



DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Part 155

[CMS-9873-P]

RIN 0938-AW03

Patient Protection and Affordable Care Act, Exchange Pre-Eligibility Verification

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

ACTION: Proposed rule.

SUMMARY: This proposed rule would implement new requirements specified under the Working Families Tax Cut (WFTC) legislation related to Exchange eligibility and verification. This proposed rule contains related updates to provisions affecting inconsistency periods, inconsistency verification procedures, annual eligibility redeterminations and eligibility redeterminations during the plan year, as well as expanding enrollment methods during the verification process and establishing new coverage effective dates.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, by [INSERT DATE 30 DAYS AFTER DATE OF PUBLICATION IN THE **FEDERAL REGISTER**].

ADDRESSES: In commenting, please refer to file code CMS-9873-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 <https://www.regulations.gov/docket/CMS-2026-3367>. 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-9873-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-9873-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, Jeff.Wu@cms.hhs.gov, Grace Bristol, Grace.Bristol@cms.hhs.gov, or Dan Brown, Daniel.Brown@cms.hhs.gov, for general information.

Leah Nason, Leah.Nason@cms.hhs.gov, or Maria Liddane, Maria.Liddane@cms.hhs.gov, for matters related to eligibility process and annual re-enrollment.

Claire Curtin, Claire.Curtin@cms.hhs.gov, Marisa Beatley, Marisa.Beatley@cms.hhs.gov, or Arshdeep Dhanoa, arshdeep.dhanoa@cms.hhs.gov, for matters related to residency verification.

Grace Platt, Grace.Platt@cms.hhs.gov, Hollynd Boyden, Hollynd.Boyden@cms.hhs.gov,

or Katherine Bentley, Katherine.Bentley2@cms.hhs.gov, for matters related to data matching issues and inconsistency periods.

Mary Evans, Mary.Evans1@cms.hhs.gov, for matters related to family size special enrollment period waiver.

Asfiya Mariam, Asfiya.Mariam@cms.hhs.gov, for matters related to eligibility redeterminations during a benefit year.

Dena Nelson, Dena.Nelson@cms.hhs.gov, or Kathryn Martucci, Kathryn.Martucci@cms.hhs.gov, for matters related to annual pre-open enrollment verification period.

Claire Curtin, Claire.Curtin@cms.hhs.gov, for matters related to family size verification.

Morgan Schonfeld, Morgan.Schonfeld@cms.hhs.gov, or Dan Brown, Daniel.Brown@cms.hhs.gov, for matters related to coverage effective dates.

John Kenna, John.Kenna@cms.hhs.gov, or Marisa Beatley, Marisa.Beatley@cms.hhs.gov, for matters related to pended plan selections.

Nicholas Eckart, Nicholas.Eckart@cms.hhs.gov, for matters related to payment of binder for new enrollments.

Courtney De La Mater, Courtney.DeLaMater@cms.hhs.gov, or Jenny Chen, Jenny.Chen@cms.hhs.gov, for matters related to the approval and establishment of State Exchanges.

Riley Strayer, Riley.Strayer@cms.hhs.gov, for matters related to Collection of Information Requirements and Regulatory Impact Analysis.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All 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 all comments received before the close of the comment period on the following website as soon as possible after they have been

received: <https://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. 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 that 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 CMS in analyzing the comments.

Plain Language Summary: In accordance with 5 U.S.C. 553(b)(4), a plain language summary of this rule may be found at <https://www.regulations.gov/>.

I. Executive Summary

A. Purpose

This proposed rule would update provisions related to Exchange eligibility and verification consistent with new requirements specified under section 71303 of Pub. L. 119-21 (July 4, 2025), which we refer to as the Working Families Tax Cut (WFTC) legislation. We solicit input on ways Exchanges can strengthen certain verifications to promote program integrity while minimizing unnecessary or duplicative administrative burdens to the extent practicable. This proposed rule also contains related updates to provisions affecting inconsistency periods, enrollment options during inconsistency verification procedures, annual eligibility redeterminations and eligibility redeterminations during the plan year. It also expands enrollment methods during the verification process and establishes new effective dates.

B. Summary of Major Provisions

We propose to modify 45 CFR 155.106 to require that the 15-month requirement for a

State to submit its application for HHS’ review and approval be oriented around when a State begins operations as a State Exchange for the pre-open enrollment (pre-OE) verification period, instead of the Open Enrollment period (OEP).

We propose to retain the existing regulatory requirements in § 155.315(d) related to verification of residency. We seek comment on how HHS might strengthen requirements for Exchanges to verify residency in the short and long term to improve program integrity, and ideas on how Exchanges can move away from primarily accepting self-attestation of residency without further verification.

We propose to amend § 155.315(f)(4)(ii) to state that Exchanges would not be able to authorize payment for advance payments of the premium tax credit (APTC) and cost-sharing reductions (CSRs) for applicants who have data matching issues (DMIs) described in § 155.315(c) for citizenship¹ and lawful presence status; § 155.315(d) for residency; § 155.320(b) for non-employer sponsored minimum essential coverage (MEC);² § 155.320(c)(3) for annual household income, family size, and eligible noncitizen status; and § 155.320(d) for employer-sponsored plans, until such DMIs are adjudicated by the Exchange, if otherwise eligible. Additionally, we propose in § 155.315(f)(4)(ii) that the above requirement would not apply if the applicant’s tax household is eligible for a special enrollment period (SEP) described in § 155.420(d)(2)(i) or (ii).

We propose to add new § 155.315(f)(4)(iii) to describe the requirements related to providing APTC and CSRs for enrollees who have reported a change to eligibility criteria during the plan year after an Exchange has completed verification of those same criteria. We also propose to add new § 155.315(f)(4)(iv) to specify that Exchanges would be required to determine

¹ When referring to verification of “citizen” or “citizenship” status in this proposed rule, we are also referring to verification of status as a U.S. National. U.S. Nationals are defined as “A person who, though not a citizen of the United States, owes permanent allegiance to the United States (for example, persons born in American Samoa or Swains Island).” Please see <https://www.uscis.gov/glossary-term/50718>.

² References to minimum essential coverage or MEC throughout this rule may refer to coverage through an employer-sponsored plan or other coverage, such as Medicaid. References to “other MEC” throughout this rule are intended to refer to coverage other than Exchange coverage.

eligibility for APTC and CSRs on behalf of an applicant following successful verification of information as described in proposed new § 155.315(f)(4)(ii) and to establish effective dates of those eligibility determinations or redeterminations. We also propose to add new § 155.315(f)(4)(v) to state that applicants with DMIs unrelated to the information outlined in proposed § 155.315(f)(4)(ii) receive APTC and CSRs during an inconsistency period if otherwise eligible, as currently required. We further propose to add new § 155.315(f)(4)(vi) to move the requirement that a tax filer must acknowledge that any APTC are subject to reconciliation that is already outlined in existing § 155.315(f)(4)(ii). Finally, we propose to amend § 155.315(f)(4)(i) to remove language around proceeding with all other elements of eligibility determination to align with proposed changes to § 155.315(f)(4)(ii).

We propose to retain the existing regulatory requirements at § 155.320(c) related to verification of family size, and we seek comment on how we might strengthen requirements for Exchanges to verify family size to improve program integrity.

We propose to amend § 155.330(f) to specify effective dates for eligibility redeterminations during the plan year. Specifically, we propose that eligibility redeterminations resulting from enrollee-reported changes would be effective on the first day of the month following the eligibility redetermination, unless the enrollee qualifies for certain SEPs. At § 155.330(f)(2), we propose to add cross-references to the newly proposed effective date rules at § 155.315(f)(4)(iv) that apply when an Exchange resolves a consumer's DMI described in § 155.315(f)(4)(ii) or § 155.315(f)(4)(iii)(A). Finally, at § 155.330(f)(3), we propose effective date rules for consumers whose DMIs are expired because they do not submit sufficient documentation.

We propose to amend § 155.335 to require that Exchanges continue redetermining the eligibility of an enrollee on an annual basis but newly require that an Exchange may not redetermine an enrollee eligible for APTC and CSRs for the subsequent plan year unless the enrollee or the enrollee's application filer provides or confirms household income and family

size; U.S. citizenship or status as an eligible noncitizen; eligibility for or enrollment in other MEC; and place of residence for the subsequent plan year on or after August 1 and no later than December 31 of the year preceding the applicable plan year, and the Exchange would be required to attempt to verify the specified eligibility information using the processes in §§ 155.315 and 155.320, including the relevant provisions in those sections regarding DMIs.

We also propose to amend § 155.335(b) to state the annual eligibility redetermination would be effective on the first day of the applicable plan year, and the Exchange would be required to adhere to the existing notification standard for eligibility determinations under § 155.310(g). We propose an exception in instances where an enrollee has an unresolved DMI under § 155.315(f)(4)(ii) as of December 31 of the year preceding the plan year and for whom APTC and CSRs are not provided during the inconsistency period. In these cases, we propose that the redetermination of APTC and CSRs take effect in accordance with §§ 155.315(f)(4)(iv)(A) or 155.330(f)(3), as applicable. We propose to remove § 155.335(c) through (i); redesignate § 155.335(j) as new § 155.335(c); and remove § 155.335(k) through (n).

We propose to modify § 155.400(e) to account for new enrollment requirements proposed in this rule. Specifically, we propose that Exchanges may, and the Federally-facilitated Exchange (FFE) and State-based Exchanges on the Federal platform (SBE-FPs) would be required to, make retroactive enrollments under proposed §§ 155.410(f)(5)(i)(A) and (B), 155.410(f)(ii)(A) and (B), and 155.420(b)(6)(i), subject to the current binder payment rules for retroactive enrollments under § 155.400(e)(1)(iii). We also propose to make conforming amendments at § 155.400(e)(1), including combining current (i) and (ii) as proposed (i), and redesignating current (iii) as proposed (ii).

We propose to add new § 155.400(i) to require that Exchanges permit applicants and enrollees to “pend” their plan selection such that the plan selection would only be sent to the issuer, and qualified health plan (QHP) coverage only becomes effective, after the Exchange determines the applicant or enrollee eligible for APTC and CSRs, as applicable, as described by

§ 155.315(f)(4)(iv).

We propose to add § 155.410(h) to require all Exchanges to provide a pre-OE verification period during which Exchanges would enable consumers to choose to provide certain eligibility information for the subsequent plan year. Exchanges would be required to attempt to verify such information provided. We propose that the pre-OE verification period for all Exchanges begin each year on August 1 and continue until an Exchange's OEP begins.

We propose new effective date rules for pended plan selections made during the annual OEP or during an SEP, in § 155.410(f)(5) and § 155.420(b)(6), respectively. These rules would provide that, in general, if an Exchange resolves all of a consumer's DMIs described in § 155.315(f)(ii) by the 15th of the month following the consumer's otherwise prescribed effective date under § 155.410(f)(5) or § 155.420(b)(6), then the consumer can maintain that coverage effective date. If, however, they do not resolve all of their DMIs by the 15th of the month following their otherwise prescribed effective date, then their coverage effective date would depend on when their DMIs were resolved. If their DMIs were resolved by the 15th of the month, their coverage effective date would be the first of the month of resolution. If their DMIs are resolved between the 16th and the end of the month, then their coverage effective date would be the first of the following month.

We are considering expanding the application submission timeframe described in the SEP at § 155.420(d)(11), which is commonly referred to as the Medicaid denial SEP, and seek comment on this possible change. For this SEP, if a consumer applies for Medicaid and CHIP coverage, either through the Marketplace eligibility application or directly with the State Medicaid or CHIP agency during the OEP and is denied Medicaid and CHIP, the consumer is granted an SEP to gain access to Exchange coverage. Specifically, we seek comment on whether consumers who apply for Medicaid or CHIP during the pre-OE verification period should also be eligible for this SEP, if otherwise eligible.

II. Background

A. Legislative Overview

The Patient Protection and Affordable Care Act (Pub. L. 111-148) was enacted on March 23, 2010. The Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), which amended and revised several provisions of the Patient Protection and Affordable Care Act, was enacted on March 30, 2010. In this proposed rule, these statutes are collectively referred to as the Affordable Care Act.

Section 1311(b) and (c)(6) of the Affordable Care Act outlines provisions for the establishment of Exchanges that facilitate the purchase of insurance coverage by qualified individuals through QHPs during an annual OEP or SEP. Section 1401 of the Affordable Care Act created section 36B of the Internal Revenue Code (Code), which provides for a premium tax credit (PTC) for eligible individuals who enroll in a QHP through an Exchange. Section 1402 of the Affordable Care Act establishes provisions to reduce the cost-sharing obligations of certain eligible individuals enrolled in a QHP offered through an Exchange through the provision of CSRs.

Under section 1411 of the Affordable Care Act, the Secretary of HHS is directed to establish a program for determining whether an individual meets the eligibility standards for enrollment in a QHP through an Exchange, APTC, and CSRs. Section 1411(b) of the Affordable Care Act specifies the information to be provided by applicants for enrollment in QHPs offered through an Exchange, including what is required for applicants seeking APTC and CSRs. This applicant information may include names, addresses, dates of birth, and Social Security Numbers; information about citizenship and immigration status; and, for individuals applying for APTC and CSRs, information about household income, family size, and offers of health coverage from employers. Section 1411(c) of the Affordable Care Act requires Exchanges to submit certain applicant information to specified data sources for verification of its accuracy. Section 1411(c)(4) of the Affordable Care Act generally requires verifications of certain

applicant information to be performed electronically using online systems. However, section 1411(c)(4)(B) of the Affordable Care Act grants HHS flexibility to modify the methods of such verifications to reduce administrative costs and burden on applicants, and section 1411(d) of the Affordable Care Act delegates to HHS responsibility for the manner in which certain other verifications are completed.

Consistent with the requirements of section 1411 of the Affordable Care Act, when an applicant applies through an Exchange, they attest to information on the application, such as their citizenship or immigration status, and their household's expected annual income. As part of the application process, Exchanges check trusted data sources to determine if application information is reasonably compatible with information from those data sources. In cases where the information is not reasonably compatible or data is unavailable, generally the applicant will receive notification of a data matching issue (DMI). Consistent with additional requirements of section 1411(e) described below, the applicant will have 90 or 95 days to resolve the DMI by submitting requested documentation. The applicant will be provided 95 days for document submission for DMIs related to the verification of citizenship or immigration status. Throughout this proposed rule, we refer to this 90/95-day period as an "inconsistency period," and we refer to instances where an applicant has an inconsistency as the applicant having a DMI.

Section 1411(e)(2)(A) of the Affordable Care Act establishes that when certain information has been verified, an applicant becomes eligible to enroll in a QHP through an Exchange, and for APTC and CSRs, as applicable. Section 1411(e)(3) of the Affordable Care Act specifies the process Exchanges must follow when applicants have a DMI related to citizenship or immigration status by referencing section 1902(ee) of the Social Security Act. In the March 27, 2012 **Federal Register** (77 FR 18310) (Exchange Establishment Rule), we interpreted this to require the Exchange to notify applicants of their DMI and provide them an opportunity to submit evidence to verify their information within 95 days from the date the notice is received. In the Exchange Establishment Rule, we also interpreted section 1411(e)(3) of

the Affordable Care Act as requiring Exchanges to make eligibility determinations on the basis of information provided on the application during an inconsistency period related to citizenship or immigration status.

Similarly, section 1411(e)(4)(B)(i) of the Affordable Care Act requires that Exchanges make eligibility determinations on the basis of information provided on the application during an inconsistency period related to information other than citizenship or immigration status. This means that applicants with a DMI may be able to enroll in a QHP and receive APTC and CSRs during an inconsistency period, if eligible based on the information provided on their application. Section 1411(e)(4) specifies the process Exchanges must follow when applicants have DMIs, other than those related to citizenship or immigration status, including notifying applicants and providing them an opportunity to submit evidence to verify their information within 90-day inconsistency periods.

Under section 36B of the Code, a taxpayer is only allowed a PTC for months that are coverage months for the taxpayer or other individuals in the taxpayer's family (a taxpayer's family consists of the taxpayer, the taxpayer's spouse if filing a joint tax return, and the taxpayer's tax dependents). Section 71303(a) of the WFTC legislation amends section 36B of the Code to provide additional requirements before a month can be a coverage month, effective for tax years beginning after December 31, 2027.³ Effective January 1, 2028, section 36B(c)(5)(A) of the Code provides that a month is generally not a coverage month for an enrollee in a QHP unless an Exchange "verifies", "using applicable enrollment information that shall be provided or verified by the applicant," the enrollee's eligibility to enroll in a QHP through an Exchange and, to the extent relevant, for APTC for the coverage for that month. In this proposed rule, we use the term "confirm" as a synonym to "verify" when referring to the requirement in section 36B(c)(5)(A) of the Code that information shall be "verified by the applicant." We reserve the term "verify" to describe the section 36B(c)(5)(A) of the Code requirement for Exchanges to

³ See section 71303(c) of the WFTC legislation.

verify eligibility. This terminology avoids confusion throughout this proposed rule about which subject of the statute (that is, “the Exchange” or “the applicant”) is the subject of the term “verify.” Section 36B(c)(5)(B) of the Code provides, “applicable enrollment information” referenced in subsection (c)(5)(A) includes, to the extent relevant: (i) household income and family size of the enrollee, (ii) whether the enrollee is an eligible alien, (iii) any health coverage status or eligibility for coverage, (iv) the enrollee’s place of residence, and (v) such other information as may be determined by the Secretary of the Treasury (in consultation with the Secretary of HHS) as necessary to the verification prescribed under section 36B(c)(5)(A) of the Code.

Section 36B(c)(5)(C) of the Code allows months that begin before the verification required by section 36B(c)(5)(A) of the Code to be considered coverage months if an Exchange completes the required verification for those months. Section 36B(c)(5)(D) of the Code provides that a consumer must not be treated as ineligible to enroll in a QHP solely for failing to meet the requirements of section 36B(c)(5) of the Code for a month. Section 36B(c)(5)(E) of the Code delegates to the Secretary of the Treasury authority to waive the verification requirements of section 36B(c)(5)(A) of the Code for individuals who enroll in a QHP during an SEP granted due to a change in family size.

Section 71303(b) of the WFTC legislation added new section 36B(c)(3)(A)(ii) of the Code. This change modifies the definition of QHP for the purpose of section 36B of the Code. Specifically, it excludes from the definition of QHP any plan that is enrolled in through an Exchange that does not provide a process through which any consumer may verify their household income and eligibility for QHP enrollment for the following plan year. This process must be in place no later than August 1, 2027 (and by August 1 for each subsequent year) to ensure applicants and current enrollees in QHP coverage who are seeking QHP coverage with APTC for plan year (PY) 2028 and subsequent years remain eligible for PTC and APTC, if otherwise eligible.

Section 71305 of the WFTC legislation removed section 36B(f)(2)(B) of the Code. This change eliminated the limitation on repayment of excess APTC for tax years after December 31, 2025.

III. Provisions of the Proposed Regulations

A. Part 155 – Exchange Establishment Standards and Other Related Standards Under the Affordable Care Act

1. Election to Operate an Exchange after 2014 (§ 155.106)

We propose to amend § 155.106(a)(2) to require an Exchange submitting a Blueprint application to do so at least 15 months prior to the date on which it proposes to begin its pre-OE verification period instead of at least 15 months prior to the date on which it proposes to begin its OEP. In section III.A.9.c. of this proposed rule, we are proposing to add § 155.410(h) to require that all Exchanges permit consumers to provide eligibility information to Exchanges for the upcoming plan year prior to the beginning of the OEP each year, beginning on August 1, 2027, for PY 2028 and August 1 of each subsequent year. Accordingly, we have considered the implication of the new proposed pre-OE verification period on our current requirements and process for approval of States currently utilizing the Federal platform, as an FFE or SBE-FP, that wish to establish a State Exchange.

As part of the State Exchange establishment process under 45 CFR part 155, subpart B, we currently require at § 155.106(a)(2) that any State on the Federal platform that intends to establish and operate a State Exchange must submit its Exchange Blueprint application to HHS for review and approval 15 months prior to when the State intends to begin OEP operations as a State Exchange. The State Exchange Blueprint continues to serve as a vehicle for a State to document its progress toward implementing its intended Exchange operational model. HHS approves a State's Exchange Blueprint Application and subsequently provides approval for a State to operate a State Exchange, based upon a State meeting the State Exchange implementation requirements noted in the Blueprint Application.

Under the proposed pre-OE verification period requirement, the proposed pre-OE verification period would immediately precede the OEP. Accordingly, an Exchange would not only need to be responsible for its OEP activities but would also need to be responsible for the proposed pre-OE verification period activities. We are of the view that a State that is in the process of establishing a State Exchange should be responsible for its pre-OE verification activities as well as its OEP activities, since eligibility determinations made during the pre-OE period also would relate to eligibility for enrollment in the following plan year. We therefore determined that a State that is in the process of establishing a State Exchange should be ready to do so by the beginning of the pre-OE verification period, instead of by OEP, as currently required. As such, in HHS' State Exchange Blueprint application review and State Exchange approval process, we would need to account for assessing the readiness of a transitioning State Exchange to conduct the proposed pre-OE verification period functions for the August 1 timeframe. HHS' existing review and approval timeline has been oriented around the first OEP for a transitioning State Exchange. This is when a new State Exchange becomes operational (that is, "goes live") and accordingly, HHS notifies a transitioning State Exchange of its decision prior to the OEP start date. HHS' decision is based on a 15-month period of time that HHS needs to sufficiently assess the readiness of a transitioning State Exchange to operate its own Exchange platform and perform the essential functions of an Exchange and allow for a sufficient period of time for HHS to then remove the transitioning State Exchange and its State Medicaid agency from the Federal Exchange platform. Due to the August 1 timeframe associated with this new proposal that needs to be included into the State Exchange readiness assessment, the overall timeline for HHS' review and assessment of State Exchange functionality would need to be moved up so that notification to a transitioning State Exchange of HHS' decision occurs earlier than August 1, rather than prior to the start of the OEP, since the start of the pre-OE verification period would be the new date for when an approved transitioning State Exchange first becomes operational.

Accordingly, in conjunction with the proposed addition of § 155.410(h), we are proposing to modify § 155.106 to provide that a State seeking to operate as a State Exchange would be required to submit its Blueprint application 15 months before the date it proposes to begin its pre-OE verification period, rather than the date it proposes to begin its OEP. We are of the view that this rule, if finalized, would not materially burden States, as any State offering an FFE or SBE-FP that is considering establishing a State Exchange, and that has not yet submitted a State Exchange Blueprint application to HHS, would have sufficient time after the release of the final rule to include the new pre-OE verification period requirements into their planning and decision-making leading up to submitting a State Exchange Blueprint application and establishing a State Exchange. Building the pre-OE verification period in tandem with the initial OEP may require some more start-up effort for a State newly establishing a State Exchange, in comparison to an initial OEP only, but we are of the view that this would be minimal and less burdensome overall than if a State were to first establish an OEP as a State Exchange and then subsequently build out the pre-OE verification period as a State Exchange.

We seek comment on this proposal.

2. Definitions and General Standards for Eligibility Determination (§ 155.300)

We propose a non-substantive edit to update a cross reference in § 155.300(c)(2) from § 155.315(f)(4)(ii) through 155.315(f)(4)(vi). We make this proposal because elsewhere in this rule we propose to move the content of § 155.315(f)(4)(ii)—which describes an attestation for APTC reconciliation—to § 155.315(f)(4)(vi). This proposal is intended to ensure that the meaning of § 155.300(c)(2) remains the same.

We seek comment on this proposal.

3. Eligibility Process (§ 155.310)

We propose to add new cross references to § 155.310(f) to account for new effective dates proposed in this rule. The proposed revisions to § 155.310(f) would require Exchanges to implement determinations of a consumer's eligibility for enrollment in a QHP through the

Exchange, for APTC, and for CSRs, as applicable, in accordance with the effective date rules specified in other subsections of part 155. Currently, § 155.310(f)(1) requires that Exchanges make initial eligibility determinations in accordance with the dates specified in §§ 155.410(c) and (f) and 155.420(b), and § 155.310(f)(2) requires that Exchanges make redeterminations in accordance with the dates specified in § 155.330(f) and (i), as applicable.

First, we propose to update § 155.310(f)(1), regarding effective dates for initial eligibility determinations, so that it also cross-references proposed § 155.315(f)(4)(iv). As described in detail in section III.A.4.b.iv. of this proposed rule, we propose at § 155.315(f)(4)(iv) new effective date rules that would apply to certain initial eligibility determinations for consumers who resolve DMIs described in proposed § 155.315(f)(4)(ii). This additional cross-reference ensures that § 155.310(f)(1) includes a complete list of the places within part 155 where effective dates for initial eligibility determinations would be specified.

Second, we propose to update a cross-reference currently at § 155.310(f)(2), regarding eligibility redeterminations. Specifically, we propose to update the current cross-reference from § 155.335(i) to § 155.335(b). This is a technical update that is needed because, as part of our proposed updates to § 155.335 described in detail in section III.A.7. of this proposed rule, the proposed effective dates for annual redeterminations would be covered in proposed § 155.335(b). As a result, this proposed update is needed to ensure that the cross-reference in § 155.310(f)(2) remains accurate.

We seek comment on this proposal.

4. Verification Process Related to Eligibility for Enrollment in a QHP through the Exchange (§ 155.315)

a. Verification of Residency

We are not proposing any changes to the existing regulatory requirements in § 155.315(d) related to verification of residency for the reasons described further in this section. However, we are considering the feasibility of new residency verification requirements and are seeking

comment on whether the existing requirements to verify residency should be updated in the final rule or in future rulemaking to reflect advancements in technology and the availability of new data sources or alternative verification methods. We acknowledge that historically, verifying residency has been challenging for Exchanges due to a variety of reasons that we discuss in this section, however, we are seeking comment on whether there are ways to overcome these past challenges to allow Exchanges to begin to transition from primarily accepting an applicant's self-attestation of residency without verification, except in limited circumstances where an Exchange has no other option.

Since the establishment of the Exchanges in 2014, the landscape has changed significantly, and, due to challenges Exchanges have faced over time, we have reevaluated our position that permitting Exchanges to accept an applicant's attestation of residency without further verification may no longer be appropriate and a risk to Exchange program integrity. We hold this view because of the increased number of unauthorized enrollments of consumers in Exchange coverage by agents, brokers, and web-brokers, achieved in part through inaccurate residency attestations. Therefore, we seek comment on how 1) Exchanges can move away from primarily accepting self-attestation of residency without further electronic or manual verification to an alternative verification method or procedure; 2) how Exchanges can potentially strengthen requirements to verify residency, including new methods that Exchanges might employ in the short and long term to improve program integrity; and 3) whether the final rule should require Exchanges to adopt such methods so that accepting self-attestation of residency is limited to circumstances where there is truly no other option for an Exchange to electronically or manually verify residency. We may finalize one or more of the approaches discussed in this section rather than retaining the existing requirements at § 155.315(d), or consider alternative approaches suggested by commenters for future rulemaking, if necessary. We acknowledge that any residency verification method discussed in this section would require a period of implementation that is likely not feasible to complete in time for PY 2028. Thus, we additionally solicit

comment, particularly from State Exchanges, on the anticipated time that would be needed to implement any such residency verification methods. When providing comments, we also welcome robust solutions that take into consideration ongoing operational costs for States, the Federal Government, and Exchanges.

To be eligible for enrollment in a QHP, an applicant or enrollee must reside in the State where an Exchange is established per section 1312(f) of the Affordable Care Act, and § 155.305(a)(3) specifies the residency requirements an applicant or enrollee must meet to be eligible for enrollment in a QHP. Generally, with some exceptions, an applicant or enrollee who is age 21 or over and not living in an institution meets the residency requirements if the applicant or enrollee 1) is living and intends to reside in the service area of the Exchange; or 2) is living and has entered into a job commitment or is seeking employment in the service area of the Exchange. An applicant or enrollee under age 21 and not living in an institution generally meets the residency requirements if they 1) reside in the service area of the Exchange; or 2) reside with a parent or caretaker who has met the residency standard for the service area of the Exchange. In addition, applicants or enrollees are not required to have a fixed address to meet the residency requirements; however, they must live in the State where they are applying for coverage with the intent to reside in that State. This is a critical protection for individuals experiencing homelessness or housing instability.

Section 1411 of the Affordable Care Act does not specify the data source or verification method that the Exchanges must use to verify residency. Therefore, under section 1411(d) of the Affordable Care Act, the Secretary of HHS has broad authority to specify any appropriate manner of verification for Exchanges to verify the residency requirements so long as it is accurate and appropriate. Generally, as outlined in § 155.315(d), if information provided by an applicant regarding residency is reasonably compatible with other information provided by the individual or in the records of the Exchange, an Exchange may either verify information with an electronic data source that is sufficiently current and accurate and minimizes administrative costs

and burdens, or by accepting the applicant or enrollee's attestation without further electronic or manual verification. If the information provided by the applicant or the enrollee regarding residency is not reasonably compatible with other information provided by the individual or in the records of the Exchange, the Exchange is required to verify information with an electronic data source that is sufficiently current and accurate and minimizes administrative costs and burdens. If the information provided by the applicant or enrollee does not match the information returned via the approved data source, then a DMI is created in accordance with § 155.315(f).

Currently, we have not identified any single data source to verify residency for the FFE and SBE-FPs that is current, accurate, and minimizes administrative costs and burdens. Using the flexibility provided in section 1411 of the Affordable Care Act, we have implemented operations for the FFE and SBE-FPs to validate that the address provided by an Exchange applicant or enrollee is a real address, but it does not validate that the applicant or enrollee actually resides at that address. This validation process requires the applicant or enrollee to provide a home address on their Exchange application. Once the address is provided, the FFE or SBE-FP confirms whether the home address is within the service area of the Exchange where the applicant or enrollee is applying for coverage. The FFE or SBE-FP then attempts to validate the home address to ensure it exists by checking United States Postal Service (USPS) records, and the applicant or enrollee is prompted to either agree with their provided home address or accept a corrected address from USPS records. Address validation provides HHS with benefits such as better data quality and assurance that mail is delivered to a real address, which reduces downstream administrative costs associated with incorrect addresses. However, because it does not validate that an applicant lives at a specified address and given our ongoing concerns regarding unauthorized or potentially fraudulent enrollments, we are of the view that address validation is not enough and relying on self-attestation without further verification, is a program integrity risk and should only be reserved for instances where Exchanges have no other option to verify residency.

Over the years, we have explored options to successfully verify residency for applicants or enrollees applying for Exchange coverage and identified several challenges. The first challenge relates to the lack of available data sources that are current, accurate, and would minimize administrative burden. Historically, we have considered data sources such as a single database that an Exchange could directly query to verify information, similar to how Exchanges connect with Social Security Administration (SSA) to verify Social Security Numbers (SSNs). We have also considered verification services provided by third-party companies that generally use multiple data sources or have their own proprietary verification product or method to verify residency. This is similar to the optional Verify Current Income Hub (or “Hub”) service Exchanges may use to verify a consumer’s projected household income. As we noted earlier in this section, there is no data source or other verification method mentioned in the statute for the verification of residency, although the Secretary of HHS may specify one as needed. This means that to implement a stronger process for residency verification, we would need to identify a suitable data source (or multiple ones), verification service, or another process to meaningfully verify a consumer’s residency, as well as create a DMI process to resolve verifications for any consumers for whom we cannot verify residency through either a data source or a verification service.

We are of the view that States and State Exchanges generally are better positioned to verify residency for insurance affordability programs such as Medicaid and CHIP and for QHP coverage because they have access to a variety of State data that could be leveraged to verify residency. For example, States and State Exchanges likely have access to data sources specific to their State, such as the State Directory of New Hires or quarterly wage and unemployment insurance data from State workforce agencies (the underlying data that is reported in the National Directory of New Hires (NDNH)), which are currently unavailable to Exchanges on the Federal platform, in addition to casework conducted in their State at the local level.

Another challenge to verifying residency is that we would need to determine which

document(s) would be acceptable to successfully verify an applicant or enrollee's residency in accordance with § 155.315(f), when any approved data source could not do so. Certain populations may be harder than others to verify through documentation, such as consumers living with roommates, consumers who sublease, or consumers who move frequently. If we require a new residency verification process, and we continue to be unable to electronically verify residency for many applicants or enrollees, Exchanges would have to establish a DMI process for residency to manually verify residency through document submission for many applicants or enrollees. As a result, total DMI volumes would increase, and could lead to increasing operational costs for Exchanges.

After exploring the challenges related to implementing residency verification, we considered several potential approaches to adjust residency verification for applicants or enrollees applying for Exchange coverage with APTC and CSRs. The first approach we considered was imposing additional residency verification for all Exchange consumers. In 2024, we conducted an address matching pilot with LexisNexis to determine the feasibility and accuracy of using that verification service for residency verification. This pilot was limited to Exchanges on the Federal platform. During the pilot, we found that data was only available for about half of the pilot population, likely due to consumers who move frequently or do not update their addresses in a timely manner after a move. Based on the pilot and past experience with DMIs, we estimate that about half of all Exchange applicants or enrollees would receive a DMI and be required to submit documentation to verify their residency, due to the lack of data available for verifying residency. Ultimately, we determined that the low rate of data matching combined with the potential costs of using the LexisNexis service did not meet the regulatory standard for using LexisNexis as a data source.

Another approach we considered to verify residency for all Exchange applicants was contracting with the IRS, a data broker, or both, to develop a Hub service that could verify residency. From our research, we determined that, like our pilot with LexisNexis, any of the

available data brokers or government agencies that could create a Hub service to verify residency would likely encounter similar coverage rates and result in a large portion of consumers receiving residency DMIs.

A third approach we considered was a risk-based approach to target applications with a higher risk of insurance fraud. Based on our own experience, residency fraud on the FFE is largely driven by instances of residential health care providers, frequently associated with sober living facilities, working with unlicensed agents (known as “body brokers”) to direct consumers to misrepresent their State of residence so that the provider receives greater compensation from a plan with more generous out-of-network benefits. This type of residency fraud typically occurs in States where QHP issuers offer more generous out-of-network benefits, usually in States that are large geographically but have a small population. This fraud has been identified when QHP issuers have requested QHP rescissions⁴ due to the applicant’s or enrollee’s misrepresentation of their State of residence. We have also identified other factors that could signal an application has a higher fraud risk including mailing addresses outside of the State in which an applicant or enrollee is applying for coverage, or applications in States with high rates of fraud. However, we cannot identify enrollments resulting from transactions with “body broker” agents directly and efficiently. We estimate that to be able to adequately identify such enrollments, we would need to use a broad sampling methodology that casts a very wide net, such as verifying the enrollments of entire States to uncover instances of fraudulent activity. This would be costly and does not solve the challenges Exchanges would still face regarding lack of reliable data sources to use in a risk-based verification approach, or the challenges consumers might face to secure suitable documentation to prove their residency, examples of which are discussed above. Therefore, we concluded that a risk-based approach may not be the best approach either, but we welcome comment from interested parties, in particular States and State Exchanges to share their experiences, if they have tried implementing risk-based approaches.

⁴ In accordance with § 147.128.

We are of the view that there may be additional solutions, such as leveraging federated identity (ID) verification sources, that can reasonably verify a consumer's provided address. Such solutions provide Exchanges with a higher degree of assurance as addresses are associated with applicants who have verified their identities through standards-based identity proofing mechanisms. Similar to how other Federal agencies use federated ID verification sources to link a claimed identity with a real individual, we are of the view that Exchanges could leverage such verification methods to verify both identity and residency at once and may alleviate many of the challenges Exchanges have faced in the past with limited coverage or out-of-date data sources. Furthermore, because federated ID verification sources create a unique digital identity tied to a specific individual, we are of the view that this could reduce potential fraudulent activities and create more trust in the self-attestations of residency that applicants with verified identities provide on their applications. We are also of the view that this verification method would deter bad actors from pursuing some insurance fraud schemes. This solution could operate in addition to the address validation checks that the FFE and SBE-FPs conduct today to ensure that the provided address is standardized and deliverable. We are considering requiring Exchanges to use federated ID verification and invite comments on its use as a residency verification source.

Additionally, recognizing that availability of data between States and Exchanges is a challenge, we are also interested in exploring the idea of mutual data sharing between States and Exchanges, to the extent permitted under applicable law, to alleviate the challenges States and Exchanges all face regarding residency verification. One avenue to achieve such mutual data exchange could be through the Hub, whereby States and State Exchanges could make available State data sources through the Hub for all requestors, namely the FFE, SBE-FPs, other State Exchanges, and State Medicaid Agencies, to access. We are of the view that access to more data streams could further mitigate unauthorized enrollments and residency fraud. Therefore, we also seek comment on whether States are able to share their residency data with HHS to facilitate verifications for their State's consumers, as well as any barriers that could prevent States from

sharing data with HHS, such as State law, and whether statutory or regulatory changes in their respective State laws would be necessary for them to be able to do so. We also invite comment on any data quality standards that we should consider to ensure that these data are current, accurate, and minimize administrative costs and burdens. Finally, we seek comment from State Exchanges and State Medicaid agencies about their experiences with verifying residency and any challenges they currently face.

Based on all the considerations laid out in this section, we are of the view that without a more robust residency verification process, the risk of applicants or enrollees, and potentially agent, broker, or web-broker bad actors inappropriately attesting to residing in a State or at a particular address to receive Exchange coverage remains. We want to emphasize that it is imperative, to the extent practical, that Exchanges exercise program integrity measures to discourage potentially fraudulent behavior in this area and that is why we are considering options for requiring new methods of residency verification, such as by using federated ID verification and are seeking comment from interested parties on other potential data sources that might be more economical for States and/or the Federal Government to procure.

At this time, we do not propose changes to the current regulatory requirements regarding verification of residency as outlined in § 155.315(d); however, we may instead require new methods of residency verification and are exploring options for Exchanges to strengthen residency verification using these new methods or through improving historically difficult to use data sources. We are using this proposed rule to solicit additional ideas for consideration to inform the final rule and potentially future policy and regulatory changes. We also seek comment on any additional Exchange operational updates that could be done in the near term for residency verification that could ultimately strengthen program integrity while protecting Exchange risk pools.

We seek comment on these proposed plans and invite interested parties to share their experiences with residency verification, including challenges, risk for residency fraud, feasibility

of other verification approaches or methods such as risk-based approaches, and cost/budget impacts.

b. DMIs

We propose to amend § 155.315(f)(4)(ii) to state that Exchanges would generally not be permitted to authorize payment for APTC and CSRs for applicants who have DMIs described in § 155.315(c) for citizenship status or lawful presence status; § 155.315(d) for residency; § 155.320(b) for eligibility for MEC other than through an employer sponsored plan; § 155.320(c)(3) for annual household income, family size, and eligible noncitizen status; and § 155.320(d) for enrollment in an eligible employer-sponsored plan and eligibility for qualifying coverage in an eligible employer-sponsored plan, until such DMIs are adjudicated and applicants are determined eligible for APTC and CSRs, as applicable. We also propose in § 155.315(f)(4)(ii) to exempt those who qualify for an SEP due to a change in family size as described under § 155.420(d)(2) from the verification requirements described in proposed new § 155.315(f)(4)(ii), which is described in section III.A.4.c. of this proposed rule.

Additionally, we propose to add § 155.315(f)(4)(iii) to establish the requirements related to providing APTC and CSRs during inconsistency periods described in § 155.315(f)(4)(ii) created from an eligibility redetermination when the information related to the DMIs described in § 155.315(f)(4)(ii) was previously verified for the plan year. This is described in section III.A.4.d. of this proposed rule. We also propose to add new § 155.315(f)(4)(iv) to establish that Exchanges would be required to determine eligibility for APTC and CSRs on behalf of an applicant following successful verification of information as described in proposed new § 155.315(f)(4)(ii), and to establish new effective dates of those eligibility determinations or redeterminations. We additionally propose to add § 155.315(f)(4)(v) specifying that applicants with DMIs other than those described in proposed § 155.315(f)(4)(ii) are able to receive APTC and CSRs during the inconsistency period if eligible based on the information provided on their application. Finally, we propose to amend § 155.315(f)(4)(i) to remove language around

proceeding with all other elements of eligibility determination to align with proposed changes to § 155.315(f)(4)(ii).

(i) Statutory and Regulatory Overview

(A) Applicable enrollment information

As described in section II.A. of this proposed rule, under section 36B(c) of the Code, a taxpayer is only allowed PTC for months that are considered coverage months for the taxpayer or other individuals in the taxpayer's family. Section 71303(a) of the WFTC legislation added section 36B(c)(5) of the Code to provide that, starting in 2028, a month is generally not a coverage month for an enrollee in a QHP for any month that an Exchange fails to verify specific criteria related to the enrollee's eligibility to enroll in a QHP through an Exchange and, to the extent relevant, for APTC for the coverage for that month, referred to as "applicable enrollment information". The specific criteria include household income and family size, whether the individual is an eligible alien, any health coverage status or eligibility for coverage, place of residence, and other information determined by the Secretary of the Treasury in consultation with the Secretary of HHS. As outlined in the Department of Treasury's Premium Tax Credit proposed rule (PTC proposed rule), "any health coverage status or eligibility for coverage" refers to "minimum essential coverage" as interpreted by the Department of Treasury (91 FR 65499), which aligns with § 155.20 which says the term MEC has the meaning given in section 5000A(f) of the Code. Additionally, as explained later in this section, the Secretary of the Treasury has proposed regulatory changes to include lawful presence status and citizenship in addition to the explicitly referenced criteria.

(B) Application to APTC and CSRs

Section 1411 of the Affordable Care Act outlines the requirements for establishing eligibility for QHP⁵ and APTC. We interpret section 1411(a)(2)(A) of the Affordable Care Act

⁵ When referencing QHP in this rule, this specifically refers to coverage in an individual market QHP offered

as requiring Exchanges to make APTC eligibility determinations consistent with the PTC eligibility requirements of 36B of the Code,⁶ including for whether an applicant has met the requirements for a month to be considered a coverage month. Therefore, we read section 71303(a) of the WFTC legislation as requiring verification of specified information before APTC can be paid.

Additionally, section 1402 of the Affordable Care Act outlines requirements for CSRs. Specifically, section 1402(g)(2) states that CSRs cannot be allowed for months that are not coverage months for PTCs as defined under section 36(B) of the Code. Given this, we have also interpreted section 1402(g)(2) of the Affordable Care Act to require that an Exchange only provide CSRs for months that qualify as coverage months under section 36B of the Code, and therefore we find the new eligibility limitations on APTC also apply to Exchange determinations of eligibility for CSRs. As discussed later in this rule, there is an exception for CSRs for American Indians and Alaska Natives (AI/AN) that are not income based.

