# Final Federal Marketplace Integrity Rule: Implications for States

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## Background

The Centers for Medicare & Medicaid Services (CMS) has finalized a set of policy and operational changes relating to the Affordable Care Act (ACA) and health insurance Marketplaces. The administration's goals for these regulations are to change Marketplace eligibility and enrollment systems to prevent "waste, fraud and abuse," reduce premiums for people ineligible for premium tax credits (PTC), and limit federal spending.

CMS received over 26,000 public comments on its draft rules, including from state government agencies, and representatives of insurers, providers, and consumers. The regulations are effective on August 25, 2025. Overall, the agency estimates that between 725,000 and 1.8 million people will lose insurance coverage in 2026 as a result of this rule. The rule is projected to reduce federal spending on PTCs by between $10.3 billion and $12.4 billion in 2026.

## Summary of Major Changes Between Proposed and Final Rules

The final rule adopts most of the policies proposed with minor modifications, but with some significant changes to the effective dates. In response to comments, CMS has also granted some additional flexibilities to State-Based Marketplaces (SBMs).

### *New Sunset Dates*

One of the most significant changes CMS has made is to provide a "sunset" date of December 31, 2026 for several policy and operational provisions. Specifically, the following policies will sunset prior to plan year (PY) 2027:

- Termination of advance premium tax credits (APTCs) for failure to file taxes and reconcile advance premium tax credits after one year.
- Requiring income verification when data sources indicate income less than 100% of the federal poverty level (FPL).
- Requiring income verification when tax data is unavailable.
- Requiring annual eligibility redetermination for people eligible for zero dollar premiums.
- Curtailing insurer flexibility on premium payment thresholds.
- Eliminating the monthly special enrollment period (SEP) for people with income at or below 150% of the FPL.
- Requiring pre-enrollment verification for SEPs.

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CMS explains that it is adopting these sunset dates in response to commenters' concerns about making these policies permanent, while balancing their need to improve program integrity in response to "high levels of improper enrollments," which the agency attributes to the enhanced PTCs that expire at the end of 2025. However, the agency is presumably also aware that the House-passed budget reconciliation bill (H.R. 1) would codify the proposed version of these regulations into federal statute permanently.

***Responding to Requests for State-Based Marketplace Flexibility***

Many commenters, including state agencies, SBMs, consumer advocates, and insurers, urged CMS to grant states greater flexibility to meet the needs of their residents and respond to the needs of their markets. While the agency declined to grant SBMs the full range of flexibilities requested, the final rule softens some of the proposed federal mandates in several areas. In particular, as summarized in greater detail below, SBMs will have slightly more flexibility to set open enrollment period (OEP) dates than proposed (although 19 out of 20 SBMs will still need to shorten their OEPs). The final rule also gives states more time to implement the shortened OEP by delaying implementation from PY 2026 to the OEP for PY 2027.

SBMs will also have greater flexibility to set pre-enrollment verification requirements for SEPs, as well as their re-enrollment policies for enrollees eligible for zero dollar premiums.

## Changes to Affordability and Benefits

The final rule includes policy changes that increase net premiums, particularly for low- and moderate-income consumers, and increase out-of-pocket costs. It also prohibits insurers from covering gender-affirming care (GAC) as part of essential health benefits (EHBs).

***Increasing Consumers' Premium Contributions and Out-of-Pocket Costs***

CMS finalized the provision to change the methodology for calculating the premium adjustment percentage index. While in the weeds, this provision is not just important in lowering PTCs for Marketplace enrollees, but it also raises cost-sharing in the entire private insurance market, including for those with employer-sponsored coverage (ESI).

Under the ACA, the premium adjustment percentage is a measure of premium growth that affects several important calculations. First, it determines the maximum out-of-pocket (MOOP) annual limitation on cost-sharing for private insurance in the ACA-regulated market. The premium adjustment percentage is also used by the Internal Revenue Service (IRS) to establish the required contribution percentage used to determine Marketplace enrollees' contributions toward premiums and their premium tax credit. It also sets other parameters, such as the determination of the affordability of ESI and the employer shared responsibility payment amounts.

