027 and 20 percent occurring in 2028.

Using the methodology described in the preceding paragraphs, we anticipate the provisions in this final rule, when considered jointly, could reduce enrollment, premiums, and APTC each year beginning in 2026. We provide lower bound estimates in Table 15 and upper bound estimates in Table 16.

TABLE 15: Overall Enrollment and APTC Impacts of the Program Integrity Rule – Lower Bound Estimates

	Calendar Year	**2025**	**2026**	**2027**	**2028**	**2029**
Baseline						
	Total Enrollment (millions)	21.625	17.240	17.426	17.682	18.213
	APTC Enrollment (millions)	20.061	15.614	15.635	15.741	15.798
	Premiums ($ billions)	159.448	136.980	143.822	151.597	159.043
	APTC ($ billions)	130.960	110.188	115.911	122.564	128.584
Policies in this rule						
	Total Enrollment (millions)	21.625	16.515	17.273	17.672	18.203
	APTC Enrollment (millions)	20.061	14.958	15.498	15.732	15.789
	Premiums ($ billions)	159.448	124.134	139.070	148.953	156.270
	APTC ($ billions)	130.960	99.854	112.081	120.427	126.342
Change						
	Total Enrollment (millions)	-	-0.725	-0.153	-0.010	-0.010
	APTC Enrollment (millions)	-	-0.656	-0.137	-0.009	-0.009
	Premiums ($ billions)	-	-12.846	-4.752	-2.643	-2.773
	APTC ($ billions)	-	-10.334	-3.830	-2.137	-2.242

TABLE 16: Overall Enrollment and APTC Impacts of the Program Integrity Rule – Upper Bound Estimates

	Calendar Year	**2025**	**2026**	**2027**	**2028**	**2029**
Baseline						
	Total Enrollment (millions)	21.625	17.240	17.426	17.682	18.213
	APTC Enrollment (millions)	20.061	15.614	15.635	15.741	15.798
	Premiums ($ billions)	159.448	136.980	143.822	151.597	159.043
	APTC ($ billions)	130.960	110.188	115.911	122.564	128.584
Policies in this rule						
	Total Enrollment (millions)	21.625	15.440	17.046	17.657	18.187
	APTC Enrollment (millions)	20.061	13.984	15.295	15.719	15.776
	Premiums ($ billions)	159.448	121.574	139.313	149.870	157.231
	APTC ($ billions)	130.960	97.795	112.277	121.168	127.119
Change						
	Total Enrollment (millions)	-	-1.800	-0.380	-0.025	-0.026

	APTC Enrollment (millions)	-	-1.630	-0.340	-0.022	-0.022
	Premiums ($ billions)	-	-15.406	-4.509	-1.727	-1.812
	APTC ($ billions)	-	-12.393	-3.634	-1.396	-1.465

Taken together, the provisions of this final rule are expected to address errors and improper enrollments, which means that as presented in the preceding paragraphs, we expect approximately 725,000 to 1,800,000 individuals to lose coverage as a result of the provisions in this rule. This range may overestimate the actual number of individuals impacted, as we believe that this range includes many individuals improperly enrolled by agents, brokers, and web-brokers without their knowledge or consent, as well as enrollees with multiple forms of coverage. Likewise, this range may underestimate the actual number of individuals impacted, as eligible enrollees may lose coverage as a result of the administrative burdens imposed by the provisions of this rule. Finally, as explained by the Department in the proposed rule and this final rule, as well by commenters, estimation of the number of individuals impacted may likely be skewed due to the general difficulty in assigning with certainty the causes of improper enrollments. We note that coverage losses are expected to be concentrated in nine States where erroneous and improper enrollment is most noticeable (that is, Alabama, Florida, Georgia, Mississippi, North Carolina, South Carolina, Tennessee, Texas, and Utah), although we also expect minor coverage losses across all States as the administrative burdens associated with this rule would be applied uniformly across the country.

An individual who loses coverage may be required to incur additional expense to obtain coverage or may go uninsured. An increase in the rate of uninsurance may impose greater burdens on the health care system through strain on emergency departments, additional costs to the Federal Government and to States to provide limited Medicaid coverage for the treatment of an emergency medical condition, and may cause an overall reduction to labor productivity.

In contrast, if individuals who do not maintain coverage following the finalization of this rule would otherwise be subsidized QHP enrollees, as we anticipate, there would be a savings to

the Federal Government in the form of reduced APTC payments (net of increased QHP-related payments), thereby saving taxpayer dollars. As we explain earlier in this final rule, the Department has strong reason to believe many of the individuals who would lose coverage as a result of the policies in this rule may represent improper enrollments.

While we acknowledge the finalization of this rule may impact enrollment of self-employed individuals, some of whom may qualify for subsidies, we anticipate that premiums will decrease as a result of this final rule. We note that variables—including those impacting enrollment, premiums, and APTC—have changed over time and may continue to fluctuate. When considering the overall impact of the provisions in this final rule, we also recognize that the degree of impact from the individual provisions working in concert with each other may vary more than what we estimate due to the inherent uncertainty in predicting enrollment trends. Therefore, it is possible that the overall impact of this final rule could be outside of the estimates provided in this section.

We sought comment on the proposed impacts and assumptions.

After consideration of comments and for the reasons outlined in the proposed rule and this final rule, including our responses to comments, we are finalizing these impact estimates for this rule with the modifications presented earlier in this section. We summarize and respond to public comments received on the proposed estimates below.

Comment: Several commenters noted that a decrease in enrollment would result in increased emergency care utilization and increased costs of uncompensated care, Medicare, and State Medicaid expenditures. These commenters also discussed how uninsurance leads to disrupted continuity of care and poorer health outcomes. A few comments from State entities provided estimates of enrollment reductions and premium increases in their specific States.

Some commenters alleged that the proposed rule would negatively impact market stability, discourage issuer participation, worsen the risk pool, and increase premiums for all

enrollees. A few of these commenters stated that coverage losses would be concentrated in healthy populations, resulting in premium increases that would especially impact unsubsidized enrollees.

Response: We appreciate the additional data provided by States and have considered it in the analysis in this final rule. As discussed previously in this RIA, we acknowledge that a decrease in enrollment may have the consequences noted by commenters. However, we anticipate that most of this decrease in enrollment will be attributable to improper enrollments that should never have enrolled in Exchange coverage. As documented in a CMS press release from 2024, we received and resolved over 180,000 unauthorized enrollment complaints from January to August 2024.[311] Therefore, we do not anticipate that the decrease in enrollment estimated in this final rule will impact many enrollees who are properly enrolled.

Furthermore, as discussed earlier in this final rule, we also acknowledge that some enrollees dropping coverage will likely be healthier than those remaining in the risk pool, but other enrollees losing coverage due to improper enrollments could potentially be less healthy as well. Earlier in this RIA, we discuss our methodology for estimating a premium reduction resulting from the provisions in this rule, which we anticipate will benefit all enrollees regardless of subsidy receipt. We do not believe this rule will destabilize the market or discourage issuer participation, as issuers expressed in their comments their appreciation for the finalization of these program integrity provisions. We did not receive issuer comments that the proposed policy would discourage issuer participation.

Comment: One commenter stated that the RIA failed to account for the expiration of enhanced subsidies in the IRA.

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[311] CMS (2024, October). CMS Update on Action to Prevent Unauthorized Agent and Broker Marketplace Activity. *https://www.cms.gov/newsroom/press-releases/cms-update-actions-prevent-unauthorized-agent-and-broker-marketplace-activity.*

Response: As discussed earlier in this section, we account for the expiration of enhanced subsidies in the IRA by assuming approximately 42 percent of recent enrollment growth will discontinue coverage and will be healthier than enrollees maintaining coverage. We then use higher overall premiums PMPM as a starting point for our analysis of the impact of this rule.