Therefore, given the changes outlined under section 36B of the Code as amended by section 71303(a) of the WFTC legislation as discussed above, we propose that Exchanges can no longer provide APTC and CSRs for any month before an Exchange “verifies, using applicable enrollment information that shall be provided or verified by the applicant” the individual’s eligibility to enroll in a QHP through an Exchange and for APTC. Throughout this rule, “DMI(s) related to applicable enrollment information” means a DMI for at least one of the specific criteria set forth in proposed § 155.315(f)(4)(ii), as described in section III.A.4.b.i.A. of this proposed rule. For an applicant who is not eligible for the family size SEP waiver as described in section III.A.4.c. of this proposed rule, or for an eligibility redetermination during the plan year as described in section III.A.4.d. of this proposed rule, such a DMI prevents an Exchange from

through an Exchange. In accordance with section 1411(a)(1) of the Affordable Care Act, Exchange eligibility requirements described in this proposed rule would generally not apply to QHPs that are offered outside an Exchange.

⁶ See, for example, in the 2027 Payment Notice proposed rule (91 FR 6351).

providing or increasing any APTC and CSR amounts during the inconsistency period. The term therefore excludes DMI for one of the specific criteria set forth in proposed § 155.315(f)(4)(ii) when the family size SEP waiver applies, as discussed in section III.A.4.c. of this proposed rule, as well as during an eligibility redetermination during the plan year, as discussed in section III.A.4.d. of this proposed rule.

(C) Requirement to Verify

Section 71303(a) of the WFTC legislation does not specify how eligibility for enrollment in a QHP and for APTC and CSRs, as applicable, must be “verif[ied]” using applicable enrollment information. However, section 1411 of the Affordable Care Act specifies detailed requirements for verifying eligibility for enrollment in a QHP and for APTC and CSRs, which have been codified in §§ 155.315 and 155.320. Therefore, we read the term “verify” in section 71303(a) of the WFTC legislation to refer to verification procedures under section 1411 of the Affordable Care Act, its implementing regulations, and any successor or other applicable regulations as may be issued.

Under section 1411 of the Affordable Care Act, applicants attest to information related to eligibility for enrollment in a QHP offered through the Exchange and APTC and CSRs, if applicable, on their Exchange application, and Exchanges verify the attestations. For most eligibility information, Exchanges must verify an applicant’s attestation by comparing it to a trusted data source. For other eligibility information, Exchanges may accept attestation without verification, although as discussed in other sections of this proposed rule (section III.A.4.a. for residency verification and III.A.5. for family size verification) we are considering adopting requirements that would further limit instances where verification by self-attestation would be permissible, unless there are no available data sources that are current, accurate, and minimize administrative costs or burdens, or methods to verify the information provided by a consumer. We describe the verification process for different eligibility information below.

Section 1411 of the Affordable Care Act requires that Exchanges verify certain

information through specific government entities: the Commissioner of Social Security and Secretary of Homeland Security for citizenship and lawfully present immigration status, and, beginning in PY 2027, eligible noncitizen⁷ statuses in section 1411(c)(2), and the Secretary of Treasury for household income and family size in section 1411(c)(3). Per current Exchange procedures, for citizenship and immigration statuses under § 155.315(c), and, beginning in PY 2027, eligible noncitizen status⁸ and household income under § 155.320(c)(3), Exchanges are generally required to request information from the specified trusted data sources, as applicable, to verify the applicant's attestation. In the case of family size, current requirements in § 155.320(c)(3)(i) state that Exchanges are generally permitted to accept the applicant's attestation without further verification when family size cannot be verified through the IRS.⁹ As described further in section III.A.5. of this proposed rule, we are interested in comments related to the future state of family size verification.

For other criteria, such as residency, enrollment in an eligible employer-sponsored plan and eligibility for qualifying coverage in an eligible employer-sponsored plan, and eligibility for MEC other than through an eligible employer-sponsored plan, the Affordable Care Act does not prescribe specific data sources to use, and instead section 1411(d) of the Affordable Care Act gives the Secretary of HHS the flexibility to determine the verification process in any manner the secretary determines appropriate.¹⁰ For residency under § 155.315(d), Exchanges generally may accept attestation or may use any electronic data sources that have been approved by HHS based on evidence that they are sufficiently available, current, accurate, and minimize administrative costs and burden. Currently, the FFE, SBE-FPs, and some State Exchanges, accept attestation, while other State Exchanges utilize data sources to request information and attempt to verify

⁷ See 91 FR 29601-29602.

⁸ See 91 FR 29601-29602.

⁹ The verification requirements for eligible noncitizen status, household income, and family size apply only to applicants applying for financial assistance.

¹⁰ The verification requirements for enrollment in an eligible employer-sponsored plan and eligibility for qualifying coverage in an eligible employer-sponsored plan, and eligibility for MEC other than through an eligible employer-sponsored plan apply only to applicants applying for financial assistance.

attestation. However, we are interested in exploring potential ways for Exchanges to move away from primarily accepting self-attestation without further verification to verify residency through a trusted data source or documentation in the near future. Further information is available in section III.A.4.a. of this proposed rule.

For enrollment in an eligible employer-sponsored plan and eligibility for qualifying coverage in an eligible employer-sponsored plan, under § 155.320(d), Exchanges must use: (1) any electronic data sources that HHS has approved as being sufficiently current, accurate, and minimizing administrative burden; (2) any electronic data sources that provide data on coverage based on Federal employment, and (3) any data available for the Small Business Health Options Program (SHOP) in the applicable State. HHS has not approved any data sources as being sufficiently current, accurate, and minimizing administrative burden. Therefore, Exchanges are only required to verify eligibility and enrollment in employer-sponsored coverage electronically with the Office of Personnel Management (OPM) and the applicable SHOP. If those data sources indicate that the consumer is enrolled in eligible employer-sponsored plan or eligible for qualifying coverage in an eligible employer-sponsored plan, then the consumer receives a DMI and is required to submit documentation to verify their attested information. Finally, if an Exchange does not expect to obtain data from at least one electronic data source that has been approved by HHS to be sufficiently current, accurate, and minimize administrative burden, it may follow an alternative process described in paragraph (d)(4)(i). Specifically, an Exchange may use a risk-based approach to verify whether an applicant is enrolled in an eligible employer-sponsored plan or eligible for qualifying coverage in an eligible employer-sponsored plan. If an Exchange's assessment of risk shows a low risk for inappropriate payment of APTC or CSRs, an Exchange is permitted to accept an applicant's attestation without further verification.

In the HHS Notice of Benefit and Payment Parameters for 2023 final rule (2023 Payment Notice) (87 FR 27208, 27270 and 27271), we provided guidance that if Exchanges do not have access to an approved data source that provides accurate and up-to-date information regarding

eligibility for or enrollment in coverage offered through an employer and determined through research that the risk of improper eligibility determinations for APTC and CSRs is low, that Exchanges are permitted to accept a consumer's attestation without any further verification. This is the verification procedure that the FFE and SBE-FPs adopted as a risk-based approach since the risk for inappropriate APTC and CSRs was deemed to be low, as discussed in the 2023 Payment Notice. Because we are still of the view that the risk is still low of improper eligibility determinations for APTC and CSRs resulting from attestations regarding eligibility for an employer-sponsored plan and eligibility for qualifying coverage in an eligible employer-sponsored plan, we do not propose any changes to the process for verifying such information. Accordingly, Exchanges are permitted to continue following whatever approved risk-based approach they currently are approved to use by HHS.

Finally, under § 155.320(b), for verification related to eligibility for MEC other than through an eligible employer-sponsored plan, such as Medicaid and Medicare, Exchanges use electronic data sources to verify applicants' attestations.

Regardless of the type of eligibility information, section 1411(e)(3) and (e)(4)(B)(i) of the Affordable Care Act require that, when application information is required to be verified through a trusted data source but cannot be, Exchanges must set a DMI and provide applicants 90 or 95 days (depending on the type of DMI) to provide documentation to resolve the DMI. Exchanges must determine eligibility for QHP coverage and APTC and CSRs based on attested information on the application and provide such coverage and APTC or CSRs, as applicable, during the inconsistency period. Accordingly, in the March 27, 2012, Exchange Establishment Rule (77 FR 18310), we finalized that Exchanges must determine eligibility for APTC and CSRs for applicants based on attested information on the application during an inconsistency period, which was done through adding § 155.315(f)(4). Specifically, § 155.315(f)(4)(i) and (ii) currently require Exchanges to proceed with all other elements of eligibility determination using the applicant's attestation during an inconsistency period and grant QHP eligibility if otherwise

qualified, provided that the applicant attests that they understand their APTC is subject to reconciliation when they file their Federal income taxes. This means that, currently, consumers who receive DMI(s) are deemed eligible for QHP coverage through Exchanges and, if applicable, APTC and CSRs, based on the information on their application while those DMI(s) remain open (as long as the attestation is provided if required).

As set forth in § 155.315(f)(2)(ii), Exchanges can resolve a DMI either when the consumer submits sufficient documentation to verify their attested information or when Exchanges receive updated information from data sources that verifies the attested information. Once a DMI is resolved, the applicant's eligibility is verified, and they can continue receiving QHP coverage through the Exchange and APTC and CSRs as applicable. However, as noted in § 155.315(f)(5), if an Exchange is unable to resolve a DMI within the 90/95-day inconsistency period, an Exchange redetermines eligibility based on information from data sources, typically resulting in a loss of enrollment in QHP coverage or a loss or decrease in APTC and CSRs. In cases of an application with multiple applicants, eligibility is determined for each applicant who has a DMI, with the exception of DMI types that apply at the household level, such as annual household income DMIs, in which case the DMI applies to the entire household. Applicants who update their application during the coverage year and receive an eligibility redetermination follow the same process as outlined above.

While this is the current process, as discussed above, we read section 71303(a) of the WFTC legislation to generally prohibit Exchanges from providing APTC and CSRs for any month before it has verified, using certain specified information, a consumer's eligibility for enrollment in a QHP and for APTC and CSRs, as applicable, for those months. Also as previously mentioned, we read that the requirement to "verif[y]" such information to mean to verify in accordance with section 1411 of the Affordable Care Act and implementing regulations. For citizenship, lawfully present immigration status, eligible noncitizen status, and annual household income, Exchanges must verify an applicant's attestation through a trusted data

source, and if the trusted data source cannot verify the attestation, set a DMI and provide an applicant with a 90/95-day inconsistency period to provide documents to resolve their DMI. Therefore, we read section 71303(a) of the WFTC legislation to prohibit payment of APTC and CSRs for any month before an Exchange verifies an applicant's attestation regarding citizenship, lawfully present immigration status, eligible noncitizen status,¹¹ and annual household income through a trusted data source or, if the applicant's attestation cannot be verified through a trusted data source, until the applicant provides documents to resolve their DMI and they have been determined eligible for APTC and CSRs.

Regarding verification of family size, Exchanges must submit family size information to the Secretary of Treasury for verification. However, per § 155.320(c)(3)(i)(A), if the Secretary of Treasury cannot verify family size, Exchanges may accept an applicant's attestation of family size if the consumer attests that a change in circumstance has occurred or is likely to occur, as long as the data provided by the applicant is reasonably compatible with other information provided about their family. More information regarding family size verification can be found in section III.A.4.c. of this proposed rule.

In contrast, for verification of residency, enrollment in an eligible employer-sponsored plan and eligibility for qualifying coverage in an eligible employer-sponsored plan, and eligibility for MEC other than through an eligible employer-sponsored plan, section 1411(d) of the Affordable Care Act does not specify specific data sources to use. As such, and as explained above, HHS regulations sometimes require attestations about such information to be verified through a trusted data source, or, if the trusted data source cannot verify the information, through documentation, and other times permit Exchanges to verify such information through attestation.

Therefore, we read section 71303(a) of the WFTC legislation to prohibit payment of APTC and CSRs for any month before an Exchange verifies residency, enrollment in an eligible employer-sponsored plan and eligibility for qualifying coverage in an eligible employer-

¹¹ PTC proposed rule (91 FR 65498).

sponsored plan, eligibility for MEC other than through an eligible employer-sponsored plan, and family size—however verification is required under section 1411 of the Affordable Care Act, its implementing regulations, and any successor or other applicable regulations as may be issued, and we are exploring further updates to residency and family size verification as outlined further in sections III.A.4.a. and III.A.4.c. of this proposed rule. Additionally, we emphasize that some State Exchanges may have data available to them that are sufficiently current, accurate, minimizes administrative burden, and approved by the Secretary of HHS for usage and therefore may already be setting DMIs for criteria that the Federal Exchange currently does not, and this proposed rule does not limit State Exchanges from setting DMIs in those instances. In summary, when attestations about such information must be verified through a trusted data source or documentation, we read section 71303(a) of the WFTC legislation to prohibit payment of APTC and CSRs until such verification is complete.

As such, we are proposing to amend § 155.315(f) to reflect the new requirement of section 71303(a) of the WFTC legislation. Specifically, we propose in § 155.315(f)(4)(ii) that if an applicant receives a DMI related to the applicable enrollment information, Exchanges would be prohibited from providing APTC and CSRs until those DMIs are adjudicated and the Exchange determines that the applicant is eligible for enrollment in a QHP and for APTC and CSRs, as applicable. In contrast, for a DMI not related to applicable enrollment information, or if a family size SEP waiver applies, as discussed in section III.A.4.c. of this proposed rule, and during eligibility redeterminations during the plan year, as discussed in section III.A.4.d. of this proposed rule, Exchanges would be required to continue payment APTC and CSRs, if otherwise eligible, during an inconsistency period. Specifically, this includes DMIs for AI/AN status.

We acknowledge that section 71303(a) of the WFTC legislation could be read to allow Exchanges to always treat an applicant's information as "verified" such that a month can be considered a "coverage month" if the applicant affirms (that is, attests to) the required information. As previously mentioned, section 71303(a) of the WFTC legislation added section

36B(c)(5)(A) of the Code, effective beginning in 2028, and section 36B(c)(5)(A) states that a coverage month cannot include any month before an Exchange “verifies, using applicable enrollment information that shall be *provided or verified* by the applicant, such individual’s eligibility” to enroll in a QHP or receive APTC. (Emphasis added). Section 71303(a) of the WFTC legislation that added section 36B(c)(5)(B) of the Code, effective beginning in 2028, and section 36B(c)(5)(B) provides that “applicable enrollment information shall include affirmation” of the specified criteria. One could read these provisions together as permitting Exchanges to verify an applicant’s eligibility using only the applicant’s provided affirmation (or attestation) of the enumerated eligibility criteria, rather than using an external data source or submitted documentation. However, as explored further below, we are of the view that this reading of section 71303(a) of the WFTC legislation is implausible.

As discussed previously in this proposed rule, given that the term “verifies” is ambiguous in section 71303 of the WFTC legislation, the statutory language is best read to mean that an Exchange verifies the specified criteria in accordance with the verification procedures articulated in section 1411 of the Affordable Care Act, its implementing regulations, and any successor or other applicable regulations as may be issued.¹² These successor applicable regulations include potential future updates to perform further verification of residency beyond accepting attestation, as described in section III.A.4.a. of this proposed rule. This is supported by the language in section 71303(a) of the WFTC legislation stating that an Exchange must verify eligibility for enrollment in a QHP and for APTC and CSRs, as applicable, using the specified information “provided” or “verified” by the applicant. We read that the terms “provided” and “verified” to refer to the verification procedures under section 1411 of the Affordable Care Act and

¹² We note that neither the current verification processes conducted by Exchanges, nor the proposed verification processes that would be conducted by Exchanges if the proposals in this rule were finalized, would in any way change the obligations of agents, brokers, and web-brokers to comply with the FFE Standards of Conduct at 45 CFR 155.220(j), including the obligation to provide the FFEs with correct information, and document that eligibility application information has been reviewed by and confirmed to be accurate by the consumer or their authorized representative prior to submission to the Exchange. *See* 45 CFR 155.220(j)(2)(ii). These obligations extend to agents, brokers, and web-brokers assisting consumers on the SBE-FPs. *See* 45 CFR 155.220(l).

implementing regulations which, as explained previously in this proposed rule, allow Exchanges to verify some eligibility criteria using an attestation provided by the applicant and which require further verification from a trusted data source or documentation in the case of other eligibility criteria. Given that the WFTC legislation does not prescribe any new specific methods of verification, we read it as permitting existing verification processes to continue, except that generally a month may not be a coverage month, and therefore no APTC or CSRs can be provided, until verification under section 1411 of the Affordable Care Act, its implementing regulations, and any successor or other applicable regulations as may be issued, is complete. As previously stated, we are requesting comments on whether updates should be made to the verification of residency as defined under § 155.315(d), which is discussed further in section III.A.4.a. of this proposed rule, and the verification of family size as defined under § 155.320(c)(3), which is discussed further in section III.A.5. of this proposed rule.

Additionally, we are of the view that reading section 71303(a) of the WFTC legislation to permit Exchanges to treat all attested information as verified would, effectively, render the changes under section 71303(a) meaningless as, under current rules, that reading would result in a month likely being considered a coverage month based on just an applicant's attestation of eligibility criteria. Therefore, we are of the view that the intention of the WFTC legislation is to rely on existing verification procedures in section 1411 of the Affordable Care Act, its implementing regulations, and any successor or other applicable regulations as may be issued for purposes of verification under section 71303 of the WFTC legislation.

In summary, due to the new requirements in section 71303 of the WFTC legislation, we are of the view that APTC and CSRs cannot be provided to consumers when eligibility for enrollment in a QHP and for APTC and CSRs, as applicable, have not been verified using the specified criteria in accordance with section 1411 of the Affordable Care Act and implementing regulations—which allows certain information to be verified through attestation and which requires certain other information to be verified by either a trusted data source or documentation

provided by the applicant during an inconsistency period. Therefore, we have determined that significant changes to the verification procedures in § 155.315(f)(4) related to providing APTC and CSRs during an inconsistency period are required. These changes are described below.

(ii) APTC and CSRs during Certain Inconsistency Periods (§ 155.315(f)(4)(ii))

As described in section II.A. of this proposed rule, section 71303(a) of the WFTC legislation describes the specific criteria that must be verified before a month is considered a coverage month. These criteria are household income and family size; whether an individual is an eligible alien; any health coverage status or eligibility for coverage; place of residence; and other information as may be determined by the Secretary of Treasury, in consultation with the Secretary of HHS, as necessary to the verification described in section 36B(c)(5)(A) of the Code, as added by section 71303(a) of the WFTC legislation. Per the PTC proposed rule (91 FR 65498), the Secretary of the Treasury proposes to include citizenship and lawful presence status as criteria under section 36B(c)(5)(B)(v) of the Code that must be verified before a month can be a coverage month. Therefore, in light of the Secretary of Treasury's PTC proposed rule, and our interpretation of section 1411(a)(2)(A) of the Affordable Care Act that Exchanges must make APTC eligibility determinations consistent with the PTC eligibility requirements of section 36B of the Code, we are proposing to require citizenship and lawful presence be verified before Exchanges can provide APTC or CSRs.

Accordingly, when an applicant receives a DMI for annual household income and family size, citizenship, lawful presence status, eligible noncitizen status, residency, eligibility for MEC other than through an employer-sponsored plan, or eligibility for or enrollment in employer-sponsored coverage,¹³ we propose that any DMI generated for these applicable enrollment information would need to be adjudicated by an Exchange (that is, the applicant's eligibility for APTC and CSRs must be verified) before APTC or CSRs can be paid for the applicant for any

¹³ Consistent with the Secretary of Treasury in the PTC proposed rule (91 FR 65499), we interpret "any health coverage status or eligibility for coverage" to refer to "minimum essential coverage" as described in § 155.20.

months, including prior months as described later in section III.A.4.b.iv. of this proposed rule. We note that although lawful presence status is included in these criteria and would be required to be verified before APTC and CSRs are provided, we do not expect this would have a functional impact on Exchanges. Beginning in PY 2027, only consumers who have eligible noncitizen status as defined in § 155.20 are eligible for APTC and CSRs. Eligible noncitizens are a subset of lawfully present noncitizens, specifically individuals who have been lawfully admitted for permanent residence (sometimes referred to as a “lawful permanent resident” or “green card holder”), those who have been granted the status of Cuban and Haitian entrant as defined in section 501(e) of the Refugee Education Assistance Act of 1980, and those who are lawfully residing in the United States in accordance with the Compacts of Free Association (COFA) as defined at 8 U.S.C. 1612(b)(2)(G) (sometimes referred to as a “COFA migrant”). We anticipate that, given Exchange operations, the functional impact of the proposed requirement to verify lawful presence status would be handled through the verification of eligible noncitizen status per § 155.320(c)(3)(ix).

Notwithstanding the above, as mentioned earlier in this section, section 71303(a) of the WFTC legislation provides for an exception to the verification requirements described in section 36B(c)(5)(A) of the Code. Specifically, section 71303(a) of the WFTC legislation adds section 36B(c)(5)(E) of the Code, which allows the Secretary of Treasury to waive the verification requirements (for coverage month purposes) for applicants who enroll during an SEP based on a change in the applicant’s family size, including current enrollees who are eligible to enroll due to a family size SEP. As a result, and consistent with the PTC proposed rule (91 FR 65494), we are proposing in § 155.315(f)(4)(ii) to require Exchanges to provide this exception for SEPs where an applicant, or a member of their household, has a qualifying life event related to a change in family size, such as birth or adoption of a child. Further information about this proposal is provided in section III.A.4.c. of this proposed rule and in the PTC proposed rule (91 FR 65499). In addition, as discussed in section III.A.4.d. of this proposed rule, we are also proposing

modified procedures when an eligibility redetermination results in DMIs related to applicable enrollment information that was previously verified for the plan year.

Additionally, for the reasons described in section III.A.4.b.i. of this proposed rule, we are not proposing to amend the Exchanges verification requirements except to prohibit (in most situations) payment of APTC and CSRs before eligibility for enrollment in a QHP and for APTC and CSRs, as applicable, have been verified in accordance with section 1411 of the Affordable Care Act, its implementing regulations, and any successor or other applicable regulations as may be issued is complete. We discuss below in more detail the current process for verifying enrollment in an eligible employer-sponsored plan and eligibility for qualifying coverage in an eligible employer-sponsored plan. Additionally, we are requesting comments on whether updates should be made to the verification of residency as defined under § 155.315(d) and discussed further in section III.A.4.a. of this proposed rule and the verification of family size as defined under § 155.320(c)(3) and discussed further in section III.A.5. of this proposed rule.

In addition, while section 71303 of the WFTC legislation does not specifically mention CSRs, we are also of the view that Exchanges are required to withhold CSRs during the specified inconsistency periods. As mentioned earlier in this section, section 1402(g)(2) of the Affordable Care Act, which is codified in § 155.305(g), outlines that applicants are only eligible for CSRs for months in which they are also eligible for APTC and meet all other CSR eligibility criteria. Therefore, we propose to require Exchanges to withhold CSRs prior to an Exchange having verified eligibility for enrollment in a QHP and for APTC and CSRs using the applicable information required under section 36B(c)(5) of the Code.

One important clarification is that the special cost-sharing rule specific to AI/AN applicants specifically for items and services provided through the Indian Health Service, an Indian Tribe, Tribal Organization, an Urban Indian Organization, or through referrals under contracted health services (hereinafter “Indian health providers”) under section 1402(d)(2) of the Affordable Care Act, and implemented in § 155.350(b), is not impacted by new requirements in

section 71303 of the WFTC legislation because it is not conditioned on being eligible for APTC. Under § 155.350(b), Exchanges must determine an AI/AN applicant eligible for special cost-sharing described in section 1402(d)(2) of the Affordable Care Act without requiring them to request an eligibility determination for insurance affordability programs in accordance with § 155.310(b). To clarify, an individual who is a member of a Federally recognized tribe or is an ANCSA Corporation shareholder may be subject to cost sharing under the special cost-sharing rule even if they do not apply for any financial assistance (as in, APTC and CSRs) when they apply for QHP coverage through an Exchange or if they apply but are determined ineligible.

In contrast, income-based CSRs that AI/AN applicants may receive are tied to APTC eligibility, as described in § 155.350(a), and therefore would be subject to the requirements proposed in this section. As an example, if a consumer who is a member of a Federally recognized tribe applies for QHP coverage through an Exchange with financial assistance, the Exchange would be required to follow the verification processes outlined in section 1411 of the Affordable Care Act and implementing regulations. In cases where they receive a DMI related to the applicable enrollment information, they would be able to receive cost sharing under the special cost sharing rule for AI/AN individuals for items and services provided through Indian healthcare providers, as previously described, but would not receive income-based CSRs until all DMIs related to the applicable enrollment information are adjudicated and they have been determined eligible for APTC and CSRs.

As an additional point of clarification, while we propose that Exchanges would be prohibited from determining an applicant eligible for APTC and CSRs during an inconsistency period for DMIs related to the applicable enrollment information, we are not proposing to prohibit Exchanges from determining eligibility for enrollment in a QHP during the same period, even if the DMI related to the applicable enrollment information is related to eligibility for enrollment in a QHP (such as citizenship or lawful presence status). Section 71303(a) of the WFTC legislation states that an individual's eligibility to enroll in a QHP and for APTC must be

verified using applicable enrollment information for a month to be considered a “coverage month” under section 36B of the Code. A coverage month is required for APTC and CSRs to be paid but has no bearing on an applicant’s eligibility for enrollment in a QHP. Additionally, section 36B(c)(5)(D) of the Code, as added by section 71303(a) of the WFTC legislation, explicitly states that applicants cannot be treated as ineligible to enroll in a QHP through an Exchange solely for failing to meet the requirements to verify applicable enrollment information as required by section 36B(c)(5)(A) and (B) of the Code.

Therefore, we propose that an applicant would be required to be determined eligible for enrollment in, and may enroll in, a QHP during any period in which the applicant has any DMI, including when the DMI relates to information necessary to determine eligibility for a QHP, such as citizenship or lawful presence status, if otherwise eligible. Accordingly, we only propose a minor conforming edit to § 155.315(f)(4)(i), which would still state that Exchanges must provide eligibility for a QHP if an applicant is otherwise eligible during an inconsistency period. We note that an applicant who enrolls in a QHP during an inconsistency period related to QHP eligibility information must verify such eligibility by the end of their 90-day inconsistency period. If they fail to do so, their QHP enrollment through the Exchange would be terminated.¹⁴

In summary, we propose to amend § 155.315(f)(4)(ii) to state that Exchanges cannot provide APTC and CSRs based on attested information on the application when an applicant has a DMI related to the applicable enrollment information.

(iii) Eligibility Redeterminations during the Plan Year (§ 155.315(f)(4)(iii))

As previously stated, we propose to amend § 155.315(f)(4)(ii), which would prohibit Exchanges from providing APTC and CSRs based on application information during inconsistency periods for DMIs related to the applicable enrollment information. Exchanges

¹⁴ However, failure to meet eligibility requirements for enrollment through the Exchange generally is not a basis for a health insurance issuer to terminate health insurance coverage under the guaranteed renewability requirements of section 2703 of the Public Health Service Act and 45 CFR 147.106. Accordingly, an individual whose Exchange enrollment is terminated for failure to meet Exchange eligibility criteria generally would have a right to renew or continue in force such coverage outside the Exchange.

would, therefore, be prohibited from providing APTC and CSRs during inconsistency periods as they currently do, including for the entire application household in cases of household-level DMIs such as those related to annual income and family size. However, for applicants who submit an application and receive new DMIs after they had previously verified all of the eligibility criteria specified in proposed § 155.315(f)(4)(ii) for the current plan year, we propose to add § 155.315(f)(4)(iii) to permit Exchanges to provide APTC and CSRs during an inconsistency period. This is discussed in detail in section III.A.4.d. of this proposed rule.

(iv) Resolution of DMIs (§ 155.315(f)(4)(iv))

We also propose to add new § 155.315(f)(4)(iv) to establish that Exchanges would be required to determine eligibility for APTC and CSRs on behalf of an applicant following a successful verification of the information described in § 155.315(f)(4)(ii) and to provide effective dates for the eligibility determination. Specifically, these proposed effective dates rules would apply to determinations and redeterminations in two circumstances. First, they would apply to determinations resulting from resolution of DMIs related to applicable enrollment information. Second, they would apply to redeterminations resulting from an applicant resolving all DMIs when the applicant would qualify for a greater amount of APTC than they were receiving during their inconsistency period upon DMI resolution – that is, DMIs described in proposed § 155.315(f)(4)(iii)(A). These rules would apply to the DMIs described in § 155.315(f)(4)(ii) and (iii)(A) because resolution of these DMIs would generally result in changes to a consumer's APTC and CSR eligibility. In contrast, when a DMI described in § 155.315(f)(4)(iii)(B) is resolved, such resolution would instead confirm the consumer's eligibility for the APTC and CSRs, as applicable, that they were already authorized to receive during their inconsistency period based on their attestation, and the amount of APTC and CSRs would remain the same.

We propose in § 155.315(f)(4)(iv)(A) that, if a consumer is already enrolled in a QHP when such DMIs are resolved by an Exchange, an Exchange would generally be required to

implement the resulting APTC and CSR eligibility determination effective the first day of the first month in which all the following criteria are met: (1) an Exchange determined all eligibility criteria described in proposed § 155.315(f)(4)(ii) to be verified for that month, (2) the consumer was enrolled in a QHP on the first day of that month, and (3) the consumer's DMI was generated prior to the first of that month. This would allow APTC and CSRs to be paid prospectively, as well as retroactively, subject to the conditions described. We propose one exception to these rules, for cases where these rules would otherwise result in Exchanges being required to provide APTC for months in the prior coverage year. In these cases, we propose that Exchanges would not provide APTC for months in the prior coverage year, and consumers would instead claim any PTC for which they were eligible on their Federal income tax return.

This proposal would implement section 36B(c)(5)(C) of the Code, which was added by section 71303(a) of the WFTC legislation. Section 36B(c)(5)(C) of the Code provides that a month that begins before completion of the verification prescribed by section 36B(c)(5)(A) of the Code must be treated as a coverage month for an individual if the Exchange verifies (using applicable enrollment information) that the individual is eligible to enroll in a QHP and for APTC. This provision effectively requires an Exchange to provide APTC and CSRs, as applicable, retroactively after verification of applicable enrollment information.¹⁵

Section 36B(c)(2)(A)(i) of the Code requires an individual to be enrolled in a QHP as of the first of a month before the month can be a coverage month. Section 36B(c)(5)(A) of the Code provides, in relevant part, that a coverage month does not include any month that begins before the Exchange verifies an individual's eligibility to enroll in a QHP and for APTC. Accordingly, we propose that the retroactive period would go no further than the first of the month in which all the following conditions are met: an Exchange verified all eligibility criteria described in

¹⁵ As discussed throughout this proposed rule, we interpret section 1411(a)(2) of the Affordable Care Act to require Exchanges to make APTC eligibility determinations consistent with the PTC eligibility requirements of section 36B of the Code, including whether an applicant has met the requirements for a month to be considered a coverage month. Also as previously discussed, we have also interpreted section 1402(g)(2) of the Affordable Care Act to require that an Exchange only provide CSRs for months that qualify as coverage months under section 36B of the Code.

proposed § 155.315(f)(4)(ii), the consumer was enrolled in a QHP on the first day of that month, and the consumer's DMI was generated prior to the first of that month.

First, at § 155.315(f)(4)(iv)(A)(I), we propose that the retroactive period would not extend beyond the first day of the first month for which the Exchange verified all eligibility criteria described in proposed § 155.315(f)(4)(ii). This implements the requirement in section 36B(c)(5)(C) of the Code that a month beginning prior to verification only be considered a coverage month if the Exchange verifies the consumer's eligibility "for such month."

Under this proposal, Exchanges would be required to consider annual household income to be verified for months prior to the resolution of an annual household income DMI. This is because when verifying annual household income, Exchanges are verifying an individual's projected household income for the entire coverage year, and a successful verification therefore indicates that the individual's projection is considered verified for all months of the year unless and until a change is reported.

Exchanges would also be required to consider U.S. citizenship to be verified for months prior to the resolution of a U.S. citizenship DMI, if the consumer submits documents indicating that they are a U.S. citizen by birth, or that they are a naturalized citizen whose naturalization occurred prior to when they provided their attestation of U.S. citizenship to the Exchange. However, if an individual attests on their application that they are a U.S. citizen, receives a DMI, and subsequently submits documents that indicate that they became naturalized in a month following such attestation, then the Exchange would only be required to consider the individual's citizenship verified for the months that the submitted documents indicated that the individual was a U.S. citizen.

Similarly, if an individual attests to lawful presence or eligible noncitizen status, receives a DMI, and subsequently submits documents that indicate that they gained their lawfully present or eligible noncitizen status in a month following such attestation, then the Exchange would only be required to consider the individual's lawful presence or eligible noncitizen status verified for

the months that the submitted documents indicated that the individual was lawfully present or an eligible noncitizen. If the individual submitted documents demonstrating that they gained their lawfully present or eligible noncitizen status in a month prior to their attestation, then the Exchange would be required to consider lawful presence and eligible noncitizen status, as applicable, to be verified for months prior to the resolution of the DMI.

Finally, if an individual attests that they are not eligible for MEC other than through an eligible employer-sponsored plan, receives a DMI, and subsequently submits documents that indicate that they ceased to be eligible for or enrolled in their other MEC in a month following such attestation, then the Exchange would only consider the individual's lack of eligibility for or enrollment in other MEC verified for the months the submitted documents indicated that the individual was not eligible for or enrolled in other MEC. If the individual submitted documents demonstrating that they were ineligible for or not enrolled in other MEC in a month prior to their attestation, then the Exchange would be required to consider this criterion verified for any applicable prior months.

Exchanges would be required to communicate to consumers regarding whether past months were successfully verified, and the impact of this verification outcome on the Exchange's determination of the consumer's APTC and CSR eligibility, via the notification required by § 155.310(g). We note that this notification would be required by § 155.515(a)(2) to include information about appeal rights. Existing regulations at § 155.505(b)(1) specify that applicants and enrollees have the right to appeal an Exchange's eligibility determinations, and we interpret this existing requirement to extend to eligibility determinations made on the basis of an Exchange's assessment regarding whether eligibility criteria were successfully verified for months prior to verification.

We acknowledge that Exchanges would need to make case-by-case determinations to determine whether each eligibility criterion can be considered verified for months occurring prior to verification. We request comment from State Exchanges regarding the feasibility of parsing

whether applicable criteria can be considered verified for specific months as described.

Second, at § 155.315(f)(4)(iv)(A)(2), we propose that the retroactive period for which an Exchange may provide APTC and CSRs would not extend beyond the first day of the first month in which the enrollee is enrolled in a QHP. This is consistent with Section 36B(c)(2)(A)(i) of the Code, which requires an individual to be enrolled in a QHP as of the first of a month before the month can be a coverage month. Rules regarding Exchange enrollment periods and their effective dates are addressed at §§ 155.410 and 155.420, with some modifications proposed in sections III.A.9. and III.A.10. of this proposed rule.

Third, we propose at § 155.315(f)(4)(iv)(A)(3) that the Exchange's determination of an individual's APTC and CSR eligibility following the resolution of their DMIs related to applicable enrollment information may not be effective earlier than when the individual's DMIs were generated. We are proposing this rule to align with Exchanges' existing effective date framework, described at § 155.330(f), under which changes to eligibility are generally¹⁶ implemented prospectively, in relation to when the consumer provides the attestations that produce such changes in eligibility. This proposal that an Exchange's determination of an individual's APTC and CSR eligibility following the resolution of their DMIs may not be effective earlier than when the individual's DMIs were generated ensures consistent effective dates for consumers who verify the applicable enrollment information electronically as compared to those who verify the applicable enrollment information via document submission during their inconsistency period. To illustrate, consider a consumer who does not provide or confirm their eligibility information for the upcoming coverage year, and is re-enrolled in a QHP without APTC or CSRs effective January 1.¹⁷ If that consumer subsequently updates their application on

¹⁶ Changes to eligibility may be implemented retroactively, in relation to when the consumer provides the attestations that produce such changes in eligibility, in the case that a consumer qualifies for an SEP due to gaining a dependent, described at § 155.420(b)(2)(i). However, because consumers who qualify for an SEP due to gaining a dependent would qualify for the waiver described at proposed § 155.315(f)(4)(ii), the effective dates described in this section would not be applicable to them, since the resolution of their DMIs would not produce a change in their APTC or CSR eligibility. These proposed effective date rules therefore would not permit changes in eligibility to take effect prior to when the consumer provided their attestation of a change in circumstance.

¹⁷ See section III.A.7 of this proposed rule for further discussion of annual eligibility redeterminations.

January 10 and their applicable enrollment information are verified in real-time through trusted data sources on that same date, then, under the proposed effective date rules at § 155.330(f)(1), their redetermination of eligibility for APTC and CSRs would take effect prospectively, on February 1. If, instead, the same consumer updates their application on January 5, the Exchange opens a DMI related to the applicable enrollment information on the same date, and the DMI is resolved through document submission on January 10, then the effective date rules proposed in this section apply. Without the proposed policy at § 155.315(f)(4)(iv)(A)(3) – which would require that APTC and CSR eligibility determinations not take effect before the date the DMI was generated – the consumer could qualify for a January 1 effective date for their APTC and CSRs. Specifically, under the rules proposed at § 155.315(f)(4)(iv)(A)(1) and § 155.315(f)(4)(iv)(A)(2), if the information related to the applicant’s DMIs was verified for January, the consumer’s effective date for their APTC and CSRs would be January 1 because they were enrolled in a QHP as of January 1. This would produce different effective dates for APTC and CSRs for consumers who verify electronically versus through documentation on the same date. Proposed § 155.315(f)(4)(iv)(A)(3) would prevent this illogical outcome. Under this proposal, the effective date for the consumer’s APTC and CSR eligibility would be February 1 – consistent with the effective date for the consumer whose eligibility was verified electronically.

Finally, at § 155.315(f)(4)(iv)(A)(4), we propose an exception to the effective date rules proposed at § 155.315(f)(4)(iv)(A)(1) through (3). Specifically, if these rules would result in an APTC and CSR effective date in the prior coverage year, we propose that the Exchange would not be permitted to provide or increase APTC for those months in the prior year. This exception is intended to mitigate tax administration issues and consumer burden that would result if Exchanges provided APTC for a month after the Exchange had already generated a consumer’s Form 1095-A for the coverage year.

Consider the following example. A consumer submits an application to the Exchange on November 15, 2028, and qualifies for an SEP due to a November 30, 2028, loss of MEC. The

consumer selects a plan on November 15, 2028, and in accordance with § 155.420(b)(2)(iv), qualifies for a coverage effective date of December 1, 2028. The consumer has a DMI related to their annual household income for 2028. The consumer chooses to enroll in a QHP effective December 1, 2028, without APTC or CSRs. Subsequently, the consumer submits documents to the Exchange, and the Exchange verifies the consumer's annual household income for 2028 and resolves their DMI on February 1, 2029. Were an exception not applied, under the rules proposed at § 155.315(f)(4)(iv)(A)(I)-(3), the Exchange would be required to provide retroactive APTC, effective December 1, 2028.

This proposed exception is necessary to avoid significant tax administration issues. Exchanges generate Form 1095-A for enrollees in January following the applicable coverage year, which includes information about any APTC paid for each month in the coverage year. If, in the scenario described above, the consumer's Form 1095-A is generated prior to the Exchange's determination on February 1 that the consumer qualifies for APTC for December, the consumer's Form 1095-A would reflect that they were enrolled in a QHP but no APTC was paid for the month of December. Assume the consumer used this Form 1095-A to file their Federal income tax return and claim PTC for the month of December. If, in February, the Exchange then provided APTC for the month of December, the Exchange would need to issue a corrected Form 1095-A, a process that generally takes multiple months. Then, upon receipt of the corrected Form 1095-A, the consumer would have to file an amended 2028 tax return, reduce the December PTC the consumer claimed by the amount of APTC paid for the consumer's December coverage, and include a tax payment equal to the December APTC, plus interest and perhaps penalties, with the 2028 amended return. Instead, if there is no retroactive payment of APTC for December, the consumer would, on the consumer's 2028 tax return, lower his or her tax liability or receive a tax refund for the amount of the December PTC for which the consumer is eligible.

Thus, to alleviate these burdens on Exchanges, consumers, and the IRS, we propose that

Exchanges would not provide or increase APTC for months in prior coverage years. We clarify that this exception applies only to APTC; Exchanges would still be required to increase CSRs for months in prior coverage years if the enrollee is eligible under the rules proposed at § 155.315(f)(4)(iv)(A)(1) through (3). We further clarify that, as proposed, this exception would only prevent Exchanges from providing APTC for months in a prior coverage year in the specific situation where a consumer is enrolled in a QHP and subsequently their DMI described at § 155.315(f)(4)(ii) or (iii)(A) is resolved.

We acknowledge that there are limited additional situations in which Exchanges may already be providing or increasing APTC for months in a prior coverage year, including if a consumer qualifies for an SEP with a retroactive effective date, or in the case of certain appeals. At the FFE, consumers are only able to receive prior year APTC through manual processes, by calling the Marketplace Call Center and having their case reviewed on an individual basis. As a result, we have determined that the current volume of cases where prior-year APTC is permitted is quite low. In contrast, the consumers to whom the effective date rules proposed in this section would apply would be able to use an online, automated process to enroll and to resolve their DMIs, and we therefore expect that the volume of consumers who may qualify for prior year APTC as a result could be quite significant by comparison. Therefore, we are only proposing to prevent Exchanges from providing prior-year APTC in this specific situation, but we seek comment regarding whether this principle should apply in other cases as well.

Regarding the rules proposed at § 155.315(f)(4)(iv)(A), we seek comment from issuers and other interested parties on operational considerations regarding retroactive provision of APTC and CSRs for eligible consumers. Specifically, we understand that providing CSRs for weeks or months prior to DMI resolution may be operationally challenging for issuers and consumers. We understand that, today, correctly re-processing claims that a consumer incurred during a period prior to an Exchange's determination of CSR eligibility often requires a consumer to manually submit, and an issuer to manually process and reimburse, costs incurred

by consumers in the past. We seek comment on these and any other operational considerations.

Finally, at § 155.315(f)(4)(iv)(B), we propose that for consumers who select a plan and elect that it would only become effective once verification requirements are met, as described in section III.A.8.b. of this proposed rule, an Exchange's APTC eligibility determination would be required to be implemented on the same date that the consumer's plan becomes effective.

Proposed effective date rules for such plan selections are described in section III.A.9. of this proposed rule for individuals who make a plan selection during the annual OEP, and in section III.A.10. of this proposed rule for individuals who select a plan during an SEP. This proposal would ensure that, for consumers who elect that their plan only become effective once verification requirements are met, enrollment and APTC would start on the same date, resulting in a clear process for consumers and streamlined communications for Exchanges, as well as ensuring that the consumer does not have a period of unsubsidized coverage.

We seek comment on this proposal. We understand State Exchanges may find it challenging to implement these requirements for PY 2028. Therefore, we specifically seek comment from State Exchanges regarding any risks that State Exchanges would not be able to implement these proposed effective date rules by PY 2028, and whether there are alternative proposals that could achieve similar outcomes while alleviating operational burden.

