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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

45 CFR Parts 147, 155, and 156

[CMS-9884-P]

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: Proposed rule.

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

DATES: To be assured consideration, comments must be received at one of the addresses provided below, by **[**Insert date 30 days after date of display in the **Federal Register]**.

ADDRESSES: In commenting, please refer to file code CMS-9884-P.

Comments, including mass comment submissions, must be submitted in one of the following three ways (please choose only one of the ways listed):

1. *Electronically*. You may submit electronic comments on this regulation to *http://www.regulations.gov*. Follow the "Submit a comment" instructions.

2. *By regular mail*. You may mail written comments to the following address ONLY:

Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

Attention: CMS-9884-P,

P.O. Box 8016,

Baltimore, MD 21244-8016.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail*. You may send written comments to the following address ONLY:

Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

Attention: CMS-9884-P,

Mail Stop C4-26-05,

7500 Security Boulevard,

Baltimore, MD 21244-1850.

For information on viewing public comments, see the beginning of the "SUPPLEMENTARY INFORMATION" section.

FOR FURTHER INFORMATION CONTACT:

Jeff Wu, (301) 492-4305, Rogelyn McLean, (410) 786-1524, Grace Bristol, (410) 786-8437, for general information.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: Comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post comments received before the close of the comment period on the following website as soon as possible after they have been received: *http://www.regulations.gov*. Follow the search instructions on that website to view public comments. We will not post on *Regulations.gov* public comments that make threats to individuals or institutions or suggest that the commenter will take actions to harm an individual. We continue to encourage individuals not to submit duplicative comments. We will post acceptable comments from multiple unique commenters even if the content is identical or nearly identical to other comments.

Plain Language Summary: In accordance with 5 U.S.C. 553(b)(4), a summary of not more than 100 words in length of this proposed rule, in plain language, may be found at *https://www.regulations.gov/*.

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 relief from rising health care costs, we propose 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. We expect these actions would provide premium relief to families who do not qualify for Federal premium subsidies and reduce the burden of the ACA premium subsidy expenditures to the Federal taxpayer.

Based on our review of enrollment data and our experience fielding consumer complaints, we believe several regulatory policies recently put in place to make it easier to enroll in subsidized coverage severely weakened program integrity and put consumers at risk from improper enrollment. In particular, these policies put consumers at risk for accumulating surprise tax liabilities and substantial inconveniences from resolving these liabilities, as well as other issues related to coverage changes and access to care, due to the improper enrollment. The substantial 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.[2] We note, fraudulent enrollments involve enrollments

[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.

[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*

obtained through willful misrepresentations whereas improper enrollments involve any enrollment determination that was made incorrectly for any reason which can include fraud.[3]

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 proposed provisions here aim to address these serious program integrity problems while at the same time delivering a streamlined enrollment and eligibility determination process for individual market consumers.

Before summarizing these proposed rules, 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 believe the program integrity and premium relief policies contained within these proposed rules are necessary to improve the individual health insurance market. As a starting point, the ACA establishes American Health Benefit Exchanges, or "Exchanges" to facilitate the purchase of qualified health plans (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

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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

[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.

[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".

reduced through cost-sharing reductions (CSR). Most individuals who claim PTCs receive APTC, which subsidizes 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 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 for everyone.

To discourage people from waiting until they need health care services to sign up for coverage, the ACA permits issuers to limit enrollment periods to certain times. The ACA also provides PTC for plans sold through Exchanges to subsidize coverage for certain households.

Several policies included in the ACA attempt to address its adverse selection bias. For example, adverse selection between plans can occur when one plan enrolls a disproportionate number of people with high risks. 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] In addition, to avoid adverse selection between plans sold on and off the Exchanges, the ACA requires issuers to keep issuers to keep all individual market plans subject to the law's main coverage mandates in the same risk pool.

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] In practice, however, 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, like grandfathered and short-term plans) nationwide in 2023.[8] Further, subsidies, especially price-linked subsidies like PTCs, generally distort markets and weaken competition because the subsidized enrollee is no longer price sensitive to the full cost.[9] In a market where everyone is subsidized, prices would generally be much higher due to the subsidized consumers' lower level of price sensitivity.[10] When Congress enacted the ACA, the Congressional Budget

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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/

[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 Feb. 23, 2025).

[8] 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/#.

[9] *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.

[10] 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

Office (CBO) projected the law would enroll 15 million unsubsidized consumers—about the same as without the law—and another 19 million subsidized consumers.[11] 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.[12] To improve the attractiveness of the market, several States 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.

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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.

[11] 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.

[12] 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 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.

After reviewing individual market data and responding to a substantial increase in consumer complaints, we believe several rules we have implemented removed necessary program integrity protections and facilitated the substantial increase in improper enrollments on the Exchanges. Some of those rules removed or reduced eligibility verifications related to qualifying for APTC and CSR subsidies. Other rules amended enrollment period policies by removing verifications and expanding when and under what conditions a consumer can enroll. We believe the data and analysis presented in this preamble show how these rules have led to higher premiums and costs for consumers and taxpayers alike. Therefore, we propose the following regulatory changes to improve program integrity and protect against adverse selection, while at the same time keeping the enrollment process streamlined and accessible, especially for low-income consumers who utilize Exchanges for subsidized individual market coverage.

We propose to remove § 147.104(i), which would reverse the policy restricting an issuer from attributing payment of premium for new coverage to past-due premiums from prior coverage. This current policy, in effect, restricts issuers from establishing premium payment policies that require enrollees to pay past-due premiums to effectuate new coverage. While we previously concluded that this restriction 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 coverage to when they need health care services. Alongside the removal of this restriction, we propose to allow issuers, subject to applicable State law, to add past-due premium amounts owed to the issuer to the initial premium the enrollee must pay to effectuate new coverage and to not effectuate new coverage if the past-due and initial premium amounts are not paid in full. We believe this change would strengthen the risk pool and lower gross premiums.

We propose to modify 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.[13] The BHP regulations at 42 CFR 600.5 cross-reference the definition of lawfully present at 45 CFR 155.20. This change would reflect the explicit statutory requirements of the ACA by once again excluding "Deferred Action for Childhood Arrivals" (DACA) recipients from the definition of "lawfully present" that is used to determine eligibility to enroll in a QHP through an Exchange, for APTC and CSRs, and for a BHP in States that elect to operate a BHP.

We propose to revise § 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 also propose to add a definition for "preponderance of the evidence" to § 155.20. We believe this change would 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.

We propose to revise the failure to file and reconcile (FTR) process at § 155.305(f)(4) to reinstate the policy 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 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. This proposed process would replace the existing requirement that Exchanges may not determine a tax filer eligible for APTC if HHS

[13] Currently, Minnesota and Oregon operate a BHP. See their approved BHP Blueprints, available at: https://www.medicaid.gov/basic-health-program/index.html.

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. We believe this change would reduce the number of ineligible enrollees who continue to receive APTC, which would, in turn, lower APTC expenditures and protect ineligible enrollees from accumulating surprise tax liabilities. We also propose to amend the notice requirement at § 155.305(f)(4)(i) and remove the notice requirement at § 155.305(f)(4)(ii) to conform with the notice policy under the previous FTR policy.

To further protect against consumers receiving APTC and CSR subsidies when they do not meet eligibility requirements, we propose policies to strengthen the verification process when there is an income inconsistency with trusted data sources. We propose to remove § 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) would end APTC payments to individuals who have failed to provide documentation verifying their eligibility for APTC within 90 days and further protect them from surprise tax liabilities if they are ineligible. We also propose to revise § 155.320(c)(3)(iii) to specify that all Exchanges must generate annual household income inconsistencies when a tax filer's attested projected annual household income is greater than or equal to 100 percent and not more than 400 percent of the Federal poverty level (FPL) and trusted data sources indicate that projected household income is under 100 percent of the FPL. Finally, we propose to remove § 155.320(c)(5) which would remove 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 would 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 would strengthen program integrity by improving the accuracy of eligibility determinations across all Exchanges.

To prevent fully subsidized enrollees from being automatically re-enrolled without taking an action to confirm their eligibility information, we propose an amendment to the annual eligibility redetermination regulation and are seeking comment on a range of potential measures to ensure program integrity with respect to re-enrollments. We propose that, when an enrollee does not contact an Exchange to obtain an updated eligibility determination and select a plan on or before the last day to do so 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 dollars after application of APTC through the Exchange's annual redetermination process, 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 their eligibility for APTC. Consistent with § 155.310(c) and (f), enrollees automatically reenrolled with a $5 monthly premium after APTC under this policy would 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 propose that the Federally-facilitated

Exchanges (FFEs) and the State-based Exchanges on the Federal platform (SBE-FPs) must implement this change starting with annual redeterminations for benefit year 2026. We propose that the State Exchanges must implement it starting with annual redeterminations for benefit year 2027. We believe these proposals would strengthen the program integrity of the Exchanges and protect consumers.

We are also seeking 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 are seeking 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 are seeking comment on removing the option for Exchanges to auto-reenroll individuals who qualify for fully or partially subsidized plans, ensuring individuals affirmatively choose their plan and verify their income during the open enrollment period, dramatically reducing the likelihood of improper payments of the APTC.

We propose to amend 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 believe the consumer awareness problem the current policy aimed to address is

substantially less today and, therefore, no longer outweighs the negative consequences from not automatically re-enrolling consumers whose current plan remains available for an upcoming plan year without the active consent of the consumer, including that the policy could confuse consumers, undermine consumer choice, and create unexpected tax liability.

We propose to modify § 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. 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 allow an enrollee to remain enrolled in coverage for extended periods of time after payment of the binder. Therefore, we propose to limit issuers to the net percentage-based premium payment threshold at § 155.400(g)(1).

For benefit years starting January 1, 2026, and beyond, we propose to change the annual Open Enrollment Period (OEP) for coverage through all individual market Exchanges from November 1 through January 15 to November 1 through December 15 of the calendar year preceding the benefit year of enrollment. This change would also apply to non-grandfathered individual health insurance coverage offered outside of an Exchange.

We propose to remove § 155.420(d)(16) and make conforming changes to repeal the monthly special enrollment period (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. We believe this proposal and the proposal to change the length of the OEP would improve the risk pool by reducing adverse selection from people who may otherwise wait to enroll until they need health care services and would

encourage enrollees to maintain continuous coverage for the full year. We also anticipate this would lower premiums.

Based on recent evidence[14] suggesting an increase in the misuse and abuse of SEPs to gain coverage outside the OEP, we propose to amend § 155.420(g) to enable HHS to reinstate pre-enrollment verification of eligibility of applicants for all categories of individual market SEPs. We propose 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. We understand that most Exchanges most likely would be able to meet this requirement by verifying just two of their most used SEPs.

We propose to amend § 156.115(d) to provide that an issuer of coverage subject to EHB requirements may not provide sex-trait modification as an EHB beginning with Plan Year (PY) 2026.

We propose to update the premium adjustment percentage methodology to establish a premium growth measure that comprehensively reflects premium growth in all affected markets. This premium growth measure is used to ensure that certain parameters change with health insurance market premiums over time, including 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 proposed change would re-adopt the premium growth measure that was in place for PY 2020 and PY 2021 and apply it to the related parameters starting with PY 2026. As such, we also propose the PY 2026 maximum annual limitation on cost sharing, reduced maximum

[14] 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 1/03/2025.

annual limitations on cost sharing, and required contribution percentage under § 155.605(d)(2) using the proposed premium adjustment percentage methodology.

Beginning in PY 2026, we propose changing the de minimis thresholds for the 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,[15] for which we propose a de minimis range of +5/-4 percentage points, as well as establishing wider de minimis thresholds for income-based CSR plan variations.

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.

Section 2703 of the PHS Act, as added by the ACA, and sections 2712 (former) and 2741 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 of Health and Human Services (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,

[15] 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.

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 of HHS 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 Social Security Act (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 be 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 more specifically, section 1331(e) requires that an individual must either be a citizen or national of the United States or be lawfully present in the United States to enroll in a BHP in States that elect to operate a BHP.

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 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 "first Program Integrity Rule" published in the August 30, 2013 **Federal Register** (78 FR 54069), and the "second Program Integrity 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 (2019 Program Integrity 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, et al. v. Cochran*, No. 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

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. Provisions of the Individual Health Insurance Market and Exchange Program Integrity Proposed Rule

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

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

As further discussed in section III.B.8. of this preamble 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 propose 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 open enrollment period (OEP) for coverage offered outside of an Exchange. In proposing the removal of § 147.104(b)(2)(i)(G), we do not intend to include § 155.420(d)(16) as a triggering event for a limited OEP for coverage offered outside of an Exchange; rather, we are proposing to remove § 147.104(b)(2)(i)(G) to reflect the removal of the SEP at § 155.420(d)(16). We request comment on this proposal.

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

We propose to remove § 147.104(i) that restricts an issuer from attributing payment of premium for new coverage to past-due premiums from prior coverage. Similar to the policy we

articulated in the Market Stabilization Rule (82 FR 18349 through 18353), we also propose to allow issuers to attribute to past-due premium amounts they are owed the initial premium the enrollee pays to effectuate new coverage. Unlike the policy articulated in the Market Stabilization Rule (82 FR 18349 through 18353), the proposal would not limit the policy to past-due premium amounts accruing over the prior 12 months. States would remain free to impose such a limitation and apply additional parameters governing issuers' premium payment policies, to the extent permitted under Federal law.

As background, when we initially proposed the guaranteed availability regulations in the proposed 2014 Market Rules (77 FR 70584, 70599), we noted concerns about the ability of individuals to manipulate guaranteed availability each year. We also noted how guaranteed renewability requirements under section 2703 of the PHS Act allow issuers to non-renew or discontinue coverage for non-payment of premiums while the guaranteed availability requirements under section 2702 of the PHS Act do not include an exception allowing issuers to refuse to cover individuals with histories of non-payment under other policies with the same issuer or other issuers. We then solicited comments on ways to discourage people from gaming guaranteed availability rights while, at the same time, ensuring consumers retained the right afforded by law. In response, commenters, including the National Association of Insurance Commissioners (NAIC), suggested that there are several tools States use to limit adverse selection.[16] In the 2014 Market Rules (78 FR 13406, 13416 through 13417), we did not provide

[16] Tools identified by commenters included, for example, (1) allowing issuers to require pre-payment of premiums each month; (2) allowing issuers to require payment of all outstanding premiums before enrollees can re-enroll in coverage after termination due to non-payment of premiums; (3) allowing late enrollment penalties or surcharges (similar to those in Medicare Parts B and D); (4) allowing issuers to establish waiting periods or delayed effective dates of coverage; (5) allowing issuers to offset claims payments by the amount of any owed premiums; (6) allowing issuers to prohibit individuals who have canceled coverage or failed to renew from enrolling until the second open enrollment period after their coverage ceased (unless they replace coverage with other creditable coverage); (7) restricting product availability (for example, to a catastrophic, bronze, or silver level plan) outside of enrollment

any further guidance on what the statute's guaranteed availability provision requires and took no further actions to address these concerns over gaming the guaranteed availability requirement.

After finalizing the 2014 Market Rules (78 FR 13406), we published instructions in annual Exchange enrollment manuals that interpreted the guaranteed availability requirement to mean that an issuer may not apply any premium payment made for coverage under a new enrollment to any outstanding debt owed from any previous coverage that has been terminated for non-payment of premiums and then refuse to effectuate the new enrollment based on failure to pay premiums.[17] Under that interpretation, enrollment under an SEP or annual OEP subsequent to a termination for non-payment of premium would be considered a new enrollment that would fall under the guaranteed availability requirements and the consumer must be allowed to purchase coverage without having to pay past-due premiums. However, we also provided guidance that in situations where an enrollee's grace period for non-payment of premiums spans 2 plan years,[18] and the individual seeks to renew prior coverage with the same issuer in the same

periods to prevent high-risk individuals from enrolling in more generous coverage when medical needs arise; and (8) allowing individuals to move up one metal level each year through the Exchange shopping portal (78 FR 13406, 13416).

[17] CMS. (version as of 2016, July 19). *Federally-facilitated Marketplace and Federally-facilitated Small Business Health Options Program Enrollment Manual*. Section 6.3 Terminations for Non-Payment of Premiums. https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/ENR_FFMSHOP_Manual_080916.pdf (stating that if a consumer selects a QHP from which they had been previously terminated for non-payment of premium by qualifying for another SEP or during the next OEP, then the QHP cannot attribute any payment from the individual toward the outstanding debt from the prior, terminated enrollment and then refuse to enroll the applicant based on failure to pay premiums); and CMS. (version as of 2015, Oct. 1). *Federally-facilitated Marketplace and Federally-facilitated Small Business Health Options Program Enrollment Manual*. Section 6.3 Terminations for Non-Payment of Premiums. *https://www.cms.gov/cciio/resources/regulations-and-guidance/downloads/updated_enr_manual.pdf.* See also, CMS. (2013, Oct. 3). *Federally Facilitated Marketplace, Enrollment Operational Policy & Guidance. https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/ENR_OperationsPolicyandGuidance_5CR_100313.pdf* (stating that "If the [qualified individual] selects the same QHP from which he or she was previously terminated [for non-payment of premiums], the QHP cannot terminate enrollment in the QHP in which the [qualified individual] newly enrolled based on failure to pay for any previously owed and unpaid premium.").

[18] This could occur if enrollees who are receiving APTC fail to timely pay their premium in full or in an amount necessary to satisfy a payment threshold, if applicable, for November or December coverage.

product, the issuer could attribute the enrollee's premium payments to the oldest outstanding debt in the existing grace period (that is, the prior non-payments).[19]

Due to substantial market instability and data confirming prior concerns over consumers gaming the guaranteed availability requirement, we revisited these Exchange enrollment instructions through formal rulemaking in the Market Stabilization Rule (82 FR 18346). In that rule, we modified our interpretation of the guaranteed availability requirement with respect to non-payment of premiums. Under that modification, we allowed issuers, subject to applicable State law, to apply a premium payment to an individual's past debt owed for coverage from the same issuer or a different issuer in the same controlled group within the prior 12 months before applying the payment toward a new enrollment. The Market Stabilization Rule (82 FR 18346) cited third-party research and our own internal analysis showing a substantial portion of enrollees' coverage had been terminated due to non-payment of premium and, among these terminations, a large portion repurchased plans the following plan year from the same issuer.

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

[19] CMS. (version as of 2016, July 19). *Federally-facilitated Marketplace (FFM) and Federally-facilitated Small Business Health Options Program Enrollment Manual*. Section 6.5.2 Grace Period Spanning Two Plan Years, https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/ENR_FFMSHOP_Manual_080916.pdf.

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.

On January 28, 2021, President Biden issued Executive Order (E.O.) 14009,[20] directing the Department of Health and Human Services (HHS), and the heads of all other executive departments and agencies with authorities and responsibilities related to the ACA, to review all existing regulations, orders, guidance documents, policies, and any other similar agency actions to determine whether such agency actions were inconsistent with that Administration's policy with respect to the ACA. After reviewing the interpretation of guaranteed availability that we codified in the Market Stabilization Rule (82 FR 18349 through 18353), we concluded that interpretation had the unintended consequence of creating barriers to health coverage that disproportionately affect low-income individuals. In the 2023 Payment Notice (87 FR 27208), consistent with section 3(iv) of E.O. 14009 and section 2(a) of E.O. 14070, we then re-interpreted the guaranteed availability requirement and added a new § 147.104(i) to specify that a health insurance issuer that denies coverage to an individual or employer due to the individual's or employer's failure to pay premium owed under a prior policy, certificate, or contract of insurance, including by attributing payment of premium for a new policy, certificate, or contract of insurance to the prior policy, certificate, or contract of insurance, violates § 147.104(a).

In finalizing that current interpretation, we attempted to assess the policy impact of our prior interpretation. In the 2023 Payment Notice (87 FR 27369), we conducted an internal analysis and estimated the percent of enrollees in Exchanges using the Federal platform that had their coverage terminated for non-payment of premiums was 17.3 percent in 2017, 12.4 percent

[20] 86 FR 7793. E.O. 14009 was subsequently revoked by E.O. 14148, "Initial Rescissions of Harmful Executive Orders and Actions." *See* 90 FR 8237.

in 2018, 10.7 percent in 2019, and 7.8 percent in 2020.[21] This steady decline is consistent with what would be expected to happen if the Market Stabilization Rule (82 FR 18346) successfully encouraged enrollees to continue paying premiums. However, due to data limitations we concluded that we were unable to directly attribute any changes in enrollment behavior in the Exchanges using the Federal platform to the interpretation of the guaranteed availability requirement stated in the Market Stabilization Rule (82 FR 18346).

It is possible, however, that this decline in the rate of enrollees who had their coverage terminated from 2017 to 2020 happened in part because the interpretation of the guaranteed availability requirement adopted in the Market Stabilization Rule (82 FR 18349 through 18353) successfully encouraged enrollees to continue paying premiums. Actions by issuers to require enrollees to pay initial and past-due premiums to obtain coverage may have contributed to an improved risk pool by keeping healthier people enrolled who may have otherwise stopped payment if they anticipated they would not need covered health services for the rest of the plan year.

We previously determined that reversing the Market Stabilization Rule's policy would increase access to health insurance coverage for individuals who stop paying premiums due to reasons such as financial hardship or affordability and who are currently unable to enroll in coverage because they cannot afford to pay both past-due premiums and the first month premium for new coverage. Given the availability of premium support for many who experience financial hardship, we anticipate that enrollment loss from requiring payment of past-due premiums would be minimal. Enrollment losses should be minimal because the amount most individuals owe in

[21] The regulatory impact analysis stated that these annual figures should not necessarily be interpreted as trends, as some States moved from Exchanges using the Federal platform to State Exchanges and the overall composition of the dataset may have changed (87 FR 27369, fn 381).

past-due premiums is relatively small and thus having to pay those amounts generally would not impose a substantial financial burden to enroll in coverage. Because of rules regarding grace periods and termination of coverage, individuals with past-due premiums who receive APTC would generally owe no more than 1 to 3 months of past-due premium amounts.[22] Furthermore, for individuals on whose behalf the issuer received APTC, their past-due premiums would be net of any APTC that was paid on the individual's behalf to the issuer, with respect to any months for which the individual is paying past-due premiums, and thus, the typical past-due premium is quite small. We continue to believe that allowing issuers to require payment of past-due premiums to effectuate coverage is aligned with the statutory text in section 2702 of the PHS Act and is consistent with section 2703 of the PHS Act regarding guaranteed renewability.

Under section 2702(a) of the PHS Act, issuers are generally required to accept every individual and employer in the State that applies for coverage, subject to certain exceptions. These exceptions allow issuers to uniformly limit enrollment: (1) to certain open enrollment periods and SEPs; (2) to an employer with eligible employees who live, work, or reside in the service area of a network plan; (3) if the capacity of a network plan cannot provide adequate services to new enrollees; and (4) if the issuer does not have the financial reserves necessary to underwrite additional coverage. Under this framework, the PHS Act's guaranteed availability requirements focus on regulating matters under the control of the issuer to accept every

[22] 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.

individual and employer that applies for coverage except under a limited set of exceptions where a uniform enrollment limit protects the viability of the market and individual issuers.

Section 2703 of the PHS Act requires an issuer that offers health insurance coverage in the group or individual market to renew or continue in force such coverage at the option of the plan sponsor or individual, unless certain exceptions apply. These exceptions allow issuers to non-renew or discontinue coverage for non-payment of premium, committing fraud, violating employer participation or contribution rules, moving outside the network service area, or ceasing the membership of an employer in an association. In addition, an issuer may also uniformly terminate coverage by following a specific set of requirements. These guaranteed renewability exceptions focus on allowing issuers to respond to individual and employer behavior after their coverage is in force. Under this framework, the guaranteed renewability requirements cover both renewals and the continuing of coverage in force throughout the year.

Whether or not an exception applies would depend on the issuer's terms of coverage, and applicable State and Federal law. Section 2703 of the PHS Act gives issuers broad flexibility to establish terms of coverage related to most of the exceptions. In traditional insurance contracts, there are typically provisions related to premium payments, fraud, employer participation and contribution rates, and living, residing, or working in the network service area. By enrolling in coverage, the applicant accepts the terms of coverage. After coverage is in force (including in instances where an enrollee is renewing prior coverage), the issuer may discontinue coverage if the individual fails to follow the terms of coverage for one of the exceptions provided under the law.

Consistent with section 2702 of the PHS Act, we propose to allow issuers to establish terms of coverage that attribute the initial premium an enrollee pays to effectuate new coverage

to past-due premium amounts owed to an issuer and then to refuse to effectuate coverage if the payment does not equal the outstanding debt and the new monthly premium amount. Assuming State law does not prohibit such action, this would permit an issuer to establish terms of coverage that require a policyholder whose coverage is terminated for non-payment of premium in the individual or group market to pay all past-due premium owed to that issuer in order to purchase new coverage from that issuer. Under this proposal, similar to the policy in the Market Stabilization Rule, an issuer would be required to apply its 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.[23] The proposal would not permit an issuer 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.

This interpretation also avoids the perverse incentives introduced under the current interpretation. Under the current interpretation, an enrollee who is receiving APTC and who renews and owes past-due payments at the start of the plan year (because the individual failed to pay the full amount due starting in November or December) will be in a 3-month grace period in January and must pay the full amount owed by the end of the grace period to prevent termination.[24] In contrast, someone who is not renewing coverage under the same product but instead selects coverage under a different product and owes past-due premiums would be able to

[23] 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 non-discrimination obligations under State law.

[24] See, Federally-facilitated Exchange (FFE) Enrollment Manual, Section 6.3 Terminations for Non-Payment of Premiums (version effective as of Aug. 19, 2024), available at https://www.cms.gov/files/document/ffe-enrollment-manual-2024-5cr-082024.pdf (stating that for individuals whose grace period for non-payment of premiums extends past the end of the annual OEP and who either auto-renews or makes an active plan selection that is a continuation of the same coverage, the issuer may attribute enrollee payments to the oldest outstanding debt in the existing grace period for the current coverage).

pay the binder payment to effectuate new coverage without being in a grace period or paying past-due premiums. Therefore, by choosing new coverage versus continuing in the same coverage, the enrollee can avoid paying the outstanding debt before starting coverage for the next plan year. While the enrollee still owes a debt to the issuer related to the prior coverage, this strategy makes the debt far harder for the issuer to collect and buys the enrollee more flexibility to game their coverage period. Under our proposal, the obligation to pay the past debt does not change based on whether the annual contract is new or a renewal.

In the 2016 Payment Notice (80 FR 10750, 10794), we revised § 155.400(e) to establish a standard policy for premium payment deadlines in the FFEs, while leaving other Exchanges the option of establishing such policies. In particular, we set a uniform deadline for the payment of the first month's premium to effectuate an enrollment. When setting this policy, we received several comments recommending that HHS give issuers flexibility surrounding payment deadlines and, in response, we recognized 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. While we have established certain uniform standards for premium payment deadlines, premium payment policies are generally business decisions made by issuers, subject to State rules. We therefore propose to allow issuers, to the extent permitted by applicable State law, to establish terms of health insurance coverage that attribute to past-due premium amounts owed to an issuer the initial premium the enrollee pays to effectuate new coverage. We propose that this policy would apply starting on the effective date of the final rule. We seek comment on this proposal.

In the Market Stabilization Rule (82 FR 18349 through 18353), we also set additional parameters around this flexibility. These parameters allowed an issuer to attribute payments to

effectuate new coverage to past-due premiums amounts owed to any other issuer that is a member of the same controlled group. For this purpose, a controlled group was 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, which is the same definition used for other purposes related to the guaranteed renewability provision. HHS limited the issuer to attributing premium payments to past-due premiums for coverage within the prior 12 months. In addition, we also required issuers that adopted this premium payment policy (as well as any issuers that do not adopt the policy but are within an adopting issuer's controlled group) to provide notice of the consequences of non-payment on future enrollment in enrollment application materials and in any notice that is provided regarding non-payment of premiums. While these are reasonable parameters, we believe States are better situated to set and oversee parameters of this nature and therefore do not believe a uniform national policy on these elements is warranted. We clarify that our proposal to permit issuers to establish terms of coverage that attribute the initial premium an enrollee pays to effectuate new coverage to past-due premium amounts owed to an issuer, and then to refuse to effectuate coverage if the payment does not equal the outstanding debt plus the new monthly premium amount, would permit them to include past-due premium amounts owed to another issuer in the same controlled group, if permitted by applicable State law. We seek comments on whether we should leave such parameters to States or codify these and any other parameters to establish a more uniform Federal regulatory approach. We also seek comment on whether issuers should be required to establish terms of coverage that attribute to past-due premium amounts owed to an issuer the premium the enrollee initially pays for subsequent coverage, and the associated costs for issuers to implement such a requirement.