Comment: A few commenters stated that the RIA only demonstrated problems with improper enrollments in nine States, which are all on the FFE, while the policies in this rule will impact all States regardless of Exchange type. One commenter also stated that publicly available State Exchange data directly contradicted the analysis in the proposed rule. One commenter alleged that the majority of the enrollment losses estimated in the proposed rule would not be attributable to improper enrollments but did not provide evidence to support this statement.

Response: The provisions finalized in this rule were designed to reduce improper enrollments while ensuring individuals who are eligible to enroll in QHP coverage, and those who are also eligible to receive subsidies, are able to demonstrate their eligibility appropriately. As discussed previously in this analysis, we anticipate that many of the individuals who may lose coverage as a result of this rule were improperly enrolled. More importantly, we maintain that enrollees who are eligible will still be able to enroll under the provisions in this rulemaking. This would be true for both FFE and State Exchange States. We also note that as discussed elsewhere in this final rule, we are modifying the proposals regarding annual eligibility redeterminations, the annual OEP, and SEP verification to finalize policies permitting more State flexibility in recognition of these and other comments expressing concerns about State burdens, the data provided by commenters, and the results of our analysis.

Comment: A few commenters urged HHS to fully inform individuals negatively impacted by the rule of alternative care options. Another commenter stated that the proposed rule failed to consider additional costs on States of customer service and education that would result from the rule.

Response: We always conduct outreach and education campaigns around open enrollment each year, and intend to fully inform consumers about the changes finalized in this rule. Furthermore, we acknowledge that States may face additional costs for outreach and education as noted in the accounting table (Table 10 in the proposed rule and this final rule) but are unable to estimate these costs, as each State conducts such activities differently.

Comment: Some commenters stated that the proposed rule failed to identify data for many proposals.

Response: As discussed throughout the proposed rule and in this final rule, we provided data and analysis to the best of our ability that was available to us and where possible, we do provide information on the sources of data being used for the analysis. For example, in this section of the final rule, we identify that we used the CMS OEP PUFs as the basis of our analysis. Furthermore, in this final rule, we have also updated the analyses to reflect newly available data to support the provisions in this rule, which may be found in this RIA.

Comment: Several commenters alleged that the proposed rule relied on unsound data from a 2024 paper by the Paragon Health Institute which fails to mention or account for income misestimations and exaggerates the extent of possible enrollment fraud. A few of these commenters stated that the numerator of the enrollment reduction calculation uses Exchange data, which includes children, while the denominator of the calculation uses ACS data, which excludes children. These commenters also noted that using 2023 ACS data in the denominator of the calculation to estimate improper enrollments for 2024 fails to account for the Medicaid continuous coverage requirement in place in 2023 that was no longer in place for 2024, inflating the denominator. Additionally, these commenters stated that the income estimate used in Exchange data in the numerator of the calculation is for the year after the current year, while the income estimate used in ACS data in the denominator is for the current year, so they are not comparable estimates. Finally, a few of these commenters stated that the analysis did not

consider the agent/broker fraud prevention efforts CMS engaged in starting with the 2024 OEP, which has decreased improper enrollments since that time. All of these commenters alleged that these analysis flaws overstated the extent of possible enrollment fraud.

Response: We noted these limitations in the proposed rule and continue to reference them in this final rule. The Paragon report analysis informed our analysis, but we also incorporated Exchange data for a more fulsome analysis. There was a large variance between the population observed in our data for the 100 to 150 percent of the FPL income range and external survey data. This indicated a potential for a large number of enrollments that were either unauthorized or people misestimating or misrepresenting their income. Our range of enrollment lost estimated in the proposed rule was between 750,000 and 2,000,000, but we could not discern the amount of lost enrollments that were fraudulent or due to misrepresented income from those lost to other controls proposed in the proposed rule. We updated these estimates in this final rule as a result of finalizing modifications of some proposals based on these and other comments, as discussed previously in this final rule.

D. Regulatory Alternatives Considered

We considered taking no action regarding our proposal to remove § 147.104(i), which currently prohibits an issuer from denying coverage due to an individual's or employer's failure to pay premiums owed for prior coverage, including by attributing payment of premium for new coverage to past-due premiums owed for prior coverage. Leaving this policy in place would provide the broadest enrollment rights for consumers. However, due to concerns about adverse selection, we believe that it is reasonable to allow issuers, to the extent permitted by applicable State law, to condition the sale of new coverage on payment of past-due premiums owed to the issuer. This policy will improve the risk pool by promoting continuous coverage without imposing a significant financial burden for most people who owe past-due premiums. We also considered prohibiting issuers from collecting past due premiums for periods of coverage dating

back more than a specified time period, requiring issuers to provide enrollees notice of the past due premium policy, and other parameters. However, we decided to allow States the discretion to require and define such parameters, as they are most familiar with their markets, and to respect their traditional role of regulating insurance.

At § 155.20, we are finalizing adjustments to the definition of "lawfully present" used for purposes of determining eligibility to enroll in a QHP offered through the Exchange, eligibility for PTC, APTC, and CSR, or a BHP in States that elect to operate a BHP to exclude DACA recipients. We alternatively considered proposing to fully revert to the definition of "lawfully present" that was in place prior to the 2024 Final Rule "Clarifying the Eligibility of Deferred Action for Childhood Arrivals (DACA) Recipients and Certain Other Noncitizens for a Qualified Health Plan through an Exchange, Advance Payments of the Premium Tax Credit, Cost-Sharing Reductions, and a Basic Health Program" (89 FR 39392). However, proposing to fully reinstate the previous definition would have undone several technical and clarifying changes to the definition of "lawfully present" that were finalized in the 2024 rule (89 FR 39407).

We evaluated these technical and clarifying changes and found that some had no impact on who is considered "lawfully present" for purposes of enrolling in QHP coverage offered through the Exchange, eligibility for PTC, APTC, and CSR, and BHP coverage in States that elect to operate a BHP.[312] Other changes corrected unintentional errors in the prior definition.[313] Finally, some changes resulted in very small populations being newly considered "lawfully present." Unlike DACA recipients, the small number of individuals in these discrete categories generally would have entered the United States with inspection and would generally be able to

[312] For example, technical changes to § 155.20(4) and 155.20(5) to adjust the language we use to refer to temporary resident status and Temporary Protected Status (TPS), as described in the 2024 final rule at 89 FR 39408.
[313] For example, technical changes to § 155.20(13) to refer to individuals with an approved petition for Special Immigrant Juvenile (SIJ) status, rather than only individuals with applications for such status, as described in the 2024 Final Rule at 89 FR 39411.

adjust status to lawful permanent resident on the basis of their status.[314] Because these changes were primarily technical and clarifying in nature, and because the small groups of noncitizens newly considered "lawfully present" as a result of these changes are different from DACA recipients in important ways, we did not propose to revert or amend these provisions at this time.

We considered taking no action regarding our proposal to modify § 155.305(f)(4), which currently allows Exchanges to remove APTC after an enrollee or their tax filer has been found as failing to file their income tax return and reconcile their APTC for 2 consecutive tax years. However, due to concerns about improper enrollments, as well as concerns related to the potential for increased tax liability for tax filers, we are finalizing the proposed policy that Exchanges are required to remove APTC after an enrollee or their tax filer has been identified as failing to file and reconcile for 1 tax year, but with a modification that the policy will sunset at the end of PY 2026. Exchanges will revert back to the 2-year policy for PY 2027. We believe that FTR serves as an important check on improper enrollments and will help protect low-income consumers from larger than expected tax liabilities. However, as the Department explains in Section III.B. of this final rule, sunsetting the rule responds to commenter concerns that the 2-year FTR policy we proposed would present an unreasonable impediment to continuous coverage for vulnerable persons, especially those who traditionally have not earned an amount sufficient to require them to file annual Federal tax returns. The Department shares commenter concerns that the Federal tax filing and APTC reconciliation process may be confusing to consumers who have not previously been required to file Federal tax returns. We also understand from comments by State Exchanges that the 2-year FTR policy has potentially helped avoid unnecessary gaps in some consumers' coverage. Still, the risk remains that once the 2-year FTR

[314] For example, changes to § 155.20(6) to newly include individuals in the process of transitioning from certain employment-based immigrant visa petitions to lawful permanent resident (LPR) status, as described in the 2024 final rule at 89 FR 39408.

policy returns after PY 2026, the risk of increased consumer tax liability also returns, including for persons who genuinely believed they were eligible for the APTC paid on their behalf.