(v) APTC and CSRs during Other Inconsistency Periods (§ 155.315(f)(4)(v))

We also propose new § 155.315(f)(4)(v) to specify that applicants with DMIs not related to applicable enrollment information would be provided APTC and CSRs based on attested application information, if otherwise eligible, during an inconsistency period. Section 71303(a) of the WFTC legislation provides that no month shall be considered a coverage month until an Exchange verifies, using applicable enrollment information, an individual's eligibility to enroll in a QHP and for APTC. We read this to mean that if an Exchange has failed to verify information that is *not* applicable enrollment information, then section 71303(a) of the WFTC legislation does not apply. Therefore, we propose that if an individual has a DMI not related to

the applicable enrollment information, an Exchange would be required to follow the existing process established in section 1411 of the Affordable Care Act and implementing regulations and provide APTC and CSRs, as applicable, during the inconsistency period. An example of a DMI not related to the applicable enrollment information is verification of AI/AN status, as discussed in § 155.350(c).

(vi) Conclusion

Overall, subject to certain exceptions described in sections III.A.4.c. and III.A.4.d. of this proposed rule, these proposed changes would prevent applicants from receiving APTC and CSRs during inconsistency periods when an applicant has a DMI related to the applicable enrollment information.

We seek comment on these proposals.

c. Family Size Special Enrollment Period Waiver (§ 155.315(f)(4)(ii))

In accordance with section 1.36B-3(c)(6)(ii) of the PTC proposed rule (91 FR 65499), we propose to amend § 155.315(f)(4)(ii) to require Exchanges to ensure that APTC and CSRs, as applicable, are provided on behalf of an applicant based on the information attested on the application for coverage during an inconsistency period described in § 155.315(f)(4)(ii), when the applicant, or a member of the applicant's tax household, is eligible to enroll during an SEP in accordance with § 155.420(d)(2)(i), also known as the birth, adoption, and marriage SEP, or § 155.420(d)(2)(ii), also known as the loss of a dependent (or consideration as a dependent) through divorce, legal separation or death SEP. We refer to these SEPs collectively as the "change in family size SEPs" throughout this section. These SEPs would be subject to the requirement to verify 75 percent of enrollments via SEPs that were finalized in the HHS Notice of Benefit and Payment Parameters for 2027 (2027 Payment Notice) (97 FR 29526).¹⁸ In addition, we propose adding § 155.315(f)(4)(iii)(A) that also explains that current enrollees who

¹⁸ As of the date of this publication, this policy has been stayed by an order issued on July 16, 2026, in the *City of Columbus et al. v. Kennedy et al.* (1:26-cv-02215).

are eligible to re-enroll during an SEP in accordance with § 155.420(d)(2)(i) or (ii) are also eligible for this exception to ensure that APTC and CSRs are provided based on the information attested to on their updated application.

Section 71303(a) of the WFTC legislation adds section 36B(c)(5)(E) of the Code, which explicitly allows for a waiver of the verification requirement in section 36B(c)(5)(A) of the Code, at the option of the Secretary of the Treasury, in the case of an individual who enrolls in a QHP during an SEP due to a change in family size. We propose to require Exchanges to adopt this exception set forth in proposed Treasury Reg. § 1.36B-3(c)(6)(ii) (91 FR 65499). Adopting this exception would allow Exchanges to consider a month to be a coverage month prior to verification of the requirements set forth in the proposed § 1.36B-3(c)(6) (91 FR 65494). Under § 1.36B-3(a) (91 FR 65494), for a consumer to be eligible for PTC for that month, a month is required to be a coverage month. Furthermore, as mentioned earlier, we interpret section 1411(a)(2) of the Affordable Care Act as requiring Exchanges to make APTC and CSR eligibility determinations consistent with the PTC eligibility requirements of section 36B of the Code. Taking those two requirements together, we propose to require Exchanges to adopt this exception such that a month may be a coverage month, and APTC and CSRs may be paid, prior to verifying the information in proposed Treasury Reg. § 1.36B-3(c)(6)(i) (91 FR 65494), which is the same as the information proposed in § 155.315(f)(4)(ii) of this proposed rule, if an individual, either is eligible to newly enroll or re-enroll in a QHP during an SEP that is triggered by a change in family size as allowed at § 155.420(d)(2)(i) or (ii). If finalized, this exception would allow a consumer who qualifies for a change in family size SEP to be determined eligible for APTC and CSRs (if otherwise eligible) based on attested application information during an inconsistency period, as they are under current rules. We note that if this exception is finalized as proposed, consumers would still be subject to existing Exchange processes to verify eligibility to enroll in a QHP and eligibility for APTC and CSRs, as applicable, consistent with section 1411(c) and (d) of the Affordable Care Act and implementing regulations.

As explained previously, we interpret section 1411(a)(2)(A) of the Affordable Care Act as requiring Exchanges to make APTC and CSR eligibility determinations consistent with the PTC eligibility requirements of section 36B of the Code. Therefore, it is necessary for HHS to also adopt the Secretary of Treasury's waiver of the verification requirements of section 36B(c)(5)(A) of the Code to ensure that Exchanges make APTC and CSR eligibility determinations consistent with PTC eligibility determinations. Additionally, by aligning our requirements with those proposed by the Secretary of Treasury in the rule described above, HHS can ensure timely and continuous coverage for enrollees who qualify for SEPs due to a change in family size, particularly consumers who are adding newborns or dependents to their families. There are several situations where, without this exception, consumers could potentially lose APTC and CSRs at critical junctures of needing medical care, including the newborn and postpartum periods.

The requirements specified in section 1411(c) and (d) of the Affordable Care Act and the implementing regulations at §§ 155.315 and 155.320, which are the basis for Exchange verification processes, require verification of information provided by applicants, including citizenship or immigration status, household income and family size, and eligibility for or enrollment in employer-sponsored coverage. If a consumer, either new or current, is eligible to enroll or re-enroll during a family size SEP, generates DMIs related to the applicable enrollment information, and then is unsuccessful at resolving those DMIs and loses their APTC, the consumer may still be allowed PTC for the months during the inconsistency period when filing their tax return and reconciling their APTC with their actual allowed PTC.

Section 71303(a) of the WFTC legislation allows a waiver of the verification requirement in section 36B(c)(5)(A) of the Code for an individual who enrolls in a QHP during a SEP based on "a change in the family size of the individual." We read this as referring to the following current SEPs: gaining a dependent through marriage, birth, adoption, placement for adoption, placement in foster care, or through child support or another court order in § 155.420(d)(2)(i);

and loss of a dependent or consideration as a dependent through divorce, legal separation, or death in § 155.420(d)(2)(ii) (if offered by an Exchange). To qualify for the SEP at § 155.420(d)(2)(i) through marriage, one or both spouses need to demonstrate having one or more days of MEC in the prior 60 days preceding the date of marriage under § 155.420(d)(2)(i)(A). Exchanges on the Federal platform do not currently offer the SEP at § 155.420(d)(2)(ii), as generally the consumer who is losing or is no longer considered a dependent qualifies for a loss of MEC SEP, thereby preventing a loss of coverage.

We are requesting comment specifically on whether Exchanges should be required to offer the loss of dependent or consideration as a dependent SEP offered at § 155.420(d)(2)(ii) so that consumers who are eligible to enroll during this SEP may continue to qualify for APTC and CSRs based on their attestation during an inconsistency period that occurs due to updating their eligibility information to the Exchange. While consumers are already required to promptly report any changes that may affect their APTC or CSR eligibility, we are of the view that doing so is more important than it has been previously, in light of the change that removes APTC repayment caps in section 71305 of the WFTC legislation. For consumers that have been determined eligible to enroll during a family size SEP as described at § 155.420(d)(2) and otherwise have a DMI due to the new information on their application, this statutorily allowed exception ensures that consumers receive the APTC and CSRs that most closely reflect their attested-to situation, thereby minimizing the potential for larger tax liabilities. Requiring Exchanges to offer the loss of dependent or dependent status SEP would also prevent individuals who lose dependent status – for example, due to divorce or death of the primary policyholder – from losing potential APTC and CSRs until they newly meet pre-verification requirements.

For these reasons, we are proposing to amend § 155.315(f)(4)(ii) and add new § 155.315(f)(4)(iii)(C) to require all Exchanges to determine eligibility for APTC and CSRs based on the attested application information during an applicant's inconsistency period for DMIs related to the applicable enrollment information if the applicant's household is eligible to enroll

during a family size SEP in accordance with § 155.420(d)(2)(i) and (ii). The proposed change would ensure that both new applicants and enrollees who have previously verified their information under § 155.315(f)(4)(ii) and (iii) are eligible for APTC and CSRs based on the attested application information if they are eligible to enroll during a change in family size SEP.

We seek comment on this proposal. We understand State Exchanges may find it challenging to implement these requirements for PY 2028. Therefore, we are considering providing flexibility for State Exchanges to delay implementation of the change in family size SEP exception until PY 2029. We seek comment, in particular from State Exchanges, about whether the availability of this flexibility would be useful to ease the burden of implementing the requirements in this proposed rule.

d. Eligibility Redeterminations During the Plan Year

Consistent with the PTC proposed rule (91 FR 65499), we propose the addition of new § 155.315(f)(4)(iii) to describe the requirements for providing APTC and CSRs for enrollees who have reported a change to eligibility criteria during the plan year after an Exchange has completed verification of those same criteria using the enrollee's information from their immediately preceding eligibility determination. As outlined in section II.A. of this proposed rule, section 71303(a) of the WFTC legislation provides additional criteria for a month to be considered a coverage month. Specifically, a month generally may not be a coverage month for an enrollee in a QHP for any month that an Exchange fails to verify specific criteria related to the enrollee's eligibility to enroll in a QHP through an Exchange and, to the extent relevant, for APTC for the coverage for that month using certain criteria. More specifically, beginning with PY 2028, an Exchange must verify eligibility for enrollment in a QHP and APTC using the following information before a month is considered a coverage month and PTC may be paid: (1) household income and family size; (2) eligible noncitizen status; (3) any health coverage status or eligibility for coverage; (4) residency; and (5) other information as determined by the Secretary of the Treasury, in consultation with the Secretary of HHS.

In proposed § 155.315(f)(4)(iii)(A) and (B), we propose Exchange procedures regarding the provision of APTC and CSRs when an enrollee reports a change that generates one or more DMIs related to the applicable enrollment information. If the reported change results in an amount of APTC or CSRs that is in excess of or equal to the amount of APTC or CSRs previously determined for the individual, we propose that Exchanges would be required to continue providing APTC and CSRs (as applicable) during inconsistency periods at the same amount as previously determined. If the reported change results in an amount of APTC or CSRs that is lower than the amount previously determined for the individual, then we propose that Exchanges would lower APTC and CSRs based on the information provided by the applicant during an inconsistency period.

Section 71303(a) of the WFTC legislation amends the definition of “coverage month” and conditions PTC eligibility on successful verification of applicable enrollment information (that is, the criteria described in proposed § 155.315(f)(4)(ii)) listed above. We construe this change as a requirement that Exchanges must comply with *in addition to* (not in place of) existing verification requirements prescribed by sections 1411 and 1412 of the Affordable Care Act. Importantly, while section 71303(a) of the WFTC legislation requires that information be verified prior to treating a month as a coverage month (that is, before PTC can be allowed for an applicant’s coverage), we propose this process would not immediately supersede all prior verifications or require automatic termination of APTC and CSRs at the point that an enrollee reports a change within the plan year. Instead, we read section 71303(a) of the WFTC legislation to mean that any verification of applicable enrollment information must remain effective for the duration of the plan year, but, if an enrollee reports a change resulting in a DMI related to the applicable enrollment information, additional verification is required only before any *additional* APTC may be paid. For example, consider an enrollee receiving \$250 per month in APTC. The enrollee reports a decrease in projected annual household income during the plan year that would make the enrollee eligible for \$300 per month in APTC. The enrollee’s income cannot be

verified with IRS, resulting in a DMI. Section 71303(a) of the WFTC would prohibit an Exchange from providing the enrollee with the additional \$50 per month in APTC until the enrollee's income was verified, but it would not permit the Exchange to end APTC during the DMI period entirely (unless otherwise permitted).

Additionally, even if 71303(a) of the WFTC legislation did not compel this outcome, the Exchange may continue to draw authority from section 1412(b) of the Affordable Care Act for changes reported during the benefit year. Specifically, section 1412(b)(2) of the Affordable Care Act allows the Secretary of HHS to establish procedures to determine APTC on the basis of information other than an enrollee's prior tax return data when an enrollee's application form demonstrates substantial changes in circumstances, such as changes in income, family size, or other significant changes affecting eligibility.¹⁹

Accordingly, we propose a framework that would require an Exchange to maintain or decrease an enrollee's previously determined APTC or CSR amount (where applicable) if a reported change generates a DMI related to the applicable enrollment information after the enrollee was determined eligible for APTC or CSR for a given plan year. The maintained or decreased APTC amount would be applicable until an Exchange either resolves the DMI, the consumer reports another change in circumstance, or until the end of the inconsistency period during which the updated information remains unverified.

Throughout this paragraph, we use "previously verified" or "previously determined" to reference the enrollee's most recent verification or determination conducted by the Exchange. We propose in § 155.315(f)(4)(iii)(A) that when an individual reports a change that results in an amount of APTC or CSRs greater than or equal to the amount of APTC or CSRs previously determined for the individual, an Exchange would be required to maintain APTC or CSRs at the

¹⁹ As outlined in § 155.330(b), current enrollees who previously sought and received an eligibility determination from the Exchange are required to report changes that impact their eligibility within 30 days of such change. If an Exchange receives updated information, the enrollee's eligibility is redetermined in accordance with § 155.305 and the enrollee is notified about the determination. If an Exchange is unable to verify the updated information, the enrollee receives a DMI and is provided with a 90/95-day inconsistency period to submit documentation that verifies the attested application in accordance with §§ 155.315 and 155.320.

previously verified amount during an inconsistency period. If the DMI is not resolved, under section 1411(e)(4)(B)(ii) of the Affordable Care Act and regulations at §§ 155.315(f)(5) and 155.320(c)(3)(vi)(F) through (G), an Exchange would be required to redetermine eligibility for enrollment in a QHP and for APTC and CSRs, as applicable, on the basis of records maintained by specific Federal officials as outlined in section 1411(c) of the Affordable Care Act, which may include termination of enrollment in a QHP and/or of APTC and CSRs. We propose the approach in § 155.315(f)(4)(iii)(A) because until new information is verified, maintaining an enrollee's prior verified eligibility preserves program integrity and eases burden on enrollees related to reporting changes to the Exchanges, as stated later in this section. This is particularly relevant as it is reasonable for an individual to experience changes that significantly impact their eligibility, resulting in DMIs.

For example, consider a scenario where an enrollee reports a decrease in income from 350 percent of the FPL to 150 percent of the FPL, corresponding with an *increase* in APTC and new eligibility for CSRs, and resulting in a household income DMI. Under proposed § 155.315(f)(4)(iii)(A), Exchanges would be required to maintain the previously determined lower amount of APTC and CSRs based on previously verified information during the inconsistency period. Once the household income DMI is successfully resolved, an Exchange would be required to redetermine eligibility and adjust the amount of APTC or CSRs upwards based on the consumer's verified income attestation, with an effective date consistent with proposed § 155.315(f)(4)(iv) and other proposed changes regarding effective dates following resolution of DMIs outlined in section III.A.6.b. of this proposed rule. As noted previously, if the DMI is not resolved, the Exchange would be required to redetermine QHP and APTC and CSR eligibility, as applicable, on the basis of records maintained by a trusted data source, which may include removal of QHP and/or APTC and CSR eligibility.

By maintaining the lower amount of APTC and CSRs based on the previously verified information during the inconsistency period, Exchanges would ensure that APTC and CSRs are

only ever provided to enrollees during an inconsistency period at a level that does not exceed the amount provided based on previously verified information. Additionally, this proposed policy supports program integrity by ensuring that accurate amounts of APTC and CSRs are being provided on behalf of enrollees.

We acknowledge that this proposal would result in many consumers receiving less APTC and CSRs during an inconsistency period than they are ultimately determined eligible for when their DMIs are resolved. For APTC, consumers could be made whole during the tax filing and reconciliation process. We acknowledge that this may present a gap for some enrollees regarding CSRs when compared to APTC, because enrollees with APTC less than their PTC may claim the difference as a tax credit on their tax return for the year of coverage whereas there is no similar process for CSRs. However, we are of the view that this proposed policy strikes a balance between ensuring responsible Exchange operations regarding the provision of APTC and CSRs and encouraging enrollees to report changes.

In contrast, consider the opposite scenario, where an enrollee reports an increase in income from 150 percent of the FPL to 350 percent of the FPL, corresponding with a *decrease* in APTC and ineligibility for CSRs, and resulting in a household income DMI. We propose in § 155.315(f)(4)(iii)(B) that Exchanges would be required to adjust APTC or CSRs downward immediately after application submission based on the information provided by the enrollee on the application. Under this proposal, since the enrollee was previously verified for a higher amount of APTC or CSRs, the enrollee would be determined eligible for a lower amount of APTC or CSRs during the inconsistency period based on their newly attested applicable enrollment information. By requiring the Exchange to decrease APTC or CSRs in this manner, this proposal would help ensure that the Exchange does not pay out more APTC than that for which the consumer may be eligible based on the consumer's reported increase in income.

We are of the view that the policies described in proposed § 155.315(f)(4)(iii)(A) and (B) are permitted under section 1412(b)(2) of the Affordable Care Act, which affords discretion to

the Secretary to modify procedures for making advanced determinations as circumstances warrant. In other words, this broad authority allows the Secretary to structure Exchange rules for determining an enrollee's APTC or CSRs when the enrollee reports a change during the benefit year. We are of the view that this interpretation allows an Exchange to maintain or adjust APTC or CSRs downwards for instances described in proposed § 155.315(f)(4)(iii)(A) and (B). We are of the view that this proposed framework – maintaining or reducing APTC or CSRs during the inconsistency period for an enrollee following a mid-year change that results in a change to the amount of, or eligibility for, APTC or CSRs – best achieves Congressional intent of section 71303 of the WFTC legislation. Under both proposed § 155.315(f)(4)(iii)(A) and (B), enrollees would continue to receive APTC and CSRs during the 90/95-day DMI period as long as they are otherwise eligible for APTC.

Under this proposed framework, Exchange determinations would always utilize verified information. In the first instance where an enrollee's reported change would result in an increase of APTC and CSRs, the Exchange would maintain APTC and CSRs at the previously verified level during the inconsistency period while verification of reported changes is pending at the Exchange. In the second instance, when the enrollee's reported change would result in a decrease in APTC and CSRs, the Exchange would base their determination on the enrollee's newly reported information. This determination would not occur in the absence of verified information. Rather, this determination (and the resulting provision of APTC and CSRs during the inconsistency period) would reflect both the enrollee's newly reported information and the fact that the Exchange previously verified the enrollee eligible for a higher amount of APTC and CSRs. We are of the view that this approach is critical, as the only alternative would be to disregard an enrollee's attestation that supports eligibility for less APTC and CSRs than previously verified. Importantly, the downward adjustment of APTC and CSRs based on the enrollee's attestation simply adjusts the verified baseline amount of APTC and CSRs downward to limit the enrollee's exposure to tax liability. We considered that an enrollee would have less

incentive to report a change that results in a decrease in APTC or CSRs if they were not aware of the tax implications and did not wish to limit their tax liability.

In contrast, some enrollees may be inclined to report a change that results in an increase of APTC and CSRs because they are unaware of the tax implications or are focused on the short-term benefit of doing so (that is, lower monthly premiums). For these reasons, we believe the proposed approach best balances the interests of protecting consumers from increased tax liability and program integrity. Ultimately, the provision of APTC and CSRs during the inconsistency period while verification of reported changes is pending at the Exchange would use previously verified information as a foundational element for determinations. This two-pronged approach would ensure that enrollees and households do not receive more APTC and CSRs than they are verified for.

We considered alternatives to this proposal. We considered an approach in which Exchanges would be required to maintain an enrollee's current APTC or CSRs (that is, maintain a higher amount of APTC despite the enrollee's attested increased income) during an inconsistency period described in § 155.315(f)(4)(ii) when the enrollee reports a change that would result in a decrease in APTC or CSRs. However, since section 71305 of the WFTC legislation eliminates the limitation on repayment of excess APTC for tax years after December 31, 2025 (as set forth in section 36B(f)(2) of the Code), this approach could result in a consumer incurring a large tax liability despite correctly reporting a change. Therefore, our proposed policy serves as a key consumer protective measure by helping to safeguard consumers from large APTC repayments. We also considered requiring Exchanges to provide the higher amount of APTC or CSRs when an enrollee reports a change that results in an increase of APTC or CSRs, but encouraging consumers to take less APTC —specifically the amount they were receiving prior to reporting a change in circumstances—to avoid the risk of incurring a significant tax liability if their attestation was not verified. However, we determined that this would create consumer confusion and may not be effective as consumers would need to take additional actions

to manually adjust the amount of APTC applied to their monthly premium if desired.

This alternative operational approach could result in consumer confusion and friction, which may inadvertently disincentivize consumers from reporting changes. Importantly, we are of the view that structuring Exchange operations in the manner proposed would ensure accurate APTC determinations to the extent possible. Such a posture would enhance program integrity by ensuring that enrollees receive no more APTC than they have been determined eligible for after verification of their applicable enrollment information. Ultimately, such an approach reduces unnecessary Federal APTC outlays in the event attestations are inaccurate while safeguarding consumers from large tax liabilities, preventing an unnecessary cycle of APTC payment and repayment.

We considered another alternative approach, which would require Exchanges to remove APTC or CSRs during inconsistency periods. This approach would require individuals to pay the full premium to maintain coverage, which could be unaffordable for many individuals and result in them terminating coverage. That outcome could have a destabilizing impact on risk pools due to increases in adverse selection, as individuals with greater health needs would be more likely to maintain coverage (whether by quickly resolving DMIs or paying the full cost of premiums) than healthy individuals. Furthermore, we are of the view that it is important to structure the Exchange rules such that enrollees are motivated to report changes as required. Requiring Exchanges to terminate APTC or CSRs for consumers who report a change that results in a DMI related to the applicable enrollment information would likely discourage consumers from reporting changes.

We acknowledge that this proposal may require Exchanges to modify application and enrollment processes to accommodate scenarios where APTC and CSRs are maintained and those where APTC and CSRs are decreased. We especially acknowledge the burden that this change may impose on State Exchanges and the operational costs that may be incurred to implement these changes. However, given the high likelihood that individuals may experience

significant changes during the benefit year after their applicable enrollment information has been verified, it is critical that Exchanges implement these new requirements to motivate individuals to report changes that accurately represent their circumstances. Exchanges may leverage existing infrastructure to implement these changes, such as current functionality that enables Exchanges to maintain APTC and CSRs during an inconsistency period, or functionality that adjusts or removes APTC as required by section 1411(e)(4)(B)(ii) of the Affordable Care Act as described above.

We also acknowledge that this proposal would require changes to existing enrollee communication procedures and associated infrastructure. In particular, enrollees may find it difficult to distinguish between scenarios where their APTC or CSRs would be maintained compared to those where APTC or CSRs would be reduced. Importantly, while alternative approaches such as removing APTC or CSRs altogether or requiring enrollees to manually adjust APTC may appear simpler on their face, such approaches would simply shift complexity on to the enrollee at a later moment in the enrollment process, such as at the point of plan selection or enrollment where an enrollee (or an agent or broker applying on their behalf) must manually adjust their APTC or at tax reconciliation, where the enrollee may incur tax liabilities. Such approaches would likely deter enrollees from reporting changes during the benefit year.

We expect Exchanges to identify communication strategies that are tailored to their enrollee populations, such as updated eligibility determination notices that describe APTC or CSR changes following a mid-benefit year change, text message alerts to enrollees when APTC or CSRs are reduced, dynamic messaging for consumers after application submission and so on. We note that State Exchanges have successfully absorbed comparable operational changes, such as changes resulting from Medicaid unwinding from 2023-2024, suggesting that system changes such as these are likely within existing institutional capacity and would not impose a burden once integrated into normal operations. We anticipate that enrollee familiarity (as well as that of assisters, agents, and brokers that assist enrollees) will increase across enrollment cycles as their

application better reflects the enrollee's most recent applicable enrollment information.

To summarize, we propose the addition of § 155.315(f)(4)(iii)(A) and (B) to describe the requirements for providing APTC and CSRs for enrollees who have reported a change during the plan year that results in a DMI related to applicable enrollment information (such as household income), after an Exchange has completed verification of those same criteria for the same plan year using the enrollee's information from their immediately preceding eligibility determination. We propose that Exchanges would be required to maintain the amount of APTC or CSRs if a reported change results in an amount of APTC or CSRs that is in excess of or equal to the amount of APTC or CSRs previously determined for the individual. We propose that Exchanges would be required to reduce APTC or CSRs based on the individual's attested income if a reported change results in an amount of APTC or CSRs that is lower than the amount previously determined for the individual.

We seek comment on this proposal. We understand State Exchanges may find it challenging to implement these requirements for PY 2028. Therefore, we are considering providing flexibility for State Exchanges to delay implementation of this proposal for enrollees who have reported a change during the plan year until PY 2029. We seek comment, in particular from State Exchanges, about whether the availability of this flexibility would be useful to ease the burden of implementing the requirements in this proposed rule.

5. Verification Process Related to Eligibility for Insurance Affordability Programs (§ 155.320(c))

We do not propose any changes to the existing regulatory requirements at § 155.320(c) related to verification of family size as described further in this section. However, we seek comment on how we might strengthen requirements for Exchanges to verify family size in the future. We also seek comment on how Exchanges could verify family size using data sources, and which data sources we should consider making available for Exchanges, with the ultimate goal of increasing program integrity, while minimizing burden for Exchanges and consumers, and limiting the cost for Exchanges to procure new data sources.

As background, to be eligible to receive APTC or CSRs, applicants or enrollees must provide certain information regarding the individuals that make up their tax household, including their relationship to the tax filer (the tax anchor on the application) and tax filing status, according to section 1411(b)(3)(A) of the Affordable Care Act. Under section 1411(c)(3) of the Affordable Care Act, the Secretary of HHS must submit the family size information collected by Exchange applications to the Secretary of the Treasury for verification of both household income and family size.

Per current § 155.320(c)(3)(i)(A), an Exchange must require an applicant or enrollee applying for coverage with financial assistance, such as APTC and CSRs, to attest to information about the individuals that comprise the tax filer's family. If an applicant or enrollee attests that a change in circumstance has occurred or is likely to occur that would result in an inaccurate projection of their family size for the year for which they are applying for coverage, and so it is not representative of the family size for the plan year, an Exchange may accept the applicant or enrollee's attestation without further verification, per § 155.320(c)(3)(i)(C), as long as the data provided by the applicant is reasonably compatible with other information provided about their family. If the data provided by the applicant or enrollee is not reasonably compatible with other information provided by the application filer for the family, an Exchange generally must utilize data obtained through other electronic data sources to verify the attestation. If such data sources are unavailable or information in such data sources is not reasonably compatible with the applicant or enrollee's attestation, an Exchange must request additional documentation to support the attestation, consistent with current § 155.315(f).

Currently, the FFE application prompts the applicant or enrollee to provide information about their tax filing status and the current makeup of their household, including any dependents they plan to claim on their Federal income tax return. However, the FFE application does not allow the applicant or enrollee to provide a specific number of family members in their household. Rather, the FFE's eligibility logic works to calculate the applicant's family size based

upon the information the applicant or enrollee has provided in their application regarding tax filing status and any dependents they listed.

In light of the new requirements in the WFTC legislation, we wish to revisit family size verification and solicit comment from interested parties on possible alternatives, new data sources, or other enhancements that Exchanges could implement to strengthen family size verification. We explored additional ways Exchanges could strengthen or enhance their verification procedures for family size, but discovered some important challenges Exchanges would likely face, which we discuss in more detail in the remainder of this section.

First, we are not aware of any existing external data source currently used by any Federal agency to verify an applicant or enrollee's current or future family size, other than Federal income tax return data that Exchanges access through the IRS Hub service. Exchanges could potentially use this data to verify family size by calculating the number of dependents an applicant or enrollee claimed on their tax return and comparing with the number of dependents attested to on the coverage application; however, any such estimate is likely to often be incorrect, since IRS displays tax data for the most recent tax year for which data is available, which is typically 1 to 3 years prior to the current coverage year, due to the time delay between a tax return being filed and the time period the tax data represents, and the consumer's family size may have changed during that timeframe. Furthermore, the operational process to determine the number of dependents a tax filer plans to claim on their tax return is difficult for both an Exchange and consumers because changes to family size during the plan year may cause inconsistencies when trying to match against IRS data. For example, an applicant or enrollee who gains a dependent via a birth in October 2026 and applies for coverage during the OEP in November 2026, would not be able to electronically verify his or her family size using IRS data. This is because that new dependent was not included on the applicant's most recent Federal income tax return and, therefore, IRS data will not have any record of that new dependent until the applicant or enrollee claims them on their 2026 tax return filed in 2027. A relative dearth of

data available to prove changes in a consumer's tax household size is a major challenge with verifying family size through IRS tax data.

A second challenge for Exchanges verifying family size is navigating the complicated rules relating to who qualifies as a tax filer's dependent on their tax return. In general, a consumer is able to claim an individual as a dependent if 1) the individual is a U.S. citizen, a U.S. national, U.S. resident, or a resident of Canada or Mexico, 2) the individual, if married, does not file a joint return with his or her spouse except in limited situations, and 3) the individual is a qualifying child or a qualifying relative of the consumer. Additional tests must be met for an individual to qualify as a qualifying child or qualifying relative of a consumer. In addition, it is possible for an individual to be a qualifying child of more than one tax filer, and in those situations, there are tiebreaker rules to determine which tax filer can claim the individual as a dependent. Because of these complex rules, it may be difficult for tax filers to provide documentation supporting the attested family size provided on their application.

While considering the current challenges that Exchanges face regarding family size verification discussed previously and the new requirements in section 71303 of the WFTC legislation, we also considered two potential approaches to strengthen or enhance family size verification for applicants or enrollees applying for Exchange coverage with APTC/CSRs. The first approach involved setting a family size DMI for all applicants or enrollees whose reported household size did not match their household size in IRS tax data. Based on our analysis of FFE data that looked at IRS response codes from consumers for PY 2024 and PY 2025, we found that household size data from IRS could not be returned for 13,423,627 applications, out of a total of 30,328,781, which is roughly 44 percent. While many reasons may have contributed to a lack of available IRS data for these consumers, this approach could result in almost half of all applicants receiving a family size DMI, which would require significant technical and operational updates for all Exchanges. Additionally, we expect that the percentage of applicants or enrollees who successfully resolve their family size DMI would be low, given the lack of available

documentation types for an applicant to prove tax family size. Moreover, there is a high likelihood of inaccurate DMI processing, due to the complexities in tax rules for claiming dependents. A notable concern with this approach is that if an applicant's or enrollee's family size DMI could not be resolved, then APTC would be removed for the entire household. Finally, this approach may have negative impacts on the risk pool as it may lower overall participation in Exchanges due to the increased burden to resolve DMIs, thus increasing the risk of adverse selection as certain populations, such as younger individuals, would choose to forego Exchange coverage.

A second option we explored was a targeted, risk-based approach to modifying the family size verification process. We explored if an Exchange could either randomly verify a specific percentage of households, verify family size changes greater than two when compared to IRS tax data, verify family sizes greater than a certain amount of people, or verify non-applicant dependents without an SSN. This option would require the same technical and operational updates as the first option but would result in fewer DMIs. However, similar to the first option, we anticipate the percentage of applicants who would successfully resolve their family size DMI would be low due to the lack of available documentation options to prove tax family size. This option would likely have less of a negative impact on the risk pool as compared to the first option as a smaller subset of applicants would receive a DMI.

Given that Exchanges face such extensive challenges and costs associated with enhancing family size verification operations, we propose to retain the current regulatory requirements regarding verification of family size as outlined in § 155.320(c). We are of the view that the current regulatory requirements and Exchange operations to verify family size are sufficient given the challenges we discussed earlier in this section. We note that historically, we have seen very limited cases of fraud as it relates to family size, however, we are still interested in ways to potentially strengthen or enhance family size verification, in a way that is both cost-efficient for Exchanges and minimally burdensome on consumers.

We seek comment on alternatives and invite interested parties to share their experiences with family size verification, including challenges, risk for family size fraud, feasibility of other verification approaches such as risk-based verification, and cost/budget impacts.

6. Eligibility Redetermination During a Plan Year (§ 155.330)

a. Effective Dates for Enrollee-reported Changes (§ 155.330(f)(1))

(i) Summary of Proposed Effective Dates for Enrollee-reported Changes

In § 155.330(f)(1), we propose that if an Exchange redetermines an enrollee's eligibility to enroll in a QHP, for APTC, or for CSRs because the enrollee has provided updated information to the Exchange, such redetermination of eligibility would become effective on the first of the month following an Exchange's eligibility redetermination. We clarify that, throughout this section, when we refer to a redetermination of APTC or CSR eligibility, we are referring to both redeterminations that result in a consumer becoming eligible for a different amount or level of APTC or CSR, as applicable, and redeterminations that result in a consumer becoming newly eligible or ineligible for APTC or CSRs.

The proposal in § 155.330(f)(1) would maintain the general rule currently in § 155.330(f)(1)(i) that eligibility updates resulting from enrollee-reported changes must be effective on the first of the month following an Exchange's eligibility redetermination. Currently, § 155.330(f)(1)(i) provides that eligibility changes "resulting from a determination under this section" must be effective on the first of the month following the date of the consumer's eligibility determination notice, subject to certain exceptions enumerated in § 155.330(f)(2) through (5). Determinations "under this section" include both enrollee-reported changes as described in § 155.330(e)(1), as well as determinations made as part of the periodic data matching process described in § 155.330(e)(2). We propose effective dates for determinations made as part of the periodic data matching process in proposed § 155.330(f)(3), discussed in section III.A.6.c. of this proposed rule.

Proposed § 155.330(f)(1) would apply to eligibility redeterminations when an enrollee

provides updated information to an Exchange and the Exchange determines the enrollee has an inconsistency. For example, § 155.330(f)(1) would apply if an Exchange determines that an enrollee's APTC or CSRs, as applicable, needs to be reduced during their inconsistency period because they have a DMI as described in proposed § 155.315(f)(4)(iii)(B). In these cases, the redetermination of the enrollee's APTC or CSRs eligibility would be effective on the first of the month following the Exchange's eligibility redetermination.

At § 155.330(f)(1)(i), we propose an exception such that, if the Exchange redetermines an enrollee's eligibility because the enrollee has provided updated information to the Exchange, and the Exchange also determines that the enrollee qualifies for certain SEPs described in § 155.420(b)(2)(i) or (b)(2)(iii), then the Exchange would implement the enrollee's eligibility redetermination on the coverage effective dates described in § 155.420(b)(2)(i) or (b)(2)(iii), respectively.

Current § 155.330(f)(1)(iii) specifies that eligibility changes "affecting enrollment or premiums only" must be effective on the first day of the month following the date "the Exchange is notified of the change." Under our proposed restructure of § 155.330(f), we propose that all enrollee-reported changes, including those affecting enrollment or premiums only, would be subject to the effective dates under proposed § 155.330(f)(1) and therefore would generally be effective on the first of the next month following the eligibility determination. For Exchanges on the Federal platform, we clarify that even if a reported change only affects enrollment or premiums, an Exchange generally also redetermines an enrollee's eligibility for enrollment in a QHP and for APTC and CSRs, as applicable, before sending an updated transaction to the enrollee's issuer. We request comment from State Exchanges regarding whether State Exchanges also redetermine enrollees' eligibility in cases in which a reported change only affects enrollment or premiums, such that proposed § 155.330(f)(1) would apply. We also note that § 155.400(b)(1) requires Exchanges to send all eligibility and enrollment information, which includes updates on eligibility and enrollment, to issuers "promptly and without undue delay."

(ii) Proposal to No Longer Allow Exchanges to Delay Effective Dates for Enrollee-Reported Changes

Current § 155.330(f)(2) provides an exception to current § 155.330(f)(1), permitting Exchanges to delay the effective dates of eligibility redeterminations by one month if they occur on or after the 15th of a month. For example, if an enrollee reported a change in income to an Exchange and an Exchange redetermined the enrollee's eligibility for APTC and CSRs on May 20, an Exchange could delay the effective date of the resulting APTC and CSR change from June 1, as prescribed under the general rule at current § 155.330(f)(1), to July 1, as permitted in current § 155.330(f)(2). In proposed § 155.330(f)(1), we propose that Exchanges would no longer be permitted to delay the effective dates for eligibility redeterminations resulting from enrollee-reported changes in the manner allowed by current § 155.330(f)(2). As proposed at § 155.330(f)(1), all eligibility redeterminations resulting from enrollee-reported changes would be effective the first of the month following an Exchange's redetermination, with limited exceptions for scenarios where the enrollee also qualifies for certain SEPs. As a result, in the example described previously, a change in eligibility for APTC and CSRs resulting from an enrollee reporting a change to their income on May 20 would be effective on June 1, and Exchanges would not be permitted to delay the effective date for such changes to July 1.

We propose to no longer allow the exception currently at § 155.330(f)(2) for eligibility redeterminations following enrollee-reported changes for several reasons. First, the redeterminations discussed in proposed § 155.330(f)(1) would be limited to enrollee-reported changes, where the enrollee is actively engaging with the Exchange. They would not apply to determinations as part of the periodic data matching process or following the expiration of an inconsistency period, where the Exchange is redetermining eligibility without the enrollee's active engagement. When an enrollee reports a change to the Exchange, the enrollee is typically informed of the results of their redetermination in real-time, and there is therefore no compelling need to delay the effective date of the redetermination to ensure that an Exchange is able to

communicate with the enrollee regarding the change before it takes effect.

Second, the elimination of the limitations on repayment of excess APTC starting in PY 2026, required by section 71305 of the WFTC legislation, makes it even more important that Exchanges apply the changes that enrollees report without delay, to reduce the risk that consumers who accurately report changes to the Exchanges are faced with increased tax liability despite their efforts to proactively report changes. We seek comment on the proposal to remove the exception currently at § 155.330(f)(2) regarding eligibility redeterminations following enrollee-reported changes.

Similarly, for redeterminations resulting from enrollee-reported changes, we are proposing to remove § 155.330(f)(3), which provides that if a change results in decreased APTC or a change in CSR eligibility, and the redetermination occurs after the 15th of a month, Exchanges are required to delay the effective date of such eligibility redeterminations by one month. For example, if an enrollee reports an increase in income to an Exchange and the Exchange determines on May 20 that the enrollee is eligible for less APTC, an Exchange is required to delay the effective date of the resulting decrease in APTC from June 1, as prescribed under the general rule at current § 155.330(f)(1), to July 1, as required by the exception in current § 155.330(f)(3). For enrollee-reported changes, we are proposing to remove the required delay at § 155.330(f)(3) for the same reasons we are proposing to remove the option for Exchanges to delay under § 155.330(f)(2). For redeterminations not resulting from enrollee-reported changes – specifically, those resulting from the expiration of an inconsistency period or periodic data matching – we propose to maintain the required delay for redeterminations that result in a decreased amount of APTC or decreased level of CSR. This proposal is discussed in detail in section III.A.6.c. of this proposed rule.

We considered proposing an alternative under which Exchanges would be required or permitted to immediately implement eligibility redeterminations resulting from enrollee-reported changes. However, we determined that immediate, mid-month adjustment of APTC and CSRs

would be more difficult for Exchanges and issuers to implement. Changes to APTC and CSR amounts in the middle of a month would require Exchanges and issuers to prorate both APTC and premium amounts and would require issuers to retroactively re-bill consumers for the month in which the change was reported. For these reasons, we are proposing at § 155.330(f)(1) that eligibility redeterminations resulting from enrollee-reported changes become effective on the first of the month following an Exchange's redetermination.

(iii) Enrollee-reported Changes Resulting in an SEP

Current § 155.330(f)(4) provides another exception to current § 155.330(f)(1), requiring that eligibility redeterminations associated with an SEP due to gaining or becoming a dependent through birth, adoption, foster care, child support, or court order, as described at § 155.420(b)(2)(i), become effective on the SEP effective dates prescribed in § 155.420(b)(2)(i). We are proposing to maintain this exception at proposed § 155.330(f)(1)(i). This exception ensures that if, for example, an enrollee adds a newborn to their application, the resulting redetermination of the enrollee's eligibility due to their change in family size is effective retroactive to the newborn's date of birth.

Current § 155.330(f)(4) further provides that eligibility redeterminations associated with an SEP due to marriage become effective on the SEP effective dates prescribed in § 155.420(b)(2)(ii). We are not proposing to maintain this exception in proposed § 155.330(f)(1)(i), because § 155.420(b)(2)(ii) requires that coverage selected in accordance with an SEP due to marriage becomes effective on the first of the month following plan selection. Therefore, for consumers with a marriage SEP, their coverage effective date already generally aligns with the effective dates for eligibility redeterminations proposed at § 155.330(f)(1).

Current § 155.330(f)(5) provides an exception to current § 155.330(f)(1) such that eligibility changes associated with an SEP described in § 155.420(d)(4), (d)(5), and (d)(9) may be effective "based on the specific circumstances of each situation." The SEP at § 155.420(d)(4) is for qualified individuals who experience an error of the Exchange; the SEP at § 155.420(d)(5)

is for enrollees whose QHP violates a material provision of its contract with the enrollee; and the SEP at § 155.420(d)(9) is for qualified individuals who experience an exceptional circumstance. In proposed § 155.330(f)(1)(i), we are proposing that if an Exchange determines that an enrollee qualifies for any of the SEPs enumerated in § 155.420(b)(2)(iii) – which include the SEPs described at § 155.420(d)(4), (d)(5), and (d)(9) – then the enrollee’s eligibility redetermination would be effective on the coverage effective date prescribed by § 155.420(b)(2)(iii). Section 155.420(b)(2)(iii) provides that the Exchange “must ensure that coverage is effective on an appropriate date based on the circumstances of the special enrollment period.” Therefore, we are proposing to maintain the flexibility currently permitted under § 155.330(f)(5) for Exchanges to establish appropriate eligibility redetermination effective dates for enrollees who qualify for these SEPs.

We are newly proposing that an Exchange follow the same eligibility redetermination effective date rules for an individual eligible for the three other SEPs enumerated in § 155.420(b)(2)(iii): the SEP at § 155.420(d)(11) for qualified individuals who are determined ineligible for Medicaid or CHIP after their enrollment period has ended; the SEP at § 155.420(d)(12) for enrollees whose enrollment was influenced by a material error regarding certain plan characteristics; and the optional SEP at § 155.420(d)(13) for individuals who resolve an inconsistency after their QHP has been terminated. We do not see a compelling reason to impose different eligibility redetermination effective date rules for enrollees with these SEPs as compared to the SEPs at § 155.420(d)(4), (d)(5), and (d)(9), given that Exchanges have the discretion to establish appropriate coverage effective dates for all of these SEPs under § 155.420(b)(2)(iii). Because § 155.330(f)(5) was finalized prior to these SEPs being established, we are of the view that the lack of reference to these SEPs at § 155.330(f)(5) is merely an oversight.