Under this indexing change, rather than just including the more stable and typically lower growth of group coverage, it will now include individual market premiums. This provision will raise the MOOP in the commercial market by 15.2% over PY 2025 to $10,600 for self-only coverage (and double that amount for other coverage) and increase cost-sharing for people eligible for cost-sharing reductions (CSRs) by as much as 14.7%, to $3,500. It will also subject Marketplace enrollees to roughly 4.5% higher premiums for a benchmark silver plan than under current methodology.

***More Flexibility for Insurers' Benefit Designs – and a Reduction in Premium Tax Credits***

The ACA requires insurers in the individual and small-group markets to offer plans with specified levels of generosity (called "actuarial value"), labeled bronze (covering 60% of an average enrollee's costs), silver (70%), gold (80%), and platinum (90%). However, insurers have some flexibility in meeting these actuarial value levels. CMS is finalizing a proposal to expand this flexibility. Specifically, beginning in PY 2026 and beyond, insurers will be permitted to offer plans within a wider "de minimis" threshold for each of the metal levels, listed in Table 1 below.

**Table 1. Threshold Ranges to Achieve Actuarial Value (AV) Targets for ACA Metal Levels**

| Plan Level or Type | PY 2025 Percentile Change Range | PY 2026 Percentile Change Range |
|---|---|---|
| Bronze (60% AV) | +2/-2 | +2/-4 |
| Expanded Bronze* | +5/-2 | +5/-4 |
| Silver (70% AV) | +2/-2 | |
| Cost-sharing reduced Silver variations | +1/0 | +1/-1 |
| On-Marketplace Silver (70% AV) | +2/0 | +2/-4 |
| Gold (80% AV) | +2/-2 | +2/-4 |
| Platinum (90% AV) | +2/-2 | +2/-4 |

*Expanded bronze plans cover and pay for at least one major service, other than preventive services, before the deductible, or meet the requirements to be a high deductible health plan under the Internal Revenue Code.

While CMS acknowledges that the current policy of narrowing the threshold range for on-Marketplace silver plans has improved premium affordability for people eligible for APTC, the agency argues that unsubsidized individuals have been harmed by their inability to access lower value (and thus lower premium) plans.

The agency has finalized these changes to the de minimis threshold levels as proposed, noting that many insurers who commented on the draft rule applauded the opportunity to develop more innovative plan designs. However, CMS also received comments urging the agency to delay implementation of this change, arguing that some insurers will not be able to modify plan designs given state filing deadlines. Others expressed concern that the policy would result in higher cost-sharing for consumers and higher net premiums for subsidized consumers. CMS responded that it believes it is important to make a wider array of benefit designs available to consumers, as soon as possible. At the same time, the agency estimates that this policy alone will reduce federal spending on APTCs by $1.22 billion in 2026, rising to $1.40 billion in 2029. CMS projects that it will decrease premiums for unsubsidized enrollees by 1%.

***Ending the Bronze-to-Silver Crosswalk for Consumers Eligible for Cost-Sharing Reductions***

CSRs are available to silver plan Marketplace enrollees with incomes up to 250% of the FPL. Previously, CMS found that some people enrolled in a bronze plan, even when they qualified for an equivalent silver plan with a CSR that could substantially lower cost-sharing. Given this, in 2024, CMS began

"crosswalking" people who were otherwise automatically re-enrolling in a bronze plan into a silver plan, if there was one available in the same product, with the same provider network, and the same or lower premium.

Emphasizing the need to respect consumer choices wherever possible and the importance of other factors not considered in the crosswalk—such as a chosen plan's eligibility for a health savings account or unexpected tax liabilities if the crosswalked enrollee's projected or actual income changed—CMS will end this policy in PY 2026 and beyond. CMS cites a potential loss of consumer trust when plans are changed and highlights the importance of improved decision-making tools to help consumers navigate the plan selection process. The policy will apply to all Marketplaces, but CMS notes that under current regulations, SBMs may apply for the Secretary's approval to deviate from these re-enrollment hierarchy rules.

***Ban on Gender-Affirming Care***

CMS has finalized its proposal to prohibit insurers from covering GAC (referred to by CMS as "sex-trait modification") as part of EHB, beginning in PY 2026. They modified their proposal only slightly, by adding a definition of "specified sex-trait modification procedure" to the regulatory text.

