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DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Part 300

[TD 10031]

RIN 1545–BR28

Estate Tax Closing Letter User Fee Update

Correction

In rule document 2025–08928, appearing on pages 21410 through 21413 in the issue of Tuesday, May 20, 2025, make the following correction:

1. Page 21412, in the 1st column, in the second pictured calculation in the column. The number for ''Quality Assurance & Benefits'' should be ''$9,546'' not ''$95.46''.

2. Page 21412, in the 1st column, in the 1st pictured calculation under the heading ''3. Full Cost Per Request Calculation''. The Full Cost amount should be ''$502,573'' not ''$502.573''.

3. Page 21412, in the 1st column, in the 2nd pictured calculation under 3. Full Cost Per Request Calculation. The Full Cost amount should be ''$502,573'' not ''$502.573''.

[FR Doc. C2–2025–08928 Filed 6–24–25; 8:45 am]

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DEPARTMENT OF EDUCATION

34 CFR Chapter III

[Docket ID ED–2024–OSERS–0001]

Technical Assistance on State Data Collection—IDEA Data Management Center

AGENCY: Office of Special Education and Rehabilitative Services, Department of Education.

ACTION: Final priority.

SUMMARY: The Department of Education (Department) announces a priority for the IDEA Data Management Center (Center) under the Technical Assistance on State Data Collection program. The Department may use this priority in fiscal year (FY) 2025 and later years. This priority replaces the priority published in the **Federal Register** on August 5, 2014, and the priority published on July 10, 2020. We will use the priority to award a cooperative agreement for a Center to provide technical assistance (TA) to improve the capacity of States to meet the data collection and reporting requirements under Part B and Part C of the Individuals with Disabilities Education Act (IDEA).

DATES: The priority is effective July 25, 2025.

FOR FURTHER INFORMATION CONTACT: Amy Bae, U.S. Department of Education, 400 Maryland Avenue SW, Room 4A224, Washington, DC 20202. Telephone: (202) 987–1557. Email: *Amy.Bae@ed.gov.*

If you are deaf, hard of hearing, or have a speech disability and wish to access telecommunications relay services, please dial 7–1–1.

SUPPLEMENTARY INFORMATION:

Purpose of Program: The purpose of the Technical Assistance on State Data Collection program is to improve the capacity of States to meet IDEA data collection and reporting requirements. Funding for the program is authorized under section 611(c)(1) of IDEA, which gives the Secretary authority to reserve not more than one-half of one percent of the amounts appropriated under Part B for each fiscal year to provide TA activities, where needed, to improve the capacity of States to meet the data collection and reporting requirements under Parts B and C of IDEA. The maximum amount the Secretary may reserve under this set-aside for any fiscal year is $25,000,000, cumulatively adjusted by the rate of inflation. Section 616(i) of IDEA requires the Secretary to review the data collection and analysis capacity of States to ensure that data and information determined necessary for implementation of section 616 and 642 of IDEA are collected, analyzed, and accurately reported to the Secretary. It also requires the Secretary to provide TA, where needed, to improve the capacity of States to meet the data collection requirements, which include the data collection and reporting requirements in sections 616 and 618 of IDEA. In addition, the Further Consolidated Appropriations Act, 2024, Public Law 118–47, gives the Secretary authority to use funds reserved under section 611(c) of IDEA to ''administer and carry out other services and activities to improve data collection, coordination, quality, and use under parts B and C of the IDEA.'' Further Consolidated Appropriations Act, 2024, Public Law 118–47, Div. D, Title III, 138 Stat. 460, 685 (2024).

Assistance Listing Number: 84.373M.

Program Authority: 20 U.S.C. 1411(c), 1416(i), 1418(c), 1418(d), 1442; Further Consolidated Appropriations Act, 2024, Public Law 118–47, Div. D, Title III, 138 Stat. 460, 685 (2024).

Applicable Program Regulations: 34 CFR 300.702.

We published a notice of proposed priority (NPP) for this program in the **Federal Register** on November 7, 2024 (89 FR 88185). That document contained background information and our reasons for proposing the priority.

Public Comment: In response to our invitation in the NPP, 14 parties submitted comments addressing the proposed priority. We received two additional comments unrelated to the priority.

Generally, we do not address technical and other minor changes, or suggested changes the law does not authorize us to make under the applicable statutory authority. In addition, we do not address general comments that raised concerns not directly related to the proposed priority.

Analysis of Comments and Changes: An analysis of the comments and of any changes in the priority since publication of the NPP follows. We received comments on a number of specific topics, including the topics for TA. Each topic is addressed below.

General Comments

Comments: Eleven commenters specifically expressed support for the proposed Center, as it would assist States in collecting, reporting, and determining how to best analyze and use their Part B and Part C data.

Discussion: The Department appreciates the comments and agrees with the commenters that the Center funded under this program will provide necessary and valuable TA to States to improve the capacity of States to meet their IDEA data collection, analysis, and reporting requirements.

Changes: None.

Comment: One commenter suggested that the Center prioritize opportunities for automating required data reporting processes to improve efficiency and reduce the workload for State staff.

Discussion: The Department agrees the Center must support State educational agencies (SEAs) and lead agencies to implement services that maximize efficiency. In its proposed approach to intensive, sustained TA the Center must identify how it will maximize these investments and reduce inefficiencies. Additionally, the Center must describe how it will develop products and implement services that maximize efficiency.

Changes: None.

Alignment With Selection Criteria

Comment: None.

Discussion: In using this priority in a notice inviting applications, the priority's reference to selection criteria should align with the selection criteria being used.

Changes: We are revising the selection criteria headings with the priority by removing ''Quality of project services'' and ''Quality of the project personnel'' and replacing with ''Quality of the project design'' and just ''Adequacy of resources.'' We are also revising application and administrative requirements to align with the actual factors being used under ''Adequacy of resources'' and ''Quality of the management plan'' in the notice inviting applications.

Part C and Part B, 619 Preschool Data

Comments: All eleven commenters who wrote comments related to the Center providing TA on Part C and Part B, 619 preschool special education data were supportive of the expanded scope of the Center to enhance States' capacity to manage, collect, coordinate, report, and integrate Part C and Part B preschool special education data. Specifically, commenters supported expanding the scope to develop, in partnership with the Department, an open-source electronic tool to assist States with linking and integrating their IDEA Part C early intervention and IDEA Part B preschool special education data with other data or data systems associated with other Federal programs and services that support infants, toddlers, and young children and their families.

Discussion: The Department agrees that it is important to support the expanded scope to include Part C and Part B preschool special education data. The expanded scope supports States so that they can develop and implement Early Childhood Integrated Data Systems (ECIDS) that coordinate, link, and integrate child-level data in IDEA Part C and IDEA Part B preschool special education data with other early care and education program data in order to provide high-quality reporting of the IDEA Part C data and IDEA Part B preschool special education data required under sections 616 and 618 of IDEA; drive program improvement; improve results for children with disabilities; and improve compliance accountability.

Changes: None.

Capacity

Comments: Three commenters addressed specific challenges that make it difficult for many Part C lead agencies to engage in data linking and data integration activities. Commenters mentioned challenges such as lack of sufficient fiscal resources, major workforce shortages, technology, as well as State staff shortages and significant staff turnover.

Discussion: The Department acknowledges that States vary in their levels of interest, capability, and commitment to share, link, or integrate their Part C and Part B preschool special education data with data from other early learning data systems. Additionally, we recognize that engaging in TA regarding data sharing, linking, and integrating requires a significant commitment of State staff and resources. We also appreciate the recommendation to assess the readiness of States to engage in TA on this topic. To address these issues, applicants are required to identify the process by which the proposed project will measure the readiness of potential TA recipients to work with the project, assessing, at a minimum, their current infrastructure, available resources, and ability to build capacity at the State and local level. Additionally, as part of its intensive, sustained TA, applicants are required to identify the process by which the proposed project will address States' challenges associated with integrating IDEA Part B data within State longitudinal data systems (SLDS) and IDEA Part C and IDEA Part B preschool special education data within ECIDS.

Changes: None.

Focus

Comments: Two commenters suggested that the Center focus on developing robust resources and supporting States on linking and integrating data within and across IDEA Part C and Part B 619 before focusing on cross-sector early childhood integration work, such as work carried out through the ECIDS system.

Discussion: The Department acknowledges that States vary in their levels of interest, capability, and commitment to share, link, or integrate their Part C and Part B preschool special education data with data from other early learning data systems. This variability is influenced by factors such as staffing, existing data infrastructure, and resource availability. Additionally, we recognize that engaging in TA regarding data sharing, linking, and integrating requires a significant commitment of State staff and resources. The Center's expected outcomes focus on increasing the capacity of States to collect, report, analyze, and use Part C early intervention and Part B preschool special education data to improve State IDEA data analyses regarding results and functional outcomes for all infants, toddlers, and young children with disabilities. Recognizing that States differ in their levels of interest, capability, and commitment, the Department acknowledges that levels of readiness will vary. The Center will be equipped to support States based on their unique needs, meeting them where they are and adapting to their specific circumstances. Some States may be well-positioned to engage in cross-sector early childhood integration work, particularly through systems like ECIDS, while others may still be developing their data systems or needing additional support with Part C services before integrating with other sectors. In these cases, a more foundational approach to building data capacity will be necessary. The Center should align its support with each State's capacity, focusing on enhancing their ability to collect, report, analyze, and use Part C and Part B data to improve results and outcomes for all infants, toddlers, and young children with disabilities. This nuanced approach ensures that the Center can provide targeted support, whether that support involves foundational data integration or more advanced cross-sector collaboration. The Department is fully committed to embedding this flexibility into the Center's approach, ensuring that each State receives the right support at the right time.

Changes: To provide more flexibility in how the Center can support States based on their levels of readiness, we have changed the requirement that the Center allocate at least 50 percent of the grant award to provide targeted and intensive TA to States to only require the 50 percent allocation to targeted and intensive TA in years three through five. While the NPP required a specific funding allocation for this purpose for

all five years, we recognize that States have varying levels of readiness, resources, and capacity when it comes to sharing, linking, and integrating data. In response to comments about how much support the Part C entities might need, and their varying levels of readiness, we are changing this requirement to provide maximum flexibility to the Center in years one and two to support the States based on their levels of readiness. This change allows for more flexibility in years one and two for the provision of general TA, if needed, such as the development of innovative tools, including an open-source electronic tool, that can better support all States regardless of the stage they are in on data integration. By allowing the Center to determine how best to develop and align resources with State readiness, we create an opportunity for the Center to more effectively budget for product development and TA provision.

Collaboration/Coordination

Comments: Five commenters pointed out that there may be overlap between the work of this Center and the National Technical Assistance Center to Improve State Capacity To Collect, Report, Analyze, and Use Accurate Early Childhood IDEA Data (DaSy Center). Two commenters expressed concern that the work of this Center could duplicate the efforts of the DaSy Center, potentially leading to inefficiencies. Three commenters emphasized the necessity for better coordination between the two Centers. They noted that both Centers share complimentary objectives and working together could enhance their effectiveness and ensure resources are utilized optimally. Another commenter emphasized the importance of collaborating with centers funded by the Department of Health and Human Services, Administration for Children and Families.

Discussion: The Department recognizes the related scope between the proposed IDEA Data Management Center and the DaSy Center and agrees that coordination will be critical to maximize these investments and reduce inefficiencies, and agrees that it is important that this Center work in partnership with the other Federally funded centers. While related, the scope of the IDEA Data Management Center is not duplicative of the DaSy Center. They have distinct work scopes with different focuses. The IDEA Data Management Center supports States in improving their data systems, helping them manage the collection, reporting, analysis, and use of data. This work includes providing an open-source tool to assist with data management and reporting. In contrast, the DaSy Center provides broader support, helping States develop and use data systems to improve outcomes for young children. Additionally, as States develop and implement ECIDS, the Department recognizes the importance of collaborating with centers funded by the Department of Health and Human Services, Administration for Children and Families. Therefore, applicants must identify the process by which the proposed project will collaborate with the Office of Special Education Programs (OSEP)-funded centers and other federally funded TA centers to develop and implement a coordinated TA plan when the work of the center or centers are related to the proposed project.

Changes: None.

Privacy

Comment: One commenter recommended that the Center leverage and coordinate with the Department's Privacy Technical Assistance Center (PTAC) and other existing resources to ensure strict compliance with Federal data privacy requirements. The commenter also recommended that the notice have a clear scope of the privacy and security measures that will be required so applicants know in advance the requirements that they will need to follow. Another commentor noted that the explicit focus on compliance with data privacy, as included in IDEA and the Family Educational Rights and Privacy Act (FERPA), will provide important data security protection.

Discussion: The Department agrees that data systems must allow the States to comply with applicable privacy requirements, including the privacy and confidentiality requirements under Parts B and C of the IDEA and FERPA (20 U.S.C. 1232g) and its regulations at 34 CFR part 99. As noted in the priority, the Center's work will comply with the privacy and confidentiality protections under IDEA and FERPA. Additionally, the Center is expected to increase the capacity of States to use interagency agreements or other mechanisms to coordinate and integrate IDEA Part B and IDEA Part C data required under sections 616 and 618 of IDEA within their SLDS while meeting the applicable privacy requirements under Parts B and C of the IDEA and FERPA (which may include developing or disseminating TA resources on privacy, interagency agreements on data sharing and/or data coordination, and integration). Finally, in its proposed approach to targeted, specialized TA, the Center must identify its approach to collaborate with centers that provide TA in the area of privacy, including the DaSy Center and PTAC.

Changes: None.

Final Priority

IDEA Data Management Center.