We seek comment on this proposal. Specifically, we seek comment from State Exchanges and other interested parties regarding any operational burden these proposed changes to current

effective date policies would create, and whether a 1-year delay in implementation would mitigate any expected risk of State Exchanges having insufficient time to make necessary updates to their IT systems.

b. Effective Dates Related to the Resolution of DMIs (§ 155.330(f)(2))

In section III.A.4.b.iv. of this proposed rule and at proposed § 155.315(f)(4)(iv)(A), we propose effective date rules for APTC and CSR determinations resulting from the resolution of DMIs described in §§ 155.315(f)(4)(ii) and 155.315(f)(4)(iii)(A) for individuals who are enrolled in a QHP when such DMIs are resolved. In § 155.330(f)(2), we propose to cross-reference the effective dates proposed in § 155.315(f)(4)(iv)(A), such that the same effective date rules proposed in § 155.315(f)(4)(iv)(A) would apply for individuals described in § 155.330 – that is, QHP enrollees whose eligibility is redetermined during the coverage year due to the resolution of such DMIs.

Specifically, as proposed at § 155.315(f)(4)(iv)(A), for individuals who are enrolled in a QHP when their DMIs are resolved, any changes to the eligibility or amount of APTC or CSRs resulting from the DMI resolution would be effective on the first day of the first month in which all of the following criteria are met: all information related to the applicant's DMIs are verified for the month; the enrollee is enrolled in a QHP on the first day of the month; and the enrollee's DMIs were generated before the first of such month. We further propose an exception to these rules in cases where they would result in an Exchange determining or redetermining APTC eligibility for months in a prior coverage year.

We propose to align the effective dates proposed in § 155.330(f)(2) with those described at proposed § 155.315(f)(4)(iv)(A) for the following reasons.

Section III.A.4.b.iv. of this proposed rule and proposed § 155.315(f)(4)(iv)(A)(1) provide that an Exchange's determination of APTC or CSR eligibility upon DMI resolution would not be effective prior to the first day of the first month for which the Exchange verified all eligibility criteria described in proposed § 155.315(f)(4)(ii). In section III.A.4.b.iv. of this proposed rule,

we explain that this proposal implements the requirement in section 36B(c)(5)(C) of the Code, which specifies that a month beginning prior to verification must only be considered a coverage month if the Exchange verifies the consumer's eligibility "for such month." We propose to apply the same principle for enrollees who resolve a DMI described at § 155.315(f)(4)(ii) or § 155.315(f)(4)(iv)(iii)(A), such that any redetermination of APTC or CSR eligibility resulting from such DMI resolution does not take effect prior to the first month in which the enrollee's newly attested eligibility criteria are verified. This proposal ensures equitable treatment of new and existing enrollees regarding when their APTC and CSRs can begin or increase following DMI resolution.

Section III.A.4.b.iv. of this proposed rule and proposed § 155.315(f)(4)(iv)(A)(2) further provide that an Exchange's determination of APTC or CSR eligibility upon DMI resolution would not be effective prior to the first day of the first month that the enrollee is enrolled in a QHP. In section III.A.4.b.iv. of this proposed rule, we explain that allowing retroactive APTC or CSRs to extend further would produce illogical outcomes given that section 36B(c)(2)(A)(i) of the Code requires that a taxpayer or their family member must be enrolled in a QHP as of the first of the month for the month to be considered a coverage month. With regard to the enrollees described in this section, we have similarly determined that allowing redeterminations of APTC or CSR eligibility to take effect prior to QHP enrollment is illogical and should be prevented.

Section III.A.4.b.iv. of this proposed rule and proposed § 155.315(f)(4)(iv)(A)(3) provide that an Exchange's determination of APTC or CSR eligibility upon DMI resolution would not be effective prior to when the consumer's DMIs were generated. We explain in section III.A.4.b.iv. of this proposed rule that this proposal aligns with Exchanges' existing effective date framework, under which changes to eligibility are generally implemented prospectively, in relation to when the consumer provides the attestations that produce such changes in eligibility. This existing principle also applies to redeterminations described in this section.

Finally, in section III.A.4.b.iv. of this proposed rule and at proposed §

155.315(f)(4)(iv)(A)(4), we describe an exception to the effective date rules proposed at § 155.315(f)(4)(iv)(A)(1) through (3). Specifically, if these rules would result in an APTC effective date in the prior coverage year, we propose that the Exchange would not provide or increase APTC for those months in the prior year. This exception is intended to mitigate tax administration issues and consumer burden that would result if Exchanges provided APTC for a month after the Exchange had already generated a consumer's Form 1095-A for the coverage year. These tax administration issues pertain to both initial eligibility determinations and to the redeterminations described in this section. Therefore, we are proposing to adopt the same rules for APTC and CSR redeterminations for QHP enrollees whose eligibility is redetermined during the coverage year due to the resolution of their DMIs.

We seek comment on this proposal.

c. Effective Dates for Redeterminations Following Expiration of Inconsistency Period or Periodic Data Matching (§ 155.330(f)(3))

In § 155.330(f)(3), we propose effective date rules for eligibility redeterminations following the expiration of an inconsistency period or as part of the periodic data matching process described at § 155.330(e)(2). Currently, these rules are primarily enumerated in § 155.330(f)(3), which covers redeterminations that result in a decreased amount of APTC, or a change in the level of CSRs. We clarify that current § 155.330(f)(3) also applies in cases where an enrollee is redetermined newly ineligible for QHP, APTC, or CSRs. While current § 155.330(f)(3) does not explicitly refer to the end of an inconsistency period or periodic data matching processes, these situations are covered under § 155.330(f)(3) because they generally result in the removal or reduction of APTC.

Current regulations at § 155.330(f)(3) provide that such decreases in amount of APTC or in the level of CSRs must be effective the first of the month following the redetermination, unless the redetermination occurs after the 15th of the month, in which case the Exchange must delay the effective date by one month. At § 155.330(f)(3)(i), we are proposing to maintain these

effective date rules in cases where an eligibility redetermination is the result of an inconsistency period expiring or a periodic data matching process ending, and such redetermination results in a decreased amount of APTC or decreased level of CSRs.

Consider an example in which an enrollee is found, through the periodic data matching process described in § 155.330(e)(2), to be enrolled in other MEC, and in which an Exchange notifies the enrollee regarding this updated information on May 20. In accordance with § 155.330(e)(2)(i)(B), an Exchange provides the enrollee with 30 days, or until June 19, to respond to their notice. If the enrollee has not responded by the end of this 30-day period, an Exchange must redetermine the enrollee's eligibility, in which case the enrollee would be determined ineligible for APTC because they are enrolled in other MEC. Under current § 155.330(f)(3), because this eligibility redetermination results in a decrease in APTC and occurs on June 19, the eligibility redetermination must be effective on August 1. Under proposed § 155.330(f)(3)(i), this rule would be maintained, and the eligibility determination would also be effective on August 1.

We also propose to maintain the rules currently at § 155.330(f)(3) for eligibility redeterminations following the end of an inconsistency period, where the redetermination results in decreased APTC or a decreased level of APTC or CSRs. In a similar example where an enrollee's 90-day inconsistency period expires on June 19, the resulting eligibility determination would continue to be effective on August 1.

We are proposing to keep these rules for several reasons. First, unlike cases where a consumer is reporting updated information to the Exchange, consumers whose APTC or CSRs are redetermined following the end of an inconsistency period or as part of the periodic data matching process are not actively engaged with the Exchange. Therefore, a delay between any reduction to the consumer's APTC or level of CSRs and the effective date of that redetermination is appropriate to give the Exchange sufficient time to communicate the upcoming change in eligibility to the consumer. Second, section 71303 of the WFTC legislation does not require Exchanges to update existing effective date rules for inconsistency period

expiration or periodic data matching processes or to implement such redeterminations as soon as possible.

Finally, we have determined that maintaining these existing rules is operationally simpler for Exchanges than requiring a change to existing policy and operations. We acknowledge that the proposals in this rule would require Exchanges to make significant changes to their systems on a short timeline to meet statutory deadlines. To increase the likelihood that Exchanges can successfully implement the many changes already required by the WFTC legislation and that would be required by this proposed rule, and for the other reasons stated above, we propose to maintain the existing effective date policy with regard to periodic data matching and DMI expirations that result in a reduction in APTC or CSRs.

There are cases in which the expiration of an inconsistency period may instead result in the Exchange determining a consumer eligible for the same or an increased amount of APTC, or the same or a more generous level of CSRs. In accordance with § 155.315(f)(5), at the end of an inconsistency period, if an Exchange remains unable to verify an attestation, an Exchange must determine a consumer's eligibility based on information available from trusted data sources. In the case that the Exchange obtains income data from the Department of Treasury, as described in § 155.320(c)(1)(i) and (ii), but such data does not verify the consumer's attestation of their income, the Exchange must determine eligibility based on this data at the end of the consumer's inconsistency period. Depending on the consumer's income attestation and the data available to the Exchange from the Department of Treasury, this could result in the Exchange determining the consumer eligible for more APTC or a more generous level of CSRs than provided during their inconsistency period. Currently, such redeterminations are subject to the effective date rules in § 155.330(f)(1)(i) and (f)(2). These current rules give Exchanges the option to either consider such redeterminations effective the first of the month following the date of the redetermination notice, or to delay the effective date by a month, if the redetermination occurred after the 15th of the month.

Additionally, given the proposals enumerated in proposed § 155.315(f)(4)(ii) and (iii), the end of an inconsistency period may result in no change to a consumer's APTC or CSR eligibility. For example, if a consumer has a DMI related to their enrollment in other MEC, and the Exchange determines in accordance with the requirements in § 155.315(f)(4)(ii) and (iii) that the enrollee cannot be provided with APTC or CSRs during their inconsistency period, then the expiration of such inconsistency period simply confirms the consumer's ineligibility for APTC or CSRs and does not result in an increase or decrease.

At § 155.330(f)(3)(ii), we propose that, for redeterminations following the expiration of an inconsistency period or periodic data matching that result in the same or an increased amount or level of APTC or CSRs, the Exchange be required to implement such redeterminations on the first of the month following the redetermination. This maintains the general requirement currently enumerated at § 155.330(f)(1) but removes the flexibility for Exchanges to delay such effective dates until the first of the following month afforded under § 155.330(f)(2).

We propose these rules regarding redeterminations following the expiration of an inconsistency period or periodic data matching that result in an increased amount or level of APTC or CSRs for several reasons. First, eliminating the flexibility currently permitted under § 155.330(f)(2) better ensures timely access to APTC and CSRs for eligible consumers. While enrollees in this scenario are not actively engaged with the Exchange, we see no reason to delay implementing a change that results in the same or more APTC or CSRs. In contrast, for a change that results in a decrease of APTC or CSRs, we determined a delay would be justified to ensure consumers receive timely notice. In addition, proposing to remove the flexibility currently permitted under § 155.330(f)(2) for these eligibility redeterminations aligns with our proposed effective date rules for enrollee-reported changes, described in section III.A.6.a. of this proposed rule, thereby promoting a consistent set of rules.

We seek comment on this proposal.

d. Effective Dates for Appeals (§ 155.330(f)(4))

We are proposing to redesignate current § 155.330(f)(1)(ii), regarding effective dates for redeterminations resulting from an appeal decision, as proposed § 155.330(f)(4), with some minor wording changes. This would maintain the current requirement that, in cases where an Exchange redetermines eligibility due to an appeal decision, that the change in eligibility must be effective on the date specified in the appeal decision.

We seek comment on this proposal.

7. Annual Eligibility Redetermination (§ 155.335)

We propose to modify the title of this section to “Annual eligibility redetermination and re-enrollment.” We propose to amend § 155.335 by revising § 155.335(a) and (b); removing § 155.335(c) through (i); redesignating § 155.335(j) as new § 155.335(c); and removing § 155.335(k) through (n). Current § 155.335(a) through (i) and (k) through (n) include procedures required for an Exchange to annually redetermine eligibility for APTC and CSRs using the information previously provided by an enrollee in a QHP for the current plan year, or an earlier plan year, along with updated information from trusted data sources, when the enrollee does not contact the Exchange during the annual OEP to update their eligibility information. We are proposing to no longer permit these procedures.

Proposed § 155.335(a) would require Exchanges to redetermine the eligibility of an enrollee for enrollment in a QHP and for APTC and CSRs, as applicable, on an annual basis in accordance with § 155.305 and adhere to the existing notification standard for eligibility determinations under § 155.310(g). Proposed § 155.335(a)(1) would newly specify that for an Exchange to redetermine an enrollee eligible for APTC and CSRs for the subsequent plan year, the enrollee or the enrollee’s application filer would be required to provide or confirm household income and family size; U.S. citizenship or status as a lawfully present eligible non-citizen, as applicable; eligibility for or enrollment in other MEC; and place of residence for the subsequent plan year on or after August 1 and no later than December 31 of the year preceding the

applicable plan year, and the Exchange would verify the specified eligibility information using the processes in §§ 155.315 and 155.320, including the relevant provisions in those sections regarding DMIs.

We propose to modify § 155.335(b) to specify that the annual eligibility redetermination of QHP and for APTC and CSRs, as applicable, would be effective on the first day of the applicable plan year. We propose an exception to this effective date for the redetermination of APTC and CSRs in instances where an enrollee has an unresolved DMI under § 155.315(f)(4)(ii) as of December 31 of the year preceding the plan year and for whom APTC and CSRs are not provided during the inconsistency period. In these instances, we propose that the redetermination of APTC and CSRs under this part take effect in accordance with §§ 155.315(f)(4)(iv)(A) or 155.330(f)(3), as applicable.

Proposed § 155.335(c) would retain the QHP re-enrollment standards currently at § 155.335(j). We also clarify that under § 155.1200(b)(2), State Exchanges would still be required to submit information annually to HHS for HHS oversight on operations regarding § 155.335.

Section 71303(a) of the WFTC legislation specifically states that the applicable enrollment information must be “provided or verified” by the individual and that, generally, the term coverage month does not include months “before the Exchange verifies” that information. As described previously, PTC is allowed only for months that are coverage months. Eligibility for PTC is determined after the end of each tax year, based on information, such as household income and family size, relating to the year of coverage. As a result, section 36B(c)(5)(A) of the Code, as added by section 71303(a) of the WFTC legislation, applies to a tax year and contemplates that an Exchange must verify an individual’s eligibility at least once every plan year before a month in the year can be a coverage month and any APTC or CSRs can be paid for that month. The statutory text further reinforces the year-by-year concept by utilizing the term “any individual” covered by a QHP, rather than limiting it to new enrollees. Further, by specifying that information be provided or verified by the “applicant” in the clause following the

Exchange verification requirement, the text indicates that all applicants must provide or confirm²⁰ the applicable enrollment information that is the basis of Exchange verifications at minimum as frequently as the Exchange must verify that information. Therefore, requiring individuals seeking to re-enroll in a QHP with APTC and CSRs to provide or confirm the applicable enrollment information pertaining to the subsequent plan year is consistent with the section 71303(a) amendment to section 36B(c).

Additionally, even if section 71303(a) of the WFTC legislation did not require enrollees who are re-enrolling with APTC or CSRs to provide or confirm their information for each plan year, we would still propose this requirement under our authority in section 1411(f)(1)(B) of the Affordable Care Act, which directs the Secretary to establish procedures for redetermining eligibility on a periodic basis in appropriate circumstances, and section 1412(b)(1)(A) of the Affordable Care Act, which directs the Secretary to establish a program to make advance eligibility determinations for PTC. We have determined that annual redetermination of APTC and CSRs without an enrollee providing updated eligibility information or confirming existing information to the Exchange is no longer appropriate. We have determined that an enrollee should be required to provide or confirm their eligibility information for each plan year to be redetermined eligible for APTC and CSRs to improve the accuracy of APTC and CSR payments, mitigate the risk that enrollees receive APTC or CSRs for which they are no longer eligible, and protect enrollees from potential tax liability, as described in more detail later in this section.

We previously finalized the standards for annual eligibility redetermination under § 155.335 in the Exchange Establishment Rule (77 FR 18374) and revised those standards in the Annual Eligibility Redeterminations Final Rule (79 FR 52994) to provide additional flexibility for Exchanges in establishing annual redetermination procedures. Currently, all Exchanges have

²⁰ As described in section II.A. in this proposed rule, we use the terms “provide” or “confirm” to describe the section 36B(c)(5)(A) of the Code requirement for consumers to provide or verify applicable enrollment information; in doing so, we consider “confirm” to be synonymous with “verified” where the statute refers to “information...verified by the applicant.”

chosen to follow one of the alternate procedures under § 155.335(a)(2)(ii) or § 155.335(a)(2)(iii), rather than the procedures under § 155.335(a)(2)(i), which requires compliance with § 155.335(b) through (m). Specifically, under § 155.335(a)(2)(ii), an Exchange may conduct annual redeterminations in accordance with procedures specified by the Secretary of HHS, which are currently set forth in the “Guidance on Annual Redetermination and Re-enrollment for Marketplace Coverage for 2024 and Later Years.”²¹ Under § 155.335(a)(2)(iii), Exchanges may conduct annual redetermination in accordance with procedures approved by the Secretary of HHS based on a showing of the following: that the alternative procedures would facilitate continued enrollment in coverage for which the enrollee remains eligible, provide clear information about the process to the qualified individual or enrollee (including regarding any action by the qualified individual or enrollee necessary to obtain the most accurate redetermination of eligibility), and provide adequate program integrity protections.

Under § 155.335(a)(2)(ii) through (iii), all Exchanges have procedures in place that enable them to redetermine an enrollee’s eligibility for enrollment in a QHP and APTC and CSRs, as applicable, for the subsequent plan year when an enrollee does not provide updated eligibility information to the Exchange for the subsequent plan year. Therefore, in all Exchanges, such an enrollee who is eligible for APTC or CSRs in a plan year may remain eligible for APTC and CSRs, as applicable, for the following plan year based on data available to the Exchange without providing any updated eligibility information. These current procedures result in redeterminations for APTC or CSRs based on information that may be considerably outdated. When Exchanges rely on prior plan year information or data obtained from trusted data sources only, it means the enrollee has not confirmed that such information remains accurate for purposes of redetermining their eligibility for the subsequent plan year. Given that eligibility for APTC and CSRs is highly sensitive to changes in income, family size, and other applicable

²¹ CMS. (2023). *Guidance on Annual Redetermination and Re-enrollment for Marketplace Coverage for 2024 and Later Years*. Available at www.cms.gov/files/document/guidance-annual-redetermination-and-re-enrollment-marketplace-coverage-2024-and-later-years.pdf.

eligibility criteria, reliance on information provided for a past plan year increases the likelihood of inaccurate eligibility determinations.

For example, consider an enrollee who provided a projected annual household income for PY 2026 in November 2025 and enrolled in PY 2026 coverage, but did not contact the Exchange during Open Enrollment for PY 2027. While Exchanges can produce an estimated PY 2027 annual household income derived from the PY 2026 income amount, or currently available data sources, an enrollee-provided projection for PY 2027 annual household income is more likely to accurately reflect the enrollee's anticipated financial and family circumstances. Unlike income estimates derived from prior-year information or currently available data sources, an enrollee-provided projection includes the enrollee's current knowledge of their financial situation for the subsequent plan year. Requiring enrollees to project their household income for the applicable benefit year and requiring Exchanges to verify the enrollee's projection reduces the likelihood of significant discrepancies between projected and actual income, thereby minimizing the risk of inaccurate APTC or CSR amounts being applied to the upcoming benefit year.

We have determined that requiring an enrollee to provide updated specified information for the applicable plan year or confirm that the specified eligibility information remains accurate to be redetermined eligible for APTC and CSRs would strengthen program integrity for the Exchanges. While section 71305 of the WFTC legislation removes the limitation on repayments of excess APTC, there are cost burdens to the IRS associated with recovering excess APTC. For example, there are enrollees who do not comply with the requirement to file a Federal income tax return and reconcile APTC. While the IRS has procedures to address non-compliance with tax filing requirements, the IRS must utilize resources to initiate these procedures and assess tax liability from excess APTC. These concerns are especially true when a current Exchange enrollment is improper or unauthorized and carried over into the next coverage year. Therefore, there is a significant program integrity benefit to the Federal Government by ensuring that all Exchange enrollees seeking financial assistance provide updated information or confirm their

information remains an accurate basis upon which the Exchange can redetermine APTC or CSRs for the plan year.

Given the removal of the limitations on repayment of excess APTC under section 71305 of the WFTC legislation, we have also determined this annual requirement is critical to protecting enrollees from large potential tax liabilities. We expect that requiring enrollees to minimally confirm the applicable eligibility information, or otherwise update the information, annually to be redetermined eligible for APTC and CSRs would help ensure that an enrollee's projected household income and other applicable eligibility criteria more accurately reflect the enrollee's expected circumstances for the subsequent plan year than current procedures. As a result, eligibility determinations would be based on more current information. In turn, APTC payments would be more closely aligned with the PTC that enrollees ultimately qualify for based on their actual household income for the plan year. We anticipate that more accurate APTC determinations would reduce the likelihood that consumers receive excess APTC and incur associated tax liability at reconciliation.

In addition, we previously finalized the requirements for enrollees to report changes that may affect their eligibility during the benefit year under § 155.330(b) in the Exchange Establishment Rule (77 FR 18374). Current § 155.330(b)(1) through (3) indicates that enrollees must report any changes relevant to the eligibility standards specified in § 155.305 within 30 days; however, enrollees who did not seek a determination for insurance affordability programs are not required to report changes affecting those programs, and the Exchange may set an income change threshold below which reporting is not required.

While the existing requirements under § 155.330(b) continue to apply, our proposed policy further strengthens our approach by requiring enrollees to provide or confirm specified eligibility information on an annual basis, and the Exchange to verify that information, to receive APTC and CSRs. Requiring this action on at least an annual basis ensures eligibility information is actively reviewed, rather than passively assumed to remain unchanged. Conditioning an

enrollee's annual eligibility redetermination for APTC and CSRs on their affirmative provision or confirmation of eligibility information, and Exchange verification of that information, represents a more robust program integrity measure than the existing requirement under § 155.330(b) to report changes in circumstances within 30 days, which lacks an inherent enforcement mechanism to ensure enrollee compliance.

We are not proposing any changes to annual re-enrollment in QHPs because, as provided in section 36B(c)(5)(D) of the Code, which was added by section 71303 of the WFTC legislation, the new verification rules in section 36B(c)(5) of the Code do not affect an individual's ability to enroll in a QHP through an Exchange. We also have determined that it is appropriate under section 1411(f)(1)(B) of the Affordable Care Act to maintain this process. Annual automatic re-enrollment in health insurance plans continues to be an industry standard in the off-Exchange, unsubsidized individual and small-group markets. Continuing this practice in the Exchanges promotes continuous coverage. Exchanges would continue to be required to automatically re-enroll eligible individuals who do not make an active plan selection into a QHP under proposed § 155.335(c). This includes automatically re-enrolling individuals into a full-price QHP without APTC and CSRs, as well as re-enrolling individuals into a QHP with APTC and CSRs, if applicable, if the enrollee provided updated eligibility information pertaining to the subsequent plan year or confirmed that the prior plan year information remains accurate for the subsequent plan year and the Exchange verified that information, consistent with the requirements proposed under § 155.335(a)(1)(i) and (ii) of this subpart.

To be re-enrolled in a QHP through the Exchange with APTC and CSR, we propose that enrollees would be required to provide or confirm, and an Exchange would be required to verify, the specified eligibility criteria on or after August 1 preceding the coverage year. First, we propose the timing of this requirement to align with the start date of the proposed pre-OE verification period described in section III.A.9.c. of this proposed rule. In that section, we propose that Exchanges would be required to make available a verification period before the

OEP to support applicants and enrollees in verifying certain eligibility information for the subsequent plan year. Aligning the start date for when enrollees would be required to verify certain information to be redetermined eligible for APTC and CSRs for the subsequent plan year with the start of the annual period intended to support verifications for the subsequent year would promote operational clarity and consistency for Exchanges, consumers, and other interested parties. In other words, we have determined that it would be clearest to consumers, agents, brokers, and other assisters that August 1 is the first day consumers, especially current enrollees, may begin providing information to the Exchange for purposes of verifying eligibility information for the subsequent plan year. We emphasize that enrollees would not be required to utilize the pre-OE verification period described in section III.A.9.c of the proposed rule and may instead provide or confirm their information during the OEP or until December 31 and have it verified by the Exchange to satisfy the requirement proposed in this section.

Second, we propose August 1 because it would increase the likelihood of accurate future year attestations by current enrollees and accurate verifications by Exchanges as compared to verification on an earlier date. For example, we are of the view that consumers are less likely to be able to reliably estimate their annual household income for the subsequent plan year earlier than August of the preceding year. Permitting Exchanges to conduct annual verifications earlier than August of the preceding year would also result in the use of older data than if verifications occur in August or later. For example, if an Exchange were to conduct verification procedures in May 2027 for purposes of determining eligibility for PY 2028, a data source available in May for coverage to begin in January, would make the data at least 8 months old.

Additionally, the IRS provides tax return data for the most recent tax year for which data is available to Exchanges once it becomes available. As a result, IRS tax return data accessed earlier in the year is more likely to reflect older income information compared to data accessed later in the year. We are concerned that permitting an earlier start date would decrease both the reliability of individuals' projected eligibility information and the accuracy of the Exchange's

verification procedures, both of which this proposal is intended to improve. For example, for an enrollee who filed their Federal income tax return in March and reconciled past APTC, that latest income information is likely to be returned to an Exchange starting in May. However, for an enrollee who filed their Federal income tax return and reconciled past APTC near the April deadline or filed late, that latest income information is not likely to be returned to an Exchange starting in May or even June or July, depending on IRS processing. By August, we expect most tax filers without an extension are likely to have their latest tax data returned to the Exchange. Finally, a start date later than August 1 would mean enrollees have less time to provide or confirm their information and that there would be less time for Exchanges to verify it in time for January of the applicable plan year. Therefore, we are proposing on or after August 1 to reasonably balance all of these considerations.

We propose December 31 of the year preceding the applicable plan year as the deadline for an enrollee to provide or confirm their eligibility information for the purposes of annual redetermination for APTC and CSRs. This deadline provides enrollees the maximum amount of time during the year preceding the applicable plan year to provide or confirm such information before January 1 of the applicable plan year.

We solicit comment on the proposed August 1 to December 31 timeframe for enrollee and Exchange requirements for annual redeterminations for APTC and CSRs, especially from State Exchanges. We understand State Exchanges may find it challenging to implement these requirements for PY 2028. We also understand that some State Exchanges may be able to leverage or modify existing consumer touch-points and processes, as well as State-specific data sources – such as State wage data, which may be more current than IRS income data – to facilitate an earlier confirmation of information from enrollees than August 1 in such a way as to mitigate additional consumer burden, while still reducing the risk of inaccurate income projections.

We also note that while we propose an August 1 start date in this proposed rule, for the

reasons discussed, under section 71303 of the WFTC legislation, the requirement for Exchanges to begin their pre-OE verification period is no later than August 1, but the statute does not prescribe an earliest permissible start date. Therefore, we are considering providing flexibility related to the start date for the first year only for State Exchanges. That is, we may permit State Exchanges to offer an earlier start date than August 1 only in 2027 (for PY 2028) for the annual redetermination requirement proposed in this section. This would give State Exchanges a longer verification window, in which they could communicate this new requirement to consumers and prompt the proposed required annual action by their existing enrollees to provide or confirm certain eligibility information so that Exchanges and enrollees would have more time to complete the required verifications in the first year of implementation as they become accustomed to the new annual requirements.

While we recognize that some State Exchanges may be better able to leverage or modify their existing processes if there is flexibility around the August 1 start date for the first year, for the reasons described previously, we have determined that an earlier start date could compromise the accuracy of attestations by enrollees and the accuracy of verifications by Exchanges, generally speaking. For this reason, we would likely identify limits to how much earlier in the year that State Exchanges could reasonably allow enrollees to provide or confirm their information while maintaining accuracy of the confirmed information and verifications for the purposes of the eligibility redetermination and re-enrollment tied to the subsequent plan year. We solicit comment, particularly from State Exchanges, on all aspects of this possible flexibility for State Exchanges, but in particular comment on what existing State Exchange practices would facilitate meeting the proposed consumer confirmation requirement earlier than the proposed August 1 date and what point in the plan year do these processes typically occur. Additionally, we seek comment in particular on what State Exchange processes would mitigate the risks of inaccurate projections from consumers or outdated verifications data if an earlier start date is permitted.

We clarify that under both current and proposed regulations, as part of the annual redetermination process for QHP for enrollees who have requested financial assistance, Exchanges are required to redetermine eligibility for Medicaid, CHIP, and the Basic Health Program (BHP), as applicable. The proposal to require enrollees to confirm certain information annually before APTC and CSRs may be redetermined under § 155.335 would not alter the existing requirement under § 155.305(f)(ii)(B) that an individual must be ineligible for Medicaid and CHIP to be eligible for APTC and CSRs. For an enrollee who confirms their information on or after August 1 of the year preceding the plan year, the Exchange would be required to determine eligibility under § 155.305, once it has sufficient information to do so, and the Exchange would be required to conduct verifications under §§ 155.315 and 155.320. As discussed in section III.9.c. of this proposed rule, during the pre-OE verification period an Exchange may choose to collect comprehensive eligibility information from consumers sufficient to make an eligibility determination or may request a more limited set of information insufficient to make an eligibility determination. Therefore, the Exchange would not be permitted to determine an enrollee APTC or CSR eligible for the subsequent year until the enrollee has provided or confirmed information which demonstrates to the Exchange whether the enrollee may be eligible for or enrolled in Medicaid, CHIP, or BHP.

If the individual is eligible for Medicaid, CHIP, or BHP, the Exchange must send the information to the State agency per section 1943 of the Social Security Act (the Act), added by section 2201 of the Affordable Care Act and implementing regulations at §§ 155.302(b) and 155.345. Coverage effective dates for Medicaid eligibility are governed by those standards found in section 1902(a)(34) of the Act. We note that section 71112 of Pub. L. 119-21 amends section 1902(a)(34) of the Act effective January 1, 2027, regarding retroactive eligibility periods. In addition, States must specify a method for determining the effective date of eligibility for separate CHIP, which can be determined based on the date of application or through any other reasonable method that ensures coordinated transition of children between CHIP and other

insurance affordability programs as family circumstances change and avoids gaps or overlaps in coverage, consistent with 42 CFR 457.340(g). For BHP, States must establish a uniform method of determining the effective date of eligibility for enrollment in a standard health plan, in accordance with 42 CFR 600.320(c). States may elect to follow the Exchange effective date standards at 45 CFR 155.420(b)(1); the Medicaid effective date standards at 42 CFR 435.915, exclusive of 42 CFR 435.915(a), which will be superseded by section 71112 of Pub. L. 119-21 effective January 1, 2027; follow an effective date of eligibility of the first day of the month following the month in which BHP eligibility is determined; or, follow an effective date of eligibility standard established by the State and subject to HHS approval. If the enrollee provided or confirmed their information, is not eligible for Medicaid, CHIP, or BHP, and the Exchange successfully verified the applicable eligibility information, then the Exchange would redetermine the enrollee eligible for APTC or CSRs, if otherwise eligible under § 155.305.

We seek comment on methods for Exchanges to implement the requirement proposed in this section that minimizes burden on Exchanges and enrollees. We seek comment on the methods that an Exchange should be permitted to use to obtain a current enrollee's confirmation of, or update to, the specified eligibility criteria (that is, household income and family size, U.S. citizenship or status as a lawfully present eligible non-citizen, eligibility for or enrollment in other MEC, and place of residence). The single streamlined application under § 155.405 would be one compliant method for an Exchange to obtain an enrollee's confirmation of, or update to, the specified eligibility information. We are interested in commenters' input on this method and on other strategies. Given that this proposal intends to require enrollees to have an active role in confirming or updating specified eligibility information for purposes of the subsequent plan year, we seek input on methods of implementation that balance the policy goal of accurate attestations for the subsequent plan year with the burden it may impose on enrollees who are eligible to remain enrolled in Exchange coverage with APTC and CSRs.

We propose in § 155.335(b) that the effective date for the annual eligibility

redetermination of eligibility for enrollment in a QHP and for APTC and CSRs, as applicable, would be the first day of the applicable plan year. This means if an applicant provides or confirms the specified information and the Exchange verifies it before January 1, an Exchange would be required to redetermine APTC and CSRs under § 155.305 and proposed § 155.335 effective on January 1 of the plan year.

However, we propose an exception to redeterminations of APTC and CSRs for instances when an enrollee has an unresolved DMI related to the applicable enrollment information and for whom APTC and CSRs cannot be provided during the inconsistency period as of December 31 of the year preceding the plan year. We propose that the effective date for the APTC and CSRs redeterminations in these instances where the redetermination occurs in the applicable benefit year, rather than before, follow the rules established in §§ 155.315(f)(4)(iv) or 155.330(f)(3), as applicable.

Under proposed § 155.335(a), the Exchange would redetermine eligibility for APTC and CSRs in accordance with § 155.305 when the specified information is verified under §§ 155.315 and 155.320, including the relevant provisions in those sections regarding inconsistencies. This includes instances when enrollees are eligible for APTC and CSRs at the conclusion of the inconsistency period based on trusted data source information. For example, consider an enrollee who confirms their information for plan year 2028 on October 1, 2027. The Exchange verifies their applicable enrollment information in real-time except for income and therefore, generates an income DMI under proposed § 155.315(f)(4)(ii) that prevents APTC and CSRs from being provided during the inconsistency period. On December 31, 2027, the income DMI expires. The Exchange would redetermine eligibility for APTC and CSRs after the income DMI expires by relying on trusted data source information. In this scenario, IRS data indicates that the enrollee is eligible for APTC and CSRs, which is effective January 1 in accordance with proposed § 155.335(b). Now consider the same enrollee except they confirm their information for plan year 2028 on November 1, 2027. The enrollee's income DMI remains open as of December 31 and

then expires on January 31, 2027. IRS data indicates that the enrollee is eligible for APTC and CSRs, which is effective on February 1, 2027, in accordance with proposed § 155.335(b)(1).

We also clarify that we are proposing in this section that the proposed rules in § 155.315(f)(4)(iii) (discussed in III.A.4.d. of this proposed rule) regarding payment of APTC and CSRs during an inconsistency period resulting from mid-year redeterminations would also apply to payment of APTC and CSRs during an inconsistency period resulting from an annual redetermination. Under § 155.335(a)(1)(ii), we propose that an Exchange would verify the information in § 155.335(a)(1)(i) in accordance with §§ 155.315 and 155.320 before determining an enrollee eligible for APTC and CSRs, which includes the proposed rules described in § 155.315(f)(4)(iii). Under the proposed rules described in § 155.315(f)(4)(iii), if an enrollee reports a change that would increase the amount of APTC or CSRs after an Exchange has completed verification of the applicable enrollment information using the enrollee's information from their immediately preceding eligibility determination, then the Exchange would be required to maintain APTC or CSRs at the previously verified amount during the inconsistency period. If that DMI is successfully resolved, an Exchange would be required to redetermine eligibility and adjust the amount of APTC or CSRs upwards based on the consumer's verified information. If that DMI is not resolved, the Exchange would be required to redetermine QHP and APTC and CSR eligibility, as applicable, on the basis of records maintained by a trusted data source, which may include removal of QHP or APTC eligibility. Conversely, if an enrollee reports a change that would decrease APTC or CSRs, then the Exchange would be required to reduce APTC or CSRs based on the enrollee's attested information during the inconsistency period. All of these circumstances could occur for enrollees who have met the requirements proposed under § 155.335(a)(1) and subsequently report a change before the plan year begins that results in a DMI related to the applicable enrollment information for the following plan year. Therefore, we propose the same rules regarding APTC and CSRs would apply for the annual redetermination effective on January 1, 2028, to ensure consistent treatment of enrollees reporting changes for the

same plan year, regardless of whether the changes are reported before the plan year or within the plan year.

Consider an enrollee who confirmed their information for the subsequent plan year and such information was verified in October, satisfying the requirements in proposed § 155.335(a)(1). This enrollee would be eligible for APTC and CSRs under § 155.305, as required under proposed § 155.335(a), and the determination would be effective January 1 of the applicable benefit year, under proposed § 155.335(b). The enrollee reports a change to the Exchange in December that results in a DMI related to the applicable enrollment information, and the Exchange makes a new determination that either lowers or maintains the amount of APTC during the inconsistency period. Because the requirements under proposed § 155.335(a)(1)(i) would be met and there would be a verified APTC and CSR amount that would satisfy proposed § 155.335(a)(1)(ii) as of December 31 of the year preceding the plan year, and the APTC and CSRs redetermination – either lowered or maintained – would be effective on January 1 under this section’s proposed rules, if finalized as proposed.

We recognize that Exchanges, issuers, consumers, agents, brokers, and web-brokers may have developed reliance interests in the existing annual redetermination procedures. Many Exchanges automatically re-enroll a significant portion of their Exchange population in QHP coverage with APTC or CSRs without requiring action for enrollees without changes to report. We recognize that Exchanges have invested in their enrollee communication infrastructure and eligibility and enrollment systems to operationalize and support the current annual redetermination policy. We acknowledge that implementation of this proposal would require Exchanges to modify existing enrollee communication and eligibility redetermination and re-enrollment processes. Specifically, Exchanges would likely need to make substantial system changes to update eligibility redetermination and re-enrollment functionality, including technical processes and enrollee notice templates and other communications related to continuing or discontinuing APTC or CSRs, as applicable, to comply with the proposed requirement, if

finalized. Such changes would include modifications to annual re-enrollment backend processes to permit automatic eligibility redetermination and re-enrollment in QHP coverage only. We also anticipate that Exchanges would need to conduct system testing and validation activities after completing updates to ensure compliance with the requirements of this proposal.

Exchanges could choose to develop and implement processes designed to streamline the collection of applicable enrollment information for re-enrollees with APTC or CSRs. We anticipate that, over time, Exchanges would refine their processes and identify more efficient approaches to facilitate compliance, thus minimizing administrative burden on enrollees. For example, Exchanges could utilize the single streamlined application with pre-populated information from the enrollee's most recent application; design and implement a simplified application review mechanism that would make it easier for enrollees to review and confirm application information; provide previously submitted application information through alternative means, like a notice, that an enrollee would be required to respond to; or adopt a combination of these or other approaches, as appropriate, to best service their enrollee populations in meeting the proposed requirement. For strategies available to Exchanges for collecting the applicable enrollment information provided or confirmed by the enrollee, or their application filer, during the pre-OE verification period, see section III.A.9.c.vi. of this proposed rule.

We recognize that this proposal, if finalized, would require updates to issuers' enrollment projections and associated business procedures. We anticipate that issuers would need to modify operational and administrative processes, including coordinating more closely with Exchanges to reconcile enrollment transactions, process terminations and re-enrollments, and update enrollee communications. We also acknowledge that issuers may experience changes in enrollment patterns, including increased enrollee churn, which could affect risk pool predictability, particularly during the initial years of implementation.

Because of the longstanding policy of automatic re-enrollment with APTC or CSRs

without required action by enrollees, many enrollees may continue to expect that their coverage with financial assistance will continue from year to year with no action required on their part. Enrollees who otherwise would have taken no action but must do so to remain eligible for APTC or CSRs under this proposed policy would have additional burden to provide or confirm their eligibility information, which may result in DMIs that require the submission of documents so the Exchange can verify information that could not be verified through a trusted data source. Some of these enrollees may not provide or confirm their information at all due to a lack of knowledge about this change in policy, which would result in a loss of APTC or CSRs. Enrollees who are automatically re-enrolled into QHP without APTC or CSRs would have the opportunity to update or confirm their eligibility determination during the plan year, in which case the Exchange would redetermine eligibility for APTC and CSRs in accordance with § 155.330(a). However, some portion of these enrollees would not be able to pay the full cost of enrollment which would prompt them to disenroll or be disenrolled for nonpayment of premiums, under the termination rules in § 155.430(b)(2)(ii). In this instance, such individuals would need a qualifying life event to re-enroll in a QHP outside of the yearly OEP through an SEP. With this in mind, we expect that the required notification under § 155.410(h), Exchange outreach, and extensive training for those assisting individuals with Exchange coverage, such as agents, brokers, and assisters, would be essential to minimizing the population of enrollees who do not provide or confirm their eligibility information with the Exchange at all and therefore lose financial assistance.

Similarly, we assume that many agents, brokers, and web-brokers have structured their staffing, outreach, client management practices, and operational workflows around existing automatic eligibility redetermination and re-enrollment practices. Changes to these procedures may necessitate adjustments to how agents, brokers, and web-brokers engage with clients, including increased efforts to prompt all of their enrollees to provide or confirm information for the subsequent plan year, which may impact their staffing needs and business costs. For

example, some agents, brokers, and web-brokers who have historically adopted a staffing model focused on increasing seasonal support during the OEP may deem it necessary to expand the period of time during which they employ workers to include the pre-OE verification period to support all their clients. We expect the availability of the pre-OE verification period would support agents, brokers, and web-brokers in assisting their clients with meeting the proposed Exchange requirements for annual re-enrollment with APTC and CSRs. This is because the pre-OE verification period would give agents, brokers, and web-brokers three additional months to submit eligibility information to the Exchange on behalf of their clients and help their clients resolve DMIs, if they have them, for an applicable plan year. We also expect that agents, brokers, and web-brokers would identify opportunities to improve the services they provide within the shifting landscape to set themselves apart from their competitors.

Despite the costs associated with these groups making necessary modifications for this proposal, we have determined that the proposed change is critical to ensuring the integrity and accuracy of Exchange redeterminations and authorization of APTC and CSRs across plan years. As described in this section, we have determined that requiring enrollees to annually provide or confirm their eligibility information strengthens Exchange program integrity and better aligns APTC determinations with PTC determinations. Additionally, it would help protect enrollees from potentially significant tax liabilities at reconciliation, particularly given the removal of repayment limitations. In addition, this proposal would bring Exchange operations into closer alignment with the statutory framework established under the WFTC legislation. We seek comment on these proposals.