Here and throughout this proposed rule we encourage commenters to include supporting facts, research, and evidence in their comments. When doing so, commenters are encouraged to provide citations to the materials referenced, including active hyperlinks. Likewise, commenters who reference materials which have not been published are encouraged to upload relevant data collection instruments, data sets, and detailed findings as a part of their comment. Providing such citations and documentation will assist HHS in analyzing the comments.

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

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.[25] Section 36B of the Code, and sections 1412, 1402, and 1331 of the ACA, exclude individuals who are not "lawfully present" from eligibility for PTC,[26] APTC,[27] CSRs,[28] and enrollment in a BHP in States that elect to operate a BHP,[29] respectively. 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 or for these insurance affordability programs.[30] 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. The agency

[25] 42 U.S.C. 18032(f)(3)
[26] 42 U.S.C. 18082(d); 26 U.S.C. 36B(e)(2)
[27] 42 U.S.C. 18082(d)
[28] 42 U.S.C. 18071(e)
[29] 42 U.S.C. 18051(e)
[30] See the definition of "insurance affordability program" at 45 CFR 155.300(a) and 42 CFR 435.4.

now proposes to realign our policy with 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, eligibility for PTC, APTC, and CSRs, and for BHP coverage.

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").[31] The DHS Memo established, for the first time, the DACA policy, and it set forth three principles. First, certain individuals who were 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

[31] Napolitano, J. (2012, June 15). *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.

Affordable Care Act to these individuals." For that reason, the HHS explained (77 FR 52615), it did not intend to "inadvertently expand the scope of the DACA process."

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" the prior interpretation from 2012. The DACA Rule, which became effective on November 1, 2024, advanced several arguments for reversing the agency's prior interpretation.[32]

In light of recent Executive Orders, "Protecting the American People Against Invasion"[33] and "Ending Taxpayer Subsidization of Open Borders,"[34] and consistent with our statutory authority to define "lawfully present" for use in determining eligibility for our programs, we are now reconsidering these arguments.

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), that 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.

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[32] 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 2024 final rule at 89 FR 39392.

[33] "Protecting the American People Against Invasion," Exec. Order No. 14,159, 90 Fed. Reg. 8443 (Jan. 20, 2025). https://www.federalregister.gov/documents/2025/01/29/2025-02006/protecting-the-american-people-against-invasion. https://www.federalregister.gov/documents/2025/01/29/2025-02006/protecting-the-american-people-against-invasion.

[34] "Ending Taxpayer Subsidization of Open Borders." (Feb. 19, 2025). https://www.whitehouse.gov/presidential-actions/2025/02/ending-taxpayer-subsidization-of-open-borders/. https://www.whitehouse.gov/presidential-actions/2025/02/ending-taxpayer-subsidization-of-open-borders/.

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 long considered deferred action recipients to be "lawfully present" for purposes of certain Social Security benefits since 1996.[35] 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 scheme forecloses the contrary scheme in the DACA Memorandum."[36,37] 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, we now believe it was improper for HHS to

[35] 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 Public Law 104-193, interim final rule, 61 FR 47039)
[36] *Texas v. United States*, 50 F.4th 498, 526 (5th Cir. 2022).
[37] 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's 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.

define "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, to be eligible for PTC, APTC, CSRs, and to enroll in a BHP in States that elect to operate a BHP. 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, to be eligible for PTC, APTC, CSRs, and to be eligible to enroll in a BHP in States that elect to operate a BHP. DHS's 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 "[o]ther departments and agencies, such as HHS" (87 FR 53211 through 53212). Therefore, we believe it was improper for HHS to advance a policy goal that was contrary to the ACA's statutory limitations as they have been understood since the inception of DACA. Furthermore, DHS's 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, 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's, and there is no requirement that HHS aligns its definition of "lawfully present" with DHS's. 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's 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." Section 42 U.S.C. 18032(f)(3), section 36B(e)(2) of the Code, 42 U.S.C. 18082(d), and 42 U.SC. 18071(e)(1)(A), 42 U.S.C. 18051(e) limit 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, respectively, to an individual who is "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 seek comments on this proposal.

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

Later in this preamble, there is significant discussion regarding 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 HHS is committed to holding noncompliant agents, brokers, and web-brokers accountable to protect Exchanges and consumers. We propose 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.[38]

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 § 155.220 implement this statutory requirement.[39] 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-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

[38] 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.

[39] Also see §§ 155.221 and 155.222.

(h) sets forth procedures for subsequent review (that is, "reconsideration") of the termination action.

We propose 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 propose to add text to § 155.220(g)(2) that clearly states 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. Similar to definitions adopted by other HHS agencies and offices,[40] we propose at § 155.20 to capture this new definition, 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.[41]

In proposing the preponderance of the evidence standard, we considered the severity of the potential consequences involved in our termination for cause standards in § 155.220(g)(1) through (3),[42] 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 reasonable doubt," under which evidence must be so strong that there is no reasonable doubt

[40] 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.").

[41] *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).

[42] HHS acknowledges that there are additional enforcement actions under 45 CFR 155.220(g) that are not addressed by this proposal. We are considering future rulemaking to implement additional regulation changes to the frameworks for those actions that may strengthen our oversight and the integrity of the program.

about a defendant's guilt.[43] 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,"[44] and the "substantial evidence" standard, which means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion.[45]

HHS is of the view that the preponderance of the evidence standard is appropriate 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. However, 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.[46] 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.[47] 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 States served by Exchanges on the Federal platform. Given these potential consequences,

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[43] 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

[44] Ibid. (citing *Colorado v. New Mexico*, 467 U.S. 310 at 316 (1984)).

[45] See Reed v. Sec. of Health and Human Serv., 804 F. Supp. 914 at 918 (E.D. Mich. 1992).

[46] See 45 CFR 155.220(g)(6).

[47] See 45 CFR 155.220(g)(4) and (l).

we seek comment not only on this 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 solicit comments on our proposed definition for this new "preponderance of evidence" standard.

In addition, 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. We seek input on actions or subject matters that interested parties believe should be specifically outlined, emphasized, or otherwise addressed in the Exchange agreements for PY 2026 and beyond.

We are also inviting comments on the following questions:

1. What are States' oversight practices with respect to impermissible conduct by agents, brokers, and web-brokers for the State Exchanges? How are such standards working?
2. Would it be helpful for HHS to provide more guidance on the form, manner, and content requirements for obtaining and documenting consumer consent? If so, what guidance would be helpful?
3. Are there other measures HHS should take to assist consumers who have been enrolled in QHP coverage through the FFEs or SBE-FPs, or switched to different coverage, without

their consent to ensure they are held harmless for improper enrollments that are the result of noncompliant behavior by agents, brokers, and web-brokers?

4. Are there other measures that HHS should pursue to enhance oversight of agents, brokers, and web-brokers who assist consumer apply for and enroll in QHP coverage through the FFEs and SBE-FPs?

Comments are invited on these specific questions, and generally. We will consider public comments to help inform potential new or additional policies and changes to existing standards in future rulemaking.

3. 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. We are proposing several changes to the processes specifically related to verifying income eligibility for APTC and CSR subsidies.

Understanding the ACA's full statutory framework for making income eligibility determinations for APTC provides important context for analyzing the current regulations and the changes we are proposing. Each provision of the framework works in coordination with every other provision to strengthen the program integrity of the ACA's premium and cost sharing reduction program. Viewed in isolation, the importance of the role each provision plays can be undervalued or lost. With this in mind, after reviewing our recent rulemaking on the verification process related to income eligibility for APTC, we believe certain regulations do not align with this statutory framework. Therefore, before detailing the changes we propose, we believe it is

important to first outline the full statutory framework and how each provision connects to increase the accuracy of eligibility determinations for APTC and CSR subsidies. Accordingly, the following discussion provides a detailed discussion of ACA's statutory framework for verifying and determining income eligibility for APTC.

The ACA provides a PTC to lower net premiums for QHPs purchased through the Exchanges for eligible individuals. While taxpayers may choose to claim this credit on their tax return *after* they pay their premium, the ACA provides *advanced* payments of the premium tax credit (that is, APTC on behalf of eligible consumers, which the Federal Government pays directly to the issuer when the premium payments are due). The ACA contains an obligation on issuers to reduce cost-sharing for people with household incomes between 100 percent and 250 percent of the FPL who select a silver plan on an Exchange. The ACA imposes an obligation on the Federal Government to make periodic and timely payments to issuers equal to the value of the reductions. However, since a 2017 legal opinion determined the statute does not appropriate funding for CSR payments,[48] State Departments of Insurance have generally permitted or instructed their issuers to increase premiums only, or primarily, on silver-level QHPs, to compensate for the cost of offering CSRs, since the vast majority of eligible enrollees receiving CSRs are enrolled in silver plans. By loading premiums to compensate for lack of CSRs, issuers increase the amount of APTC the Federal Government pays them which, in turn, indirectly covers the cost of the CSR subsidies. Therefore, appropriations for APTC now effectively fund both APTC and CSR subsidies.

[48] *U.S. House of Representatives v. Burwell*, 185 F. Supp. 3d 165 (D.D.C. 2016); *see also 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 (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)).

If the APTC paid on behalf of an enrollee exceeds the PTC amount allowed for the enrollee in a taxable year, section 36B(f)(2)(A) of the Code requires repayment of the excess APTC the Department of the Treasury paid to the issuer through an increase in the income tax on the enrollee by the amount of the excess. However, section 36B(f)(2)(B) of the Code substantially limits the amount of this tax increase or repayment for people with household incomes less than 400 percent of the FPL. Therefore, the statute does not allow the Federal Government to recover a substantial portion of excess APTC payments. As such, it is critical to establish an accurate estimate of household income during the application and enrollment process to most accurately set APTC payment amounts before the APTC payments are made. Otherwise, to the extent household income estimates allow people to qualify for an excess of APTC, a large portion of these excess APTC payments cannot be recovered from the enrollee. In the case of individuals who underestimate their income on their application, they can accumulate large surprise tax liabilities.

To avoid improper payments of APTC, the ACA includes a set of procedures for determining income eligibility that work together to increase the accuracy of household income estimates provided on applications for APTC. Section 1411(a) of the ACA requires HHS to establish a program for determining, among other things, whether an individual claiming PTC or CSR meets the income requirements. For applicants claiming PTC or CSR, section 1411(b)(3)(A) of the ACA requires them to provide income information from their most recent tax return filing. If there are changes in circumstances from the most recent tax filing or when the tax filer was not required to file taxes, section 1411(b)(3)(C) of the ACA requires applicants to report additional income information in coordination with the program under section 1412 of the ACA for setting APTC amounts.

Section 1412(b)(1)(B) of the ACA requires APTC to be set on the basis of the individual's household income for the most recent taxable year for which information is available. To determine and verify household income, it is imperative that consumers file a Federal income tax return when they are required to do so. As such, the ACA relies on people meeting their statutory obligations to file Federal income taxes under sections 6011 and 6012 of the Code. However, section 1412(b)(2) of the ACA establishes a separate set of procedures for determining APTC if there are changes in circumstances from the most recent tax filing or when the tax filer was not required to file taxes.

Section 1411 of the ACA sets out procedures for verifying the information that enrollees provide on their application, including information required under both sections 1411 and 1412 of the ACA. Section 1411(c)(1) of the ACA requires Exchanges to submit an applicant's information to HHS. Section 1411(c)(3) of the ACA then requires HHS to submit income information to the IRS for the purposes of eligibility. The details of this data exchange and disclosure of taxpayer information are further specified at section 1414 of the ACA, which includes additional procedures for the exchange of information with Exchanges and State agencies to support income eligibility determinations. In the case of income information provided on an application that is not required to be submitted to the IRS for verification—that is, any income estimates that are different from the income reported on the applicant's previous tax return—section 1411(d) of the ACA requires HHS to verify its accuracy and allows HHS to delegate this responsibility to the Exchanges. Under section 1411(c)(4)(A) of the ACA, HHS must conduct these income verifications and determinations through the electronic submission of both the applicant's information and responses to the applicant, except that HHS may use a different method for income inconsistencies than the IRS per section 1411(c)(4)(B) of the ACA.

If the information provided by the applicant is verified under the foregoing procedures, HHS then determines the applicant is eligible and notifies the Secretary of the Treasury of the APTC amount to be paid, if applicable.[49]

However, if the household income information provided by the applicant is inconsistent with tax filing information from the IRS or fails the verification under section 1411(d) of the ACA, section 1411(e)(4) of the ACA requires Exchanges to take additional steps to verify income.[50] When there is a household income inconsistency, also known as a data matching issue (DMI), the Exchange must make a reasonable effort to identify and address the causes of such inconsistency, including those stemming from typographical or other clerical errors, by contacting the applicant to confirm the accuracy of the information, and by taking such additional actions as HHS, through regulation or other guidance, may identify. If the household income inconsistency persists, then the Exchange must notify the applicant and give the applicant an opportunity within 90 calendar days from the date the notice was sent to either present satisfactory documentary evidence to the Exchange or resolve the inconsistency with the IRS or the HHS verification source. If the household income inconsistency is not resolved by the end of this 90-day period, section 1411(e)(4)(B)(ii) of the ACA requires the Exchange to set the APTC and CSR based on income information from the IRS and information provided to HHS under section 1411(d) of the ACA.

To support verification and eligibility determinations, section 1413 of the ACA requires HHS to establish a system to streamline eligibility determinations across all applicable State health care subsidy programs, including QHP enrollment, PTCs, CSRs, Medicaid, the Children's

[49] Section 1411(e)(2)(A) of the ACA.
[50] The responsibility for verifying eligibility here has shifted entirely from HHS to the Exchanges. However, HHS retains responsibility in States that have not established an Exchange. In addition, HHS retains authority to regulate how Exchanges verify eligibility at this stage.

Health Insurance Program (CHIP), and BHPs in States that elect to operate them. Within this system, States must develop a secure, electronic interface and using this interface, participate in a data matching program to establish, verify, and update eligibility for State health care subsidy programs, including the APTC, on the basis of reliable, third-party data. Collectively, we refer to these third-party data sources, such as the Social Security Administration, DHS, and the IRS, as trusted data sources. Importantly, this interface for exchanging data must be compatible with the method for data verification of the household income information provided on applications under section 1411(c)(4) of the ACA.

In summary, under this statutory framework, HHS is responsible for verifying and determining income eligibility. We are tasked with verifying household income information with the IRS and verifying household income information with other trusted data sources when the IRS cannot provide enough information to verify income eligibility, or the information they provide significantly differs from the household's income attestation. 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 CSR 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. There is no statutory exception to this verification process. 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.

With that as background, we propose 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

We propose 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 2012, we first finalized the FTR policy in the Exchange Establishment Rule (77 FR 18352 through 18353) to prevent a primary tax filer or spouse who has failed to comply with tax filing rules from accumulating additional Federal tax liabilities due to overpayment of APTC. Since 2015, HHS has taken regulatory and operational steps to help increase tax filer compliance with the filing and reconciliation requirements under the Code as described at 26 CFR 1.36B-4(a)(1)(i) and (a)(1)(ii)(A) by tying eligibility for future APTC to the tax filer's reconciliation of past APTC paid. When the original FTR process was first run in December 2015, only non-filers were identified as part of the FTR process. IRS began to identify non-filers, non-reconcilers, and tax filers with a valid tax filing extension in Fall 2016, and HHS began taking action on non-reconcilers and extension tax filers in addition to non-filers in Fall 2017.

As the operations behind the FTR process evolved, Exchanges struggled to communicate with enrollees about the removal of APTC due to their tax filing status. Due to these struggles, in the 2018 Payment Notice (81 FR 94124), the FTR Recheck process was carved out of the periodic data matching regulations at § 155.330(e)(2) due to concerns related to the protection of Federal tax information (FTI). Additionally, to strengthen the FTR process, Exchanges on the Federal platform added an additional check of an enrollee's FTR status after the OEP ended. This process, referred to as FTR Recheck, is the process that occurs early in the coverage year where Exchanges on the Federal platform verify the tax filing status of enrollees who attested to filing and reconciling during the OEP. During the comment period, many State Exchanges expressed

their frustration regarding their inability to provide direct communications related to the tax filing status of the tax filers or their enrollees. In response to their comments, HHS carved out an exception to § 155.305(f)(4) that stated Exchanges could not deny APTC due to FTR unless "direct notification" was first sent to the tax filer that they would lose their eligibility for APTC related to their failure to file and reconcile. This change necessitated FTI compliant infrastructure for Exchanges. In the 2019 Payment Notice (83 FR 16982), HHS updated the FTR policy to remove the carve-out for direct notification. However, due to the earlier regulations, HHS did not run FTR Recheck in Spring 2017 because HHS would have been out of compliance with its own rule because it did not yet have the infrastructure to send direct notices that contain FTI. In Fall 2017, Exchanges on the Federal platform began sending direct notices to tax filers explicitly stating that they would lose eligibility for APTC due to their failure to comply with the requirement to file their Federal income taxes and reconcile APTC.

During the COVID-19 public health emergency (PHE), FTR operations were paused due to concerns that consumers who had filed and reconciled would lose APTC due to IRS processing delays resulting from IRS processing facility closures and a corresponding processing backlog of paper filings.

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 two-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 two-tax year FTR process, we acknowledged it could place consumers at a 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 one-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, we believe the new FTR process places a substantially higher number of tax filers at a greater risk of accumulating increased tax liabilities.[51] 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 two-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

[51] 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

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. Moreover, new evidence shows there is a substantial risk of improper enrollment, which we discuss further below.[52]

In our previous rulemaking, we were concerned about consumers losing their Exchange coverage once they lose their eligibility for APTC, as they would no longer be able to pay their entire premium for a second year under the 1 year FTR policy. This concern guided our thought process in the 2024 Payment Notice when 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 two-consecutive tax years.

According to our estimates in that rule (81 FR 25902), we found approximately 116,000 enrollees with an FTR status were automatically enrolled in an Exchange QHP without APTC during the OEP for PY 2020, and that approximately 14,000 stayed enrolled without APTC by March 2020. We estimated all 102,000 enrollees who dropped coverage would have retained coverage under the new FTR process. Among those who dropped coverage, we estimated 20,400 (20 percent) would be reenrolled in coverage without APTC due to an FTR status for two-consecutive tax years. We estimated the continuity of coverage for the 81,600 who remained covered in the second year, accounting for enrollment retention rates, would likely increase APTC expenditures by $373 million beginning in 2025.

However, considering new evidence regarding improper enrollments, it became apparent that the new FTR process could impede Exchange efforts to mitigate improper enrollments. At

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

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 FTI, the Exchanges on the Federal 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 one-tax year, while the current one-tax year FTR direct notice for PY 2025 provides notice for tax filers identified as having a one-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 one-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 one-tax year FTR direct notice. Indirect notices for tax filers in both the one-tax year and two-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 the current two-year FTR process places a substantially higher number of consumers at risk of accumulating increased tax liabilities. We have 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 two-tax year FTR status and approximately 1,500,000 potential reenrollments entered OEP 2025 with either a one-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 two-year policy for PY 2025, enrollees with a two-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 one-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, under the one-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 do not have information on the number of consumers who were identified as having a two-tax year FTR status before the OEP and who have filed and reconciled in order to remain eligible for APTC. It is probable that due to the increase in enrollment, under the two-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.

If most of these enrollees were eligible for APTC, then giving them some extra time to resolve their FTR status might be justified considering the potential confusion over the requirement to file and reconcile. However, in the proposed 2019 Payment Notice (82 FR 51086), we previously identified program integrity issues among tax filers who fail to file and reconcile. When people received notice regarding their failure to file and reconcile under the one-tax year FTR process, approximately 70 percent of households receiving the notification

took appropriate action to file a tax return and reconcile associated APTC.[53] However, because tax filers for approximately 30 percent of households receiving the notification did not take appropriate action, we concluded that, absent evidence that they had filed and reconciled, it was important for program integrity purposes that Exchanges discontinue their APTC. A reason that may explain why this population does not file their taxes and reconcile their APTC is due to the administrative burden. IRS has noted that filing an individual tax return takes an average of 8 hours and costs approximately $160.[54] While there are numerous free file options as well as assistance for low-income taxpayers, many taxpayers do not utilize those options.[55] However, we continue to believe this high rate of people who failed to take appropriate action to file and reconcile represents a program integrity issue. The current policy aggravates this program integrity problem by allowing those enrollees who failed to take appropriate action to retain coverage into the second year.

Furthermore, we believe the proposed one-tax year FTR process can serve as a backstop to improper enrollments. The Paragon Health Institute provides evidence that lead generation companies are misleading enrollees with the promise of free coverage and other enticements.[56] 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.[57] These schemes tend to target low-income people, many of whom likely earn less than the thresholds for APTC eligibility. Under these

[53] Internal CMS data.
[54] IRS. (2024). *1040 (and 1040-SR) Instructions*. Dep't of Treasury. https://www.irs.gov/pub/irs-pdf/i1040gi.pdf
[55] GAO. (2022, May 10). *Why Don't More Taxpayers Take Advantage of Free Help Filing Taxes Online?* https://www.gao.gov/blog/why-dont-more-taxpayers-take-advantage-free-help-filing-taxes-online
[56] 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/.
[57] Ibid.

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. 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—$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 likely have an income too low to meet the APTC eligibility threshold.

We established the current two-tax year FTR process at the end of the COVID-19 PHE. At that time, we had paused the removal of APTC under the FTR process because the pandemic severely impacted the IRS' ability to process tax returns for the 2019, 2020, and 2021 tax years.[58] Continuing the FTR process during that time would have removed APTC from substantial number of eligible enrollees who 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

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

improper enrollments HHS observed during PY 2024, we believe that reverting back to the pre-existing FTR policy, that is, the 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 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 one-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 failing to file and reconcile. For example, under the one-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 two-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 one-tax year and two-tax year FTR status. Enrollees with a one-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 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.[59] 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. 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 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 no longer believe this provides reasonable protection against accumulating tax liabilities.

Furthermore, the current policy also undermines program integrity by increasing the burden on taxpayers because, due to repayment limitations discussed previously, not all ineligible enrollees are held fully responsible for paying back unpaid liabilities. 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. We estimate up to 18.5 percent 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

[59] 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.

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 FPL threshold. However, this population would also be impacted by numerous other proposals in this 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 process from the other proposals included in this rule. While we previously assessed that the threat of IRS enforcement actions and penalties would mitigate improper enrollments (88 FR 25818), these data trends indicate that such consequences are insufficient to protect program integrity, and therefore, additional policy changes are necessary.

These numbers highlight the importance of complying with the statutory requirement to file a tax return. As discussed previously, an enrollee's tax return provides a main basis for establishing an accurate income estimate. Not filing a tax return undermines the accuracy of the income estimate used to set the APTC amount. Moreover, sections 6011 and 6012 of the Code, as implemented under 26 CFR 1.6011-8, requires enrollees who receive APTC to file a tax return and reconcile the APTC. We do not believe the ACA allows HHS to determine an applicant whose taxpayer has failed to meet this requirement eligible for APTC. As discussed previously, when the IRS does not have tax return information to verify an applicant's income, section 1412 of the ACA requires HHS to establish alternative procedures to determine APTC when there is a change in circumstances or "in cases where the taxpayer was not required to file a return …". Because the section 1412(b)(2)(B) only references cases where a tax filer was *not required* to file a return, we do not believe an applicant who fails to meet the requirement to file a return qualifies for this alternative process for determining APTC. Therefore, under the ACA, we believe the original regulations implementing the eligibility requirements in 2012 correctly

required Exchanges to determine an applicant ineligible for APTC if they previously received APTC and failed to file a tax return (77 FR 18352 through 18353).

Overall, 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 believe the ACA statute 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 propose 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 propose to implement the proposed one-year FTR process beginning with OEP 2026 in the fall of 2025. This would allow enrollees currently in a one-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 seek comment on this proposal.

ii. Conforming Change to Notice Requirements

To conform with this proposed FTR process, we also propose 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 two-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 two-consecutive tax years. Accordingly, for both an enrollee's first and second year with an FTR status, all Exchanges must now either (1) notify 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) send 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 are proposing to amend § 155.305(f)(4) to require Exchanges to determine people ineligible for APTC after one tax year of FTR status rather than two consecutive tax years, the current notice requirement aimed at tax filers in a two-tax year FTR status would no longer apply. Therefore, we are proposing to revise the notice requirement at § 155.305(f)(4)(i) and remove the notice requirement at § 155.305(f)(4)(ii). We invite 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 are proposing to reinstate the notice procedures that existed before we established the current FTR

process for Exchanges on the Federal platform. As background, each year, these procedures would provide a series of notices[60] to identified tax filers and enrollees beginning with two notices before the OEP for those tax filers or enrollees who the IRS has identified to HHS (and subsequently the Exchange) as not having filed and reconciled APTC received during a prior year. The indirect notice would be included in the Marketplace Open Enrollment Notice and would be sent to the enrollee according to the communication preference set by the household contact and would also be available in their online account and to the Exchange call center. This notice educates the enrollee on the requirements to file their Federal income taxes and reconcile their APTC. The direct notice, which would not be available online or to the Exchange call center, would be sent via U.S. mail directly to the tax filer in order to protect FTI. The direct notice would serve to unambiguously explain that the tax filer has been identified as having failed to meet the requirement to file and reconcile and must come into compliance to avoid termination of APTC. IRS data would then be checked again in December and enrollees who have not attested to filing and reconciling their APTC would lose their APTC for the next coverage year. Tax filers may have filed and reconciled, but due to IRS processing times, their application may still be flagged with an FTR status during the OEP. To address this issue, enrollees could attest to having filed and reconciled for a preceding tax year on their Exchange application. Then to confirm the enrollee's attestation, Exchanges on the Federal platform would perform another recheck of the IRS data in the new coverage year. For enrollees who are still flagged with an FTR status, we would send both an indirect FTR Recheck notice to the household contact and a direct FTR Recheck notice to the tax filer warning them a final time that they would lose eligibility for APTC, unless they complete the requirement to file and reconcile.

[60] Notices can be found online here: https://www.cms.gov/marketplace/in-person-assisters/applications-forms-notices/notices

Finally, in the spring, after a final recheck of the IRS data, Exchanges on the Federal platform would terminate APTC for households the IRS indicates have still not filed and reconciled. This process is summarized by Table 1.

TABLE 1: FTR Recheck Notices and Timing

Notices	Timing
Enrollees with FTR status receive 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 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 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 seek further comment on whether State Exchanges should be required to align with Exchanges on the Federal platform on this consumer noticing and recheck process.

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

We propose 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 sufficient 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 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 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 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.

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, 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 find the change weakened program integrity.

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. Between 2018 and 2021, over one third of consumers who resolved their DMIs on the Exchange did so in more than 90 days.

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 represent 55 percent of the total income DMIs. We also found that the percent of all applicants with an income DMI who used an extension represent 60 percent of total income DMIs. 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 welcome comment on this topic and suggestions to alleviate this concern.

As we discussed in other aspects of this 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.

However, 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 believe the cost to taxpayers and decline in program integrity outweigh any possible benefit to the risk pool.

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 believe the cost of the extension outweighs the benefits. We seek comment on this proposal.

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

We propose 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 amount represented by income data returned by IRS and the SSA and current income data sources is less than 100 percent of the FPL. This change would reinstate provisions HHS finalized in the 2019 Payment Notice (83 FR 16985) but were later vacated by the United States District Court for the District of Maryland decided in *City of Columbus, et al. v. Cochran*, 523 F. Supp. 3d 731 (D. Md. 2021). Though we believe we had a clear legal basis for finalizing the provisions in the 2019 Payment Notice, we also believe circumstances have substantially changed since the court vacated the prior rulemaking, which provide justification to reinstate the provisions. 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, we now have 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.[61] Additionally, while concerns were raised in *City of Columbus, et al. 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 believe enough consumers – and the agents, brokers, and web-brokers helping them apply – are intentionally inflating their incomes 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 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

[61] 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.

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. Still today, the risk of APTC overpayments under these circumstances is especially keen 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.[62] Barring other changes in circumstance, these tax filers will not have to repay any APTC. That taxpayers are not required to repay APTC in these situations 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.[63] 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."[64]

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[62] 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).

[63] 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.

[64] Ibid.

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.[65] 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.

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, et al. v. Cochran* stated that HHS "failed to point to any actual or anecdotal evidence indicating fraud in the record."[66] 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." We believe the court overlooked the GAO recommendation in the rulemaking record which provided a clear legal basis for finalizing the rule in the 2019 Payment Notice.

After the court vacated our income verification requirements, we reviewed data from the time period before the original income verification requirement was implemented from a recent research study, and believe that there is data to support that applicants inflated their income. A

[65] Ibid. at 37.
[66] 523 F. Supp. 3d 731, 762 (D. Md. 2021).

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.[67] 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 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.