Specifically, the rule defines this term to mean "any pharmaceutical or surgical intervention that is provided for the purpose of attempting to align an individual's physical appearance or body with an asserted identity that differs from the individual's sex either by (1) intentionally disrupting or suppressing the normal development of natural biological functions, including primary or secondary sex-based traits; or (2) intentionally altering an individual's physical appearance or body, including amputating, minimizing or destroying primary or secondary sex-based traits such as the sexual and reproductive organs. Such term does not include procedures undertaken (1) to treat a person with a medically verifiable disorder of sexual development, or (2) for purposes other than attempting to align an individual's physical appearance or body with an asserted identity that differs from the individual's sex."

CMS adopts this definition in response to concerns that the term "sex-trait modification" is overly ambiguous and could sweep up a broader set of services and interventions to treat conditions other than gender dysphoria.

CMS rejected the arguments from some commenters that states be allowed to adopt an EHB-benchmark plan that best fits the unique needs of their markets and residents. The agency asserts, without supporting evidence, that GAC is not typically covered by employer-sponsored plans. Because the ACA requires EHB to be equal in scope to typical employer plans, CMS argues that GAC should therefore be excluded from EHB. The agency notes that insurers could continue to cover treatment of gender dysphoria in addition to EHB, and states could require such coverage, so long as they defray the cost of those services as prescribed under federal rules.

Finally, CMS acknowledges that establishing an effective date of PY 2026 for this policy requires insurers to alter their plan filings well after state deadlines for filing 2026 plans and rates. The agency asks state departments of insurance to allow insurers to change rate filings "as appropriate" to reflect these changes.

### New Administrative Requirements and Reduced Opportunities for Enrollment

The final rule includes several provisions that reduce the duration and availability of enrollment

opportunities and require consumers to submit additional paperwork for Marketplace eligibility and enrollment determinations.

***Shortening the Open Enrollment Period***

CMS proposed shortening the Marketplace OEP, beginning with the OEP for PY 2026 so that it begins on November 1 and runs through December 15. In response to comments, CMS is finalizing this proposal with modifications.

First, CMS is delaying the effective date by one year, so that the shortened OEP will be required for PY 2027. In addition, CMS is offering SBMs greater flexibility over the start and end dates of their OEPs. Specifically, for PY 2027 enrollment, all Marketplaces must start their OEPs by November 1 and end their OEPs by no later than December 31 for January 1 coverage, and no OEP may run for more than 9 weeks. All plan selections during the OEP must be effective for January 1 coverage. The agency is silent on whether an SBM can use its authority to establish SEPs to allow people to enroll in Marketplace plans after January 1.

For the Federally-Facilitated Marketplace (FFM), CMS intends to run its OEP for PY 2027 from November 1 to December 15. The agency did not provide dates for the OEP for PY 2026 coverage. However, the agency acknowledges that many consumers will face premium increases due to the expiration of the enhanced PTCs, and may need more time to make plan selections for 2026.

The final rule would also extend the new OEP policy to non-grandfathered individual health insurance coverage offered off-Marketplace. There is no sunset date for this provision of the rule.

CMS notes that all commenters supported states' flexibility to set their own OEP dates, including insurers that have historically preferred a shorter OEP. Further, the agency acknowledges that 19 of 20 SBMs will need to shorten their OEPs under the final rule, and several SBMs submitted data showing that those who enroll later in the OEP are, on average, younger and healthier than most Marketplace enrollees. However, CMS has concluded that a nine-week OEP provides "more than sufficient time" for consumers to enroll into coverage.

CMS estimates it will cost SBMs over $7 million in one-time system update costs to implement the shortened OEP. The agency does not anticipate any enrollment declines due to the shorter OEP, arguing that consumers will "benefit from clearer enrollment rules." Of note, however, the Congressional Budget Office (CBO) has estimated that a shortened OEP, combined with pre-enrollment verification requirements for SEPs, will result in 100,000 people becoming uninsured.

***"Pausing" the Low-Income Special Enrollment Period***

In 2022, the FFM and most SBMs adopted a monthly SEP for individuals with income at or below 150% of the FPL. Initially the SEP was only available so long as these individuals were eligible for the enhanced PTCs enacted in the American Rescue Plan Act (ARPA) of 2021 and extended until December 31, 2025 in the Inflation Reduction Act. For PY 2025, CMS revised the rules so that low-income individuals would continue to have a monthly opportunity to enroll even if the enhanced PTCs are not extended.