8. Enrollment of Qualified Individuals into QHPs (§ 155.400)

a. Binder Payment for New Enrollments (§ 155.400(e))

We are proposing to modify § 155.400(e) to ensure the new enrollments proposed in §§ 155.410 and 155.420 of this rule are subject to appropriate binder payment rules, as well as to ensure that certain existing SEPs are subject to the binder payment rules, when they were

previously inadvertently omitted.²² Specifically, we propose to merge § 155.400(e)(1)(i) and (ii) into paragraph (e)(1)(i), which would provide that Exchanges may, and the FFE and SBE-FPs must, make prospective enrollments (including both prospective enrollments through OEP and SEPs) subject to the binder payment rules for prospective enrollments under current § 155.400(e)(1)(ii). This would include prospective enrollments under §§ 155.410(f); 155.420(b)(1), (2), (3), (5); and proposed § 155.420(b)(6)(ii) (which is discussed in III.A.10. of this proposed rule). In § 155.400(e)(1)(ii), we propose that Exchanges may, and the FFE and SBE-FPs must, make retroactive enrollments under proposed § 155.410(f)(5)(i)(A) and (B); § 155.410(f)(5)(ii)(A) and (B); § 155.420(b)(1), (2), (3), and (5); and proposed § 155.420(b)(6)(i) subject to the current binder payment rules for retroactive enrollments under current § 155.400(e)(1)(iii) (proposed to be redesignated as § 155.400(e)(1)(ii)). The proposals related to retroactive enrollments are discussed in sections III.A.9 and III.A.10. of this proposed rule. We also propose to make a conforming amendment at § 155.400(e)(1)(i). Finally, we propose certain technical amendments to § 155.400(e)(1).

As background, HHS' regulations currently require that, on FFEs and SBE-FPs, and in State Exchanges that adopt a binder payment policy, the deadline for making the binder payment must be within a specified range:

(1) For enrollments with regular coverage effective dates, the deadline must be no earlier than the coverage effective date, and no later than 30 calendar days from the coverage effective date;

(2) For enrollments with special effective dates,²³ the deadline must be no earlier than the coverage effective date and no later than 30 calendar days from the date the issuer receives the enrollment transaction or the coverage effective date, whichever is later; and

²² HHS regulations require enrollees to pay the first month's premium, known as the binder payment, to effectuate coverage.

²³ Special effective dates are described in § 155.420(b)(2) and refer to effective dates for certain SEPs (such as the marriage SEP described in (b)(2)(ii)).

(3) For enrollments with retroactive effective dates, the deadline must be no earlier than 30 calendar days from the date the issuer receives the enrollment transaction. In addition, effectuation of retroactive coverage requires payment of premium for all retroactive months of coverage through the first prospective month, and if only one month's premium is paid, coverage is effectuated prospectively.

In the 2015 Payment Notice (79 FR 30240), HHS established in § 155.400(e) that Exchanges may, and the FFE and SBE-FPs must, require payment of the first month's premium to effectuate an enrollment. In the 2016 Payment Notice (80 FR 10750), HHS established the initial requirements regarding deadlines for making the binder payment under regular coverage effective dates (no earlier than the coverage effective date, and no later than 30 calendar days from the coverage effective date), and special effective dates (30 days from the date the issuer received the enrollment transaction). These rules were updated in the 2017 Payment Notice (81 FR 12204), to provide that, for making the binder payment under special effective date rules, the deadline may be no earlier than the coverage effective date and no later than 30 calendar days from the date the issuer receives the enrollment transaction or the coverage effective date, whichever is later. HHS also established the rules regarding making the binder payment for retroactive enrollments.

HHS established the binder payment rules to ensure a consistent process on the FFE for collection of the first month's premium by issuers. HHS further established specific deadlines for issuers to collect binder payments to balance the interests of flexibility for issuers in collecting premiums (traditionally a business decision made by issuers), and consumer protection. The rules that we established balanced these needs by ensuring that issuers could not require payment of the first month's premium earlier than the coverage effective date, but also that they must require payment within 30 days. For retroactive enrollments, which may require payment of multiple months of premiums, the rule ensured that consumers would have at least 30 days from the date the issuer received the enrollment transaction to pay the binder payment, while also providing

flexibility to issuers to set a later payment due date.

We propose to amend § 155.400(e)(1)(i) to state that the binder payment rules in that section would continue to apply to prospective enrollments under § 155.410(f) but would not apply to retroactive enrollments under proposed § 155.410(f)(5)(i) and (ii). Similarly, we propose that the binder payment rules in § 155.400(e)(1)(i) would apply to prospective enrollments under § 155.420, including §§ 155.420(b)(1), (2), (3), (5) as well as proposed § 155.420(b)(6)(ii). Additionally, and as a mirror to proposed § 155.400(e)(1)(i), we propose to amend § 155.400(e)(1)(iii) and redesignate it as paragraph § 155.400(e)(1)(ii) to specify that the binder payment rules in that section would apply to retroactive enrollments in proposed § 155.410(f)(5)(i)(A) and (B) and (ii)(A) and (B); § 155.420(b)(2), (3), and (5); and proposed § 155.420(b)(6)(i). We propose these changes to ensure that the new enrollments proposed in this rule are subject to appropriate binder payment rules. We also propose these changes to ensure that certain existing SEPs are subject to the binder payment rules, when they were previously inadvertently omitted. The proposed new enrollments are described below.

In section III.A.9. of this proposed rule, we propose to add new § 155.410(f)(5)(i) and (ii), which would (depending on the annual OEP dates in effect)²⁴ establish new effective date rules for when an applicant resolves a DMI as described in proposed § 155.315(f)(4)(ii) and has elected to pend their plan selection as described in proposed § 155.400(i). Specifically, we propose in §§ 155.410(f)(5)(i)(A) and (ii)(A) that if a consumer's DMIs are resolved on or before the fifteenth of the month following the consumer's otherwise-prescribed coverage effective date, then their QHP would be effective on their prescribed coverage effective date. These enrollments could be prospective or retroactive depending on when DMIs are resolved. In § 155.410(f)(5)(i)(B) and (ii)(B), we propose new retroactive effective date rules when DMIs described in § 155.315(f)(4)(ii) are not resolved by the 15th of the month following the consumer's otherwise-prescribed coverage effective date. This would be the first time that plan

²⁴ For a discussion of the OEP effective date provisions, see section III.A.9.b of this proposed rule.

selections made through OEP could result in a retroactive enrollment.

In section III.A.10. of this proposed rule, we also propose to add § 155.420(b)(6) to provide the effective dates for coverage if a consumer qualifies for an SEP and elects to pend their enrollment until all DMIs related to the applicable enrollment information are resolved. Under proposed § 155.420(b)(6)(i), if the DMI is resolved on or before the 15th of a month, coverage would be effective the 1st of the same month.²⁵ This would establish a new retroactive effective date for coverage enrolled in through an SEP.

As a result of these proposed changes, consumers would, in certain circumstances, be permitted to pend plan selections made through OEP, which would be released to the issuer upon successful resolution of the DMIs related to the applicable enrollment information. This could result in a situation where a prospective enrollment is released to the issuer after the coverage effective date. For example, if a consumer resolves their DMIs on December 31, the pended plan selection may not be released until after the January 1 coverage effective date. In contrast, under current rules, plan selections with prospective enrollments are usually released to the issuer prior to the coverage effective date.²⁶ For example, plan selections made on or before December 15 are generally released to the issuer no later than December 16, approximately two weeks before the coverage effective date of January 1.

Therefore, we propose to merge current § 155.400(e)(1)(i) and (ii) into § 155.400(e)(1)(i) such that all prospective enrollments would be governed under the rules for payment of the binder payment under current § 155.400(e)(1)(ii). This would ensure that the deadline for making the binder payment is not before the issuer receives the enrollment transaction when the enrollee would not have a chance to pay the binder payment, and that the enrollee has enough time (at least 30 days) to make the binder payment and effectuate coverage. The binder payment

²⁵As above, under proposed § 155.420(b)(6)(i), if the inconsistency is resolved after the 15th of the month, coverage would be effective on the 1st of the following month.

²⁶One exception would be situations in which a consumer enrolls through an SEP on the last day of a month with a coverage effective date of the 1st of the following month, in which case the enrollment transaction may not be sent to the issuer until on or after the coverage effective date.

would be required to consist of the premium for all months of retroactive coverage (which in this scenario would be limited to 1 month) plus the premium for the following months' coverage, which means that the enrollee would always have to pay a minimum of two months of premium in this scenario to effectuate coverage. However, enrollees would also have the option to pay one month of premium and effectuate prospective coverage only.

We also propose to make amendments to § 155.400(e)(1)(i) and (ii) to add references to SEPs that were inadvertently omitted. Specifically, we propose to add a reference to the SEPs at § 155.420(b)(1) (describing regular coverage effective dates) and (b)(5) (describing the option for earlier effective dates due to untimely notice of triggering event) to § 155.400(e)(1)(i). We also propose to add references to the SEPs at § 155.420(b)(3) (describing the option for earlier effective dates) and (b)(5) (describing the option for earlier effective dates due to untimely notice of triggering event) to § 155.400(e)(1)(ii). We are of the view that these prospective and retroactive enrollments should, like all others, be subject to the binder payment rules for prospective and retroactive enrollments, respectively.

Finally, we propose to make several technical edits to § 155.400(e)(1) which would clarify the requirements of this regulation. First, we propose to change the phrase “from the date the issuer receives the enrollment transaction” to “after the later of the dates the issuer receives the enrollment transaction or the coverage effective date” in proposed § 155.400(e)(1)(i), and to make similar edits to proposed § 155.400(e)(1)(ii), to more clearly set forth the binder payment deadline in each provision. In proposed § 155.400(e)(1)(ii), we propose to replace “through” with “and for” when discussing payment for the first prospective month of coverage. In § 155.400(e)(1)(ii), we propose to change “only prospective coverage must be effectuated” to “issuers must effectuate prospective coverage,” in addition to adding the phrase “but less than the full amount owed,” to clarify the requirement that issuers must effectuate prospective coverage when an enrollee who is eligible for retroactive coverage pays at least one month of premium, but less than the full amount owed by the binder payment deadline. Finally, we

propose to remove the references to “regular effective dates” and “special effective dates” from § 155.400(e)(1), since these phrases are used differently in § 155.420, which may cause confusion. For example, in § 155.420(b)(1), the phrase “regular effective dates” refers to SEP enrollments other than those specified in § 155.420(b)(2) and (3), whereas in the current § 155.400(e)(1)(i) the phrase “regular effective dates” refers to enrollments through OEP.

We seek comment on this proposal.

b. Plan Selection in the Case of Certain DMIs (§ 155.400(i))

We are proposing to add new § 155.400(i) to require that Exchanges permit applicants and enrollees to “pend” their plan selection until the information for DMIs related to the applicable enrollment information is verified.

As described in section III.A.4.b. of this proposed rule, we propose that Exchanges may not be permitted to authorize payment for APTC and CSRs, as applicable, for applicants and enrollees who have DMIs related to the applicable enrollment information until that information is verified. While applicants and enrollees with these DMIs may choose to enroll in full-cost coverage through an Exchange according to the effective date rules described at §§ 155.410 and 155.420 while the DMI is pending, some may be unable to afford to do so. Therefore, we propose to require Exchanges to permit applicants and enrollees to “pend” their plan selection during their inconsistency period such that the plan selection is only sent to the issuer, and QHP coverage only becomes effective, after the Exchange determines the applicant or enrollee eligible for APTC and CSRs, as applicable, as described by § 155.315(f)(4)(iv) or § 155.315(f)(5). For a discussion of when an applicant’s or enrollee’s pended plan selection (PPS) would become effective, refer to section III.A.9. of this proposed rule.

As background, a PPS is an option provided to applicants utilizing the FFE and SBE-FPs today while their SEP pre-enrollment verification, referred to as SEP Verification, is in progress. Currently, new applicants enrolling through the FFE and SBE-FPs can pend a plan selection after submitting an application that requires SEP Verification in accordance with § 155.420(g). New

applicants subject to SEP Verification generate a special enrollment period verification issue (SEP verification issue) and are required to provide documentation to an Exchange demonstrating that they have experienced an SEP qualifying event before they can enroll in QHP coverage. New applicants are permitted to select and “pend” the QHP they would like to be enrolled in upon resolution of their SEP verification issue so they do not have to return to the Exchange to select a plan and enroll after their SEP verification issue is resolved. These PPSs are stored within an Exchange’s records only and are released to the issuer upon successful resolution of the applicant’s SEP verification issue. We have determined that a similar process is needed to allow applicants to pend QHP enrollments when they are not eligible to receive APTC or CSRs during an inconsistency period for DMIs related to the applicable enrollment information because applicants may be unwilling or unable to enroll in a full price QHP during that period. Therefore, we propose that an Exchange would be required to allow applicants and enrollees to elect to pend a plan selection that would be released to the issuer if and when the Exchange determines the applicant or enrollee eligible for APTC and CSRs, as applicable, as described by § 155.315(f)(4)(iv) or § 155.315(f)(5). This would streamline the enrollment process for applicants and enrollees who elect not to enroll in a full-price QHP during their inconsistency period because it would remove the burden of them returning to an Exchange to enroll in a plan once the relevant DMIs are resolved. Under our proposed rule, applicants and enrollees would also have the option to enroll in a full-price QHP during the inconsistency period, which, as of today, could be selected in a single session along with the application submission.

We note that this policy is particularly important for individuals who enroll using an SEP. As described in section III.A.4.b. of this proposed rule, applicants and enrollees with a DMI related to the applicable enrollment information would have a 90-day window to resolve their DMI. Upon resolution of their DMIs by an Exchange, as described in proposed § 155.315(f)(4)(ii), such applicants or enrollees could start receiving APTC and CSRs, if

otherwise eligible. In contrast, individuals enrolling through an SEP generally have only 60 days from the triggering event to select a plan. For example, if an applicant becomes newly eligible to enroll in a QHP on March 1, they would generally have until April 30, which is 60 days from the date they became eligible to enroll in a QHP, to select a QHP using that SEP. If, on April 30, this applicant submits an application to enroll through the SEP and also generates a DMI related to the applicable enrollment information, then this applicant would have a 90-day inconsistency period until July 29 to provide documentation to an Exchange to resolve their DMI. In this scenario, if the applicant used any of the 90-day period to resolve their DMI and did not have the opportunity to pend their enrollment, they would be unable to enroll in a plan after an Exchange resolved their DMI because the 90-day inconsistency period would begin after the 60-day SEP window to select a plan ended.

We have similar concerns regarding the mismatch between inconsistency period timelines and enrollment period timelines for applications submitted during the OEP. Based on policies proposed elsewhere in this rule, starting with the PY 2028, applicants and enrollees seeking to enroll with APTC and CSRs would miss the opportunity to enroll during OEP if an Exchange does not resolve their DMIs related to the applicable enrollment information before the end of the OEP, unless they are permitted to pend their plan selections. For example, suppose on December 15 an applicant applies for QHP coverage and financial assistance which generates a DMI related to the applicable enrollment information, the applicant provides documentation to resolve the DMI on January 5, and it takes an Exchange 15 days to resolve the DMI which occurs January 20. If the applicant waits until their DMI is resolved to enroll in a QHP, then (absent an SEP) they would be unable to enroll because OEP would have already ended if the Exchange has a January 15 OEP end date. Despite Exchanges' best efforts to create efficient processes for DMI resolution, the potential for Exchange backlogs and delays in processing documents creates a risk that many DMIs generated during the OEP will not be resolved before the end of the OEP for reasons beyond the applicant or enrollee's control. Therefore, permitting

PPSs is crucial for applicants and enrollees who cannot, or do not want to, enroll in an unsubsidized QHP during an inconsistency period when APTC and CSRs cannot be paid.

To address these concerns, we are proposing to add new § 155.400(i), so that an Exchange would be required to: (1) accept a QHP selection from applicants and enrollees with DMIs related to the applicable enrollment information; and (2) at the option of the applicant or enrollee, transmit to a QHP issuer the enrollment information necessary to enable the QHP issuer to enroll the consumer only upon the Exchange determining the applicant or enrollee eligible for APTC and CSRs, as applicable, as described by § 155.315(f)(4)(iv) or § 155.315(f)(5).

We are adding, “at the option of the consumer” language, to make it clear that an applicant also has the option to enroll in full price QHP coverage during the inconsistency period for a DMI related to the applicable enrollment information if they so choose. Additionally, we note that some households may have DMIs that only prevent APTC and CSRs for some household members and not others (such as those related to eligibility or enrollment in other coverage), in which case APTC would be payable but the total amount of APTC payable during the inconsistency period would be lower than if the information related to the DMI was verified. In this circumstance, all household members may want to enroll in a QHP during the inconsistency period as they would not be required to pay the full cost.

We seek comment on this proposal. We understand that State Exchanges may find it challenging to implement these requirements for PY 2028. Therefore, we are considering providing flexibility to State Exchanges to delay implementation of the proposed PPS requirements until PY 2029. In particular, we seek comment from State Exchanges and other interested parties on the operational burden these proposed requirements would create and whether flexibility is needed to provide sufficient time for State Exchanges to build appropriate IT systems. We additionally welcome suggestions on equivalent alternatives to PPS for State Exchanges that would accomplish the same goal.

Furthermore, we are also considering allowing the release of the PPS at the end of the

inconsistency period when an applicant has failed to verify their attested information and an Exchange redetermines the applicant ineligible for APTC and CSRs based on trusted data sources as described in § 155.315(f)(5). We are concerned that applicants may not have alternate paths to coverage when their DMI is expired outside of the OEP and we want to preserve applicants' access to health insurance even without financial assistance. The applicant would still have the ability to cancel their plan if they do not wish to maintain the coverage without assistance.

We seek comment from State Exchanges and other interested parties on whether a PPS should also be released when applicants are redetermined ineligible for APTC and CSRs at the end of their inconsistency period or if applicants should be given an option at point of application to decide if they would like their PPS to be released without APTC or CSRs at the end of their inconsistency period. We also seek comment from State Exchanges and other interested parties on other situations where releasing a PPS before the end of the inconsistency period might be warranted and options for doing so.

9. Initial and Annual Open Enrollment Periods (§ 155.410)

a. Notice of Annual Open Enrollment Period

We propose to revise § 155.410 to redesignate § 155.410(d) as § 155.410(d)(1) and add § 155.410(d)(2) to require Exchanges, starting in 2027, to provide the written annual OE notification to each enrollee no earlier than the first of the month preceding the pre-OE verification period proposed in section III.A.9.c. of this proposed rule and no later than the first day of the OEP.

Exchanges are currently required to provide the annual OE notification in the month before the start of the OEP. This notification generally provides consumers with important information and requested actions for the subsequent plan year. Given that the proposed pre-OE verification period would be available to consumers to satisfy some of the verification requirements for a future plan year, it is important to permit Exchanges to send the required

annual OE notification earlier than is currently permitted. We considered creating a separate new requirement for Exchanges to send a written notification in advance of the pre-OE verification period. However, we are of the view that requiring separate notifications could inhibit Exchanges from designing the most effective outreach strategy to educate consumers about the earlier verification period and the existing OEP, though nothing would prohibit them from sending multiple notices as long as one satisfies the requirements of proposed § 155.410(d)(2).

Exchanges are best positioned to create effective communications for their consumers to ensure they understand the availability of the pre-OE verification period, the OEP, and what steps they are required to take in advance of the subsequent plan year.

We request comment on this proposal.

b. Effective Dates for QHP Selections

We propose to add new § 155.410(f)(5), which would provide limited exceptions to the annual OEP effective date rules otherwise specified in § 155.410(f). These exceptions would provide the QHP effective date rules when, during the annual OEP, a consumer pends their plan selection because they have a DMI related to the applicable enrollment information. We also propose amendments to the open enrollment and related effective date rules in § 155.410(e)(4) and (f)(3) to account for ongoing litigation.

Sections 1311(c)(6) and 1321(a) of the Affordable Care Act afford HHS broad authority to offer enrollment periods and to operate Exchanges. Section 155.410(e) provides annual OEP dates and § 155.410(f) provides effective dates for such enrollments. Until we finalized the Marketplace Integrity and Affordability final rule (90 FR 27074), § 155.410(e)(4) required that, for benefit year 2022 and later, the annual OEP must begin on November 1 of the calendar year preceding the benefit year and end January 15 of the benefit year. There were two exceptions to these start and end dates. First, State Exchanges had the option to adopt an end date later than January 15. Second, State Exchanges were permitted to maintain an annual OEP start date that was earlier than November 1 preceding the benefit year, in certain cases. Throughout this

section, we refer to these policies as the “extended OEP.” Effective date rules for plan selections made during the extended OEP policy were enumerated at § 155.410(f)(3).

In the Marketplace Integrity and Affordability final rule, we finalized new § 155.410(e)(5) requiring that, for PY 2027 and beyond, the annual OEP for all Exchanges must begin no later than November 1 and end no later than December 31 preceding the benefit year. Throughout this section, we refer to this policy as “shortened OEP.” We also finalized effective date rules for plan selections made during the shortened OEP at § 155.410(f)(4), requiring a coverage effective date of January 1. Finally, we finalized conforming amendments to § 155.410(e)(4) (related to the OEP) and (f)(3) (related to effective dates) to indicate that they would cease to apply after benefit year 2026.

On June 12, 2026, the U.S. District Court for the District of Maryland vacated the addition of § 155.410(e)(5) and (f)(4) in the Marketplace Integrity and Affordability final rule, which required a shortened OEP and imposed related effective dates for 2027 and later.²⁷ The court did not explicitly vacate the conforming amendments to § 155.410(e)(4) and (f)(3), which sunset the previous open enrollment period and related effective dates at the end of 2026. As such, § 155.410(e) and (f), do not currently specify an open enrollment period or related effective dates for PY 2027 and beyond. Notwithstanding, we interpret the court’s vacatur to extend to the conforming amendments, such that the version of § 155.410(e)(4) and (f)(3) in effect immediately before the effective date of the Marketplace Integrity and Affordability final rule—requiring an extended OEP and related effective dates—did not sunset and continues to apply in PY 2022 and beyond.²⁸

HHS is appealing the District Court’s decision.²⁹ As such, we are uncertain whether the extended OEP or shortened OEP policies will be in place for PY 2028, when this proposed rule

²⁷ See *City of Columbus v. Kennedy*, No. 1:25-cv-2114 (D. Md.), https://litigationtracker.law.georgetown.edu/wp-content/uploads/2025/07/City-of-Columbus_2026.06.12_ORDER.pdf.

²⁸ See for example, www.cms.gov/files/document/statement-re-city-columbus-080426.pdf and <https://www.healthcare.gov/quick-guide/dates-and-deadlines/>, setting forth extended OEP dates for PY 2027.

²⁹ See *City of Columbus v. Kennedy*, No. 26-1938 (4th Cir.).

would go into effect. Therefore, we are proposing two distinct sets of coverage effective date rules for PY 2028 and beyond for consumers who pend their plan selections during the annual OEP. First, at § 155.410(f)(5)(i), we are proposing rules for benefit years when the extended OEP policies enumerated in § 155.410(e)(4) apply. Second, at § 155.410(f)(5)(ii), we are proposing rules for benefit years when the shortened OEP policies enumerated in § 155.410(e)(5) apply. Additionally, we propose two amendments to account for the fact that the U.S. District Court for the District of Maryland did not explicitly vacate the conforming amendments to § 155.410(e)(4) and (f)(3). First, we propose language in new § 155.410(e)(4)(iv) to indicate that, if our appeal is unsuccessful and § 155.410(e)(5) is vacated, the requirements of § 155.410(e)(4) would apply for PY 2022 and beyond. Second, we propose language in new § 155.410(f)(3)(iii) to indicate that, if our appeal is unsuccessful and § 155.410(f)(4) is vacated, the requirements of § 155.410(f)(3) would apply for PY 2022 to 2027 only—as the requirements of proposed § 155.410(f)(5) would apply for PY 2028 and beyond. For the proposal to establish new coverage effective dates for PY 2028 and beyond, first, at § 155.410(f)(5)(i), we propose coverage effective date rules for consumers who pend their plan selection during the annual OEP for benefit years when there is an extended OEP. At § 155.410(f)(5)(i)(A), we propose that if a consumer pends their plan selection during the annual OEP and resolves all of their DMIs related to the applicable enrollment information by the 15th of the month following the effective date specified in § 155.410(f)(3), then coverage would be effective on the date specified in § 155.410(f)(3). If, however, they do not resolve all of their DMIs on or before the 15th of the month following the effective date specified in § 155.410(f)(3), then their coverage effective date would depend on when their DMIs were resolved. If their DMIs were resolved on or before the 15th of the month, their coverage effective date would be the first of that month. If their DMIs are resolved between the 16th and the end of the month, then their coverage effective date would be the first of the following month.

To illustrate, consider a consumer who pends their plan selection on December 20 and

resolves all DMIs related to the applicable enrollment information on February 6. Because their plan selection was received by the Exchange between December 16 and January 15, then their coverage effective date under § 155.410(f)(3)(i)(B) would be February 1.³⁰ Additionally, because they resolved all DMIs related to the applicable enrollment information on February 6, which is on or before the 15th of the month following February 1, the consumer's coverage effective date would remain February 1. If, however, such DMIs were not resolved until February 20, then, under proposed § 155.410(f)(5)(i)(C), their coverage effective date would be March 1. If their DMIs were not resolved until March 5, then, under proposed § 155.410(f)(5)(i)(B), their coverage effective date would be March 1.

Consider an alternative example where a consumer pends their plan selection on December 20 and resolves all DMIs related to the applicable enrollment information on January 10. Because their plan selection was received by the Exchange between December 16 and January 15, the coverage effective date under § 155.410(f)(3)(i)(B) would be February 1. However, assume that in this case, the Exchange chooses to exercise the flexibility afforded under § 155.410(f)(3)(ii), and to permit an earlier, January 1 coverage effective date instead. Under proposed § 155.410(f)(5)(i)(A), because they resolved all DMIs related to the applicable enrollment information on January 10, which is on or before the 15th of the month following January 1, then the consumer's coverage effective date would remain January 1. If, however, such DMIs were not resolved until January 20, then, under proposed § 155.410(f)(5)(i)(C), their coverage effective date would be February 1. If their DMIs were not resolved until February 5, then, under proposed § 155.410(f)(5)(i)(B), their coverage effective date would be February 1.

At § 155.410(f)(5)(ii), we propose separate effective date rules for benefit years when the shortened OEP policies at § 155.410(e)(5) apply. Specifically, we propose that when all DMIs related to the applicable enrollment information are resolved (and an applicant's eligibility for

³⁰ Section 155.410(f)(3)(ii) permits State Exchanges to prescribe earlier effective dates than those allowed under § 155.410(f)(3)(i). For purposes of this example, we are assuming that the Exchange is not exercising this option.

APTC and CSRs, as applicable, is therefore verified) on or before January 15 of the benefit year, the applicant's QHP would be effective on January 1. If all DMIs related to the applicable enrollment information are resolved (and APTC and CSR eligibility, as applicable, is verified) after January 15, and between the 1st and 15th of the current month, the applicant's QHP would be effective the first of the month in which the resolution occurs. If all DMIs related to the applicable enrollment information are resolved after the 15th of the current month, the applicant's QHP would be effective the first of the following month.

To illustrate, consider a consumer for whom an Exchange resolves all of their DMIs related to the applicable enrollment information in January. If the resolutions occur between January 1 and January 15, the applicant's pended plan selection would be effective starting January 1. If the DMIs are resolved by an Exchange between January 16 and January 31, the applicant's pended plan selection would be effective on February 1. For a resolution in February, if the DMIs are resolved by an Exchange between February 1 and February 15, the applicant's pended plan selection would be effective on February 1. If the DMIs are resolved by an Exchange between February 16 and the end of the month, the applicant's pended plan selection would be effective on March 1.

We propose these rules for the following reasons. Under the proposed new DMI process described in section III.A.4.b. of this proposed rule, some applicants who newly apply or update their application during the annual OEP would receive DMIs that result in APTC and CSRs being withheld until the DMI is resolved by an Exchange. While some consumers may have their DMIs resolved by an Exchange during the pre-OE verification period described in section III.A.9.c. of this proposed rule, or during the annual OEP, there might be others who have DMIs resolved after the end of the annual OEP. This would mean that APTC and CSRs may not be available on the consumer's otherwise-permitted coverage effective date. As a result, and as described in section III.A.8.b. of this proposed rule, we propose that applicants would have the choice to pend their plan selection until all DMIs related to the applicable enrollment information

are resolved by an Exchange if they prefer to only enroll once they are determined eligible for APTC and CSRs, as applicable. For such consumers, these proposed rules provide clarity regarding when their QHP coverage, APTC, and CSRs must become effective, once their DMIs are resolved.

The proposals in this section are intended to align with existing OEP effective date rules to the extent possible. We propose that coverage become effective in accordance with applicants' original coverage effective dates even if the applicant's DMIs are not resolved until 15 days later to prevent applicants' coverage from being delayed due to the time it takes for Exchanges to review and verify documentation. Given the large volume of applicants who apply for January 1 coverage during the annual OEP and the potential for Exchanges to have backlogs of documents to process, we want to ensure that if, for example, a consumer submits documents to verify their DMI related to the applicable enrollment information by the December 15 deadline for January 1 coverage, that their QHP coverage can begin on January 1, even if the Exchange cannot resolve the DMI until later in January – for example, because the Exchange needed to request different or additional documents from the consumer.

In instances where DMIs generated during OEP are not resolved by an Exchange until more than 15 days after their originally prescribed coverage effective date, this proposed policy attempts to balance the benefits of immediate coverage availability to a consumer with the potential harms imposed by requiring consumers to pay premiums for past periods of coverage, when the coverage could not have been meaningfully used by the consumer. We also carefully considered the potential impacts of this policy on adverse selection and market stability. If we permit coverage to extend too far retroactively, then consumers may have an incentive to wait and see whether they incur medical bills before submitting documents to resolve their DMIs, which would have a negative impact on the risk pool. By proposing to limit retroactive coverage to a maximum of 15 calendar days, we limit potential adverse selection as it would not be practical for consumers to wait until they incur medical bills to submit documents because

consumers could not be assured that an Exchange would resolve their DMI within the same 15-day period. We seek comment regarding whether consumers should instead be permitted to enroll in a QHP and access APTC and CSRs on their originally prescribed coverage effective date regardless of when their DMIs are resolved, and if so, what strategies HHS should consider to mitigate adverse selection and promote market stability.

We also considered proposing that, in instances where an applicant pends a plan selection during the annual OEP and resolves their DMIs after their otherwise-prescribed effective date, plan selections would become effective on the day that all DMIs were resolved. Like our proposal, this approach would balance the benefits of immediate coverage availability with the harms imposed by requiring consumers to pay premiums for past periods of coverage and would limit risks of adverse selection. However, we are of the view that requiring mid-month effective dates would be administratively challenging for issuers and Exchanges, given that it would require them to prorate APTC and premiums.

We have determined that this proposal minimizes administrative burdens on both Exchanges and issuers associated with providing retroactive coverage. If coverage effective dates for a pended plan selection made during the OEP were always extended back to the consumer's original coverage effective date, then issuers might struggle to collect multiple months of past premiums from new enrollees and may need to expend excessive resources to appropriately administer cost-sharing reductions for months of previous medical bills. We are of the view that these proposals balance the interests of consumers to have coverage start in a timely manner and not owe premiums for months of coverage they did not meaningfully utilize, and the interests of Exchanges and issuers to maintain a stable risk pool and limit administrative burden.

Finally, we considered whether section 36B(c) of the Code would require coverage effective dates retroactive to the consumer's original coverage effective date regardless of when an Exchange resolves their DMI. Sections 36B(c)(2) and (5) of the Code relate to when a month can be a coverage month for purposes of the PTC. Section 36B(c)(2)(A)(i) of the Code requires

an individual to be enrolled in a QHP as of the first of a month before the month can be a coverage month. Section 36B(c)(5)(A) of the Code provides, in relevant part, that a coverage month does not include any month that begins before the Exchange verifies an individual's eligibility to enroll in a QHP and for APTC. Section 36B(c)(5)(D) provides that an individual shall not be treated as ineligible to enroll in a QHP for a month solely because of failing to meet the requirements of section 36B(c)(5) for the month. We read these requirements to mean that months prior to verification must be treated as coverage months if they would otherwise be considered coverage months under the requirements prescribed in section 36B(c) of the Code, including the requirement that an individual be enrolled in a QHP as of the first of the month. Section 36B does not relate to coverage effective dates and cannot reasonably be read to require HHS to prescribe specific coverage effective dates.

In section III.A.4.b. of this proposed rule, we describe our proposal to implement section 36B(c)(5)(C) of the Code by requiring Exchanges to provide APTC and CSRs, as applicable, for all months prior to verification that the applicant was enrolled in a QHP, as long as the Exchange verified all eligibility criteria described in proposed § 155.315(f)(4)(ii) for such months. The authority to permit pended plan selections, and to prescribe reasonable effective dates for those pended plan selections, is drawn from the broad authority to offer enrollment periods and to operate Exchanges afforded to HHS in sections 1311(c)(6) and 1321(a) of the Affordable Care Act, and Exchange enrollment period and coverage effective date rules are not explicitly addressed in section 71303 of the WFTC legislation.

Under the authority afforded to HHS under sections 1311(c)(6) and 1321(a) of the Affordable Care Act, and for the reasons described in this section, we propose to add § 155.410(f)(5) to provide effective date rules for consumers who pend their plan selections during the annual OEP.

We seek comment on this proposal. We understand State Exchanges may find it challenging to implement these requirements for PY 2028. Therefore, we specifically seek

comment from State Exchanges regarding any risks that State Exchanges will not be able to implement these proposed effective date rules by PY 2028, and whether there are alternative proposals that could achieve similar outcomes while alleviating operational burden.

c. Annual Pre-Open Enrollment Verification Period (§ 155.410(h))

(i) Overview

Section 71303(b) of the WFTC legislation adds section 36B(c)(3)(A)(ii) of the Code modifying the definition of “qualified health plan” to provide that, for purposes of PTC, the term will not include any plan enrolled through an Exchange that fails to provide a verification period that begins not later than August 1 prior to the beginning of the OEP each year. Absent the establishment of a verification period beginning not later than August 1 before the upcoming plan year, no PTC (and therefore no APTC or CSRs) would be allowed for the coverage of enrollees in plans offered by the Exchange for the plan year.

Because providing access to APTC and CSRs for enrollees is one of the fundamental purposes of an Exchange, we have determined that it is necessary that all Exchanges make a pre-OE verification process available. Thus, we are proposing to require that all Exchanges make this new pre-OE verification period available to applicants prior to the 2028 plan year on August 1, 2027. Also, it is important to note that neither the statute nor the regulatory changes we are proposing require consumers to participate in a pre-OE verification process, only that Exchanges make such a process available.

We propose to add new § 155.410(h), which would require Exchanges to make available a pre-OE verification period that begins on August 1 each year for purposes of verifying certain consumer eligibility criteria for the following plan year. The first pre-OE verification period would start on August 1, 2027, in advance of PY 2028. The pre-OE period would end the day before the OE period for the plan year begins. For example, the pre-OE period would end on October 31 for Exchanges where the OE period begins on November 1.

During the pre-OE verification period, we propose at § 155.410(h)(2) that Exchanges

would be required to allow consumers to provide their information, including, at a minimum, their household income, citizenship or lawful presence, incarceration status, and place of residence. Added section 36(B)(c)(3)(A)(ii) of the Code requires Exchanges to provide a process through which applicants may “verify” eligibility information “with the Exchange.” In proposed § 155.410(h), we reserve the term “verify” for the role of the Exchange to avoid confusion about which subject of the statute (that is, “the Exchange” or “the applicant”) we are referring to when using the term “verify.” In proposed § 155.410(h)(2), we use the term “provide” to represent “the applicant’s” role in the process to “verify with the Exchange.”³¹ During the pre-OE period the Exchange would be required to enable consumers to provide and confirm their eligibility information which may come in the form of attestations or documents including an attestation that previously provided information remains the same.

For consumers who choose to provide eligibility information to an Exchange during the pre-OE verification period, we propose in § 155.410(h)(3) that Exchanges would be required to follow the verification procedures in §§ 155.315 and 155.320 for verifying such information. Specifically, for information that is required to be verified using trusted data sources and, for which verification is unsuccessful, Exchanges would be required to follow the proposed DMI procedures in § 155.315(f) (see section III.A.4.b. of this proposed rule for more information).

(ii) Timing (§ 155.410(h)(1))

While section 71303(b) of the WFTC legislation specifies that the pre-OE verification period must start no later than August 1 of the year preceding the coverage year, we propose in §

³¹ This is similar to the language convention described in section II.A. of this proposed rule regarding our intended use of the term “verify” throughout this proposed rule to clarify the multiple uses of the word “verify” in section 36(B)(c)(5)(A) of the Code. Specifically, the text of section 36(B)(c)(5)(A) of the Code refers to two subjects, both of which are tasked with “verifying” (that is, “the Exchange verifies...eligibility” and “information...shall be...verified by the applicant”). We sought to use language that distinguishes the required functions under the statute of these two entities and elected to use “confirm” to refer to the applicant’s role to “verify” instead of using “verify” when referring to both the Exchange’s and applicant’s distinct functions. Section 36(B)(c)(3)(A)(ii) of the Code similarly refers to the same two subjects, both of which are again tasked with a role in “verification” (that is, “such Exchange provides a process for...verification” and “any applicant may...verify with the Exchange”). Therefore, here, we again seek to distinguish the required functions under the statute of these two entities and elected to use “provide” to refer to the applicant’s role to “verify with the Exchange” since the primary role of applicants in verifying eligibility with the Exchange is to “provide” the Exchange with information.

155.410(h)(1) that all Exchanges start their annual pre-OE verification period on August 1 each year and no earlier. We are of the view that a start date prior to August 1 may be too early for consumers to make informed projections of their household income and family size for the following year. While the IRS generally makes updated tax data available on a rolling basis as it processes returns, the IRS' updated failure to file and reconcile codes for the previous tax year are not available until the last week of July. Exchanges may need to again use these codes to determine APTC eligibility for PY 2028 and beyond, given the changes to coverage month made by section 36B(c)(6) of the Code. Furthermore, limiting eligibility verification for the future year to August 1 or later would facilitate the use of more recent data for the verification process. Finally, we have determined that an August 1 start date for the pre-OE verification period would best accommodate the annual implementation timelines of plan-year specific policy changes required by legislation and regulations. For example, each year Exchanges make changes to eligibility logic in their systems for the following coverage year based on the annual publication of the final HHS Notice of Benefit and Payment Parameters (typically April of each year) and the annual publication of the IRS revenue procedure providing the indexing adjustment for the applicable percentage table and the required contribution percentage. (For PY 2026, the revenue procedure was released by the IRS on July 18, 2025). We request comment on whether Exchanges should be allowed to start pre-OE verification periods earlier, especially if State Exchanges have evidence that an earlier start date would work better for their markets.

Section 71303(b) of the WFTC legislation does not specify an end date for the pre-OE verification period. Thus, we propose in § 155.410(h)(1) that the pre-OE verification period ends as soon as an Exchange's OEP starts, to account for the fact that State Exchanges have varying OEP start dates that begin before November 1.

We seek comment on this proposal.

(iii) Collection of information (§ 155.410(h)(2))

Section 71303(b) of the WFTC legislation specifies that during the pre-OE period,

applicants must have the opportunity to verify household income and eligibility for enrollment in a QHP. We therefore propose that the minimum information that Exchanges would be required to allow consumers to provide or confirm prior to the OE period is limited to household income, as that is mentioned specifically in section 71303(b) of the WFTC legislation, and citizenship or lawful presence status, incarceration status, and residency, as those are the criteria pertinent to eligibility for enrollment in a QHP. Minimizing the information that Exchanges would accept during the pre-OE period is intended to give Exchanges flexibility to design this period in the manner most appropriate for their consumers and their operations. However, the proposed rule at § 155.410 does not reduce the amount of information that the Exchange would collect to adjudicate an applicant's eligibility for insurance affordability programs in accordance with § 155.305. Therefore, while we do not propose to require that Exchanges collect or verify information beyond what is specified in section 71303(b) of the WFTC legislation during the pre-OE period, an Exchange may find it more efficient to include additional information collection in their pre-OE process. For example, Exchanges may find value in collecting information during the pre-OE period about an applicant's expected tax filing status, eligibility for other MEC, and their compliance with tax reconciliation requirements to determine APTC and CSR eligibility. The Exchange may seek to collect AI/AN status for purposes of CSR eligibility.

For first-time applicants, the Exchange would also need to collect identifying information from the applicant—such as name, birthdate, and SSN (if the applicant has one)—for purposes of verifying eligibility using electronic data sources, as described in §§ 155.315 and 155.320. We have determined that because section 71303(b) of the WFTC legislation specifies that an Exchange provides a pre-enrollment verification process during which “any applicant” may verify their eligibility, an Exchange may not restrict the pre-OE verification period only to current enrollees.

While we do not construe section 71303(b) of the WFTC legislation to require Exchanges

to permit consumers to provide all information that could impact their eligibility for insurance affordability programs, we expect that collecting information about all relevant eligibility criteria during pre-OE would reduce consumer burden and unnecessary operational steps for Exchanges. Note that if an Exchange chooses not to collect and verify information on consumer eligibility or enrollment in MEC during the pre-OE verification period, then the Exchange would not have sufficient information to make APTC or CSR eligibility determinations during the pre-OE period for any applicant or re-enrollee. As described in section III.A.4.b. of this proposed rule, starting in 2028, Exchanges would be required to verify eligibility for or enrollment in MEC prior to providing APTC and CSRs. As described in section III.A.7. of this proposed rule, a current enrollee would be required to provide or confirm their eligibility for, or enrollment in, other MEC annually as part of the annual redetermination process to be determined eligible for APTC and CSRs for a subsequent plan year. Therefore, for applicants or enrollees seeking an eligibility determination for insurance affordability programs during the pre-OE verification period, the Exchange would need to request additional information regarding eligibility for or enrollment in other MEC. This additional information would include not only an attestation and verification of whether the applicant is currently enrolled in other coverage, but also the collection of information related to potential Medicaid and CHIP eligibility (such as pregnancy and former foster care status) required to determine whether the consumer should be assessed or determined eligible for Medicaid or CHIP rather than for APTC and CSRs. As noted in § 155.410(h)(3)(ii), we propose that when making an eligibility determination during the pre-OE period, an Exchange would be required to comply with the standards for eligibility determinations established at § 155.305, including paragraphs (c), (d), and (e), which require the Exchange to determine eligibility for Medicaid, CHIP and BHP.

For re-enrollees, Exchanges may be able to perform a full information collection in a streamlined format, such as by permitting a re-enrollee to attest that they have had no changes since the previous year. In this proposed rule, we propose to defer to Exchanges on the extent

and method of information collection beyond the minimum criteria designated in the statute. We provide additional information on implementation strategies in subsection (vi) of this section.

We seek comment on whether the information collection requirements should be different for returning enrollees as compared to consumers new to an Exchange.