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.[68] 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. This leads 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

[67] 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.
[68] Ibid.

from Census surveys and found actual enrollment was 136 percent higher than the total population of potential enrollments.[69]

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.[70] 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.[71]

As illustrated in Table 2, Federal tax return data also show a substantial increase in the percent of returns with APTC that report excess APTC at lower household income levels between 2019 and 2022. Returns with household incomes above $15,000—just higher than the income eligibility threshold for PTC—report largely consistent levels of excess APTC returns as a percent of all APTC returns between 2019 and 2022. However, this percentage jumped for all reported incomes below $15,000. 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.

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

TABLE 2: Percent of APTC Tax Returns with Excess APTC

	2019	2022	Percentage Point Difference
All returns, total	52%	60%	8%
No adjusted gross income	13%	33%	20%
$1 under $5,000	25%	35%	10%
$5,000 under $10,000	20%	35%	15%
$10,000 under $15,000	22%	36%	14%
$15,000 under $20,000	35%	34%	-1%
$20,000 under $25,000	47%	46%	-2%
$25,000 under $30,000	58%	54%	-4%
$30,000 under $40,000	63%	65%	3%
$40,000 under $50,000	68%	73%	5%
$50,000 and over	85%	84%	-1%

Sources: IRS Statistics of Income, Affordable Care Act Items for Tax Year 2019 data and Mid-Year Filing for Selected Income Items, Adjustments, Credits, and Taxes for Tax Year 2022 (through Filing Season 2023 Cycle 47) data.

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 commissions from enrollments of consumers who, absent financial assistance, would not enroll—when they apply for APTC.[72] Moreover, 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.[73] 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

[72] 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/.
[73] See ibid.

improper enrollment.[74] Therefore, to strengthen program integrity and reduce the burden of APTC expenditures on taxpayers, we propose 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.

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 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

[74] 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' Marketplace 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

have annual household income above 100 percent of the FPL, 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.

As discussed previously, 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 fits squarely 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 be compelled by statute to deny eligibility for APTC and CSR subsidies based on the inconsistency with IRS data. Importantly, this statutory framework does not include a specific exception for income inconsistencies when IRS data indicate income is below the APTC eligibility threshold and income information provided on applications estimates a higher income above the APTC eligibility threshold, and the household income attestation is lower than income information from data sources by more than the acceptable reasonable threshold. 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 has discretion to not require the use of the data matching program if its administrative and other costs outweigh 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 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 request comments on whether adding these additional data matching issue requirements will outweigh its expected gains as described above.

Accordingly, we propose to modify § 155.320(c)(3)(iii)(D) and (c)(3)(vi)(C)(2) to specify that the Exchange would follow the procedures in § 155.315(f)(1) through (4) to create an annual income data matching DMI for consumers if: (1) The consumer attested to projected annual household income between 100 percent and 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 propose that a reasonable threshold must not be less than 10 percent and can also include a threshold dollar amount.[75] We welcome 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, 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

[75] 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

applicant fails to provide documentation verifying their household income attestation, 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). The adjustment and notification process would work like other inconsistency adjustments laid out in § 155.320(c)(3)(vi)(F). We are also proposing to modify § 155.320(c)(3)(iii)(A) to add a cross-reference to paragraph § 155.320(c)(3)(iii)(D).

We estimate that answering verification questions and submitting supporting documents would take consumers approximately 1 hour. 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 believe that the 90-day 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.

Finally, the statute compels HHS to verify household incomes with the IRS data and directs HHS and Exchanges to take further steps to verify income if the applicant’s estimated household income is inconsistent with the IRS data. While HHS does have some discretion to use other third-party data sources for verification, we believe the critical program integrity benefits to Federal taxpayers from limiting opportunities for people to inflate their income to qualify for APTC substantially exceeds the potential burden on some applicants. We also believe this proposal would also help limit tax filers' potential liability at tax reconciliation to repay excess APTC.

We seek comment on this proposal.

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

We propose 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 played a key role in 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 no longer believe the prior alternative verification process was overly punitive. 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 for 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. 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 welcome comments on the accuracy of this estimate of administrative burden. 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 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 now believe 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. We previously stated 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. We address our reinterpretation of these statutes below.

This policy violates the express requirements of section 1411(e)(4)(A) of the ACA, which establishes a two-step process to address income inconsistencies. First, Exchanges must make a reasonable effort to identify and address the causes of income inconsistencies, including through typographical or other clerical errors, by contacting the applicant to confirm the accuracy of the information, and by taking such additional actions as the Secretary of HHS (the Secretary), through regulation or other guidance, may identify. Second, if step one does not resolve the inconsistency, the Exchange must notify the applicant of such fact and provide the applicant an opportunity to present documentary evidence or resolve the inconsistency with the source of the DMI during the 90-day period after the notice is sent.

We implemented the requirements of section 1411(e)(4)(A) of the ACA at § 155.315(f)(1) through (4). When tax return data and other trusted data sources are unavailable, § 155.320(c)(3)(vi) directs Exchanges to follow this process. There is no statutory exception to this process. Nonetheless, § 155.320(c)(5) requires Exchanges to accept attestation without further verification when tax return data is unavailable, which restricts Exchanges from following the statutorily required process established under § 155.315(f)(1) through (4). We believe restricting Exchanges from using the process under § 155.315(f)(1) through (4) violates section 1411(e)(4)(A) of the ACA.

We also believe our previous statutory justifications for the current policy were mistaken. Previously, we stated the policy was consistent with two statutory provisions: the flexibility under section 1411(c)(4)(B) of the ACA to modify methods for verification of the information where we determine such modifications will reduce the administrative costs and burdens on the applicant and section 1412(b)(2) of the ACA, which allows the Exchange to utilize alternate

verification procedures. After reviewing the statute, we no longer believe the current policy is consistent with either of these statutory provisions.

Regarding section 1411(c)(4)(B) of the ACA, this provision gives HHS the authority to modify the methods used for the exchange and verification of information. While we previously suggested this provision gave HHS broad flexibility to modify any aspect of the verification process under section 1411 of the ACA, we believe Congress would have made a clearer statement if the intent were to grant such broad flexibility. Rather, section 1411(c)(4)(B) provides flexibility to "*modify the methods* used under the program established by this section *for the Exchange and verification of information*," (emphasis added) which, based on the language and the surrounding context, suggests the flexibility relates only to the methods used to exchange and verify information between HHS and trusted data sources.

Looking closer at the statutory language, a footnote included in the statute as published by the U.S. Government Publishing Office explains how the word Exchange in the text "[p]robably should not be capitalized."[76] We believe this is the correct reading, which then strongly suggests Congress intended to limit modifications to how information is exchanged and verified between HHS and trusted data sources. The use of the term "modify" supports this more limited reading. As the U.S. Supreme Court has explained, the word modify means "to change moderately or in minor fashion"[77] and "connotes moderate change."[78] Reading section 1411(c)(4)(B) of the ACA to allow HHS to suspend the verification process entirely under certain circumstances, as § 155.320(c)(5) permits, would allow a more dramatic change to the

[76] Note 2 at 42 U.S.C. 18081(c)(4)(B). https://www.govinfo.gov/content/pkg/USCODE-2022-title42/html/USCODE-2022-title42-chap157-subchapIV-partB-sec18081.htm#18081_2_target.
[77] *Biden v. Nebraska*, 600 U.S. 477, 494 (2023).
[78] *MCI Telecommunications v. AT&T*, 512 U.S. 218 (1994) (holding the Federal Communications Commission's decision to make tariff filing optional for all nondominant long-distance carriers is not a valid exercise of its authority to "modify any requirement" of 47 U.S.C. 203).

verification process than the term "modify" permits. This more modest reading is supported by how section 1411 of the ACA appends this flexibility at the end of paragraph (c) which addresses the verification of information contained in records of specific Federal officials, including HHS under paragraph (d). Placing the flexibility here strongly suggests this flexibility is directly tied to the exchange and verification of information from the IRS, DHS, SSA, and other sources HHS relies on under paragraph (d). This reading is further strengthened by the statute's addition of a specific example of the flexibility envisioned which focuses on modifying how the IRS can provide income information under section 1411(c)(3) of the ACA.[79] Because the flexibility under section 1411(c)(4)(B) of the ACA is limited to modifications to how information is exchanged and verified between HHS and trusted data sources, this flexibility does not extend to other aspects of the verification process. In addition, it does not provide flexibility to create exceptions to the requirement to verify the accuracy of information.

Similarly, the flexibility to utilize alternative verification procedures under section 1412(b)(2) of the ACA when tax return information is not available does not change or allow exceptions to the basic requirement to verify the accuracy of the income information. We previously stated the language in section 1412(b)(2) of the ACA included permissive language that allowed the Exchange to utilize alternative verification processes when an applicant was not required to file a tax return. However, section 1412(b)(2) of ACA is not permissive and does not directly reference the alternative verification process. Rather, this provision mandates HHS to provide procedures for making advance determinations of income eligibility for premium and cost-sharing subsidies on the basis of information other than income information from the most recent tax year for which the IRS has information in cases where the application demonstrates

[79] Presumption of Nonexclusive 'Include'":587 "[T]he term 'including' is not one of all-embracing definition, but connotes simply an illustrative application of the general principle."

substantial changes in income, including cases where an applicant was not required to file a tax return. This advanced determination program is coordinated with the income eligibility determination and verification program in section 1411 of the ACA. To comply with the application requirements to determine eligibility for premium and cost sharing subsidies under section 1411(b)(3)(C) of the ACA, applicants must report any additional information required for advance determination under section 1412(b)(2) of the ACA. As such, section 1412(b)(2) of the ACA adds to the requirements of section 1411 of the ACA and does not provide any additional flexibility to HHS.

Importantly, section 1412(b)(2) of the ACA puts HHS in charge of establishing the procedures for determining APTC when there is a change in circumstances or no tax return information. This makes sense considering IRS data is limited to the taxes previously filed which clearly does not help when there is no tax filing. Verifying any change in circumstance beyond the deviation from previous tax filings also requires access to additional income information sources. Therefore, the ACA makes HHS responsible for verifying information not verified by other Federal agencies and establishing the data matching program under section 1413 of the ACA. The eligibility verification and determination framework established under sections 1411 through 1414 of the ACA clearly envisions HHS building out a robust process for verifying and determining eligibility for APTC. Under this framework, we do not believe section 1412(b)(2) of the ACA can be read to permit blanket exceptions across this framework.

Because sections 1411(c)(4)(B) and 1412(b)(2) of the ACA do not provide HHS with flexibility to change the overall framework for verifying and determining eligibility for APTC, we do not believe the statute authorizes HHS to provide exceptions to the statutory process for resolving income inconsistencies with trusted data sources.

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

We seek comment on this proposal.

4. Annual Eligibility Redetermination (§ 155.335)

We propose 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 propose 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 dollars 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 propose 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 propose at new § 155.335(n)(2) that the State Exchanges must implement it starting with annual redeterminations for benefit year 2027.

We recognize that $5 may not provide a meaningful enough incentive for individuals to re-confirm their income and plan and, as such, seek comment on other options available to us to ensure program integrity in re-enrollments. As discussed in the preamble, 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 seek 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 seek 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 seek 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 this preamble, 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 presents 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 premium tax credit for certain consumers,[80] 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 American Rescue Plan of 2021 (ARP)[81] and Inflation Reduction Act of 2022 (IRA),[82] 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 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

[80] Section 1401 of the ACA; Sec. 36B(f)(2)(B) of the Code.
[81] Pub. L. 117-2.
[82] Pub. L. 117-169.

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, fully subsidized QHPs became available before enhanced tax credits were passed into law and will continue to be available to some consumers after the expiration of the enhanced tax credits. As discussed earlier in preamble, in 2018, issuers began increasing silver plan premiums to compensate for the cost of offering CSRs. In 2020, 900,000 consumers were enrolled in fully subsidized bronze plans (89 FR 26321). Additionally, in 2020, 77 percent of the consumer population with household incomes at or below 150 percent of the FPL had access to a fully subsidized bronze plan with 16 percent of the same population having access to a fully subsidized silver plan in addition to the fully subsidized bronze plan (89 FR 26321).

We believe the expanded availability of fully subsidized QHPs due to silver loading creates a need for more active engagement during the annual redetermination and re-enrollment process by enrollees who do not pay monthly premiums in order to ensure the coverage is authorized and desired by the enrollee. To address this issue, we believe it is important to require 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 believe that the changes proposed here are critical to reduce the financial impact to consumers and to the Federal Government of the substantial increase in people who are improperly enrolled without their knowledge by an agent, broker, or web-broker on the FFEs and SBE-FPs and are then automatically re-enrolled, also without their consent; or who intentionally enrolled through any Exchange but then did not update their eligibility prior to re-enrollment and so have an incorrect amount of APTC paid on their behalf. We believe 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 because the law limits how much of the excess APTC they are required to repay.[83]

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 dollars 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,

[83] Section 1401 of the ACA; Sec. 36B(f)(2)(B) of the Code.

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 APTC and automatic re-enrollments, as previously outlined, we seek comment on these proposals once again. We also 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 open enrollment period are extensive and already successfully prompt most 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 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 seek comment on this idea.

Instead, 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 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 this proposed rule, we propose 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 believe that this approach would create undue financial hardship for these enrollees and act as a significant barrier to accessing health coverage. We also 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 seek 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 are proposing an amount of $5, which 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 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. 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 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 seek comment on this proposal. Specifically, we seek comment on whether an amount other than $5 would better address the program integrity concerns we have described. In addition, we seek 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.[84] Researchers regularly track and study the "Medicaid undercount" which represents the difference in actual Medicaid

enrollments to what people report on Census surveys.[85] 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 3 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 larger for consumers with incomes less than 250 percent of FPL who likely qualify for CSRs. The undercount for these consumers grew from 33 percent in 2021 to 57 percent in 2024.

TABLE 3: 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% FPL	Subsidized Total	Feb CSR	Feb APTC	CSR	APTC
2019	3,750,261	7,055,972	5,468,004	9,250,243	-31%	-24%

[85] 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

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 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 4 draws a similar comparison between the reported level of Exchange coverage on the National Health Interview Survey (NHIS)[86] 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.

TABLE 4: 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

[86] OMB Control Number 0920-0214.

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.[87] Some of these people may have confused their Medicaid coverage for Medicare or Exchange coverage. But these findings suggest 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[88] had multiple types of coverage, up from 27.7 million people in 2022[89] and 18 million in 2021.[90] 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 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

[87] 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.
[88] Congressional Budget Office, (2004, 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.
[89] 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.
[90] 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.

enrollees who are adults,[91] employed,[92] at higher income levels overlapping with APTC income eligibility levels,[93] and qualify for automatic re-enrollment.[94] 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.[95] Research on the increase in the Medicaid undercount links the increase to the Medicaid continuous coverage condition under the COVID-19 PHE that kept people unknowingly covered after they obtained other coverage.[96] Similar to the Medicaid continuous coverage condition, under the current Exchange annual eligibility redetermination process, someone with a fully subsidized QHP can remain continuously enrolled in a QHP from year to year.[97] The 2022 OEP was the first year where people with fully

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[91] 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/.

[92] 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/.

[93] 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/.

[94] 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.

[95] Pub. L. 117-2.

[96] 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.

[97] 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

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 believe the ARP's expansion of fully subsidized QHP coverage in combination with the existing annual eligibility redetermination process—a process that does not require active participation from the qualified enrollee—further allowed individuals to remain enrolled without their knowledge.

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 is a clear program integrity issue. To address this issue, we 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 seek comment on this proposal.

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

We propose 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

rules or whose authorization for the Exchange to obtain tax data from the IRS has expired (which is limited to 5 years).

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 standards at § 155.335(j)(4) that require Exchanges to take into account differences between the consumer's current plan and new plan in situations where the renewal process places a consumer in a different plan (88 FR 25822). Accordingly, these amendments would better support consumer choice and restrict Exchanges from enrolling consumers in a new plan based on factors beyond the retention of the most similar plan available. We also propose amendments to § 155.335(j)(1) and (2) to conform with the removal of § 155.335(j)(4).

In the Exchange Establishment Rule (77 FR 18374), we implemented standards for annual eligibility redetermination and renewal of coverage under § 155.335(j) which required Exchanges to, if an enrollee remains eligible for coverage in a QHP upon annual redetermination, automatically re-enroll the enrollee in the QHP selected the previous year unless the enrollee terminates coverage, including termination of coverage in connection with enrollment in a different QHP. This rulemaking implemented procedures to redetermine the eligibility of individuals on a periodic basis in appropriate circumstances as required by section 1411(f)(1)(B) of the ACA.

We later adopted amendments to § 155.335(j) in the Annual Eligibility Redeterminations Rule (79 FR 52998 through 53001) which added a re-enrollment hierarchy to address situations where an issuer cannot re-enroll an enrollee in the plan they chose the previous year because the plan is no longer available. This hierarchy provided a structured process for renewal and re-enrollment into a new plan when the current plan was no longer available. We designed the

process to limit the differences between the consumer's current plan and new plan. In response to this proposed rule, commenters expressed concern over consumers losing access to APTC and CSRs if they are re-enrolled into a product outside the Exchange. In response, we affirmed that while the guaranteed renewability requirements under section 2703(c) of the PHS Act and § 147.106(c) would require the issuer, at the option of the individual, to re-enroll a current enrollee in their same product outside the Exchange if the issuer stopped offering that product through the Exchange but continued to offer it outside of the Exchange, issuers would still be subject to the re-enrollment hierarchy with regards to an enrollee's on-Exchange coverage and therefore must, subject to applicable State law, re-enroll in accordance with the hierarchy even if it results in re-enrollment in a plan under a different product offered by the same issuer. To harmonize these requirements, we stated that an enrollment completed pursuant to the re-enrollment hierarchy in § 155.335(j) would be considered a renewal of the enrollee's coverage, provided the enrollee also is given the option to renew coverage within the consumer's current product outside the Exchange. We further noted our intent to evaluate this policy and potentially provide future guidance on how an issuer continuing to offer an enrollee's product outside the Exchange can comply with the guaranteed renewability provisions.

In the 2017 Payment Notice (81 FR 12270), we amended the hierarchy to give Exchanges flexibility to 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 2024 Payment Notice (88 FR 25821 through 25822), we further amended the hierarchy and established the "bronze to silver crosswalk policy" to allow Exchanges to direct re-enrollment for enrollees who are eligible for CSRs from a bronze QHP to a silver QHP if a silver QHP is available within the same product, with the same provider network, and with a lower or

equivalent premium after the application of APTC as the bronze level QHP into which the Exchange would otherwise re-enroll the enrollee (in other words, if the silver QHP has a lower or equivalent "net premium"). In effect, this change allowed Exchanges to terminate an enrollee's coverage in a bronze QHP and re-enroll them in a silver QHP. We made this change after concluding the bronze to silver crosswalk would help to ensure that additional enrollees are able to benefit from more generous coverage at a lower cost to the enrollee that provides the same benefits and provider network. Some commenters on this rule (88 FR 25823) expressed concerns that re-enrolling a consumer into an alternative QHP when the consumer's current plan remains available on the Exchange would violate the guaranteed renewability requirements with which issuers must comply. In response, we explained in the 2024 Payment Notice (88 FR 25823 through 25824) how the change is consistent with the explanation of the guaranteed renewability requirements in the Annual Eligibility Redeterminations Rule discussed previously.

We have revisited whether the consumer benefits that motivated the current requirements at § 155.335(j)(4) continue to outweigh the problems we previously acknowledged some consumers would face if the Exchange terminated a consumer's prior choice in coverage. In 2024 Payment Notice proposed rule (87 FR 78206, 78259), we proposed to amend § 155.335(j) to provide greater financial security to bronze plan enrollees who do not actively re-enroll and may not be aware that a more generous silver plan at the same or lesser cost may be available with dramatically more costs covered by the plan. At the time, we highlighted that some of these consumers may have been initially enrolled before the more generous APTC became available with the passage of the ARP as extended by the IRA,[98] and may not have been initially income-based CSR-eligible when they first enrolled, or may have been helped by an agent, broker, web-

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

broker, or Navigators who did not adequately explain the benefits of silver enrollment for CSR-eligible enrollees. Today, this lack of awareness of more generous subsidies due to their newness is no longer an issue. We believe consumers and the agents, brokers, web-brokers, and Navigators who help them are largely aware of the more generous subsidies.[99] Therefore, we believe the consumer awareness problem the bronze to silver crosswalk policy aimed to address is substantially less today. Moreover, since the enhanced subsidies under the IRA expire at the end of this year, this policy's goal of increasing consumer awareness of these enhanced subsidies is no longer relevant.

With fewer people benefiting from the policy today, we believe there is now a greater harm to enrollees when the Exchange terminates an enrollee's enrollment in a bronze QHP which they had previously chosen. After we proposed the crosswalk policy currently at § 155.335(j)(4), as noted in the 2024 Payment Notice (88 FR 25823), several commenters expressed concerns about the bronze to silver crosswalk proposal. Some commenters expressed concern that the proposal would cause consumer confusion, and they cautioned against interpreting consumer inaction as indifference. In particular, these commenters noted that consumers sometimes research their options and make a decision to allow themselves to be auto re-enrolled, without taking action on *HealthCare.gov*. These commenters also noted that consumers select plans for many reasons other than the monthly premium amount, including provider network, benefit structure, and health savings account (HSA) eligibility, and raised the concern that auto re-enrolling some consumers from a bronze plan to a silver plan would disregard these consumer priorities. Some commenters also expressed concern that consumers who are auto re-enrolled

[99] 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/.

into a silver plan could incur unexpected tax liability, including consumers aware of their auto re-enrollment, if their APTC amount was determined based on inaccurate household income for the future year, which is a particular risk for hourly workers.

We explained in the 2024 Payment Notice (88 FR 25824) that consumers auto re-enrolled from a bronze to a silver QHP because of this new policy would not experience network changes or benefit changes because of the policy, since § 155.335(j)(5) only permits Exchanges to apply the policy for consumers who have access to a silver plan in the same product and with a Provider Network ID that matches that of their future year bronze plan. However, considering there is now substantially more consumer awareness around the availability of more generous subsidies, we believe the concerns commenters expressed over creating consumer confusion, respecting consumer choice, and the potential for enrollees to incur unexpected tax liability outweigh the benefits of moving from bronze to silver plans enrollees who may not be aware that the silver plan provides lower cost sharing at the same or lesser premium.[100] Moreover, we acknowledge how the current rule terminates coverage that the consumer may have actively chosen, or, if they were auto re-enrolled into the plan, may reasonably expect to be auto re-enrolled into it again, which represents a major intervention and interference with the consumer experience. We believe this level of interference requires a stronger policy basis than we previously acknowledged. We agree with commenters on the 2024 Payment Notice (88 FR 25823) who raised the concern that consumers should be able to rely on an assumption that the

[100] As discussed in the 2024 Payment Notice, enrollees who were auto re-enrolled from a bronze to a silver QHP under § 155.335(j)(4) could incur unexpected tax liability if their APTC amount was determined based on inaccurate household income for the future year, either because an enrollee did not update their household income in advance of the new plan year or because they estimated their income incorrectly. An enrollee in bronze coverage who does not need to use the entire amount of the APTC for which they qualify towards their premiums during the year has some protection against tax liability in the event of an unexpected increase in household income, and they may have a larger tax liability upon tax filing if the APTC they apply to a monthly silver plan premium is greater than the amount they would have had to apply to a monthly bronze plan premium, and this APTC exceeds the PTC amount for which they ultimately qualify when they file their taxes.

Exchange will re-enroll them in the same plan as the enrollee's current QHP if it is still available through the Exchange, and who advocated for HHS to improve decision-making tools on *HealthCare.gov* instead of changing consumers' default plan selections. Providing consumers with the information they need to make informed choices, and then honoring consumer choices, is a matter of trust. We believe the current requirements unnecessarily risks 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.

Because we believe § 155.335(j)(4) unnecessarily risks harming the consumer experience without sufficient benefit, we propose to remove § 155.335(j)(4).

We seek comment on this proposal.

6. Premium Payment Threshold (§ 155.400)

We propose 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 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 propose 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.

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.

In the 2017 Payment Notice (81 FR 12271 through 12272), in which HHS established the option for issuers to implement a percentage-based premium payment threshold, we received a comment requesting that issuers be allowed to establish a flat dollar amount threshold. At that time, we stated that we did not consider implementing such a threshold because there may be cases in which even a low flat dollar amount may represent a large percentage of an enrollee's portion of the premium less APTC (81 FR 12272).

In the 2026 Payment Notice (90 FR 4478), we stated that it was important to give issuers additional flexibility to maintain coverage for enrollees who owe only de minimis amounts of

premium. In addition, we also stated that even though the fixed dollar threshold amount may represent a large percentage of an enrollee's portion of the premium less APTC, triggering a grace period or terminating enrollment through the Exchange was too severe a consequence for non-payment of such limited dollar amounts.

Since the publication of the 2026 Payment Notice (90 FR 4478), the open enrollment period for 2025 individual market coverage has ended and we have compiled data regarding enrollments effectuated during the open enrollment period. 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.Although these numbers represent a decrease from the high of 39,985 complaints received in February 2024,[101] the fact that the number of complaints for 2024 remains substantially higher than for 2023 demonstrates that previous program integrity measures[102] have not resulted in a decrease in improper enrollments such that additional measures are not necessary. 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. 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

[101] 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.

[102] 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.

threshold policies, we believe the burden of eliminating these policies on issuers and consumers is outweighed by the potential increase in program integrity.

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 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).This policy therefore increases the risk that improper enrollments remain undetected, since the enrollee is less likely to receive invoices, and a delinquency[103] 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, an enrollee who stops paying premium 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

[103] 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.

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. 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).

We also received and addressed one comment in the 2026 Payment Notice (90 FR 4479 through 4480)[104] that stated that the fixed-dollar threshold would incentivize improper activity directed at the most flexible premium payment threshold policies and that a flexible threshold would lead to agents, brokers, or web-brokers leveraging these unique carrier-specific policies as a marketing lever. The commenter suggested that agents, brokers, or web-brokers would be incentivized to enroll consumers in an Exchange plan with a generous premium policy threshold (such as the gross premium percentage-based threshold), in which the consumer would be less likely to lose coverage due to not paying premiums, to secure a commission each time the policy is renewed. At the time we disagreed with this statement, as we did not believe that the fixed-dollar and gross-premium percentage-based thresholds alone would cause an increase in the incidences of improper enrollments by agents, brokers, and web-brokers, but we do recognize that there is an incentive for agents, brokers, or web-brokers to enroll consumers in plans with a generous premium policy since they would allow collection of monthly commission for a longer period of time. We believed that our efforts in calendar year 2024 to implement certain system

[104] Comment ID CMS-2024-0210, 11/12/2025, available at https://www.regulations.gov/comment/CMS-2024-0311-0210

changes[105] and strengthen oversight of agents and brokers would substantially reduce incidences of improper enrollments. However, as noted previously, due to the continued high number of complaints of improper enrollments, it has become apparent that additional program integrity measures are necessary. Given the multiple avenues that some agents and brokers to date have taken to improperly enroll consumers in QHPs offered on Exchanges, we are now reconsidering the impact that the fixed-dollar and gross-premium percentage-based thresholds may have in obscuring improper enrollments from the victim of the improper enrollment by delaying the time it would take for the consumer to be placed in the grace period and informed of their delinquency.

We also received and addressed several comments in the 2026 Payment Notice (90 FR 4478) that stated that the fixed-dollar and gross-premium percentage-based thresholds would prevent disruptions of care caused by terminating enrollees for owing small amounts of premium.

However, because of the program integrity concerns we have stated, we remain concerned that these policies allow enrollees to unknowingly remain in 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-

[105] See CMS. (2024, Oct. 14). CMS Update on Actions 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

payment that year. As such, we estimate that, if finalized, this rule would likely result in about 184,111 policy terminations after application of the available grace period. 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.

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.[106] These cases have caused disruptions in coverage for consumers, due to Medicaid's refusal to pay for services[107] when the consumer is enrolled in a QHP, and has also caused delays in payments to health care providers. As noted above, we expect that the removal of these premium threshold options will 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.

HHS has also previously taken steps to address concerns about enrollees losing their coverage, such as the requirement at § 156.270(d) that issuers must provide a grace period of 3 consecutive months for an enrollee who is receiving the benefit of APTC and fails to timely pay premiums. In addition, § 156.270(f) requires QHP issuers to provide enrollees with notice of payment delinquency when an enrollee is delinquent on premium payment, promptly and without undue delay, within 10 business days of the date the issuer should have discovered the

[106] See § 156.1010(e)
[107] As required by section 1902(a)(25) of the Social Security Act, Medicaid is the payer of last resort.

delinquency. These requirements ensure that enrollees receive notice and are thus aware well in advance of the risk of losing their coverage if they do not take action to pay their past due premiums.

We seek comments on this proposal.