Priority

The purpose of this priority is to fund a cooperative agreement to establish and operate an IDEA Data Management Center (Data Management Center). The Data Management Center will respond to State needs as States determine whether and how to coordinate and integrate their IDEA Part B and Part C data required to meet the data collection requirements in sections 616 and 618 of IDEA into their longitudinal data systems (including SLDS and ECIDS) while ensuring applicable IDEA and FERPA privacy protections are met. This integration will improve the capacity of States to collect, report, analyze, and use high-quality IDEA Part B and Part C data to establish and meet high expectations for each child with a disability. The Data Management Center will help States address challenges with data management procedures and data systems architecture and better meet current and future IDEA Part B and Part C data collection and reporting requirements. The Data Management Center's work will comply with the privacy and confidentiality protections under IDEA and FERPA. The Data Management Center will not provide the Department with access to child-level data and will further ensure that such data is de-identified, as defined in FERPA at 34 CFR 99.31(b)(1).

The Data Management Center must be designed to achieve, at a minimum, the following expected outcomes:

(a) Increased capacity of States to use interagency agreements or other mechanisms to coordinate and integrate IDEA Part B and IDEA Part C data required under sections 616 and 618 of IDEA within their SLDS while meeting the applicable privacy requirements under Parts B and C of the IDEA and FERPA (which may include developing or disseminating TA resources on privacy, interagency agreements on data sharing and/or data coordination, and integration);

(b) Increased use of IDEA Part B and IDEA Part C data within States by developing products to allow States to report their special education, preschool special education, and early intervention data to various partners (*e.g.,* other State agencies, policymakers, school and early care and education program personnel, local and State school boards, local educational agency (LEA) administrators, early care and

education childhood administrators, researchers, charter school authorizers, parents and advocates, Indian Tribes, and Tribal organizations) through their longitudinal data systems;

(c) Increased number of States that use data governance and data management procedures to increase their capacity to meet the IDEA Part B and IDEA Part C reporting requirements under sections 616 and 618 of IDEA;

(d) Increased capacity of States to utilize their SLDS and ECIDS to collect, report, analyze, and use high-quality IDEA Part B and IDEA Part C data (including data required under sections 616, 618, and 642 of IDEA);

(e) Increased capacity of States to use their SLDS and ECIDS to analyze high-quality data on the participation and outcomes of children with disabilities who receive services under IDEA and under Title I of the Elementary and Secondary Education Act of 1965, as amended (ESEA), to improve IDEA and ESEA programs and the outcomes of children with disabilities; and

(f) Increased capacity of States to coordinate and use available IDEA Part C early intervention data with IDEA Part B preschool special education data (and to integrate or link such data with ECIDS, if applicable) to analyze high-quality data on the participation and outcomes of infants, toddlers, and children with disabilities served under IDEA who may also participate in other programs and services (*e.g.,* child care, Early Head Start, Head Start, publicly funded preschool, and home visiting programs).

In addition to these program requirements, to be considered for funding under this priority, applicants must meet the application and administrative requirements in this priority, which are:

(a) Describe, in the narrative section of the application under ''Significance,'' how the proposed project will—

(1) Address State challenges associated with State data management procedures, data systems architecture, and building ED*Facts* data files and reports for timely reporting of the IDEA Part B and IDEA Part C data to the Department and the public. To meet this requirement the applicant must—

(i) Present applicable national, State, or local data demonstrating the difficulties that States have encountered in the collection and submission of valid and reliable IDEA Part B and IDEA Part C data;

(ii) Demonstrate knowledge of current educational and technical issues and policy initiatives relating to IDEA Part B data and IDEA Part C collections and ED*Facts* file specifications for the IDEA Part B and IDEA Part C data collections; and

(iii) Present information about the current level of implementation of integrating IDEA Part B data within SLDS and IDEA Part C and IDEA Part B preschool special education data within ECIDs, and the reporting of high-quality IDEA Part B and IDEA Part C data to the Department and the public.

(b) Describe, in the narrative section of the application under ''Quality of the project design,'' how the proposed project will—

(1) Achieve its goals, objectives, and intended outcomes. To meet this requirement, the applicant must provide—

(i) Measurable intended project outcomes; and

(ii) In Appendix A, the logic model (as defined in 34 CFR 77.1) by which the proposed project will achieve its intended outcomes that depicts, at a minimum, the goals, activities, outputs, and intended outcomes of the proposed project;

(2) Use a conceptual framework (and provide a copy in Appendix A) to develop project plans and activities, describing any underlying concepts, assumptions, expectations, beliefs, or theories, as well as the presumed relationships or linkages among these variables, and any empirical support for this framework;

Note: The following website provides more information on logic models and conceptual frameworks: *https://ies.ed.gov/ncee/rel/Products/Region/central/Resource/100644.*

(3) Be based on current research and make use of evidence-based [1] practices (EBPs). To meet this requirement, the applicant must describe—

(i) The current research on data collection strategies, data management procedures, and data systems architecture; and

(ii) How the proposed project will incorporate current research and EBPs in the development and delivery of its products and services;

(4) Develop products and provide services that are of high quality and sufficient intensity and duration to achieve the intended outcomes of the proposed project. To address this requirement, the applicant must describe—

(i) How it proposes to identify or develop the knowledge base on States' data management processes and data systems architecture;

(ii) A plan to provide a range of products and services to—

(A) Improve States' capacity to report high-quality IDEA Part B and Part C data required under sections 616, 618, and 642 of IDEA through their SLDS and other applicable data systems; and

(B) Improve States' capacity to link and integrate (where determined appropriate by States) their IDEA Part C early intervention and IDEA Part B preschool special education data with data/data systems associated with other Federal programs and services that support infants, toddlers, and young children and their families in order to report high-quality IDEA Part C data and IDEA Part B preschool special education data required under sections 616 and 618 of IDEA. The plan must include, at a minimum, how the project will—

(*1*) In Years 1 through 5—

(*i*) Support, in partnership with the Department, the implementation of an existing open-source electronic tool to assist States in building ED*Facts* data files and reports that can be submitted to the Department and made available to the public. The tool must utilize Common Education Data Standards (CEDS) and meet all States' needs associated with reporting the IDEA Part B and Part C data required under sections 616, 618, and 642 of IDEA;

(*ii*) Provide maintenance to support the appropriate functionality of the open-source electronic tool as changes are made to data collections, reporting requirements, file specifications, and CEDS (such as links within the system to include TA products developed by other Office of Special Education Programs (OSEP) and Department-funded centers or contractors);

(*iii*) Provide TA focused on data governance to facilitate the use of the open-source electronic tool and training to State staff to implement the open-source electronic tool;

(*iv*) Revise the CEDS ''Connections'' to calculate metrics needed to report the IDEA Part B and Part C data required under sections 616 and 618 of IDEA;

(*v*) Develop other outputs (*e.g.,* reports, Application Programming Interface, new innovations) of an open-source electronic tool that can support reporting by States of IDEA Part B data to different partner groups (*e.g.,* LEAs, charter schools, legislative branch, parents);

(*vi*) Implement strategies to support the inclusion of other OSEP and Department-funded TA centers' products within the open-source electronic tool or build connections that

[1] For the purposes of these requirements, ''evidence-based'' means the proposed project component is supported by one or more of strong evidence, moderate evidence, promising evidence, or evidence that demonstrates a rationale (as such terms are defined in 34 CFR 77.1).

allow the SEAs to pull IDEA Part B data efficiently into the other TA products;

(*vii*) Support a user group of States that are using an open-source electronic tool for reporting IDEA Part B data required under sections 616 and 618 of IDEA; and

(*viii*) Develop products and presentations that include tools and solutions to challenges in data management procedures and data system architecture for reporting the IDEA Part B and Part C data required under sections 616 and 618 of IDEA;

(*2*) In Years 2 through 5—

(*i*) Develop, in partnership with the Department, an open-source electronic tool to assist States with linking and integrating their IDEA Part C early intervention and IDEA Part B preschool special education data with other data/data systems associated with other Federal programs and services that support infants, toddlers, and young children and their families, in order to provide high-quality reporting of the IDEA Part C data and IDEA Part B preschool special education data required under sections 616 and 618 of IDEA; drive program improvement; improve results for children with disabilities; and improve compliance accountability. The tool must utilize CEDS and meet States' needs associated with linking or integrating their Part C early intervention and Part B preschool special education data with other data/data systems associated with other Federal programs that support infants, toddlers, and young children and their families;

(*ii*) Develop the CEDS ''Connections'' to ensure the electronic tool is built for States to conduct analyses related to reporting the IDEA Part C data and IDEA Part B preschool special education data required under sections 616 and 618 of IDEA, driving program improvement, improving results for children with disabilities and their families, and improving compliance accountability;

(*iii*) Provide maintenance to support the appropriate functionality of the open-source electronic tool as changes are made to data reporting requirements and CEDS;

(*iv*) Provide TA on data governance to facilitate the use of the open-source electronic tool and training to State staff to implement the open-source electronic tool; and

(*v*) Support a user group of States that are using an open-source electronic tool for reporting the IDEA Part C data and IDEA Part B preschool special education data required under sections 616, 618, and 642 of IDEA;

(iii) Its proposed approach to universal, general TA,[2] which must identify the intended recipients, including the type and number of recipients, that will receive the products and services, a description of the products and services that the Center proposes to make available, and the expected impact of those products and services under this approach;

(iv) Its proposed approach to targeted, specialized TA,[3] which must identify—

(A) The intended recipients, including the type and number of recipients, that will receive the products and services, a description of the products and services that the Center proposes to make available, and the expected impact of those products and services under this approach; and

(B) Its proposed approach to measure the readiness of potential TA recipients to work with the project, assessing, at a minimum, their current infrastructure, available resources, and ability to build capacity at the local level; and

(C) The process by which the proposed project will collaborate with Department-funded centers (including TA centers such as the DaSy Center that provides Department-funded TA on early childhood data privacy, and the PTAC) and other federally funded TA centers to develop and implement a coordinated TA plan when they are involved in a State;

(v) Its proposed approach to intensive, sustained TA,[4] which must identify—

(A) The intended recipients, including the type and number of recipients from a variety of settings and geographic distribution, that will receive the products and services under this approach;

(B) Its proposed approach to address States' challenges associated with integrating IDEA Part B data within SLDS and IDEA Part C and IDEA Part B preschool special education data within ECIDS and to report high-quality IDEA Part B and IDEA Part C data to the Department and the public, which should, at a minimum, include providing on-site consultants to SEAs and Part C lead agencies to—

(*1*) Model and document data management and data system integration policies, procedures, processes, and activities within the State;

(*2*) Support the State's use of an open-source electronic tool and provide technical solutions to meet State-specific data needs;

(*3*) Develop a sustainability plan for the State to maintain the data management and data system integration work in the future; and

(*4*) Support the State's cybersecurity plan in collaboration, to the extent appropriate, with the Department's Student Privacy Policy Office and its Privacy Technical Assistance Center;

(*5*) Develop products and implement services that maximize efficiency. To address this requirement, the applicant must describe—

(i) How the proposed project will use technology to achieve the intended project outcomes;

(ii) With whom the proposed project will collaborate and the intended outcomes of this collaboration; and

(iii) How the proposed project will use non-project resources, such as non-Federal funds and in-kind contributions, to achieve the intended project outcomes; and

(*6*) Develop a dissemination plan that describes how the applicant will systematically distribute information, products, and services to varied intended audiences, using a variety of dissemination strategies, to promote awareness and use of the Center's products and services.

(c) In the narrative section of the application under ''Quality of the project evaluation or other evidence-building,'' describe how the project will develop an evaluation plan in consultation with, and to be implemented by, a third-party evaluator.[5] The evaluation plan must—

[2] ''Universal, general TA'' means TA and information provided to independent users through their own initiative, resulting in minimal interaction with TA center staff and including one-time, invited or offered conference presentations by TA center staff. This category of TA also includes information or products, such as newsletters, guidebooks, or research syntheses, downloaded from the TA center's website by independent users. Brief communications by TA center staff with recipients, either by telephone or email, are also considered universal, general TA.

[3] ''Targeted, specialized TA'' means TA services based on needs common to multiple recipients and not extensively individualized. A relationship is established between the TA recipient and one or more TA center staff. This category of TA includes one-time, labor-intensive events, such as facilitating strategic planning or hosting regional or national conferences. It can also include episodic, less labor-intensive events that extend over a period of time, such as facilitating a series of conference calls on single or multiple topics that are designed around the needs of the recipients. Facilitating communities of practice can also be considered targeted, specialized TA.

[4] ''Intensive, sustained TA'' means TA services often provided on-site and requiring a stable, ongoing relationship between the TA center staff and the TA recipient. ''TA services'' are defined as negotiated series of activities designed to reach a valued outcome. This category of TA should result in changes to policy, program, practice, or operations that support increased recipient capacity or improved outcomes at one or more systems levels.

[5] A ''third-party'' evaluator is an independent and impartial program evaluator who is contracted by

Continued

(1) Articulate formative and summative evaluation questions, including important process and outcome evaluation questions. These questions must be related to the project's proposed logic model required under paragraph (b)(2)(ii);

(2) Describe how progress in and fidelity of implementation, as well as project outcomes, will be measured to answer the evaluation questions. Specify the measures and associated instruments or sources for data appropriate to the evaluation questions. Include information regarding reliability and validity of measures where appropriate;

(3) Describe strategies for analyzing data and how data collected as part of this plan will be used to inform and improve service delivery over the course of the project and to refine the proposed logic model and evaluation plan, including subsequent data collection;

(4) Provide a timeline for conducting the evaluation and include staff assignments for completing the plan. The timeline must indicate that the data will be available annually for the Annual Performance Report (APR) and at the end of Year 2; and

(5) Dedicate sufficient funds in each budget year to cover the costs of developing or refining the evaluation plan in consultation with a third-party evaluator, as well as the costs associated with the implementation of the evaluation plan by the third-party evaluator.