We considered taking no action regarding our policy to remove § 155.315(f)(7) which requires that applicants must receive an automatic 60-day extension in addition to the 90 days currently provided by § 155.315(f)(2)(ii) to allow applicants sufficient time to provide documentation to verify household income. However, we believe it is important we remove it to align with the 90-day statutory period. Additionally, we believe the cost to taxpayers caused by continued APTC beyond the 90-day period and decline in program integrity outweighs any possible benefits to the risk pool that were identified the 2024 Payment Notice.

We considered taking no action regarding our policy to add amendments to § 155.320(c)(3)(iii) to specify that all Exchanges must generate annual income inconsistencies when a tax filer's attested projected annual would qualify the taxpayer as an applicable taxpayer according to 26 CFR 1.36B-2(b) and trusted data sources indicate that projected income is under 100 percent of the FPL. Due to concerns related to applicants inflating their incomes or having applications submitted on their behalf with inflated incomes, as outlined in this final rule, the Department determined that immediate action is necessary to protect consumers and Federal funds. must take immediate action to we believe it is reasonable and necessary to carry out the alternative income verification process in this scenario. However, in response to commenter concerns and additional reasons we outline in Section III.B. of this final rule, the Department is finalizing the policy to be effective only through PY 2026. Exchanges may revert back to not setting income DMIs when an applicant’s annual household income attestation would qualify the taxpayer as an applicable taxpayer according to 26 CFR 1.36B-2(b) and trusted data sources indicate that projected income is under 100 percent of the FPL for PY 2027. This will help to limit tax filers’ potential liability at tax reconciliation to repay excess APTC.

We considered taking no action regarding our policy to remove § 155.320(c)(5) which currently requires Exchanges to accept attestations, and not set an Income DMI, when the Exchange requests tax return data from the IRS to verify attested projected annual household income, but the IRS confirms there is no such tax return data available. However, we believe that removing § 155.320(c)(5) is important for program integrity to address the level of improper enrollments due in large part to the enhanced premium subsidies. We too are cognizant of commenter concerns that this policy represents an impediment to coverage. Given this, for those reasons we outline in section III.B. of this final rule, we are finalizing this policy so that it is effective only through the end of PY 2026. Exchanges will revert back to requirements laid out in § 155.320(c)(5) for PY 2027. This policy respects the Department's duty to safeguard Federal funds, while allowing the Department, Exchanges, and other interested parties to collect additional data on these newly generated income DMIs and their impacts on consumers and coverage to support future policy analysis.

We are finalizing adding § 155.335(a)(3) and (n) to require that when an enrollee does not submit an application for an updated eligibility determination on or before the last day to select a plan for January 1, 2026 coverage and the enrollee's portion of the premium for the entire policy would be zero dollars after application of APTC through an Exchange on the Federal platform's annual redetermination process, all Exchanges on the Federal platform decrease the amount of the APTC applied to the policy such that the remaining monthly premium owed by the enrollee for the policy equals $5 for the first month and for every following month that the enrollee does not confirm or update the eligibility determination. This amendment is being finalized for benefit year 2026 only for Exchanges on the Federal platform, with a reversion to the previous policy for benefit year 2027 and beyond. We are not finalizing this amendment for State Exchanges.

We alternatively considered whether other methods, such as outreach, could sufficiently prompt fully-subsidized enrollees to update or confirm their eligibility information and actively re-enroll in coverage, but over half of enrollees in the Exchanges on the Federal platform actively re-enroll by the applicable deadlines for January 1 coverage. As discussed previously in this preamble, however, we do not believe additional or different notifications will prompt action from enrollees who choose not to submit an application for an updated eligibility determination and actively re-enroll.

In addition, we considered taking no action regarding our policy at § 155.335; however, we believe that it is important to address the significant increase in the number of enrollees who are automatically re-enrolled in a fully-subsidized QHP, and change is critical to reduce the financial impact of improper enrollments in QHPs with APTC through the Exchanges on the Federal platform. The current annual redetermination process puts fully-subsidized enrollees at risk of accumulating surprise tax liabilities and increases the cost of PTC to the Federal Government as Federal law limits repayments, and there is no provision to recoup overpayments from issuers when they follow the eligibility determinations made by the Exchanges.

We also considered modifying the Exchange's annual redetermination process to require that when an enrollee does not submit an application to obtain an updated eligibility determination on or before the last day to select a plan for January 1 coverage and the enrollee's portion of the premium for the entire policy would be zero dollars after application of APTC through the Exchange's annual redetermination process, the enrollee would be automatically re-enrolled without any APTC. This would ensure that enrollees in this situation need to return to the Exchange and obtain an updated eligibility determination prior to having any APTC paid on their behalf for the upcoming year. Ultimately, however, we determined that this approach would create undue financial hardship for these enrollees and act as a significant barrier to accessing health care coverage. The loss of lower-risk enrollees, who are least likely to actively re-enroll,

due to an inability to pay could destabilize the market risk pool and increase premiums and the uninsured rate. Based on comments received on this approach in the 2021 Payment Notice proposed rule, we believe that our temporary amendment, which decreases the amount of the APTC applied to the policy such that the remaining premium owed by the enrollee for the policy equals $5, strikes an appropriate balance between encouraging active and proper enrollment and ensuring market stability.

The 2024 Payment Notice updated § 155.335(j) to allow Exchanges to move a CSR-eligible enrollee from a bronze QHP and re-enroll them into a silver QHP for an upcoming plan year, if a silver QHP is available in the same product, with the same provider network, and with a lower or equivalent net premium after the application of APTC as the bronze plan into which the enrollee would otherwise have been re-enrolled. We considered taking no action and leaving this policy in place; however, for reasons further discussed in section III.B.5. of this final rule, we believe that consumers, and the agents, brokers, web-brokers, and Navigators who help them, are largely aware of the more generous subsidies. Therefore, we believe that the consumer awareness problem the bronze to silver crosswalk policy aimed to address is substantially less today, and therefore the possible benefits of this policy no longer outweigh its potential to confuse consumers, undermine consumer choice, and create unexpected tax liability.

We considered taking no action regarding modifications to § 155.400(g) to remove flexibilities that would allow issuers to adopt a fixed-dollar premium payment threshold or a gross premium-based percentage payment threshold. We also considered removing just the fixed-dollar threshold policy and allowing issuers the option to utilize the gross premium percentage-based premium threshold. However, given the continued and increased numbers of improper enrollments and plan switches and other improper enrollment trends, both the fixed-dollar and gross-premium percentage-based thresholds present program integrity risks that may allow consumers (and Medicaid beneficiaries who are victims of dual improper enrollment into a QHP)

to remain in coverage for a much longer or indefinite amount of time, after payment of the binder. Consumers who never wanted, or no longer need, QHP coverage could remain enrolled for longer than the 3-month grace period, accruing premium debt and potentially facing complications when they file their taxes. Issuers will still have the option to implement the existing net premium percentage-based policy to allow consumers who pay the majority of their premium to avoid being put into a grace period.