7. Annual Open Enrollment Period (§ 155.410)

We propose 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 propose 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 are making 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 5 below). 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. We established a lengthy initial enrollment period lasting from October 1, 2013, to March 31, 2014, to allow time for individuals and

families to explore their new coverage options and provide outreach and education to raise awareness. However, recognizing the need to limit adverse selection, we established a much shorter OEP for the PY 2015 and beyond running from October 15 to December 7. Due to challenges in the first year, in the 2015 Payment Notice (79 FR 13796 through 13797, 13838), the PY 2015 OEP was delayed and extended to run from November 15 to February 15 to give more time to collect additional rating experience to help reduce 2015 premium rates. The change also gave issuers another month to prepare to accept applications and staggered the Exchange OEP from that of Medicare Advantage. In the 2016 Payment Notice (80 FR 10795 through 10797, 10866), for PY 2016, we set the OEP to run from November 1 to January 31. While we had proposed a shorter OEP, we finalized this more modest change primarily to limit the burden of a shift on Exchanges still experiencing implementation challenges. As Exchange operations became more stable, in the 2017 Payment Notice (81 FR 12273, 12343), we removed the prior extensions to the OEP and set it to run from November 1 to December 15 for PY 2019 and beyond. We gave Exchanges and issuers 2 years to prepare for this shift by extending the PY 2016 OEP start and end dates to PY 2017. This reestablished a permanent policy of a December 15 OEP end date for PY 2019 and beyond to support a full year of coverage and reduce adverse selection risk for issuers. However, in response to increasing challenges to the stability of the individual market and after concluding the market and issuers were ready for the adjustment sooner, we decided in the Market Stabilization Rule (82 FR 18353, 18381) to implement this permanent OEP policy a year ahead of schedule for PY 2018. At the time, we acknowledged the shorter period could lead to a reduction in enrollees, primarily younger and healthier enrollees who usually enroll late in the enrollment period. However, we concluded the positive impacts on consumers and market stability outweighed this potential decline in enrollment.

Table 5: Summary of Open Enrollment Period Length (PY 2014-2026)

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[108] 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[109] 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[110] 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[111] 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	
Proposed 2026	11/1/2025	12/15/2025	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

[108] 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
[109] 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
[110] See CMS (2020). Public Use Files: FAQs. https://www.cms.gov/files/document/2020-public-use-files-faqs.pdf
[111] See CMS (2021). Public Use Files: FAQs. https://www.cms.gov/files/document/2021-public-use-files-faqs.pdf

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 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 believe this data shows consumers became accustomed to the deadline. Also, 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 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 5 for a summary of OEPs in effect from PY 2014 to PY 2025.

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.[112] 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.[113] 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.

Our analysis found that 3 percent of enrollees in Exchanges on the Federal platform did drop their coverage renewals after December 15 during the most recent extended OEP. Some of these people may have switched to a more affordable plan after receiving a bill in January with unexpected plan costs. However, 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. As we have noted elsewhere, we recently began receiving substantially

[112] See CMS. (2024, Oct. 17). State-based Marketplaces: 2025 Open Enrollment. https://www.cms.gov/files/document/state-exchange-oe-chart-py-2025.pdf.
[113] Whether or not a State expanded Medicaid can have a substantial impact on enrollment between States.

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 their commissions.[114] However, we also note 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 request 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 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 do believe the change would reduce consumer confusion over the two deadlines under the current OEP that can increase administrative burdens and lead people to miss a whole month of coverage in January. Consistent with our observations after the December 15 end date was adopted for the 2018 OEP, we expect that consumer casework volumes related to coverage start dates and inadvertent dual enrollment would decrease if the same policy is put in place for the 2026 OEP. Reducing the OEP by a month should also reduce burdens on Exchanges, issuers, and people who assist with plan selections; however, the Federal government, State Exchanges, and issuers may incur costs if additional outreach is needed to alert consumers of the change in OEP end date. We will continue to leverage various

[114] 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 due to agent or broker noncompliant behavior.

methods to inform consumers before and during the Open Enrollment Period of key items and changes, including sending Marketplace Open Enrollment and Annual Redetermination Notices; developing advertising campaigns on television, radio, social media, and other platforms; collaborating with assistors; and utilizing the *HealthCare.gov* website as a central hub of information. We seek 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 note the crucial role 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 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. Enrollment periods are one of the few tools established by the ACA to mitigate adverse selection and contribute to a more stable, affordable market.

We previously noted that the experience from State Exchanges operating their own eligibility and enrollment platforms suggests that extending the OEP into January does not introduce adverse selection into the market. However, this conclusion was based largely on comments we received from State Exchanges that did not include supporting evidence. Other commenters expressed the opposite view that the risk of adverse selection warranted keeping the December 15 end date. 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.

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 no longer believe the benefits of the OEP extension outweigh the risk of adverse selection. We welcome comments on whether the risk of adverse selection supports changing the OEP end date to December 15.

We anticipate 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. While we have previously given State Exchanges the flexibility to extend their OEPs, the previous analysis suggests these extensions do not increase enrollment. Accordingly, we believe all extensions, regardless of the Exchange platform, present an unnecessary risk of adverse selection. Any increase in adverse selection due to these extensions may increase premiums which, in turn, increases the Federal cost of PTC subsidies and undermines affordability for people who do not qualify for subsidies. Applying this proposal to State Exchanges would be consistent with our decision to apply the December 15 end date for the 2018 OEP and beyond on a nationwide basis.

We recognize that the proposal to adopt and transition to a consistent OEP start and end date might lead to operational difficulties for State Exchanges. We have previously recognized that State Exchanges could use existing regulatory authority to supplement the OEP with an SEP as a transitional measure. Given our proposal to adopt a standard OEP, we seek comment on whether we should also prohibit Exchanges from extending an OEP through application of a blanket special enrollment period. Where available, we request that comments include data demonstrating the impact of the OEP end date on enrollment and adverse selection. Additionally, we seek 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.

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)

We propose 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 propose 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), § 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 preamble). We also propose to amend the introductory text of § 155.420(a)(4)(iii) to remove reference to paragraph (d)(16). Finally, we also propose 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 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, more experience with this SEP suggests it has substantially increased the level of 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. We encourage commenters and other interested parties to provide comments on whether and how the 150 percent FPL SEP has exacerbated these issues. Finally, 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.[115] 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

[115] 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 are proposing 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 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.

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),[116] combined with easier access to these fully subsidized plans through the 150 percent FPL SEP, led to a substantial increase in improper enrollments. 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. Based on our

[116] 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.

own analysis, 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.

Because of these practices, in 2024, we implemented various system and logic changes to decrease and/or prevent some agent, broker, and web-broker behavior in an effort to mitigate improper enrollments, and we have observed some improvements. However, 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 the agent, broker, or web-broker canceled or eventually learns they must reconcile surprise APTC on their taxes. In December 2024 we 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. This has caused us to reconsider the existence of 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.[117] The complaint alleges that the false ads created by the defendants "resulted in hundreds of thousands of enrollments by class members."[118] 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.[119] This analysis estimates between 4 to 5 million improper enrollments in 2024 at a cost of $15 to $26 billion in improper PTC payments.[120]

Our own analysis confirms that 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 estimate that only 1.5 million people who live in Florida fall within that income level.[121] Unlike the previously cited analysis by the Paragon Health Institute (see footnote 35), our comparison includes everyone under the

[117]Complaint, *Conswallo Turner et al. v. Enhance Health, et al*., Case 0:24-cv-60591-MD. (S.D. Fla.2024).
[118] Ibid. at 56.
[119] Blase, B.; Gonshorowski, D. (2024, June). *The Great Obamacare Enrollment Fraud*. Paragon Health Institute. https://paragoninstitute.org/private-health/the-great-obamacare-enrollment-fraud.
[120] Ibid.
[121] U.S. Census Bureau (2022). *American Community Survey*. Dep't of Commerce. https://www.census.gov/programs-surveys/acs/data.html.

age of 65 and therefore includes people who are unlikely Exchange enrollees such as Medicaid-eligible children, people with disabilities on Medicaid and Medicare, and people who receive coverage through their employer. Therefore, it underrepresents the level of improper enrollments. This disparity between the number of plan selections and Census population estimates suggests there were likely over 1 million improper enrollments in Florida alone. 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.[122] We encourage commenters and other interested parties to share their experiences in their respective States, including the extent of improper enrollments and other data disparities.

As such, 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. 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. This allows agents, brokers, and web-brokers to conduct unauthorized enrollments or change enrollments 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, we believe that by immediately ending this SEP as of the effective date of the final rule, the Exchanges would be protecting consumers by preventing

[122] Ibid.

improper enrollments in addition to working to stem 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 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. Additional research is necessary to accurately quantify the negative impacts of this behavior to the risk pool, and we seek 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 abused and misused. 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 propose changes to pre-enrollment verification for SEPs at § 155.420(g) of this proposed rule.

Our concern over people waiting to enroll 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 people must pay to reconcile any misestimate on their taxes. 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 is limited to $375 in 2024.[123] The limit is $950 for single filers with

[123] IRS (n.d.) *Rev. Proc. 2023-34*. Dep't of Treasury. https://www.irs.gov/pub/irs-drop/rp-23-34.pdf.

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. 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, 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. 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.[124,125]

This wide flexibility in estimating income may also be open to misuse by Navigators and CACs. 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 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.[126] Navigators must provide progress reports to CMS and future grant funding levels are based in part on progress toward this goal.[127] Navigators and CACs may even believe it is their mission to encourage or allow applicants to aggressively

[124] 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/.
[125] 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/.

understate their income to gain more affordable coverage. We seek comments on this issue and the proposal generally.

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 believe stronger enforcement measures can substantially reduce improper enrollments, 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. 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 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 believe that the loopholes and incentives created by the 150 percent FPL SEP are too large to simply police retrospectively.

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).

These conclusions no longer seem valid considering the recent *Conswallo Turner et al. v. Enhance Health, et al.,* litigation, higher numbers of consumer complaints about to 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. This new information suggests the increase in the portion of Exchange enrollees who report household incomes under 150 percent of the FPL is driven by improper enrollments. In addition, 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. People already enrolled in fully subsidized plans clearly have little incentive to drop their plan. 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. People who wait can avoid enrollment if they never become sick and, therefore, avoid contributing when healthy. 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 in 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 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. After fully accounting for the impact of people not enrolling during the OEP and waiting

to enroll until sick, we project the premium impact of the current policy is between 0.5 to 3.6 percent. Based on the premium increase and the increase in improper enrollments which was exacerbated by our previous SEP policy, 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 believe that the costs may exceed the benefits and we encourage commenters and other interested parties to provide comments on the cost impact the 150 percent FPL SEP.

We note 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. While these negative impacts from the 150 percent FPL SEP are related, we do account for them separately in our consideration. 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. 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,"[128] 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."

[128] *Texas Med. Ass'n v. U.S. Dep't of Health and Human Servs.*, --- F.4th ---, 2024 WL 3633795, *8 (Aug. 2, 2024) (citing *Nat'l Pork Producers Council v. EPA*, 635 F.3d 738, 753 (5th Cir. 2011); *Texas v. U.S.*, 809 F.3d 134, 179, 186 (5th Cir. 2015), aff'd by an equally divided court, 579 U.S. 547 (2016)).

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 Social Security Act." 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 year of eligibility. The 150 percent FPL SEP is likewise not one of the SEPs specified in section 9801 of the Code, nor similar to such SEPs.

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 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 believe that Congress was prescient to provide the Secretary with a comprehensive statutory list of SEPs that omitted the 150 percent FPL SEP. We seek comments on this proposal.

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. 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. 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 request further comment on this proposal.

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

We propose 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 special enrollment periods under paragraph (d)(1) of this section.[129] We propose 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 implemented verification processes for SEPs in the Market Stabilization Rule (82 FR 18357 through 18358).[130] 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 believe the current SEP

[129] Currently, § 155.420(g) provides that Exchanges on the Federal platform will conduct pre-enrollment special enrollment verification of eligibility only for special enrollment periods 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.
[130] 82 FR 18346.

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 believe the positive impact of verification on the risk pool far exceeds the potential negative impact on the risk pool. Therefore, we propose to amend § 155.420(g) to remove the provision that limits Exchanges on the Federal platform to 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 propose 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.[131] In 2016 we added warnings on *HealthCare.gov* regarding inappropriate use of SEPs. We also eliminated several SEPs and tightened certain eligibility rules.[132] 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.[133] Finally, we proposed to implement (beginning in June 2017) a pilot program for conducting pre-enrollment verification of eligibility for certain SEPs.[134]

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 eligible people from enrolling, we studied the initial consumer experience with this pre-enrollment verification process and published our findings in 2018.[135] 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

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[131] 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.
[132] CMS. (2016, Feb. 24). *Fact Sheet: Special Enrollment Confirmation Process*. https://www.cms.gov/newsroom/fact-sheets/fact-sheet-special-enrollment-confirmation-process.
[133] Ibid.
[134] 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.
[135] 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.

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.[136] 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 eliminated pre-enrollment verification for every SEP 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 three years of experience applying pre-enrollment verification to only the SEP for losing minimum

[136] More consumers resolve passed 30 days due to extensions that they are eligible to receive.

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 the 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.[137] This suggests that individuals who 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-

[137] Comment ID CMS-2021-0196-0196, 01/27/2022 available at https://www.regulations.gov/comment/CMS-2021-0196-0196

19 public health emergency.[138] 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.[139] 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.[140] 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.

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 enrollment. We also note 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

[138] Comment ID CMS-2021-0196-0222, 01/27/2022 available at https://www.regulations.gov/comment/CMS-2021-0196-0222
[139] Derived from issuer enrollment data, CMS. (2024, Sept. 10). *Issuer Enrollment Data*. https://www.cms.gov/marketplace/resources/data/issuer-level-enrollment-data
[140] Ibid.

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.[141] 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.[142] 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, 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 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

[141] Descriptions and information on the length of SEPs can be found at 45 CFR § 155.420 (c).
[142] This statistic is based on SEPV resolution data from PY 2019.

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, 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 propose 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, in order 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 believe State Exchange enrollments would benefit from implementing a similar policy.

We also believe State Exchanges now have more experience with conducting SEP verifications, which would make broader implementation less burdensome than before. We welcome 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 propose to amend § 155.420(g) to require all Exchanges to conduct eligibility verification for SEPs.

We also propose 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 are proposing that Exchanges must verify at least 75 percent of such new enrollments based on the current volume of SEP verification by Exchanges. 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 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. The determination of how many enrollments would constitute 75 percent would be required to be based on enrollment through all SEPs. 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 propose to eliminate the current flexibility Exchanges have under § 155.420(g) to provide exceptions to SEP verification processes, we continue 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 propose 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).[143] 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 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 are proposing to allow Exchanges until PY 2026 to implement SEP verification. We welcome comment on this topic and suggestions to alleviate this concern.

We seek comment on these proposals. With respect to SEP verification, we seek comment from States about the 75 percent verification threshold and whether it should be based 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

[143] Such requests would be made through the State-based Marketplace Annual Reporting Tool (SMART; OMB Control Number 0938-1244).

year-to-year. 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 invite 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.

C. Part 156 —Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges

1. Prohibition on Coverage of Sex-trait Modification as an EHB (§ 156.115(d))

We propose 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 Secretary of HHS), 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.[144]

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,

[144] 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.

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.[145,146]

On January 20, 2025, President Trump issued Executive Order 14168, "Defending Women From Gender Ideology Extremism and Restoring Biological Truth to the Federal Government" (E.O. 14168) that requires agencies to "take all necessary steps, as permitted by law, to end the Federal funding of gender ideology." Then, on January 28, 2025, President Trump issued Executive Order 14187, "Protecting Children From Chemical and Surgical Mutilation" (E.O. 14187) that directs the Secretary of HHS to take all appropriate actions consistent with applicable law to end the chemical and surgical mutilation of children. The phrase "chemical and surgical mutilation" in E.O. 14187 means the use of puberty blockers, sex hormones, and surgical procedures that attempt to transform an individual's physical appearance to align with an identity that differs from his or her sex or that attempt to alter or remove an individual's sexual organs to minimize or destroy their natural biological functions. As noted in the definition of "chemical and surgical mutilation" in E.O. 14187, this phrase sometimes is referred to as "gender affirming care," and is referred to in this proposed rule as "sex-trait modification." For purposes

[145] 78 FR 12845.
[146] In the 2025 Payment Notice (89 FR at 26343), we removed routine non-pediatric dental services from § 156.115(d).

of this definition, the term "sex" is a person's immutable biological classification as either male or female; the term "female" is a person of the sex 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.[147] Because coverage of sex-trait modification is not typically included in employer-sponsored plans, and EHB must be equal in scope to a typical employer plan, we propose to add "sex-trait modification" to the list of items and services that may not be covered as EHB beginning in PY 2026.

Although the fact that sex-trait modification is not typically included in employer-sponsored plans is an independent, sufficient, and legally compelled reason for this rule, the agency acknowledges recent executive orders that have been subject to preliminary injunctions. The agency makes 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 acknowledges that two courts have issued preliminary injunctions relating to the executive orders described above, and the agency does not rely on the enjoined sections of the executive orders in making this proposal.

In particular, 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

[147] 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.

(W.D. Wash. Feb. 28, 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, 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). If finalized, the rule proposed here 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. In any event, 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.

With regard to whether or not sex-trait modification is typically included in an employer-sponsored plan, 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. This includes many small group plans that do not cover such services; we note that 42 States chose or defaulted to small group plans as their EHB-benchmark plan selections in 2014 and 2017.[148] In

[148] CMS. (2016, April 8). *Final List of BMPs*. https://www.cms.gov/cciio/resources/data-resources/downloads/final-list-of-bmps_4816.pdf

addition, of those 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. 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: our understanding is 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.[149] In addition, 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.[150]

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;[151] this low utilization is apparent in the External Data Gathering Environment (EDGE) limited data set.[152] In this data set, which encompasses the majority of health insurance enrollees covered outside of large group

[149] Movement Advancement Project. 2025. "Equality Maps: Healthcare Laws and Policies." https://www.mapresearch.org/equality-maps/healthcare_laws_and_policies. Accessed Feb. 23, 2025.
[150] Ibid.
[151] 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.
[152] 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.

plans, approximately 0.11 percent of enrollees in non-grandfathered individual and small group market plans utilized sex-trait modification during PYs 2022 and 2023.[153]

We note 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 are also aware that some stakeholders 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.[154] As discussed later, 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 are also concerned about the scientific integrity of claims made to support their use in health care settings. As such, we seek 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 are not proposing a definition of "sex-trait modification." However, we solicit 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.

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[153] 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.

[154] EHB categories defined in Section 1302(b) are ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorders – 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.

We also recognize that there are some medical conditions, such as precocious puberty, or therapy subsequent to a traumatic injury, where items and services that are also used for sex-trait modification may be appropriate. We seek 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.

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.

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.[155] If this proposal is finalized as proposed, health insurance issuers will be prohibited from providing coverage for sex-trait modification as an EHB in any State beginning in PY 2026. 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 considered in addition to

[155] 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.

EHB pursuant to § 155.170. However, 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. 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, 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, they may opt to continue covering sex-trait modification consistent with applicable State law, but not as an EHB. We seek comment on whether additional program integrity measures are necessary to ensure Federal subsidies do not continue to fund sex-trait modification if this proposal is finalized.

Lastly, we seek comment on the proposed effective date of this proposal. We are proposing PY 2026 as the beginning effective date for when issuers subject to EHB requirements would be prohibited from covering sex-trait modification as an EHB. We seek 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.

We seek comment on this proposal.

2. Premium Adjustment Percentage (§ 156.130(e))

We propose to update the premium adjustment percentage methodology to establish a premium growth measure that captures premium changes in the individual market in addition to employer-sponsored insurance (ESI) premiums for PY 2026 and beyond. Based on the proposed update to the premium adjustment methodology, we propose 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. If this proposal is 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 this rule would supersede the values published in the guidance document "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" published on CMS' website on October 8, 2024 (October 2024 PAPI Guidance).[156]

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. Section 156.130(e) also provides that this percentage will be published in guidance in January of the calendar year preceding the benefit year for which the premium adjustment percentage is applicable, unless HHS proposes changes to the methodology, in which case, HHS will publish the annual premium adjustment

[156] 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.

percentage in an annual HHS notice of benefit and payment parameters or another appropriate rulemaking.

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 propose to 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). Based on the general trend of stabilizing premiums and our conclusion that including individual market premium changes going forward would more accurately reflect true premium growth, in the 2020 Payment Notice (84 FR 17537 through 17541), we finalized the proposal to use 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 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 this proposed rule, 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, which was the methodology used for PY 2015 through PY 2019. Although we did not propose to change the methodology in the 2022 Payment Notice proposed rule, we nonetheless received comments requesting that we revert to the use of the NHEA ESI premium measure to estimate premium growth. 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. Additionally, we concluded that this methodology aligned with the policy objectives in the January 28, 2021 Executive Order on Strengthening the

Affordable Care Act and Medicaid (86 FR 7793)[157] and the ARP,[158] which both emphasized making health coverage accessible and affordable for consumers of all income levels.

Because the COVID-19 PHE has ended[159] and should no longer impact the premium adjustment percentage, and because evidence described below 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), we now propose 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 propose 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.[160] 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 propose 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

[157] We note that the January 20, 2025 Executive Order on Initial Rescissions of Harmful Executive Orders and Actions (90 FR 8237) revoked Executive Order 14009 of January 28, 2021 (Strengthening Medicaid and the Affordable Care Act).
[158] ARP, Pub. L. 117-2.
[159] HHS. (2023, May 11). *HHS Secretary Xavier Becerra Statement on End of the COVID-19 Public Health Emergency*. https://public3.pagefreezer.com/browse/HHS.gov/02-01-2024T03:56/https://www.hhs.gov/about/news/2023/05/11/hhs-secretary-xavier-becerra-statement-on-end-of-the-covid-19-public-health-emergency.html.
[160] 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*.

casualty insurance),” consistent with the approach finalized in the 2020 Payment Notice (84 FR 17537 through 17541).

We are proposing to exclude Medigap and property and casualty insurance from the premium measure since these types of coverage are not considered primary medical coverage for individuals who elect to enroll.[161] For example, Medigap coverage supplements Original Medicare[162] Plan coverage by helping to pay certain out-of-pocket costs not covered by Original Medicare such as co-payments, coinsurance, and deductibles. Specifically, 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). 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. 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.

We believe this proposal aligns closely with the criteria we have previously used for establishing the premium adjustment percentage methodology. As discussed in the 2015 Payment Notice (79 FR 13801 through 13804) and 2020 Payment Notice (84 FR 17537 through 17541),

[161] 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.”

[162] 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

we considered four criteria when finalizing the premium adjustment percentage methodology for those plan years:

(1) Comprehensiveness—the premium adjustment percentage should be calculated based on the average per capita premium for health insurance coverage for the entire market, including the individual and group markets, and both fully insured and self-insured group health plans;

(2) Availability—the data underlying the calculation should be available by the summer of the year that is prior to the calendar year so that the premium adjustment percentage can be published in the annual HHS notice of benefit and payment parameters in time for issuers to develop their plan designs;

(3) Transparency—the methodology for estimating the average premium should be easily understandable and predictable; and

(4) Accuracy—the methodology should have a record of accurately estimating average premiums.

Using this methodology, we originally proposed a more comprehensive measure that reflected the entire market in the 2015 Payment Notice proposed rule (78 FR 72359 through 72361). We only deviated from fully following the comprehensiveness criteria in the 2015 Payment Notice (79 FR 13801 through 13804) to account for the significant changes occurring in the individual market during the initial years of the implementation of the ACA's insurance market rules. As we noted at that time, under these market rules, the individual market was likely to be the most affected by changes in benefit design and market composition. Due to the uncertainty over how these changes would impact enrollment and enrollee claims experience, the individual market was also more likely to be subject to risk premium pricing to account for this uncertainty. Thus, we anticipated a level of premium volatility in the individual market that may

compromise the criteria for accuracy in estimating the premium for the entire market. As noted previously, we further anticipated changing the methodology once the premium trend was more stable and, accordingly, we then changed the methodology in the 2020 Payment Notice (84 FR 17537 through 17541) to include individual market premiums after premium trends stabilized.

When we established the current premium adjustment percentage methodology in part 2 of the 2022 Payment Notice (86 FR 24233 through 24237), we focused on how we believed the change would mitigate the uncertainty regarding premium growth during the COVID-19 PHE and outlined similar concerns over the accuracy of premium estimates as we had during the initial years of the ACA's market rules. Specifically, we referenced that private health insurance premiums are more likely to be influenced by risk premium pricing, or premium pricing based on changes in benefit design and market composition in the individual market. Particularly during times of economic uncertainty, such as that experienced as a result of the COVID-19 PHE, we noted how private health insurance premium growth could reflect issuer uncertainty in market developments and could be reflected in the NHEA private insurance premium measure (excluding Medigap and property and casualty insurance). Due to these concerns, we noted that we believed NHEA ESI premium data would provide a more stable premium measure. Therefore, we concluded that using the NHEA ESI premium measure would provide a more appropriate and fair measure of average per capita premiums for health insurance coverage when considering the goal of consumer protection.

We published the current premium adjustment percentage methodology in part 2 of the 2022 Payment Notice (86 FR 24233 through 24237) on May 5, 2021, during the COVID-19 PHE. As noted above, we finalized this methodology after concluding in part that it was consistent with the will and interest of interested parties. After taking into consideration changes

in circumstances since this time (including the end of the COVID-19 PHE) and examining new data on health insurance premiums that have since become available, we believe it is appropriate to add individual market premiums back to the premium adjustment percentage methodology. We acknowledge that a higher number of comments can suggest a position we should consider more closely. However, we must also consider that many parties who comment on rulemaking may represent the will of special interests who do not necessarily represent all special interests or the general public interest in the faithful and efficient administration of the statute. It is not uncommon to receive comments that only represent one side and no opposing comments that might represent other special interests or a more general interest in good governance or the equities of the taxpayer. As our constitutional role is to faithfully execute the statute, we are responsible for considering all comments, as well as perspectives that may not be fully represented in comments, within the context of what the statute requires.

We have also revisited the rationale for establishing the current premium adjustment percentage based, in part, on how it aligns with certain policy objectives, such as objectives that emphasize making health coverage accessible and affordable for consumers of all income levels. Specifically, the ACA directs the Secretary to base the premium adjustment percentage on "the average per capita premium for health insurance coverage in the United States" [163] and does not provide further direction on the premium measure to use, giving the Secretary discretion over what premium measure to select. Consideration of other policy objectives in selecting this premium measure should not undermine or weaken the specific objective that Congress intended for the statutory provision to meet. Here, the premium adjustment percentage is the mechanism

[163] See Section 1302(c)(4) of the ACA.

in the ACA meant to ensure that certain parameters of the ACA change with health insurance premiums over time. As such, the premium adjustment percentage serves a specific objective to ensure that annual limits on cost sharing, eligibility for hardship exemptions, and employer shared responsibility payment amounts remain aligned with premium growth to account for future inflation. We believe accounting for other policy objectives, such as making coverage more accessible and affordable or reducing the burden on taxpayers, can only serve to distort the alignment the ACA requires HHS to maintain between premium growth and the parameters subject to the premium adjustment percentage. Therefore, we continue to believe the four criteria of comprehensiveness, availability, transparency, and accuracy that we first identified in the 2015 Payment Notice (79 FR 13801 through 13804) remain the best guide for setting a methodology that supports the objective of the premium adjustment percentage within the statute.

Although we did not reference these criteria in part 2 of the 2022 Payment Notice (86 FR 24233 through 24237), part of our justification did align with how we used the criteria in the 2015 Payment Notice (79 FR 13801 through 13804). Specifically, we were concerned that there was a potential for uncertainty in the private health insurance premium measure that includes the individual market due to issuer responses to the COVID-19 PHE, impacting the accuracy of a premium measure that included individual market premiums. However, we now have evidence that the COVID-19 PHE did not create the same uncertainty in the individual market that was present during the initial implementation of the ACA. As discussed previously, we decided to not use individual market premiums in the 2015 Payment Notice (79 FR 13801 through 13804) due to the uncertainty over how the ACA's market rules would change benefit designs and market composition of the individual market and how this uncertainty would be more likely to subject the individual market to risk premium pricing than the ESI market. We largely made the same

points in part 2 of the 2022 Payment Notice (86 FR 24233 through 24237) to justify not using individual market premiums due to uncertainty around the COVID-19 PHE. Yet, the COVID-19 PHE did not introduce new benefit designs as the implementation of the ACA's market rules did. The COVID-19 PHE also did not introduce a clear and distinctive risk to the market composition of the individual market. Individual and group markets were similarly exposed to the health risks associated with the COVID-19 PHE. Although there was uncertainty over whether the individual market would enroll more people who lost ESI due to COVID-19 PHE-related job losses, there was no reason to believe this population would introduce a higher risk to the individual market pool. By comparison, in the early period of implementation, the ACA's market rules were expected to shift large numbers of people with potentially high claims costs who lacked insurance or were covered in State high-risk pools into the individual market risk pool. Consequently, the individual market premiums were not subject to any more uncertainty due to the COVID-19 PHE than ESI premiums and each market would, therefore, likely face similar levels of risk premium pricing due to the COVID-19 PHE. Based on this analysis, we do not believe that the rationales we cited in part 2 of the 2022 Payment Notice (86 FR 24233 through 24237) continue to justify removing individual market premiums from the premium adjustment methodology.

