

Issue Brief

FEDERAL ISSUE BRIEF



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CMS Finalizes Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability Rule

The Centers for Medicare and Medicaid Services (CMS) are releasing a final rule regarding "Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability." As we write this analysis, the rule has not yet been posted on the **Federal Register** website. However a copy is available from CMS at: <https://www.cms.gov/files/document/cms-9884-f-2025-pi-rule-master-5cr-062025.pdf>.

The rule revises (1) standards relating to denial of coverage for failure to pay past-due premiums; (2) excludes Deferred Action for Childhood Arrivals recipients from the definition of "lawfully present;" (3) establishes the evidentiary standard HHS would use to assess an agent's, broker's, or web-broker's potential noncompliance; (4) revises the Exchange automatic reenrollment hierarchy; (5) revises standards related to the annual open enrollment period and special enrollment periods; (6) revises standards relating to failure to file and reconcile, income eligibility verifications for premium tax credits and cost-sharing reductions, annual eligibility redeterminations, de minimis thresholds for the actuarial value for plans subject to essential health benefits (EHB) requirements, and income-based cost-sharing reduction plan variations. The rule also revises the premium adjustment percentage methodology and prohibits issuers of coverage subject to EHB requirements from providing coverage for specified sex-trait modification procedures as an EHB. At 501-pages this is an exhaustingly long-rule.

Comments

Again, a major rule without a table of contents. We are adding page numbers in red to the CMS version, as well as providing a table of contents at the end of this analysis.

The 2025 Marketplace Integrity and Affordability proposed rule was published in the **Federal Register** on March 19, 2025, with a comment period that ended on April 11, 2025. CMS says it received over 26,000 comments from State governments or entities, the National Association of Insurance Commissioners (NAIC), the American Academy of Actuaries (AAA), issuers or issuer groups, providers/provider groups/provider associations, general advocacy groups, individuals, and others. The vast majority of comments were from individuals. (Page 10)

According to CMS, the provisions of this final rule will result in approximately 725,000 to 1,800,000 individuals that may lose coverage.

The rule's Section II (Background) contains additional information building on the Executive Summary. Note, the material starts with a provision titled "A". However, there is no "B".

The rule's section III provides a "summary" of the proposed provisions, public comments, and responses to comments. This Section extends 324 pages because of the number comments being addressed and extensive CMS responses. It's hard to call a 324-page discussion section a "summary." (Page 35)

Unfortunately, there is no overall summary of the changes CMS is making in section III. The reader must look at each response to a comment that is being addressed for CMS' final actions.

Nonetheless, referring to the Executive Summary and the regulatory analysis section should provide the reader with the knowledge to understand what is being changed. This analysis focuses on these sections of the rule.

The Regulatory Impact Analysis is very detailed with projection cost/ savings as well as trying to explain further, the changes being finalized. (Page 382)

Executive Summary

The rule states that "On January 20, 2025, President Trump issued a memorandum entitled 'Delivering Emergency Price Relief for American Families and Defeating the Cost-of-Living Crisis.'

"This memorandum instructed all executive departments and agencies to deliver emergency price relief for the American people and to increase the prosperity of the American worker. Health care represents a substantial portion of a family's budget and a tremendous cost to Federal taxpayers. To provide emergent relief from rising *improper* (emphasis added) enrollments and health care costs, we are finalizing several regulatory actions aimed at strengthening the integrity of the Patient Protection and Affordable Care Act (ACA) eligibility and enrollment systems to reduce waste, fraud, and abuse that we proposed in the 2025 Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability proposed rule."

Highlights of Changes

1. Denial of Coverage for Past-Due Premiums

CMS is finalizing revisions to § 147.104(i) that reverse the current policy prohibiting an issuer from denying coverage due to an individual's or employer's failure to pay premiums owed for prior coverage, including by attributing payment of premium for new coverage to past-due premiums.