(d) Describe, in the narrative section of the application under ''Adequacy of resources,'' how—

(1) The project will make positive efforts to employ and advance in employment qualified individuals with disabilities;

(2) The applicant and any key partners have adequate resources to carry out the proposed activities; and

(3) The proposed costs are reasonable in relation to the anticipated results and benefits, and funds will be spent in a way that increases their efficiency and cost-effectiveness, including by reducing waste or achieving better outcomes.

(e) Describe, in the narrative section of the application under ''Quality of the management plan,'' how—

(1) The proposed management plan will ensure that the project's intended outcomes will be achieved on time and within budget. To address this requirement, the applicant must describe—

(i) Clearly defined responsibilities for key project personnel, consultants, and subcontractors, as applicable; and

(ii) Timelines and milestones for accomplishing the project tasks;

(2) Key project personnel and any consultants and subcontractors will be allocated and how these allocations are appropriate and adequate to achieve the project's intended outcomes;

(3) The proposed key project personnel, consultants, and subcontractors have the qualifications and experience to carry out the proposed activities and achieve the project's intended outcomes; and

(4) The proposed management plan will ensure that the products and services provided are of high quality, relevant, and useful to recipients.

(f) Address the following application requirements. The applicant must—

(1) Include, in Appendix A, personnel-loading charts and timelines, as applicable, to illustrate the management plan described in the narrative;

(2) Include, in the budget, attendance at the following:

(i) A one and one-half day kick-off meeting in Washington, DC, after receipt of the award, and an annual planning meeting in Washington, DC, with the OSEP project officer and other relevant staff during each subsequent year of the project period.

Note: Within 30 days of receipt of the award, a post-award teleconference must be held between the OSEP project officer and the grantee's project director or other authorized representative;

(ii) A three-day project directors' conference in Washington, DC, during each year of the project periods, provided that, if the meeting is conducted virtually, the project must reallocate unused travel funds no later than the end of the third quarter of each budget period;

(iii) Three annual two-day trips to attend Department briefings, Department-sponsored conferences, and other meetings, as requested by OSEP; and

(3) Include, in the budget, a line item for an annual set-aside of five percent of the grant amount to support emerging needs that are consistent with the proposed project's intended outcomes, as those needs are identified in consultation with, and approved by, the OSEP project officer. With approval from the OSEP project officer, the project must reallocate any remaining funds from this annual set-aside no later than the end of the third quarter of each budget period;

(4) Provide an assurance that it will maintain a high-quality website, with an easy-to-navigate design, that meets government or industry-recognized standards for accessibility;

(5) Include, in Appendix A, an assurance to assist OSEP with the transfer of pertinent resources and products and to maintain the continuity of services to States during the transition to a new award at the end of this award period, as appropriate; and

(6) Budget at least 50 percent of the grant award, in years three through five, for providing targeted and intensive TA to States.

Types of Priorities

When inviting applications for a competition using one or more priorities, we designate the type of each priority as absolute, competitive preference, or invitational through a notice in the **Federal Register**. The effect of each type of priority follows:

Absolute priority: Under an absolute priority, we consider only applications that meet the priority (34 CFR 75.105(c)(3)).

Competitive preference priority: Under a competitive preference priority, we give competitive preference to an application by (1) awarding additional points, depending on the extent to which the application meets the priority (34 CFR 75.105(c)(2)(i)); or (2) selecting an application that meets the priority over an application of comparable merit that does not meet the priority (34 CFR 75.105(c)(2)(ii)).

Invitational priority: Under an invitational priority, we are particularly interested in applications that meet the priority. However, we do not give an application that meets the priority a preference over other applications (34 CFR 75.105(c)(1)).

This document does not preclude us from proposing additional priorities, subject to meeting applicable rulemaking requirements.

Note: This document does *not* solicit applications. In any year in which we choose to use this priority, we invite applications through a notice in the **Federal Register**.

Executive Orders 12866, 13563, and 14192

Regulatory Impact Analysis

Under Executive Order 12866, the Office of Management and Budget (OMB) must determine whether this regulatory action is ''significant'' and, therefore, subject to the requirements of the Executive order and subject to review by OMB. Section 3(f) of Executive Order 12866 defines a

the grantee to conduct an objective evaluation of the project. This evaluator must not have participated in the development or implementation of any project activities, except for the evaluation activities, nor have any financial interest in the outcome of the evaluation.

''significant regulatory action'' as an action likely to result in a rule that may—

(1) Have an annual effect on the economy of $200 million or more (adjusted every three years by the Administrator of Office of Information and Regulatory Affairs (OIRA) for changes in gross domestic product); 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 entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or

(4) Raise legal or policy issues for which centralized review would meaningfully further the President's priorities, or the principles set forth in the Executive order, as specifically authorized in a timely manner by the Administrator of OIRA in each case.

This final regulatory action is not a significant regulatory action subject to review by OMB under section 3(f) of Executive Order 12866. Pursuant to the Congressional Review Act (5 U.S.C. 801 *et seq.*), OIRA designated this rule as not a ''major rule,'' as defined by 5 U.S.C. 804(2).

Since this regulatory action is not a significant regulatory action under section 3(f) of Executive Order 12866, it is not considered an ''Executive Order 14192 regulatory action.''

We have also reviewed this final regulatory action under Executive Order 13563, which supplements and explicitly reaffirms the principles, structures, and definitions governing regulatory review established in Executive Order 12866. To the extent permitted by law, Executive Order 13563 requires that an agency—

(1) Propose or adopt regulations only upon a reasoned determination that their benefits justify their costs (recognizing that some benefits and costs are difficult to quantify);

(2) Tailor its regulations to impose the least burden on society, consistent with obtaining regulatory objectives and taking into account—among other things and to the extent practicable—the costs of cumulative regulations;

(3) In choosing among alternative regulatory approaches, select those approaches that maximize net benefits (including potential economic, environmental, public health and safety, and other advantages; and distributive impacts);

(4) To the extent feasible, specify performance objectives, rather than the behavior or manner of compliance a regulated entity must adopt; and

(5) Identify and assess available alternatives to direct regulation, including economic incentives—such as user fees or marketable permits—to encourage the desired behavior, or provide information that enables the public to make choices.

Executive Order 13563 also requires an agency ''to use the best available techniques to quantify anticipated present and future benefits and costs as accurately as possible.'' The OIRA of OMB has emphasized that these techniques may include ''identifying changing future compliance costs that might result from technological innovation or anticipated behavioral changes.''

We are issuing the final priority only on a reasoned determination that their benefits justify the costs. In choosing among alternative regulatory approaches, we selected those approaches that maximize net benefits. Based on the analysis that follows, the Department believes that this regulatory action is consistent with the principles in Executive Order 13563.

We also have determined that this regulatory action does not unduly interfere with State, local, and Tribal governments in the exercise of their governmental functions.

In accordance with these Executive orders, the Department has assessed the potential costs and benefits, both quantitative and qualitative, of this regulatory action. The potential costs are those resulting from statutory requirements and those we have determined as necessary for administering the Department's programs and activities.

Discussion of Potential Costs and Benefits

The Department believes that this regulatory action does not impose significant costs on eligible entities, whose participation in this program is voluntary. While this action does impose some requirements on participating grantees that are cost-bearing, the Department expects that applicants for this program will include in their proposed budgets a request for funds to support compliance with such cost-bearing requirements. Therefore, costs associated with meeting these requirements are, in the Department's estimation, minimal.

The Department believes that these benefits to the Federal government outweigh the costs associated with this action.

Paperwork Reduction Act of 1995

The final priority contains information collection requirements that are approved by OMB under OMB control number 1820–0028; the final priority does not affect the currently approved data collection.

Regulatory Flexibility Act Certification: The Secretary certifies that this final regulatory action will not have a significant economic impact on a substantial number of small entities.

The small entities that this final regulatory action will affect are LEAs, including charter schools that operate as LEAs under State law; institutions of higher education; other public agencies; private nonprofit organizations; freely associated States and outlying areas; Indian Tribes or Tribal organizations; and for-profit organizations. We believe that the costs imposed on an applicant by the final priority will be limited to paperwork burden related to preparing an application and that the benefits will outweigh any costs incurred by applicants.

Participation in the Technical Assistance on State Data Collection program is voluntary. For this reason, the final priority imposes no burden on small entities unless they applied for funding under the program. We expect that in determining whether to apply for Technical Assistance on State Data Collection program funds, an eligible entity will evaluate the requirements of preparing an application and any associated costs and weigh them against the benefits likely to be achieved by receiving a Technical Assistance on State Data Collection program grant. An eligible entity will apply only if it determines that the likely benefits exceed the costs of preparing an application.

We believe that the final priority will not impose any additional burden on a small entity applying for a grant than the entity would face in the absence of the proposed action. That is, the length of the applications those entities would submit in the absence of this final regulatory action and the time needed to prepare an application would likely be the same.

This final regulatory action would not have a significant economic impact on a small entity once it receives a grant because it will be able to meet the costs of compliance using the funds provided under this program.

Intergovernmental Review: This program is subject to Executive Order 12372 and the regulations in 34 CFR part 79. One of the objectives of the Executive order is to foster an intergovernmental partnership and a

strengthened federalism. The Executive order relies on processes developed by State and local governments for coordination and review of proposed Federal financial assistance.

This document provides early notification of our specific plans and actions for this program.

Accessible Format: On request to the program contact person listed under **FOR FURTHER INFORMATION CONTACT**, individuals with disabilities can obtain this document in an accessible format. The Department will provide the requestor with an accessible format that may include Rich Text Format (RTF) or text format (txt), a thumb drive, an MP3 file, braille, large print, audiotape, compact disc, or other accessible format.

Electronic Access to This Document: The official version of this document is the document published in the **Federal Register**. You may access the official edition of the **Federal Register** and the Code of Federal Regulations at *www.govinfo.gov.* At this site you can view this document, as well as all other Department documents published in the **Federal Register**, in text or Portable Document Format (PDF). To use PDF you must have Adobe Acrobat Reader, which is available free at the site.

You may also access Department documents published in the **Federal Register** by using the article search feature at *www.federalregister.gov.* Specifically, through the advanced search feature at this site, you can limit your search to documents published by the Department.

Diana Diaz,

Deputy Assistant Secretary and Acting Assistant Secretary for Special Education and Rehabilitative Services.

[FR Doc. 2025–11608 Filed 6–24–25; 8:45 am]

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DEPARTMENT OF EDUCATION

34 CFR Chapter III

[Docket ID ED–2024–OSERS–0144]

Technical Assistance on State Data Collection—National Technical Assistance Center To Improve State Capacity To Collect, Report, Analyze, and Use Accurate IDEA Part B and Part C Fiscal Data

AGENCY: Office of Special Education and Rehabilitative Services, Department of Education.

ACTION: Final priority.

SUMMARY: The Department of Education (Department) announces the priority for the National Technical Assistance Center to Improve State Capacity to Collect, Report, Analyze, and Use Accurate IDEA Part B and Part C Fiscal Data Center (Fiscal Data Center) under the Technical Assistance on State Data Collection program. The Department may use this priority for competitions in fiscal year (FY) 2025 and later years. This priority replaces the priority published in the **Federal Register** on August 11, 2014, and the priority published on June 16, 2020. We will use the priority to award a cooperative agreement for a Center to provide technical assistance (TA) to improve the capacity of States to meet the fiscal data collection requirements under Part B and Part C of the Individuals with Disabilities Education Act (IDEA). This Fiscal Data Center will support States in collecting, reporting, and determining how to best analyze and use their IDEA Part B and Part C fiscal data to establish and meet high expectations for each child with a disability and will customize its TA to meet each State's specific needs.

DATES: The priority is effective July 25, 2025.

FOR FURTHER INFORMATION CONTACT: Charles D. Kniseley, U.S. Department of Education, 400 Maryland Avenue SW, Room 4A127, Washington, DC 20202. Telephone: (202) 245–6313. Email: *Charles.Kniseley@ed.gov.*

If you are deaf, hard of hearing, or have a speech disability and wish to access telecommunications relay services, please dial 7–1–1.

SUPPLEMENTARY INFORMATION:

Purpose of Program: The purpose of the Technical Assistance on State Data Collection program is to improve the capacity of States to meet IDEA data collection and reporting requirements. Funding for the program is authorized under section 611(c)(1) of IDEA, which gives the Secretary authority to reserve not more than one-half of one percent of the amounts appropriated under Part B for each fiscal year to provide TA activities, where needed, to improve the capacity of States to meet the data collection and reporting requirements under Parts B and C of IDEA. The maximum amount the Secretary may reserve under this set-aside for any fiscal year is $25,000,000, cumulatively adjusted by the rate of inflation. Section 616(i) of IDEA requires the Secretary to review the data collection and analysis capacity of States to ensure that data and information determined necessary for implementation of sections 616 and 642 of IDEA are collected, analyzed, and accurately reported to the Secretary. It also requires the Secretary to provide TA, where needed, to improve the capacity of States to meet the data collection requirements, which include the data collection and reporting requirements in sections 616 and 618 of IDEA. In addition, the Further Consolidated Appropriations Act, 2024, Public Law 118–47, gives the Secretary authority to use funds reserved under section 611(c) of IDEA to ''administer and carry out other services and activities to improve data collection, coordination, quality, and use under Parts B and C of the IDEA.'' Further Consolidated Appropriations Act, 2024, Public Law 118–47, Division D, Title III, 138 Stat. 460, 685 (2024).

Assistance Listing Number: 84.373F.

Program Authority: 20 U.S.C. 1411(c), 1416(i), 1418(c), 1418(d), 1442, 1482; Further Consolidated Appropriations Act, 2024, Public Law 118–47, Div. D, Title III, 138 Stat. 460, 685 (2024).