(iv) Verification and Determination (§ 155.410(h)(3))

In § 155.410(h)(3), we propose that Exchanges would be required to attempt to verify information collected during the pre-OE verification period using the verification procedures in §§ 155.315 and 155.320. If verification using a trusted data source is required and is unsuccessful, Exchanges would be required to follow the proposed DMI procedures in § 155.315(f), which, in most cases, require the Exchange to resolve the DMI prior to the consumer receiving APTC or CSRs. If a consumer generates a DMI during the pre-OE verification period, we note that an Exchange may extend the 90/95-day inconsistency period under existing authority described in § 155.315(f)(3) but recommend that Exchanges not provide extensions that would enable the inconsistency period to go beyond December 15 to align with the date that consumers using Exchanges on the Federal Platform must generally select a plan to begin coverage on January 1. However, we are still assessing the best date for these extensions and request comment, especially from State Exchanges, on this recommendation. Consumers who utilize the pre-OE verification period to verify their information prior to OE are likely demonstrating a good faith effort to obtain their documentation and verify their information, as they are doing so ahead of the beginning of the plan year, when they could instead wait until the annual OEP to provide information for the subsequent year.

Operationally, such extensions may facilitate a smoother enrollment process, specifically in cases where the DMI generated during the pre-OE period has a 90/95-day inconsistency period that ends either before or during the Open Enrollment period and before the deadline for a January 1st effective date in the future coverage year. If an Exchange successfully verifies information for the criteria described in proposed § 155.335(a)(1) through (4), then consumers

may be eligible for APTC and CSRs, as applicable, upon their coverage effective date.

However, Exchanges maintain the authority to decide whether a consumer is demonstrating a good faith effort to obtain documentation. If an Exchange finds evidence that a consumer, or a non-Exchange entity or authorized representative assisting the consumer, is submitting suspicious or false documentation or attempting to manipulate the application to circumvent DMI document submission requirements, the Exchange may find that the consumer (or person or entity assisting the consumer) is not demonstrating a good faith effort to obtain documentation and therefore may rescind or refuse to provide an extension to the inconsistency period under this authority.

Allowing Exchanges to extend the inconsistency period for consumers who generate DMIs during the pre-OE verification period is necessary to reduce administrative burden on applicants and operational complexity for Exchanges because individuals who generate DMIs during the pre-OE verification period may have 90/95-day inconsistency periods that end before December 15, which is the date that consumers using Exchanges on the Federal Platform must generally select a plan by to receive coverage starting January 1. If an individual does not resolve their DMI by the end of the 90/95-day period, Exchanges would be required by § 155.315(f)(5) to redetermine eligibility based on trusted data sources, often resulting in the individual being redetermined ineligible for a QHP, and APTC and CSRs, as applicable. As a result, consumers would likely re-submit an application during the OEP, which would restart the entire DMI process, even though their attestation likely remained unchanged. This process would impose administrative burden on applicants, who would have to submit a new application to start another 90/95 DMI period, and operational complexity for Exchanges, who would have to process two DMIs based on the same attestation instead of one.

Furthermore, this optional extension for DMIs generated during the pre-OE verification period is distinct from the former 60-day extension for household annual income DMIs outlined in the 2025 Marketplace Integrity and Affordability final rule because the optional extension is

for the specific population of consumers who generates DMIs during the pre-OE verification period rather than the entire population who generate an annual income DMI. Unlike the automatic 60-day extension for annual household income DMIs, the optional extension would not be granted for DMIs generated during the OEP or any SEP.

We read section 71303 of the WFTC legislation to require an Exchange to make an information collection and verification process available during the pre-OE verification period, but not to require an Exchange to make an eligibility determination. If an Exchange collects only the minimum information outlined in proposed § 155.410(h)(2)(i) during the pre-OE verification period, then the Exchange would have sufficient information to determine eligibility for enrollment in a QHP but would not have sufficient information to make an eligibility determination for insurance affordability programs. We expect that the most useful way for Exchanges to collect information during the pre-OE verification period would be to use the single streamlined application as described in proposed § 155.410(h)(2)(ii). We also expect that, for many Exchanges, the operational burden of creating a new pre-OE verification period would be reduced if the Exchange makes use of its existing application infrastructure rather than designing something new. In § 155.410(h)(3)(ii), we propose to require Exchanges to make an eligibility determination in accordance with §§ 155.305 and 155.310 during the pre-OE verification period if they collect and verify sufficient information to do so.

Thus, the proposed rule would require that, when making eligibility determinations during the pre-OE verification period, Exchanges adhere to the timeliness and notice standards at § 155.310(e) and (g) as well as the requirements in paragraph (d) of that section related to eligibility determinations for insurance affordability programs. This would include transmitting account transfers to the State Medicaid or CHIP agency in the case of an assessment or determination that an applicant is eligible for Medicaid or CHIP. Still, we also seek to maintain flexibility for Exchanges that have a different view of how to make the pre-OE verification period most useful and efficient. We request comment on this proposed requirement, especially

from State Exchanges.

We note that for many Exchanges, including those operating on the Federal platform, QHP data for the upcoming plan year would not be available during much or all of the pre-OE verification period. If future year plan data is unavailable when an Exchange verifies a consumer's information, an Exchange would not have the Second Lowest Cost Silver Plan (SLCSP) information required to determine any applicable amount of APTC. Therefore, when a consumer provides eligibility information to an Exchange during the pre-OE verification period, an Exchange would need to process and verify that information but may not have sufficient information available to determine the amount of APTC for which the consumer may be eligible. We acknowledge that there are drawbacks to communicating an APTC eligibility result to an applicant prior to calculating an APTC amount. For example, an individual may be determined eligible for APTC during the pre-OE verification period but, once SLCSP information is available, the amount of APTC for which they qualify is \$0. In contrast, before plan data is available, an Exchange would be able to make a determination regarding an applicant's eligibility for CSRs and the level of CSRs for which they qualify as described in § 155.305(g). Unlike APTC, the available amount of CSRs is based on the household's projected annual income without regard to the cost of the SLCSP.

If an Exchange notifies a consumer of their eligibility determination without providing an APTC amount because plan data is not yet available, then the Exchange would need to communicate the APTC amount to the consumer once plan data becomes available. We are of the view that Exchanges must determine the best method for providing that amount in accordance with their operations and preferred communication channels, so long as consumers are entitled to appeal rights regarding the determination of their APTC amount once it is available.

We seek comment on this proposal.

(v) Plan Selection

If an Exchange does have certified plan data available during the pre-OE verification period, that Exchange could permit consumers to view plan information and indicate their preferred plan ahead of the OEP. The Exchange could store the consumer's plan selection and transmit it to the issuer once the OEP begins or confirm the consumer's preferred plan during the OEP prior to transmitting it to the issuer. This could reduce the burden on consumers, and on individuals assisting consumers with the application and enrollment process, because consumers who use the pre-OE verification period would not have to return to an Exchange website or call center during the OEP to select a plan and enroll for the upcoming plan year. A consumer would still be allowed to update their application and change plans during the OEP.

Under this proposal, if an Exchange allows an applicant to select a plan during the pre-OE verification period, that selection could be a full-price plan without APTC or CSRs (either because applicable enrollment information was not verified or because the applicant was not eligible for APTC or CSRs), a plan with verified APTC or CSRs applied, or a plan with APTC or CSRs for which enrollment would be pended until all DMIs described in § 155.315(f)(4)(ii) are resolved. We propose adding § 155.400(i) to describe the option for consumers to "pend" a plan selection such that it would only be transmitted to the issuer if and when applicable DMIs are resolved, as described in section III.A.8.b. of this proposed rule. We also note that we outline the proposed Exchanges' re-enrollment requirements for existing enrollees who do not select a plan for the upcoming year in proposed § 155.335.

We acknowledge the logistical and operational barriers to having certified plan data available prior to the OEP, including issuer rate-setting timelines, State Department of Insurance review timelines, and certification timelines. As noted previously, QHP data for the upcoming plan year would likely not be available at the start of the pre-OE verification period for Exchanges operating on the Federal platform.

We seek comment on this proposal.

(vi) Implementation Strategies

For Exchanges on the Federal platform, we intend to collect applicant and re-enrollee information both through consumer pathways on *HealthCare.gov* and the Marketplace Call Center and through direct enrollment entity websites (also known as Enhanced Direct Enrollment or EDE entities³²) which are CMS-approved third party platforms that assist consumers with enrollment in QHPs offered through the Exchange in a manner considered to be through the Exchange as authorized by existing regulations at §§ 155.220(c)(3), 155.221, or 156.1230. State Exchanges may also choose to make their pre-OE information collection available through direct enrollment entities as outlined in § 155.221(j).

There are a range of acceptable strategies that Exchanges could use to leverage the pre-OE period to minimize administrative burden, and thereby minimize adverse selection. Under the proposed rule, Exchanges would have flexibility in how they implement the pre-OE verification process and the extent to which they conduct outreach to encourage consumers to participate. We recommend that Exchanges consider the implementation and ongoing costs of the available strategies, and weigh those against the potential benefits for consumers, and overall Exchange enrollment and market stability. As was true of previous implementations of new policies within the Exchanges, we expect this will be an iterative process with continuous adjustments and improvements after the initial implementation of the pre-OE verification period.

The example implementation approaches below illustrate some of the acceptable options for Exchanges if this proposal is finalized. Note that we do not intend the listed approaches to be requirements or limitations. We request comment on the following potential approaches:

- To meet the pre-OE requirements, Exchanges may make available the entire eligibility application specified at § 155.405. Exchanges could provide pre-populated information in the application based on previous information or based on information from trusted data sources,

³² For more information on EDE, including a list of approved EDE entities, operational readiness, and oversight guidelines, see www.cms.gov/marketplace-private-insurance/agents-brokers/direct-enrollment-partners.

where allowable under privacy and data use agreements.

- Alternatively, Exchanges could ask consumers to provide information only regarding the required criteria outlined in proposed § 155.410(h)(2)(i) and could choose to pre-populate that information where possible. Exchanges could permit current enrollees to provide their information either by confirming that the information they previously provided to an Exchange remains accurate for the upcoming plan year, or by updating the information they previously provided to an Exchange for purposes of the upcoming plan year.

- Exchanges could send a customized notice to all current enrollees early in the pre-OE period that includes the most recent eligibility information for each consumer and invites consumers to log into their secure online account or contact the call center or their agent or broker to confirm or update such information.

- The Exchange could conduct generalized outreach about the pre-OE period that informs consumers about the requirements for verification and the option to get started early to prepare for the following year by visiting the Exchange website or a certified enrollment partner website. For consumers who take up the option, the process for reviewing and confirming the accuracy of eligibility information could emphasize review of key information that tends to change year to year, while also providing the opportunity for the consumer to review and adjust any of their previous attestations.

We acknowledge that there is presently no pre-OE verification process, and all Exchanges would need to develop system functionality to meet the proposed requirements for collecting and verifying information for the future plan year. We seek comment on this proposal. Specifically, we seek comment on ideas to mitigate the burden of implementing a pre-OE verification period. We understand State Exchanges may find it particularly challenging to implement these requirements by August 1, 2027. Therefore, we specifically seek comment from State Exchanges regarding any risks that State Exchanges may be unable to implement these proposed requirements by August 1, 2027, and whether there are alternative proposals that could

achieve similar outcomes while alleviating operational burden.

10. Special Enrollment Periods (§ 155.420)

We propose to add § 155.420(b)(6) to provide the effective dates for coverage if a consumer qualifies for an SEP and elects to pend their enrollment until all DMIs related to the applicable enrollment information are resolved by an Exchange. Currently, § 155.420(b) describes the coverage effective dates that are applicable for consumers enrolling under an SEP based on the SEP type and the trigger date for the SEP. We propose that if an Exchange resolves a consumer's DMIs related to the applicable enrollment information prior to the effective date specified in § 155.420(b)(1) through (b)(3), then the consumer's coverage effective date would be the date specified in § 155.420(b)(1) through (b)(3). However, if the DMIs related to the applicable enrollment information are resolved by an Exchange after the applicable coverage effective date described in § 155.420(b)(1) through (3), then the new proposed rule at in § 155.420(b)(6) would apply. Under proposed § 155.420(b)(6), if such DMIs are resolved by an Exchange on or before the 15th of a month, then we propose an Exchange would make coverage effective the first of the same month. If such DMIs are resolved after the 15th of a month, then we propose that an Exchange would make coverage effective the first of the following month.

For example, consider a consumer who becomes newly eligible to enroll in a QHP on August 1, on August 30 submits an application to enroll through an SEP, and generates a DMI related to the applicable enrollment information. The consumer submits documents to verify their DMI on September 1, and the Exchange resolves their DMI on September 10. If this consumer pended their plan in accordance with proposed § 155.400(i), then, because the DMI was resolved before the 15th of the month, the effective date of the plan selection would be September 1. If instead an Exchange resolved the DMI on September 16, then the effective date of the plan selection would be October 1.

As described in section III.A.9.b. of this proposed rule, this effective date proposal would balance the benefits of continuous coverage promoted through the earliest possible effective

dates with the need to minimize administration burdens associated with retroactive coverage and avoid the risks of adverse selection. If coverage effective dates for pended plan selections were always extended back to the original coverage effective date under § 155.420(b)(1) through (b)(3), then issuers may struggle to collect multiple months of past premiums from new enrollees and may need to expend excessive resources to appropriately administer CSRs to months of previous medical bills. In addition, the opportunity for an extended retroactive coverage period could promote adverse selection by incentivizing consumers to delay document submissions to an Exchange until they know their medical needs during the inconsistency period. We seek comment regarding whether consumers should instead be permitted to enroll in a QHP and access APTC and CSRs on their originally prescribed coverage effective date regardless of when their DMIs are resolved, and if so, what strategies HHS should consider to mitigate adverse selection and promote market stability.

As discussed in section III.A.9.b. of this proposed rule, we are not proposing that pended plan selections become effective on the day that all DMIs are resolved by an Exchange due to the administrative challenges associated with requiring mid-month effective dates. As further discussed in section III.A.9.b. of this proposed rule, we do not read section 36B(c)(5)(C) of the Code as prescribing any requirements related to coverage effective dates.

We also propose conforming changes to § 155.420(b)(1), (b)(2)(iii) through (vi) to cross-reference the new proposed effective date rules in § 155.420(b)(6).

We request comment on this proposal. We understand State Exchanges may find it challenging to implement these requirements for PY 2028. Therefore, we specifically seek comment from State Exchanges regarding any risks that State Exchanges will not be able to implement these proposed effective date rules by PY 2028, and whether there are alternative proposals that could achieve similar outcomes while alleviating operational burden.

In addition to requesting comment on this proposal, we also request comment on whether we should consider expanding the timeframe of the SEP at § 155.420(d)(11) in the final rule.

Specifically, we are concerned with the application submission component of the SEP at § 155.420(d)(11), which is commonly referred to as the Medicaid/CHIP denial SEP. For this SEP, if a consumer applies for Medicaid or CHIP during the Open Enrollment period either indirectly through their Marketplace application or directly through their State's Medicaid or CHIP agency and is subsequently determined ineligible for Medicaid and CHIP that is MEC, then they are granted an SEP to enroll in Marketplace coverage. We request comment on whether we should include a minor revision to the Medicaid/CHIP denial SEP at § 155.420(d)(11) such that individuals who apply for Medicaid or CHIP either during the annual OEP or during the pre-OE verification period may be eligible for an SEP, if other otherwise eligible. This would ensure that consumers applying for coverage during the pre-OE verification period and during the annual OEP are treated similarly. Depending on how long a State Medicaid agency takes to process the consumer's Medicaid application and make a determination, as well as the length of the OEP in the future, a consumer may not receive a Medicaid eligibility determination prior to the end of the OEP if they apply during the pre-OE period. Granting these consumers an SEP that begins based on the date of their Medicaid denial date would enable them to gain access to coverage that they might have otherwise had had their initial applications been approved. We seek comment on whether this addition of the pre-OE application period to the Medicaid denial SEP is necessary.

B. Severability

We generally intend this rule's provisions, if finalized, to be severable from each other. In this rule, we propose distinct policies regarding requirements for consumers to provide or confirm certain eligibility information annually, requirements that Exchanges provide a pre-OE verification period, requirements that Exchanges generally not provide APTC and CSRs during certain inconsistency periods, requirements that Exchanges provide APTC and CSRs during certain other inconsistency periods, and requirements that Exchanges permit applicants to pend plan selections. In addition to these major policies, we include proposals regarding effective

dates and binder payments.

We are of the view that the policies proposed in this rule are well-supported in law and practice and must be upheld in any legal challenge. We also are of the view that this exercise of our statutory authority reflects sound policy. However, if any portion of a final rule is declared invalid, we have determined that these provisions are generally capable of functioning sensibly on an independent basis. It is our 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 may be construed so as to continue to give maximum effect as permitted by law, unless the holding may be one of utter invalidity or unenforceability. In the event a provision as finalized is found to be utterly invalid or unenforceable, we intend that provision to be severable. We solicit comment on the severability of these provisions.

C. Applicability Dates

In this proposed rule, most policies, if finalized, would become applicable for plan years beginning on or after January 1, 2028.

We provide further specificity where applicability dates of certain provisions may vary. We request comment on the proposed applicability dates summarized below, in Table 1.

TABLE 1: Proposed Applicability Dates

Topic	Section Number	Proposed Applicability Date
Election to Operate an Exchange after 2014	§ 155.106	PY 2029
Verification of Residency	§ 155.315(d)	N/A
Verification of Inconsistencies	§ 155.300(c)(2), § 155.310(f)(1), and § 155.315(f)(4)(ii)-(v)	PY 2028
Family Size Special Enrollment Period Waiver	§ 155.315(f)(4)(ii)	PY 2028
Eligibility Redeterminations During the Plan Year	§ 155.315(f)(4)(iii)	PY 2028
Verification Process Related to Eligibility for Insurance Affordability Programs	§ 155.320(c)	N/A
Effective Dates for Eligibility Changes During a Plan Year	§ 155.330(f)	PY 2028
Annual Eligibility Redetermination	§ 155.310(f)(2) and § 155.335	PY 2028
Binder Payment for New Enrollments	§ 155.400(e)	PY 2028
Plan Selection in the Case of Certain DMIs	§ 155.400(i)	PY 2028
Notice of Annual Open Enrollment Period	§ 155.410(d)	PY 2028
Effective Dates for QHP Selections	§ 155.410(f)(5)	PY 2028
Annual Pre-Open Enrollment Verification	§ 155.410(h)	August 1, 2027
Special Enrollment Periods	§ 155.420(b)	PY 2028

IV. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA), 44 U.S.C. 3501–3520, we are required to provide 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 must be approved by OMB, 44 U.S.C. 3506(c)(2)(A) requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency, including whether the information will have practical utility.
- The accuracy of our estimate of the information collection burden, including the validity of the methodology and assumptions used.
- 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 are soliciting public comment on each of these issues for the following sections of this document that contain information collection requirements (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.³³ Table 2 presents the median hourly wage, the cost of fringe benefits and overhead, and the adjusted hourly wage.

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 have determined that doubling the hourly wage to estimate total cost is a reasonably accurate estimation method.

TABLE 2: Adjusted Hourly Wages Used in Burden Estimates

Occupation Title	Occupational Code	Median Hourly Wage (\$/hr.)	Fringe Benefits and Overhead (\$/hr.)	Adjusted Hourly Wage (\$/hr.)
Eligibility Interviewers, Government Programs	43-4061	\$26.06	\$26.06	\$52.12
Database and Network Administrators and Architects	15-1240	\$53.26	\$53.26	\$106.52
Computer Programmers	15-1251	\$48.26	\$48.26	\$96.52
Technical Writers	27-3042	\$43.46	\$43.46	\$86.92
Management Analysts	13-1111	\$48.97	\$48.97	\$97.94

We propose to 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

³³ See U.S. Bureau of Labor Statistics (n.d.). Occupational Employment and Wage Statistics, May 2025 Occupation Profiles. Dep't. of Labor. https://www.bls.gov/oes/current/oes_stru.htm.

(ASPE) report on “Valuing Time in U.S. Department of Health and Human Services Regulatory Impact Analyses: Conceptual Framework and Best Practices.”³⁴ We start with a measurement of the usual weekly earnings of wage and salary workers of \$1,233.³⁵ We divide this weekly rate by 40 hours to calculate an hourly pre-tax wage rate of approximately \$30.83. We adjust this hourly rate downwards by an estimate of the effective tax rate for median income households of about 17 percent, resulting in a post-tax hourly wage rate of approximately \$25.58. We adopt this as our estimate of the hourly value of time for changes in time use for unpaid activities.

We seek comment on these proposed burden estimates and assumptions.

B. ICRs Regarding DMIs (§§ 155.315, 155.320, 155.330)

The following changes will be submitted for review under OMB Control Number 0938-1191.

We are proposing to modify § 155.315(f)(4)(ii) to state that Exchanges generally cannot provide APTC and CSRs to consumers who receive DMIs related to the applicable enrollment information. We also propose to exempt those who qualify for an SEP due to a change in family size from these new requirements to verify certain factors of eligibility before providing APTC within proposed § 155.315(f)(4)(ii) and proposed § 155.315(f)(4)(iii)(A). We are also proposing to add § 155.315(f)(4)(iii) to describe that Exchanges would be required to continue to provide APTC and CSRs (as applicable) during inconsistency periods created due to reporting a change to eligibility criteria during the plan year after an Exchange has completed verification of those same criteria.

We also propose to add § 155.315(f)(4)(iv), which provides that Exchanges would be required to determine eligibility for APTC and CSRs on behalf of an applicant per new effective

³⁴ 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>.

³⁵ U.S. Bureau of Labor Statistics. Employed full time: Median usual weekly nominal earnings (second quartile): Wage and salary workers: 16 years and over [LES1252881500Q], retrieved from FRED, Federal Reserve Bank of St. Louis. <https://fred.stlouisfed.org/series/LES1252881500Q>. Annual Estimate, 2026.

dates following successful verification of information as described in proposed new § 155.315(f)(4)(ii). We additionally propose to add § 155.315(f)(4)(v), clarifying that applicants with DMIs other than those related to the applicable enrollment information would be able to continue receiving APTC and CSRs if otherwise eligible during the inconsistency period.

We also propose to amend § 155.330(f)(1) such that if an Exchange redetermines an enrollee's eligibility to enroll in APTC or CSRs because the enrollee has provided updated information to the Exchange, then the redetermination of eligibility would become effective on the first of the month following an Exchange's eligibility redetermination, with an exception at § 155.330(f)(1)(i) for enrollees who qualify for certain SEPs.

We propose to amend § 155.330(f)(2) to state that if a consumer is already enrolled in a QHP when their DMI is resolved, an Exchange would be required to implement their APTC and CSR eligibility determination effective the first day of the first month in which an Exchange determined all relevant eligibility criteria to be verified, as long as the consumer was enrolled in a QHP as of the first of that month, and the consumer's DMI was generated prior to the first of that month.

Finally, we propose to amend § 155.330(f)(3) to provide effective date rules for an Exchange's redetermination of eligibility following the expiration of a DMI or the end of a periodic data matching period. This proposal maintains current effective date rules for such redeterminations, with the exception that, if the redetermination results in the consumer qualifying for the same or an increased amount or level of APTC or CSRs, then Exchanges are no longer permitted to delay the effective dates for such redeterminations beyond the first of the next month.

We clarify that the impacts of the proposed effective dates for consumers who choose to pend their plan selection during their inconsistency period as described at § 155.315(f)(4)(iv)(B), are addressed in sections IV.D. of this proposed rule. We further clarify that the proposal at § 155.330(f)(4) maintains current policy and therefore, is not expected to result in new

information collection or regulatory impacts.

In this section, we have included the proposed policies at § 155.315(f)(4)(ii) regarding Exchange provision of APTC and CSRs during inconsistency periods and applicants who qualify for an SEP due to a change in family size; § 155.315(f)(4)(iii) regarding DMIs during the coverage year; and § 155.330(f)(1), (2), and (3) regarding effective dates. We are considering these policies together in our analysis in both this section and in the Regulatory Impact Analysis in section VI.C.1. of this proposed rule due to their related and overlapping impacts. It would be difficult to calculate the costs and burdens of these policies independently, as we anticipate Exchanges will make similar updates and changes across the same areas to implement these proposals. Attempting to calculate independently would likely result in overestimating costs, since many of the technical updates and burdens would be counted multiple times in cases where updates and changes would occur simultaneously for different policies. Given this, we have determined that the more accurate estimation is by estimating these policies together.

We anticipate one-time financial costs to State Exchanges and Exchanges on the Federal platform associated with the implementation of these changes, including Exchanges' updates to their eligibility and enrollment systems for blocking APTC during an inconsistency period; creating exceptions to that process for both a Family Size SEP waiver and a new DMI set during an eligibility redetermination during the plan year, and the proposed changes to APTC and CSR effective dates for enrollee-reported changes, the resolution of DMIs, and the expiration of DMIs.

We estimate that it would take Exchanges on the Federal platform and each State Exchange 30,000 hours across 2026 and 2027 to make these updates. Using the median wage rates estimated in IV.A., we estimate that this total for Exchanges on the Federal platform and each State Exchange would include 7,500 hours from a database and network administrator and architect at \$106.52 per hour and 22,500 hours from a computer programmer at \$96.52 per hour. Given this, we estimate that Exchanges on the Federal platform will incur a one-time burden

across 2026 and 2027 of \$2,970,600 ($7,500 \times \$106.52 + 22,500 \times \$96.52$) to make these eligibility system updates, with all 22 State Exchanges incurring a total of 660,000 hours at a cost of \$65,353,200 ($[7,500 \times \$106.52 + 22,500 \times \$96.52] \times 22$ State Exchanges) across 2026 and 2027. In total, the burden associated with all system updates would be 690,000 hours at a cost of \$68,323,800 across Exchanges on the Federal platform and State Exchanges.

We do not anticipate that modifying the DMI process for these types of DMIs to block APTC and CSRs during the inconsistency period—including proposed changes related to exceptions for a family size SEP or an eligibility redetermination during the plan year, and effective date changes related to enrollee-reported changes and DMI resolution and expiration—would result in additional burden by consumers to complete application questions or submit supporting documentation. Currently, consumers are already required to answer application questions and submit documentation for the existing DMI process. As mentioned in this proposed rule, Exchanges can generally continue their existing processes around setting and processing DMIs, so we do not expect a notable difference in consumer burden. Additionally, the proposed changes to effective dates of coverage and APTC would not result in additional application questions or submitted documents.

We seek comment on these proposed burden estimates and assumptions.

C. ICRs Regarding Annual Eligibility Redetermination (§ 155.335)

The following changes would be submitted under OMB Control Number 0938-1191 (CMS-10440).

We propose to modify § 155.335(a) by specifying that for an Exchange to redetermine an enrollee eligible for APTC and CSRs for the subsequent plan year, the enrollee or the enrollee's application filer would be required to provide or confirm household income and family size; U.S. citizenship or status as a lawfully present eligible non-citizen; eligibility for or enrollment in other MEC; and place of residence for the subsequent plan year on or after August 1 and no later than December 31 of the year preceding the applicable plan year, and the Exchange must verify

the specified eligibility information using the processes in §§ 155.315 and 155.320, including the relevant provisions in those sections regarding DMIs.

We also propose to amend § 155.335(b) to state the annual eligibility redetermination would be effective on the first day of the applicable plan year, and the Exchange would be required to adhere to the existing notification standard for eligibility determinations under § 155.310(g). We propose an exception in instances where an enrollee has an unresolved DMI under § 155.315(f)(4)(ii) as of December 31 of the year preceding the plan year and for whom APTC and CSRs are not provided during the inconsistency period. In these cases, we propose that the redetermination of APTC and CSRs under this part take effect in accordance with §§ 155.315(f)(4)(iv)(A) or 155.330(f)(3), as applicable. We propose to remove § 155.335(c) through (i); redesignate § 155.335(j) as new § 155.335(c); and remove § 155.335(k) through (n).

We estimate that implementing this proposed policy would require one-time costs to the Federal Government and each State Exchange. Based on preliminary analysis, we estimate that it would take the Federal Government and each State Exchange 22,000 hours in 2026 and 2027 to develop and implement system changes to their annual eligibility redetermination and re-enrollment logic. These changes would enable Exchanges to correctly evaluate whether enrollees have provided or confirmed the eligibility information described previously and to discontinue APTC and CSRs, as applicable. Of those 22,000 hours, we estimate it would take a database and network administrator and architect 5,500 hours at \$106.52 per hour and a computer programmer 16,500 hours at \$96.52 per hour. In aggregate, for State Exchanges, we estimate a burden across 2026 and 2027 of 484,000 hours (22 State Exchanges × 22,000 hours) at a cost of \$47,925,680 (22 States × [(5,500 hours × \$106.52 per hour) + (16,500 hours × \$96.52 per hour)]) for completing the necessary updates to State Exchange systems. For the Federal Government, we estimate a burden across 2026 and 2027 of 22,000 hours at a cost of \$2,178,440 ((5,500 hours × \$106.52 per hour) + (16,500 hours × \$96.52 per hour)). In total, the burden associated with all system updates would be 506,000 hours at a cost of \$50,104,120.

As discussed in III.A.7. of this proposed rule, we propose to require that current enrollees in a QHP provide or confirm the specified eligibility information to an Exchange on an annual basis as a condition of an Exchange redetermining and continuing their APTC and CSRs, as applicable, for the subsequent plan year. As a result, we estimate that an additional 3,969,403 consumers³⁶ who previously would not have been required to contact the Exchange to be re-enrolled in QHP coverage with APTC and CSRs through Exchanges on the Federal platform for the subsequent plan year, after being determined eligible under an Exchange's procedures at § 155.335(a)(2)(ii), would instead have to actively return to the Exchanges on the Federal platform to provide or confirm the specified eligibility information under the proposed policy. Similarly, we estimate that for State Exchanges, an additional 1,703,494 consumers³⁷ who previously would not have been required to contact the Exchange to be re-enrolled in QHP coverage with APTC and CSRs for the subsequent plan year, after being determined eligible under an Exchange's procedures at § 155.335(a)(2)(iii), would instead have to actively return to State Exchanges, under the proposed policy, to provide or confirm the specified eligibility information. We arrived at these estimates by starting with the projected enrollment in section VI.C.6. of this proposed rule and applying a percentage of 46 percent to account for consumers who we estimate may not have returned to an Exchange without the proposed changes in this rule.

For both Exchanges on the Federal platform and State Exchanges, we estimate that it would take approximately 30 minutes (0.5 hours) on average for a consumer to provide or confirm their information annually.³⁸ Using the estimate of the hourly value of time for unpaid activities calculated at \$25.58 per hour in section IV.A. of this proposed rule, we estimate that the increase in cost for each Exchange consumer providing or confirming the specified eligibility

³⁶ This estimate is based on internal FFE data.

³⁷ This estimate is based on internal FFE data.

³⁸ This estimate aligns with past estimates for the amount of time it takes a consumer to complete an online application for insurance affordability programs, as outlined in the Data Collection to Support Eligibility Determinations for Insurance Affordability Programs and Enrollment through Health Benefit Exchanges, Medicaid and CHIP Agencies (CMS-10440), OMB Control Number 0938-1191.

information beginning with the pre-OE verification period for PY 2028, which would occur in 2027, would be approximately \$12.79 (0.5 hours × \$25.58). In aggregate, we estimate the total increased burden on both Federal Exchange and State Exchange consumers for this additional data collection to be \$72,556,353 ([3,969,403 Federal Exchange consumers × \$12.79] + [1,703,494 State Exchange consumers × \$12.79]) per year.

We also are of the view that requiring consumers to annually return to Exchanges to provide or confirm the specified eligibility information to maintain enrollment in QHP coverage with APTC and CSRs would likely result in increased burden for consumers and administrative costs for Exchanges. In particular, Exchanges would likely experience an increase in the number of consumers for whom the Federal Government must generate and process DMIs. This is because, today, consumers who do not contact the Exchanges on the Federal platform for the subsequent plan year do not generate DMIs, and in accordance with current policy at § 155.335(a)(2)(ii), may be redetermined eligible for APTC or CSRs based on previously verified information or data available from trusted sources. Under the proposal in this rule, however, enrollees would be required to provide or confirm certain information with Exchanges on the Federal platform for the applicable plan year before Exchanges can make APTC or CSRs available for the plan year, and they may generate DMIs as part of this process. Because we assume that most consumers who previously did not contact Exchanges on the Federal platform for the upcoming year would now return to provide or confirm information, and because they may generate DMIs as part of this new process, we expect an increase in the number of consumers who would generate DMIs. Based on historical data, we estimate that approximately 1,289,913 additional consumers³⁹ would receive DMIs for Exchanges on the Federal platform annually beginning in the pre-OE verification period for PY 2028, which would occur in 2027. We arrived at this estimate by starting with the 3,969,403 consumers on Exchanges on the Federal platform who must return to an Exchange to provide or confirm information and

³⁹ This estimate is based on internal FFE data.

estimated that ~32 percent of these consumers would generate DMIs based on historical DMI trends.

State Exchanges currently employ varying approaches for DMI generation during annual eligibility redetermination and re-enrollment. As a result, we anticipate that some State Exchanges may experience an increase in DMI activity beginning in the pre-OE verification period for PY 2028 (which would occur in 2027), while others may not. We are unable to estimate the potential impacts on State Exchange consumers or State Exchanges, and we solicit comment from State Exchanges regarding the anticipated impacts of the proposed policy on their expected DMI volumes.

The additional DMIs for Exchanges on the Federal platform because of the proposed policy would increase information collection burden on consumers. Based on internal FFE data, we estimate that consumers will require approximately 1 hour each to respond to the associated questions or to submit the required documentation. Using the estimate of the hourly value of time for unpaid activities calculated at \$25.58 per hour in section IV.A. of this proposed rule, we estimate that the increased burden on consumers to compile and submit documents, beginning with the pre-OE verification period for PY 2028, which would occur in 2027, would be approximately \$25.58 (1 hour $\times$ \$25.58), and the cost increase for Federal Government consumers starting in PY 2027 would be approximately \$32,995,975 (1 hour $\times$ \$25.58 $\times$ 1,289,913 Federal Government consumers) per year.

Additionally, we estimate that the Federal Government would generate and process an additional 1,749,325 DMIs,⁴⁰ resulting in an increase in burden for Exchanges. We arrived at this estimate by starting with the 1,289,913 consumers on Exchanges on the Federal platform who we estimate would generate DMIs and estimated that they would on average generate ~1.36 DMIs each based on historical DMI trends. Once a document is submitted, we estimate that it would take approximately 1 hour and 12 minutes (1.2 hours) for an eligibility support staff person (BLS

⁴⁰ This estimate is based on internal FFE data.

occupation code 43-4061), at an hourly cost of \$52.12, to receive, review, and verify submitted verification documents as well as conduct outreach and determine DMI outcomes. Therefore, adding these DMIs would result in an increase in annual burden on Exchanges on the Federal platform of 2,099,190 hours ($1,749,325 \text{ DMIs} \times 1.2 \text{ hours per DMI}$) at a cost of \$109,409,783 ($2,099,190 \text{ hours} \times \$52.12$) beginning in the pre-OE verification period for PY 2028, which would occur in 2027.

We seek comment on these proposed burden estimates and assumptions.

D. ICRs Regarding Plan Selection during Inconsistency Period (§§ 155.400, 155.410, 155.420, 155.330)

The following changes will be submitted for review under OMB Control Number 0938-1191.

We propose to add new § 155.400(i) to expand the enrollment options available to applicants or enrollees who are subject to the new verification requirements described in section III.A.4.b of this proposed rule. The proposed update at § 155.400(i) would require Exchanges to allow applicants or enrollees to “pend” their plan selection during their inconsistency period such that the plan selection is only sent to the issuer, and QHP coverage only becomes effective, after the applicant’s or enrollee’s DMI related to the applicable enrollment information, are resolved by an Exchange and APTC becomes available.

We also propose to add new § 155.410(f)(5), which would provide QHP effective date rules for instances in which a consumer pends their plan selection during the annual OEP, as described in section III.A.8. of this proposed rule. In general, we propose that if an applicant’s DMIs are resolved by the 15th of the month following the effective date they would have otherwise qualified for under § 155.410(f), then the applicant’s QHP would become effective on that otherwise prescribed effective date. If the applicant’s DMIs are not resolved by the 15th of the month following their otherwise prescribed effective date, and their DMIs are resolved before the 15th of the month, then their QHP would be effective the first of the month in which the

resolution occurs. If their DMI resolution occurs after the 15th of the month, their QHP would be effective the first of the following month. In § 155.315(f)(4)(iv)(B)(1), we propose that, in these scenarios, the effective date for the consumer's APTC and CSR determinations would align with their coverage effective date.

Lastly, we propose to add new § 155.420(b)(6) to state the effective dates for coverage if a consumer qualifies for an SEP and selects a QHP that, in accordance with § 155.400(i), is not released to the issuer until the consumer resolves their DMIs. Currently, § 155.420(b) describes the effective dates that are applicable for consumers enrolling via an SEP based on the SEP type and the trigger date for the SEP. If an Exchange resolves a consumer's DMIs prior to the effective date specified in § 155.420(b)(1) through (3) of this section, then we propose that the effective date specified in § 155.420(b)(1) through (3) is transmitted to the issuer when the plan selection is released. However, in the case that the DMI resolution described at § 155.400(i)(2) occurs after the applicable coverage effective date described in § 155.420(b)(1) through (3) of this section, then the new proposed rule at § 155.420(b)(6) would apply. The new proposed rule at § 155.420(b)(6) specifies that if the consumer's DMI is resolved on or before the 15th of a month, coverage would be effective the 1st of the same month; if the consumer's DMI is resolved after the 15th of the month, coverage would be effective the 1st of the following month. In § 155.315(f)(4)(iv)(B)(2), we clarify that, in these scenarios, the effective date for the consumer's APTC and CSR determination would align with their coverage effective date.

As mentioned previously, the proposed addition at § 155.400(i) would enable applicants or enrollees to select a plan while their information is being verified by an Exchange in cases where consumers prefer their enrollment to be contingent on the availability of APTC. Both State Exchanges and Exchanges on the Federal platform will have a one-time implementation cost to create new processes for consumers to select a pended plan. Currently, there are 21 State Exchanges (20 States plus the District of Columbia), and we are aware of 1 additional State that plans to transition to a State Exchange for PY 2027, thus bringing the total to 22 State Exchanges

(21 States plus the District of Columbia). We estimate that it would take Exchanges 25,000 hours across 2026 and 2027 to make these updates.

Using the median wage rates estimated in IV.A., we estimate that this total for Exchanges would include 6,250 hours from a database and network administrator and architect at \$106.52 per hour and 18,750 hours from a computer programmer at \$96.52 per hour. Given this, we estimate that Exchanges on the Federal platform will incur a one-time burden across 2026 and 2027 of \$2,475,500 $[(6,250 \times \$106.52) + (18,750 \times \$96.52)]$ to make these eligibility system updates, with all 22 State Exchanges incurring a total of \$54,461,000. In total, the burden associated with all system updates would be 575,000 hours at a cost of \$56,936,500. This process is optional for consumers who are under no requirement to pend a plan before they find out if they are eligible for APTCs and CSRs.

We seek comment on these proposed burden estimates and assumptions.

E. ICRs Regarding Pre-Open Enrollment Verification Period (§ 155.410(h))

The following changes will be submitted for review under OMB Control Number 0938-1191 and OMB Control Number 0938-1254.

We are proposing to add § 155.410(h) to require all Exchanges to provide consumers with a verification period that begins prior to the beginning of the OEP each year during which Exchanges would be required to verify eligibility information that consumers choose to provide for the upcoming plan year. We propose that all Exchanges would make this process available beginning on August 1, 2027, for PY 2028 and August 1 of each subsequent year. We propose that Exchanges would be required to allow consumers to provide, update, or confirm their information, including, at a minimum, their household income, incarceration status, citizenship or lawful presence status, and place of residence.

We propose in § 155.410(h)(2) to require that during the pre-OE verification period, consumers can provide their information for the upcoming plan year. We propose at § 155.410(h)(3) that Exchanges would be required to attempt to verify this information and, if

verification is unsuccessful, to follow the updated DMI procedures in § 155.315(f). (See ICR on § 155.335 for burden estimates related to trusted data sources.)

The burden to issuers related to sending the Federal standard notices is currently approved under OMB Control Number 0938-1254 (CMS-10527). We will revise the information collection to include 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.

We estimate that it would take Exchanges 15,000 hours across 2026 and 2027 to make these one-time updates. Using the median wage rates estimated in IV.A., we estimate that this total for Exchanges would include 3,750 hours from a database and network administrator and architect at \$106.52 per hour and 11,250 hours from a computer programmer at \$96.52 per hour. Given this, we estimate that Exchanges on the Federal Platform will incur a one-time burden across 2026 and 2027 of \$1,485,300 ($3,750 \times \$106.52 + 11,250 \times \$96.52$) to make these eligibility system updates, and all 22 State Exchanges will incur a total of \$32,676,600. In total, the burden associated with all system updates would be 345,000 hours at a cost of \$34,161,900.

We seek comment on these proposed burden estimates and assumptions.

F. Summary of Annual Burden Estimates for Proposed Requirements

TABLE 3: Proposed Annual Recordkeeping and Reporting Requirements

Regulation Section(s)	OMB Control Number	Total Annual Burden (hours)	Total Cost (\$)
155.315, 155.320, 155.330	0938-1191	690,000	\$68,323,800
155.335	0938-1191	6,731,552	\$265,066,231
155.400, 155.410, 155.420, 155.330	0938-1191	575,000	\$56,936,500
155.410(h)	0938-1191, 0938-1254	345,000	\$34,161,900

G. 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 previously, please visit CMS' website at www.cms.hhs.gov/PaperworkReductionActof1995, or call the Reports Clearance Office at 410-786-1326.

If you comment on these information collection, that is, reporting, recordkeeping or third-party disclosure requirements, please submit your comments electronically as specified in the ADDRESSES section of this proposed rule.

Comments must be received by the date and time specified in the "DATES" section of this rule.

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

This proposed rule includes proposed updates to provisions related to Exchange eligibility and verification consistent with new requirements specified under the WFTC legislation. This proposed rule also proposes related updates to provisions affecting inconsistency periods, reported modifications to eligibility criteria, verification procedures, and eligibility redeterminations. Additionally, this proposed rule proposes to remove annual eligibility redetermination and re-enrollment requirements for APTC and CSRs while continuing the same for QHP coverage, expand enrollment options during the verification process, and establish new effective dates.

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). 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, territorial, 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 impacts 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) was prepared for this rule in keeping with Executive Order 12866. Based on our estimates, 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). We have prepared an RIA that, to the best of our ability, presents the costs and benefits of the rulemaking.