Under this final rule, issuers may, to the extent permitted by applicable State law, add past-due premium amounts owed to the issuer (or owed to another issuer in the same controlled group) to the initial premium the applicant must pay to effectuate new coverage and not effectuate new coverage if the past-due and initial premium amounts are not paid in full. (Page 11)

2. Definition of "Lawfully Present"

CMS is finalizing modifications to the definition of "lawfully present" currently articulated at § 155.20 and used for the purpose of determining whether a consumer is eligible to enroll in a Qualified Health Plan (QHP) through an Exchange or a Basic Health Program (BHP) in States that elect to operate a BHP.

This change reflects CMS' best view of the 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 premium

tax credit (PTC), advance payments of the premium tax credit (APTC), and cost-sharing reductions (CSRs), and for a BHP in States that elect to operate a BHP”

CMS is finalizing this policy to be applicable upon the effective date of this final rule and beyond.”
(Page 11)

3. Evidentiary Standard for Agent/Broker Termination

CMS is finalizing revisions to § 155.220(g)(2) to require HHS to apply a “preponderance of the evidence” standard of proof for terminations for cause by HHS of an agent’s, broker’s, or web-broker’s Exchange agreements under § 155.220(g)(1). CMS is also finalizing the addition of the definition for “preponderance of the evidence” at § 155.20. CMS says it believes this change will improve transparency in the process for holding agents, brokers, and web-brokers accountable for compliance with applicable law, regulatory requirements, and the terms and conditions of their Exchange agreements. This change is a consumer protection unrelated to the subsidy levels set by Congress. CMS will finalize this standard to be applicable upon the effective date of this final rule and beyond. (Page 12)

4. Failure to File and Reconcile APTC

CMS is finalizing revisions to the failure to file and reconcile (FTR) process at § 155.305(f)(4) to reinstate the 1-year policy in PY 2026 that Exchanges must determine a tax filer ineligible for APTC if: (1) HHS notifies the Exchange that the tax filer (or their spouse if the tax filer is a married couple) received APTC for a prior year for which tax data will be utilized for verification of income, and (2) the tax filer or tax filer’s spouse did not comply with the requirement to file a Federal income tax return and reconcile APTC for that year. (Page 12)

5. Income Inconsistency Verification

CMS is finalizing the removal of § 155.315(f)(7) which requires that applicants receive an automatic 60-day extension to the 90-day period set forth in section 1411(e)(4)(A) of the ACA to provide documentation to verify household income when there is an income inconsistency. Removing § 155.315(f)(7) will adjust APTC payments to individuals who have failed to provide documentation verifying their income attestation within 90 days and further protect them from surprise tax liabilities if they are ineligible. CMS no longer believes the automatic 60-day extension is allowed by statute and is therefore finalizing this change, which will be applicable as of the effective date of this rule and beyond. (Page 13)

6. Changes to Automatic Re-enrollment

CMS is finalizing that, when an enrollee does not submit an application for an updated eligibility determination for the future coverage year (2026) by the last day to select a plan for January 1, 2026 coverage, in accordance with the effective dates specified in § 155.410(f), and the enrollee’s

portion of the premium for the entire policy is zero dollars after application of APTC through the annual redetermination process, Exchanges on the Federal platform must decrease the amount of the APTC applied to the policy such that the remaining monthly premium owed by the enrollee for the entire policy equals \$5 for the first month and for every following month that the enrollee does not confirm their eligibility for APTC. (Page 14)

7. Re-enrollment Hierarchy

CMS is finalizing amendments to the automatic reenrollment hierarchy by removing § 155.335(j)(4), which currently allows Exchanges to move a CSR-eligible enrollee from a bronze QHP and re-enroll them into a silver QHP for an upcoming plan year, if a silver QHP is available in the same product, with the same provider network, and with a lower or equivalent net premium after the application of APTC as the bronze plan into which the enrollee would otherwise have been re-enrolled. (Page 15)