Applicable Program Regulations: 34 CFR 300.702.

We published a notice of proposed priority (NPP) for this program in the **Federal Register** on January 21, 2025 (90 FR 6915). That document contained background information and our reasons for proposing the priority.

There are differences between the NPP and this notice of final priority (NFP) as discussed in the *Analysis of Comments and Changes* section of this document. The most significant change, as discussed below, is the removal of the requirement that the Center specifically engage underserved families to support the development of products and services.

Public Comment: In response to our invitation in the NPP, three parties submitted comments addressing the proposed priority. We received two additional comments unrelated to the priority.

Generally, we do not address technical and other minor changes, or suggested changes the law does not authorize us to make under the applicable statutory authority. In addition, we do not address general comments that raised concerns not directly related to the proposed priority.

Analysis of Comments and Changes: An analysis of the comments and of any changes in the priority since publication of the NPP follows.

General Comments

Comments: Two commenters expressed support for the proposed Center, and one specifically referenced the benefits that members of its association have received from the current Center and agreed with the priority's support to States. Further, the commentor identified the need for the Center due to changes related to Federal fiscal requirements that impact the

fiscal data States must submit to the Department, as well as changes in lead agency or shifting lead agency responsibility under IDEA Part C to reorganize their early childhood programs and create offices that serve children birth through five. No changes were requested.

Discussion: The Department appreciates the comments and agrees with the commenters that the Center funded under this program will provide necessary and valuable TA to States to improve the capacity of States to meet their IDEA fiscal data collection, analysis, and reporting requirements.

Changes: None.

Individuals To Be Served

Comments: One commenter indicated that the proposed Center should serve all constituents fairly, as opposed to focusing on a target population.

Discussion: The Department agrees that the proposed Center should focus on providing services to all States and that TA should focus on meeting the needs of all constituents in the State.

Changes: The Department has clarified that the Center should focus on meeting the needs of all constituents in a State by removing the requirement that the Center specifically engage underserved families to support the development of products and services.

Alignment With Selection Criteria

Comment: None.

Discussion: In using this priority in a notice inviting applications, the priority's reference to selection criteria should align with the selection criteria being used.

Changes: We are revising the selection criteria headings with the priority by removing ''Quality of project services'' and ''Quality of the project personnel'' and replacing with ''Quality of the project design'' and just ''Adequacy of resources.'' We are also revising application and administrative requirements to align with the actual factors being used under ''Adequacy of resources'' and ''Quality of the management plan'' in the notice inviting applications.

Final Priority

National Technical Assistance Center to Improve State Capacity to Collect, Report, Analyze, and Use Accurate IDEA Part B and Part C Fiscal Data.

Priority

The purpose of this priority is to fund a cooperative agreement to establish and operate the National Technical Assistance Center to Improve State Capacity to Collect, Report, Analyze, and Use Accurate IDEA Part B and Part C Fiscal Data (Fiscal Data Center).

The Fiscal Data Center will provide TA to improve the capacity of States to meet the IDEA Part B and Part C fiscal data collection requirements under IDEA sections 618 and 642 and increase States' knowledge of the underlying IDEA fiscal requirements and calculations necessary to submit valid and reliable data for the following collections: (1) Maintenance of State Financial Support (MFS) in Section V of the IDEA Part B Annual State Application; (2) Local Educational Agency (LEA) Maintenance of Effort (MOE) Reduction and Coordinated Early Intervening Services (CEIS); (3) Description of Use of IDEA Part B Section 611 Funds reserved for State administration and other State-level activities in Section III of the IDEA Part B Annual State Application; (4) Description of Use of Federal IDEA Part C Funds for the Lead Agency (LA) and the Interagency Coordinating Council in Section III of the IDEA Part C Annual State Application; (5) IDEA Part C MOE requirements; (6) Restricted Indirect Cost Rate/Cost Allocation Plan Information in Sections III and IV of the IDEA Part C Annual State Application; and (7) Part C Subgranting, in Section III.F. of the Part C Annual State Application.

The Fiscal Data Center must be designed to achieve, at a minimum, the following expected outcomes:

(a) Increased capacity of States to collect, report, analyze, and use high-quality IDEA Part B and Part C fiscal data;

(b) Increased capacity of States to accurately perform calculations related to IDEA Part B and Part C statutory and regulatory fiscal requirements, and submit valid and reliable fiscal data under IDEA Part B and Part C;

(c) Improved State fiscal infrastructure to communicate and coordinate effective IDEA Part B and Part C fiscal data collections and reporting strategies among relevant State offices, including State educational agencies (SEAs), LAs and other State agencies, LEAs, schools, public charter schools that are LEAs, and early intervention services (EIS) programs or providers;

(d) Increased capacity of States to submit accurate and timely IDEA Part B and Part C fiscal data, and enhance State validation procedures to prevent errors in State-reported IDEA data;

(e) Increased capacity of States to train personnel to meet the IDEA Part B and Part C fiscal data collection and reporting requirements under sections 616, 618, and 642 of IDEA; and

(f) Increased capacity of SEAs and LAs to work with LEAs, including public charter schools that are LEAs, and EIS programs or providers to analyze and use IDEA fiscal data to identify issues and address those issues through monitoring, TA, and partner involvement.

In addition to these program requirements, to be considered for funding under this priority, applicants must meet the application and administrative requirements in this priority, which are:

(a) Describe, in the narrative section of the application under ''Significance,'' how the proposed project will—

(1) Address the current and emerging needs of States and local systems to collect, report, analyze, and use high-quality IDEA Part B and Part C fiscal data. To meet this requirement, the applicant must—

(i) Demonstrate knowledge of how SEAs, LAs, LEAs, including public charter schools that are LEAs, and EIS programs and providers are meeting IDEA Part B and Part C fiscal data collection and reporting requirements and the underlying statutory and regulatory fiscal requirements, as well as knowledge of State and local data collection systems, as appropriate; and

(ii) Present applicable national, State, and local data to show the current capacity needs of SEAs, LAs, LEAs, including public charter schools that are LEAs, and EIS programs and providers to meet IDEA Part B and Part C fiscal data collection and reporting requirements; and

(2) Improve how SEAs and LAs use IDEA section 618 fiscal data as a means of both improving data quality and identifying programmatic strengths and areas for improvement, and indicate the likely magnitude or importance of the improvements.

(b) Describe, in the narrative section of the application under ''Quality of the project design,'' how the proposed project will—

(1) Achieve its goals, objectives, and intended outcomes. To meet this requirement, the applicant must provide—

(i) Measurable intended project outcomes; and

(ii) In Appendix A, the logic model (as defined in 34 CFR 77.1) by which the proposed project will achieve its intended outcomes that depicts, at a minimum, the goals, activities, outputs, and intended outcomes of the proposed project;

(2) Use a conceptual framework (and provide a copy in Appendix A) to develop project plans and activities, describing any underlying concepts,

assumptions, expectations, beliefs, or theories, as well as the presumed relationships or linkages among these variables, and any empirical support for this framework;

(3) Be based on current research and make use of evidence-based [1] practices (EBPs). To meet this requirement, the applicant must describe—

(i) The current research on the capacity of SEAs, LEAs, including public charter schools that are LEAs, LAs, and EIS providers to report and use IDEA Part B and Part C data submitted under section 616 and section 618, as a means of both improving data quality and identifying strengths and areas for improvement; and

(ii) How the proposed project will incorporate current research and EBPs in the development and delivery of its products and services;

(4) Develop products and provide services that are of high quality and sufficient intensity and duration to achieve the intended outcomes of the proposed project. To address this requirement, the applicant must describe—

(i) How it proposes to expand the knowledge base for States on—

(A) Fiscal data management and data system integration needed for IDEA Part B and Part C data collection and reporting;

(B) IDEA fiscal data validation that leads to improvements in the validity and reliability of fiscal data required by IDEA; and

(C) Effective ways to communicate fiscal data to local consumers (*e.g.,* parents, LEAs, including public charter schools that are LEAs, EIS programs or providers, the general public);

(ii) Its proposed approach to universal, general TA,[2] which must describe—

(A) The intended recipients, including the type and number of recipients, that will receive the products and services;

(B) The products and services that the project proposes to make available;

(C) The development and maintenance of a high-quality website, with an easy-to-navigate design, that meets or exceeds government- or industry-recognized standards for accessibility; and

(D) The expected reach and impact of universal, general TA;

(iii) Its proposed approach to targeted, specialized TA,[3] which must describe—

(A) The intended recipients, including the type and number of recipients, that will receive the products and services;

(B) The products and services that the project proposes to make available; and

(C) The proposed approach to measure the readiness of potential TA recipients to work with the project, including, at a minimum, an assessment of potential recipients' current infrastructure, available resources, and ability to build capacity at the local level; and

(iv) Its proposed approach to intensive, sustained TA,[4] which must describe—

(A) The intended recipients, including the type and number of recipients from a variety of settings and geographic distribution, that will receive the products and services;

(B) Its proposed approach to addressing States' challenges reporting high-quality IDEA fiscal data to the Department and the public, which should, at a minimum, include providing virtual and on-site consultation to the SEA or LA to—

(*1*) Implement model practices for the management of IDEA data and data system integration policies, procedures, processes, and activities within the State;

(*2*) Develop, use, or adapt tools to meet State-specific IDEA data needs;

(*3*) Develop a sustainability plan for the State to continue the management of IDEA data and data system integration work in the future; and

(*4*) Implement a cybersecurity plan to ensure a secure IDEA fiscal data system;

(C) Its proposed approach to measure the readiness of SEAs and LAs to work with the project, including their commitment to the initiative, alignment of the initiative to their needs, current infrastructure, available resources, and ability to build capacity at the State and local levels;

(D) Its proposed plan to prioritize States with the greatest need for intensive TA to receive products and services;

(E) Its proposed plan for assisting SEAs and LAs to build or enhance training systems that include professional development based on adult learning principles and coaching;

(F) Its proposed plan for working with appropriate levels of the education system (*e.g.,* SEAs, LAs, regional TA providers, LEAs, including public charter schools that are LEAs, local EIS programs and providers, and families) to ensure that there is communication between each level and that there are systems in place to support the collection, reporting, analysis, and use of high-quality IDEA fiscal data as well as IDEA fiscal data management and data system integration; and

(G) The expected impact of intensive, sustained TA; and

(v) How the proposed project will intentionally engage families of children with disabilities and individuals with disabilities in the development, implementation, and evaluation of its products and services across all levels of TA;

(5) Develop products and implement services that maximize efficiency. To address this requirement, the applicant must describe—

(i) How the proposed project will use technology to achieve the intended project outcomes;

(ii) With whom the proposed project will collaborate and the intended outcomes of this collaboration, including the process by which the proposed project will collaborate with Department-funded centers (including privacy TA centers such as the DaSy Center that provides Department-funded TA on early childhood data privacy, and the Privacy Technical Assistance Center) and other federally funded TA centers to develop and implement a coordinated TA plan when they are involved in a State; and

(iii) How the proposed project will use non-project resources, such as non-Federal funds and in-kind contributions, to achieve the intended project outcomes; and

[1] For purposes of these requirements,''evidence-based'' means the proposed project component is supported by one or more of strong evidence, moderate evidence, promising evidence, or evidence that demonstrates a rationale (as such terms are defined in 34 CFR 77.1).

[2] ''Universal, general TA'' means TA and information provided to independent users through their own initiative, resulting in minimal interaction with TA center staff and including one-time, invited or offered conference presentations by TA center staff. This category of TA also includes information or products, such as newsletters, guidebooks, or research syntheses, downloaded from the TA center's website by independent users. Brief communications by TA center staff with recipients, either by telephone or email, are also considered universal, general TA.

[3] ''Targeted, specialized TA'' means TA services based on needs common to multiple recipients and not extensively individualized. A relationship is established between the TA recipient and one or more TA center staff. This category of TA includes one-time, labor-intensive events, such as facilitating strategic planning or hosting regional or national conferences. It can also include episodic, less labor-intensive events that extend over a period of time, such as facilitating a series of conference calls on single or multiple topics that are designed around the needs of the recipients. Facilitating communities of practice can also be considered targeted, specialized TA.

[4] ''Intensive, sustained TA'' means TA services often provided on-site and requiring a stable, ongoing relationship between the TA center staff and the TA recipient. ''TA services'' are defined as negotiated series of activities designed to reach a valued outcome. This category of TA should result in changes to policy, program, practice, or operations that support increased recipient capacity or improved outcomes at one or more systems levels.

(6) Systematically disseminate information, products, and services to varied intended audiences. To address this requirement the applicant must describe—

(i) The variety of dissemination strategies the project will use throughout the five years of the project to promote awareness and use of its products and services;

(ii) How the project will tailor dissemination strategies across all planned levels of TA to ensure that products and services reach intended recipients, and those recipients can access and use those products and services;

(iii) How the project's dissemination plan is connected to the proposed outcomes of the project; and

(iv) How the project will evaluate and correct all digital products and external communications to ensure they meet or exceed government or industry-recognized standards for accessibility.