We also considered finalizing the modifications at § 155.400(g) as proposed, instead of sunsetting the fixed-dollar and gross-premium thresholds after PY 2026. However, for the reasons specified earlier in this final rule, as well as the fact that this approach will enable interested parties to collect data regarding the impact of the removal of the fixed-dollar and gross-premium payment thresholds in order to inform future policy direction, we are finalizing this provision such that the fixed-dollar and gross-premium percentage-based thresholds will be removed as a flexibility for all Exchanges until and after PY 2026.

We considered maintaining the length of the OEP, and we considered designating November 1 to December 15 as the OEP for all Exchanges without flexibility, as proposed. However, based on comments, we are of the view that setting clear parameters for the date range and duration of the annual OEP, instead of proscribing specific OEP start and end dates, strikes the appropriate and best balance between providing flexibility for states and reducing the potential for adverse selection. Additionally, we considered moving the OEP to a different period in the calendar year – such as beginning March 1 and running to April 15 – as a measure to both minimize adverse selection and maximize consumer choice (by moving the OEP to a season in which financial stress is generally lessened), but we recognize that mandating such a dramatic shift in the OEP would cause considerable disruption to the market. Instead, our final rule does allow flexibility for Exchanges to start their OEP at an earlier point in the calendar year, as long

as the OEP does not extend more than 9 weeks and all plan selections made during the OEP are effective on January 1 of the plan year.

We also considered finalizing the 150 percent FPL SEP provision as proposed, instead of pausing the SEP until the end of PY 2026. However, for the reasons specified in section III.8. of this final rule, as well as the fact that this approach will enable CMS to collect data regarding the impact of the SEP discontinuation in order to inform future policy direction, we are finalizing this provision such that current regulations allowing the 150 percent FPL SEP will become effective again after PY 2026.

We are finalizing amendments to § 155.420(g) to require Exchanges on the Federal platform to conduct pre-enrollment eligibility verification for SEPs. Specifically, we are finalizing the removal of the limit on Exchanges on the Federal platform to conducting pre-enrollment verifications for only the loss of minimum essential coverage SEP. With this limitation removed, we are finalizing conducting pre-enrollment verifications for most categories of SEPs for Exchanges on the Federal platform in line with operations prior to the implementation of the 2023 Payment Notice. This provision will sunset after PY 2026 and we will return to previous policy for PY 2027 as discussed in section III.B.9. of this final rule. We considered leaving the limitation of SEP verification to loss of minimum essential coverage for Exchanges on the Federal platform in place. We determined that the risks associated with the potential enrollment of ineligible individuals were greater than the potential benefits of reducing administrative burden on consumers by only verifying loss of minimum essential coverage. We also determined that consumers will benefit from increased verification due to its potential to limit improper enrollments occurring without their awareness and to bring down risk in Exchanges on the Federal platform by ensuring that only qualified individuals are enrolling through SEPs throughout the year.

We are also finalizing the requirement that Exchanges on the Federal platform conduct pre-enrollment SEP verification for at least 75 percent of new enrollments through SEPs for consumers not already enrolled in coverage through the applicable Exchange. We are finalizing that Exchanges must verify at least 75 percent of such new enrollments based on the current implementation of SEP verification by Exchanges. This provision will sunset after PY 2026 and we will return to previous policy for PY 2027 as discussed in section III.B.9. of this final rule. We are declining to finalize this proposal for State Exchanges. We considered finalizing the provision with a modification for State Exchanges to implement SEP verification for PY 2027. After consideration of comments received regarding State administrative and financial burden and the assertion by many State Exchanges that they do not have similar issues with fraud, we decline to finalize the provision for State Exchanges.

We considered not finalizing the proposal to prohibit issuers of plans subject to EHB requirements from providing coverage for sex-trait modifications as EHB. We also considered finalizing the proposal but without a definition of "specified sex-trait modification procedure." We also considered finalizing the proposal with the addition of a definition of "specified sex-trait modification procedure" but delaying the effective date until PY 2027. Although public comments overwhelmingly did not support the proposal, we are finalizing the prohibition to more closely align with statutory requirements. We also considered finalizing the proposal exactly as proposed, that is, without a definition of "specific sex-trait modification procedure." However, we were persuaded by comments that by finalizing a definition that includes exceptions, affected parties will have greater certainty from consumer knowledge, issuer pricing, and issuer compliance perspectives. This will also minimize premium impacts, since there will be less opportunity for issuers to price for any uncertainty. While we appreciate concerns that the provision will require issuers to modify claims and other systems at significant cost and effort, issuers should already have processes in place to determine when a service is an EHB and when

it is not. Therefore, we are finalizing this policy, which will be applicable for PY 2026 and beyond.

In proposing the change to the premium measure used in the premium adjustment percentage calculation under § 156.130, we considered continuing to use the current premium measure based on NHEA's estimates and projections of average per enrollee ESI premiums for purposes of calculating the premium adjustment percentage for PY 2026. We are finalizing the proposal to change this measure to instead use a private health insurance premium measure (excluding Medigap and property and casualty insurance), so that the premium growth measure more closely reflects premium trends in the private health insurance market since 2013. Alternatively, we considered using NHEA estimates and projections of average per enrollee private health insurance premiums. NHEA's private health insurance premium measure includes premiums for ESI, direct purchase insurance (which includes Medigap insurance), and property and casualty insurance. However, we are finalizing the inclusion of only those premiums for expenditures associated with the acquisition of one's primary health insurance coverage purchased through their employer or purchased directly from a health insurance issuer. We believe it is inappropriate to include Medigap premiums in the measure as this type of coverage is not considered primary coverage for those enrollees who supplement their Medicare coverage with these plans. Moreover, although total spending for private health insurance in the NHEAs includes the medical portion of accident insurance (property and casualty insurance), we do not believe it is appropriate to include those expenditures for this purpose as they are associated with policies that do not serve as a primary source of health insurance coverage.

Accordingly, in § 156.130 we are finalizing the use of a measure that includes only premiums for ESI and direct purchase insurance, but not premiums for property and casualty, or Medigap insurance. We sought comment in the proposed rule on the source of premium data we proposed to use in the premium adjustment percentage calculation, and specifically the proposal

to use average per enrollee private health insurance premiums (excluding Medigap and property and casualty insurance), or whether we should continue to use ESI premiums for purposes of calculating the premium adjustment percentage for PY 2026.

We are finalizing changing the allowable de minimis ranges in § 156.140 beginning in PY 2026 to +2/-4 percentage points for all individual and small group markets subject to AV requirements under the EHB package, other than for expanded bronze plans, for which we are changing to a de minimis range of +5/-4 percentage points. We are also finalizing a revision to § 156.200(b)(3) to remove from the conditions of QHP certification the de minimis range of +2/0 percentage points for individual market silver QHPs. We are also finalizing amendments to the definition of "de minimis variation for a silver plan variation" in § 156.400 to specify a de minimis range of +1/-1 percentage points for income-based silver CSR plan variations. In proposing these changes, we considered delaying the implementation until PY 2027, which was recommended by some commenters who noted that the timing of this rule's release would make it difficult for some issuers to take advantage of wider de minimis ranges in PY 2026. However, we maintain that the de minimis changes proposed do not require issuers to take additional action to revise their plan designs. Additionally, finalizing these changes earlier allows more time for consumers to benefit from plan designs that are more appropriate for their needs.

E. Regulatory Flexibility Act (RFA)

The RFA requires agencies to analyze options for regulatory relief of small entities, if a rule has a significant impact on a substantial number of small entities. The RFA generally defines a "small entity" as (1) a proprietary firm meeting the size standards of the Small Business Administration (SBA), (2) a not-for-profit organization that is not dominant in its field, or (3) a small government jurisdiction with a population of less than 50,000. States and individuals are not included in the definition of "small entity." The data and conclusions presented in this section, along with the rest of the RIA, amount to our final regulatory flexibility analysis under

the RFA.