8. Premium Payment Threshold

CMS is temporarily finalizing modifications to § 155.400(g) to pause paragraphs (2) and (3), which establish an option for issuers to implement a fixed-dollar and/or gross percentage-based premium payment threshold, with the following modification: the removal of the fixed-dollar and gross-premium threshold flexibilities will sunset after the completion of one new coverage year, PY 2026, on December 31, 2026. (Page 16)

9. Open Enrollment Period Changes

For benefit years starting January 1, 2027, and beyond, CMS is finalizing a change to the annual Open Enrollment Period (OEP) for coverage through all individual market Exchanges. Rather than specifying November 1 through December 15 as the OEP period as proposed, the final rule at § 155.410(e) provides that the OEP must begin no later than November 1 and end no later than December 31 of the calendar year preceding the benefit year of enrollment. Exchanges have flexibility to determine their specific OEP dates within these guidelines as long as the OEP length does not exceed 9 weeks per § 155.410(e)(5)(ii) and all OEP plan selections are effective on January 1 of the plan year per § 155.410(f)(4). Beginning with benefit year 2027, the dates of the OEP each year for Exchanges operating on the Federal platform will be November 1 through December 15. (Page 17)

10. Monthly Special Enrollment Period (SEP) for Low-Income

CMS is temporarily finalizing the removal of § 155.420(d)(16) and making conforming changes to pause 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 Federal Poverty Level (FPL) through PY 2026. (Page 17)

11. Pre-Enrollment SEP Verifications

CMS is finalizing temporary amendments to § 155.420(g) to enable HHS to reinstate pre-enrollment verification of eligibility of applicants for all categories of individual market SEPs. CMS is further finalizing temporary amendments to § 155.420(g) to require all Exchanges to conduct pre-enrollment verification of eligibility for at least 75 percent of new enrollments through SEPs. Given the primary concern with fully-subsidized plans, CMS is finalizing these proposals through PY 2026, to give the market the opportunity to fully shed improper enrollments resulting from the subsidy expansion. (Page 18)

12. Essential Health Benefits: Exclusion of Sex-Trait Modification Procedures

CMS is finalizing amendments to § 156.115(d) to provide that an issuer of coverage subject to EHB requirements may not provide coverage for specified sex-trait modification procedures as an EHB beginning with PY 2026. In response to comments, CMS is also adding a definition of "specified sex-trait modification procedure" at § 156.400. These changes are effective for PY 2026 and beyond.

13. Premium Adjustment Percentage Methodology

CMS is finalizing updates to the premium adjustment percentage methodology to establish a premium growth measure that comprehensively reflects premium growth in all affected markets for PY 2026 and beyond. (Page 18)

14. Actuarial Value De Minimis Range

Beginning in PY 2026, CMS is finalizing changes to the de minimis thresholds for the Actuarial Value (AV) for plans subject to EHB requirements to +2/-4 percentage points for all individual and small group market plans subject to the AV requirements under the EHB package, other than for expanded bronze plans, for which CMS is finalizing a de minimis range of +5/-4 percentage points, as well as finalizing wider de minimis thresholds for income-based CSR plan variations. These changes are effective for PY 2026 and beyond as they are unrelated to the subsidy level set by Congress, but are "rather important measures to promote affordability and choice." (Page 19)

Impact Estimates of the Final Individual Market Program Integrity Provisions and Accounting Tables (Page 386)

CMS has prepared an accounting statement in Table 10 showing the classification of the impact associated with the provisions of this final rule. CMS has included the undiscounted annual impacts in Table 11.

