Fact Sheets Jun 20, 2025

2025 Marketplace Integrity and Affordability Final Rule

Affordable Care Act Marketplace

Introduction

Today, the Centers for Medicare & Medicaid Services (CMS) issued the "Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability Final Rule," setting standards for the Health Insurance Marketplaces, which connect millions of consumers to Affordable Care Act (ACA) coverage. The rule finalizes additional safeguards to protect consumers from improper enrollments and changes to their health care coverage, as well as establishes standards to ensure the integrity of the ACA Exchanges.

Key finalized policies include revised standards relating to strengthening income verification processes; modifying eligibility redetermination procedures; removing Deferred Action for Childhood Arrivals (DACA) recipients from the definition of "lawfully present" for eligibility and enrollment in Exchanges and Basic Health Program (BHP) coverage in states that elect to operate a BHP; and pre-enrollment verification for special enrollment periods (SEPs) aimed at reducing improper enrollments and improving the risk pool. Additionally, the rule adopts in regulation the evidentiary standard CMS uses to assess whether to terminate an agent's, broker's, or web-broker's Marketplace Agreements for non-compliance; prohibits issuers of coverage subject to essential health benefits (EHB) requirements from providing coverage for specified sex-trait modification procedures as an EHB; revises de minimis thresholds for the actuarial value (AV)

for plans subject to EHB requirements; requires Exchanges to deny eligibility for advance payments of the premium tax credit (APTC) upon a tax filer's failure to reconcile APTC for one year; revises the federally facilitated Exchange automatic reenrollment hierarchy; requires individuals who are automatically re-enrolled in a QHP with a $0 premium and don't confirm their eligibility to pay a $5 monthly premium; changes the rule setting the dates for the annual Open Enrollment Period (OEP); eliminates the SEP for persons with projected annual household incomes at or below 150% of the federal poverty level (FPL); and revises the premium adjustment percentage methodology and related parameters.

In response to COVID-19, ACA premium subsidies were temporarily expanded and provided a larger subsidy to cover the full premium for people with incomes between 100 percent and 150 percent of the federal poverty line. CMS believes this temporary expansion of premium subsidies resulted in conditions that were exploited to improperly gain access to fully-subsidized coverage.

A number of the policies that CMS is finalizing are temporary measures to immediately tamp down on improper enrollments and the improper flow of federal funds. Given the expiration of the enhanced APTC benefits, CMS has also concluded it would be reasonable to accept some risk of future improper enrollments after these policies sunset, in favor of limiting overall disruptions as the market adjusts and sheds holdover improper enrollments.

These and other policies in the final rule are designed to stabilize the risk pool, lower premiums, and reduce improper enrollments with a goal of improving healthcare affordability and access while maintaining fiscal responsibility.

Overview of Finalized Policies

Increasing Consumer Accountability and Continuous Coverage

Satisfaction of Debt for Past-due Premiums

CMS is finalizing the repeal of the rule that prohibits issuers from denying health insurance coverage based on unpaid past-due premiums. Similar to the policy established under the 2017 Market Stabilization Rule and later reversed in the 2023 Payment Notice, this change will permit an issuer, to the extent permitted by applicable State law, to require payment of both the initial and past-due

premium amounts in order to effectuate new coverage. This change will reduce adverse selection and encourage continuous coverage, potentially leading to more stable premiums and fostering a more stable insurance market.

Eliminating Gross Premium Percentage-Based and Fixed-Dollar Premium Payment Thresholds

CMS is finalizing elimination of the fixed-dollar and gross percentage-based premium payment thresholds, allowing issuers to only adopt the net percentage-based threshold. This change will enhance program integrity by better ensuring that consumers are aware of their enrollments, mitigating risk that consumers are enrolled in coverage improperly or without their knowledge, and increasing transparency and accountability in premium payments. As explained above, this provision, along with several other program integrity measures, is being implemented on a temporary basis through PY 2026.

Standardizing the Annual OEP for Individual Market Coverage

CMS is finalizing changes to the annual OEP beginning with the OEP for plan year 2027. This adjustment will apply to both on- and off-Marketplace individual market coverage. The final rule allows all Exchanges flexibility to set their own OEPs within set parameters for timing and duration. Each OEP must start no later than November 1 and end no later than December 31, and the OEP may not exceed 9 calendar weeks. Finally, all enrollments pursuant to Open Enrollment Period must begin on January 1. For Exchanges on the Federal platform, the OEP will run from November 1 through December 15 preceding the coverage year, beginning with the OEP for plan year 2027. This change aims to reduce consumer confusion, align more closely with open enrollment dates for many employer-based health plans, encourage continuous coverage, and reduce the risk of adverse selection from consumers who may otherwise wait to enroll until they need health care services.

