

Fact Sheets Mar 10, 2025

2025 Marketplace Integrity and Affordability Proposed Rule

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Introduction

Today, the Centers for Medicare & Medicaid Services (CMS) issued the “Marketplace Integrity and Affordability Proposed Rule” that proposes standards for the Health Insurance Marketplaces, as well as for health insurance issuers, brokers, and agents who connect millions of consumers to Affordable Care Act (ACA) coverage. The rule proposes additional safeguards to protect consumers from improper enrollments and changes to their health care coverage, as well as establish standards to ensure the integrity of the Marketplaces.

Key proposals 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 Marketplace and Basic Health Program (BHP) coverage; and adopting pre-enrollment verification for special enrollment periods (SEPs), aimed at reducing improper enrollments and improving the risk pool. Additionally, the rule proposes to adopt in regulation the evidentiary standard CMS uses to assess whether to terminate an agent’s, broker’s, or web-broker’s Marketplace Agreements for cause; prohibit issuers from providing coverage of sex-trait modifications as an essential health benefit (EHB); revise actuarial value standards for health plans; require Marketplaces to deny eligibility for advance payments of the premium tax credit (APTC) upon a

tax filer's failure to reconcile APTC for one year; revise the automatic reenrollment hierarchy; change the annual Open Enrollment Period (OEP); eliminate the SEP for persons with annual household incomes below 150% of the federal poverty level (FPL); and revise the premium adjustment percentage methodology.

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

View the 2025 Marketplace Integrity and Affordability Proposed Rule (CMS-9884-P) here: <https://www.cms.gov/files/document/MarketplacePIRule2025.pdf>

Overview of Proposals

Increasing Consumer Accountability and Continuous Coverage

Satisfying Debt for Past-Due Premiums

CMS proposes to allow issuers to require payment of past-due premiums before effectuating new coverage, which would adopt a policy similar to one initially established under the 2017 Market Stabilization Rule and later reversed in the 2023 Payment Notice. To the extent permitted by state law, this would permit an issuer to 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. This change is expected to 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 proposes to eliminate the fixed-dollar and gross percentage-based premium payment thresholds, allowing issuers to only adopt the net percentage-based threshold. This change is intended to enhance program integrity by ensuring enrollees pay at least some of the premium owed, reducing the risk of improper enrollments. This proposed policy would mitigate the risk that

consumers are enrolled in coverage improperly or without their knowledge and increase transparency and accountability in premium payments, helping to prevent unintended financial obligations for consumers.

Shortening the Annual Open Enrollment Period for Individual Market Coverage

CMS proposes changing the annual OEP for all individual market coverage to run from November 1 through December 15 preceding the coverage year, instead of through January 15 of the coverage year. This adjustment would apply to both on- and off-Marketplace individual market coverage. This proposal aims to reduce consumer confusion, streamline the enrollment process, 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 otherwise may wait to enroll until they need health care services.

Ensuring Subsidies for Eligible Individuals

Affirming Previous Interpretation of “Lawfully Present” Definition

CMS proposes to amend the definition of “lawfully present” to exclude DACA recipients, realigning with the interpretation set forth in the 2012 Interim Final Rule (77 FR 52614). This change would make DACA recipients ineligible to enroll in a Qualified Health Plan (QHP) through the Marketplace, for premium tax credits, APTC, and cost-sharing reduction (CSRs), and for the BHP in states that elect to operate a BHP, reversing the 2024 DACA Rule. This proposed policy would align with statutory requirements and ensure that subsidies are reserved for eligible individuals.

Verifying Consumer Income Eligibility for Insurance Affordability Programs

Addressing Failure to File and Reconcile

CMS proposes to reinstate its 2015 policy requiring Exchanges to determine an individual ineligible for APTC if they (or their tax filer) failed to file their federal income tax and reconcile APTC for one year, instead of for two consecutive tax years as implemented in the 2024 Payment Notice. Under this proposed change, the 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 tax return and reconcile APTC for that year. This change aims to minimize improper enrollments and protect consumers from accumulating tax liabilities.

Verifying Income When Data Sources Indicate Household Income Less than 100% of the Federal Poverty Level

CMS proposes to require Marketplaces to generate annual income inconsistencies in certain circumstances when a tax filer's attested projected annual household income is equal to or greater than 100% of the FPL and no more than 400% of the FPL, while the income data returned by the Internal Revenue Service (IRS), Social Security Administration, or current income data sources are less than 100% of the FPL. This proposed policy would 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.