After reviewing trends between individual premiums and ESI premiums, we now believe that individual premiums remained stable during the COVID-19 PHE. As shown in Table 6, per enrollee expenditure growth from the NHEA historical tables was actually more stable in the on-Exchange individual market than ESI during the COVID-19 PHE, with significantly lower

premium growth rates in every year from 2019 through 2023.[164] Moreover, premiums for other forms of direct purchase insurance,[165] which would also be included in the private health insurance premiums (excluding Medigap and property and casualty insurance) measure have had lower growth rates than ESI from 2021 through 2023 and have experienced lower growth rates since 2019 than in years prior to the COVID-19 PHE. Similarly, a comparison of premiums from medical loss ratio data[166] in Table 7 shows individual market premiums remained more stable than small group and large group premiums from 2019 through 2023. In addition, based on our review of premium trends before 2014, individual market premium trends were also comparably stable to ESI. Taken together, these data suggest that the COVID-19 PHE did not result in greater volatility in the individual market than in the ESI market as had been anticipated in part 2 of the 2022 Payment Notice (86 FR 24233 through 24237). Instead, the premium data show premium

[164] See the "NHE Tables" link under the "Downloads Section" at CMS. (2024, Dec. 18). *NHE Historical Data*. https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/historical (Page Updated December 18, 2024; Retrieved January 29, 2025). We use the historical tables for this analysis because they reflect estimates of actual 2023 values and have been updated more recently than the projected tables used to calculate the premium adjustment percentage. The historical tables do not include a grouped measure of private health insurance premiums (excluding Medigap and property and casualty insurance), so we have separate columns for On Exchange and Other Direct Purchase, which are the major components of the proposed premium measure. The projected tables include a measure of private health insurance premiums (excluding Medigap and property and casualty insurance), but do not include separate measures of On Exchange and Other Direct Purchase premiums and only include projections of values (that is, non-historical values) after 2022. The projected tables are expected to be updated in the summer 2025 to match the values in the historical tables through 2023 for ESI premiums and will also include updated historical values for private health insurance premiums (excluding Medigap and property and casualty insurance) at that time. Consistent with the policy finalized in the 2021 Payment Notice (85 FR 29227 through 29229), even if the NHEA projected tables are updated before the publication of the final rule, we will finalize the payment parameters that depend on the NHEA projected tables data, including the premium adjustment percentage and required contribution percentage, based on the data that are available as of the publication of the proposed rule to increase the predictability of benefit design.

[165] This category of insurance premiums includes insurance purchased on the private market that is not associated with an employer or a Medigap or Exchange plan. Examples of direct purchase insurance include group plans purchased through AARP or other associations, individual market plans (both plans that are subject to the ACA market rules and those that are not subject to all the ACA market rules, such as grandfather and grandmother plans), Short-Term Limited Duration (STLD) health plans, and the Basic Health Program (BHP). See the Definitions, Sources, and Methods used for the OACT estimates, available at: CMS. (December 18, 2024). *NHE Historical Data*. https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/historical

[166] See the Public Use Files for Medical Loss Ratio reporting available at CMS. (December 23, 2024). *Medical Loss Ratio Data and System Resources.* https://www.cms.gov/marketplace/resources/data/medical-loss-ratio-data-systems-resources.

trends remained generally stable between individual and ESI markets outside the initial years of the ACA's market rules including years impacted by the COVID-19 PHE, suggesting that a more comprehensive measure of premium growth for these years would also be a more accurate measure. As such, we do not believe there is a justification for de-prioritizing the comprehensiveness criterion by excluding individual market premiums from the premium adjustment percentage methodology for PY 2026 and beyond.

TABLE 6: Annual Growth Rate in Per Enrollee Expenditures

Plan year	Employer-Sponsored Insurance		On Exchange Individual Market		Other Direct Purchase	
	Per Capita Premium	Percentage Change	Per Capita Premium	Percentage Change	Per Capita Premium	Percentage Change
2014	$4,955	--	$4,371	--	$3,049	--
2015	$5,080	2.50%	$4,425	1.20%	$3,630	19.10%
2016	$5,304	4.40%	$4,704	6.30%	$4,107	13.10%
2017	$5,479	3.30%	$5,648	20.10%	$4,723	15.00%
2018	$5,678	3.60%	$7,129	26.20%	$5,457	15.50%
2019	$5,805	2.20%	$7,095	-0.50%	$5,638	3.30%
2020	$5,840	0.60%	$6,870	-3.20%	$5,754	2.10%
2021	$6,267	7.30%	$6,849	-0.30%	$6,085	5.80%
2022	$6,621	5.70%	$6,930	1.20%	$6,408	5.30%
2023	$7,326	10.60%	$7,079	2.10%	$6,821	6.40%

Source: National Health Expenditures Accounts, Historical Tables, Table 21.

TABLE 7: Annual Growth in Premiums Per Member Per Month

Market	2019	2020	2021	2022	2023
Large Group Market	3.4%	3.1%	3.6%	4.8%	5.6%
Small Group Market	3.1%	3.5%	4.2%	4.4%	6.6%
Individual Market	1.8%	-1.9%	0.8%	2.7%	2.7%

Source: CMS, MLR Data

We believe removing individual market premiums from the premium adjustment percentage methodology was an unnecessary policy change that seemed reasonable during the

COVID-19 PHE. As noted previously, this deviation from the full application of the four criteria we first identified in the 2015 Payment Notice (79 FR 13801 through 13804) was intended to favor accuracy over comprehensiveness. However, our analysis of recent data suggests that the justification we cited in part 2 of the 2022 Payment Notice (86 FR 24233 through 24237) that individual market premiums were at greater risk of a volatile response to the COVID-19 PHE did not prove to be correct.

Using the private health insurance premium measure data (excluding Medigap and property and casualty insurance) proposed above, we propose 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 per enrollee premiums for private health insurance (excluding Medigap and property and casualty insurance) for 2013 ($4,714).[167] Using this formula, the proposed premium adjustment percentage for 2026 would be 1.6726771319 ($7,885/$4,714), which would be an increase in private health insurance (excluding Medigap and property and casualty insurance) premiums of approximately 67.3 percent over the period from 2013 to 2025 and would reflect an overall growth rate for this period that would be approximately 7.2 percentage points higher than the overall growth rate

[167] 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

reflected by the previously published PY 2026 premium adjustment percentage[168] (1.6002042901).

We believe that our proposal to use per enrollee private health insurance premiums (excluding Medigap and property and casualty insurance) in the premium adjustment percentage calculation could result in a more comprehensive and higher overall estimate of premium growth rate for the foreseeable future than if we continued to use only ESI premiums as in prior plan years. This higher overall growth rate is driven by the fact that, between 2015 and 2018, private individual health insurance market per enrollee premiums offered on-Exchange grew faster than ESI premiums, most notably in PY 2017 and PY 2018 (See Table 6). However, we note that on-Exchange individual market premiums[169] have grown more slowly than ESI premiums since 2019. If this trend continues, then the immediate impact of a higher overall premium growth rate for PY 2026 could be reduced in the future, which may lead to a lower overall growth rate over the long-term.

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[168] 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.

[169] See the "NHE Tables" link under the "Downloads Section" at CMS. (2024, Dec. 18). *NHE Historical Data*. https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/historical (Page Updated December 18, 2024; Retrieved January 29, 2025). We use the historical tables for this analysis because they reflect estimates of actual 2023 values and have been updated more recently than the projected tables used to calculate the premium adjustment percentage. The historical tables do not include a grouped measure of private health insurance premiums (excluding Medigap and property and casualty insurance), so we have separate columns for On Exchange and Other Direct Purchase, which are the major components of the proposed premium measure. The projected tables include a measure of private health insurance premiums (excluding Medigap and property and casualty insurance), but do not include separate measures of On Exchange and Other Direct Purchase premiums and only include projections of values (that is, non-historical values) after 2022. The projected tables are expected to be updated in the summer 2025 to match the values in the historical tables through 2023 for ESI premiums and will also include updated historical values for private health insurance premiums (excluding Medigap and property and casualty insurance) at that time. Consistent with the policy finalized in the 2021 Payment Notice (85 FR 29227 through 29229), even if the NHEA projected tables are updated before the publication of the final rule, we will finalize the payment parameters that depend on the NHEA projected tables data, including the premium adjustment percentage and required contribution percentage, based on the data that are available as of the publication of the proposed rule to increase the predictability of benefit design.

We anticipate that this proposed change could have several impacts on the health insurance market. As explained above, the premium adjustment percentage is used to set the rate of increase for the maximum annual limitation on cost sharing, the required contribution percentage used to determine eligibility for certain exemptions under section 5000A of the Code, and the employer shared responsibility payment amounts under section 4980H(a) and (b) of the Code. Accordingly, a more comprehensive premium adjustment percentage that reflects a faster premium growth rate would result in a higher maximum annual limitation on cost sharing, higher reduced annual limitations on cost sharing, a higher required contribution percentage, and higher employer shared responsibility payment amounts than if the current premium adjustment percentage premium measure (ESI only) were used for PY 2026.

Furthermore, to date the Department of the Treasury and the IRS have used the same measures for determining the applicable percentage in section 36B(b)(3)(A) of the Code and the required contribution percentage in section 36B(c)(2)(C) of the Code as those selected by HHS for the calculation of the premium adjustment percentage.[170] The applicable percentage in section 36B(b)(3)(A) of the Code is used to determine the amount an individual must contribute to the cost of an Exchange QHP and thus relates to the amount of the individual's PTC. This is because, in general, an individual's PTC is the lesser of (1) the premiums paid for the Exchange QHP, and (2) the excess of the premium for the benchmark plan over the contribution amount.

[170] Section 36B(b)(3)(A)(ii) of the Code generally provides that the applicable percentages are to be adjusted after 2014 to reflect the excess of the rate of premium growth over the rate of income growth for the preceding year. Section 36B(c)(2)(C) of the Code provides that the required contribution percentage is to be adjusted after 2014 in the same manner as the applicable percentages are adjusted in section 36B(b)(3)(A)(ii) of the Code. The Department of the Treasury and the IRS has provided in annual guidance that the rate of premium growth for purposes of the section 36B provisions would be based on the same measures HHS selected following HHS' establishment of the methodology for calculating premium growth for purposes of the premium adjustment percentage using NHEA ESI for benefit years 2015-2019 (See IRS Rev. Proc. 2014-37), NHEA private health insurance (excluding Medigap and property and casualty insurance) for PYs 2020-2021 (See IRS Rev. Proc. 2019-29), and NHEA ESI for PYs 2022-2025 (See IRS Rev. Proc. 2021-36).

The contribution amount is the product of the individual's household income and the applicable percentage.

The required contribution percentage in section 36B(c)(2)(C) of the Code is used to determine whether an offer of ESI is considered affordable for an individual, which relates to eligibility for the PTC because an individual with an offer of affordable ESI that provides minimum value is ineligible for the PTC. Specifically, an offer of ESI is considered affordable for an individual if the employee's required contribution for ESI is less than or equal to the required contribution percentage (set at 9.5 percent in 2014) of the individual's household income.[171]

Section 36B(b)(3)(A)(ii) of the Code generally provides that the applicable percentages are to be adjusted after 2014 to reflect the excess of the rate of premium growth over the rate of income growth for the preceding year. Section 36B(c)(2)(C) of the Code provides that the required contribution percentage is to be adjusted after 2014 in the same manner as the applicable percentages are adjusted in section 36B(b)(3)(A)(ii) of the Code. As noted above, the Department of the Treasury and the IRS have provided in annual guidance that the rate of premium growth for purposes of these section 36B provisions is based on the same measures as those selected by HHS for the calculation of the premium adjustment percentage.[172] If we finalize a change to the premium measure used in the premium adjustment percentage for PY

[171] See also IRS Notice 2015-87, Q&A 12 for discussion of the adjustment of the required contribution percentage as applied for certain purposes under sections 4980H and 6056 of the Code.

[172] Section 36B(b)(3)(A)(ii) of the Code generally provides that the applicable percentages are to be adjusted after 2014 to reflect the excess of the rate of premium growth over the rate of income growth for the preceding year. Section 36B(c)(2)(C) of the Code provides that the required contribution percentage is to be adjusted after 2014 in the same manner as the applicable percentages are adjusted in section 36B(b)(3)(A)(ii) of the Code. The Department of the Treasury and the IRS has provided in annual guidance that the rate of premium growth for purposes of the section 36B provisions would be based on the same measures HHS selected following HHS' establishment of the methodology for calculating premium growth for purposes of the premium adjustment percentage using NHEA ESI for benefit years 2015-2019 (See IRS Rev. Proc. 2014-37), NHEA private health insurance (excluding Medigap and property and casualty insurance) for PYs 2020-2021 (See IRS Rev. Proc. 2019-29), and NHEA ESI for PYs 2022-2025 (See IRS Rev. Proc. 2021-36).

2026, we expect the Department of the Treasury and the IRS to adopt the same premium measure for purposes of future indexing of the applicable percentage and required contribution percentage under section 36B of the Code.

We anticipate that a measure of premium growth that reflects a faster premium growth rate would increase the portion of the premium the consumer is responsible for paying and therefore would decrease the amount of PTC for which consumers qualify under section 36B(b)(3)(A) of the Code. It also would increase the required contribution percentage under section 36B(c)(2)(C) of the Code, such that individuals with an offer of ESI would be more likely to be ineligible for the PTC. Therefore, we anticipate that adding individual premiums to the premium adjustment methodology would reduce the tax expenditure associated with PTCs. However, we anticipate this reduction in the availability of PTC would increase net premiums for consumers who are currently eligible for PTC and, as a result, contribute to a small decline in Exchange enrollment. It is possible that this could ultimately result in small net premium increases for enrollees that remain in the individual market, both on and off the Exchanges, if healthier enrollees elect not to purchase Exchange coverage.

Additionally, we are aware that the annual limitation on cost sharing is often a limiting factor for issuers in designing plan parameters that meet the permissible de minimis ranges for bronze plans at § 156.140.[173] The increase in the premium adjustment percentage and maximum annual limitation on cost sharing created by incorporating the more comprehensive measure of private health insurance premiums (excluding Medigap and property and casualty insurance) may help to provide additional flexibility for issuers to design plans at the bronze metal level by allowing issuers to meet AV requirements through lower deductibles, coinsurance, and copay

[173] Section 156.140 defines bronze health plans as a health plan that has an AV of 60 percent.

parameters rather than through setting a maximum out-of-pocket limit equal or less than the lower maximum annual limitation on cost sharing calculated using the ESI-based premium adjustment percentage.

We seek 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 seek comment on the proposed premium adjustment percentage for PY 2026 of 1.6726771319.

Additionally, based on the proposed PY 2026 premium adjustment percentage, we propose the following 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 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 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,[174] we propose 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. This

[174] See IRS. (n.d.) *Rev. Proc. 2013-25*. Dep't of Treasury. http://www.irs.gov/pub/irs-drop/rp-13-25.pdf.

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.[175]

We seek comment on this proposal.

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. In the 2014 Payment Notice (78 FR 15410), 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.[176] At § 156.420(a), we detailed the structure of these plan variations and specified that QHP issuers must ensure that each silver 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. 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

[175] 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.

[176] 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.

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).

We note that for PY 2026, as described in § 156.135(d), States are permitted to request HHS approval of State-specific datasets for use as the standard population to calculate AV. For PY 2026, no State submitted a dataset by the September 1, 2024 deadline.

As indicated in Table 8, we are proposing 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. These proposed values reflect 4.3 to 4.5 percent increases relative to the previously published PY 2026 parameters.[177]

[177] 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.

TABLE 8: Proposed Reductions in Maximum Annual Limitation on Cost Sharing for PY 2026

Eligibility Category	Proposed Reduced Maximum Annual Limitation on Cost Sharing for Self-only Coverage for BY 2026	Proposed 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.

Generally, to confirm consistency with past results of the analysis for the reduced maximum annual limitation on cost sharing, we tested the proposed PY 2026 reduced maximum annual limitations for cost sharing on the AV levels of silver level QHPs with varying cost sharing structures. We previously conducted this analysis in the October 2024 PAPI Guidance[178] with the following parameters for PY 2026 test plans: the test QHPs included a preferred provider organization (PPO) with typical cost sharing structure ($8,850 annual limitation on cost sharing, $3,250 deductible, and 25 percent in-network coinsurance rate); a PPO with a lower annual limitation on cost sharing ($6,650 annual limitation on cost sharing, $4,500 deductible, and 25 percent in-network coinsurance rate); and a health maintenance organization (HMO) ($8,850 annual limitation on cost sharing, $3,700 deductible, 25 percent in-network coinsurance

[178] 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.

rate, and the following services with copayments that are not subject to the deductible or coinsurance: $2500 inpatient stay per day, $1200 emergency department visit, $35 primary care office visit, and $80 specialist office visit). We repeated this analysis for the proposed PY 2026 reduced annual limitations on cost sharing using the same test plans used in the October 2024 PAPI Guidance.[179]

We entered these test plans into a draft version of PY 2026 AV Calculator and observed how the proposed PY 2026 reductions in the maximum annual limitation on cost sharing specified in the ACA affected the AVs of the plans. We found that the proposed PY 2026 reductions in the maximum annual limitation on cost sharing using the parameters specified in section 1402(c)(1)(A)(i) the ACA for enrollees with a household income greater than or equal to 100 percent of the FPL and less than or equal to 150 percent of the FPL (2/3 reduction in the maximum annual limitation on cost sharing), and greater than 150 percent of the FPL and less than or equal to 200 percent of the FPL (2/3 reduction), would not cause the AV of any of the model QHPs to exceed the AV levels of 94 and 87 percent, specified in sections 1402(c)(2)(A) and (B) of the ACA for each of these income bands, respectively.

As with prior years, and as with the findings described in the October 2024 PAPI Guidance,[180] we continue to find that using the reduction in the maximum annual limitation on cost sharing specified in section 1402(c)(1)(A)(ii) of the ACA for enrollees with a household income greater than 200 percent of the FPL and less than or equal to 250 percent of the FPL (1/2 reduction) would cause the AVs of multiple of the test QHPs to exceed the AV level of 73 percent specified for this income band in section 1402(c)(1)(B)(i)(III) of the ACA. Furthermore, as with prior years, for individuals with household incomes greater than 250 and less than or equal to

[179] Ibid.
[180] Ibid.

300 percent of the FPL, or greater than 300 and less than or equal to 400 percent of the FPL without any change in other forms of cost sharing, the reductions in the maximum annual limitation on cost sharing specified in sections 1402(c)(1)(A)(ii) and (iii) of the ACA would cause an increase in AV for multiple of the test QHPs that exceeds the maximum 70 percent level set forth for these income bands in section 1402(c)(1)(B)(i)(IV) of the ACA.

Therefore, as has been the case since the 2015 Payment Notice (79 FR 13803 through 13804), we propose to continue to reduce the maximum annual limitation on cost sharing by 2/3 for enrollees with a household income greater than or equal to 100 percent of the FPL and less than or equal to 200 percent of the FPL, 1/5 for enrollees with a household income greater than 200 percent of the FPL and less than or equal to 250 percent of the FPL, and no reduction for individuals with household incomes greater than 250 percent of the FPL and less than or equal to 400 percent of the FPL for PY 2026. The resulting proposed PY 2026 reduced maximum annual limitations on cost sharing are displayed in Table 8 above.

c. Proposed 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, we are proposing 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[181] 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 PY 2026 premium adjustment percentage proposed in this rule, 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. 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

[181] Pub. L. 115-97, 131 Stat, 2054.

increase of approximately 0.77 percentage points above the 2025 value (7.28 percent) and an increase of approximately 0.35 percentage points above the previously published PY 2026 value[182] (7.70 percent).

We note 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.

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 this rule would supersede the values published in the October 2024 PAPI Guidance.[183] We seek 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 seek comment on 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 this rule.

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

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[182] 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.

[183] Ibid.

We propose 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 requirements under the EHB package, other than for expanded bronze plans, for which we propose a de minimis range of +5/-4 percentage points. We also propose 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 propose 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 actuarial value (AV), is determined based on its coverage of the EHB for a standard population. Sections 1302(d)(1)(A)-(D) of the ACA require 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.[184] 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 provided 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 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

[184] 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, 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.

+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 (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 SLCSP, the benchmark plan for calculating PTC and APTC.

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. 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. Due to these effects, issuers have also voiced concern about their ability to continue to participate in the market generally. Sustained, robust issuer participation in the market is key to ensuring overall market stability and keeping costs down.

Based on this feedback, we are proposing 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,[185] for which we propose a de minimis range of +5/-4 percentage points. We believe that reverting to the de minimis ranges in effect from PYs 2018 to 2022 offers the best balance between comparability

[185] 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.

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 note that an expansion of the universe of permissible plan AVs would 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 higher AV would attract enrollment, they would remain free to do so under this proposal.

We also propose, 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. 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 states 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 believe that 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 that 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. 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 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 believe premiums for all consumers in the risk pool may be lower.

Maximizing premium tax credits 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 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. 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 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. 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 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 propose 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. 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 do 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 would note 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 seek comment on this proposal.

D. Applicability

Some proposals in this rule, if finalized, would become applicable beginning on or after January 1, 2026. These proposal include the proposed provisions requiring all Exchanges 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 covering sex trait modification as EHB, would be applicable for plan years beginning on or after January 1, 2026. Also, if finalized, the proposal to update the premium adjustment percentage methodology would apply beginning with PY 2026 limits. If finalized, the proposal 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 would be applicable starting with annual redeterminations for PY 2027. The proposal 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 would be applicable beginning with redetermination for PY 2027. We believe this applicability date provides issuers and Exchanges ample time to prepare for these changes. However, we understand that different States and issuers face different resource issues and implementation hurdles. We therefore seek comment on whether regulated entities would require additional time to comply with these proposals.

The remaining proposals in this rule, if finalized, would become applicable upon the effective date of the final rule. These proposals include, among others, the proposed provision to repeal the monthly SEP for APTC-eligible qualified individuals with a projected annual

household income at or below 150 percent of the FPL. Our experience with this SEP suggests it has substantially increased the level of improper enrollments, as well as increased the risk for adverse selection. The remaining proposals aim to increase the program integrity of the Exchange and protect Federal tax dollars. We therefore believe it is appropriate for these provisions to become applicable immediately upon the effective date of the final rule. We seek comment on any operational considerations or other issues that may impede compliance by the proposed applicability date.

E. Severability

As demonstrated by the number of distinct programs addressed in this rulemaking and the structure of this proposed rule in addressing them independently, HHS generally intends the rule's provisions if finalized to be severable from each other. For example, the proposed rule refines the interpretation of "lawfully present" as applicable for eligibility to enroll in a QHP offered on an Exchange or BHP coverage in States that elect to operate a BHP. It also outlines the proposed discontinuation of the SEP for individuals with an income less than 150 percent of the FPL and makes a proposed change in the calculation of the premium adjustment percentage. It also proposes an update in the automatic re-enrollment hierarchy and makes a proposed change in the process of income verification where tax return data is unavailable. HHS believes that these provisions are generally capable of functioning sensibly on an independent basis. It is HHS' intent that if any provision of these proposed rules, if finalized, is held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, the other provisions in the 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 as

finalized is found to be utterly invalid or unenforceable, HHS intends that that provision to be severable. HHS solicits comment on the severability of these provisions.

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 solicit 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.[186] Table 9 presents the median hourly wage, the cost of fringe benefits and overhead, and the adjusted hourly wage.

[186] See U.S. Bureau of Labor Statistics (2024, April 3). *Occupational Employment and Wage Statistics, May 2023 Occupation Profiles.* Dep't. of Labor. https://www.bls.gov/oes/current/oes_stru.htm.

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 9: 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	50.83	50.83	101.66
Computer Programmers	15-1251	47.94	47.94	95.88
Eligibility Interviewers, Government Programs	43-4061	24.17	24.17	48.34

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."[187] We started with a measurement of the usual weekly earnings of wage and salary workers of $1,185.[188] We divided this weekly rate by 40 hours to calculate an hourly pre-tax wage rate of approximately $29.63. We adjusted this

[187] 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.

[188] 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.

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 $24.59. We adopt this as our estimate of the hourly value of time for changes in time use for unpaid activities and seek comment on these estimates and assumptions.

B. ICRs Regarding Deferred Action for Childhood Arrivals

1. Basic Health Program (42 CFR 600.5)

The following proposed changes will be submitted for review under OMB Control Number 0938-1218 (CMS-10510).

The proposed changes to 42 CFR 600.5 would 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. The impact of this change would 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 would take each State 100 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 proposed 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 would take a database and network administrator and architect 25 hours at $101.66 per hour and a computer programmer 75 hours at $95.88 per

hour.[189] In the aggregate, we estimate a one-time burden of 200 hours (2 States × 100 hours) at a cost of $19,465 (2 States × [(25 hours × $101.66 per hour) + (75 hours × $95.88 per hour)]) for completing the necessary updates to the application for BHP coverage.

These proposed changes, if finalized, would reduce costs on States related to the decrease in applications for individuals who would have applied for coverage if not for this proposed 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 proposed rule, which pertains to the streamlined application.

2. Exchanges and Processing Streamlined Applications (§ 155.20)

The following proposed changes will be submitted for review under OMB Control Number 0938-1191 (CMS-10440). As discussed previously, we propose to modify 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 proposed change would apply to the 20 State Exchanges, as well as Exchanges on the Federal platform.

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). 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

[189] See U.S. Bureau of Labor Statistics (2024, April 3). *Occupational Employment and Wage Statistics, May 2023 Occupation Profiles.* Dep't. of Labor. https://www.bls.gov/oes/current/oes_stru.htm.

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 proposed rule, but that are currently blocked in these three State Exchanges due to the court's injunction. We estimate that it would 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 proposed rule. This estimate is informed by the FFE's prior experience implementing similar system changes. Of those 1,000 hours, we estimate it would take a database and network administrator and architect 250 hours at $101.66 per hour and a computer programmer 750 hours at $95.88 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 $1,946,500 (20 States × [(250 hours × $101.66 per hour) + (750 hours × $95.88 per hour)]) for completing the necessary updates to State Exchange eligibility systems.[190] For the Federal Government, we estimate a one-time burden in 2025 of 1,000 hours at a cost of $97,325 ((250 hours × $101.66 per hour) + (750 hours × $95.88 per hour)). In total, the burden associated with all system updates would be 21,000 hours at a cost of $2,043,825.

[190] 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). 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.

Next, we estimate costs associated with termination operations to end Exchange coverage for any DACA recipients who are already enrolled. This work would need to be done by the Federal Government, which would 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 would 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 State has already undertaken the work necessary to end coverage for DACA recipients and therefore would not need to perform additional work as a result of this rule.

We estimate that it would take the Federal Government and each of the 17 State Exchanges 1,000 hours in 2025 to terminate Exchange coverage for DACA recipients.[191,192] This estimate is informed by the FFE's prior experience implementing similar system changes. Of those 1,000 hours, we estimate it would take a database and network administrator and architect 250 hours at $101.66 per hour and a computer programmer 750 hours at $95.88 per hour. In aggregate for the States, we estimate a one-time burden in 2025 of 17,000 hours at a cost of $1,654,525 (17 States × [(250 hours × $101.66 per hour) + (750 hours × $95.88 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 $97,325 ((250 hours × $101.66 per hour) + (750 hours × $95.88 per hour)). Collectively, we estimate that it would take the Federal Government and each of the State Exchanges 18,000 hours at an associated cost of $1,751,850 to end coverage for

[191] Section 155.310(g).

[192] 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). 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.

DACA recipients. We seek 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 proposed rule.

For assisting eligible enrollees and processing their applications, we estimate this would take a government programs eligibility interviewer 10 minutes (0.17 hours) per application at a rate of $48.34 per hour, for a cost of approximately $8.22 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 proposal would complete the application annually. Therefore, the total application processing burden associated with this proposal would be reduced by 1,870 hours (0.17 hours × 11,000 applications) for a total cost savings of $90,396 (1,870 hours × $48.34 per hour). As discussed further in this section, we anticipate an overall reduction in application processing burden for States and the Federal Government. We estimate these proportions as follows and seek comment on these estimates and the methodology and assumptions used to calculate them.