Ensuring Subsidies for Eligible Individuals

Affirming Previous Interpretation of "Lawfully Present" Definition

CMS is finalizing amendments to the definition of "lawfully present" to exclude DACA recipients, returning to the interpretation adopted in the 2012 Interim Final

Rule (77 FR 52614). This change will make DACA recipients ineligible to enroll in a Qualified Health Plan (QHP) through the Marketplace, for premium tax credits, APTC, and cost-sharing reductions (CSRs), and for Basic Health Programs (BHPs) in states that elect to operate a BHP, reversing the 2024 DACA Rule. This policy aligns with statutory requirements and ensures that subsidies are reserved for eligible individuals.

Verifying Consumer Income Eligibility for Insurance Affordability Programs

Failure to File and Reconcile

CMS is finalizing the reinstatement of its 2015 policy requiring Exchanges to determine an individual ineligible for APTC if they (or their tax filer) failed to file their federal income taxes and reconcile APTC for one year instead of for two consecutive tax years as implemented in the 2024 Notice of Benefit and Payment Parameters (the 2024 Payment Notice). Under this change, a Marketplace must determine a tax filer ineligible for APTC if (1) CMS notifies the Marketplace that the tax filer or someone in their household received APTC for a prior year for which tax data would be utilized for verification of income, and (2) the tax filer or someone in their household did not comply with the requirement to file a federal income tax return and reconcile APTC for that year. This change will minimize improper enrollments and protect consumers from accumulating large tax liabilities. For the reasons listed above, this policy will sunset at the end of 2026.

60-Day Extension to Resolve Income Inconsistency

CMS is finalizing the removal of the automatic 60-day extension of the statutorily-required 90-day period for resolving income inconsistencies introduced in the 2024 Payment Notice. This change will ensure enrollees verify their incomes on a timely basis within the 90-day window prescribed in statute and reduce the opportunity for enrollees with unverified incomes to receive APTC premiums through the full length of the verification period.

Income Verification When Data Sources Indicate Household Income Less than 100% of the FPL

CMS is finalizing the requirement that Marketplaces generate annual income inconsistencies in certain circumstances when a tax filer's attested projected

annual household income would qualify the taxpayer as an applicable taxpayer according to 26 CFR 1.36B-2(b), while the income data returned by the Internal Revenue Service reports that the tax filer's income is less than 100% of the FPL. This policy will improve program integrity, reduce the burden of APTC on the federal taxpayer, and benefit consumers by ensuring subsidies are appropriately allocated and reducing their risk of improper tax liabilities. CMS is finalizing the requirement through plan year 2026 only.

Income Verification When Tax Data is Unavailable

CMS is finalizing the removal of the requirement that Exchanges accept an applicant's or enrollee's self-attestation of projected annual household income when the Exchange attempts to verify the attested projected annual household income with the IRS, but the IRS confirms there is no such tax return data available. Under this change, Exchanges will be required to verify income with other trusted data sources (if available) and to require applicants to submit documentary evidence or otherwise resolve the income inconsistency. This policy will improve program integrity by reducing the risk of improper enrollments, benefit consumers by helping reduce surprise tax liabilities, and reduce APTC overpayments and expenditures. Consistent with the approach mentioned above, CMS is finalizing the requirement through plan year 2026 only.

Reducing Improper Enrollments through Annual Eligibility Redeterminations and SEPs

Requiring $5 Premium Responsibility

CMS is finalizing modifications to the annual eligibility redetermination process by requiring Marketplaces on the Federal platform to ensure that consumers who are automatically re-enrolled with no premium responsibility following application of APTC and without affirming or updating their eligibility information, are automatically re-enrolled with a $5 monthly premium beginning in plan year 2026. Once consumers confirm or update their information, the $5 monthly bill will be eliminated if they continue to be eligible for a $0 premium after application of APTC. As with all enrollees, they may receive a refund or reduction on the taxes they owe (or may owe) when they file and reconcile their APTC on their federal income tax return. CMS is not finalizing this requirement for State Marketplaces. This policy will reduce improper enrollments in

Marketplaces on the Federal platform and help prevent Marketplace coverage from continuing for consumers who are unaware of their Marketplace enrollments. This change will also benefit consumers by increasing awareness and engagement in their health coverage decisions and reducing the likelihood of surprise tax liabilities. This policy will sunset at the end of the 2026 plan year.

Re-enrollment Hierarchy Standards

CMS is finalizing the repeal of a regulation that allows Marketplaces to automatically re-enroll CSR-eligible bronze QHP enrollees in a silver QHP if the silver QHP is in the same product, has the same provider network, and has a lower or equivalent net premium as the bronze plan into which the enrollee would otherwise have been re-enrolled. State Marketplaces may continue seeking approval from the Secretary to design and conduct their own annual eligibility redetermination process. This policy benefits consumers by respecting consumer choice and reducing confusion caused by changing a consumer's plan from bronze to silver, even when their existing bronze plan remains available. These changes will also decrease any likelihood of unexpected tax liabilities related to re-enrolling bronze enrollees into a silver plan without their knowledge.