Table 10

Benefits:	Estimate	Year Dollar	Discount Rate	Period Covered
Annualized Monetized (\$/year)	\$0.2 million	2025	7 percent	2025-2029
Annualized Monetized (\$/year)	\$0.2 million	2025	3 percent	2025-2029
Quantified:				
<ul style="list-style-type: none"> Annual reduction in costs starting in 2025 of \$41,250 in application processing savings for the Federal Government and \$51,352 total for State Exchanges and States that choose to operate BHPs as a result of fewer individuals applying for coverage associated with the policy regarding the definition of "lawfully present." Annual reduction in costs starting in 2025 of \$10,102 total for State Exchanges and \$9,706 for the Federal Government as a result of fewer individuals generating immigration status inconsistencies associated with the policy regarding the definition of "lawfully present." One-time reduction in costs in 2026 of \$92,400 total for States and \$292,000 for the Federal Government as a result of not sending an additional 2-tax year notice to consumers found as failing to file and reconcile. 				
Non-quantified:				
<ul style="list-style-type: none"> Reduction in the risk of adverse selection associated with the policy to permit attribution of payment for new coverage to past-due premium amounts. Reduction in outstanding premium debt amount for enrollees resulting in potential improvement in their financial standing over time and a reduced likelihood of any debt being placed into collections associated with the policy to permit attribution of payment for new coverage to past-due premium amounts. Improved continuous coverage for enrollees and premium collection rates and reduced administrative costs for issuers associated with the policy to permit attribution of payment for new coverage to past-due premium amounts. Increased transparency for agents, brokers, and web-brokers by establishing an evidentiary standard to be used during investigations of agent, broker, or web-broker noncompliance under § 155.220(g)(1)-(3). Reduced potential for APTC recipients to incur large tax liabilities in 2026 as a result of the policies regarding FTR and income verification in this final rule. Simplified operational processes for issuers and the Exchanges associated with the policy regarding the annual OEP length. Improved continuous coverage for the full year and improved risk pool associated with the policy regarding the annual OEP length. Increased issuer participation and improved coverage options, resulting in an improved overall risk pool and reduced overall costs associated with the policy to revise the AV de minimis ranges. Better matches between consumers' coverage preferences and available coverage offerings and a reduction in financial burden due to improper enrollment associated with the policies in this rule. Reduction in improper enrollments of fully-subsidized enrollees by agents, brokers, and web-brokers associated with the policies in this rule. 				

Costs:	Estimate	Year Dollar	Discount Rate	Period Covered
Annualized Monetized (\$/year)	\$132.0 million	2025	7 percent	2025-2029
Annualized Monetized (\$/year)	\$125.6 million	2025	3 percent	2025-2029

Quantified:

- One-time costs in **2025** of \$1,959,299 total for State Exchanges and States operating BHPs and \$96,995 for the Federal Government to make changes to eligibility systems regarding the definition of "lawfully present" finalized in this rule.
- One-time costs in **2025** of \$1,648,915 total for State Exchanges and \$96,995 for the Federal Government to end QHP coverage for individuals no longer considered "lawfully present" due to policies in this final rule.
- One-time costs in **2025** of \$969,950 for the Federal Government and \$19,399,000 total for State Exchanges to develop and code changes to the eligibility systems to evaluate and verify FTR status under the revised FTR process finalized in this rule, plus an additional cost of \$1,939,900 for two additional States that plan to transition to State Exchanges to complete system builds for FTR.
- One-time costs in **2026** of \$969,950 for the Federal Government and \$19,399,000 total for State Exchanges to develop and code changes to the eligibility systems to evaluate and verify FTR status under the 2-year process that this rule would sunset back to.
- One-time costs in **2025** of approximately \$14.7 million total for State Exchanges and \$775,960 for the Federal Government to complete the necessary system changes and other technical changes to implement the policy regarding creating annual income DMIs when applicants attest to income that would qualify the taxpayer as an applicable taxpayer per 26 CFR 1.36B-2(b) but trusted data sources show income below 100 percent of the FPL.
- One-time costs in **2026** of approximately \$14.7 million total for State Exchanges and \$775,960 for the Federal Government to complete the necessary system changes and other technical changes to sunset the policy regarding creating annual income DMIs when applicants attest to income that would qualify the taxpayer as an applicable taxpayer per 26 CFR 1.36B-2(b) but trusted data sources show income below 100 percent of the FPL.
- One-time operating costs of approximately \$20.2 million for the Federal Government and approximately \$12.4 million total for State Exchanges in **2026** to review and verify submitted documents, communicate with consumers, and process DMIs for applicants with incomes below 100 percent of the FPL.
- Increase in burden of \$13,179,400 in **2026** for consumers with incomes below 100 percent of the FPL to fulfill income verification requirements addressing DMIs.
- One-time costs in **2025** of approximately \$16.6 million total for State Exchanges and approximately \$873,000 for the Federal Government to complete the necessary system changes and other technical changes to implement the policy to no longer permit Exchanges to accept an applicant's income attestation without further verification when tax return data is unavailable.
- One-time costs in **2026** of approximately \$16.6 million total for State Exchanges and approximately \$873,000 for the Federal Government to complete the necessary system changes and other technical changes to reimplement the policy to require Exchanges to accept an applicant's income attestation without further verification when tax return data is unavailable.
- Increase in burden of approximately \$102.3 million for the Federal Government and approximately \$62.8 million total for State Exchanges in **2026** to review and verify submitted documents, communicate with consumers, and process DMIs for applicants whose tax return data is unavailable.
- Increase in burden of \$66.8 million in **2026** for consumers whose tax return data is unavailable to fulfill income verification requirements addressing DMIs.
- One-time costs in **2025** of approximately \$9,500,000 total for State Exchanges and approximately \$500,000 for the Federal Government to complete the necessary changes to implement the policy to remove the automatic 60-day extension to resolve income DMIs.

- One-time costs in **2025** of \$969,950 for the Federal Government to complete the necessary system changes and other technical changes for Exchanges on the Federal platform associated with the temporary amendment to the annual eligibility redetermination regulation.
- One-time costs in **2026** of \$969,950 for the Federal Government to complete the necessary system changes and other technical changes for Exchanges on the Federal platform associated with the sunset of the temporary amendment to the annual eligibility redetermination regulation.
- One-time costs in **2026** of \$387,980 for the Federal Government and \$7,371,620 total for State Exchanges associated with the policy to shorten the OEP.
- One-time costs in **2025** of approximately \$390,000 for the Federal Government and approximately \$7 million total for State Exchanges to pause the functionality to grant the 150 percent FPL SEP and make any necessary updates to Exchange eligibility logic systems.
- One-time cost in **2026** of approximately \$390,000 for the Federal Government and approximately \$7 million total for State Exchanges to re-add functionality to grant the 150 percent FPL SEP and make any necessary updates to Exchange eligibility logic systems in accordance with sunset of the policy to pause this SEP until the end of 2026.
- One-time processing cost in **2026** of approximately \$11,675,000 for Exchanges on the Federal platform to comply with finalized pre-enrollment verification requirements.
- One-time labor cost increase for the Federal Government of \$2,902,615 in 2026 associated with the policies regarding SEP verification.
- One-time cost increase for consumers of approximately \$7,048,406 in 2026 associated with the policies regarding SEP verification.
- One-time cost in **2025** of \$2,973,300 to the Federal Government to develop and code changes associated with the policies regarding SEP verification.
- Regulatory review costs of \$15,493,869 for interested parties to review and analyze this final rule in **2025**.