As outlined in section VI.C.1. of this proposed rule, we estimate that as a result of this proposal, if finalized, 10,000 fewer individuals would enroll in QHP coverage and 1,000 fewer

individuals would 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.[193] As such, we assume 100 percent of the BHP application processing savings would fall on these two States. Using the per-application processing burden of 10 minutes (0.17 hours) per application at a rate of $48.34 per hour, and the estimate that 1,000 fewer individuals would apply for BHP, we anticipate a burden reduction of 170 hours with an associated cost savings of $8,218, for States to process BHP applications.

For the Exchanges, we use data from the 2024 Open Enrollment Period 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 therefore processed by the Federal Government, while 51 percent were submitted to and processed by the 20 State Exchanges.[194] As such, we anticipate that 49 percent of Exchange application processing savings would be attributed to the Federal Government and 51 percent of Exchange application processing savings would be attributed to States using their own eligibility and enrollment platforms.

For the Exchanges, if we estimate 10,000 fewer applications would be processed, 51 percent of those (5,100) would no longer be processed by State Exchanges and 49 percent (4,900) would 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 $48.34 per hour, we

[193] 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.
[194] 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.

anticipate cost savings of $41,911 or a reduction by 867 hours for State Exchanges to process applications. Additionally, we estimate cost savings of $40,267 or a reduction by 833 hours for the Federal Government to process applications at a rate of $48.34 per hour. Therefore, the total burden on State Exchanges to assist eligible beneficiaries and process their applications would 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 $50,129. The total burden on the Federal Government would be reduced by 833 hours annually beginning in 2025 (entirely for Exchanges), with a net cost reduction of $40,267.

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.[195] An applicant's lawful presence may not be able to be verified if, for example, the applicant opts to not include information about their 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 would apply for Exchange coverage as a result of this rule, we estimate that 20 percent, or 2,000, would have generated an immigration status inconsistency.[196] Of these 2,000 inconsistencies, we assume that 51 percent of those

[195] Section 155.315(f).
[196] 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.

(1,020) would no longer be processed by State Exchanges and 49 percent (980) would no longer be processed by the Federal Government.[197] 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 $48.34 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 $9,861 (204 hours × $48.34 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 $9,475 (196 hours × $48.34 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 $19,336 (400 hours × $48.34 per hour).

We seek comment on these estimates and the methodology and assumptions used to calculate them.

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.[198] We note that this proposed rule proposes no changes to the eligibility application for Medicaid and CHIP. Hence, this section only includes data on the burden associated with completing an application

[197] 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.
[198] 42 U.S.C. 18083.

and submitting additional information to verify lawful presence, if necessary, for health coverage in a QHP through an Exchange and for BHP coverage.[199]

In the existing information collection request for this application (OMB Control Number 0938-1191), we estimate that the application process would take an average of 30 minutes (0.5 hours) to complete for those applying for insurance affordability programs and 15 minutes (0.25 hours) for those applying without consideration for insurance affordability programs.[200] Based on internal data from the previous open enrollment period when DACA recipients were eligible to complete the application, we estimate that approximately 11,000 such individuals would have completed the application. We estimate that of the 11,000 fewer individuals who would have applied for QHP coverage through an Exchange or for BHP coverage were it not for these proposed changes, 98 percent would have applied for insurance affordability programs and 2 percent would have applied without consideration of insurance affordability programs. Using the hourly value of time for changes in time use for unpaid activities discussed in section IV.A. of this proposed rule (at an hourly rate of $24.59), the average opportunity cost to an individual for completing this task is estimated to be approximately 0.495 hours [(0.5 hours × 98 percent) + (0.25 hours × 2 percent)] at a cost of $12.17. Therefore, given the proposed changes to the definition of "lawfully present" and the impact on the 11,000 individuals who may have otherwise completed the application, we anticipate net annual cost savings of approximately $133,870, or a reduction of approximately 5,445 hours.

As discussed above, based on recent internal data from the Federal platform, we estimate that of the 11,000 individuals impacted by the changes proposed to the definition of "lawfully

[199] We assume that the burden of completing an application is essentially the same regardless of whether the individual were to apply directly with the State agency responsible for administering the BHP or with an Exchange.
[200] We note that this analysis includes estimates for completing electronic applications only. Internal CMS data show that less than 1 percent of applicants utilize the paper application.

present" in this rule, approximately 80 percent (or 8,800) of applicants would have been able to have their lawful presence electronically verified, and the remaining 20 percent (or 2,200) of applicants would have been unable to have their lawful presence electronically verified and would therefore have had to submit supporting documentation to confirm their lawful presence.[201] We estimate that a consumer would have, on average, spent approximately 1 hour gathering and submitting required documentation. Using the hourly value of time for changes in time use for unpaid activities discussed in section IV.A. of this proposed rule (at an hourly rate of $24.59), the opportunity cost for an individual to complete this task would have been approximately $24.59. Therefore, we anticipate a net annual burden reduction of approximately 2,200 hours with an equivalent cost savings of approximately $54,098 for the 2,200 individuals who would have been unable to electronically verify their lawful presence and therefore would have needed to submit supporting documentation.

As previously stated, for the 11,000 individuals impacted by the proposal regarding the definition of "lawfully present" this rule, the annual additional burden of completing the application would be 0.495 hours per individual on average. Under this proposed rule, if finalized, we anticipate a net reduction of 5,445 hours or cost savings of $66,266. For the 2,200 individuals who would have been unable to electronically verify their lawful presence, the total annual burden of submitting documentation to verify their lawful presence would have been 2,200 hours at a cost savings of $54,098. The average annual burden per respondent would have been 0.695 hours ((0.495 hours × 80 percent of individuals) + (1.495 hours × 20 percent of

[201] Estimates are based on internal CMS data comparing the number of immigration data matching issues (DMIs) generated to the number of noncitizen enrollees during similar time periods during 2024, rounded to the nearest 5 percent.

individuals)). Under this proposed rule, if finalized, we anticipate a net reduction of annual burden equaling 7,645 hours (5,445 hours + 2,200 hours) with an associated cost savings of $187,991 ($133,893 + $54,098).

We seek comment on these burden estimates.

C. ICRs Regarding Failure to File and Reconcile (§ 155.305(f)(4))

We are proposing to amend 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 two-consecutive tax years to increase the program integrity of the Exchange. We are proposing to require Exchanges to find enrollees ineligible for APTC after they or their tax filer has failed to file and reconcile their APTC for one tax year. For Exchanges on the Federal platform, the FTR process would otherwise be conducted similarly to the previous iterations of FTR prior to the 2024 Payment Notice, except that those identified as being in a one-tax year FTR status would be at risk for removal of APTC and there would no longer be a two-tax year FTR status population. Minimal changes to the language of the Exchange application questions would be necessary to obtain relevant information; as such, we anticipate that the proposed amendment would not impact the information collection burden for consumers. We anticipate that there would no longer be a 2 year FTR population, and thus the notices sent to the FTR population would be similar in inciting an urgency to act to the current two-tax year FTR notices, but that all consumers with an FTR status would be in a one-tax year FTR status. Due to this, we do not anticipate PRA impacts related to noticing requirements.

We seek comment on these assumptions and any information collection burdens not identified in this section.

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

The following proposed changes will be submitted for review under OMB Control Number 0938-1191 (CMS-10440). We seek comment on these burden estimates.

We are proposing 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 is greater than or equal to 100 percent and not more than 400 percent of the FPL and trusted data sources indicate that projected income is under 100 percent of the FPL.

We anticipate that adding this income verification requirement would result in approximately 1 hour time spent by consumers to complete associated questions in the application or submit supporting documentation. Based on historical data from the FFE, HHS estimates that approximately 548,000 inconsistencies would be generated at the household level across all Exchanges. Therefore, adding these inconsistencies would increase burden on consumers by approximately 548,000 hours. Using the estimate of the hourly value of time for changes in time use for unpaid activities calculated at $24.59 per hour in section IV.A. of this preamble, we estimate that the annual increase in cost for each consumer would be approximately $24.59, and the annual cost increase for all consumers who would generate this income inconsistency would be approximately $13,475,320.

Additionally, we estimate that adding this income verification requirement would result in an increase in burden on all Exchanges. Based on historical FFE data, we anticipate that approximately 340,000 inconsistencies would be generated at the household level for Exchanges using the Federal platform, and 208,000 inconsistencies would be generated at the household level for State Exchanges. Once households have submitted the required verification documents,

we estimate that it would 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 $48.34, to receive, review, and verify submitted verification documents as well as conduct outreach and determine DMI outcomes. Therefore, adding these inconsistencies would result in an increase in annual burden on the Federal Government of 408,000 hours (340,000 verifications x 1.2 hours per verification) at a cost of $19,722,720 (408,000 hours x $48.34 per hour) and an increase in annual burden on State Exchanges of 249,600 hours (208,000 verifications x 1.2 hours per verification) at a cost of $12,065,664 (249,600 hours x $48.34 per hour).

Finally, we estimate that adding this income requirement would require costs related to updating the technical systems, including the eligibility system. We estimate that it would take the Federal Exchange and each State Exchange 8,000 hours in 2025 to make these updates. Of those 8,000 hours, we estimate it would take a database and network administrator and architect 2,000 hours at $101.66 per hour and a computer programmer 6,000 hours at $95.88 per hour. Given this, we estimate that the Federal Exchange would incur a one-time burden of $778,600 (2,000 x $101.66 + 6,000 x $95.88) to make these eligibility system updates. State Exchanges would incur a one-time burden of $14,793,400 ($778,600 x 19) total associated with a total of 123,500 (8,000 x 19) burden hours.

We seek comment on these burden estimates and assumptions.

E. ICRs Regarding Income Verification When Tax Data is Unavailable (§ 155.320(c)(5))

The following proposed changes will be submitted for review under OMB Control Number 0938-1191 (CMS-10440). We seek comment on these burden estimates.

We are proposing 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.

Based on internal historical DMI data, we estimate that approximately 1,313,000 inconsistencies would be generated at the household level for Exchanges using the Federal platform, and 805,000 would be generated at the household level for State Exchanges if this proposal were finalized. Once households have submitted the required verification documents, we estimate that it would take approximately 1 hour and 12 minutes for an eligibility support staff person (BLS occupation code 43–4061), at an hourly cost of $48.34, 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) would result in an increase in annual burden for the Federal Government of 1,575,600 hours (1,313,000 verifications x 1.2 hours per verification) at a cost of $76,164,504 (1,575,600 hours x $48.34 per hour) and an increase in annual burden on State Exchanges of 966,000 hours (805,000 verifications x 1.2 hours per verification) at a cost of $46,696,440 (966,000 hours x $48.34 per hour).

In addition to the increased administrative burden on Exchanges, if finalized, the change would increase the number of consumers who are required to submit documentation to verify their income. We estimate that consumers would each spend 1 hour to answer the associated questions and submit documentation. Based on historical data from the FFE, we estimate that approximately 2,118,000 inconsistencies would 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 $24.59 per hour in section IV.A. of this preamble, we estimate that the

annual increase in cost for each consumer would be approximately $24.59 and that the proposed change would increase burden on consumers by 2,118,000 hours per year at an associated cost of $52,081,620 (2,118,000 hours x $24.59 per hour).

Finally, we estimate that removing the current process of verifying income attestations when IRS returns no data would require costs related to updating the eligibility system. We estimate that it would take the Federal Exchange and each State Exchange 9,000 hours in 2025 to make these updates. Of those 9,000 hours, we estimate it would take a database and network administrator and architect 2,250 hours at $101.66 per hour and a computer programmer 6,750 hours at $95.88 per hour. Given this, we estimate that the Federal Government would incur a one-time burden of $875,925 (2,250 x $101.66 + 6,750 x $95.88) to make these eligibility system updates. State Exchanges would incur a one-time burden total of $16,642,575 ($875,925 x 19) associated with a total of 171,000 (9,000 x 19) burden hours.

We seek comment on these estimates and assumptions.

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.[202] Under § 156.1255, QHP issuers in the individual market must include certain

[202] 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

information in the applicable renewal and discontinuation notices.[203] 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 proposed rule proposes to amend the automatic re-enrollment hierarchy by removing § 155.335(j)(4), which currently allows 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 proposed change, we propose to remove language related to the bronze to silver crosswalk from the Federal standard notices.

This proposed rule also proposes to require enrollees who would otherwise be automatically re-enrolled in a QHP with a zero-dollar premium after application of APTC ("fully subsidized") to instead be automatically re-enrolled with APTC applied to the policy reduced such that the enrollee owes a five-dollar premium. We propose to update the Federal standard notices to include language related to this proposed requirement.

The burden to issuers related to sending the Federal standard notices is currently approved under OMB Control Number 0938-1254 (CMS-10527).[204] CMS will revise the information collection to incorporate the necessary language modifications in the Federal standard notices due to the changes proposed in this proposed rule. However, we do not anticipate any change in burden to issuers.

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of the PHS Act and § 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.

[203] Section 156.1255(a) through (d).

[204] OMB Control Number 0938-1254 (CMS-10527, Annual Eligibility Redetermination, Product Discontinuation and Renewal Notices).

G. ICRs Regarding Pre-Enrollment Verification for Special Enrollment Periods (§ 155.420)

The following proposed changes will be submitted for review under OMB Control Number 0938-1191 (CMS-10440). We seek comment on these burden estimates.

We are proposing to amend § 155.420(g) to require all Exchanges to conduct eligibility verification for SEPs. Specifically, we propose to remove 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 propose 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.

We also propose 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 propose that Exchanges must verify at least 75 percent of such new enrollments based on the current implementation of SEP verification by Exchanges.

We anticipate that adding this expansion of pre-enrollment verification for SEPs would 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 would be generated at the household level on the Federal Exchange. Therefore, adding these inconsistencies would 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 $24.59 per hour in section IV.A. of this preamble, we estimate that the annual increase in cost for each consumer would be

approximately $24.59, and the annual cost increase for all consumers who would generate this income inconsistency would be approximately $7,206,665.

Additionally, we estimate that expanding pre-enrollment verification for SEPs would 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 would be generated at the household level for Exchanges using the Federal platform, and 179,625 inconsistencies would 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 would take approximately 12 minutes for an eligibility support staff person (BLS occupation code 43–4061), at an hourly cost of $48.34, to review and verify submitted verification documents. Therefore, expanding verification would result in an increase in annual burden on Exchanges using the Federal platform of 58,615 hours (293,073 verifications x 0.2 hours per verification) at a cost of $2,833,449 (58,615 hours x $48.34 per hour) and an increase in annual burden on Exchanges not using the Federal platform of 35,925 hours (179,625 verifications x 0.2 hours per verification) at a cost of $1,736,615 (35,925 hours x $48.34 per hour).

We seek comment on these burden estimates and assumptions.

H. Summary of Annual Burden Estimates for Finalized Requirements

TABLE 10: Proposed 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	0.21	-2,270	-$109,732	-$109,732
155.20 (Application)	0938-1191	-11,000	-11,000	0.695	-7,645	-$187,991	-$187,991
155.320(c)(3)(iii) (Consumer)	0938-1191	548,000	548,000	1	548,000	$13,475,320	$13,475,320
155.320(c)(3)(iii) (Exchange)	0938-1191	548,000	548,000	1.2	657,600	$31,788,384	$31,788,384
155.320(c)(5) (Consumer)	0938-1191	2,118,000	2,118,000	1	2,118,000	$52,081,620	$52,081,620
155.320(c)(5) (Exchange)	0938-1191	2,118,000	2,118,000	1.2	2,541,600	$122,860,944	$122,860,944
155.420 (Consumer)	0938-1191	293,073	293,073	1	293,073	$7,206,665	$7,206,665
155.420 (Exchange)	0938-1191	472,698	472,698	0.2	94,540	$4,570,064	$4,570,064
TOTAL					**6,242,898**		**$231,685,274**

I. Submission of PRA-Related Comments

We have submitted a copy of this proposed 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 the OMB.

To obtain copies of the supporting statement and any related forms for the proposed collections discussed above, please visit CMS' website at *www.cms.hhs.gov/PaperworkReductionActof1995,* or call the Reports Clearance Office at 410-786-1326.

V. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will

consider all comments we receive by the date and time specified in the "DATES" section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

VI. Regulatory Impact Analysis

A. Statement of Need

We propose to exclude 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. This proposed rule also proposes to reverse the policy restricting an issuer from attributing payment of premium for new coverage to past-due premiums from prior coverage. Additionally, we propose to revise 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. We also propose policies to strengthen the verification process around annual household income. We further propose to require enrollees who would otherwise be automatically re-enrolled in a QHP with a zero-dollar premium after application of APTC ("fully-subsidized") to instead be automatically re-enrolled with APTC applied to the policy reduced such that the enrollees owe a five-dollar premium, if they do not submit an application for an updated eligibility determination to an Exchange. We also propose to amend 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 also propose to remove the fixed-dollar and gross percentage-based premium payment thresholds at § 155.400(g). We further propose to change the annual OEP for coverage through all individual market Exchanges from November 1 through January 15 to November 1 through December 15 of the calendar year preceding the plan year. Additionally, we propose to repeal § 155.420(d)(16) and make 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. We also propose to amend § 155.420(g) to enable HHS to reinstate (with modifications) pre-enrollment verification of eligibility of applicants for all categories of individual market SEPs and to require all State Exchanges to conduct pre-enrollment verification of eligibility for at least 75 percent of new enrollments through SEPs. Finally, we propose to update the premium adjustment percentage methodology to establish a premium growth measure that comprehensively reflects premium growth in all affected markets.

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"; Executive Order 14192, "Unleashing Prosperity Through Deregulation"; the Regulatory Flexibility Act (RFA) (Pub. L. 96-354); section 1102(b) of the Social Security Act; and section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104-4).

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; and equity). 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 section 3(f)(1) of E.O. 12866. The Office of Management and Budget's (OMB) Office of Information and Regulatory Affairs (OIRA) has determined that this rulemaking is significant per section 3(f)(1). Accordingly, we have prepared an RIA that to the best of our ability presents the costs and benefits of the rulemaking. OMB has reviewed these proposed regulations under E.O. 12866, and the Department has provided the following assessment of their impact.

Executive Order 14192, titled "Unleashing Prosperity Through Deregulation," was issued on January 31, 2025. Section 3(a) of Executive Order 14192 requires an agency, unless prohibited by law, to identify at least ten existing regulations to be repealed when the agency issues a new regulation. In furtherance of this requirement, section 3(c) of Executive Order 14192 requires that the new incremental costs associated with new regulations shall, to the extent permitted by law, be offset by the elimination of existing costs associated with prior regulations. A significant regulatory action (as defined in section 3(f) of Executive Order 12866) that would

impose total costs greater than zero is considered an Executive Order 14192 regulatory action. This proposed rule, if finalized as proposed, is, therefore, expected to be an Executive Order 14192 regulatory action. Details on the estimated costs appear in the preceding analysis.

C. Impact Estimates of the Proposed Individual Market Program Integrity Provisions and Accounting Table

Consistent with OMB Circular A-4 (available at *https://trumpwhitehouse.archives.gov/sites/whitehouse.gov/files/omb/circulars/A4/a-4.pdf*), we have prepared an accounting statement in Table 11 showing the classification of the impact associated with the provisions of this proposed rule. We have included the undiscounted annual impacts in Table 12.

This proposed rule would implement standards for programs that would 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 proposed rule. The effects in Table 11 reflect qualitative assessment of impacts and estimated direct monetary costs and transfers resulting from the provisions of this proposed rule for Exchanges, health insurance issuers, and consumers. The individual effects of each provision in this proposed rule are presented separately in Table 11 and collectively in Table 12, but we anticipate these estimates may overlap, as some individuals could be impacted by multiple provisions. Therefore, in section VI.C.18 of this RIA, we present overall impact estimates of all provisions considered jointly.

TABLE 11: Accounting Table

Benefits:	Estimate	Year Dollar	Discount Rate	Period Covered

Annualized Monetized ($/year)	$0.6 million	2025	7 percent	2025-2029
Annualized Monetized ($/year)	$0.6 million	2025	3 percent	2025-2029

Quantified:

- Annual reduction in costs starting in 2025 of $40,267 in application processing savings for the Federal Government and $50,129 total for State Exchanges and States that choose to operate BHPs as a result of fewer individuals applying for coverage associated with the proposal regarding the definition of "lawfully present."
- Annual reduction in costs starting in 2025 of $9,861 total for State Exchanges and $9,745 for the Federal Government as a result of fewer individuals generating immigration status inconsistencies associated with the proposal regarding the definition of "lawfully present."
- Annual reduction in costs starting in 2025 of $187,991 to individuals who would no longer be applying for BHP or Exchange health coverage or submitting documents to verify their lawful presence status for purposes of those enrollments.
- Annual reduction in costs starting 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 gaming and adverse selection by consumers exploiting or utilizing loopholes in the insurance system associated with the proposal 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 proposal 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 proposal 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 as a result of the proposals regarding FTR and income verification in this proposed rule.
- Simplified operational processes for issuers and the Exchanges associated with the proposal regarding the annual OEP length.
- Improved continuous coverage for the full year and improved risk pool associated with the proposal 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 proposal 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 proposals in this rule.
- Reduction in improper enrollments of fully subsidized enrollees by agents, brokers, and web-brokers associated with the proposals in this rule.

Costs:	Estimate	Year Dollar	Discount Rate	Period Covered
Annualized Monetized ($/year)	$276.0 million	2025	7 percent	2025-2029
Annualized Monetized ($/year)	$276.7 million	2025	3 percent	2025-2029

Quantified:

- One-time costs in 2025 of $1,965,965 total for State Exchanges and States operating BHPs and $97,325 for the Federal Government to make changes to eligibility systems regarding the definition of "lawfully present" proposed in this rule.
- One-time costs in 2025 of $1,654,525 total for State Exchanges and $97,325 for the Federal Government to end QHP coverage for individuals no longer considered "lawfully present" if the proposals in this rule are finalized.
- One-time costs in 2025 of $19,465,000 total for State Exchanges and $973,250 for the Federal Government to develop and code changes to the eligibility systems to evaluate and verify FTR status under the revised FTR process proposed in this rule.
- One-time costs in 2025 of approximately $14.8 million total for State Exchanges and $778,600 for the Federal Government to complete the necessary system changes and other technical changes to implement the proposal regarding creating annual income DMIs when applicants attest to income above 100 percent of the FPL but trusted data sources show income below 100 percent of the FPL.
- Annual operating costs of approximately $19.7 million for the Federal Government and approximately $12.1 million total for State Exchanges beginning in 2025 to review and verify submitted documents, communicate with consumers, and process DMIs for applicants with incomes below 100 percent of the FPL.
- Increase in annual burden of $13,475,320 beginning in 2025 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 $876,000 for the Federal Government to complete the necessary system changes and other technical changes to implement the proposal to no longer permit Exchanges to accept an applicant's income attestation without further verification when tax return data is unavailable.
- Increase in annual burden of approximately $76.2 million for the Federal Government and approximately $46.7 million total for State Exchanges beginning in 2025 to review and verify submitted documents, communicate with consumers, and process DMIs for applicants whose tax return data is unavailable.
- Increase in annual burden of $52,081,620 beginning in 2025 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 proposal to remove the automatic 60-day extension to resolve income DMIs.
- One-time costs in 2025 of $973,250 for the Federal Government and $19,465,000 total for State Exchanges associated with the proposals regarding annual eligibility redeterminations.
- One-time costs in 2025 of $389,300 for the Federal Government and $7,786,000 for State Exchanges associated with the proposal to shorten the Open Enrollment Period.
- One-time costs in 2025 of $390,000 for the Federal Government to remove functionality to grant the 150 percent FPL SEP and make any necessary updates to eligibility logic systems for Exchanges on the Federal platform.
- One-time cost of approximately $60 million total in 2026 for the five State Exchanges that did not previously verify SEPs associated with the proposal to remove the limit for verification of SEPs to only those SEPs that deal with loss of minimum essential coverage.
- Annual processing cost beginning in 2026 of approximately $46.7 million for Exchanges to comply with proposed pre-enrollment verification requirements.
- Annual labor cost increase for the Federal Government of $2,833,449 and $1,736,615 total for State Exchanges starting in 2025 associated with the proposals regarding SEP verification.
- Annual cost increase for consumers of approximately $7,206,665 starting in 2025 associated with the proposals regarding SEP verification.
- One-time cost in 2025 of $1,849,270 to the Federal Government to develop and code changes associated with the proposals regarding SEP verification.
- Regulatory review costs of $2,532,810 for interested parties to review and analyze this proposed rule in 2025.

Non-quantified:

- Total reduced annual enrollment between 750,000 and 2,000,000 individuals, including:
    - Reduced annual QHP enrollment of 10,000 and annual BHP enrollment of 1,000 associated with the

proposal 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 and who may be deterred from enrolling and lose coverage due to a higher initial premium payment associated with the proposal to permit attribution of payment for new coverage to past-due premium amounts.
    - Potential loss of coverage 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 to an Exchange, 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 would adopt the use of the same premium measure proposed 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 proposal 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
- Potential 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 would become uninsured if the proposal pertaining to DACA recipients in this rule is finalized.
- Increase in costs for care and medical debt if care is needed for people deterred from enrolling due to a higher initial premium payment, which could in turn be incurred by hospitals and municipalities associated with the proposal 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 proposals in this 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 proposal 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 zero-dollar premium after application of APTC to submit an application for an updated eligibility determination to an Exchange associated with the annual eligibility redetermination provision.
- Costs to the Federal Government, State Exchanges, and issuers for outreach activities associated with the proposed shortened open enrollment period.
- 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)	-$8.7 billion	-$11.4 billion	2025	7 percent	2025-2029
Annualized Monetized ($/year)	-$8.9 billion	-$11.6 billion	2025	3 percent	2025-2029

Quantified:

- Reduced annual transfers from the Federal Government to issuers of $34 million in APTC payments and $3.2 million in BHP payments associated with the proposal 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 2025.
- Reduced annual APTC transfers from the Federal Government to issuers of between $1.16 billion to $1.86 billion associated with the proposals regarding FTR beginning 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.

• Annual reduction in APTC transfers from the Federal Government to issuers of $189 million beginning in 2025 for consumers across all Exchanges who receive fewer months of APTC due to reinstatement of DMIs where households attest to income above 100 percent of the FPL and data sources show income below 100 of the percent FPL. • Annual reduction in APTC transfers from the Federal Government to issuers of $956 million beginning in 2025 for households across all Exchanges who receive fewer months of APTC due to reinstatement of DMIs when IRS data is not available. • Annual reduction in APTC transfers from the Federal Government to issuers of $817,571,843 beginning in 2026 associated with the proposal regarding premium payment thresholds. • Reduction in APTC transfers from the Federal Government to issuers of approximately $3.4 billion in 2026, $3.6 billion in 2027, $3.8 billion in 2028, and $4.0 billion in 2029 associated with the proposal to repeal the 150 percent FPL SEP, which is anticipated to reduce premiums by 3 to 4 percent. • Annual reduction in APTC transfers from the Federal Government to issuers of approximately $105.4 million associated with the proposal to revise pre-enrollment verification requirements for SEPs, associated with a reduction in premiums of approximately 0.5-1.0 percent for PY 2026 and 1.0-2.0 percent for PY 2027 and beyond. • 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 would adopt the use of the same premium measure proposed 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 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 would adopt the use of the same premium measure proposed 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 proposal 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 if enrollees do not pay their portion of the premium and a reduction in improper enrollments occurs due to the annual eligibility redetermination provision. • Reduced premiums and APTC cost to the Federal Government associated with the proposal regarding the annual OEP length. • Decreased premiums for plans that do not include sex-trait modification as a covered benefit as a result of the proposal. • 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 proposals in this rule.

TABLE 12: Summary of Undiscounted Annual Impacts Reported in Accounting Table

	2025	2026	2027	2028	2029
Benefits	$0.3 million	$0.7 million	$0.7 million	$0.7 million	$0.7 million
Costs	$210.8 million	$338.7 million	$278.7 million	$278.7 million	$278.7 million
Transfers – Low	$0	-$10.5 billion	-$11.0 billion	-$11.7 billion	-$12.2 billion
Transfers – High	$0	-$13.7 billion	-$14.4 billion	-$15.2 billion	-$15.9 billion

1. Guaranteed Availability of Coverage (§ 147.104(i))

This proposed rule would remove § 147.104(i), which would reverse the policy prohibiting an issuer from attributing payment of premium for new coverage to past-due premiums from prior coverage. We propose that an issuer may, to the extent permitted by applicable State law, establish terms of coverage that add past-due premium amounts owed to the issuer to the initial premium the enrollee 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.

The proposed policy aims to promote continuous coverage while providing issuers with an additional mechanism for past-due premium collection. The proposed policy could help reduce outstanding premium debt amount for enrollees, potentially benefiting their financial standing over time and reduce the likelihood of any debt being placed into collections. Additionally, the proposed rule could potentially improve premium collection rates and reduce administrative costs associated with repeated enrollment-termination cycles and other collection methods.