Despite framing this SEP as a primary mechanism for agent, broker, and web-broker fraud in the FFM, CMS is only "pausing" the availability of this SEP—for all Marketplaces—from 60 days after the rule's August 25 effective date through PY 2026. As justification for reinstating the provision in PY 2027, CMS points to less likelihood of unauthorized enrollments or plan switches after the end of PY 2025, when

the enhanced PTC expires and people with income up to 150% of the FPL are no longer guaranteed a zero-premium silver benchmark plan. According to CMS, pausing this SEP is an important part of the PY 2026 “transition” year.

CMS estimates one-time costs in 2025 at $390,000 for the FFM and $7 million total across SBMs to remove this SEP functionality from eligibility systems and an additional cost increase of the same amount to reinstate the provision at the end of 2026. The rule does not quantify consumer education expenses. While CMS predicts as much as $3.4 billion in APTC savings from the provision, it does not estimate its coverage impact. It estimates a 3% to 4% reduction in gross premiums, owing to its perception that the SEP is responsible for adverse selection.

***Requiring Additional Documentation of Special Enrollment Period Triggering Events***

The ACA requires insurers and the Marketplaces to allow individuals to enroll in coverage outside the annual OEP after certain life events, such as the loss of ESI, a move, marriage, or the birth or adoption of a child. In the early years of the ACA Marketplaces, consumers were largely allowed to self-attest that they had experienced one of the allowable “triggering events” to qualify for a SEP. However, in response to concerns from insurers that some people were using SEPs to wait until they were sick to purchase insurance, the first Trump administration required consumers shopping on the federal platform (HealthCare.gov) to submit documentation proving their eligibility for most SEPs prior to enrollment. SBMs have long had flexibility to determine the most appropriate way to ensure the proper use of SEPs.

Beginning in 2023, CMS put in place rules permitting attestation to serve as eligibility verification for most SEPs, except the SEP for people losing minimum essential coverage (and the SEP for people with income up to 150% of FPL, through the standard income verification procedure). This was done to lower administrative burdens for SEP-eligible people and to mitigate the negative impacts to the risk pool that result from younger and healthier people being deterred from enrolling. The proposed rule would have put verification requirements back into place for all Marketplaces and required all Marketplaces to verify eligibility for at least 75% of their new SEP enrollees.

In a “win” for SBM flexibility under the rule, the proposal for Marketplaces to verify eligibility for SEPs prior to enrollment was only finalized for federal platform states. CMS reasoned here that state flexibility in SEP verification is acceptable because the majority of the enrollment fraud occurs in states on the federal platform and due to the administrative and cost burdens the proposal would have put on SBMs.

***Canceling Advance Premium Tax Credits for Failure to Reconcile***

Enrollees who receive an APTC are required to file taxes and reconcile the credit, with their final credit amount (the PTC) based on their actual year-end income, household size, and filing status. When enrolling in Marketplace coverage, the application asks if the person has filed and reconciled, then checks that answer against the most recently available tax records. If someone has not filed and reconciled, or files late (such that their filing is not yet captured in the available tax records), they cannot receive APTC. This provision has undergone nearly annual adjustments. Most recently, the Biden administration said the APTC would only be stopped if (1) the consumer failed to reconcile for two consecutive years; and (2) the Marketplace sent a notice to the consumer about their reconciliation obligation.

In the preamble to this rule, CMS asserts that the current provision harms consumers because of the potential for accumulating increased tax liabilities, that taxpayers could be incentivized to delay reconciliation in order to retain eligibility for an additional year, and that the policy is a contributor to improper or unauthorized enrollments. Going forward, beginning in the fall of 2025 for PY 2026, CMS will require all Marketplaces to block receipt of APTC based on a single tax year of failure to file and reconcile, but this is another provision only in place for a single year. The rule reinstates the two-year requirement for PY 2027. CMS estimates it will take the federal government and each SBM 10,000 hours to implement the provisions for PY 2026 and the same amount of time to revert to the prior rules for PY 2027.