Monthly SEP for APTC-Eligible Individuals with Household Incomes at or Below 150% of FPL

CMS is finalizing the repeal of the monthly SEP for individuals with projected household incomes at or below 150% of the FPL, due to concerns over increased unauthorized enrollments and adverse selection risk, as the SEP has been exploited to enroll consumers or change their plans without their knowledge. This policy is effective 60 days after the enactment of the final rule and will help to reduce opportunities for unauthorized enrollments and unauthorized plan switching. As noted above, in response to some commenters' concerns, this provision will be effective only for the 2026 plan year. HHS also clarifies that a change in income is not an Exceptional Circumstance within the meaning of 45 CFR 155.420(d)(9). Thus, Marketplaces may not offer income-based SEPs under this authority.

All Marketplaces Conducting Eligibility Verification for SEPs

CMS is finalizing a requirement that Marketplaces conduct pre-enrollment verification for SEP eligibility beginning plan year 2026 for Marketplaces on the Federal platform, but is not finalizing this requirement for State Marketplaces at this time. The final rule provides that this requirement will sunset for Marketplaces on the Federal platform at the end of the 2026 plan year. For the reasons mentioned above and in the final rule, CMS believes that this approach sufficiently addresses commenters' concerns and will avoid any sustained negative impacts of regulatory efforts to stop improper enrollments in the Marketplaces.

Marketplaces Conducting Eligibility Verification for 75% of New Enrollments through SEPs

CMS is finalizing a rule mandating pre-enrollment eligibility verification for at least 75% of new enrollments through SEPs beginning plan year 2026 for Marketplaces on the Federal platform, with the policy to sunset at the end of the 2026 plan year. HHS is not finalizing this requirement for State Marketplaces at this time to address issues concerning operational feasibility and increased burdens and costs.

Aligning EHB with Benefits Covered by Typical Employer-Sponsored Plans

Prohibiting Coverage of Specified Sex-trait Modification Procedures as an EHB

CMS is finalizing that, effective beginning in plan year 2026, issuers subject to EHB requirements (that is, non-grandfathered individual and small group market plans) may not cover specified sex-trait modification procedures, as an EHB. In the final rule, CMS is also adding a definition of the term "specified sex-trait modification procedure" in response to comments and specifying that certain services would not qualify as a "specified sex-trait modification procedure" under this definition. This policy will not prohibit issuers of coverage subject to EHB requirements from voluntarily covering specified sex-trait modification procedures, nor will it prohibit states from requiring coverage of such services, subject to the rules related to state-mandated benefits at 45 CFR § 155.170. This policy will align EHB with the benefits covered by typical employer-sponsored plans, as required by the applicable statute.

Improving Cost-Sharing, Premium Adjustments, and Plan Options

Premium Adjustment Percentage (PAPI) Methodology

CMS is finalizing updates to the methodology for calculating the premium adjustment percentage to establish a premium growth measure that captures premium changes in both the individual and employer-sponsored insurance markets for the 2026 plan year and beyond. CMS is also finalizing the plan year 2026 maximum annual limitation on cost sharing, reduced maximum annual limitations on cost sharing, and required contribution percentage using the finalized premium adjustment percentage methodology. This policy will ensure these annual adjustments to ACA parameters align more closely with the changes in premium trends in the markets they aim to track.

De Minimis Thresholds

CMS is finalizing widening the de minimis ranges 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. CMS is also finalizing removing from the conditions of QHP certification the de minimis range of +2/0 percentage points for individual market silver QHPs and specifying a de minimis range of +1/-1 percentage points for income-based silver CSR plan variations. This policy will allow for greater flexibility in plan design, providing consumers with increased plan options and lower premiums as issuers adjust plan designs to attract a broader range of enrollees, improving market competition and stability.

Establishing Evidentiary Standard for Termination of Agent, Broker, and Web-Broker Marketplace Agreements for Cause

CMS is finalizing the adoption of a “preponderance of the evidence” standard of proof with respect to issues of fact for HHS to assess whether an agent, broker, or web-broker’s Marketplace Agreement should be terminated due to noncompliance with applicable HHS rules and the terms of their Marketplace Agreements. This change will improve transparency in the process for holding agents, brokers, and web-brokers accountable for compliance with applicable law, regulatory requirements, and their Marketplace Agreements and protect consumers from the impacts of potential noncompliance, including improper enrollments.

Previous Newsroom Article

Next Newsroom Article