Non-quantified:

- Total reduced annual enrollment between 725,000 and 1,800,000 individuals in PY 2026, including:
 - Reduced annual QHP enrollment of 10,000 and annual BHP enrollment of 1,000 associated with the policy to exclude DACA recipients from the definition of “lawfully present” used to determine eligibility for enrollment in a QHP through an Exchange, for APTC and CSRs, and for a BHP in States that operate BHPs.
 - Potential increase in the number of people who owe past-due premiums who may be deterred from enrolling in new coverage due to a higher initial premium payment associated with the policy to permit attribution of payment for new coverage to past-due premium amounts.
 - Potential loss of coverage for PY 2026 only due to non-payment of premiums for some automatically re-enrolled, fully-subsidized enrollees associated with the annual eligibility redetermination provision, if these enrollees do not submit an application for an updated eligibility determination and subsequently experience a decrease in the amount of APTC applied to their policy such that the remaining monthly premium owed by the enrollee for the entire policy equals \$5 for the first month and for every following month that the enrollee does not confirm or update the eligibility determination, and fail to make payment of the premium amount due.
 - Reduced annual enrollment by 80,000 beginning in 2026 due to decreases in PTC subsidies for enrollees, based on an assumption that the Department of the Treasury and the IRS will adopt the use of the same premium measure finalized for the calculation of the premium adjustment percentage in this rule for purposes of calculating the indexing of the PTC applicable percentage and the required contribution percentage under section 36B of the Code.
- Small negative impact on the individual market risk pool associated with the policy to exclude DACA recipients from the definition of “lawfully present” for purposes of enrolling in a QHP offered through an Exchange, APTC, PTC, CSRs, or BHP

coverage in States that elect to operate a BHP, as well as the return to the FTR 1-year policy for QHPs offered on an Exchange, which is likely offset by the improvement in the risk pool as a result of the reduced premiums anticipated to result from this final rule.

- Potential costs to the Federal Government and to States to provide limited Medicaid coverage for the treatment of an emergency medical condition for DACA recipients who have an emergency medical condition and meet all other Medicaid eligibility requirements in their State, applicable to those DACA recipients who would become uninsured due to the policy regarding the definition of “lawfully present.”
- Potential increase in costs and medical debt for individuals who are deterred from enrolling due to a higher initial premium payment, which could in turn lead to increased costs incurred by hospitals and municipalities associated with the policy to permit attribution of payment for new coverage to past-due premium amount.
- Potential costs to State governments and private hospitals in the form of charity care for individuals who become uninsured as a result of the policies in this final rule.
- Potential increase in Federal and State Medicaid expenditures by enrolling more people in Medicaid who would otherwise have enrolled in APTC-subsidized QHP coverage due to the policy regarding income verification for individuals with incomes below 100 percent of the FPL.
- Time costs to enrollees who would be automatically re-enrolled in their QHP with a \$0 premium after application of APTC to submit an application for an updated eligibility determination to the Exchanges on the Federal platform associated with the annual eligibility redetermination provision for PY 2026 only.
- Costs to the Federal Government, State Exchanges, and issuers for outreach activities associated with the shortened OEP.
- Enrollment for 293,073 enrollees potentially delayed for 1-3 days for SEP verification.

Transfers:	Low	High	Year Dollar	Discount Rate	Period Covered
Annualized Monetized (\$/year)	-\$3.8 billion	-\$3.9 billion	2025	7 percent	2025-2029
Annualized Monetized (\$/year)	-\$3.7 billion	-\$3.8 billion	2025	3 percent	2025-2029

Quantified:

- Reduced annual transfers from the Federal Government to issuers of \$34 million in APTC payments and \$3.2 million in BHP payments associated with the policy to exclude DACA recipients from the definition of “lawfully present” for purposes of enrolling in a QHP offered through an Exchange, APTC, PTC, CSRs, or BHP coverage in States that elect to operate a BHP, beginning in **2026**.
- Reduced one-time APTC transfers from the Federal Government to issuers of up to \$1.28 billion associated with the policies regarding FTR in **2026**.
- Annual reduction in APTC transfers from the Federal Government to issuers of \$266 million beginning in **2025** for households across all Exchanges who receive fewer months of APTC due to no longer receiving an automatic 60 days of additional time to resolve their income DMI.
- Reduction in APTC transfers from the Federal Government to issuers of \$191 million in **2026** for consumers across all Exchanges who receive fewer months of APTC due to reinstatement of DMIs where households attest to income that would qualify the tax payer as an applicable taxpayer per 26 CFR 1.36B-2(b) and data sources show income below 100 percent of the FPL.
- Reduction in APTC transfers from the Federal Government to issuers of \$957 million in **2026** for households across all Exchanges who receive fewer months of APTC due to reinstatement of DMIs when IRS data is not available.