(c) In the narrative section of the application under ''Quality of the project evaluation or other evidence-building,'' describe how the project will develop an evaluation plan in consultation with, and to be implemented by, a third-party evaluator.[5] The evaluation plan must—

(1) Articulate formative and summative evaluation questions, including important process and outcome evaluation questions. These questions must be related to the project's proposed logic model required in paragraph (b)(1)(ii) of these application and administrative requirements;

(2) Describe how progress in and fidelity of implementation, as well as project outcomes will be measured to answer the evaluation questions. In measuring progress of implementation across all levels of TA, the plan must include criteria for determining the extent to which the project's products and services reached intended recipients; data, including feedback from recipients, on how recipients used the products and services; and the impact of the products and services. The plan must also specify sources for data, and measures and instruments appropriate to the evaluation questions, including information on reliability and validity of the measures and associated instruments where appropriate;

(3) Describe strategies for analyzing data and how data collected as part of this plan will be used to inform and improve service delivery over the course of the project and to refine the proposed logic model and evaluation plan, including subsequent data collection;

(4) Provide a timeline for conducting the evaluation, and include staff assignments for completing the plan. The timeline must indicate that the data will be available annually for the annual performance report and at the end of Year 2; and

(5) Dedicate sufficient funds in each budget year to cover the costs of developing or refining the evaluation plan in consultation with a third-party evaluator, as well as the costs associated with the implementation of the evaluation plan by the third-party evaluator.

(d) Describe, in the narrative section of the application under ''Adequacy of resources,'' how—

(1) The project will make positive efforts to employ and advance in employment qualified individuals with disabilities;

(2) The applicant and any key partners have adequate resources to carry out the proposed activities;

(3) The proposed project will have processes, resources, and funds in place to provide access for project staff, contractors, and partners, who require digital accessibility accommodations;[6] and

(4) The proposed costs are reasonable in relation to the anticipated results and benefits, and funds will be spent in a way that increases their efficiency and cost-effectiveness.

(e) Describe, in the narrative section of the application under ''Quality of the management plan,''—

(1) How the proposed management plan will ensure that the project's intended outcomes will be achieved on time and within budget. To address this requirement, the applicant must describe—

(i) Clearly defined responsibilities for key project personnel, consultants, and subcontractors, as applicable; and

(ii) Timelines and milestones for accomplishing the project tasks;

(2) Allocations of key project personnel and any consultants and subcontractors and how these allocations are appropriate and adequate to achieve the project's intended outcomes;

(3) How the proposed key project personnel, consultants, and subcontractors have the qualifications and experience to carry out the proposed activities and achieve the project's intended outcomes;

(4) How the proposed management plan will ensure that the products and services provided are of high quality, relevant, and useful to recipients; and

(5) How the proposed project will benefit from a variety of perspectives, including those of families, educators, TA providers, researchers, and policy makers, among others, in its development and operation.

(f) Address the following application requirements. The applicant must—

(1) Include, in Appendix A, personnel-loading charts and timelines, as applicable, to illustrate the management plan described in the narrative;

(2) Include, in the budget, attendance at the following:

(i) A one and one-half day kick-off meeting in Washington, DC, after receipt of the award, and an annual planning meeting in Washington, DC, with the Office of Special Education Program (OSEP) project officer and other relevant staff during each subsequent year of the project period.

Note: Within 30 days of receipt of the award, a post-award teleconference must be held between the OSEP project officer and the grantee's project director or other authorized representative;

(ii) A three-day project directors' conference in Washington, DC, during each year of the project period, provided that, if the conference is conducted virtually, the project must reallocate unused travel funds no later than the end of the third quarter of each budget period; and

(iii) Three annual two-day trips to attend Department briefings, Department-sponsored conferences, and other meetings, as requested by OSEP;

(3) Include, in the budget, a line item for an annual set-aside of five percent of the grant amount to support emerging needs that are consistent with the proposed project's intended outcomes, as those needs are identified in consultation with, and approved by, the OSEP project officer. With approval from the OSEP project officer, the project must reallocate any remaining funds from this annual set-aside no later than the end of the third quarter of each budget period;

(4) Budget at least 50 percent of the grant award for providing targeted and intensive TA to States; and

(5) Include, in Appendix A, an assurance to assist OSEP with the transfer of pertinent resources and products and to maintain the continuity of services to States during the

[5] A ''third-party'' evaluator is an independent and impartial program evaluator who is contracted by the grantee to conduct an objective evaluation of the project. This evaluator must not have participated in the development or implementation of any project activities, except for the evaluation activities, or have any financial interest in the outcome of the evaluation.

[6] For information about digital accessibility and accessibility standards from Section 508 of the Rehabilitation Act, visit *https://sites.ed.gov/idea/topic-areas/#Accessibility-Creating-Content.*

transition to these new award period and at the end of this award period, as appropriate.

Types of Priorities

When inviting applications for a competition using one or more priorities, we designate the type of each priority as absolute, competitive preference, or invitational through a notice in the **Federal Register**. The effect of each type of priority follows:

Absolute priority: Under an absolute priority, we consider only applications that meet the priority (34 CFR 75.105(c)(3)).

Competitive preference priority: Under a competitive preference priority, we give competitive preference to an application by (1) awarding additional points, depending on the extent to which the application meets the priority (34 CFR 75.105(c)(2)(i)); or (2) selecting an application that meets the priority over an application of comparable merit that does not meet the priority (34 CFR 75.105(c)(2)(ii)).

Invitational priority: Under an invitational priority, we are particularly interested in applications that meet the priority. However, we do not give an application that meets the priority a preference over other applications (34 CFR 75.105(c)(1)).

This document does not preclude us from proposing additional priorities, subject to meeting applicable rulemaking requirements.

Note: This document does *not* solicit applications. In any year in which we choose to use this priority, we invite applications through a notice in the **Federal Register**.

Executive Orders 12866, 13563, and 14192

Regulatory Impact Analysis

Under Executive Order 12866, the Office of Management and Budget (OMB) must determine whether this regulatory action is ''significant'' and, therefore, subject to the requirements of the Executive order and subject to review by OMB. Section 3(f) of Executive Order 12866 defines a ''significant regulatory action'' as an action likely to result in a rule that may—

(1) Have an annual effect on the economy of $200 million or more (adjusted every three years by the Administrator of Office of Information and Regulatory Affairs (OIRA) for changes in gross domestic product); 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 entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or

(4) Raise legal or policy issues for which centralized review would meaningfully further the President's priorities, or the principles set forth in the Executive order, as specifically authorized in a timely manner by the Administrator of OIRA in each case.

This final regulatory action is not a significant regulatory action subject to review by OMB under section 3(f) of Executive Order. Pursuant to the Congressional Review Act (5 U.S.C. 801 *et seq.*), the Office of Information and Regulatory Affairs designated this rule as not a ''major rule,'' as defined by 5 U.S.C. 804(2).

Since this regulatory action is not a significant regulatory action under section 3(f) of Executive Order 12866, it is not considered an ''Executive Order 14192 regulatory action.''

We have also reviewed this final regulatory action under Executive Order 13563, which supplements and explicitly reaffirms the principles, structures, and definitions governing regulatory review established in Executive Order 12866. To the extent permitted by law, Executive Order 13563 requires that an agency—

(1) Propose or adopt regulations only upon a reasoned determination that their benefits justify their costs (recognizing that some benefits and costs are difficult to quantify);

(2) Tailor its regulations to impose the least burden on society, consistent with obtaining regulatory objectives and taking into account—among other things and to the extent practicable—the costs of cumulative regulations;

(3) In choosing among alternative regulatory approaches, select those approaches that maximize net benefits (including potential economic, environmental, public health and safety, and other advantages; distributive impacts; and equity);

(4) To the extent feasible, specify performance objectives, rather than the behavior or manner of compliance a regulated entity must adopt; and

(5) Identify and assess available alternatives to direct regulation, including economic incentives—such as user fees or marketable permits—to encourage the desired behavior, or provide information that enables the public to make choices.

Executive Order 13563 also requires an agency ''to use the best available techniques to quantify anticipated present and future benefits and costs as accurately as possible.'' The Office of Information and Regulatory Affairs of OMB has emphasized that these techniques may include ''identifying changing future compliance costs that might result from technological innovation or anticipated behavioral changes.''

We are issuing the final priority only on a reasoned determination that their benefits justify the costs. In choosing among alternative regulatory approaches, we selected those approaches that maximize net benefits. Based on the analysis that follows, the Department believes that this regulatory action is consistent with the principles in Executive Order 13563.

We also have determined that this regulatory action does not unduly interfere with State, local, and Tribal governments in the exercise of their governmental functions.

In accordance with these Executive orders, the Department has assessed the potential costs and benefits, both quantitative and qualitative, of this regulatory action. The potential costs are those resulting from statutory requirements and those we have determined as necessary for administering the Department's programs and activities.

Discussion of Potential Costs and Benefits

The Department believes that this regulatory action does not impose significant costs on eligible entities, whose participation in this program is voluntary. While this action does impose some requirements on participating grantees that are cost-bearing, the Department expects that applicants for this program will include in their proposed budgets a request for funds to support compliance with such cost-bearing requirements. Therefore, costs associated with meeting these requirements are, in the Department's estimation, minimal.

The Department believes that these benefits to the Federal government outweigh the costs associated with this action.

Paperwork Reduction Act of 1995

The final priority contains information collection requirements that are approved by OMB under OMB control number 1820–0028. The final priority does not affect the currently approved data collection.

Regulatory Flexibility Act Certification: The Secretary certifies that

this final regulatory action will not have a significant economic impact on a substantial number of small entities. The small entities that this final regulatory action will affect are LEAs, including charter schools that operate as LEAs under State law; institutions of higher education; other public agencies; private nonprofit organizations; freely associated States and outlying areas; Indian Tribes or Tribal organizations; and for-profit organizations. We believe that the costs imposed on an applicant by the final priority will be limited to paperwork burden related to preparing an application and that the benefits will outweigh any costs incurred by applicants.

Participation in the Technical Assistance on State Data Collection program is voluntary. For this reason, the final priority imposes no burden on small entities unless they applied for funding under the program. We expect that in determining whether to apply for Technical Assistance on State Data Collection program funds, an eligible entity will evaluate the requirements of preparing an application and any associated costs and weigh them against the benefits likely to be achieved by receiving a Technical Assistance on State Data Collection program grant. An eligible entity will apply only if it determines that the likely benefits exceed the costs of preparing an application.

We believe that the final priority will not impose any additional burden on a small entity applying for a grant than the entity would face in the absence of the proposed action. That is, the length of the applications those entities would submit in the absence of this final regulatory action and the time needed to prepare an application would likely be the same.

This final regulatory action would not have a significant economic impact on a small entity once it receives a grant because it will be able to meet the costs of compliance using the funds provided under this program.

Intergovernmental Review: This program is subject to Executive Order 12372 and the regulations in 34 CFR part 79. One of the objectives of the Executive order is to foster an intergovernmental partnership and a strengthened federalism. The Executive order relies on processes developed by State and local governments for coordination and review of proposed Federal financial assistance.

This document provides early notification of our specific plans and actions for this program.

Accessible Format: On request to the program contact person listed under **FOR FURTHER INFORMATION CONTACT**, individuals with disabilities can obtain this document in an accessible format. The Department will provide the requestor with an accessible format that may include Rich Text Format (RTF) or text format (txt), a thumb drive, an MP3 file, braille, large print, audiotape, compact disc, or other accessible format.

Electronic Access to This Document: The official version of this document is the document published in the **Federal Register**. You may access the official edition of the **Federal Register** and the Code of Federal Regulations at *www.govinfo.gov.* At this site you can view this document, as well as all other Department documents published in the **Federal Register**, in text or Portable Document Format (PDF). To use PDF you must have Adobe Acrobat Reader, which is available free at the site.

You may also access Department documents published in the **Federal Register** by using the article search feature at *www.federalregister.gov.* Specifically, through the advanced search feature at this site, you can limit your search to documents published by the Department.

Diana Diaz,

Deputy Assistant Secretary and Acting Assistant Secretary for Special Education and Rehabilitative Services.

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DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 300

[Docket No. 250620–0102]

RIN 0648–BN54

Pacific Halibut Fisheries of the West Coast; Management Measures for the Area 2A Pacific Halibut Directed Commercial Fishery

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Final rule.

SUMMARY: NMFS is implementing annual management measures for the 2025 non-Tribal directed commercial Pacific halibut fishery that operates south of Point Chehalis, WA, (lat. 46°53.30′ N) in the International Pacific Halibut Commission's (IPHC) regulatory Area 2A off Washington, Oregon, and California. Annual management measures include fishing periods and fishing period limits. NMFS is also implementing modified permit deadlines for all Area 2A non-Tribal commercial fisheries and is modifying inseason action announcement procedures for the Area 2A non-Tribal directed commercial fishery. These actions are intended to conserve Pacific halibut and provide fishing opportunity where available.

DATES: This rule is effective on June 24, 2025.

FOR FURTHER INFORMATION CONTACT: Heather Fitch, West Coast Region, NMFS, (360) 867–8608, *heather.fitch@noaa.gov.*

SUPPLEMENTARY INFORMATION:

Background

The Northern Pacific Halibut Act of 1982 (16 U.S.C. 773–773k) (Halibut Act) gives the Secretary of Commerce the responsibility of implementing the provisions of the Convention between Canada and the United States for the Preservation of the Halibut Fishery of the North Pacific Ocean and Bering Sea (Convention), signed at Ottawa, Ontario, on March 2, 1953, as amended by a Protocol Amending the Convention (March 29, 1979).

As provided in the Halibut Act at 16 U.S.C. 773b, the Secretary of State, with the concurrence of the Secretary of Commerce, may accept or reject, on behalf of the United States, regulations recommended by the IPHC in accordance with the Convention. Following acceptance by the Secretary of State, the annual management measures recommended by the IPHC are published in the **Federal Register** through a NMFS rulemaking to provide notice of their immediate regulatory effectiveness and to inform persons subject to the regulations of their restrictions and requirements (50 CFR 300.62).

The Halibut Act also provides that Regional Fishery Management Councils may develop and recommend, and the Secretary of Commerce may implement, regulations governing Pacific halibut fishing in U.S. waters that are in addition to, and not in conflict with, approved IPHC regulations (16 U.S.C. 773c(c)). The Pacific Fishery Management Council (Council) developed a catch sharing plan guiding the allocation of halibut across the various sectors for the IPHC's regulatory Area 2A. The catch sharing plan is available on the Council's website at: *https://www.pcouncil.org/managed_fishery/pacific-halibut/*.