For purposes of the RFA, we believe that health insurance issuers would be classified under the NAICS code 524114 (Direct Health and Medical Insurance Carriers). According to SBA size standards, entities with average annual receipts of $47 million or less would be considered small entities for this NAICS code. Issuers could possibly be classified in 621491 (HMO Medical Centers) and, if this is the case, the SBA size standard will be $44.5 million or less.[315] We believe that few, if any, insurance companies underwriting comprehensive health insurance policies (in contrast, for example, to travel insurance policies or dental discount policies) would fall below these size thresholds. Based on data from MLR annual report submissions for the 2023 MLR reporting year, approximately 84 out of 479 issuers of health insurance coverage nationwide had total premium revenue of $47 million or less.[316] We estimate that approximately 80 percent of these small issuers belong to larger holding groups based on the MLR data, and many, if not all, of these small companies are likely to have non-health lines of business that result in their revenues exceeding $47 million. We sought comment on these estimates and did not receive any comments on these estimates. We are providing additional detail in this final rule that we assume approximately 20 percent, or 16, of the 84 potential small issuers are in fact small issuers for purposes of this analysis. We believe this is an overestimate, as many if not all of these small issuers are likely to have non-health lines of business that result in their revenues exceeding $47 million, but we use 16 small issuers for purposes of this analysis.

We anticipate that small issuers could be impacted by the provisions in this final rule. We are unable to quantify the impact of these changes on small issuers due to uncertainty regarding their market share, market participation, membership in larger holding groups,

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[315] SBA. (n.d.). Table of size standards. *https://www.sba.gov/document/support--table-size-standards.*
[316] CMS. (n.d.). Medical Loss Ratio Data and System Resources. *https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr.html.*

enrollment and risk mix, and APTC receipts. However, we anticipate that there will not be a significant change in revenue for issuers since a reduction in APTC payments will mean consumers would be responsible for the balance of the premium not covered by APTC. We also anticipate that due to the small reduction in enrollment anticipated to result from the policies in this rule, issuers may experience a reduction in premium revenue. However, we anticipate this could be balanced by a reduction in claims experience, and we are unable to quantify this impact on small issuers due to uncertainty and a lack of data. The alternative policies we considered in developing the proposed and final rules are discussed in section V.D. of this final rule. We considered not sunsetting certain policies in this final rule that would impose burdens on small issuers for operational and financial changes and therefore adopt them in perpetuity, but we determined sunsetting these policies would aid in understanding their impact on all issuers, including small issuers. We are of the view that none of these alternatives would both achieve the policy objectives and goals of this final rule as previously stated and be less burdensome to small entities.

We sought comment in the 2025 Marketplace Integrity and Affordability proposed rule on the proposed estimates and assumptions. We did not receive any comments on the assumptions in the proposed rule.

As discussed in section V.C.17 of this final rule, we anticipate that entities such as issuers, including small issuers, will face regulatory review costs as a result of needing to familiarize themselves with this final rule. The cost per entity to review this final rule is estimated to be $595.46. The total cost for 16 small issuers to review this rule is estimated to be $9,527.36.

In addition, section 1102(b) of the Act requires us to prepare an RIA if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section

1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a metropolitan statistical area and has fewer than 100 beds. Although we acknowledge that this final rule may increase uninsurance and therefore increase uncompensated care as discussed previously in this RIA, this final rule is not subject to section 1102 of the Act and therefore a fulsome analysis under section 1102(b) of the Act is not required.

F. Unfunded Mandates Reform Act (UMRA)

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2025, that threshold is approximately $187 million. Although we have not been able to quantify all costs, we expect that the combined impact on State, local, or Tribal governments and the private sector does not meet the UMRA definition of an unfunded mandate.

This final rule will not impose a mandate that will result in the expenditure by State, local, and Tribal Governments, in the aggregate, or by the private sector, of more than $187 million in any 1 year.

G. Tribal Government and Consultation

Executive Orders 12866 and 13175 directs that significant regulatory actions avoid undue interference with Tribal governments[317] and that Agencies respect Indian Tribal self-government and sovereignty, honor Tribal treaty and other rights, and strive to meet the responsibilities that arise from the unique legal relationship between the Federal Government and Indian Tribal governments Indian Tribal governments.[318] The Department does not believe that the final rule would implicate the requirements of Executive Orders 12866 and 13175 with respect to Tribal sovereignty. Executive Order 13175 directs agencies to consult with Tribal officials

[317] Executive Order 12866 at § 6(a)(3)(B).
[318] Executive Order 13175 at § 2(a).

prior to the formal promulgation of regulations having Tribal implications. Because many Tribal members rely on Exchange coverage and benefits provided by other HHS programs, HHS conducts monthly outreach to Tribal officials through the CMS Tribal Technical Advisory Group to discuss Medicare, Medicaid, CHIP, and Exchange policies and issues, and specifically engaged the group in a discussion of the proposed rule. In doing so, HHS has met the requirements of Executive Order 13175.

H. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it issues a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications.

In compliance with the requirement of Executive Order 13132 that agencies examine closely any policies that may have Federalism implications or limit the policy making discretion of the States, we have engaged in efforts to consult with and work cooperatively with affected States, including participating in conference calls with and attending conferences of the NAIC, and consulting with State insurance officials on an individual basis.

While developing this final rule, we attempted to balance the States' interests in regulating health insurance issuers with the need to ensure market stability. By doing so, we complied with the requirements of Executive Order 13132.

Because States have flexibility in designing their Exchange and Exchange-related programs, State decisions will ultimately influence both administrative expenses and overall premiums. States are not required to establish an Exchange. For States that elected previously to operate an Exchange, those States had the opportunity to use funds under Exchange Planning and Establishment Grants to fund the development of data. Accordingly, some of the initial cost of creating programs was funded by Exchange Planning and Establishment Grants. After

establishment, Exchanges must be financially self-sustaining, with revenue sources at the discretion of the State. Current State Exchanges charge user fees to issuers.

In our view, this regulation has Federalism implications due to potential direct effects on the distribution of power and responsibilities among the State and Federal Governments relating to determining standards relating to health insurance that is offered in the individual and small group markets. For example, State Exchanges and States operating a BHP will be required to update their eligibility systems in order to no longer consider DACA recipients "lawfully present" for purposes of such programs. However, these Federalism implications may be balanced by the fact that we do not anticipate that these policies will impose substantial direct costs on the affected States, which in any event have chosen to operate their own Exchanges and eligibility and enrollment platforms, or the optional BHP. Additionally, the final rule will start the OEP for Exchanges on November 1 and end it on December 15 of the year preceding the benefit year, including for State Exchanges. For the 2025 annual OEP, 19 of 20 State Exchanges ended their OEP on or after January 15 of benefit year and one began before November 1 of the benefit year. This has Federalism implications because it will curtail flexibility in place to continue doing so. However, these implications may be balanced by limiting overall costs and burdens to State Exchanges on the basis of a truncated timeframe to hold open enrollment while maintaining flexibility to administer certain SEPs to support qualifying consumers. We intend that this final rule will preempt State law only to the extent such State law would prevent the application of these rules.[319]

This final rule also has Federalism implications as related to the provision finalizing a prohibition on coverage of specified sex-trait modification procedures as EHB. We understand that some States believe sex-trait modification services must be covered pursuant to State

[319] *See* section 1321(d) of the ACA.

nondiscrimination laws, one State requires coverage of sex-trait modification services as EHB by virtue of explicitly adding it to its EHB-benchmark plan through the process described at § 156.111(a)(1), and some States consider sex-trait modification services to be covered as EHB because it is included in their State EHB-benchmark plan, even though they did not update their EHB-benchmark plan. If these States want to require coverage of specified sex-trait modification procedures, as finalized in this rule, they will need to mandate that coverage outside of the EHB-benchmark update process at §156.111(a)(2) and defray the cost. However, as noted earlier in this final rule, we believe that such costs would be very small, as reflected by both low utilization and comments made in response to the proposed rule that costs are at most minuscule and may in fact be cost-neutral. Further, we note that Colorado, when it updated its EHB-benchmark plan to include sex-trait modification procedures, estimated that adding such benefits would have a 0.04 percent cost impact.