***Requiring Active Re-Enrollment for Some Marketplace Enrollees***

In some cases, a person's APTC fully subsidizes their plan's premium, meaning that the plan requires no up-front payment. Zero-premium plans were made more common with the ARPA enhanced PTC which reduced premiums across the board and lowered the premium for a benchmark plan to zero for people with income up to 150% of the FPL. As a consequence, in PY 2025, 39% of enrollees using the federal platform enrolled in zero-premium plans, compared to 16% prior to the PTC enhancements. The rule's preamble says the availability of zero-premium plans "created the incentive and opportunity for fraudulent and improper enrollments at scale" through fraud by enrollees and third-parties. The proposed rule would have required people being automatically re-enrolled in a zero-premium plan to pay a $5 per month premium, having their APTC reduced, until the enrollee enters their Marketplace application to re-confirm their personal information and plan choice and again be fully subsidized. This change was proposed to begin in PY 2026 for federal platform states and in PY 2027 for SBMs.

CMS is finalizing this rule only for states on the federal platform. The provision is effective for only PY 2026.

In the proposed rule, CMS had also sought general comment on whether auto re-enrollment, writ large, should continue, but says here that it agrees with commenters that such proposals "present too great a risk of widespread coverage loss to legitimate enrollments." Notably, the House-passed budget reconciliation bill and the Senate Finance Committee-proposed provisions would end automatic re-enrollment.

***Administrative Barriers for People with Data Matching Inconsistencies***

Under the ACA, Marketplaces determine APTC eligibility by checking an applicant's best guess as to their income against their most recent tax return data. If the individual's projected income is lower than the income in their prior tax return, the Marketplace flags a "data matching issue" (DMI), requiring the consumer to provide documentation of their projected income. CMS proposes three provisions that tighten paperwork requirements for consumers whose income cannot be verified using federal data sources.

***Shortened Window to Submit Documentation***

Under the ACA, consumers with a DMI are guaranteed 90 days to provide the necessary documentation to prove their income. While the DMI is being resolved, the consumer can enroll in a plan and receive APTCs, although they may need to pay some or all of those funds back if they are not eligible.

In 2024, the Biden administration granted consumers with DMIs an additional 60 days to submit the required paperwork, without having to proactively request an extension. Beginning with the effective date of the final rule, CMS removes this automatic 60-day extension. The change is permanent.

CMS acknowledges that it received comments from states arguing for greater flexibility to extend the resolution period to meet the needs of their distinct populations. However, the agency argues that the 60-day extension "weakened program integrity" and violated the statutory directive in the ACA to provide only a 90-day period to resolve a DMI.

The agency estimates this will impose a one-time implementation cost on SBMs of $9.5 million and that, across all Marketplaces, 140,000 consumers will lose coverage.

***Mandatory Data Matching Issue for Consumers Under the Poverty Line***

Under the ACA, individuals above 100% of the FPL may be eligible for APTCs through the Marketplaces if they are not eligible for other coverage, such as Medicaid. In states that have not expanded Medicaid, the only source of coverage for many individuals between 100% to 138% of the FPL is the Marketplace. Many of these individuals may have gig economy or seasonal jobs, making it challenging for them to accurately project their annual income a year in advance.

Historically, a DMI is not generated if the applicant projects higher income than in their tax return, because their APTC would be lower than what federal data sources show they are eligible for. As of the effective date of this final rule, all Marketplaces would be required to generate a DMI when an applicant attests projected income equal to or greater than 100% of the FPL, but electronic data sources show their current income is less than 100% of the FPL. However, CMS will sunset this requirement at the end of PY 2026. The agency's stated rationale for implementing this policy on a temporary basis is to help the Marketplaces "shed excess improper enrollments" and adjust to the "changing subsidy environment."

CMS disagrees with commenters who argue that the new paperwork requirements will pose a particular burden on low-income applicants and lead to adverse selection because younger, healthier consumers will be less willing to submit all the necessary documentation. The agency estimates it will take the average consumer "only one hour" to resolve the DMI.

The agency also rejected concerns from SBMs about the costs associated with implementing this new requirement, arguing that "program integrity" concerns necessitate the extra expenditures. CMS further dismissed arguments that SBMs do not experience the same level of improper enrollments as FFM states, particularly among people close to 100% of the FPL who would be eligible for Medicaid or the Children's Health Insurance Program (CHIP) in those states. The agency believes that all states experience some instances of consumers overestimating their annual household income.