Fishery Allocation

At its annual meeting held January 27–31, 2025, the IPHC adopted an Area 2A catch limit, called a fishery constant exploitation yield (FCEY), of 1.53 million pounds (694 metric tons (mt)), net weight (*i.e.,* the weight of Pacific halibut that is without gills and entrails, head-off, washed, and without ice and slime) for 2025. The FCEY was derived from the total constant exploitation yield (TCEY) of 1.65 million pounds (748 mt), net weight, for Area 2A, which includes commercial discards and bycatch projections calculated using a formula developed by the IPHC. Based on the FCEY for Area 2A and the allocation framework in the Council's catch sharing plan, the non-Tribal directed commercial fishing allocation is 259,515 pounds (118 mt), net weight for the 2025 fishing season (90 FR 13293, March 21, 2025).

This final rule implements management measures for the 2025 directed commercial Pacific halibut fishery in Area 2A that are not part of the annual IPHC regulations. This final rule adopts, without changes, the management measures from the proposed rule published on April 8, 2025 (90 FR 15129).

Fishing Periods

Fishing periods, often referred to as fishery openers, are the time during the annual commercial Pacific halibut season when fishing for non-Tribal directed commercial Pacific halibut in Area 2A is allowed. This action implements two fishing periods. The first 58-hour fishing period for the 2025 directed commercial fishery will begin on June 24, 2025, at 8 a.m. PDT and close on June 26, 2025, at 6 p.m. PDT. The second fishing period will occur 2 weeks later, beginning on July 8, 2025, at 8 a.m. PDT and closing on July 10, 2025, at 6 p.m. PDT. If another fishing period is necessary to attain the allocation, NMFS intends to open a third fishing period on July 22, 2025 at 8 a.m. PDT and closing on July 24, 2025 at 6 p.m. PDT, through inseason action. If subsequent fishing periods are necessary to reach the allocation, NMFS intends to have them follow the same pattern, occurring 2 weeks after the previous fishing period (beginning on August 5, August 12, *etc.*), as announced by inseason action. If it is determined that additional fishing periods are warranted, and if for any reason a fishing period cannot be scheduled on this two-week schedule, NMFS intends to skip a fishing period in order to follow the outlined every two-week schedule. NMFS will use email addresses obtained from 2025 Pacific halibut directed commercial fishery permit applications for email notice of inseason actions. Fishing periods may be added inseason consistent with 50 CFR 300.63(e)(1)(iii).

Fishing Period Limits

A fishing period limit, also called a vessel catch limit, is the maximum amount of Pacific halibut that may be retained and landed by a vessel during one fishing period. Each vessel may retain no more than the fishing period limit of Pacific halibut for its vessel class, which is determined by vessel length. NMFS is implementing the directed commercial fishing period limits, shown in table 1 below, for the first 2 fishing periods.

Fishing period limits are intended to ensure that the Area 2A directed commercial fishery does not exceed its allocation, while also providing fair and equitable access across participants to an attainable amount of harvest.

If NMFS determines that more than two fishing periods are warranted, NMFS will set the fishing period limits for subsequent fishing periods equal across all vessel classes through inseason action consistent with 50 CFR 300.63(e)(1)(iii).

TABLE 1—FISHING PERIOD LIMITS BY SIZE CLASS FOR THE 2025 FIRST AND SECOND FISHING PERIODS OF THE AREA 2A PACIFIC HALIBUT NON-TRIBAL DIRECTED COMMERCIAL FISHERY

Vessel class	Length range in feet (meters)	Fishing period limit in pounds (mt)
A	1–25 (0.3–7.8)	2,000 (0.907)
B	26–30 (7.9–9.3)	2,000 (0.907)
C	31–35 (9.4–10.9)	2,000 (0.907)
D	36–40 (11.0–12.4)	3,400 (1.542)
E	41–45 (12.5–13.9)	3,400 (1.542)
F	46–50 (14.0–15.4)	4,300 (1.950)
G	51–55 (15.5–16.9)	4,300 (1.950)
H	56+ (17.0+)	5,000 (2.268)

Notes: Fishing period limits are in dressed weight (head-on, with ice and slime). If a vessel's size is between lengths, its length will be rounded up for the purpose of fishing period limits.

Inseason Action Announcement Procedures

This action adds email as a means to notify the affected public of an inseason action. Inseason actions will also be published in the **Federal Register** and will appear on the NMFS website. Inseason actions will be effective upon the date and time of either the receipt of notice by the direct email or publication in the **Federal Register**, whichever occurs first.

Permit Deadlines

Permits are required for all vessels participating in the Area 2A non-Tribal commercial directed and incidental Pacific halibut fisheries. Vessels may not be permitted for both the Pacific halibut fishery incidental to salmon troll and the directed commercial Pacific halibut fishery. This action implements a March 15 permit deadline for all Area 2A non-Tribal commercial Pacific halibut fisheries.

Comments

NMFS published a proposed rule on April 8, 2025 (90 FR 15129) and accepted public comments on the 2025 Area 2A Pacific halibut directed commercial fishery annual management measures through May 8, 2025. NMFS received one public comment. The comment spoke generally in support of an annual management plan; however, it is not clear that the comment is responsive to this rulemaking and the comment did not call for any changes from the proposed rule. No comments in opposition to this action were received.

Classification

Regulations governing the U.S. fisheries for Pacific halibut are developed by the IPHC, the Council, the North Pacific Fishery Management Council, and the Secretary of

Commerce. Section 5 Halibut Act (16 U.S.C. 773c) allows the Regional Council having authority for a particular geographical area to develop regulations governing the allocation and catch of halibut in U.S. Convention waters as long as those regulations do not conflict with IPHC regulations. Those regulations may only be implemented with the approval of the Secretary of Commerce. Through this action, NMFS approves and implements the Council's recommendations. Accordingly, this action is consistent with both the Council's role and NMFS's authority to regulate the halibut fishery in waters off Washington, Oregon, and California.

There is good cause under 5 U.S.C. 553(d)(3) to waive the 30-day delay in effective date in order to open the Area 2A non-Tribal directed Pacific halibut commercial fishery by June 24, 2025. This rule implements Area 2A non-Tribal commercial fishery management measures as published in the proposed rule (90 FR 15129; April 8, 2025), and based on Council recommendations, following a public Council process. The non-Tribal directed commercial Pacific halibut fishery had 97 vessels participate in 2024, and similar participation is expected in 2025. A delay in the effectiveness of these measures would result in the Area 2A Pacific halibut non-Tribal directed commercial fishery not being opened on its intended timeline and, thus, the fishery not being open on the dates that the affected public is expecting. Business decisions have likely been made surrounding this fishery opening date. A delay could cause economic harm to fishery participants and fishing communities, and would be contrary to public interest. The management measures were discussed at multiple Council meetings in 2024, which are open to the public and where public comment was accepted. Additionally, NMFS has determined that this rule qualifies for a waiver of the 30-day delay in effective date pursuant to 5 U.S.C. 553(d)(1) because participants would otherwise be unable to fish on the expected dates.

NMFS received one comment in response to the proposed rule. The comment provided general support of an annual management plan; however, it does not appear responsive to this rulemaking and the comment did not call for changes from the proposed rule. No changes were made in response to that comment.

This final rule has been determined to be not significant for purposes of Executive Order (E.O.) 12866. This final rule is not an E.O. 14192 regulatory action because this action is not significant under E.O. 12866.

NMFS has determined that this action would not have a substantial direct effect on one or more Indian Tribes, on the relationship between the Federal Government and Indian Tribes, or on the distribution of power and responsibilities between the Federal Government and Indian Tribes; therefore, consultation with Tribal officials under E.O. 13175 is not required, and the requirements of sections (5)(b) and (5)(c) of E.O. 13175 also do not apply. A Tribal summary impact statement under section (5)(b)(2)(B) and section (5)(c)(2)(B) of E.O. 13175 is not required and has not been prepared.

The Chief Counsel for Regulation of the Department of Commerce certified to the Chief Counsel for Advocacy of the Small Business Administration during the proposed rule stage that this action would not have a significant economic impact on a substantial number of small entities for purposes of the Regulatory Flexibility Act. The factual basis for the certification was published in the proposed rule and is not repeated here. NMFS received one comment in response to the proposed rule, which did not address the certification. As a result, a regulatory flexibility analysis was not required for this action and none was prepared.

This final rule contains no new information collection requirements under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

List of Subjects in 50 CFR Part 300

Administrative practice and procedure, Antarctica, Canada, Exports, Fish, Fisheries, Fishing, Imports, Indians, Labeling, Marine resources, Reporting and recordkeeping requirements, Russian Federation, Transportation, Treaties, Wildlife.

Dated: June 20, 2025.

Samuel D. Rauch, III,

Deputy Assistant Administrator for Regulatory Programs, National Marine Fisheries Service.

For the reasons set out in the preamble, NMFS amends 50 CFR part 300, subpart E, as follows:

PART 300—INTERNATIONAL FISHERIES REGULATIONS

Subpart E—Pacific Halibut Fisheries

■ 1. The authority citation for part 300, subpart E, continues to read as follows:

Authority: 16 U.S.C. 773–773k.

■ 2. In § 300.63, revise paragraphs (d)(2)(ii)(A) and (B), (e)(1)(iii), and (e)(2)(i), to read as follows:

§ 300.63 Catch sharing plan and domestic management measures in Area 2A.

* * * * *

(d) * * *

(2) * * *

(ii) * * *

(A) Applications for permits for the directed commercial fishery in Area 2A must be received by NMFS no later than 2359 PDT on March 15, or by 2359 PDT the next business day in March if March 15 is a Saturday, Sunday, or Federal holiday.

(B) Applications for permits that allow for incidental catch of Pacific halibut during the salmon troll fishery or the sablefish primary fishery in Area 2A must be received by NMFS no later than 2359 PDT March 15, or by 2359 PDT the next business day in March if March 15 is a Saturday, Sunday, or Federal holiday.

* * * * *

(e) * * *

(1) * * *

(iii) *Inseason action to add fishing periods and associated fishing period limits.* Fishing periods in addition to those originally implemented at the start of the fishing year may be warranted in order to provide the fishery with opportunity to achieve the Area 2A directed commercial fishery allocation, if performance of the fishery during the initial fishing period(s) is different than expected and the directed commercial allocation is not attained through the initial period(s). If NMFS makes the determination that sufficient allocation remains to warrant additional fishing period(s) without exceeding the allocation for the Area 2A directed commercial fishery, the additional fishing period(s) and fishing period limits may be added during the fishing year. If NMFS determines fishing period(s) in addition to those included in an annual management measures rule is warranted, NMFS will send an email with notification of the inseason action to affected permit holders. This action will also be published in the **Federal Register** as soon as practicable. The inseason action will be effective upon the earlier of either receipt of email of such notification, or publication in the **Federal Register**. If the amount of directed commercial allocation remaining is determined to be insufficient for an additional fishing period, the allocation is considered to be taken and the fishery will be closed, as described at paragraph (e)(2) of this section.

(2) * * *

(i) If NMFS determines that the non-Tribal directed commercial fishery has attained its annual allocation or is projected to attain its allocation if additional fishing was to be allowed, the Regional Administrator will take automatic action to close the fishery via email to affected permit holders and announcement in the **Federal Register**. Automatic closure of the non-Tribal directed commercial fishery will be effective upon the earlier of either: receipt of email of such notification, or publication in the **Federal Register**.

* * * * *

[FR Doc. 2025–11654 Filed 6–24–25; 8:45 am]

BILLING CODE 3510–22–P

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 622

[Docket No. 250623–0109]

RIN 0648–BN06

Fishery Management Plans of Puerto Rico, St. Croix, and St. Thomas and St. John; Amendment 3

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Final rule.

SUMMARY: NMFS issues regulations to implement management measures described in Amendment 3 to the Fishery Management Plans (FMPs) for Puerto Rico, St. Croix, and St. Thomas and St. John (Amendment 3), as prepared by the Caribbean Fishery Management Council (Council). This final rule establishes new management measures for dolphinfish (*Coryphaena hippurus*) and wahoo (*Acanthocybium solandri*) in U.S. Caribbean Federal waters, including commercial and recreational minimum size limits and recreational bag and possession limits. The purpose of the management measures contained in this final rule and Amendment 3 is to ensure dolphinfish and wahoo have adequate time to mature and reproduce and to help protect against overfishing.

DATES: This final rule is effective July 25, 2025.

ADDRESSES: Electronic copies of Amendment 3, which includes a fishery impact statement, an environmental assessment, a regulatory impact review, and a Regulatory Flexibility Act (RFA) analysis, may be obtained from the Southeast Regional Office website at *https://www.fisheries.noaa.gov/action/amendment-3-puerto-rico-st-croix-and-st-thomas-and-st-john-fishery-management-plans.*

FOR FURTHER INFORMATION CONTACT: Sarah Stephenson, 727–824–5305, *sarah.stephenson@noaa.gov.*

SUPPLEMENTARY INFORMATION: NMFS, with the advice of the Council, manages the Puerto Rico, St. Croix, and St. Thomas and St. John fisheries in U.S. Caribbean Federal waters under the Puerto Rico, St. Croix, and St. Thomas and St. John FMPs. NMFS implements the FMPs through regulations at 50 CFR part 622 under the authority of the Magnuson-Stevens Fishery Conservation and Management Act (Magnuson-Stevens Act).