- One-time reduction in APTC transfers from the Federal Government to issuers of \$817,571,843 in **2026** associated with the policy regarding premium payment thresholds.
 - Reduction in APTC transfers from the Federal Government to issuers of approximately \$3.4 billion in **2026** associated with the policy to pause the 150 percent FPL SEP, which is anticipated to reduce premiums by 3 to 4 percent.
 - Reduction in APTC transfers from the Federal Government to issuers of approximately \$105.4 million in **2026** associated with the policy to revise pre-enrollment verification requirements for SEPs, associated with a reduction in premiums of approximately 0.5-1.0 percent for PY.
 - Reduced annual transfers from the Federal Government to issuers of between \$1.27 billion and \$1.55 billion in APTC payments beginning in **2026**, assuming that the Department of the Treasury and the IRS will adopt the use of the same premium measure finalized for the calculation of the premium adjustment percentage in this rule for purposes of calculating the indexing of the PTC applicable percentage and the required contribution percentage under section 36B of the Code.
 - Increased annual transfers from large employers to the Federal Government of between \$3 million and \$20 million in Employer Shared Responsibility Payments annually over the period of **2028 to 2030**, based on an assumption that the Department of the Treasury and the IRS will adopt the use of the same premium measure finalized for the calculation of the premium adjustment percentage in this rule for purposes of calculating the indexing of the PTC applicable percentage and the required contribution percentage under section 36B of the Code.
 - Reduced annual APTC transfers from the Federal Government to issuers of approximately \$1.22 billion in **2026**, \$1.28 billion in **2027**, \$1.33 billion in **2028**, and \$1.40 billion in **2029** associated with an estimated 1 percent premium decrease on average for individuals eligible for PTC due to the policy to require individual market silver QHPs to provide an AV between 66-72 percent and associated income-based CSR plan variations to follow a de minimis range of +1/-1.
- Non-quantified:
- Reduction in net Federal PTC spending associated with policy terminations during PY 2026 if enrollees do not pay their portion of the premium and a reduction in improper enrollments occurs due to the temporary annual eligibility redetermination provision.
 - Reduced premiums and APTC cost to the Federal Government associated with the policy regarding the annual OEP length.
 - Decreased premiums for plans that do not cover specified sex-trait modification procedures as an EHB as a result of this final rule.
 - Reduction in commission payments from issuers to agents, brokers, and web-brokers associated with a reduction in improper enrollments of fully-subsidized enrollees by agents, brokers, and web-brokers due to the policies in this final rule.

Table 11

Summary of Undiscounted Annual Impacts Reported in Accounting Table

	2025	2026	2027	2028	2029
Benefits	\$0.1 million	\$0.5 million	\$0.1 million	\$0.1 million	\$0.1 million
Costs	\$234.7 million	\$368.7 million	\$0	\$0	\$0
Transfers – Low	\$0	-\$10.3 billion	-\$3.8 billion	-\$2.1 billion	-\$2.2 billion
Transfers – High	\$0	-\$12.4 billion	-\$3.6 billion	-\$1.4 billion	-\$1.5 billion

Final Thoughts

No matter how CMS says this rule is improving on waste, fraud and abuse, the bottom line is it will remove over a million current beneficiaries from accessing health care.

While the rule appears to address the costs/savings from state plans, the rule will impact providers due to the rise in individuals without any health insurance who present themselves as uninsured.

Finally, the actual regulatory changes only accounts for 16 pages of the rule.

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