This final regulation is subject to the Congressional Review Act provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801 et seq.) and has been transmitted to the Congress and the Comptroller General for review.

Mehmet Oz, Administrator of the Centers for Medicare & Medicaid Services, approved this document on June 10, 2025.

List of Subjects

45 CFR Part 147

Aged, Citizenship and naturalization, Civil rights, Health care, Health Insurance, Individuals with disabilities, Intergovernmental relations, Reporting and record keeping requirements, Sex discrimination.

45 CFR Part 155

Administrative practice and procedure, Advertising, Aged, Brokers, Citizenship and naturalization, Civil rights, Conflict of interests, Consumer protection, Grant programs-health, Grants administration, Health care, Health insurance, Health maintenance organizations (HMO), Health records, Hospitals, Indians, Individuals with disabilities, Intergovernmental relations, Loan programs-health, Medicaid, Organization and functions (Government agencies), Public assistance programs, Reporting and recordkeeping requirements, Sex discrimination, State and local governments, Taxes, Technical assistance, Women, Youth.

45 CFR Part 156

Administrative practice and procedure, Advertising, Advisory committees, Brokers, Conflict of interests, Consumer protection, Grant programs-health, Grants administration, Health care, Health insurance, Health maintenance organization (HMO), Health records, Hospitals, Indians, Individuals with disabilities, Loan programs-health, Medicaid, Organization and functions (Government agencies), Public assistance programs, Reporting and recordkeeping requirements, State and local governments, Sunshine Act, Technical assistance, Women, and Youth.

For the reasons set forth in the preamble, under the authority at 5 U.S.C. 301, the Department of Health and Human Services amends 45 CFR subtitle A, subchapter B as set forth below.

PART 147—HEALTH INSURANCE REFORM REQUIREMENTS FOR THE GROUP AND INDIVIDUAL HEALTH INSURANCE MARKETS

1. The authority citation for part 147 continues to read as follows:

Authority: 42 U.S.C. 300gg through 300gg-63, 300gg-91, 300gg-92, and 300gg-111 through 300gg-139, as amended, and section 3203, Pub. L. 116-136, 134 Stat. 281.

2. Section 147.104 is amended by—

a. Revising paragraphs (b)(2)(i)(E) and (F);

b. Removing paragraph (b)(2)(i)(G); and

c. Revising paragraph (i).

The revisions read as follows:

§ 147.104 Guaranteed availability of coverage.

* * * * *

(b) * * *

(2) * * *

(i) * * *

(E) Section 155.420(d)(12) of this subchapter (concerning plan and benefit display errors); and

(F) Section 155.420(d)(13) of this subchapter (concerning eligibility for insurance affordability programs or enrollment in the Exchange).

* * * * *

(i) *Coverage denials for failure to pay premiums for prior coverage.* To the extent permitted by applicable State law, a health insurance issuer may deny coverage to an individual or employer due to the individual's or employer's failure to pay premiums owed under a prior policy, certificate, or contract of insurance offered by the issuer (or, if the issuer is a member of a controlled group (as defined in § 147.106(d)(4)), any other issuer that is member of such controlled group), including by attributing payment of premium for a new policy, certificate, or contract of insurance to the prior policy, certificate, or contract of insurance, provided the issuer applies its past-due premium payment policy uniformly to all individuals or employers in similar circumstances in the applicable market and State regardless of health status, and consistent with applicable nondiscrimination requirements, and does not condition the effectuation of new coverage on payment of past-due premiums by any individual other than the person contractually responsible for the payment of premium. The amount of the past-due premium an issuer may require for this purpose is subject to any premium payment threshold the issuer has adopted pursuant to § 155.400(g) of this subchapter. The Secretary may specify additional clarifications of acceptable parameters for coverage denials for failure to pay premiums for prior coverage in guidance.

* * * * *

PART 155—EXCHANGE ESTABLISHMENT STANDARDS AND OTHER RELATED STANDARDS UNDER THE AFFORDABLE CARE ACT

3. The authority citation for part 155 continues to read as follows:

Authority: 42 U.S.C. 18021-18024, 18031-18033, 18041-18042, 18051, 18054, 18071, and 18081-18083.

4. Section 155.20 is amended by—

a. In the definition of “Lawfully present”, revising paragraph (9) and adding paragraph (14); and

b. Adding a definition of "Preponderance of the evidence" in alphabetical order.

The revision and additions read as follows:

§ 155.20 Definitions.

* * * * *

Lawfully present * * *

(9) Is granted deferred action;

* * * * *

(14) An individual with deferred action under the Department of Homeland Security's Deferred Action for Childhood Arrivals process, as described at 8 CFR 236.22, shall not be considered to be lawfully present as described in any of the above categories in paragraphs (1) through (13) of this definition.

* * * * *

Preponderance of the evidence means proof by evidence that, compared with evidence opposing it, leads to the conclusion that the fact at issue is more likely true than not.

* * * * *

5. Section 155.220 is amended by revising paragraph (g)(2) introductory text to read as follows:

§ 155.220 Ability of States to permit agents and brokers and web-brokers to assist qualified individuals, qualified employers, or qualified employees enrolling in QHPs.

* * * * *

(g) * * *

(2) An agent, broker, or web-broker may be determined noncompliant under paragraph (g)(1) of this section if HHS finds by a preponderance of the evidence that the agent, broker, or web-broker violated—

* * * * *

6. Section 155.305 is amended by revising paragraph (f)(4) introductory text and adding paragraph (f)(4)(iii) to read as follows:

§ 155.305 Eligibility standards.

* * * * *

(f) * * *

(4) *Compliance with filing requirement.* Except as set forth in paragraph (f)(4)(iii) of this section, the Exchange may not determine a tax filer eligible for advance payments of the premium tax credit (APTC) if HHS notifies the Exchange as part of the process described in § 155.320(c)(3) that APTC payments were made on behalf of either the tax filer or spouse, if the tax filer is a married couple, for 2-consecutive years for which tax data would be utilized for verification of household income and family size in accordance with § 155.320(c)(1)(i), and the tax filer or the tax filer's spouse did not comply with the requirement to file an income tax return for that year and for the previous year as required by 26 U.S.C. 6011, 6012, and in 26 CFR chapter I, and reconcile APTC for that period.

* * * * *

(iii) For plan year 2026 only, an Exchange may not determine a tax filer eligible for APTC if HHS notifies the Exchange as part of the process described in § 155.320(c)(3) that APTC payments were made on behalf of the tax filer or either spouse, if the tax filer is a married couple, for a year for which tax data would be utilized for verification of household income and family size in accordance with § 155.320(c)(1)(i), and the tax filer or the tax filer's spouse did not comply with the requirement to file an income tax return for that year as required by 26 U.S.C. 6011, 6012 and implementing regulations, and reconcile the advance payments of the premium tax credit for that period.