Verifying Income When Tax Data is Unavailable

CMS proposes changes to strengthen the verification process for income eligibility by removing the requirement that Marketplaces accept an applicant's or enrollee's self-attestation of projected annual household income when the Marketplace 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. Under this proposal, Marketplaces would be required to verify income with other trusted data sources (if available) and follow the alternative verification process, which requires applicants to submit documentary evidence or otherwise resolve the income inconsistency. This proposed policy would improve program integrity by reducing the risk of improper enrollments, benefit consumers by helping reduce surprise tax liabilities, and reduce annual APTC expenditures.

Stopping Extensions of the Period to Resolve Income Inconsistencies

CMS proposes to remove the 60-day extension of the statutorily-required 90-day period for resolving income inconsistencies, introduced in the 2024 Payment Notice. This change aims to ensure enrollees verify their income on a timelier

basis within the 90-day window prescribed in statute and reduce the opportunity for unverified enrollees to take advantage and keep receiving APTC premiums through the full length of the verification period.

Reducing Improper Enrollments through Annual Eligibility Redeterminations and SEPs

Requiring \$5 Premium Responsibility

CMS proposes to modify the annual eligibility redetermination process by requiring Marketplaces to ensure that consumers who are automatically re-enrolled without affirming or updating their eligibility information, and who would have been automatically re-enrolled in a QHP with a fully subsidized premium after the application of APTC, to instead be automatically re-enrolled with a \$5 monthly premium. Once consumers confirm their eligibility, the \$5 monthly bill could be eliminated. Any premium paid would potentially be rebated to the enrollee when they file and reconcile their APTC on their taxes if they remain eligible for a fully-subsidized premium. This proposed policy would potentially reduce improper enrollments and surprise tax liabilities, benefiting consumers by increasing awareness and engagement in their health coverage decisions, ensuring that their coverage aligns with their current needs and eligibility.

Removing Re-enrollment Hierarchy Standards

CMS proposes to remove the provision of current regulations that allows Marketplaces to automatically re-enroll CSR-eligible enrollees from a bronze to 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. This proposal 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. The proposed changes also decrease the likelihood of unexpected tax liabilities related to re-enrolling bronze enrollees into a silver plan without their knowledge.

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

CMS proposes to remove 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 risks, as the SEP has been exploited by some agents and brokers to enroll consumers without their knowledge. This proposed policy would help to reduce opportunities and incentives for unauthorized enrollments. It would also strengthen and improve the risk pool by reducing adverse selection, which could lead to lower premiums and a more sustainable individual market, ultimately enhancing the affordability and accessibility of health coverage.

Conducting Eligibility Verification for SEPs

CMS proposes to mandate pre-enrollment verification for SEP eligibility across all Marketplaces, including state Marketplaces. This proposed policy would reduce improper enrollments, ensure that only eligible individuals gain coverage during SEPs, and improve the risk pool, increasing market stability and potentially lowering premiums, benefiting consumers.

Conducting Eligibility Verification for 75% of New Enrollments through SEPs

CMS proposes to require that Marketplaces, including state Marketplaces, verify eligibility for at least 75% of new enrollments through SEPs. If the Marketplace is unable to verify the consumer's eligibility for enrollment through the SEP, then the consumer would not be eligible for enrollment through the Marketplace. This proposed policy would ensure more consistent application of eligibility criteria and reduce instances of improper enrollments, which can lead to a more balanced risk pool and potentially lower premiums, benefiting consumers.

Aligning Essential Health Benefit and Employer-Sponsored Benefits

Prohibiting Coverage of Sex-Trait Modification Services on EHB

CMS proposes 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 sex-trait modification services as an EHB. This proposal would not prohibit health plans from voluntarily covering sex-trait modification services; nor would it prohibit states from requiring such services in health plans, subject to the rules related to state-mandated benefits at § 155.170. This

proposed policy aims to align EHBs with typical employer-sponsored benefits, potentially leading to more consistent coverage offerings and clearer definitions of EHBs.

Improving Cost-Sharing, Premium Adjustments, and Plan Options

Updating Premium Adjustment Percentage (PAP) Methodology

CMS proposes to update 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 (ESI) markets, for the 2026 plan year and beyond. CMS also proposes the plan year 2026 maximum annual limitation on cost sharing, reduced maximum annual limitations on cost sharing, and required contribution percentage using the proposed premium adjustment percentage methodology. This proposed policy would ensure these annual adjustments to ACA parameters align more closely with the changes in premium trends they aim to track.

Simplifying De Minimis Thresholds

CMS proposes to widen the de minimis ranges to +2/-4 percentage points for all individual and small group market plans subject to the actuarial value (AV) requirements under the EHB package, other than for expanded bronze plans, for which CMS proposes a de minimis range of +5/-4 percentage points. CMS also proposes 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 proposed policy would allow for greater flexibility in plan design, providing consumers with increased plan options and potentially 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 proposes to adopt in regulation 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 Agreements should be terminated due to

noncompliance and to add a definition of “preponderance of the evidence.” This proposed change would 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.

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