CMS estimates it will cost SBMs almost $15 million to implement this new DMI policy in 2025 and another $15 million to revert to the previous policy for PY 2027. Further, the agency estimates all Marketplaces will spend over $13 million to process consumers' documents and resolve these DMIs until the policy sunsets. The agency projects that this provision will reduce the number of people receiving APTCs by 81,000.

***New Documentation When Tax Data is Unavailable***

In 2023, CMS adopted a policy enabling Marketplaces to rely on an applicant's self-attestation of projected income, if the IRS was unable to provide information from the individual's prior tax return. This meant that no DMI would be generated, relieving the applicant and the Marketplace from the submission and review of additional documentation.

Beginning on the effective date of this final rule, CMS will require the Marketplaces to create a DMI for applicants who lack tax data to check against their projected income. The agency believes that allowing applicants to attest to their projected income has contributed to "weakening" the eligibility system, and that consumers will be able to verify their income "with relative ease."

Most commenters opposed this policy, arguing it would create barriers for consumers who are low-income or have variable sources of income, increase administrative costs, and destabilize the risk pool. SBMs also expressed concerns about implementation costs, and some provided data indicating that younger individuals are more likely to be deterred by the increased paperwork requirements. SBMs further argued that they already have robust income verification protocols and have not experienced the same level of fraud as the FFM.

CMS will sunset this policy after PY 2026, and suggests it is doing so in response to the concerns indicated by SBMs, noting that this provision "may not be necessary to ensure program integrity" in SBMs in the long term. However, CMS notes in its impact analysis that SBMs will need to spend $16.6 million in system changes in 2025 to implement the policy and another $16.6 million in 2026 to sunset the policy. SBMs will also need to spend $62.8 million to process consumers' paperwork and confirm eligibility. Across all Marketplaces, CMS estimates that over 400,000 applicants will have their APTCs reduced, potentially to zero dollars, as a result of this policy. Of note, CBO estimates that 100,000 people will become uninsured because of a similar provision in H.R. 1, the House-passed budget reconciliation bill.

### Limiting Eligibility

The final rule includes provisions that reverse existing Marketplace policy and insurance rules in ways that narrow eligibility. It terminates coverage for recipients of the Deferred Action for Childhood Arrivals (DACA) policy, and allows insurers to deny or cancel policies for people who have nominal or past-due premium debt.

#### *Termination of Coverage for DACA Recipients*

CMS finalized its proposal to exclude DACA recipients from the definition of "lawfully present" and thereby end those individuals' ability to enroll in a qualified health plan (QHP) or Basic Health Program (BHP) or receive APTC, PTC, or CSRs. This returns to the policy in place from the time the DACA status was created during the Obama administration until CMS' 2024 reversal.

CMS pushed back on commenters' legal concerns regarding potential conflicts with sections 1554 (prohibiting unreasonable barriers to care) and 1557 (nondiscrimination) of the ACA, the Equal Protection Clause of the Fourteenth Amendment, and Title VI of the Civil Rights Act, and the ongoing litigation under appeal in the Eighth Circuit that would be preempted by the final rule. (Late last year, the North Dakota federal district court stayed the enrollment of DACA recipients in the 19 states that sued the federal government over the provision.) Some commenters discussed the potential rise in uncompensated care costs and the impact on safety net providers due to having additional uninsured people, while other commenters said that the DACA population is generally healthy and that excluding

them may have an adverse impact on the risk pool. CMS also responded to concerns about the technical and operational challenges of commencing such a policy upon the rule's effective date, as proposed, rather than at the start of the following PY. CMS indicated that Marketplaces and BHPs would be expected to take steps to end coverage for people as of the effective date and that, if needed, CMS would provide SBMs with any technical assistance needed to do so. Insurers are also required to provide DACA enrollees with a termination notice (as required under other circumstances when coverage ends). The new policy is applicable immediately upon the effective date of the rule.

#### *Removing Fixed Dollar and Gross Premium Payment Thresholds*

If a state permits, issuers can accept slightly less than the full premium due without putting the enrollee into a grace period or terminating coverage. For PY 2026, under the Biden administration, CMS finalized a rule expanding issuers' options to create a threshold that is: (1) an amount that is at least 95% of the net premium paid by the enrollee; (2) an amount that is at least 98% of the gross monthly premium; or (3) a fixed-dollar amount that is up to $10. Citing program integrity concerns, the final rule scales back the circumstances in which the premium payment threshold is used to an amount that is no greater than 95% of net premium. This provision applies to all Marketplaces, but it does so for only PY 2026 and is sunset after that.