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 exploiting or utilizing loopholes in the insurance system, such as extended grace periods and allowing coverage to lapse without addressing premium obligations even when seeking to enroll in new coverage. By addressing these circumstances, the proposed policy would encourage continuous coverage and reduce the burden on issuers to collect past-due premiums in other ways. The proposed policy would reduce the risk of gaming and adverse selection by consumers.

The proposed policy could 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 due to a higher initial premium payment.

Some enrollees, particularly those facing financial constraints, might need to adjust their household budgeting to maintain coverage or, if they are not able to, become uninsured. Depending on the circumstances, these enrollees, if they become uninsured, could face higher costs for care and medical debt if care is needed. These costs could in turn be incurred by hospitals and municipalities in the form of uncompensated care. The proposed policy aims to encourage continuous coverage, reduce coverage gaps, and promote consistent payment of premiums by reducing consumers' ability to game the guaranteed availability requirement. However, others might face additional barriers to regaining coverage due to owing past-due premiums. The proposed policy seeks to balance market stability considerations by maintaining appropriate access to coverage and promoting continuity of coverage amongst enrollees. While some consumers may face challenges paying past-due premiums and could become or remain uninsured, the longer-term effects could include more stable risk pools and potentially more moderate premium trends. We seek comment on these impacts and assumptions.

There is some uncertainty regarding whether the coverage gains from moderate premium trends and promoting continuous coverage would be higher than coverage losses due to the proposed policy that would allow issuers to require payment of past-due premiums. We anticipate any discouragement from enrolling would be minimal. As discussed earlier in this preamble, when this proposed 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 cost to issuers related to collection of past-due premiums. We expect this

proposed policy would result in similar benefits. While we lack data to quantify these effects, we believe that these effects could collectively contribute to more stable market conditions over time. We seek comment on these impacts and assumptions.

This proposed policy aims to encourage continuous coverage. Therefore, we do not anticipate any significant impact on PTCs. We seek comment on this impact estimate and assumptions.

The projected impacts of this proposed policy reflect current understanding of market dynamics while acknowledging the uncertainty inherent in predicting response to the proposed policy.

2. Deferred Action for Childhood Arrivals (§ 155.20)

We propose to modify 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 would 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 anticipate excluding DACA recipients from the definition of "lawfully present" would reduce annual QHP enrollment through the Exchanges by 10,000 and annual BHP enrollment by 1,000 beginning in 2025. We project this decline in enrollment in QHP enrollment through the Exchanges would reduce annual APTC expenditures by $34.0 million and the decline in enrollment in BHP would 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[205] 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.

Because DACA recipients are young,[206] they generally tend to be healthier. We therefore anticipate that excluding DACA recipients from individual market QHP coverage offered through the Exchanges would 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 would 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.

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[205] 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

[206] 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

We also anticipate that this proposed change would result in costs to State Exchanges and the Federal Government to update eligibility systems in accordance with this proposal. As discussed further in section IV.B. of this proposed rule, in aggregate for the States, we estimate a one-time cost in 2025 of $1,965,965 total ($1,946,500 for State Exchanges + $19,465 for BHPs) total and $97,325 for the Federal Government. We also estimate a one-time cost in 2025 for termination operations of $1,654,525 total for State Exchanges and $97,325 for the Federal Government, as discussed further in section IV.B.2. of this proposed rule. In addition, we estimate cost savings annually beginning in 2025 for State Exchanges and States that operate BHPs of $50,129 total and for the Federal Government of $40,267 associated with assisting fewer eligible beneficiaries and processing their applications as a result of this proposal. We also estimate cost savings annually beginning in 2025 for State Exchanges of $9,861 total and for the Federal Government of $9,745 associated with processing fewer immigration status inconsistencies. Finally, we anticipate a net reduction in costs to individuals to complete the application of $187,991 annually, as discussed further in section IV.B.3. of this proposed rule. We seek comment on these impact estimates and assumptions, the details of which may be found in section IV.B. of this proposed rule.

3. Standards for Termination for Cause from the FFE (§ 155.220(g)(2))

As discussed in the preamble to this proposal, we propose 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 conditions of their Exchange agreements. Specifically, we propose to add 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 make a determination there was a specific finding or

pattern of noncompliance that is sufficiently severe. Our proposed regulatory change would put all agents, brokers, and web-brokers assisting consumers with enrollment on the FFEs and SBE-FPs on notice of the evidentiary standard we would use in leveraging our enforcement authority under § 155.220(g)(1) through (3). We believe this proposed update would 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 proposed change would have positive impacts on agents, brokers, and web-brokers. Codifying the evidentiary standard would provide agents, brokers, and web-brokers under investigation for noncompliant behavior more transparency into HHS' evidentiary expectations. We anticipate agents, brokers, and web-brokers would 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 proposals as we are not proposing to expand the bases under which HHS may find them noncompliance under § 155.220(g)(1) through (3) or otherwise require more from agents and brokers as part of this enforcement framework; rather, we are proposing to clarify an evidentiary standard that is not explicit at present.

We seek comment on these impact estimates and assumptions.

4. Failure to File and Reconcile (§ 155.305(f)(4))

We are proposing to amend the FTR process at § 155.305(f)(4) to require Exchanges 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. This proposal would remove the current flexibility that gives tax filers two-consecutive tax years to file and reconcile before removing APTC. To conform with

this proposal, we further propose to amend 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 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 two-tax year FTR status.

Previously, we estimated the cost of giving enrollees two-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 one tax year and retain their APTC eligibility. Since making that estimate, the number of improper enrollments has increased dramatically, and we believe a lack of enforcement under the current FTR policy has contributed to this increase. In 2024, HHS 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 FTR notices that 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 proposal would have on APTC expenditures. While the current two-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 two-tax year FTR process would catch those consumers for PY 2026, as would this proposed change to the FTR process.

Therefore, it is likely that the APTC savings resulting from this proposed policy change would not be derived from the decrease in unauthorized enrollments, but rather from the proportion of consumers who are not eligible for APTC for income eligibility related reasons. Taking all of these considerations into account, we still anticipate that APTC expenditures would 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 prior to OEP 2025, our initial run of FTR Recheck in January 2025, has already reduced this number to approximately 690,000 households.

It is difficult to draw historically similar comparisons for multiple reasons: FTR had been inactive for three consecutive filing seasons prior to this point due to the COVID-19 PHE, the increase in improper enrollments, and the newly implemented two-tax year FTR process. However, historically, between removal of APTC at auto-reenrollment and the FTR Recheck process, the overall population of enrollees that has ended up losing APTC compared to the initially identified population prior to OEP has ranged from 18 percent to 43 percent from 2016 to 2020. On average, 30 percent of enrollees lost their APTC due to FTR. Reasonable expectations of the proportion of one-tax year FTR enrollees as a percentage of our currently identified FTR population could range from 50 percent of the 690,000 to approximately 80 percent of the 690,000 remaining FTR enrollees. Historically, approximately 55 percent of those identified at FTR Recheck go on to lose their APTC for FTR reasons. Therefore, based on our current knowledge of this year's FTR population, the range of one-tax year FTR consumers who would lose APTC under this proposed policy could be approximately 189,000 to 303,000 households. 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, the average Federal APTC savings could range from $1.16 billion to $1.86 billion annually; however, these impacts likely overstate the possible savings available in the future due to the competing impact of implementing the program integrity measures in the Exchange, the resumption of FTR noticing for PY 2025, as well as the other impacts of this proposed rule that would impact a similar population as the FTR population.

This proposal would 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 proposal would also minimize the potential for APTC recipients to incur large tax liabilities.

Using the proposed notice policy that is similar to our prior notice procedure before FTR was paused, we anticipate eligible enrollees would 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 Open Enrollment as well as a notice at the time of FTR Recheck. The tax filer (and enrollee if they are the same person) would also receive a direct notice prior to Open Enrollment 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 and, therefore, anticipate the proposal would continue to avoid situations where eligible enrollees become uninsured when their APTC is terminated. Because the proposal would discontinue APTC for a

larger number of enrollees, we anticipate a portion of those enrollees would drop coverage and become uninsured. This may result in costs to State 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 one-tax year FTR status and two-consecutive tax years of FTR status. This proposal streamlines the notice process by eliminating the separate notice for enrollees in their second year of FTR status. Therefore, we anticipate this proposal would also reduce the burden of providing notice to enrollees with an FTR status. In the 2026 Payment Notice (90 FR 4524), we estimated that sending two-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, HHS is 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, we would remove at least some of the associated noticing requirements and corresponding two-tax year FTR population so this cost savings would provide a benefit to the Federal Government and State Exchanges.

We estimate that it would 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 one 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 $101.66 per hour and a computer programmer 7,500 hours at $95.88 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 $19,465,000 (20 States × [(50,000 hours × $101.66 per hour) + (150,000 hours × $95.88 per hour)]) for completing the necessary updates to State Exchange eligibility systems.[207] For the Federal Government, we estimate a one-time burden in 2025 of 10,000 hours at a cost of $973,250 ((2,500 hours × $101.66 per hour) + (7,500 hours × $95.88 per hour)). In total, the burden associated with all system updates would be 210,000 hours at a cost of $20,438,250. We recognize the burden this proposal may place on State Exchanges, if finalized, and seek comment on the impact of this burden and potential less burdensome alternatives that would still further the program integrity goals of this proposal.

We seek comment on these impact estimates and assumptions.

5. 60-Day Extension to Resolve Income Inconsistency (§155.315(f)(7))

We propose 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

[207] 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). 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.

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 would result in a one-time cost of approximately $500,000 to Exchanges. For the 19 State Exchanges, we anticipate this would be a total cost of approximately $9,500,000 ($500,000 x 19). We recognize the burden this proposal may place on State Exchanges, if finalized, and seek comment on the impact of this burden and potential less burdensome alternatives that would still further the program integrity goals of this proposal.

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 would result in $266 million (140,000 x $588.07 x 2 + 86,000 x $588.07 x 2) less APTC expenditures annually across all Exchanges. We accept comments on whether this number may be slightly less because of potential decreased enrollment if the enhanced premium tax credits are no longer in effect.

We seek comment on these impact estimates and assumptions.

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

This proposed rule would amend § 155.320(c)(3)(iii) to create annual income DMIs when applicants attest to income above 100 percent of the FPL, but trusted data sources show income below 100 percent of the FPL. As discussed further in section IV.D. of this proposed rule, we also estimate an approximate increase in annual burden costs of $19.7 million for the Federal Government and $12.1 million total 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 to update the eligibility systems and perform other technical updates for this change of $778,600 for the Federal Government and approximately $14.8 million total for State Exchanges. Finally, as also discussed further in section IV.D. of this preamble, we estimate an increase in annual burden of $13,475,320 for consumers to submit documentation to fulfill income verification requirements. We recognize the burden this proposal may place on State Exchanges, if finalized, and seek comment on the impact of this burden and potential less burdensome alternatives that would still further the program integrity goals of this proposal.

By reducing the number of applicants who inflate income to qualify for APTC and the opportunities for improper enrollments, we anticipate this proposal would 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 would reduce the number of people who receive APTC by 50,000 for Exchanges on the Federal platform, and by 31,000 for State Exchanges. Using an estimated average four months reduced APTC and an average monthly APTC rate of $588.07 per person, we estimate total APTC expenditures would be reduced by approximately $189 million annually (50,000 x $588.07 x 4 + 31,000 x $588.07 x 4 months).

We also anticipate that stronger income verification standards would increase Federal and State Medicaid expenditures by enrolling more people in Medicaid who 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 seek comment on 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 seek comment on these impact estimates and assumptions.

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

We propose to remove § 155.320(c)(5) which requires Exchanges to accept an applicant's income attestation without further verification when tax return data is unavailable. As further discussed in section IV.E. of this proposed rule, we estimate an increase in annual burden costs of approximately $76.2 million for the Federal Government and approximately $46.7 million total for State Exchanges 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 $876,000 for the Federal Government and approximately $16.6 million total for State Exchanges. As also further discussed in section IV.E. of this proposed rule, we also estimate an increase in annual burden of $52,081,620 for

consumers to submit documentation to fulfill income verification requirements associated with this proposal. We recognize the burden this proposal may place on State Exchanges, if finalized, and seek comment on the impact of this burden and potential less burdensome alternatives that would still further the program integrity goals of this proposal.

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 would result in a decrease in APTC, potentially to nothing, by 252,000 enrollees for Exchanges on the Federal platform, and by 155,000 enrollees for State Exchanges. Using an estimated average four months reduced APTC and with an average monthly APTC rate of $588.07 per person, we anticipate that this proposed change could result in a reduction of $956 million (252,000 x $588.07 x 4 + 155,000 x $588.07 x 4) in annual APTC expenditures. We accept comments on whether this number may be slightly less because of potential decreased enrollment if the enhanced premium tax credits are no longer in effect.

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.

We seek comment on these impact estimates and assumptions.

8. Annual Eligibility Redetermination (§ 155.335)

We propose an 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. Specifically, 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 dollars after application of APTC through the Exchange's annual redetermination process, we propose to require all Exchanges to 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 re-enrolled with a $5 monthly premium after APTC under this policy would be able to update their Exchange application and re-confirm their plan 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 propose that the FFEs and the SBE-FPs must implement this change starting with annual redeterminations for benefit year 2026. We propose that the State Exchanges must implement it starting with annual redeterminations for benefit year 2027.

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,[208] we view this figure to be an upper-bound estimate of the number of enrollees with coverage through Exchanges on

[208] Baseline enrollment projections are presented in Table 11 in section VI.C.18 of this preamble. 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.

the Federal platform who could be affected by this proposed provision. Due to a lack of data, we are unable to estimate the number of fully subsidized, automatically re-enrolled enrollees on State Exchanges, and request comment on this figure.

Regarding the benefits associated with this proposed provision, we believe this proposed change would lead to increased price sensitivity to premiums and premium changes among enrollees whose premiums are fully subsidized and who would be automatically re-enrolled in their current policies. This is because these enrollees would pay $5 more in net premiums per month if they do not submit an application for an updated eligibility determination from an Exchange. Enrollees would therefore be incentivized to return to an Exchange, evaluate available coverage options and premiums, and make an active enrollment decision. We therefore anticipate that this proposed provision would lead to better matches between consumers' coverage preferences and available coverage offerings in the individual market.

As noted 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 proposed policy would contribute to reducing the financial stress that ineligible enrollees may experience by protecting them from accumulating surprise tax liabilities.[209] Additionally, we anticipate that this proposed provision would reduce the number of improper enrollments of fully subsidized enrollees by agents, brokers, and web-brokers.

Regarding the potential costs associated with this proposed provision, if some enrollees with fully subsidized premiums are unaware of the APTC adjustments that would be made and the premium amounts that would be due because they have not submitted an application for an

[209] 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.

updated eligibility determination or decide not to pay the $5 per month premium amount, this proposed provision could lead some enrollees to have their coverage terminated due to non-payment of premiums. This, in turn, could lead to adverse health outcomes for those enrollees who experience a coverage gap. However, we expect the number of fully subsidized enrollees who ultimately have their coverage terminated due to non-payment of premiums would 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. We request comment on this assumption.

Enrollees who otherwise would not have obtained an updated eligibility determination would also incur time costs associated with the need to submit an application to an Exchange to obtain an updated determination notice in order to obtain a zero-dollar premium, if they are still eligible for one.

Exchanges would incur costs to comply with this proposed provision. Specifically, Exchanges would need to make changes to their IT systems to be able to identify enrollees who would 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 submit an application for an updated eligibility determination to the Exchange. We estimate that it would take the Federal Government and each of the State Exchanges not on the Federal platform 10,000 hours to develop and code the changes to their IT systems. We do not expect States operating SBE-FPs to incur any implementation costs. These estimates are based on past experience with similar system changes.

Of those 10,000 hours, we estimate it would take a database and network administrator and architect 2,500 hours at $101.66 per hour and a computer programmer 7,500 hours at $95.88 per hour. In aggregate for the State Exchanges not on the Federal platform, we estimate a one-time burden in 2025 or 2026 of 200,000 hours (20 State Exchanges × 10,000 hours) at a cost of $19,465,000 (20 States × [(2,500 hours × $101.66 per hour) + (7,500 hours × $95.88 per hour)]) for completing the necessary updates to State Exchange systems. For the Federal Government, we estimate a one-time burden in 2025 of 10,000 hours at a cost of $973,250 ((2,500 hours × $101.66 per hour) + (7,500 hours × $95.88 per hour)). In total, the burden associated with all system updates would be 210,000 hours at a cost of $20,438,250. We recognize the burden this proposal may place on State Exchanges, if finalized, and seek comment on the impact of this burden and potential less burdensome alternatives that would still further the program integrity goals of this proposal.

Exchanges would also likely incur costs associated with responding to customer service requests related to this change. Exchanges could also incur costs associated with outreach and enrollee, agent/broker/web-broker and Navigator, and issuer education regarding this proposed provision.

Regarding the potential transfers associated with this proposed provision, this proposed provision 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. The need for fully subsidized enrollees to actively re-enroll in their current policies to continue with fully subsidized coverage could 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 would also reduce net Federal PTC spending. Lastly, this proposed

provision would 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.

Due to a lack of data, we are unable to quantify all anticipated benefits, costs, and transfers associated with this proposed provision, and request comment and data on the potential impacts.

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

We propose to amend 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 would 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 revert to the prior re-enrollment hierarchy standards in place before the 2024 OEP that were structured to limit the differences between the consumer's current plan and new plan in situations where the renewal process places a consumer in a different plan (88 FR 25822). We believe this proposed change would improve the consumer experience by retaining consumer choice, reducing consumer confusion, and removing the risk of accumulating tax liabilities created by the policy. We believe the removal of the bronze to silver crosswalk criteria in the Federal hierarchy for re-enrollment would 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 would require operational and system changes to reverse the

policy including related consumer outreach. We do not anticipate that these changes would 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 solicit comment on that assumption.

By retaining consumer choice, we anticipate this proposal 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 would reduce APTC expenditures. We are not able to quantify the reduction in APTC expenditures because, we do not expect the current policy would lead 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 seek comment on these impact estimates and assumptions.

10. Premium Payment Threshold (§ 155.400(g))

We propose to modify § 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). Removing the options for issuers to implement either a fixed dollar and/or gross percentage would help address concerns about program integrity by ensuring that enrollees cannot remain enrolled in coverage for extended periods of time without paying any premium. We anticipate that there would be some costs for issuers who had already implemented a fixed-dollar or gross premium percentage-based threshold and would 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 $817,571,843 in APTC payments 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 would not be incurred with the removal of the fixed dollar and gross premium percentage-based thresholds.

We seek comment on these impact estimates and assumptions.

11. Annual Open Enrollment Period (§ 155.410(e))

We propose to amend § 155.410(e) to change the annual OEP for the benefit years starting January 1, 2026 and beyond to begin on November 1 and end on December 15 of the calendar year preceding the benefit year. 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 would 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.

We estimate that it would take the Federal Government and each of the State Exchanges 4,000 hours to develop and code the changes to their IT systems. Of those 4,000 hours, we estimate it would take a database and network administrator and architect 1,000 hours at $101.66 per hour and a computer programmer 3,000 hours at $95.88 per hour. We do not expect States operating SBE-FPs to incur any implementation costs. These estimates are based on past experience with similar system changes. For the Federal Government, we estimate a one-time burden in 2025 of 4,000 hours at a cost of $389,300 (1,000 hours × $101.66 per hour) + (3,000 hours × $95.88 per hour). In aggregate, for State Exchanges, we estimate a one-time burden in 2025 of 80,000 hours (20 State Exchanges × 4,000) at a cost of $7,786,000 (20 States × [(1,000 hours × $101.66 per hour) + (3,000 hours × $95.88 per hour)]). In total, the burden associated with all system updates would be 84,000 hours at a cost of $8,175,300. We recognize the burden this proposal may place on State Exchanges, if finalized, and seek comment on the impact of this burden and potential less burdensome alternatives that would still further the program integrity goals of this proposal.

We do not anticipate that the proposed change to the OEP end date to December 15 would have a negative impact on enrollment or the consumer experience due to the maturity of the enrollment systems. This proposed change is expected to simplify operational processes for issuers and 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 note that there also may be administrative costs for issuers and Exchanges associated with an increase in SEP casework. Consumers would benefit from clearer enrollment rules that would encourage all annual enrollment activities to be complete by December 15 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 seek comment on these impact estimates and assumptions.

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 proposing to remove § 155.420(d)(16) and repeal the 150 percent FPL SEP. 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 the preamble of this proposed 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, *Conswallo Turner et al. v. Enhance Health, et al,* 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, but we believe improper enrollments would continue to be a problem so long as access to fully subsidized plans is made easier through the 150 percent FPL SEP. It is hard to predict the level of improper enrollments in the years ahead 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 also believe repealing the 150 percent FPL SEP would 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 repealing this SEP could decrease premiums by 3 to 4 percent compared to baseline premiums if this rule is finalized, and therefore annual APTC outlays would decrease by approximately $3.4 billion in 2026, $3.6 billion in 2027, $3.8 billion in 2028, and $4.0 billion in 2029. We seek comment on how this policy would impact premiums and APTC/PTC outlays.

Quantifying the impact of the 150 percent FPL SEP on enrollment also 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. Our analysis of the SEPs suggests that the 150 percent FPL SEP did offset the use of other SEPs, which suggests it may have less enrollment impact than previously expected.

To repeal the monthly 150 percent FPL SEP, we estimate a one-time cost of approximately $390,000 to remove functionality to grant the 150 percent FPL SEP and make any necessary updates to eligibility logic systems for Exchanges on the Federal platform. 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 $101.66) and 75 percent of the work is being performed by a computer programmer (hourly wage of $95.88). This allocation of work between a network administrator and computer programmer was informed by our experience with past system changes.

We also estimate a similar one-time cost for any State Exchanges that operate their own eligibility and enrollment systems and currently offer the 150 percent FPL SEP. However, as of February 2025, we do not believe that any State Exchange has offered the 150 percent FPL SEP as this SEP was optional for all Exchanges.

We seek comment on these impact estimates and assumptions.

13. Pre-Enrollment Verification for Special Enrollment Periods (§ 155.420)

We are proposing to amend § 155.420(g) to require all Exchanges to conduct pre-enrollment eligibility verification for SEPs. Specifically, we propose to remove 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 propose 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.

We also propose to require that Exchanges, including all State Exchanges, 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 proposing that Exchanges must verify at least 75 percent of such new enrollments based on the current implementation of SEP verification by Exchanges.

We anticipate that revisions to § 155.420 would have a positive impact on program integrity by verifying eligibility for SEPs. Increasing program integrity through this proposal would reduce improper subsidy payments and could contribute to keeping premiums low and therefore, further protecting taxpayer dollars. However, the premium impact would likely be minimal for State Exchanges that already conduct SEP verification largely in accordance with this proposal. This proposal may deter enrollments among younger people at higher rates, which could worsen the risk pool and increase premiums. However, we expect any such deterrence would 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 would reduce premiums by approximately 0.5-1.0 percent for PY 2026 and 1.0-2.0 percent for PY 2027 and beyond, and would reduce APTC spending by approximately $105.4 million.[210]

We anticipate this proposal would moderately increase the regulatory burden on Exchanges using the Federal platform and on existing State Exchanges that conduct the additional pre-enrollment verifications. Based on information included in State Exchange SMART tools, a majority of State Exchanges had conducted SEP verification for the same SEP

[210] 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).

types for which the FFEs had conduct SEP verifications before the limit on verifying only the loss of minimum essential coverage SEP was put in place for PY 2023. Therefore, we expect most Exchanges continue to have the infrastructure in place to conduct verifications. Of the 15 State Exchanges that currently attest to verifying at least one SEP, seven State Exchanges attested to verifying loss of minimum essential coverage.[211]

As of PY 2025, only one State Exchange conducts SEP verifications for only one type of SEP. The five State Exchanges established since 2021 vary in how they conduct SEP verification with four State Exchanges verifying at least one type of SEP (three of those four State Exchanges verify loss of minimum essential coverage). State Exchanges bear the full cost of the SEP verification activities they conduct. Eleven State Exchanges that conduct verifications for SEPs are verifying at least 75 percent or more of their respective SEP enrollments. [212] For five State Exchanges that conduct SEP verifications for at least one type of SEP, a single SEP type consistently represents over 60 percent of all SEP enrollments. An additional three State Exchanges reach the same consistent 60 percent threshold when accounting for their top two SEP types.[213]

Based on the implementation of pre-enrollment SEP verification in the Exchanges using the Federal platform, we estimate that the overall one-time cost of implementing pre-enrollment SEP verification by an Exchange would be approximately $12 million. Therefore, we estimate that the total cost to comply with this requirement for the five State Exchanges that did not

[211] This information was provided to CMS through SMART attestations encompassing PY2023.
[212] SMART attestations encompassing PY2023; Operational Readiness Assessment performed by Georgia in preparation for their transition to an SBE-FP.
[213] This is based on internal enrollment metrics data provided from State Exchanges to CMS and reflects SEP enrollment from 1/1/23-6/30/23. S

previously conduct SEP verification for at least 75 percent of enrollments for newly enrolling consumers enrolling through SEPs would be $60 million for PY 2026.

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 would 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 preamble, we anticipate that the expansion of SEP verification would result in increased income inconsistencies, with an associated annual cost increase for consumers of approximately $7,206,665. There would also be an increase in ongoing costs for Exchanges on the Federal platform and State Exchanges 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 would be approximately $46.7 million for PY 2026 to PY 2029. Furthermore, as discussed in section IV.G. of this preamble, we anticipate that expanding verification would result in an increase in annual burden in labor costs on Exchanges using the Federal platform at a cost of $2,833,449 and an increase in annual burden on State Exchanges at a cost of $ 1,736,615 total. We recognize the burden this proposal may place on State Exchanges, if finalized, and seek comment on the impact of this burden and potential less burdensome alternatives that would still further the program integrity goals of this proposal.

Additionally, we anticipate that the expansion of SEP verification would have a one-time development cost for Exchanges using the Federal Platform of $1,849,270 (19,000 hours x $97.33). This assumes that 25 percent of the hours needed to expand SEP verification are being

performed by a database and network administrator (hourly wage $101.66) and 75 percent of the work is being performed by a computer programmer (hourly wage $95.88). This allocation of work between network administrator and computer programmer was informed by our experience with past system changes. We do not anticipate this proposal would increase regulatory burden or costs on issuers. We seek comment on these impact estimates and assumptions.

14. Prohibition on Sex-trait Modification as an EHB (§§ 156.50 and 156.115(d))

We propose to amend § 156.115(d) to provide that an issuer of a plan offering EHB may not provide sex-trait modification as an EHB. If finalized as proposed, this proposal would mean that individuals currently seeking or considering seeking sex-trait modification could not access such care 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. If this proposed policy is finalized as proposed, these provisions would not apply to sex-trait modification to the extent such care is included in health plans, including in large group market and self-insured group health plans. This includes a prohibition of sex-trait modification in the five States that include sex-trait modification 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 document.[214]

Utilization of sex-trait modification is low; therefore, the impact of this proposal would be limited. Approximately 0.11 percent of enrollees in the EDGE data set gathered from issuers as part of the HHS-operated risk adjustment program utilized sex-trait modification between PYs 2022 and 2023. In the aggregate, the total allowed cost of sex-trait modification amounts to 0.08

[214] California, Colorado, New Mexico, Vermont, and Washington EHB-benchmark plans specifically include coverage of some sex-trait modification. Six other States do not expressly include or exclude coverage of sex-trait modification in EHB-benchmark plans. Forty States include language that excludes coverage of sex-trait modification in EHB-benchmark plans.

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 or not, 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 would expect an impact to the amount of PTC. Plans that stop coverage of sex-trait modification would see premiums and PTC decrease as the generosity of plan benefit coverage decreases. Plans that decide to cover sex-trait modification as non-EHB would see premiums rise or stay the same to account for this benefit generosity, but would see any existing PTC decrease as the benefits would no longer be EHB. States that choose to mandate such coverage as a benefit in addition to the EHB would be required to defray its cost pursuant to § 155.170; in this circumstance, we would expect premiums and tax credits to decrease to account for the State's defrayal obligations. We seek comment on these impact estimates and assumptions.