On September 6, 2024, NMFS published a notice of availability for Amendment 3 and requested public comment (89 FR 72794). On September 27, 2024, NMFS published a proposed rule for Amendment 3 and requested public comment (89 FR 79220). NMFS approved Amendment 3 on November 27, 2024. The proposed rule and Amendment 3 outline the rationale for the actions contained in this final rule. The management measures described in Amendment 3 and implemented by this final rule are described below.

Executive Order 14172, ''Restoring Names that Honor American Greatness'' (January 20, 2025), directs that the Gulf of Mexico be renamed the Gulf of America. Consistent with the order, NMFS uses Gulf of America to refer to the geographical area previously known as the Gulf of Mexico, except when a statute or existing regulations explicitly refer to the ''Gulf of Mexico.'' Relevant to this rulemaking, existing regulations contained in 50 CFR part 622, including the heading for that part, refer to the Gulf of Mexico, as well as the South Atlantic and Caribbean. Amending the heading of 50 CFR part 622 is beyond the scope of this rulemaking.

Background

The Magnuson-Stevens Act requires NMFS to prevent overfishing and achieve, on a continuing basis, the optimum yield from federally managed fish stocks to ensure that fishery resources are managed for the greatest overall benefit to the Nation, particularly with respect to providing food production and recreational opportunities, and protecting marine ecosystems.

This action is taken under the statutory authority of the Magnuson-Stevens Act section 303(a)(1) as necessary and appropriate for the conservation and management of the fishery to prevent overfishing and to promote the long-term health and stability of the fishery.

On September 22, 2020, the Secretary of Commerce approved the Puerto Rico, St. Croix, and St. Thomas and St. John FMPs under section 304(a)(3) of the Magnuson-Stevens Act. The FMPs took effect on October 13, 2022, after NMFS published the final rule to implement the FMPs (87 FR 56204, September 13, 2022). Each FMP contains management measures applicable for Federal waters off the respective island management area. Federal regulations at 50 CFR part 622 subparts S, T, and U describe management measures for Puerto Rico, St. Croix, and St. Thomas and St. John, respectively. Federal waters around Puerto Rico extend seaward from 9 nautical miles (nmi) or 16.7 kilometers (km) from shore to the offshore boundary of the U.S. Caribbean exclusive economic zone (EEZ). Federal waters around St. Croix and St. Thomas and St. John extend seaward from 3 nmi (5.6 km) from shore to the offshore boundary of the U.S. Caribbean EEZ.

Prior to implementation of the Puerto Rico, St. Croix, and St. Thomas and St. John FMPs, dolphinfish and wahoo were not federally managed in Federal waters in the U.S Caribbean. Because of the economic importance to the region of these fast-growing, short-lived pelagic species, they were included for management under each of the Puerto Rico, St. Croix, and St. Thomas and St. John FMPs, even though they are exposed to harvest pressure across a wide area of the Atlantic Ocean, the Gulf of America, and the Caribbean Sea due to their migratory nature. While each FMP established annual catch limits (ACLs), annual catch targets (ACTs), and accountability measures (AMs) for dolphinfish and wahoo, the FMPs did not establish other management measures often used to limit harvest or effort, such as minimum size limits, recreational bag and possession limits, or commercial trip limits.

Two species of dolphinfish occur and are federally managed in the U.S. Caribbean. The dolphinfish species affected by Amendment 3 and this final rule is *Coryphaena hippurus,* also known as dolphinfish, dolphin, dorado, or mahi mahi.

At its December 2021 meeting, the Council began discussing management measures that could address the increasing risk of overharvest of juvenile dolphinfish as a result of the increasing influx and presence of *Sargassum* in the region. *Sargassum* is a type of floating brown algae that provides food, protection, and habitat for many marine

species. The *Sargassum* mats are natural fish aggregating devices for dolphinfish and wahoo, including juveniles of each species, making them easier to locate and catch. In addition, the lack of information available on the recreational harvest of dolphinfish and wahoo and the potential for excess harvest of these species to occur during recreational fishing trips is a source of uncertainty for the management of these species.

The Puerto Rico, St. Croix, and St. Thomas and St. John FMPs and the final rule implementing those FMPs did not include minimum size limits for dolphinfish or wahoo because these species were new to Federal management in the U.S. Caribbean. This final rule establishes minimum size limits for dolphinfish and wahoo for all fishing in U.S. Caribbean Federal waters (commercial and recreational sectors) to address the potential for small-sized (*i.e.,* juvenile) individuals of these species to be caught year-round. Dolphinfish and wahoo are usually seasonally-caught species, but the annual influx of *Sargassum* to the region increases the likelihood that smaller fish could easily be harvested. Although there currently is not a large market for smaller-sized dolphinfish or wahoo, such a fishery could develop in the future and the Council recommended being proactive in the management of these species. Protecting smaller-sized dolphinfish and wahoo increases the potential that they have enough time to reproduce before being harvested.

Before this rulemaking, there were no recreational bag or possession limits for dolphinfish or wahoo for the same reasons noted above. This final rule establishes recreational bag and possession limits for dolphinfish and wahoo to help regulate recreational harvest in U.S. Caribbean Federal waters. While the Puerto Rico FMP established recreational ACLs and ACTs for dolphinfish and wahoo, the Marine Recreational Information Program (MRIP) that collected recreational data for Puerto Rico was suspended in 2017 and has not resumed to date. Recreational data were not collected for St. Croix or St. Thomas and St. John. As a result, neither the St. Croix FMP nor the St. Thomas and St. John FMP established sector-specific ACLs and ACTs for dolphinfish and wahoo. Though some catch information is available from recreational fishing tournaments that occur in Puerto Rico and the U.S. Virgin Islands (USVI), that information likely underrepresents the total number of dolphinfish or wahoo caught each year by the recreational sector. Thus, the number of recreational fishermen and the amount of dolphinfish or wahoo removed by the sector are largely unknown for the region. Setting recreational bag and possession limits for the recreational sector in Federal waters around Puerto Rico, St. Croix, and St. Thomas and St. John could reduce the risk of overfishing the resource, while allowing fishermen access to the species.

Because the commercial landings of dolphinfish and wahoo in each island management area have been less than the corresponding ACLs, additional harvest constraints for the commercial sector are not needed at this time.

Management Measures Contained in This Final Rule

For dolphinfish and wahoo, this final rule establishes commercial and recreational minimum size limits and recreational bag and possession limits in Federal waters around Puerto Rico, St. Croix, and St. Thomas and St. John.

Minimum Size Limits

Before this rulemaking, no minimum size limits were in place for dolphinfish or wahoo in Federal waters around Puerto Rico, St. Croix, and St. Thomas and St. John. For commercial and recreational fishing in the Federal waters around Puerto Rico, St. Croix, and St. Thomas and St. John, this final rule establishes a 24 inches (61.0 centimeter (cm)) fork length (FL), minimum size limit for dolphinfish and a 32 inches (81.3 cm) FL, minimum size limit for wahoo. As described in Amendment 3, these minimum size limits are based on size at maturity information reported for each species in the U.S. Caribbean.

Recreational Bag and Possession Limits

Before this rulemaking, no recreational bag or possession limits were in place for dolphinfish or wahoo in Federal waters around Puerto Rico, St. Croix, and St. Thomas and St. John. For Federal waters around Puerto Rico, this final rule establishes a recreational bag and possession limit of 5 dolphinfish per person per day, not to exceed 15 dolphinfish per vessel per day, whichever is less and a recreational bag and possession limit of 5 wahoo per person per day, not to exceed 10 wahoo per vessel per day, whichever is less. The Federal recreational bag and possession limits for dolphinfish established by this rule are more conservative than the recreational bag and possession limits that apply in Puerto Rico territorial waters, but consistent with the recreational bag and possession limits that apply in St. Croix and St. Thomas and St. John territorial waters. With respect to wahoo, the Federal recreational bag and possession limits established by this rule are consistent with the recreational bag and possession limits that apply in Puerto Rico territorial waters, but more conservative than the recreational bag and possession limits that apply in St. Croix and St. Thomas and St. John territorial waters.

For Federal waters around St. Croix and St. Thomas and St. John, this final rule establishes recreational bag and possession limits of 10 dolphinfish per person per day, not to exceed 32 dolphinfish per vessel per day, whichever is less and recreational bag and possession limits of 2 wahoo per person per day, not to exceed 10 wahoo per vessel per day, whichever is less. As described in Amendment 3, these recreational bag and possession limits for Federal waters are either consistent with, or more conservative than, current territorial bag limit regulations for dolphinfish and wahoo.

Comments and Reponses

NMFS received 15 unique comments during the public comment periods on the notice of availability and proposed rule for Amendment 3, which were submitted by individuals in the general public, fishing organizations, and a non-governmental organization. The majority of the comments were in support of some or all of the actions within Amendment 3 and the proposed rule to reduce the risk of overfishing dolphinfish and wahoo resources. For example, one commenter points to technological advances driving increased catch rates, while another noted that a research program in Puerto Rico is documenting declining catch. NMFS appreciates the information provided and agrees with those comments.

Four comments were opposed to one or more of the proposed actions specific to Amendment 3 and the proposed rule. Additional comments were submitted, which although relevant to the management of dolphinfish and wahoo, were outside the scope of Amendment 3 and the proposed rule. These comments are grouped as appropriate and summarized below, followed by NMFS' respective responses. NMFS has not made any changes from the proposed rule to this final rule based on public comment.

Comment 1: The size limit for dolphinfish (*i.e.,* dorado) should be 30 inches (76.2 cm) FL, instead of the proposed 24 inches (61.0 cm) FL, size limit that would be implemented in Federal waters of the U.S. Caribbean.

Response: Before this rulemaking, there were no size limits established for dolphinfish in Federal waters around Puerto Rico, St. Croix, or St. Thomas and St. John. Amendment 3 and this final rule establish a size limit based on the size at maturity information reported for the species in the U.S. Caribbean. At 24 inches (61.0 cm) FL, almost all dolphinfish females caught off Puerto Rico and the USVI would be mature and would have had the opportunity to reproduce. NMFS and the Council determined that the 24 inches (61.0 cm) FL size limit will reduce fishing pressure on the smaller individuals, but, based on the analysis included in Amendment 3, will not greatly reduce the amount of commercial catch or recreational harvest for dolphinfish. A size limit greater than the 24 inches (61.0 cm) FL limit in this final rule would be more likely to impact commercial and recreational fishing. Because this species is new to Federal management in the U.S. Caribbean, NMFS determined, based in part on the Council's recommendation, that the 24 inches (61.0 cm) FL, size limit appropriately balances the biological benefits to the species with the social and economic impacts to fishermen.

Comment 2: A recreational bag limit of 10 dolphinfish per person per day or 32 dolphinfish per vessel per day in the USVI is too high. A harvest limit for dolphinfish similar to that proposed for Puerto Rico (5 fish per person per day or 15 per vessel, whichever is less) would be more reasonable.

Response: Before this rulemaking, no recreational bag and possession limits existed for dolphinfish in Federal waters around the USVI. The recreational bag limit of 10 dolphinfish per person per day or 32 dolphinfish per vessel per day, which will apply in Federal waters off St. Croix and off St. Thomas and St. John, is compatible with current regulations in the territorial waters of the USVI. Consistent and compatible regulations among Federal and USVI waters will make it easier for fishermen to comply with the new Federal regulations and for law enforcement to monitor compliance with and enforce the regulations. Additionally, MRIP did not collect recreational data in the USVI, and the number of dolphinfish harvested by recreational fishermen in Federal waters around the USVI is unknown. Recreational catch and effort data (*e.g.,* the number of recreational anglers and methods used when fishing) previously collected by MRIP for Puerto Rico were not used as a proxy for the USVI because of the differences among the islands. The recreational bag limits for dolphinfish were developed through the Council process, including input from each District Advisory Panel and the public. NMFS believes these bag limits best represent catch and effort levels that could occur under current fishing practices. Thus, the more restrictive bag limit being implemented for Puerto Rico Federal waters was not as suitable for USVI Federal waters at this time.

Comment 3: The recreational bag limit of 2 wahoo per person per day for the USVI is too low. A recreational bag limit of 4–5 per person not to exceed 10 per day per vessel for wahoo is preferable.

Response: Before this rulemaking, no recreational bag and possession limits existed for wahoo in Federal waters around the USVI. In USVI territorial waters, the recreational bag limit for wahoo is 4 per person per day not to exceed 20 per vessel per day. For management of wahoo in Federal waters around St. Croix and St. Thomas and St. John, NMFS determined, based in part on the Council's recommendation, that a more conservative Federal recreational bag and possession limit is appropriate because the Federal minimum size limit selected for wahoo (*i.e.,* 32 inches [81.3 cm] FL) is less conservative than the non-selected alternative (*i.e.,* 40 inches [101.6 cm] FL). NMFS is aware that the more conservative Federal recreational bag and possession limits could result in adverse social and economic effects due to the increase in associated discards, especially if recreational fishermen catch and release smaller fish while trying to harvest larger fish to retain subject to the bag limit. However, NMFS determined that the selected alternative balances the biological benefits to these species with the social and economic impacts to fishermen, especially in the absence of recreational fishing data.

Comment 4: The recreational bag limits for dolphinfish and wahoo in Puerto Rico are too high and should be reduced to two per person per day for dolphinfish and one per person per day for wahoo. Given that most recreational anglers in Puerto Rico catch only one dolphinfish and wahoo per trip (as acknowledged in Appendix B3 in Amendment 3), this recommendation is still a reasonable and fair catch limit.