#### *End of Guaranteed Issue for Past-Due Premiums*

CMS has finalized its proposal to revert to a policy adopted under the first Trump administration that would allow insurers to deny policies to individuals with past-due premiums from prior coverage. In addition, CMS will allow insurers to add the past-due premiums to the amount owed for the initial premium payment, and require payment in full before coverage can be effectuated. Insurers may include in the payment owed any premium amounts owed to a different insurer that is part of the same controlled group. This policy is effective beginning on the effective date of the final rule.

States may choose whether to permit insurers in their state to adopt this policy, as well as to set limits on whether insurers can require payment in full before coverage is effectuated. States may also impose a limited "lookback" period for insurers or cap the amount of past-due premium a consumer would owe to effectuate coverage.

### Oversight of Agents, Brokers, and Web-Brokers

Despite its concerns about fraudulent and improper enrollments in Marketplace coverage, largely driven by unscrupulous brokers, CMS' final rule contains minimal policy to improve the oversight of such brokers. The only relevant provision simply clarifies that the agency uses a "preponderance of the evidence" standard of proof in the adjudication of cases involving agent, broker, or web-broker misconduct.

**Table 2. Final Rule Provision Applicability Dates and Comparison With Reconciliation Language**

| Policy | Applicability Date<br>*Rule is effective August 25* | Inclusion in House/Senate Reconciliation Provisions[1] |
|---|---|---|
| **Coverage Denials for Failure to Pay Premiums for Prior Coverage (§ 147.104(i))** | Effective date of this rule | House |
| **DACA (§ 155.20)** | Effective date of this rule | House |
| **Standards for Termination of an Agent, Broker, or Web-broker's Agreement for Cause (§ 155.220(g)(2))** | Effective date of this rule | n/a |
| **60-Day Extension to Resolve Income Inconsistency (§ 155.315)** | Effective date of this rule | House |
| **Income Verification When Data Sources Indicate Income Less Than 100% of the FPL (§ 155.320(c)(3)(iii))** | Effective date of this rule through PY 2026 only | House |
| **Income Verification When Tax Data is Unavailable (§ 155.320(c)(5))** | Effective date of this rule through PY 2026 only | House |
| **Premium Payment Thresholds (§ 155.400(g))** | Effective date of this rule through PY 2026 only | House |
| **Monthly SEP for Individuals With Income Up To 150% of the FPL (§ 155.420)** | 60 days after the effective date of this rule through PY 2026 only | House/Senate |

[1] This table includes only the congressional provisions that are the same or nearly the same as the final rule and does not include all provisions of the House-passed and Senate draft legislation. All House and Senate provisions are permanent (i.e., do not sunset).

| Policy | Applicability Date<br><br>*Rule is effective August 25* | Inclusion in House/Senate Reconciliation Provisions[1] |
|---|---|---|
| **Reenrollment in Zero-Premium Plans (§ 155.335(a),(n))** | PY 2026 only on HealthCare.gov; not finalized for SBMs | House (for all Marketplaces) |
| **Failure to File Taxes and Reconcile APTC (§ 155.305(f)(4))** | PY 2026 only | House/Senate |
| **Conducting SEP Eligibility Verification (§ 155.420(g))** | PY 2026 only on HealthCare.gov; not finalized for SBMs | House (for all Marketplaces) |
| **Automatic Reenrollment Hierarchy (§ 155.335(j))** | PY 2026 and beyond[2] | House |
| **Prohibition on Coverage of Gender Affirming Care as EHB (§§ 156.115(d), 156.400)** | PY 2026 and beyond | House |
| **Premium Adjustment Percentage Index (§ 156.130(e))** | PY 2026 and beyond | House |
| **Actuarial Value (§§ 156.140, 156.200, 156.400)** | PY 2026 and beyond | House |
| **Annual OEP (§ 155.410)** | PY 2027 OEP | Similar to House[3] (PY 2026) |

[2] The rule notes that under existing regulations Marketplaces can ask the Secretary for an exception to the reenrollment hierarchy rules.
[3] The House provision reflects the proposed rule's provision limiting the OEP to November 1 to December 15 rather than that in the revised final rule.