(A) If HHS notifies the Exchange as part of the process described in § 155.320(c)(3) that APTC payments were made on behalf of either the tax filer or spouse, if the tax filer is a married

couple, for a year for which tax data would be utilized for verification of household income and family size in accordance with § 155.320(c)(1)(i), and the tax filer or the tax filer's spouse did not comply with the requirement to file an income tax return for that year as required by 26 U.S.C. 6011, 6012, and their implementing regulations and reconcile APTC for that period ("file and reconcile"), the Exchange must:

(*1*) Send a notification to the tax filer, consistent with the standards applicable to the protection of Federal Tax Information, that directly informs the tax filer that the Exchange has determined that the tax filer or the tax filer's spouse, if the tax filer is married, has failed to file and reconcile, and educate the tax filer of the need to file and reconcile or risk being determined ineligible for APTC if they fail to file and reconcile immediately upon receipt of notice; or

(*2*) Send a notification to either the tax filer or their enrollee, that informs the tax filer or enrollee that they may be at risk of being determined ineligible for APTC for the applicable coverage year. These notices must educate tax filers or their enrollees on the requirement to file and reconcile, while not directly stating that the IRS indicates the tax filer or their enrollee, or the tax filer's spouse, if the tax filer is married, has failed to file and reconcile.

(B) [Reserved]

* * * * *

7. Section 155.315 is amended by removing paragraph (f)(7).

§ 155.315 [Amended]

8. Section 155.320 is amended by revising paragraphs (c)(3)(iii)(A), (c)(3)(vi)(C)(*2*), and (c)(5) to read as follows:

§ 155.320 Verification process related to eligibility for insurance affordability programs.

* * * * *

(c) * * *

(3) * * *

(iii) * * *

(A) For plan years before plan year 2027, except as specified in paragraphs (c)(3)(iii)(B), (C), and (D) of this section, if an applicant's attestation to projected annual household income, as described in paragraph (c)(3)(ii)(B) of this section, would qualify the tax payer as an applicable taxpayer according to 26 CFR 1.36B-2(b) for the plan year for which coverage is requested and is more than a reasonable threshold above the annual household income computed in accordance with paragraph (c)(3)(ii)(A) of this section, the data described in paragraph (c)(3)(ii)(A) of this section indicates that projected annual household income is under 100 percent of the FPL, and the Exchange has not verified the applicant's MAGI-based income through the process specified in paragraph (c)(2)(ii) of this section to be within the applicable Medicaid or CHIP MAGI-based income standard, the Exchange must proceed in accordance with § 155.315(f)(1) through (4). However, this paragraph does not apply if the applicant is a non-citizen who is lawfully present and ineligible for Medicaid by reason of immigration status through the process specified in § 155.305(f)(2). For the purposes of this paragraph, a reasonable threshold is established by the Exchange in guidance and approved by HHS, but must not be less than 10 percent, and can also include a threshold dollar amount.

* * * * *

(vi) * * *

(C) * * *

(*2*) For plan years before plan year 2027, if the data described in paragraph (c)(3)(vi)(A) of this section indicates that projected annual household income is under 100 percent of the FPL and the applicant's attestation to projected household income, as described in paragraph (c)(3)(ii)(B) of this section, would qualify the tax payer as an applicable taxpayer according to 26 CFR 1.36B-2(b) for the plan year for which coverage is requested and is more than a reasonable threshold above the annual household income as computed using data sources described in

paragraph (c)(3)(vi)(A) of this section, in which case the Exchange must follow the procedures specified in § 155.315(f)(1) through (4). The reasonable threshold used under this paragraph must be equal to the reasonable threshold established in accordance with paragraph (c)(3)(iii)(D) of this section.

* * * * *

(5) *Acceptance of attestation*. For plan years 2027 and after, notwithstanding any other requirement described in this paragraph (c) to the contrary, when the Exchange requests tax return data and family size from the Secretary of Treasury as described in paragraph (c)(1)(i)(A) of this section but no such data is returned for an applicant, the Exchange will accept that applicant's attestation of income and family size without further verification.

* * * * *

9. Section 155.335 is amended by—

a. Adding paragraph (a)(3);

b. Revising paragraphs (j)(1) introductory text and (j)(2) introductory text;

c. Removing paragraph (j)(4) and redesignating paragraph (j)(5) as paragraph (j)(4); and

d. Adding paragraph (n).

The revisions and additions read as follows:

§ 155.335 Annual eligibility redetermination.

(a) * * *

(3) The annual redeterminations described in paragraph (a)(2)(ii) of this section are subject to the requirements in paragraph (n) of this section.

* * * * *

(j) * * *

(1) The product under which the QHP in which the enrollee is enrolled remains available through the Exchange for renewal, consistent with § 147.106 of this subchapter, the Exchange

will renew the enrollee in a QHP under that product, unless the enrollee terminates coverage, including termination of coverage in connection with voluntarily selecting a different QHP, in accordance with § 155.430, or unless otherwise provided in paragraph (j)(1)(iii)(A) of this section, as follows:

* * * * *

(2) No plans under the product under which the QHP in which the enrollee is enrolled are available through the Exchange for renewal, consistent with § 147.106 of this subchapter, the Exchange will enroll the enrollee in a QHP under a different product offered by the same QHP issuer, to the extent permitted by applicable State law, unless the enrollee terminates coverage, including termination of coverage in connection with voluntarily selecting a different QHP, in accordance with § 155.430, as follows:

* * * * *

(n) *Additional consumer protections.* For benefit year 2026 annual redeterminations, if an enrollee does not submit an application for an updated eligibility determination for the immediately forthcoming coverage year (2026) on or before the last day on which a plan selection must be made for coverage effective January 1, 2026, in accordance with the effective dates specified in § 155.410(f), and the enrollee's portion of the premium for a policy after the application of advance payments of the premium tax credit through the annual redetermination process would be zero dollars, the Exchange on the Federal platform must decrease the amount of the advance payment applied to the policy such that the remaining monthly premium owed for the policy equals $5.

10. Section 155.400 is amended by revising paragraph (g) introductory text, paragraph (g)(2), and paragraph (g)(3) introductory text to read as follows:

§ 155.400 Enrollment of qualified individuals into QHPs.

* * * * *

(g) *Premium payment threshold.* Except as otherwise provided in this paragraph, Exchanges may, and the Federally-facilitated Exchanges and State-Based Exchanges on the Federal platform will, until December 31, 2026, allow issuers to implement a percentage-based premium payment threshold policy which can be based on the net premium after application of advance payments of the premium tax credit, provided that the threshold policy is applied in a uniform manner to all applicants and enrollees. Effective beginning January 1, 2027, an Exchange may allow issuers to implement a percentage-based premium payment threshold policy (which can be based on either the net premium after application of advance payments of the premium tax credit or gross premium) and/or a fixed-dollar premium payment threshold policy, provided that the threshold and policy are applied in a uniform manner to all applicants and enrollees.

* * * * *

(2) Effective beginning January 1, 2027, under a gross premium percentage-based premium payment threshold policy, issuers can consider enrollees to have paid all amounts due for the following purposes, if the enrollees pay an amount sufficient to maintain a percentage of the gross premium of the policy before the application of advance payments of the premium tax credit that is equal to or greater than 98 percent of the gross monthly premium owed by the enrollees. If an enrollee satisfies the gross premium percentage-based premium payment threshold policy, the issuer may:

(i) Avoid triggering a grace period for non-payment of premium, as described by § 156.270(d) of this subchapter or a grace period governed by State rules.

(ii) Avoid terminating the enrollment for non-payment of premium as, described by §§ 156.270(g) of this subchapter and 155.430(b)(2)(ii)(A) and (B).