C. Detailed Economic Analysis

1. DMIs (§§ 155.315, 155.320, 155.330)

We are proposing to modify § 155.315(f)(4)(ii) to state that Exchanges cannot provide

APTC and CSRs to consumers who receive DMIs related to the applicable enrollment information. We also propose to exempt those who qualify for an SEP due to a change in family size from these new requirements to verify certain factors of eligibility before providing APTC within proposed § 155.315(f)(4)(ii) and proposed § 155.315(f)(4)(iii)(A). We are also proposing to add § 155.315(f)(4)(iii) to describe that Exchanges would be required to continue to provide APTC and CSRs (as applicable) during inconsistency periods created due to reporting a change to eligibility criteria during the plan year after an Exchange has completed verification of those same criteria.

We also propose to add § 155.315(f)(4)(iv), which provides that Exchanges would be required to determine eligibility for APTC and CSRs on behalf of an applicant per new effective dates following successful verification of information as described in proposed new § 155.315(f)(4)(ii). Finally, we propose to add § 155.315(f)(4)(v) to clarify that applicants with DMIs other than those outlined in § 155.315(f)(4)(ii) would be able to continue receiving APTC and CSRs if otherwise eligible during the inconsistency period.

We also propose to amend § 155.330(f)(1) such that if an Exchange redetermines an enrollee's eligibility to enroll in APTC or CSRs because the enrollee has provided updated information to the Exchange, then the redetermination of eligibility would become effective on the first of the month following an Exchange's eligibility redetermination, with an exception at § 155.330(f)(1)(i) to allow APTC or CSR effective dates that align with SEP effective dates in cases of retroactive or case-by-case SEPs.

We propose to amend § 155.330(f)(2) to provide that if a consumer is already enrolled in a QHP when their DMI is resolved, an Exchange would be required to implement their APTC and CSR eligibility determination effective the first day of the first month in which an Exchange determined all relevant eligibility criteria to be verified, as long as the consumer was enrolled in a QHP as of the first of that month, and the consumer's DMI was generated prior to the first of that month.

Finally, we propose to amend § 155.330(f)(3) to provide effective date rules for an Exchange's redetermination of eligibility following the expiration of a DMI or the end of a periodic data matching period. This proposal maintains current effective date rules for such redeterminations, with the exception that, if the redetermination results in the consumer qualifying for the same or an increased amount or level of APTC or CSRs, then Exchanges are no longer permitted to delay the effective dates for such redeterminations beyond the first of the next month.

As mentioned in section IV.B. of this proposed rule, we are providing analysis of all of these sections together due to their intertwining impacts on costs and burdens between the provisions on consumers' DMIs, the requirements for Exchanges to adjudicate DMIs prior to a consumer receiving APTC, and the dates those changes are effective. In section IV.B. of this proposed rule, we estimated that to implement all of these proposed changes, including withholding APTC during an inconsistency period; creating exceptions to that process for both a Family Size SEP waiver and a new DMI set during an eligibility redetermination during the plan year, and adding in rules for effective dates for enrollee-reported changes and the resolution and expiration of DMIs, it would result in a one-time burden cost of \$2,970,600 to Exchanges on the Federal platform and a one-time burden cost of \$65,353,200 for all State Exchanges across 2026 and 2027.

We anticipate that both Exchanges on the Federal platform and State Exchanges would each incur an ongoing, annual cost burden related to requiring a new Eligibility Determination Notice (EDN) be generated in relation to changes in § 155.315. This would result in an estimated annual increase of 1.5 million notices for each Exchange. Using the cost of \$0.62 per notice, we estimate this will result in an annual ongoing burden cost of \$930,000 for Exchanges on the Federal Exchange (1,500,000 notices x \$0.62 cost per notice) and \$20,460,000 for State Exchanges (1,500,000 notices x \$0.62 cost per notice x 22) for a total of \$21,390,000 annually, beginning in 2027.

In addition to the annual ongoing costs of generating additional EDNs, we also expect one-time costs related to updating notices. Currently, Exchanges on the Federal platform and State Exchanges send notices to consumers when their eligibility for coverage and financial assistance changes, as well as potentially in instances where a consumer submits an insufficient document to resolve a DMI, when a DMI expires, when a DMI is resolved, and other potential related scenarios. Given the significant changes included in these proposals, such as the requirement to resolve DMIs prior to determining eligibility for APTC, the exception to that requirement during a family size SEP and when a DMI generates during a mid-year change, and the associated effective dates for being determined eligible for APTC, we expect that all Exchanges will need to make significant updates to their noticing processes.

These processes will include language-related updates across these types of notices, as well as considering whether current noticing efforts must be changed to account for these significant proposed changes. Given this, using the median wage rates estimated in IV.A., we estimate that it would require Exchanges a total of 5,000 hours to update the associated notices, split between a technical writer and a management analyst. The median wages were doubled to account for overhead and fringe benefits ($2,500 \times \$86.92 + 2,500 \times \$97.94$). Therefore, we estimate that Exchanges on the Federal Platform may incur an estimated one-time cost of \$462,150 and all State Exchanges may incur 110,000 hours for an estimated one-time cost of \$10,167,300 ($92,500 \times \$86.92 + 2,500 \times \$97.94$] x 22 State Exchanges) to update associated notices in 2027, for a total of 115,000 hours at a cost of \$10,629,450.

We estimate that our proposal to amend § 155.315(f)(4) to allow for Exchanges to provide APTC during an applicant's inconsistency period if the applicant's household is eligible for an SEP in accordance with § 155.420(d)(2), as well as our proposal to add § 155.315(f)(4)(iii) to require Exchanges to continue to provide APTC and CSRs during inconsistency periods created due to reporting a change to eligibility criteria during the plan year after an Exchange has completed verification of those same criteria, would not impose

substantial ongoing burdens or costs on Exchanges, issuers, or consumers (besides the one-time implementation cost that was mentioned in section IV.B. of this proposed rule) beyond the ongoing costs that are already accounted for as part of the existing policy to allow APTC to be paid on behalf of consumers during their inconsistency period.

We also are of the view that requiring a consumer to adjudicate their DMI prior to receiving APTC may cause Exchanges to have increased operational needs to decrease the amount of time needed to review and approve documentation to ensure that consumers receive APTC in a timely fashion. Exchanges currently have a 90/95-day period to help consumers resolve DMIs while they receive APTC and CSRs, and current consumer behavior leads to consumers tending to submit the needed documentation near the end of this period. However, with our proposed changes, consumers will not be eligible for APTC or CSRs until after they have resolved their DMIs.

We have determined that this change would also result in a change in consumer behavior where a consumer is more likely to resolve a DMI towards the beginning of their inconsistency period versus delaying their efforts until closer to when their inconsistency period is ending. While consumers are generally shielded from the time that it takes an eligibility support worker to process their DMI in the current environment as there is no effect on their APTC eligibility (within their current 90/95-day period), consumers will be acutely aware of the delay in processing DMIs in this new regime due to their unresolved DMI impacting their APTC and CSR eligibility. If there are delays in determining a consumer eligible for APTC and CSRs, it could create consumer satisfaction pressure for Exchange operations to decrease the amount of time that it takes for an Exchange to process a DMI, especially at points in the year such as towards the end of Open Enrollment to ensure that consumers will be able to receive APTC and CSRs beginning in January if they are indeed eligible. Some Exchanges may find that it is necessary to increase seasonal staffing to help consumers resolve their DMIs and therefore receive APTC and CSRs. We seek comment on estimates from Exchanges as to the time that it

takes to resolve different DMIs and whether Exchanges predict any staffing changes could be made in response to these proposed changes.

Additionally, these changes could help mitigate potentially fraudulent behavior done by agents, brokers, and web-brokers. As outlined in the 2025 Marketplace Program Integrity and Affordability Rule and the 2027 Payment Notice, many agents, brokers, and web-brokers may be incentivized to enroll consumers with potentially incorrect income amounts that result in maximum APTC amounts for the consumers. While this would typically result in at least an income DMI, under current regulations, those consumers would be enrolled for at least 90 days with that level of APTC before the income DMI would expire, allowing agents, brokers, and web-brokers to receive commissions for the time that consumers are enrolled.

With the proposed change to not determine APTC and CSR eligibility until all DMIs related to the applicable enrollment information are adjudicated, agents, brokers, and web-brokers that have historically participated in fraudulent behavior would no longer be able to have consumers receive APTC or CSRs until they work with those consumers to submit documents and resolve those DMIs. This is especially true for agents, brokers, and web-brokers who mislead consumers into believing they are eligible for more APTC than they may be eligible for. Given this, we anticipate that Exchanges may see a decrease in costs associated with combating fraud in relation to inaccurate application attestations and may see a decrease in agents, brokers, and web-brokers who have potentially fraudulent motivations participating in Exchanges.

While potentially less significant than the proposals to generally disallow APTC and CSR during inconsistency periods, we expect that there will also be qualitative impacts of the proposals in § 155.330 related to APTC and CSR effective dates. We propose eliminating the exceptions currently at § 155.330(f)(2) and (3), and therefore no longer allowing Exchanges to delay effective dates for certain eligibility redeterminations. We anticipate this proposed change will benefit consumers insofar as it requires their updated eligibility redetermination to take effect sooner than it would under current rules, resulting in more accurate APTC determinations

and reduced risk of consumer tax liability at reconciliation. This is particularly important given that section 71305 of the WFTC legislation removes caps on the amount of APTC a consumer may be liable to repay when filing their taxes and reconciling their APTC. However, we also expect that some consumers may find that the shorter time between eligibility redetermination and APTC and CSR effective date makes it more difficult to anticipate and plan for unexpected increases to their net premium or cost-sharing responsibilities.

Finally, we acknowledge that these proposed changes may result in one-time changes to issuer operations. Due to both the timing of DMIs and new use cases in which consumers may qualify for retroactive APTC and CSRs, we assume issuers would need to make updates to their notices to consumers. Specifically, because proposed effective date changes would allow for retroactive APTC and CSRs upon DMI adjudication in cases where an Exchange is able to verify APTC and CSR eligibility for previous months, issuers would likely see an increase in the number of consumers that are requesting the application of retroactive APTC and CSRs on their plans. We seek comment from issuers and other affected parties on what these cost burdens may look like for the proposed updates to effective dates upon DMI resolution.

We seek comment on these proposed impacts and assumptions.

2. Annual Eligibility Redetermination (§ 155.335)

We are proposing to modify § 155.335(a) to specify that for an Exchange to redetermine an enrollee eligible for APTC and CSRs for the subsequent plan year, the enrollee or the enrollee's application filer would be required to provide or confirm household income and family size; U.S. citizenship or status as a lawfully present eligible non-citizen; eligibility for or enrollment in other MEC; and place of residence for the subsequent plan year on or after August 1 and no later than December 31 of the year preceding the applicable plan year, and the Exchange would be required to verify the specified eligibility information using the processes in §§ 155.315 and 155.320, including the relevant provisions in those sections regarding DMIs.

We also propose to amend § 155.335(b) to state the annual eligibility redetermination

would be effective on the first day of the applicable plan year, and the Exchange would be required to adhere to the existing notification standard for eligibility determinations under § 155.310(g). We propose an exception in instances where an enrollee has an unresolved DMI related to the applicable enrollment information as of December 31 of the year preceding the plan year and for whom APTC and CSRs are not provided during the inconsistency period. In these cases, we propose that the redetermination of APTC and CSRs under this part take effect in accordance with §§ 155.315(f)(4)(iv)(A) or 330(f)(3), as applicable. We propose to remove § 155.335(c) through (i); redesignate § 155.335(j) as new § 155.335(c); and remove § 155.335(k) through (n).

a. Costs

As discussed in section IV.C. of this proposed rule, we estimate that implementing this proposed policy would require one-time costs to the Federal Government and each State Exchange. For the Federal Government, we estimate a burden between 2026 and 2027 of 22,000 hours at a cost of \$2,178,440. For State Exchanges, we estimate a burden in 2026 and 2027 of 484,000 hours at a cost of \$47,925,680 for completing the necessary updates to State Exchange systems. In total, the burden associated with all system updates would be 506,000 hours at a cost of \$50,104,120.

In section IV.C. of this proposed rule, we estimate that an additional 3,969,403 consumers in Exchanges on the Federal platform and an additional 1,703,494 consumers in State Exchanges who previously would not have been required to contact the Exchange to be re-enrolled with APTC and CSRs for the subsequent plan year, after being determined eligible under an Exchange's procedures, would instead have to return to Exchanges to provide or confirm the specified eligibility information under the proposed policy. In aggregate, we estimate the total annual cost burden to all Federal Government and State Exchange consumers for the additional data collection beginning with the pre-OE verification period to be \$72,556,353, beginning in 2027.

As further discussed in section IV.C. of this proposed rule, we estimate that the proposed policy would result in an increase of 1,749,325 DMIs generated and processed by Exchanges on the Federal platform. We estimate that the increase in cost for consumers from Exchanges on the Federal platform beginning with the pre-OE verification period for PY 2028 would be approximately \$32,995,975 per year.

Additionally, we estimate that an increase in the number of DMIs that the Federal Government would generate and process would result in an increase in burden for Exchanges. In aggregate, we estimate the total annual cost burden to Exchanges on the Federal platform because of increase of DMIs would be \$109,409,783 beginning with the pre-OE verification period for PY 2028, which is in 2027.

We also anticipate an increase in the number of transactions transmitted by the Federal Government to trusted data sources for the purpose of verifying consumer eligibility information. The costs associated with these transactions vary by data source and the type of information returned. State Exchanges currently employ varying operational approaches for utilizing trusted data sources to verify information. As a result, we anticipate that some State Exchanges may experience an increase in trusted data source transactions, while others may not. We solicit comment from State Exchanges regarding the anticipated operational impacts of the proposed policy on trusted data sources transactions.

Currently, the Federal Government submits verification requests to the Department of Homeland Security (DHS) Systematic Alien Verification for Entitlements (SAVE) via the Federal Data Services Hub (“the Hub”) to confirm consumer immigration status. Because the price per transaction for HHS data is proprietary information, we are unable to provide those numbers in this rulemaking as this would be a direct conflict with the contract that HHS holds with DHS. In 2027, the projected annual cost for such verification requests is estimated to increase by \$5,830,080 for Exchanges on the Federal platform, relative to projected annual costs in the absence of the proposed policy, according to HHS internal data. This represents a 31

percent increase in the number of DHS SAVE transactions compared to DHS SAVE transaction volume without the proposed policy.

The Federal Government also submits verification requests to the Social Security Administration (SSA) to validate Social Security numbers and verify if a consumer is a U.S. citizen, as well Title II income information to verify projected household income. Because the price per transaction for SSA data is proprietary information, we are unable to provide those numbers in this rulemaking as this would be a direct conflict with the contract that HHS holds with SSA. As described in IV.B. of this proposed rule, we estimate an additional 3,969,403 consumers will provide or confirm their information on Exchanges on the Federal platform. As a result of this proposed policy, we further estimate based on internal HHS analysis that the annual cost to Exchanges on the Federal platform for verification requests to the SSA would increase by \$636,240 in 2027, relative to projected costs in the absence of the proposed policy. This represents a 21 percent increase in transactions compared to SSA transaction volume without the proposed policy.

In addition to use of IRS data, verification of income data is conducted through the Current Sources of Income (CSI) Hub service, which is an optional service for State Exchanges. If State Exchanges choose to use the CSI Hub service, they are required to pay for their utilization of the CSI service in full. Because the price per transaction for CSI data is proprietary information, we are unable to provide those numbers in this rulemaking, or the precise utilization rates for the 10 State Exchanges that currently use this optional service, as this would be a direct conflict with the contract that HHS holds with the CSI contractor. However, based on internal HHS analysis, we estimate the annual cost of utilization of the CSI Hub service to increase by \$2,676,103 for the Federal Government, relative to 2027 estimates without the proposed policy change. This represents a 14 percent increase in transaction volume.

Under our proposed rule, the volume of verification inquiries submitted to each of these trusted data sources is expected to increase as a greater number of consumers are required to

provide or confirm the specified eligibility information annually. In aggregate, the total burden associated with all verification inquiries submitted to trusted data sources across the Federal Government would be \$9,142,423 (\$5,830,080 + \$636,240 + \$2,676,103), based on the rates described previously and the anticipated incremental increase in inquiry volume relative to the 2027 baseline without the proposed policy.

Other trusted data sources that the Federal Exchange uses to verify eligibility do not have a per-transaction cost associated, and we therefore do not expect increased costs with regard to these verifications as a result of this proposed rule. We seek comment from State Exchanges regarding whether they incur additional per-transaction verification costs not addressed in this analysis.

b. Benefits

Beyond these cost estimations, we expect that requiring consumers to provide or confirm specified eligibility information as a condition of re-enrollment with APTC and CSRs in the subsequent plan year and Exchanges verifying that information would mitigate the risk that individuals receive APTC or CSRs for which they are no longer eligible, thereby reducing incidences of improper or fraudulent enrollment. As discussed in the 2025 Marketplace Program Integrity and Affordability final rule (90 FR 27074) and the HHS Notice of Benefit and Payment Parameters for 2026 final rule (90 FR 4424), we have observed instances in which agents, brokers, and web-brokers enroll consumers using potentially inaccurate income information that results in the application of maximum APTC amounts for consumers. Improper payments are a fiscal risk to the Federal Government and undermine public trust in the integrity of the Exchanges. We are of the view that our proposed policy is likely to substantially reduce fraudulent or abusive practices by agents, brokers, and web-brokers by interrupting the perpetuation of inaccurate subsidy amounts across plan years. This verification requirement strengthens the overall credibility of the Exchanges, improves program integrity, and protects consumers from downstream financial and coverage consequences of enrollment fraud.

In addition, we anticipate that the proposed policy would improve APTC accuracy by aligning subsidy determinations more closely with a consumer's projected household income, for example, and other applicable eligibility criteria and circumstances for the upcoming plan year. More accurate APTC determinations on at least an annual basis would reduce the likelihood of excess APTC and the associated tax liability at reconciliation for consumers.

We seek comment on these proposed impact estimates and assumptions.

3. Plan Selection during Inconsistency Period (§§ 155.400, 155.410, 155.420, 155.330)

We anticipate that the proposed modifications to binder payment regulations at § 155.400(e)(1), which would update the rules for collection of binder by Exchange issuers under the new enrollment scenarios proposed in this rule, would have a minor but positive impact on the risk pool, and would result in minor costs to issuers associated with the potential need for system changes. These regulations would provide issuers with additional flexibility to set binder payment deadlines, and in some circumstances would require issuers to set a later binder payment deadline than they might under current rules. As a result, to the extent that issuers grant applicants additional time to pay binder and effectuate coverage, more enrollments will likely be effectuated, though we do not have adequate data to determine exactly how many. Because sicker enrollees are, overall, more likely to enroll and pay premiums even when doing so represents a financial hardship, providing additional time to pay binder will likely result in healthier and less costly applicants effectuating coverage.

Due to the changes this provision makes to the rules on when issuers are permitted to set the deadline for paying binder, there may be some costs to issuers associating with updating their systems to reflect a different deadline for the first month's premium, or to account for additional scenarios in which binder must be collected. In addition, issuers may need to make changes to their system to reflect the need to collect more than one month's premium for the binder payment in additional scenarios. However, we do not have adequate data to estimate these costs. The proposed addition to § 155.400(i) that would enable applicants or enrollees to "pend" their plan

selection during their inconsistency period such that the plan selection is only sent to the issuer, and QHP coverage only becomes effective, upon the Exchange determining the applicant or enrollee eligible for APTC and CSRs, as applicable, as described by § 155.315(f)(4)(iv) or § 155.315(f)(5). Specifically, this reduces consumer burden introduced by the proposed changes in section III.A.4.b. of this proposed rule by allowing them to choose their plan in the same session as their application without having to come back again to choose a plan after they are determined eligible for APTC.

The addition to § 155.400(i) would increase enrollment under the proposed policies as it would streamline the enrollment process for applicants or enrollees who cannot afford to enroll in a full-price QHP during their inconsistency period because it would remove the burden of returning to Exchanges once the relevant DMIs are resolved. It may be time-consuming for applicants or enrollees to have to return to Exchanges after submitting an application to provide a document or select a plan. It would be likely many people would miss the deadline and fail to enroll without the addition at § 155.400(i) due to the time that DMI resolution often takes. Starting with the PY 2028, applicants or enrollees seeking to enroll with APTC and CSRs will miss the opportunity to enroll if Exchanges do not resolve their DMIs related to the applicable enrollment information before the end of the OEP, and they are not permitted to pend any plan selections to enroll in their desired QHP plan. The plan is only sent to the issuer once the Exchange determines the applicant or enrollee eligible for APTC and CSRs, as applicable, as described by § 155.315(f)(4)(iv) or § 155.315(f)(5). This highlights a positive impact in that only those who qualify to be on Exchanges will receive coverage, and Exchanges will only provide APTC and CSRs to those who truly qualify. The proposed changes to §§ 155.410(f)(5) and 155.420 are being made to enable the change to § 155.400, so they do not have any separate impact.

As discussed in section IV.D. of this proposed rule, we estimate one-time implementation costs of \$2,475,500 for Exchanges on the Federal platform and \$54,461,000 for all 22 State

Exchanges in 2027 to make these eligibility system updates.

We seek comment on these impact estimates and assumptions.

4. Pre-Open Enrollment Verification Period (§ 155.410(h))

We propose to add § 155.410(h) to require all Exchanges to permit consumers to provide eligibility information to Exchanges for the upcoming plan year prior to the beginning of the OEP each year. We propose that all Exchanges make this process available beginning on August 1, 2027, for the 2028 Plan Year and August 1 of each subsequent year. We propose that Exchanges would be required to allow consumers to provide, update, or confirm their information, including, at a minimum, their household income, citizenship or lawful presence status, incarceration status and place of residence for the upcoming plan year. We propose in § 155.410(h)(2) to require that during the pre-OE verification period, consumers can provide their information for the upcoming plan year. We propose in § 155.410(h)(3) that Exchanges would be required to attempt to verify this information and, if verification is unsuccessful, to follow the updated DMI procedures in § 155.315(f). (See ICR on § 155.315 for burden estimates related to trusted data sources.)

As discussed in section IV.E. of this proposed rule, we estimate one-time implementation costs of \$1,485,300 for Exchanges on the Federal platform and \$32,676,600 for all 22 State Exchanges in 2027 to implement functionality for the pre-OE verification period.

We anticipate that all Exchanges may incur costs associated with annual advertising costs to announce the new pre-OE verification process so that consumers are aware that the eligibility process for the subsequent year may be completed earlier than before. Additionally, we anticipate that all Exchanges may incur ongoing maintenance of the pre-OE verification process website annually.

On an ongoing basis, Exchanges also may need to adjust staffing models for their call centers, documentation review personnel, and casework teams to increase capacity before open enrollment. We expect plan data will be unavailable during most or all of the pre-OE verification

period for most or all Exchanges. Therefore, Exchanges would be unable to provide updated amounts of APTC to consumers who submit applications during the pre-OE verification period and who are determined eligible for APTC. We anticipate that as a result, Exchanges may incur costs to adjust their standard eligibility determination notices and results to account for the missing information. We anticipate additional noticing costs for Exchanges to update consumers with the amount of APTC when plan data does become available.

For Exchanges that allow third parties to collect eligibility information from consumers, as described in § 155.221, we estimate costs for such enrollment partner changes to permit consumers to provide information earlier for the subsequent year as well. Costs for enrollment partners are likely to mirror some percentage of Exchange costs, both for initial implementation and on an on-going basis. We are aware of approximately 11 primary Enhanced Direct Enrollment (EDE) entities that would incur costs as described here. Agents, brokers, navigators, certified assistance counselors, and other assisters may need to adjust their staffing and/or business model to adjust to the change in timing of Exchange activities in anticipation of the subsequent coverage year. We note that the proposed regulations do not require consumers to complete their application or verification prior to Open Enrollment, but consumers who seek to take advantage of the new opportunity may depend on assistance personnel to facilitate their participation in the pre-OE process. 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. We seek comment on these proposed impact estimates and assumptions.

Consumers who choose to utilize the pre-OE verification period would generally be spending time on application and verification tasks that otherwise would have been completed during Open Enrollment, and we therefore estimate the net consumer burden as a result of the existence of the pre-OE verification period to be minimal. However, because we expect plan data would not be available for most of the pre-OE verification period for most Exchanges,

consumers who take advantage of the pre-OE process would have to make an additional later visit to Exchanges to shop for a plan. We estimate there would be some net increase in time spent on Exchange processes as a result of dividing application completion from plan shopping into two separate interactions with the Exchange. In addition, if consumers choose to provide eligibility information to Exchanges further in advance of the coverage year due to the availability of the pre-OE verification period, it increases the chance that the consumer would experience a change in their information prior to the coverage year that also results in an additional visit to an Exchange to report the change. These net increases in time spent completing eligibility and enrollment activities would impact consumers as well as the agents, brokers and other assisters who assist consumers with the process.

There is inherent uncertainty regarding the proportion of consumers who would utilize the pre-OE verification process. In addition, part of the potential increase in time consumers would spend using the pre-OE verification process may overlap with the burden quantified in section VI.C.2. related to enrollees who use the pre-OE period to provide information newly required for annual redetermination. However, we estimate here that 5 percent of consumers, 829,125 ($16,582,500$ total enrollees across Exchanges on the Federal platform and 22 State Exchanges $\times 0.05$) overall would spend more time on their eligibility and enrollment process due to electing to provide information during the pre-OE period and subsequently needing to return to the Exchange to provide additional information, choose a plan, or report a change. As noted, the time spent on the pre-OE process would largely replace time that consumers would otherwise spend providing the same information during the OEP, so we estimate the net time increase per consumer to be only about 5 minutes to account for a subsequent additional log-in to the Exchange website or to set up an additional call with an agent, broker or assister, but without any net additional information requested at any point. Using the estimate of the hourly value of time for unpaid activities calculated at \$25.58 per hour in section IV.A. of this proposed rule, we estimate the total annual cost burden to all consumers across Exchanges on the Federal Platform

and the 22 State Exchanges who opt to use the pre-OE verification period to be \$1,767,425 (829,125 enrollees x (5 minutes ÷ 1 hour) × \$25.58).

For the eligibility determination notice sent by the FFE, we estimate that there would be 690,938 households (derived from 829,125 enrollees) who will receive an additional EDN as a part of this process, leading to an ongoing cost of \$299,867 (690,938 total households across Exchanges on the Federal platform and 22 State Exchanges x 70 percent x \$0.62 to mail a notice) to mail additional notices. Currently about 70 percent of consumers opt to receive print notices, so we assume we will print a similar number of additional notices.

We request comment on the assumptions described here regarding the percentage of consumers impacted and the likely magnitude of burden per consumer.

5. Regulatory Review Cost Estimation

Due to the uncertainty involved with accurately quantifying the number of entities that will review the rule, we assume that the mid-point between the actual number of commenters received on the 2027 Payment Notice proposed rule (2,861) and the number of page views on the **Federal Register** website as of March 26, 2026 (25,723) would be the approximate number of reviewers (14,292) of this proposed rule. We acknowledge that this assumption may understate or overstate the costs of reviewing this proposed rule, and we seek comments on these assumptions.

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 \$119.10 per hour, including overhead and fringe benefits.⁴¹ Assuming an average reading speed of 250 words per minute, we estimate that it will take approximately 3.31 hours for the staff to review this proposed rule. For each entity that reviews the rule, the estimated cost is \$394.22 (3.31 hours ×

⁴¹ See U.S. Bureau of Labor Statistics (n.d.). Occupational Employment and Wage Statistics, May 2025 Occupation Profiles. Dep't. of Labor. https://www.bls.gov/oes/current/oes_stru.htm.

\$119.10 per hour). Therefore, we estimate that the total cost of reviewing this regulation is approximately \$5,634,207 (\$394.22 per reviewer × 14,292 reviewers).

6. Overall Impact of the Proposed Exchange Eligibility Verification Provisions

We anticipate that the provisions of this proposed rule, although 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 for enrollment, APTC, and premiums that minimize the overlap of individuals affected. These estimates consider the enrollment, APTC, and premium impact due to the provisions in this proposed rule, if finalized, compared to what would occur if these proposals were not finalized.

We propose to amend current regulations to align with section 71303(a) of the WFTC legislation amendments to section 36B of the Code. The proposed updates specify changes to processes that all Exchanges would be required to use following the actions taken to confirm applicants' eligibility for APTC and CSRs, as applicable.

Proposed updates at sections III.A.7. of this proposed rule would increase the number of individuals who need to update their information annually and therefore would increase the number of individuals who receive DMIs, which younger and healthier consumers often do not resolve. This would result in a decrease in enrollment and the amount of APTC paid out, while affecting the risk pool so that premiums would increase due to younger individuals dropping coverage.

Additionally, proposed updates in section III.A.4.b of this proposed rule would increase verification-related barriers to enrollment with APTC/CSRs by requiring eligibility verification be complete prior to providing APTC/CSRs to enrollees rather than providing them during the inconsistency period.

We expect this to result in fewer enrollees due to delays in receiving APTC so that many enrollees will receive APTC for fewer months. Younger and healthier consumers would be less incentivized to complete this process since they have lower perceived need for health care and would opt out when faced with administrative barriers, leading to less APTC being paid out as well as increased premiums as these consumers leave the risk pool.

Overall, more individuals may lose coverage because they are unlikely to be able to afford to enroll in a full-price QHP while they complete the verification process, leading to an increase in the rate of uninsurance. This increase may impose greater burdens on the health care system as treatment may shift to under-prepared emergency departments, additional costs to the Federal Government and to States to provide Medicaid coverage limited to the treatment of an emergency medical condition and cause an overall reduction to labor productivity due to a reduction in preventative as well as readily available care for illness.

We do expect these updated verification processes to decrease the occurrence of fraudulent activity by agents, brokers, and web-brokers in the Exchanges. These changes could help prevent fraudulent behavior by agents, brokers, and web-brokers who intentionally provide incorrect application attestations. By not providing APTC and CSRs until the resolution of all DMIs related to the applicable enrollment information, agents, brokers, and web-brokers that have historically participated in fraudulent behavior, especially those who mislead consumers into believing they are eligible for more APTC than they may actually be eligible for, would have to work with consumers to submit documents and resolve those DMIs before the consumers receive APTC or CSRs. Agents, brokers, and web-brokers are incentivized to engage in fraudulent behavior because current rules let them collect commissions for the duration a consumer is enrolled with financial assistance, even after that assistance is revoked. Requiring eligibility verification to be completed before APTC or CSRs are issued would eliminate this avenue for collecting unearned commissions on ineligible consumers.

Furthermore, requiring consumers to return to their application each year to provide or confirm specified eligibility information to re-enroll could mitigate the risk that consumers receive APTC or CSRs for which they are no longer eligible, thereby reducing incidences of improper or fraudulent enrollment.

Though we do acknowledge that these provisions will result in a decrease in improper and fraudulent enrollment, we do not quantify the impacts of this mitigation of fraud in this section because the baseline estimates used in the following sections are derived from the 2028-2030 estimates finalized in Table 28 of the Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program final rule (91 FR 29526).⁴² These baseline estimates account for the decrease in future enrollment due to the expected decrease in the level of improper enrollments through additional eligibility verification standards as a result of the WFTC legislation.

a. Enrollment

We estimate that the proposed updates to the eligibility and verification process would result in a decrease in enrollment volume for all Exchanges. A large portion of this decrease in enrollment can be attributed to the decrease in improper enrollments we expect to occur because of additional eligibility verification standards. The 2028-2030 baseline enrollment estimates account for this decrease in enrollment due to WFTC legislation that is expected to reduce improper enrollments. Not accounted for in the baseline estimates is the expected decrease in enrollment due to the additional barriers to enrollment for properly enrolled consumers that will result from the additional eligibility verification standards proposed by this rule. This additional expected decrease in enrollment is discussed in this section.

The withholding of APTC during the inconsistency period and increased manual documentation verification would reduce the number of consumers who enroll in a QHP.

⁴² Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2027, 91 Fed. Reg. 29,526, 29,856 (May 20, 2026) (to be codified at 45 CFR pts. 153, 155, 156) (Table 28).

Consumers whose information cannot be verified upon application submission will not be determined eligible for APTC/CSRs until the relevant information can be verified through the DMI process per proposed updates in section III.A.4.b. of this proposed rule. Therefore, consumers would have to make plan choices with less certainty about their APTC/CSRs and either enroll in a full-price QHP during the inconsistency period or select a plan that would be released to the issuer upon DMI resolution per proposed updates in section III.A.8.b. of this proposed rule.

It is unlikely that many consumers would be able to afford to enroll in a full-price QHP while they complete the verification process, so the proposed updates in section III.A.8.b. of this proposed rule may mitigate some enrollment decrease. Additionally, the proposed updates in sections III.A.4.c. and III.A.4.d. of this proposed rule that would allow for exceptions to withholding APTC during the inconsistency period would also mitigate some enrollment decrease. However, we estimate overall that fewer eligible consumers would be enrolled and those who are eventually enrolled through a pended plan selection following the DMI process would be enrolled for fewer months compared to current requirements and processes.

The requirements to provide or confirm eligibility verification information on an annual basis per proposed updates in sections III.A.4.b. and III.A.7. of this proposed rule would increase the amount of consumers who receive DMIs and must submit documentation to verify their information and therefore, would negatively impact eligible consumers' ability to enroll in a QHP due to the proposed requirement to withhold APTC/CSRs during inconsistency periods for DMIs related to the applicable enrollment information. Eligible consumers who are unable to complete the verification process will not be eligible to receive APTC or may also be ineligible to enroll in a QHP because they were unable to submit sufficient documentation. Consumers who remain eligible to enroll in a QHP are unlikely to be able to afford to enroll in a full-price QHP and may choose not to enroll. However, overall, we estimate that the increase in the number of consumers who must return on an annual basis combined with the increase in the

number of consumers who will be required to submit documentation will decrease enrollment due to administrative barriers.

For Exchanges on the Federal platform, we estimate an annual decrease of approximately 237,500 enrollees (11,840,500 enrollees in baseline estimates – 11,603,000 enrollees in estimates that account for this proposed rule). For State Exchanges, we estimate an annual decrease of 95,000 enrollees (5,074,500 enrollees in baseline estimates – 4,979,500 enrollees in estimates that account for this proposed rule). Together, 332,500 fewer individuals in all Exchanges (237,500 enrollees for Exchanges on the Federal Platform + 95,000 enrollees for State Exchanges) would enroll in QHP coverage per year as a result of the proposed updates to the previously mentioned regulations. These estimates are made in comparison to the enrollment projections presented in the Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program final rule (91 FR 29526)⁴³, which accounts for a decrease in 2028 enrollment due to the expected impact of the WFTC legislation which is expected to reduce the level of improper enrollments through additional eligibility verification standards.

b. APTC

We estimate that the proposed updates to the verification process would reduce the amount of APTC payments for all Exchanges. If this rule is finalized, assuming that individuals who do not maintain or enroll in coverage would otherwise be subsidized QHP enrollees, we expect savings to the Federal Government in the form of reduced APTC payments.

Additionally, withholding APTC during the inconsistency period would result in enrollees receiving APTC for fewer months compared to current rules, under which APTC is paid out during the inconsistency period.

Consumers who cannot receive APTC during their inconsistency period may either

⁴³ Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2027, 91 Fed. Reg. 29,526, 29,856 (May 20, 2026) (to be codified at 45 CFR parts 153, 155, 156) (Table 28).

choose to enroll in a full-price QHP during that time or may choose to select a plan where they would only be enrolled in such plan once they are deemed eligible for APTC per proposed updates in section III.A.8.b. of this proposed rule. For consumers who choose to pend their plan selection until their information is verified, APTC will be provided either on the 1st of the current month or 1st of the next month depending on when the information is verified per proposed effective dates in sections III.A.9.b. and III.A.10. of this proposed rule. Therefore, we estimate these consumers would receive APTC for 1.5 fewer months on average, because they may receive APTC later in the plan year than would currently be provided. Alternatively, a consumer who enrolls in a full-price QHP during their inconsistency period may receive APTC retroactively to their coverage start date per proposed updates in section III.A.4.b.iv. of this proposed rule, but if the Exchange cannot verify the information back to that date, then the consumer would only receive APTC starting the month that the information was verified. Therefore, we estimate these consumers would also receive APTC for 1.5 fewer months on average than they would have with current requirements to provide APTC during the inconsistency period.

The effect of the projected enrollment decrease is calculated by multiplying the 12 months of coverage those enrollees will not receive and by the average monthly APTC amount of \$655. For Exchanges on the Federal platform APTC expenditures are expected to decrease by \$1.9 billion annually beginning in PY 2028 (237,500 fewer enrollees x 12 months x \$655 APTC per month per enrollee). In total, across all 22 State Exchanges, APTC expenditures are estimated to decrease by \$747 million annually beginning in PY 2028 (95,000 fewer enrollees x 12 months x \$655 APTC per month per enrollee). Across all Exchanges, APTC expenditures would decrease by \$2.6 billion annually beginning in PY 2028 (\$1.9 billion for Exchanges on the Federal Platform + \$0.7 billion for State Exchanges).

We expect that APTC would be paid out for an average of 1.5 months less for consumers who generate a DMI and go on to verify their information and enroll in coverage with financial

assistance. For Exchanges on the Federal platform, we estimate the amount of APTC paid will decrease by \$3.5 billion annually, beginning with PY 2028 (3.5 million enrollees x 1.5 months x \$655 APTC). In total, across all 22 State Exchanges, we estimate the amount of APTC paid will decrease by \$1.5 billion annually, beginning with PY 2028 (1.5 million enrollees x 1.5 months x \$655 APTC). Across all Exchanges, APTC expenditures would decrease by \$5 billion annually, beginning with PY 2028 (\$3.5 billion for Exchanges on the Federal Platform + \$1.5 billion for State Exchanges).

Due to the expected enrollment decrease as well as enrollment being expected for less months because APTC would be withheld during the inconsistency period would result in APTC expenditures decreasing across all Exchanges by \$7.6 billion (\$5.4 billion for Exchanges on the Federal Platform + \$2.2 billion for State Exchanges).

c. Revealed-Preference Valuation of Interrupted Coverage

TABLE 4: Revealed-preference Valuation Calculations

Affected population	Coverage interruption	Subsidized premium (lower bound) (millions)	Full-premium (upper bound) (millions)	Forgone APTC (millions)	Midpoint (millions)	Gross net benefit (millions)
Consumers who do not enroll due to verification requirements	12 months	\$359.10	\$2,972.55	\$2,613.45	\$1,665.83	\$1,306.73
Consumers who do not enroll during the verification period	1.5 months	\$688.18	\$5,696.60	\$5,008.42	\$3,192.39	\$2,504.21

Total		\$1,047.28	\$8,669.15	\$7,621.87	\$4,858.22	\$3,810.94
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Some consumers who are unable to or need extra time to complete requirements to verify their eligibility for APTC may choose not to enroll in coverage without APTC, because they would have to pay the full price of an unsubsidized QHP. These consumers' decisions provide a revealed-preference basis for valuing the coverage they would opt out of in this situation.

The true value of health coverage to the consumer who would pay for coverage at the subsidized price and also decides not to pay full price for an unsubsidized QHP is somewhere between the price the consumer would pay for the subsidized plan (lower bound) and the price for the unsubsidized plan (upper bound). The bounds do not assume that the true value is the same for every consumer, but that it would be distributed symmetrically within the range among consumers. To capture what this value could be for purposes of this analysis, in Table 4 we estimate the midpoint of this range (reflecting an assumption of symmetric distribution within the bounds) to be the true value of health coverage. We estimate that 332,500 consumers would not enroll for 12 months due to not being able to complete the verification requirements. Another estimated 5,097,630 consumers would not enroll during an average of 1.5 months while they complete the verification process; however, because premiums reflect relatively long-run equilibrium conditions, they do not necessarily represent revealed preference that can reasonably applied in the context of short-run disruptions, thus introducing uncertainty into this aspect of the quantification. The resulting calculations are shown above in millions of 2026 dollars.

With the proposed verification requirements in effect in 2028, an annual gross net benefit of \$3.81 billion results from interrupted coverage, equal to one-half of the \$7.62 billion in forgone APTC associated with consumers who do not enroll. The revealed bounds are supported by observed enrollment choices; the midpoint and resulting point estimates additionally depend on the symmetric-distribution assumption, meaning that consumer valuations are distributed symmetrically around the midpoint. This estimate represents a benefit, from a society-wide perspective, to the extent that consumers experience outcomes (including health, longevity, and

spending on medical services) affected by their status as enrolled or unenrolled in health insurance.

By contrast, if our analysis were to focus on an alternative scenario where medical services are available without consumer payment, this proposed rule would bring about a subsidy change that is less than what is estimated above, with some portion of it instead being a shift in the type of subsidy—specifically, from APTC to charity/uncompensated care or other such forms. Because this shift portion of the overall total is a transfer of value within society, rather than a benefit, the quantitative result would be framed as a benefits upper bound specifically for that substitution effect, reflecting the other caveats described in this sub-section as separate sources of uncertainty in the estimate.

We request comment on these societal effects of the proposed rule.

d. Premiums

We are of the view that applicants who choose not to enroll due to verification-related barriers are likely to be younger and healthier than those remaining in the risk pool, leading to higher overall premiums on a per member per month (PMPM) basis.

The proposed updates would result in more eligible enrollees being required to complete the manual verification process. Younger and healthier consumers are less incentivized to complete this process since they have lower perceived need for healthcare and would opt out when faced with administrative barriers. We expect that 332,500 consumers across all Exchanges are likely to opt out of enrollment due to administrative barriers associated with the verification process.

We have estimated a 0.4 percent increase in premiums assuming 332,500 enrollees leave the market. These premium impact estimates assume the 332,500 exiting enrollees have average claims expenses that are 80 percent of the average claims experience for the overall risk pool. If the average claims PMPM is 86 percent of the premium PMPM ($0.86 \times \$838.48 = \$721.09$), we estimate the 332,500 exiting enrollees have claims costs of \$576.87 PMPM ($0.8 \times \$721.09 =$

576.87), and the remaining 16.583 million enrollees have an average claims cost of \$723.98 ($332,500/16,915,000 \times \$576.87 + 16,582,500/16,915,000 \times \$723.98 = 721.09$). Comparing the new claims PMPM of \$723.98 to the prior claims PMPM of \$721.09 shows a 0.4 percent increase in average claims ($723.98/721.09 - 1 = 0.004$).

We anticipate the provisions in this proposed rule could reduce enrollment and APTC while increasing premiums each year beginning in 2028. 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 the expected effects of this proposed rule on total enrollment. Likewise, we request comments on potential secondary effects of this proposed rule. These could, for example, include effects on premiums, burdens on the healthcare system, and effects on Federal spending due to shifts from individual market coverage to Medicaid coverage or uncompensated care. Finally, we request comment on any effects that this proposed rule might have on labor productivity.

D. Accounting Statement and Table

As required by OMB Circular A-4 (available at <https://www.whitehouse.gov/wp-content/uploads/2025/08/CircularA-4.pdf>), we have prepared an accounting statement in Table 5 showing the classification of the impact associated with the provisions of this proposed rule.