15. Premium Adjustment Percentage Index (§ 156.130(e))

We propose a premium adjustment percentage of 1.6726771319 for PY 2026 based on our proposed change to the premium measure for calculating the premium adjustment percentage. Under § 156.130(e), we propose to use average per 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 earlier in the preamble, our proposal to use private health insurance premiums (excluding Medigap and property and casualty insurance) in the premium adjustment percentage calculation would result in a higher overall premium growth rate measure than if we continued to use employer-sponsored insurance premiums as was used for prior plan years and in the October 2024 PAPI Guidance.[215] To further elaborate on the potential impacts of this proposed policy change, in § 155.605(d)(2), we propose a required contribution of 8.05 percent for PY 2026 using the proposed premium adjustment percentage in § 156.130 to supersede the required contribution of 7.70 percent for PY 2026 calculated from employer-sponsored insurance premiums previously published in the October 2024 PAPI Guidance.[216] In § 156.130(a)(2), we propose 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 employer-sponsored insurance premiums previously published in the October 2024 PAPI Guidance.[217] The CMS Office of the Actuary estimates that the proposed change in methodology for the calculation of the premium adjustment percentage may have the following impacts between 2026 and 2030:[218]

TABLE 13: Impacts of Proposed Modifications to the PY 2026 Premium Adjustment Percentage

Calendar year	2026	2027	2028	2029	2030
Exchange Enrollment Impact (enrollees, thousands)	−80	−80	−80	−80	−80

[215] 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.
[216] Ibid.
[217] Ibid.
[218] 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, employer-sponsored insurance, and individual insurance choice models that ensure consistent estimates of coverage and spending in considering legislative changes to current law.

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 13, we expect that the proposed 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 would adopt the use of the same premium measure proposed 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. We anticipate that enrollment may decline by 80,000 individuals in PY 2026, and enrollment would remain lower by 80,000 individuals in each year between 2026 and 2030 than it would if there were no proposed 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 would 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 proposed premium measure would 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 proposed 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 would 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.[219] 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 networks for such plans tend to be more expansive than plans on the individual market.[220,221] 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

[219] 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.

[220] 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.*

[221] 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/.

health outcomes.[222] We seek feedback from interested parties about these impacts and the magnitude of these changes.

As noted previously in this proposed 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). In § 156.130(a)(2), we propose a maximum annual limitation on cost sharing of $10,600 for self-only coverage for PY 2026. Additionally, we propose reductions in the maximum annual limitation on cost sharing for silver plan variations (Table 8 in section III.C.2.b. of this proposed rule). Consistent with our analyses in previous Payment Notices, we developed three test silver level QHPs and analyzed the impact on their AVs of the reductions described in the ACA to the proposed PY 2026 maximum annual limitation on cost sharing for self-only coverage. Beyond the impacts to APTC highlighted above, which overlap with impacts related to the increased reduced limitations on cost sharing applicable to silver plan variations[223] applicable to plans offered on Exchange in the individual market, we do not believe the proposed changes to the maximum annual limitation on cost sharing would result in a significant economic impact as the plans required to comply with the maximum annual limitation on cost sharing are generally required to comply with AV (or with minimum value), constraining the range of cost-sharing parameter values that issuers can offer for those plans. However, we seek comment on these impact estimates and assumptions related to the proposed change to the premium measure for calculating the premium adjustment percentage.

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[222] 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.

[223] 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.

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

We are proposing 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 requirements under the EHB package, other than for expanded bronze plans,[224] for which we propose a de minimis range of +5/-4 percentage points. We also propose 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 propose 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.

We believe that changing the de minimis ranges for standard metal level plans (except for individual market silver QHPs) would not generate a transfer of costs for consumers overall. Wider de minimis ranges would allow issuers to design plans with a lower AV than is possible currently, which would reduce the generosity in health plan coverage for out-of-pocket costs. However, we expect that issuers would, in turn, lower overall premiums. We estimate the premiums could decrease approximately 1.0 percent on average because of benefit changes issuers would make with a wider de minimis range. Lower overall premiums would have positive effects for consumers over the longer term as issuer participation increases and coverage options improved, which would 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 14 below, the proposal to widen the de minimis range for individual

[224] 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.

market silver QHPs to +2/-4 percentage points would generate a transfer of costs in the short-term from 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 would see the generosity of their current SLCSP decrease, resulting in a decrease in PTC.

Table 14: 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 proposal, 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 proposal only expands the universe of permissible plan AVs and would 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 would attract more enrollment, they would remain free to do so under this proposal.

In addition, changing the de minimis range for standard silver plans would 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 proposal, as premiums decrease, an employer would 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 seek comment on these impact estimates and assumptions, as well as any timing considerations with its proposed implementation.

17. Regulatory Review Cost Estimation

If regulations impose administrative costs on private entities, such as the time needed to read and interpret this proposed rule, we should estimate the cost associated with regulatory review. Due to the uncertainty involved with accurately quantifying the number of entities that will review the rule, we assume that a range of between the total number of unique commenters on the 2026 Payment Notice proposed rule (266) and the total number of page views on the 2026 Payment Notice proposed rule (about 13,800) will include the actual number of reviewers of this proposed rule. We therefore use an average number of approximately 7,000 reviewers of this proposed rule. We acknowledge that this assumption may understate or overstate the costs of reviewing this proposed rule. It is possible that not all commenters reviewed the 2026 Payment Notice proposed rule in detail, and it is also possible that some page viewers will not actually read this proposed rule. For these reasons, we believe that the approximate average of the number of commenters and number of page viewers on the 2026 Payment Notice proposed rule will be a fair estimate of the number of reviewers of this final rule. We seek comments on the approach in estimating the number of entities which will review this proposed rule.

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 55 percent of the rule (an average of the range from 10 percent to 100 percent of the rule). We seek comments on this assumption.

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 $106.42 per hour, including overhead and fringe benefits.[225] Assuming an average reading speed of 250 words per minute, we estimate that it will take approximately 3.4 hours for the staff to review 55 percent of this proposed rule. For each entity that reviews the rule, the estimated cost is $361.83 (3.4 hours x $106.42 per hour). Therefore, we estimate that the total cost of reviewing this regulation is approximately $2,532,810 ($351.19 per reviewer x 7,000 reviewers).

18. Overall Impact of the Proposed Individual Market Program Integrity Provisions

In the regulatory impact analysis of this proposed rule, we include impact analyses and estimates for each proposal separately, as we intend for each provision to be severable from the rest. Please see section III.E. for a more detailed discussion on the severability of the provisions of this rule. However, we anticipate that the provisions of this proposed 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 proposed rule would 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 the expiration of enhanced PTCs in the IRA on December 31, 2025, is accounted for separately from these estimates, as such a reduction would not be due to the provisions in this proposed rule, if finalized. These estimates consider the enrollment, premium, and APTC impact solely due to the provisions in this proposed rule, if finalized, compared to what would occur if these proposals were not finalized.

[225] U.S. Bureau of Labor Statistics. (2024, April 9). *Occupational Employment and Wage Statistics.* Dep't. of Labor. https://www.bls.gov/oes/current/oes_nat.htm.

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 special enrollment period and effectuated their enrollment between 2015 and 2017 with the ACS five-year public-use microdata sample for 2013-2017.[226] 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.[227] 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 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. HHS has carefully considered both of these sources and used the Paragon Health Institute methodology in the following analysis as a way to quantify erroneous and

[226] 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.
[227] Blase, B. & Gonshorowski, D. (n.d.). The Great Obamacare Enrollment Fraud. Retrieved from https://paragoninstitute.org/private-health/the-great-obamacare-enrollment-fraud/.

improper enrollments using CMS Marketplace OEP PUFs data and IPUMS USA data using the best available data.

The analysis in Table 15 below compares sign-ups during the OEP for people with expected income between 100-150 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 100-150 percent FPL are from the CMS Marketplace OEP PUFs data.[228] 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 the 2023 and 2024 plan years, 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.[229] The number of State residents in the 100-150 percent 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.[230] State residents ages 19-64 with household incomes between 100-150 percent 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 this range,[231] as well as adults ages 65 and older who are likely eligible for Medicare.[232] Because the

[228] Marketplace Products. (n.d.). Retrieved from https://www.cms.gov/data-research/statistics-trends-and-reports/marketplace-products
[229] 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
[230] Ruggles, S., et al. (2023). IPUMS USA: Version 15.0 [dataset]. Retrieved from https://www.ipums.org/projects/ipums-usa/d010.V15.0.
[231] 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/
[232] Blase, B. & Gonshorowski, D. (n.d.). The Great Obamacare Enrollment Fraud. Retrieved from https://paragoninstitute.org/private-health/the-great-obamacare-enrollment-fraud/

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.[233] This adjustment assumes that changes in population within the 100-150 percent FPL range are similar to those within the State and ignores any potential distributional changes. Minnesota, New York, 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.[234] 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.[235]

The comparisons presented in Table 15 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 the 100-150 percent FPL criteria in each year but leads to less precise estimates than the use of multi-year ACS samples with larger sample sizes.[236] Second, it uses the Census definition of

[233] 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
[234] Basic Health Program. (n.d.). Retrieved from https://www.medicaid.gov/basic-health-program/index.html
[235] 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
[236] Using 1-Year or 5-Year American Community Survey Data. (2020). Retrieved from https://www.census.gov/programs-surveys/acs/guidance/estimates.html

poverty to identify residents with family incomes between 100-150 percent FPL, which differs from the MAGI relative to poverty measure that is used to determine eligibility for premium tax credits on the Exchanges and reported in the OEP PUFs.[237] 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.[238] In addition, the ACS is fielded throughout the calendar year and asks about income during the previous 12 months,[239] 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.[240] 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,[241] those with Medicaid coverage that they did not report on the survey,[242] immigrants who are not lawfully present,[243] and people enrolled in Department of Veteran Affairs (VA) health care. Finally, the eligible population estimated using the ACS does not include certain 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

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[237] What's Included as Income. (n.d.). Retrieved from www.healthcare.gov/income-and-household-information/income/.
[238] 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
[239] 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
[240] 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
[241] People with coverage through a job. (n.d.) Retrieved from https://www.healthcare.gov/have-job-based-coverage/options/
[242] 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
[243] Coverage for lawfully present immigrants. (n.d.). Retrieved from https://www.healthcare.gov/immigrants/lawfully-present-immigrants/

Medicare.[244] We acknowledge these limitations and seek comment on ways to improve these analyses in final rulemaking. 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 premium tax credit eligibility determination.

Table 15 below 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 plan year 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 plan year 2024, indicating that there are a larger number of Exchange enrollees reporting incomes of between 100-150 percent 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 expected, or people not updating their income information if auto re-enrolled with the prior year's income data in 2023

[244] 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/

and 2024. These would constitute errors. To the extent that people with incomes below 100 percent 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 100-150 percent 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.[245] 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 FPL.[246] 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.[247]

One approach to estimate the possible reduction in erroneous and improper enrollments under the proposed changes in this rule is to sum the total number of enrollments in 2024 that exceed 100 percent of potential enrollees in Table 15. This calculation suggests that there are as many as 4.4 million erroneous or improper enrollments. In several respects, this is expected to be an upper bound estimate of the scale of erroneous and improper enrollments. First, 2024 plan year Exchange enrollments occurred prior to recent HHS actions to improve program integrity

[245] Status of State Medicaid Expansion Decisions. (2025, February 12). Retrieved from https://www.kff.org/status-of-state-medicaid-expansion-decisions/

[246] 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% FPL in Alabama, 27% FPL in Florida, 30% FPL in Georgia, 27% FPL in Mississippi, 67% FPL in South Carolina, 105% FPL in Tennessee, and 15% FPL in Texas. Other adults are not eligible.

[247] 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

(for example, from June 2024 through October 2024, CMS suspended 850 agents and brokers' Marketplace Agreements for reasonable suspicion of fraudulent or abusive conduct related to unauthorized enrollments or unauthorized plan switches).[248] Such changes were expected to reduce the number of improper and erroneous enrollments prior to the implementation of the provisions in this proposed 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 proposed 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. The excess enrollment estimate, however, does also ignore 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 proposed provisions. For all of these reasons, there is uncertainty present regarding the estimate derived from this analysis. We acknowledge this uncertainty and seek comment on how we may improve this estimate in final rulemaking.

TABLE 15: Exchange Sign-Ups Compared to Potential Enrollees at 100-150 Percent 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

[248] CMS Update on Actions to Prevent Unauthorized Agent and Broker Marketplace Activity. (2024, October 17). Retrieved from https://www.cms.gov/newsroom/press-releases/cms-update-actions-prevent-unauthorized-agent-and-broker-marketplace-activity

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
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 reduction in improper enrollments is not attributable to the proposals in this rule, if finalized as proposed, but rather by current law causing IRA subsidies to expire after PY 2025. However, there is uncertainty regarding how many improper enrollments would be reduced by the expiration of IRA subsidies compared to the proposals in this rule, if finalized. We believe the majority of improper enrollments would disenroll from coverage as a result of the enhanced subsidies, therefore, we assume a range of approximately 750,000 to 2,000,000 fewer individuals would enroll in QHP coverage in 2026 as a result of the proposals in this rule, if finalized jointly and as proposed. We seek comment on this estimate and assumptions.

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 750,000 to 2,000,000 enrollees compared to baseline estimates. Some enrollees dropping coverage would 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 750,000 reduced enrollment scenario and 0.9 percent for the 2,000,000 reduced enrollment scenario. The revised premium was calculated assuming issuers would price to an average 84 percent loss ratio, yielding a revised PMPM of $626.37 for the 750,000 reduced enrollment scenario and $656.17 for the 2,000,000 reduced enrollment scenario for 2026 if the proposals in this rule are finalized jointly and as proposed. 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.

Using the methodology described in the preceding paragraphs, we anticipate the provisions in this proposed rule, when considered jointly and if finalized as proposed, could reduce enrollment, premiums, and APTC each year beginning in 2026. We provide lower bound estimates in Table 16 and upper bound estimates in Table 17.

TABLE 16: 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
Proposals in this rule, if finalized as proposed						
	Total Enrollment (millions)	21.625	16.490	16.668	16.913	17.421
	APTC Enrollment (millions)	20.061	14.935	14.995	15.057	15.111
	Premiums ($ billions)	159.448	123.946	130.136	137.171	143.909
	APTC ($ billions)	130.960	99.703	104.882	110.901	116.348
Change						
	Total Enrollment (millions)	-	-0.750	-0.758	-0.769	-0.792
	APTC Enrollment (millions)	-	-0.679	-0.680	-0.684	-0.687
	Premiums ($ billions)	-	-13.034	-13.685	-14.425	-15.134
	APTC ($ billions)	-	-10.485	-11.030	-11.663	-12.235

TABLE 17: 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
Proposals in this rule, if finalized as proposed						
	Total Enrollment (millions)	21.625	15.240	15.404	15.631	16.100
	APTC Enrollment (millions)	20.061	13.803	13.821	13.915	13.966
	Premiums ($ billions)	159.448	119.999	125.993	132.804	139.327
	APTC ($ billions)	130.960	96.528	101.542	107.370	112.644
Change						
	Total Enrollment (millions)	-	-2.000	-2.022	-2.051	-2.113
	APTC Enrollment (millions)	-	-1.811	-1.814	-1.826	-1.832
	Premiums ($ billions)	-	-16.981	-17.829	-18.793	-19.716
	APTC ($ billions)	-	-13.660	-14.369	-15.194	-15.940

Taken together, the provisions of this rule are expected to address errors and improper enrollments, which means that as presented in the preceding paragraphs, we would expect approximately 750,000 to 2,000,000 individuals to lose coverage as a result of this rule, if all provisions are finalized as proposed. 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

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, 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 cause an overall reduction to labor productivity.

In contrast, if individuals who do not maintain coverage following the finalizing 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, thereby saving taxpayer dollars. As we believe many of the individuals who would lose coverage as a result of the proposals in this rule, if finalized jointly and as proposed, may represent improper enrollments, this would be a benefit.

We note that variables impacting enrollment, premiums, and APTC have changed over time and may continue to fluctuate. When considering the overall impact of this proposed rule, if all provisions are finalized as proposed, 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 proposed rule could be outside of the estimates provided in this section. We seek comment on these impact estimates and assumptions.

D. Regulatory Alternatives Considered

We considered taking no action regarding our proposal to remove § 147.104(i), which currently prohibits an issuer from 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 gaming and adverse selection, HHS believes 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 proposal would improve the risk pool by promoting continuous coverage without imposing a significant financial burden for most people who owe past-due premiums.

At § 155.20, we are proposing to adjust the definition of "lawfully present" used for purposes of determining eligibility to enroll in a QHP offered through the Exchange or a BHP in States that elected 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 and BHP coverage.[249] Other changes corrected unintentional errors in the prior definition.[250] 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 adjust status to lawful permanent resident on the basis of their status.[251] 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 are not proposing 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 two-consecutive tax years. However, due to concerns about improper enrollment as well as concerns related to the potential for increased tax liability for tax filers, HHS is proposing allowing Exchanges to remove APTC after an enrollee or their tax filer has been identified as failing to file and reconcile for one tax year. We believe that FTR serves as an important check on improper enrollments and would help protect low-income consumers from larger than expected tax liabilities.

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[249] 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.

[250] 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

[251] 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.

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 income is greater than or equal to 100 percent and not more than 400 percent of the FPL and trusted data sources indicate that projected income is under 100 percent of the FPL. However, due to concerns of applicants inflating their incomes or having applications submitted on their behalf with inflated incomes, as outlined in this proposed rule, we believe it would be reasonable, prudent, and even necessary to carry out the alternative income verification process in this scenario. HHS also believes that this may help 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, HHS believes that removing § 155.320(c)(5) is crucial for program integrity and that the benefit more than offsets the administrative burden of requiring an income DMI in this scenario. 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 propose 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 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, all Exchanges 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.

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 most enrollees on the FFEs and the SBE-FPs 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 would 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 FFEs. 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. As discussed previously in this preamble, we

also considered whether other methods – such as outreach – could sufficiently prompt fully subsidized enrollees to update or confirm their eligibility information. However, based on our experience operating the Exchanges on the Federal platform, the majority of enrollees update their information each year due to extensive outreach efforts, and we don't believe additional or different notifications would prompt enrollees to do so.

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 proposed 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 enrollment decision making 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 preamble, 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 considered maintaining the length of the OEP, and we considered providing flexibility to State Exchanges on the length of their OEPs. Ultimately, however, we find that reducing the potential for adverse selection is more important than providing additional time for plan changes or additional flexibility for States. We believe that efforts to reduce premium growth are more valuable for Exchange stability than additional enrollment time. Lower adverse selection should translate to lower premiums for QHPs. Additionally, we considered moving the OEP to a later date in the calendar year – 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 such a dramatic shift in the OEP would cause considerable disruption to the market. Therefore, we propose that the OEP for all Exchanges ends on December 15.

We considered not repealing the monthly 150 percent FPL SEP under § 155.420 but decided that it was important to fully repeal this SEP to ensure a stable risk pool for the Exchange and to mitigate risks for improper enrollments. Specifically, we found that the existence of fully subsidized plans creates an opportunity for some agents, brokers, and web-brokers to capture a commission by improperly enrolling people without their knowledge or consent. We find that these improper enrollments can go unnoticed until an enrollee tries to use their health plan or when they eventually must reconcile surprise APTC on their taxes. Even if we were able to sufficiently reduce the problem of some agents, brokers, and web-brokers improperly enrolling consumers, there remain substantial issues with consumers taking advantage of the 150 percent FPL SEP by falsely representing their income to take advantage of the fully subsidized plans. Additionally, we find that the consumers at or below the 150 percent of the FPL wait to enroll until they need health care services which also destabilizes the risk pool

and increases premiums. Ultimately, we do not believe the benefits of increased access to coverage for low-income consumers outweighs the higher premiums and risks of harming program integrity because of improper enrollments.

We are proposing to amend § 155.420(g) to require all Exchanges to conduct eligibility verification for SEPs. Specifically, we propose to remove 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 propose 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.

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 was greater than the potential benefit of reducing administrative burden on consumers by only verifying loss of minimum essential coverage. We also determined that consumers would benefit from increased verification due to its potential to limit improper enrollments occurring without their awareness and to bring down risk in the Federal Exchange by ensuring that only qualified individuals are enrolling through SEPs throughout the year.

We are also proposing to require that Exchanges, including all State Exchanges, 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 proposing that Exchanges must verify at least 75 percent of such new enrollments based on the current implementation of SEP verification by State Exchanges.

We considered leaving the current regulation that allows pre-enrollment SEP verification to be at the option of each State Exchange in place. However, we believe that having a standard of SEP verification across all Exchanges will be beneficial for all States regarding risk reduction in their Exchanges and protecting consumers from improper enrollments. We believe that the 75 percent threshold still leaves State Exchanges a great deal of flexibility as to which SEPs they implement pre-enrollment verification for as we know it is not cost effective for each State Exchange to verify all types. However, we are seeking comment on whether or not to require SEP verification for most SEP types in line with what we are proposing in this Rule for Exchanges on the Federal platform.

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 employer-sponsored insurance premiums for purposes of calculating the premium adjustment percentage for PY 2026. We are proposing a change to 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 employer-sponsored insurance, direct purchase insurance (which includes Medigap insurance), and property and casualty insurance. However, we propose to include 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 would be 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 propose using a measure that includes only premiums for employer-sponsored insurance and direct purchase insurance, but not premiums for property and casualty, or Medigap insurance. We seek comment on the source of premium data we 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 continue to use employer-sponsored insurance premiums for purposes of calculating the premium adjustment percentage for PY 2026.

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 initial 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.[252] 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.[253] We estimate that approximately 80 percent of these small issuers belong to larger holding groups, 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 seek comment on these estimates.

We anticipate that small issuers could be impacted by the provisions in this proposed rule. We are unable to quantify the impact of these proposed changes on small issuers due to uncertainty regarding their market share, market participation, membership in larger holding groups, enrollment and risk mix, and APTC receipts. However, we anticipate that there would not be a significant change in revenue for issuers since a reduction in APTC payments would 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 proposals in this rule, if finalized, 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. We seek

[252] SBA. (n.d.). *Table of size standards.* https://www.sba.gov/document/support--table-size-standards.
[253] CMS. (n.d.). *Medical Loss Ratio Data and System Resources.* https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr.html.

comment on these estimates and assumptions.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis 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 603 of the RFA. For the 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 this proposed rule is not subject to section 1102 of the Act, we have determined that this proposed rule would not affect small rural hospitals.

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.

G. 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 proposed 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, although this proposed rule will not impose substantial direct requirement costs on State and local governments, 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 would 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 proposals would 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 proposed rule would start the Open Enrollment Period 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 open enrollment period, 19 of 20 State Exchanges ended their open enrollment period on or after January 15 of benefit year and one began before November 1 of the benefit year. This has Federalism implications because it would 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, if finalized, these rules would preempt State law only to the extent such State law would prevent the application of these rules.[254]

Stephanie Carlton, Acting Administrator of the Centers for Medicare & Medicaid Services, approved this document on March 10, 2025.

[254] See ACA § 1321(d).

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 proposes to amend 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 paragraphs (b)(2)(i)(G) and (i); and

c. Redesignating paragraph (j) as 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).

* * * * *

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. Revising the definition of "Lawfully present"; and

b. Adding a definition of "Preponderance of the evidence" in alphabetical order.

The revisions 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) * * *

(1) * * *

(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—

a. Revising paragraph (f)(4) introductory text and paragraph (f)(4)(i); and

b. Removing paragraph (f)(4)(ii).

The revisions read as follows:

§ 155.305 Eligibility standards.

* * * * *

(f) * * *

(4) *Compliance with filing requirement.* The 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 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.

(i) 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:

(A) 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

(B) 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 the tax filer's spouse, if the tax filer is married, has failed to file and reconcile. * * * * * *

7. Section 155.315 is amended by removing paragraph (f)(7).

8. Section 155.320 is amended by—

a. Revising paragraphs (c)(3)(iii)(A) and (D) and (c)(3)(vi)(C)(2); and

b. Removing paragraph (c)(5).

The revisions read as follows:

§ 155.320 Verification process related to eligibility for insurance affordability programs.

* * * * *

(c) * * *

(3) * * *

(iii) * * *

(A) Except as specified in paragraph (c)(3)(iii)(B), (C), and (D) of this section, if an applicant's attestation, in accordance with paragraph (c)(3)(ii)(B) of this section, indicates that a tax filer's annual household income has increased or is reasonably expected to increase from the data described in paragraph (c)(3)(ii)(A) of this section for the plan year for which the applicant(s) in the tax filer's family are requesting coverage 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 accept the applicant's attestation regarding a tax filer's annual household income without further verification.

* * * * *

(D) If an applicant's attestation to projected annual household income, as described in paragraph (c)(3)(ii)(B) of this section, is greater than or equal to 100 percent but not more than 400 percent of the FPL 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 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) The data described in paragraph (c)(3)(vi)(A) of this section indicates that projected annual household income is under 100 percent FPL and the applicant's attestation to projected household income, as described in paragraph (c)(3)(ii)(B) of this section, is greater than or equal to 100 percent but not more than 400 percent of the FPL 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.

* * * * *

9. Section 155.335 is amended by—

a. Adding paragraphs (a)(3) and (n);

b. Revising paragraphs (j)(1) introductory text and (j)(2) introductory text;

c. Removing paragraph (j)(4); and

d. Redesignating paragraph (j)(5) as paragraph (j)(4).

The revisions and additions read as follows:

§ 155.335 Annual eligibility redetermination.

(a) * * *

(1) * * *

(2) * * *

(3) The annual redeterminations described in paragraph (a)(2) 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.* Subject to paragraphs (n)(1) and (2) of this section, if an enrollee does not submit an application for an updated eligibility determination on or before the last day on which a plan selection must be made for coverage effective January 1 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 a policy after the application of advance payments of the premium tax credit through the Exchange's annual redetermination process would be zero dollars, the Exchange must decrease the amount of the advance payment applied to the policy such that the remaining monthly premium owed for the policy equals $5.

(1) A Federally-facilitated Exchange or a State-based Exchange on the Federal platform must adhere to paragraph (n) of this section for annual redeterminations for benefit years on and after 2026.

(2) A State-based Exchange must adhere to paragraph (n) of this section for annual redeterminations for benefit years on and after 2027.

10. Section 155.400 is amended by—

a. Revising paragraph (g) introductory text;

b. Removing and reserving paragraph (g)(2); and

c. Removing paragraph (g)(3).

The revision reads as follows:

§ 155.400 Enrollment of qualified individuals into QHPs.

* * * * *

(g) Premium payment threshold. Exchanges may, and the Federally-facilitated Exchanges and State-Based Exchanges on the Federal platform will, 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.

* * * * *

(2) [Reserved]

* * * * *

11. Section 155.410 is amended by—

a. Revising paragraphs (e)(4) introductory text and (f)(3) introductory text; and

b. Adding paragraphs (e)(5) and (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, 2025—

* * * * *

(5) For the benefit years beginning on or after January 1, 2026, the annual open enrollment period begins on November 1 and extends through December 15 of the calendar year preceding the benefit year.

(f) * * *

(3) For benefit years beginning on January 1, 2022 through January 1, 2025, the Exchange must ensure that coverage is effective—

* * * * *

(4) For benefit years beginning on or after January 1, 2026, the Exchange must ensure that coverage is effective—

(i) January 1, for QHP selections received by the Exchange on or before December 15 of the calendar year preceding the benefit year.

(ii) [Reserved]

* * * * *

12. Section 155.420 is amended by—

a. Removing paragraph (a)(4)(ii)(D);

b. Revising paragraphs (a)(4)(ii)(B) and (a)(4)(ii)(C);

c. Revising paragraph (a)(4)(iii) introductory text;

d. Removing paragraphs (b)(2)(vii) and (d)(16); and

e. Revising paragraph (g).

The revisions read as follows:

§ 155.420 Special enrollment periods.

(a) * * *

(4) * * *

(ii) * * *

(B) Beginning January 2022, if an enrollee or their dependents become newly ineligible for cost-sharing reductions in accordance with paragraph (d)(6)(i) or (ii) of this section and the enrollee or his or her dependents are enrolled in a silver-level QHP, the Exchange must allow the enrollee and their dependents to change to a QHP one metal level higher or lower if they elect to change their QHP enrollment; or

(C) No later than January 1, 2024, if an enrollee or his or her dependents become newly ineligible for advance payments of the premium tax credit in accordance with paragraph (d)(6)(i) or (ii) of this section, the Exchange must allow the enrollee and his or her dependents to change to a QHP of any metal level, if they elect to change their QHP enrollment.

(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:

* * * * *

(g) *Special enrollment period verification.* Unless a request for modification is granted in accordance with § 155.315(h), an Exchange must conduct pre-enrollment verification of applicants' eligibility for special enrollment periods under this section. An Exchange meets this requirement if it verifies eligibility for the number of individuals newly enrolling in Exchange coverage through special enrollment periods that equals at least 75 percent of all special 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.

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 sex-trait modification 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 sex-trait modification as EHB.

16. 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.]

17. 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;

* * * * *

18. Section § 156.400 is amended by revising the definition of "De minimis variation for a silver plan variation" 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.

* * * * *

Robert F. Kennedy, Jr.,

Secretary,

Department of Health and Human Services.