(3) Effective beginning January 1, 2027, under a fixed-dollar premium payment threshold policy, issuers can consider enrollees to have paid all amounts due for the following purposes, if

the enrollees pay an amount that is less than the total premium owed, the unpaid remainder of which is equal to or less than a fixed-dollar amount of $10 or less, adjusted for inflation, as prescribed by the issuer. If an enrollee satisfies the fixed-dollar premium payment threshold policy, the issuer may:

* * * * *

11. Section 155.410 is amended by—

a. Revising paragraph (e)(4) introductory text;

b. Adding paragraph (e)(5);

c. Revising paragraph (f)(3) introductory text; and

d. Adding paragraph (f)(4).

The revisions and additions read as follows:

§ 155.410 Initial and annual open enrollment periods.

* * * * *

(e) * * *

(4) For benefit years beginning on January 1, 2022, through January 1, 2026—

* * * * *

(5) For benefit years beginning on or after January 1, 2027—

(i) The annual open enrollment period for all Exchanges must begin no later than November 1 and must end no later than December 31 of the calendar year preceding the benefit year.

(ii) The annual open enrollment period must not exceed 9 weeks in duration.

(f) * * *

(3) For benefit years beginning on January 1, 2022, through January 1, 2026, the Exchange must ensure that coverage is effective—

* * * * *

(4) For benefit years beginning on or after January 1, 2027, the Exchange must ensure that coverage is effective January 1, for QHP selections received by the Exchange on or before December 31 of the calendar year preceding the benefit year.

* * * * *

12. Section 155.420 is amended by revising paragraphs (a)(4)(ii)(D), (a)(4)(iii) introductory text, (b)(2)(vii), (d)(16), and (g) to read as follows:

§ 155.420 Special enrollment periods.

(a) * * *

(4) * * *

(ii) * * *

(D) Beginning plan year 2027, if an enrollee or his or her enrolled dependents qualify for a special enrollment period in accordance with paragraph (d)(16) of this section, the Exchange must allow the enrollee and his or her enrolled dependents to change to any available silver-level QHP if they elect to change their QHP enrollment. If a qualified individual or a dependent who is not an enrollee qualifies for a special enrollment period in accordance with paragraph (d)(16) of this section and has one or more household members who are enrollees, the Exchange must allow the enrollee to add the newly enrolling household member to his or her current QHP; or, to change to a silver-level QHP and add the newly enrolling household member to this silver-level QHP; or, to change to a silver level QHP and enroll the newly enrolling qualified individual or dependent in a separate QHP;

(iii) For the other triggering events specified in paragraph (d) of this section, except for paragraphs (d)(2)(i), (d)(4), and (d)(6)(i) and (ii) of this section for becoming newly eligible or ineligible for CSRs, and paragraphs (d)(8), (9), (10), (12), and (14) of this section, and beginning in plan year 2027, paragraph (d)(16) of this section:

* * * * *

(b) * * *

(2) * * *

(vii) Beginning plan year 2027, if a qualified individual or enrollee, or the dependent of a qualified individual or enrollee, who is eligible for advance payments of the premium tax credit, and whose household income, as defined in 26 CFR 1.36B-1(e), is expected to be no greater than 150 percent of the Federal poverty level, enrolls in a QHP or changes from one QHP to another one time per month in accordance with paragraph (d)(16) of this section, the Exchange must ensure that coverage is effective in accordance with paragraph (b)(1) of this section or on the first day of the month following plan selection, at the option of the Exchange.

* * * * *

(d) * * *

(16) Beginning plan year 2027, at the option of the Exchange, a qualified individual or enrollee, or the dependent of a qualified individual or enrollee, who is eligible for advance payments of the premium tax credit, and whose household income, as defined in 26 CFR 1.36B-1(e), is expected to be at or below 150 percent of the Federal poverty level, may enroll in a QHP or change from one QHP to another one time per month.

* * * * *

(g) *Special enrollment period verification.* Beginning January 1, 2026 unless a request for modification is granted in accordance with § 155.315(h), Exchanges on the Federal platform must conduct pre-enrollment verification of applicants' eligibility for special enrollment periods under this section. An Exchange meets this requirement if it verifies eligibility each plan year for the number of individuals newly enrolling in Exchange coverage through special enrollment periods that equals at least 75 percent of all special enrollments based on prior year enrollments. If the Exchange is unable to verify eligibility for individuals newly enrolling in Exchange coverage through a special enrollment period for which the Exchange requires verification, then

the individuals are not eligible for enrollment through the Exchange. In accordance with § 155.505(b)(1)(iii), individuals have the right to appeal the eligibility determination. This requirement will apply through December 31st 2026, unless it is renewed through rulemaking prior to that date.

PART 156 – HEALTH INSURANCE ISSUER STANDARDS UNDER THE AFFORDABLE CARE ACT, INCLUDING STANDARDS RELATED TO EXCHANGES

13. The authority citation for part 156 continues to read as follows:

Authority: 42 U.S.C. 18021-18024, 18031-18032, 18041-18042, 18044, 18054, 18061, 18063, 18071, 18082, and 26 U.S.C. 36B.

14. Section 156.115 is amended by revising paragraph (d) to read as follows:

§ 156.115 Provision of EHB.

* * * * *

(d) For plan years beginning before January 1, 2026, an issuer of a plan offering EHB may not include routine non-pediatric dental services, routine non-pediatric eye exam services, long-term/custodial nursing home care benefits, or non-medically necessary orthodontia as EHB. For plan years beginning on any day in calendar year 2026, an issuer of a plan offering EHB may not include routine non-pediatric dental services, routine non-pediatric eye exam services, long-term/custodial nursing home care benefits, non-medically necessary orthodontia, or specified sex-trait modification procedures (as defined at § 156.400) as EHB. For plan years beginning on or after January 1, 2027, an issuer of a plan offering EHB may not include routine non-pediatric eye exam services, long-term/custodial nursing home care benefits, non-medically necessary orthodontia, or specified sex-trait modification procedures (as defined at §156.400) as EHB.

15. Section 156.140 is amended by revising paragraph (c) to read as follows:

§ 156.140 Levels of coverage.

* * * * *

(c) *De minimis variation*. (1) The allowable variation in the AV of a health plan that does not result in a material difference in the true dollar value of the health plan is −4 percentage points and +2 percentage points, except if a health plan under paragraph (b)(1) of this section (a bronze health plan) either covers and pays for at least one major service, other than preventive services, before the deductible or meets the requirements to be a high deductible health plan within the meaning of section 223(c)(2) of the Internal Revenue Code, in which case the allowable variation in AV for such plan is −4 percentage points and +5 percentage points.

(2) [Reserved.]

16. Section 156.200 is amended by revising paragraph (b)(3) to read as follows:

§ 156.200 QHP issuer participation standards.

* * * * *

(b) * * *

(3) Ensure that each QHP complies with benefit design standards, as defined in § 156.20;

* * * * *

17. Section 156.400 is amended by revising the definition of "De minimis variation for a silver plan variation" and adding a definition of "Specified sex-trait modification procedure" in alphabetical order to read as follows:

§ 156.400 Definitions.

* * * * *

De minimis variation for a silver plan variation means a -1-percentage point and +1-percentage point allowable AV variation.

* * * * *

Specified sex-trait modification procedure means any pharmaceutical or surgical intervention that is provided for the purpose of attempting to align an individual's physical appearance or body with an asserted identity that differs from the individual's sex either by:

(1) intentionally disrupting or suppressing the normal development of natural biological functions, including primary or secondary sex-based traits; or

(2) intentionally altering an individual's physical appearance or body, including amputating, minimizing or destroying primary or secondary sex-based traits such as the sexual and reproductive organs.

This term does not include procedures undertaken (1) to treat a person with a medically verifiable disorder of sexual development, or (2) for purposes other than attempting to align an individual's physical appearance or body with an asserted identity that differs from the individual's sex.

* * * * *

Robert F. Kennedy, Jr.,

Secretary,

Department of Health and Human Services.