This proposed rule implements provisions related to Exchange eligibility and verification consistent with new requirements specified under the WFTC legislation, as well as updates and clarifications to provisions affecting inconsistency periods, reported modifications to eligibility criteria, verification procedures, and eligibility redeterminations. We are unable to quantify all the benefits and costs of this proposed rule. The effects in Table 5 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.

TABLE 5: Accounting Table

Benefits:	Estimate ⁴⁴	Year Dollar	Discount Rate	Period Covered
Annualized Monetized (\$/year)	\$2,130.47 Million	2026	7 percent	2026-2030
	\$2,218.67 Million	2026	3 percent	2026-2030
Quantitative: • Annual gross net benefit of \$3.81 billion results from interrupted coverage equal to one-half of forgone APTC associated with consumers who do not enroll.				
Qualitative: • Decrease in rates of fraudulent enrollment. • Increased accuracy of APTC payments by aligning subsidy determinations more closely with a consumer's projected eligibility criteria on at least an annual basis and mitigating risk that individuals receive APTC or CSRs for which they are no longer eligible				
Costs:	Estimate	Year Dollar	Discount Rate	Period Covered
Annualized Monetized (\$/year)	\$240.20 Million	2026	7 percent	2026-2030
	\$241.95 Million	2026	3 percent	2026-2030
Quantitative: • One-time costs between 2026-2027 to Exchanges on the Federal platform of \$2,970,600 and across all State Exchanges of \$65,353,200 to update eligibility and enrollment systems to align with proposed requirements related to the inconsistency period. • Recurring costs to Exchanges on the Federal platform of \$930,000 and across all State Exchanges of \$20,460,000 per year to generate a new Eligibility Determination Notice (EDN), beginning in 2027. • One-time costs in 2027 to Exchanges on the Federal platform of \$462,150 and across all State Exchanges of \$10,167,300 to update noticing procedures to provide APTC-eligible consumers who complete the pre-OE verification process with notice of amounts of APTC once plan data becomes available. • One-time costs between 2026-2027 for Exchanges on the Federal platform of \$2,178,440 and across all State Exchanges of \$47,925,680 to update annual eligibility redetermination and re-enrollment logic. • Recurring information collection costs for all consumers of \$72,556,353 per year for the additional data collection beginning with the pre-OE verification period, beginning in 2027. • Recurring costs to consumers using Exchanges on the Federal platform of \$32,995,975 per year to submit documentation for additional data matching issues (DMIs), beginning in 2027. • Recurring costs to Exchanges on the Federal platform of \$109,409,783 per year to generate and process additional DMIs, beginning in 2027. • Recurring costs to Exchanges on the Federal platform of \$9,142,423 per year to submit additional verification requests to the Department of Homeland Security (DHS) Systematic Alien Verification for Entitlements (SAVE), Social Security Administration (SSA) and Current Sources of Income (CSI) Hub service, beginning in 2027. • One-time costs in 2027 to Exchanges on the Federal platform of \$2,475,500 and across all State Exchanges of \$54,461,000 to create new processes for consumers to select a pending plan. • One-time costs in 2027 to Exchanges on the Federal platform of \$1,485,300 and across all State Exchanges of \$32,676,600 to develop pre-OE verification processes. • Recurring costs to consumers who utilize the pre-OE verification process of \$1,767,425 to provide information during the pre-OE period and then return to Exchanges to provide additional information, select a plan, or report a change, beginning in 2027. • Annual recurring costs of \$299,867 to Exchanges on the Federal platform to mail additional eligibility determination notices sent during the pre-OE verification period, beginning in 2027. • Regulatory review costs of \$5,634,207 for interested parties to review and analyze this regulation in 2026.				
Qualitative: • Recurring burden on consumers to make additional visits to Exchanges to shop for a plan if they take advantage of the pre-OE verification period.				

⁴⁴ This may be an upper bound because consumers could have access to medical services that are available without consumer payment, like charity or uncompensated care, while not covered by an APTC-subsidized plan.

- Potential for delay in enrollees' access to medical care due to requirement to resolve DMIs prior to receiving APTC or coverage gaps for consumers who fail to complete verification requirements, and potential downstream negative impacts to the risk pool due to deferred care and lower motivation among healthy and younger individuals to complete the required administrative steps.
- Increased verification-related barriers to enrollment, leading to a decrease in enrollment across all exchanges.
- Greater burdens on the health care system due to lower rates of insurance and subsequent strain on emergency departments.
- Increased seasonal staffing for Exchanges on the Federal platform and across all State Exchanges due to increased verification requirements.
- Increased staffing for agents, brokers, and web-brokers to adjust to the change in timing of Exchange activities in anticipation of the subsequent coverage year.
- One-time cost to issuers to update operations to change deadlines for first month's premium and other binder payment collection scenarios, including collecting more than one month's premium.
- One-time cost to issuers to update notices to consumers.
- One-time cost to Exchanges to develop pre-OE verification processes.
- Annual costs to issuers for maintenance of pre-OE verification process websites.
- Annual costs to Exchanges on the Federal platform and all State Exchanges for maintenance of pre-OE verification process websites.
- Recurring advertising costs to Exchanges on the Federal platform and all State Exchanges to advertise pre-OE verification period.

Transfers:	Estimate	Year Dollar	Discount Rate	Period Covered
Annualized Monetized (\$/year)	-\$4,256.40 Million	2026	7 percent	2026-2030
	-\$4,432.61 Million	2026	3 percent	2026-2030

Quantitative:

- Annual decrease in enrollment on Exchanges on the Federal platform of 237,500 enrollees and all State Exchanges of 95,000 enrollees.
- Annual decrease in APTC spending of \$7.6 billion starting in 2028 due to fewer consumers receiving APTC due to decreased enrollment as well as enrollment for fewer months for consumers who generate DMIs.
- Annual increase in average premiums of 0.4% or \$2.89 PMPM starting in 2028 due to younger and healthier individuals leaving the risk pool because of increased barriers to enrollment, beginning in 2028.

Qualitative:

- Reduce the likelihood of excess APTC and associated tax liability at reconciliation for consumers.

E. Regulatory Alternatives Considered

In developing the proposals contained in this rule, we considered a number of regulatory alternatives. The following discussion describes the alternatives we considered and explains why we did not adopt them.

1. Eligibility Redeterminations During the Plan Year (§ 155.315(f)(4)(iii))

In developing our proposal at § 155.315(f)(4)(iii) regarding the treatment of APTC when a mid-year change results in a DMI related to the applicable enrollment information, we considered several alternatives. First, in cases when an enrollee reports a change that would result in a decrease in APTC, such as an increase in income, we considered proposing to require Exchanges to maintain the enrollee's higher, previously verified APTC amount during their

inconsistency period. However, we did not propose this approach because it could expose consumers to large excess APTC repayment obligations at tax time, a concern that is particularly acute following the WFTC legislation's elimination of repayment caps.

We also considered proposing to require Exchanges to provide the higher APTC amount during the inconsistency period while encouraging consumers to voluntarily select a lower APTC amount. We did not propose this alternative because we determined that this would create consumer confusion, impose additional burden on enrollees who would need to manually adjust their APTC, and still create a risk of significant repayment obligations if consumers do not understand the downstream tax implications of failing to reduce APTC.

Finally, we considered proposing to remove APTC entirely during inconsistency periods arising from mid-year changes. We did not propose this approach because it would render coverage unaffordable for many enrollees during the inconsistency period, potentially leading to mid-year losses of coverage. We also determined that this alternative could increase adverse selection, as individuals with greater health needs would be more likely to maintain enrollment in unsubsidized coverage during their inconsistency period. Finally, we determined that this alternative would have a chilling effect on consumers' willingness to report changes in their circumstances, undermining the ability of Exchanges to make accurate eligibility determinations.

2. Effective Dates (§§ 155.315(f)(4)(iv)(A)(4), 155.330(f), 155.410(f)(5), 155.420)

We considered not proposing the exception, at § 155.315(f)(4)(iv)(A)(4), to the rules at proposed § 155.315(f)(4)(iv)(A)(1) through (3), to prohibit payment of retroactive APTC in a prior coverage year upon DMI resolution. We chose to propose this exception because permitting cross-year retroactive APTC would create significant complications for tax administration, including the need for certain enrollees to file amended Federal income tax returns. Accordingly, we are proposing to limit retroactive APTC eligibility to the current coverage year only, which we have determined appropriately balances consumer access to financial assistance while minimizing tax administration burdens.

Regarding the effective dates related to eligibility redeterminations due to enrollee-reported changes proposed at § 155.330(f)(1), we considered proposing that Exchanges be required or permitted to make such redeterminations effective immediately. While this may have improved the timeliness of eligibility determinations, we reasoned that immediate, mid-month adjustment of APTC and CSRs would be more difficult for Exchanges and issuers to implement.

In considering our proposal to maintain the current effective date rules for eligibility redeterminations following the expiration of an inconsistency period or following periodic data matching that results in a decrease in APTC or the level of CSRs, we considered whether to instead to propose to require Exchanges always to implement such redeterminations on the first of the following month. However, we reasoned that there were compelling reasons to maintain the current policy, including ensuring that enrollees were provided sufficient notice of the upcoming changes to their eligibility. We also are of the view that maintaining the current policy is operationally less burdensome for Exchanges than updating the current rules.

Finally, when developing our proposals at §§ 155.410(f)(5) and 155.420 regarding effective dates for consumers who elect to pend their plan selections, we considered a number of alternatives. Specifically, we considered proposing to allow effective dates to extend retroactively back to the effective date that a consumer could have qualified for, absent their choice to pend their plan selection. However, we elected not to propose this alternative due to the risk of increased adverse selection, given that under this policy, consumers would be able to wait to decide whether to submit documents to resolve their DMI until they incurred medical bills and would be assured that their coverage would retroactively extend to cover such claims. We also considered whether section 36B(c)(5)(C) of the Code requires coverage effective dates retroactive to the effective date that a consumer would have qualified for, absent their choice to pend their plan selection. However, we read the Code to mean that months prior to verification must be treated as coverage months if they would otherwise be considered coverage months under the requirements prescribed in 36B(c) of the Code, including the requirement that an

individual be enrolled in a QHP as of the first of the month.

We also considered proposing that plan selections become effective on the day that all DMIs are resolved. Like our proposal, this approach would balance the benefits of immediate coverage availability with the harms imposed by requiring consumers to pay premiums for past periods of coverage and would limit risks of adverse selection. However, we chose not to propose this alternative because we have determined that requiring mid-month effective dates would be administratively challenging for issuers and Exchanges.

3. Notice of Annual Open Enrollment Period

We considered proposing to add a new, separate notification requirement for the pre-OE period for all Exchanges rather than modifying the existing notice of annual OEP requirement. As described in section III.A.9.a. of this proposed rule, we determined it was preferable to permit Exchanges to send the notice of annual OE earlier than currently allowed to support Exchanges in determining the best communication strategy for their enrollees. A new notification requirement separate from the notice of annual OE would presuppose the optimal strategy for Exchanges with unique communications infrastructure and operational capabilities. Instead, this proposed amendment to the regulation would enable Exchanges to send the notice of annual OE earlier, with information about the pre-OE verification period, if they determine that approach is appropriate for their enrollee population, or to notify enrollees through a separate mechanism if they prefer.

4. Annual Pre-Open Enrollment Verification Period (§ 155.410(h))

In developing our proposal at § 155.410(h) regarding the pre-OE verification period, we considered expanding the information that Exchanges would be required to permit applicants and enrollees to provide and verify during the pre-OE period beyond the minimum specified in the statute. Specifically, we considered requiring Exchanges to additionally provide a process for applicants to provide information regarding their eligibility for or enrollment in other MEC, in addition to the household income and other information required under section 71303(b) of the

WFTC legislation. We decided, however, that it would be preferable to provide flexibility for Exchanges to collect additional information while establishing a minimum standard that does not exceed the statutory requirement. Accordingly, our proposal at § 155.410(h)(2)(i) sets forth the minimum information specified in the statute, while § 155.410(h)(2)(ii) specifies that Exchanges retain the flexibility to collect additional information during the pre-OE period if they choose to do so.

We also considered proposing detailed operational guidelines for the pre-OE period in rulemaking, including notice requirements and a requirement for Exchanges to provide a streamlined electronic re-enrollment form for existing enrollees seeking to confirm information for the upcoming coverage year. We decided not to adopt this approach to prioritize operational flexibility for Exchanges, enabling them to build a pre-OE process in a manner that is most efficient given their existing systems and processes. We are of the view that this approach reduces the risk of noncompliance, given the short timeframe for implementation. Finally, we have determined that this approach would enable Exchanges to enhance their implementation of the pre-OE process over time as they gain operational experience.

F. 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.”

For purposes of the RFA, we are of the view that health insurance issuers and group health plans would be classified under the North American Industry Classification System (NAICS) code 524114 (Direct Health and Medical Insurance Carriers) or possibly be classified in 621491 (HMO Medical Centers). Based on latest available Statistics of U.S. Businesses

(SUSB) data, 1,071 and 146 total firms fall under NAIC codes 524114 and 621491, respectively.⁴⁵ According to SBA size standards, entities with average annual receipts of \$47 million or less would be considered small entities for NAICS code 524114 and \$44.5 million or less for NAICS code 621491.⁴⁶ SUSB data confirms there are no small firms within NAIC code 621491. We are of the view 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 2025 MLR reporting year, approximately 102 out of 470 issuers of health insurance coverage nationwide had total premium revenue of \$47 million or less. We estimate that approximately 89 percent of these small issuers belong to larger holding groups based on the MLR data, and many, if not all, of these small companies are likely to have non-health lines of business that result in their revenues exceeding \$47 million. Therefore, we assume approximately 11 percent, or 11, of the 102 are in fact small issuers for purposes of this analysis. We seek comment on these estimates.

We anticipate that small issuers could be impacted by the provisions in this proposed rule. For example, under proposed revisions to § 155.315(f)(4)(iv), Exchanges would be required to ensure both retroactive and prospective coverage effective dates, as applicable, based on the timing of DMI resolution. This may impact current enrollment operations for small issuers.

We are unable to quantify the direct impact of these changes on small issuers due to uncertainty regarding their market share, market participation, membership in larger holding groups, enrollment and risk mix, and premium receipts, but we discuss possible indirect impacts on small issuers. A reduction in APTC payments means the consumers would be responsible for the balance of the premium not covered by APTC, not the issuers. However, we expect that many of the consumers who would be responsible for these balances are unlikely to be able to

⁴⁵ United States Census Bureau. (April 2025). 2022 SUSB Annual Data Tables by Establishment Industry. <https://www.census.gov/data/tables/2022/econ/susb/2022-susb-annual.html>.

⁴⁶ SBA. (n.d.). Table of size standards. <https://www.sba.gov/document/support--table-size-standards>.

afford a QHP without APTC and that this group would exit the Exchanges rather than pay premiums not covered by APTC. We also anticipate that due to the small reduction in enrollment anticipated to result from the policies in this proposed rule, issuers may experience a reduction in premium revenue. However, we anticipate this could be balanced by a reduction in claims experience, and we are unable to quantify this indirect impact on small issuers due to uncertainty and a lack of data. For more information about the proposed overall impacts on enrollment, APTC, and premiums that minimize the overlap of individuals who may be affected by multiple provisions in this proposed rule, please see section VI.C.6. Additionally, we have determined that the following provisions could impact smaller agent, broker, and web-broker firms. We have determined that small agents, brokers, and web-brokers will be classified under NAICS code 524210 (Insurance Agencies and Brokerages) that have annual receipts of \$15 million or less. According to SBA size standards, there are 120,434 firms in the Insurance Agencies and Brokerages Industry, of which 119,114 or approximately 99 percent, had annual receipts below the \$15 million size standard.⁴⁷ In addition, the 2023 Nonemployer Statistics (NES) from the Census Bureau⁴⁸ indicate there are an additional 305,281 nonemployer firms within the 524210 NAICS code, and the Departments anticipate that the vast majority of these nonemployer firms had annual receipts below the \$15 million size standard. Nearly all agents, brokers, and web-brokers affected by this proposed rule would therefore be small entities.

The proposed changes to annual eligibility redetermination and re-enrollment (§ 155.335) described in section III.A.7. of this proposed rule would require consumers who were previously automatically re-enrolled in a plan with APTC and CSRs to return to the Exchange and confirm certain eligibility information prior to receiving APTC or CSRs for the following plan year. This may change the current business model of agents, brokers, and web-brokers that currently do not

⁴⁷ U.S. Census Bureau (April 2025). 2022 SUSB Annual Data Tables by Establishment Industry, Data by Enterprise Receipts Size. <https://www.census.gov/data/tables/2022/econ/susb/2022-susb-annual.html>.

⁴⁸ U.S. Census Bureau (May 15, 2025). NES Tables 2023. <https://www.census.gov/programs-surveys/nonemployer-statistics/data/tables.html>.

engage a subset of their clients annually who are relying on automatic re-enrollment with APTC and CSRs. We expect agents, brokers, and web-brokers may experience increased consumer outreach efforts and interactions as they will likely need to communicate with more clients more frequently to verify and confirm their eligibility information to enroll them in a QHP with APTC or CSRs.

The proposed changes to the annual pre-OE verification period (§ 155.410) as described in section III.A.9.c. of this proposed rule would create a requirement for Exchanges to provide a verification period beginning August 1 of each year preceding the plan year, allowing consumers to update or provide information for verification for the upcoming plan year. Agents, brokers, and web-brokers assisted 76 percent of Exchange enrollments in PY 2026. The proposed amendments may change how agents, brokers, and web-brokers interact with their clients on an annual basis, potentially resulting in more frequent communications with their clients (for example, once during the pre-OE period and again during the OEP to select a plan for enrollment).

We seek comment on these proposed assumptions and impacts on small entities.

For regulatory alternatives considered regarding the provisions in this proposed rule, please see section VI.E. of this proposed rule.

In addition, section 1102(b) of the Social Security 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 purposes of section 1102(b) of the Social Security 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. While this proposed rule is not subject to section 1102 of the Social Security Act, we have determined that this rule would not affect small rural hospitals. Therefore, we anticipate this proposed rule would not have a significant impact on the operations of a substantial number of small rural hospitals.

G. 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 2026, that threshold is approximately \$193 million. Although we have not been able to quantify all costs, we expect that this proposed rule would not impose a mandate that would result in the expenditure by State, local, and Tribal Governments, in the aggregate, or by the private sector, of more than \$193 million in any 1 year.

H. Federalism

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, State Exchanges, and consulting with State insurance officials on an individual basis.

While developing this proposed rule, we attempted to balance the States' interest in administering their Exchanges with HHS' interest in ensuring that the statutory requirements of the WFTC legislation and the Affordable Care Act are implemented in ways that promote clarity, consistency, and market stability. By doing so, we complied with the requirements of Executive Order 13132.

Because States have flexibility in designing their Exchanges 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 their programs. Accordingly, some of the initial cost of creating programs was funded by Exchange Planning and Establishment Grants. After establishment, Exchanges must be financially self-sustaining, with revenue sources at the

discretion of the State. Current State Exchanges charge user fees to issuers.

In our view, this regulation has Federalism implications due to system and operational costs that State Exchanges will incur to implement the proposals in this rule. States will incur costs, including one-time implementation costs and ongoing operational costs, related to the proposals described in section IV.B. regarding DMIs, the proposals described in section IV.C. of this proposed rule regarding annual eligibility redeterminations, the proposals described in section IV.D. of this proposed rule allowing consumers to pend plan selections during an inconsistency period, and the proposals described in section IV.E. of this proposed rule requiring Exchanges to establish a pre-OE verification period. However, these federalism implications are mitigated in part by the fact that certain provisions, such as the proposal at § 155.315(f)(4)(ii) to no longer allow APTC or CSRs during certain inconsistency periods, are statutorily required under section 71303 of the WFTC legislation. These federalism implications are further mitigated by HHS' interest in promoting clear and consistent rules for the implementation of new statutory requirements. Finally, these federalism implications are mitigated by HHS' deference to State Exchanges regarding many aspects of the implementation of the proposals in this rule, including timing and methods for communicating with consumers, methods for collecting required information from consumers, and overall user experience and design.

I. E.O. 14192, "Unleashing Prosperity Through Deregulation"

Executive Order 14192, entitled "Unleashing Prosperity Through Deregulation" was issued on January 31, 2025, and requires that "any new incremental costs associated with new regulations shall, to the extent permitted by law, be offset by the elimination of existing costs associated with at least 10 prior regulations." This proposed rule, if finalized as proposed, is expected to be exempt from otherwise-applicable requirements under E.O. 14192, per footnote 1 of OMB's Accounting Methods.⁴⁹

⁴⁹ See Accounting Methods under Executive Order 14192.
https://www.reginfo.gov/public/pdf/eo14192/Accounting_Methods_under_EO_14192.pdf.

Mehmet Oz, Administrator of the Centers for Medicare & Medicaid Services, approved this document on October 13, 2026.

List of Subjects in 45 CFR Part 155

Administrative practice and procedure, Advertising, Aged, Brokers, Citizenship and naturalization, Civil rights, Conflicts 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 record keeping requirements, Sex discrimination, State and local governments, Taxes, Technical assistance, Women, Youth.

For the reasons set forth in the preamble, the Department of Health and Human Services proposes to amend 45 CFR subtitle A, subchapter B, as set forth below:

PART 155 – EXCHANGE ESTABLISHMENT STANDARDS AND OTHER RELATED STANDARDS UNDER THE AFFORDABLE CARE ACT

1. 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.

2. Section 155.106 is amended by revising paragraph (a)(2) introductory text to read as follows:

§ 155.106 Election to Operate an Exchange after 2014.

(a) * * *

- (2) Submit an Exchange Blueprint application for HHS approval at least 15 months prior to the date on which the Exchange proposes to begin Pre-Open Enrollment Verification Period operations as an Exchange.

* * * * *

3. Section 155.300 is amended by revising paragraph (c)(2) to read as follows:

§ 155.300 Definitions and general standards for eligibility determinations.

* * * * *

(c) * * *

- (2) The attestations specified in §§ 155.310(d)(2)(ii) and 155.315(f)(4)(vi) must be provided by the tax filer.

* * * * *

4. Section 155.310 is amended by revising paragraphs (f)(1) and (2) to read as follows:

§ 155.310 Eligibility Process.

* * * * *

(f) * * *

(1) For an initial eligibility determination, in accordance with the dates specified in §§ 155.315(f)(4)(iv), 155.410(c) and (f), and 155.420(b), as applicable,

(2) For a redetermination, in accordance with the dates specified in §§ 155.330(f) and 155.335(b), as applicable.

* * * *

5. Section 155.315 is amended by—

- a. Revising paragraphs (f)(4)(i) and (ii); and
- b. Adding paragraphs (f)(4)(iii) through (vi).

The revisions and additions read as follows:

§ 155.315 Verification process related to eligibility for enrollment in a QHP through the Exchange.

* * * *

(f) * * *

(4) * * *

(i) Provide eligibility for enrollment in a QHP to the extent that an applicant is qualified;

(ii) For applicants with inconsistencies related to citizenship, status as a national, or lawful presence as described in § 155.315(c)(3); residency as described in § 155.315(d)(4); eligibility for minimum essential coverage other than through an eligible employer-sponsored plan as described in § 155.320(b); household income, family size, and eligible noncitizen status as described in § 155.320(c)(3); or enrollment in an eligible employer-sponsored plan and eligibility for qualifying coverage in an eligible employer-sponsored plan as described in § 155.320(d), ensure that advance payments of the premium tax credit and cost-sharing reductions as described in § 155.305 are not provided on behalf of an applicant, until such information is verified in accordance with § 155.315(f)(4)(iv). However, if a member of the applicant's tax household is determined eligible for a special enrollment period as specified in § 155.420(d)(2), an Exchange must instead ensure that advance payments of the premium tax

credit and cost-sharing reductions, as applicable, are provided on behalf of the applicant based on information attested on the application for coverage to the extent they are otherwise qualified for such payments and reductions, as described in § 155.305.

(iii) For an applicant for whom an eligibility redetermination under § 155.330(e)(1) results in one or more inconsistencies described in paragraph (f)(4)(ii) of this section for a plan year; for whom the Exchange verified, under §§ 155.315 and 155.320, the information related to such inconsistency during the immediately preceding eligibility determination for the same plan year; and who otherwise is eligible for advance payments of the premium tax credit or cost-sharing reductions, as described in § 155.305:

(A) Ensure that advance payments of the premium tax credit and cost-sharing reductions, as applicable, are provided on behalf of the applicant within this period in an amount determined by the information related to such inconsistency verified during the immediately preceding eligibility determination for the same plan year, when the applicant's eligibility redetermination under § 155.330(e)(1) results in the amount of advance payments of the premium tax credit being greater than or equal to the amount provided under the immediately preceding eligibility determination for the plan year. However, if such an applicant is eligible to enroll during a special enrollment period as specified in § 155.420(d)(2), an Exchange must instead ensure that advance payments of the premium tax credit and cost-sharing reductions, as applicable, are provided on behalf of the applicant based on information attested on the application for coverage to the extent they are otherwise qualified for such payments and reductions, as described in § 155.305.

(B) Ensure that advance payments of the premium tax credit and cost-sharing reductions, as applicable, are provided on behalf of the applicant within this period in an amount determined by the attestation associated with applicant's eligibility redetermination under § 155.330(e)(1) when the applicant's eligibility redetermination under § 155.330(e)(1) results in the amount of advance payments of the premium tax credit being less than the amount provided under the

immediately preceding eligibility determination for the plan year and notify the applicant of such determination in accordance with the notice requirements specified in § 155.310(g).

(iv) For applicants described in paragraphs (f)(4)(ii) and (f)(4)(iii)(A) of this section for whom the Exchange verifies all information related to such inconsistencies, the Exchange must determine the applicant's eligibility for advance payments of the premium tax credit and cost-sharing reductions, as applicable, based on the verified information and notify the applicant of such determination in accordance with the notice requirements specified in § 155.310(g).

(A) For applicants who are enrolled in a QHP when attestations related to all such inconsistencies are verified, the Exchange must ensure that determinations of eligibility for advance payments of the premium tax credit and cost-sharing reductions, as applicable, take effect on the first day of the first month in which the criteria in paragraphs (f)(4)(iv)(A)(1) through (3) are met, subject to the exception in paragraph (f)(4)(iv)(A)(4):

(1) All information related to the applicant's inconsistencies, as specified in paragraph (f)(4)(ii), are verified for such month;

(2) The enrollee is enrolled in a QHP on the first day of such month; and

(3) The inconsistency described in paragraphs (f)(4)(ii) or (f)(4)(iii)(A) of this section was generated before the first of such month.

(4) If the first day of the month in which the criteria in paragraphs (f)(4)(iv)(A)(1) through (3) of this section are met is in the prior coverage year, the Exchange must not determine or redetermine the enrollee's eligibility for advance payments of the premium tax credit for the months in such prior year.

(B) For applicants who elect to enroll in a QHP only upon successful verification of information related to all such inconsistencies described in paragraph (f)(4)(ii) of this section, as described in § 155.400(i)(2), the Exchange must ensure that advance payments of the premium tax credit and cost-sharing reductions, as applicable, take effect as follows –

(1) In accordance with the effective dates specified in § 155.410(f)(5), if the applicant

selected a QHP during the annual open enrollment period.

(2) In accordance with the effective dates specified in § 155.420(b)(6), if the applicant selected a QHP during a special enrollment period.

(v) For applicants with inconsistencies only related to information not specified in paragraph (f)(4)(ii) of this section, ensure that advance payments of the premium tax credit and cost-sharing reductions, as applicable, are provided on behalf of the applicant within the period in paragraph (f)(2)(ii) of this section based on attestation to the extent they are otherwise qualified for such payments and reductions, as described in § 155.305.

(vi) In all cases, ensure that advance payments of the premium tax credit and cost-sharing reductions are provided on behalf of an applicant under paragraph (f)(4) of this section only if the tax filer attests to the Exchange that he or she understands that any advance payments of the premium tax credit paid on his or her behalf are subject to reconciliation.

(5) If, after the period described in paragraph (f)(2)(ii) of this section, the Exchange remains unable to verify the attestation, the Exchange must determine the applicant's eligibility based on the information available from the data sources specified in this subpart and implement such determination in accordance with the effective dates specified in § 155.330(f)(3), unless such applicant qualifies for the exception provided under paragraph (g) of this section, and notify the applicant of such determination in accordance with the notice requirements specified in § 155.310(g), including notice that the Exchange is unable to verify the attestation.

* * * * *

6. Section 155.330 is amended by revising paragraph (f) to read as follows:

§ 155.330 Eligibility redetermination during a benefit year.

* * * * *

(f) *Effective dates.* (1) *Enrollee-reported changes.* If, in accordance with paragraph (e)(1) of this section, the Exchange redetermines an enrollee's eligibility because the enrollee has provided updated information to the Exchange, the Exchange must implement such

redetermination on the first of the month following the eligibility redetermination.

(i) *Exception.* If the Exchange also determines that such enrollee qualifies for an SEP described in § 155.420(b)(2)(i) or (iii), the Exchange must implement the enrollee's eligibility redetermination on the coverage effective date described in § 155.420(b) (2)(i) or (iii), respectively.

(ii) Reserved

(2) *Redetermination following resolution of Inconsistencies.* If an enrollee has an inconsistency described in § 155.315(f)(4)(ii) or § 155.315(f)(4)(iii)(A), and the enrollee verifies the information related to such inconsistency, the Exchange must redetermine eligibility for advance payments of the premium tax credit or cost-sharing reductions, as applicable, in accordance with the effective dates specified in § 155.315(f)(4)(iv)(A).

(3) *Redetermination following expiration of an inconsistency period or data matching.* In the case that the Exchange redetermines an enrollee's eligibility for enrollment in a QHP and for APTC and CSRs, as applicable, following the expiration of an inconsistency period in accordance with the procedures in § 155.315(f)(5), or following the data matching processes described in § 155.330(e)(2)(i)(D) or § 155.330(e)(2)(iii), because applicable information could not be verified --

(i) If the redetermination results in a decreased amount of APTC or a decreased level of CSRs:

(A) And if the Exchange redetermines eligibility on or before the 15th of the month, the Exchange must implement the redetermination on the first of the next month.

(B) And if the Exchange redetermines eligibility after the 15th of the month, the Exchange must implement the redetermination on the first of the month following the next month.

(ii) If the redetermination results the same or an increased amount of APTC or the same or an increased level of CSRs, the Exchange must implement the redetermination on the first of

the month following the eligibility redetermination.

(4) *Appeals*. In the case that the Exchange redetermines an enrollee's eligibility due to an appeal decision, the Exchange must implement such redetermination on the date specified in the appeal decision.

* * * * *

7. Section 155.335 is amended by—

- a. Revising the section heading, and paragraphs (a) and (b);
- b. Removing paragraphs (d) through (i);
- c. Redesignating paragraph (j) as new paragraph (d); and
- d. Removing paragraphs (k) through (n).

The revisions read as follows:

§ 155.335 Annual eligibility redetermination and re-enrollment.

(a) *Annual eligibility redetermination*. The Exchange must redetermine the eligibility of an enrollee for enrollment in a QHP and for APTC and CSRs, as applicable, on an annual basis in accordance with § 155.305 and notify the enrollee in accordance with requirements specified in § 155.310(g) of this part.

(1) An Exchange must not redetermine an enrollee eligible for APTC and CSRs for a subsequent benefit year unless—

(i) The enrollee or the enrollee's application filer provides or confirms the following information for the subsequent benefit year on or after August 1 and no later than December 31 of the year preceding the benefit year:

(A) Household income and family size, per § 155.305(f)(1)(i);

(B) U.S. citizenship, status as a U.S. national, or status as a lawfully present eligible noncitizen, per § 155.305(f)(1)(ii)(C), as applicable;

(C) Eligibility for or enrollment in other minimum essential coverage, per § 155.305(f)(1)(ii)(B); and

(D) Place of residence, per § 155.305(a)(3); and

(ii) The Exchange verifies the information in paragraph (a)(1)(i) of this section using the processes specified in §§ 155.315 and 155.320, including the relevant provisions in those sections regarding inconsistencies.

(2) Reserved

(b) *Effective date.* The redetermination of eligibility for enrollment in a QHP and for APTC and CSRs, as applicable, under paragraph (a) of this section must be effective on the first day of the applicable benefit year.

(1) *Exception.* In instances where an enrollee has an unresolved inconsistency under § 155.315(f)(4)(ii) as of December 31 of the year preceding the benefit year and for whom APTC and CSRs are not provided during the inconsistency period, the annual redetermination for APTC and CSRs is effective in accordance with §§ 155.315(f)(4)(iv)(A) or 155.330(f)(3), as applicable.

(2) Reserved

* * * * *

8. Section 155.400 is amended by—

- a. Revising paragraphs (e)(1); and
- b. Adding paragraph (i).

The revision and addition read as follows:

§ 155.400 Enrollment of qualified individuals into QHPs.

* * * * *

(e) * * *

(1) In a Federally-facilitated Exchange or State-Based Exchange on the Federal platform:

(i) For prospective coverage to be effectuated as provided for in § 155.410(f) (which excludes retroactive enrollments under § 155.410(f)(5)(i)(A) and (B) and (ii)(A) and (B)), and in § 155.420(b)(1), (2), (3), (5), and (6)(ii) (which excludes retroactive enrollments under §

155.420(b)(2), (3), (5)), the binder payment must consist of the first month's premium, and the deadline for making the binder payment must be no earlier than the coverage effective date, and no later than 30 calendar days after the later of the dates the issuer receives the enrollment transaction or the coverage effective date.

(ii) For retroactive coverage to be effectuated as provided for in § 155.410(f)(5)(i)(A) and (B) and (ii)(A) and (B), and in § 155.420(b)(2), (3), (5), and (6)(i), the binder payment must consist of the premium due for all months of retroactive coverage and for the first prospective month of coverage, and the deadline for making the binder payment must be no earlier than 30 calendar days after the date the issuer receives the enrollment transaction. If the premium for at least 1 month of coverage, but less than the full amount owed, is paid, the issuer must effectuate only prospective coverage.

* * * * *

(i) *QHP selection in the case of certain inconsistencies.* When an applicant or enrollee has an inconsistency as described in § 155.315(f)(4)(ii) and would otherwise be eligible for advanced payments of the premium tax credit based on the information attested on the application for coverage, an Exchange must accept a QHP selection from the applicant or enrollee, and at the option of the applicant or enrollee, transmit enrollment information to the issuer of the QHP selected such that the QHP issuer can enroll the applicant or enrollee only upon the Exchange determining the applicant or enrollee eligible for advance payments of the premium tax credit and cost-sharing reductions, as applicable, as described by § 155.315(f)(4)(iv) or § 155.315(f)(5).

9. Section 155.410 is amended by—

- a. Revising paragraph (d); and
- b. Adding paragraphs (e)(4)(iv), (f)(3)(iii), (f)(5), and (h).

The revision and additions read as follows:

§ 155.410 Initial and annual open enrollment periods.

* * * *

(d) *Notice of annual open enrollment period.* (1) Starting in 2014 and ending in 2026, the Exchange must provide a written annual open enrollment notification to each enrollee no earlier than the first day of the month before the open enrollment period begins and no later than the first day of the open enrollment period.

(2) Starting in 2027, the Exchange must provide a written annual open enrollment notification to each enrollee no earlier than the first day of the month preceding the period in paragraph (h) of this section and no later than the first day of the open enrollment period.

* * * *

(e) * *

(4) * *

(iv) Notwithstanding the introductory language of paragraph (e)(4) of this section, if paragraph (e)(5) of this section does not apply, then the requirements of paragraph (e)(4) of this section may apply for benefit years beginning on and after January 1, 2022.

* * * *

(f) * *

(3) * *

(iii) Notwithstanding the introductory language of paragraph (f)(3) of this section, if paragraph (f)(4) does not apply, then the requirements of paragraph (f)(3) of this section may apply for benefit years beginning on and after January 1, 2022, through January 1, 2027.

* * * *

(5) For benefit years beginning on or after January 1, 2028 --

(i) when § 155.410(e)(4) applies, then for an applicant whose QHP selection during the annual open enrollment period is subject to § 155.400(i), the following effective date rules apply--

(A) If all inconsistencies described in § 155.315(f)(4)(ii) are resolved on or before the 15th of the month following the effective date prescribed by § 155.410(f)(3), then the Exchange must ensure the coverage effective date prescribed by § 155.410(f)(3).

(B) If all inconsistencies are resolved after the 15th of the month following the effective date prescribed by § 155.315(f)(3), and on or before the 15th of a month, then the Exchange must ensure a coverage effective date of the first of such month.

(C) If all inconsistencies are resolved after the 15th of the month following the effective date prescribed by § 155.315(f)(3), and after the 15th of a month, then the Exchange must ensure a coverage effective date on the first of the next month.

(ii) when § 155.410(e)(5) applies, for an applicant whose QHP selection during the annual open enrollment period is subject to § 155.400(i), the following effective date rules apply—

(A) If all inconsistencies described in § 155.315(f)(4)(ii) are resolved on or before January 15 of the benefit year, then the Exchange must ensure a coverage effective date of January 1 of the benefit year.

(B) If all inconsistencies described in § 155.315(f)(4)(ii) are resolved after January 15 of the benefit year, and on or before the 15th of a month, then the Exchange must ensure a coverage effective date of the first of such month.

(C) If all inconsistencies described in § 155.315(f)(4)(ii) are resolved after January 15 of the calendar year, and after the 15th of a month, then the Exchange must ensure a coverage effective date on the first of the next month.

* * * * *

(h) *Annual pre-open enrollment verification period.* The Exchange must provide a verification period preceding the open enrollment period described in this section. During the verification period, application filers must be given the option to provide the information specified in paragraph (h)(2) of this section. The Exchange must verify any such information

provided as specified in paragraph (h)(3) of this section.

(1) *Timing.* The Exchange must accept certain applicant and enrollee information for a plan year beginning on August 1 of each year preceding the plan year and ending on the date preceding the first date of the open enrollment period described in this section.

(2) *Collection of information.* (i) At minimum, the Exchange must make available a process for all applicants and current enrollees to provide their household income; their status as a U.S. citizen or U.S. national or their status as a lawfully present non-citizen; their incarceration status; and their place of residence for the upcoming plan year.

(ii) Exchanges may at their option make available a process for all applicants and current enrollees to provide any other information relevant to their eligibility determination, including the full single streamlined application as described at § 155.405.

(3) *Verification and determination.* (i) During the period described in this section, Exchanges must attempt to verify the information described in paragraph (h)(2) of this section provided by the applicant or enrollee in accordance with §§ 155.315 and 155.320 of this subpart, including following the inconsistency procedures in § 155.315(f) if required.

(ii) If the Exchange has sufficient information during the annual pre-open enrollment verification period to make an eligibility determination in accordance with § 155.305, then the Exchange must do so in accordance with the requirements at § 155.310.

10. Section 155.420 is amended by—

- a. Revising paragraphs (b)(1) and (b)(2)(iii) through (vi); and
- b. Adding paragraph (b)(6).

The revisions and addition read as follows:

§ 155.420 Special enrollment periods.

* * * * *

(b) * * *

(1) *Regular effective dates.* Except as specified in paragraphs (b)(2), (3), and (6) of this

section, for a QHP selection received by the Exchange from a qualified individual, the Exchange must ensure a coverage effective date of the first day of the month following the QHP selection; except that before January 1, 2025, for a QHP selection received by the Exchange from a qualified individual between the sixteenth and the last day of any month, the Exchange may ensure a coverage effective date of the first day of the second month following QHP selection.

(2) * * *

(iii) Except as specified in paragraph (b)(6) of this section, in the case of a qualified individual or enrollee eligible for a special enrollment period as described in paragraphs (d)(4), (5), (9), (11), (12), or (13) of this section, the Exchange must ensure that coverage is effective on an appropriate date based on the circumstances of the special enrollment period.

(iv) Except as specified in paragraph (b)(6) of this section, if a qualified individual, enrollee, or dependent, as applicable, loses coverage as described in paragraph (d)(1) or (d)(6)(iii) of this section, or is enrolled in COBRA continuation coverage for which an employer is paying all or part of the premiums, or for which a government entity is providing subsidies, and the employer contributions or government subsidies completely cease as described in paragraph (d)(15) of this section, gains access to a new QHP as described in paragraph (d)(7) of this section, becomes newly eligible for enrollment in a QHP through the Exchange in accordance with § 155.305(a)(2) as described in paragraph (d)(3) of this section, becomes newly eligible for advance payments of the premium tax credit in conjunction with a permanent move as described in paragraph (d)(6)(iv) of this section, and if the plan selection is made on or before the day of the triggering event, the Exchange must ensure that the coverage effective date is the first day of the month following the date of the triggering event. If the plan selection is made after the date of the triggering event, the Exchange must ensure that coverage is effective in accordance with paragraph (b)(1) of this section or on the first day of the following month, at the option of the Exchange. Notwithstanding the requirements of this paragraph (b)(2)(iv) for losses of coverage as described at paragraphs (d)(1), (d)(6)(iii), and (d)(15) of this section, at the option

of the Exchange, if the plan selection is made on or before the last day of the month preceding the triggering event, the Exchange must ensure that the coverage effective date is the first day of the month in which the triggering event occurs.

(v) Except as specified in paragraph (b)(6) of this section, if an enrollee or his or her dependent dies as described in paragraph (d)(2)(ii) of this section, the Exchange must ensure that coverage is effective on the first day of the month following the plan selection, or it may permit the enrollee or his or her dependent to elect a coverage effective date in accordance with paragraph (b)(1) of this section. If the Exchange permits the enrollee or his or her dependent to elect a coverage effective date in accordance with paragraph (b)(1) of this section, the Exchange must ensure coverage is effective on the date duly selected by the enrollee or his or her dependent.

(vi) Except as specified in paragraph (b)(6) of this section, if a qualified individual, enrollee, or dependent newly gains access to an individual coverage HRA or is newly provided a QSEHRA, each as described in paragraph (d)(14) of this section, and if the plan selection is made before the day of the triggering event, the Exchange must ensure that coverage is effective on the first day of the month following the date of the triggering event or, if the triggering event is on the first day of a month, on the date of the triggering event. If the plan selection is made on or after the day of the triggering event, the Exchange must ensure that coverage is effective on the first day of the month following plan selection.

* * * * *

(6) For an applicant whose QHP selection during a special enrollment period is subject to § 155.400(i), and for whom all inconsistencies described in § 155.315(f)(4)(ii) are resolved after the applicable coverage effective date for such special enrollment period as described in paragraphs (b)(1) through (3) of this section, –the Exchange must ensure that coverage is effective on the following dates:

(i) If such inconsistencies are resolved on or before the 15th of a month, on the first of

such month.

(ii) If such inconsistencies are resolved after the 15th of a month, on the first of the following month.

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Robert F. Kennedy, Jr.,

Secretary,

Department of Health and Human Services.

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