Response: Before this rulemaking, no recreational bag or possession limits existed for dolphinfish or wahoo in Federal waters around Puerto Rico. In Puerto Rico territorial waters, the recreational bag limit for dolphinfish is 10 per person per day and 30 per vessel per day and for wahoo is 5 per person per day and 10 per vessel per day. The new Federal bag and possession limits of 5 dolphinfish per person per day not to exceed 15 per vessel per day and 5 wahoo per person per day not to exceed 10 per vessel per day, were developed through the Council process, including input from the Puerto Rico District Advisory Panel and the public, and are expected to best represent catch and effort levels that could occur under current fishing practices. NMFS determined, based in part on the Council's recommendation, that the selected alternative balances the biological benefits to these species with the social and economic impacts to fishermen, especially in the absence of recreational fishing data. Additionally, the recreational bag limit for wahoo implemented by this rule will be compatible with territorial regulations for the species, which will make it easier for fishermen to comply with the regulations and for law enforcement to monitor compliance with and enforce the Federal regulations.

Comment 5: The proposed recreational bag limits are too high and would therefore continue to promote the illegal sale of recreationally caught fish.

Response: The definition of recreational fishing at 50 CFR 622.2 includes fishing or fishing activities which result in the harvest of fish, none of which (or parts thereof) is sold, traded, or bartered. Thus, the sale of recreationally caught fish is illegal, regardless of the Federal recreational bag limit. The recreational bag limits implemented by the rule will help regulate the harvest of dolphinfish and wahoo in Federal waters by the recreational sector, for which catch and effort information are either limited or not available. Implementation of the recreational bag and possession limits contained in Amendment 3 are intended to protect the resource rather than address the illegal sale of recreationally-caught fish. NMFS determined that the selected alternatives balance the biological benefits to these species with the social and economic impacts to fishermen, especially in the absence of recreational fishing data.

Comment 6: Amendment 3 fails to include any limitations for commercial harvest of dolphinfish and wahoo and, therefore, lacks parity in its approach to management of these species to reduce the risk of overfishing.

Response: Under the Puerto Rico, St. Croix, and St. Thomas and St. John FMPs, commercial harvest of dolphinfish and wahoo stocks is constrained to their respective ACLs and ACTs and corresponding AMs are in place for both species. As described in Amendment 3, the Council considered actions to establish

commercial trip limits for dolphinfish and wahoo. Commercial landings for dolphinfish and wahoo were below the corresponding ACLs and ACTs at the time Amendment 3 was developed. As a result, additional harvest constraints for the commercial sector are not needed within Amendment 3. The combination of the respective ACLs and ACTs for the commercial harvest of these species along with the new recreational bag and possession limits and minimum size limits for dolphinfish and wahoo that are applicable for all fishing in Federal waters should reduce the risk of overfishing dolphinfish and wahoo resources, while allowing fishermen access to the species.

Comment 7: These size and bag limits should be applied in other Federal waters, such as Virginia, North Carolina, Maryland and other east coast states, to keep overfishing of dolphinfish and wahoo from happening.

Response: NMFS acknowledges that dolphinfish and wahoo occur over a wide geographical range that includes Atlantic waters off the U.S. east coast. While these species have a large geographical range, their Federal management remains to be carried out separately under the three U.S. Caribbean FMPs and the South Atlantic Dolphin and Wahoo FMP, based on the best scientific information available for each management area. Currently minimum size limits apply to dolphinfish in South Atlantic Federal waters off the coasts of Florida, Georgia, and South Carolina only. Bag and possession limits apply to dolphinfish and wahoo in South Atlantic Federal waters off the coasts of all the South Atlantic states where these species are managed. The managements actions that apply in South Atlantic Federal waters were implemented by NMFS, based on recommendations from the South Atlantic Fishery Management Council, and informed by public comment.

Comment 8: In addition to the management measures in Amendment 3, further work should be done to fully understand the role of dolphinfish and wahoo in the larger ecosystem of the U.S. Caribbean territories.

Response: The Council's Ecosystem-Based Fishery Management Technical Advisory Panel is developing a Fishery Ecosystem Plan (FEP) that would promote ecosystem-based approaches to ensure healthy, resilient and productive marine ecosystems and the fisheries resources dependent upon those ecosystems and evaluate how best to integrate those ecosystem-based approaches into existing fisheries management in the U.S. Caribbean (see *e.g.,* 89 FR 58721, July 19, 2024). The draft FEP is expected to be available for public review by the December 2025 Council meeting.

Comment 9: In-person meetings should be held on the four coasts of Puerto Rico to get input from fishermen during the development of an amendment. In-person meetings are more informative for commercial and recreational fishermen because no matter how much technology is available for communication, not all of the public depends on it.

Response: During the development of Amendment 3, the public had multiple opportunities to participate and provide comments in-person in Puerto Rico. Amendment 3 was discussed during hybrid (virtual and in-person) Council meetings held in San Juan (December 2021; April, August, and December 2022; August 2023; and April 2024) and Ponce (April 2023), Puerto Rico. At each of those meetings, there was time set aside for the public to comment on the actions under consideration.

Comment 10: While Amendment 3 aims to mitigate overharvesting, it lacks sufficient clarity on financial support mechanisms for communities relying economically on dolphinfish and wahoo fisheries. Given this dependency, it is recommended to create a program that incentivizes sustainable fishing practices and provides short-term economic support to offset the financial impact of restrictions on fishers.

Response: The purpose of Amendment 3 is to establish size limits and recreational bag limits for dolphinfish and wahoo under the Puerto Rico FMP, the St. Croix FMP and the St. Thomas and St. John FMP to ensure undersized individuals have adequate time to mature and reproduce and to protect against overfishing of dolphinfish and wahoo. The limited impacts to small entities from these management measures are discussed in the final regulatory flexibility analysis contained in the Classification section of this final rule. Establishing financial support mechanisms for communities relying on dolphinfish and wahoo is outside the scope of Amendment 3 and the proposed rule.

Classification

Pursuant to section 304(b)(3) of the Magnuson-Stevens Act, the NMFS Assistant Administrator has determined that this final rule is consistent with Amendment 3, the FMPs for Puerto Rico, St. Croix, and St. Thomas and St. John, other provisions of the Magnuson-Stevens Act, and other applicable laws.

This final rule has been determined to be not significant for purposes of Executive Order 12866. This final rule is not an Executive Order 14192 regulatory action because this action is not significant under Executive Order 12866.

NMFS has determined that this action would not have a substantial direct effect on one or more Indian Tribes, on the relationship between the Federal Government and Indian Tribes, or on the distribution of power and responsibilities between the Federal Government and Indian Tribes; therefore, consultation with Tribal officials under E.O. 13175 is not required, and the requirements of sections (5)(b) and (5)(c) of E.O. 13175 also do not apply. A Tribal summary impact statement under section (5)(b)(2)(B) and section (5)(c)(2)(B) of E.O. 13175 is not required and has not been prepared.

A final regulatory flexibility analysis (FRFA) was prepared. The FRFA incorporates the initial regulatory flexibility Analysis (IRFA), a summary of the significant issues raised by the public comments in response to the IRFA, NMFS responses to those comments, and a summary of the analyses completed to support the action. A copy of this analysis is available from NMFS (see **ADDRESSES**). A summary of the FRFA follows.

The Magnuson-Stevens Act provides the statutory basis for this final rule. A description of this final rule, why it is being implemented, and the purpose of this final rule are contained in the **SUMMARY** and **SUPPLEMENTARY INFORMATION** sections of this final rule. No public comments were received in response to the IRFA. Additionally, no comments were received from the Office of Advocacy for the Small Business Administration.

This final rule will apply to anglers (recreational fishers), charter vessels and headboats (for-hire vessels), and commercial fishing businesses that harvest dolphinfish and wahoo in Federal waters around Puerto Rico and the USVI. Anglers, however, are not considered small entities as that term is defined in 5 U.S.C. 601(6), whether fishing from for-hire, privately owned, or leased vessels. Therefore, neither estimates of the number of anglers nor the impacts on them are required or provided in this analysis.

Although the provisions of this final rule will apply to for-hire vessels, they are not expected to have any direct effects on these entities. For-hire vessels sell fishing services to anglers. The dolphinfish and wahoo recreational minimum size limits and recreational bag and possession limits are not expected to directly alter the services

sold by these vessels. Any change in demand for these fishing services, and associated economic effects, as a result of this final rule would be a consequence of a change in anglers' behavior, secondary to any direct effect on anglers and, therefore, an indirect effect of this final rule. Indirect effects fall outside the scope of the RFA.

For RFA purposes only, NMFS has established a small business size standard for businesses, including their affiliates, whose primary industry is commercial fishing (see 50 CFR 200.2). A business primarily involved in commercial fishing (North American Industry Classification System 11411) is classified as a small business if it is independently owned and operated, is not dominant in its field of operation (including its affiliates), and its combined annual receipts are not in excess of $11 million for all of its affiliated operations worldwide. All of the following figures are expressed in 2021 dollars and all weights described in this final rule are in round weight.

From 2017 through 2021, an annual average of 706 Puerto Rico commercial fishermen were actively fishing, and each of these fishermen is expected to represent a unique commercial fishing business. On average, they collectively landed approximately 1.87 million lb (848,217.7 kg) of marine resources with a direct value (revenue) of about $9.16 million from all waters. The highest annual landings and direct value from their combined landings during the 5-year period were in 2019: 2.47 million lb (1,120,373.2 kg) with a direct value of almost $12.03 million. The average commercial fisherman during this 5-year period had annual revenue from all landings of $12,975. None of these fishermen had annual revenue from fishing that was close to exceeding the small business size standard. Based on the above, NMFS concludes that all commercial fishing businesses in Puerto Rico are small.

Because price data are not available after 2019 in the USVI, estimates of the numbers of small commercial fishing businesses directly affected by this final rule and its impacts on them are generated using 2015 through 2019 data. From 2015 through 2019, an annual average of 127 commercial fishermen (59 in St. Croix and 68 in St. Thomas and St. John) were actively fishing and collectively they generated average annual direct revenues of $4.71 million ($1.93 million in St. Croix and $2.78 million in St. Thomas and St John). Each of these commercial fishermen is expected to represent a unique business. Therefore, NMFS concludes that all commercial fishing businesses in St. Croix and in St. Thomas and St. John are small.

Not all of the above active small commercial fishing businesses harvest dolphinfish or wahoo from Federal waters. On average, 94 (13.3 percent) of Puerto Rico's 706 small businesses land dolphinfish or wahoo annually from Federal and unknown waters. For this final rule, ''unknown waters'' represent an area around each island or island group for which the jurisdiction, Federal or territorial, was not reported on the commercial catch report form. Note that these figures include small businesses that land dolphinfish or wahoo from unknown waters, and, as such, may result in overestimates of both the numbers of small businesses directly affected and the impacts on them. Likewise, 15 (25.4 percent) of St. Croix's 59 small businesses land dolphinfish or wahoo annually from Federal and unknown waters: 14 land dolphinfish and 10 land wahoo. Twelve (17.7 percent) of St. Thomas and St. John's 68 small businesses land dolphinfish or wahoo annually from Federal and unknown waters: all land dolphinfish and 8 land wahoo.

This final rule will establish a 24 inches (61.0 cm) FL, minimum size limit for all fishing for dolphinfish in Federal waters off Puerto Rico, St. Croix, and St. Thomas and St. John. It will also establish a 32 inches (81.3 cm) FL, minimum size limit for all fishing for wahoo in Federal waters off Puerto Rico, St. Croix, and St. Thomas and St. John. These minimum size limits are based on size at maturity information reported for each species in the U.S. Caribbean. Before this rulemaking, there were no minimum size limits for either dolphinfish or wahoo in Federal waters.

Puerto Rico

An annual average of 45,016 lb (20,418.9 kg) of dolphinfish and 8,525 lb (3,866.9 kg) of wahoo are harvested from Federal and unknown waters around Puerto Rico by 94 small businesses annually. Forty-two (44.7 percent) of these small businesses land both dolphinfish and wahoo and they collectively account for 70.7 percent of dolphinfish landings and 89.5 percent of wahoo landings by weight. Forty-six small businesses (48.9 percent) account for the remainder (29.3 percent) of dolphinfish landings and six small businesses (6.4 percent) account for the remainder (10.5 percent) of wahoo landings. NMFS estimates that this final rule will reduce commercial landings (by weight) of dolphinfish by less than 1 percent and wahoo by 11.9 percent annually.

On average, each of the 42 small businesses that land both dolphinfish and wahoo from Federal and unknown waters are expected to have annual reductions of dolphinfish landings of less than 8 lb (3.6 kg) and annual reductions of wahoo landings of 22 lb (10.0 kg). At 2021 prices, the 42 small businesses that land both dolphinfish and wahoo are expected to experience annual revenue decreases of less than $130 (less than $33 from dolphinfish and $97 from wahoo). This loss represents less than 0.6 percent of the average annual revenue from all landings for these 42 small businesses.

The 48 small businesses that land dolphinfish and not wahoo from Federal and unknown waters are each expected to have an annual reduction in dolphinfish landings less than 3 lb (1.4 kg) worth $13. This loss of dolphinfish revenue represents less than 0.1 percent of the average annual revenue of these 46 small businesses.

The 6 small businesses that land wahoo and not dolphinfish from Federal and unknown waters are each expected to have an annual reduction in wahoo landings of 18 lb (8.2 kg) worth $78. This loss of wahoo revenue represents 0.6 percent of the average annual revenue of these six small businesses.

Two alternatives to the 24 inches (61.0 cm) FL, minimum size limit for dolphinfish were considered but not selected. The first, the no-action alternative, would have no adverse impact on small businesses but would not support proactive species management. The second would have a smaller minimum size limit (20 inches; 50.8 cm FL), and, similar to the size limit implemented by this final rule, it would reduce annual commercial landings of dolphinfish by less than 1 percent. This smaller size limit corresponds with only 50 percent of females being capable of reproduction as opposed to the 24 inches FL, which corresponds with approximately all females being mature. As such, the 24 inches FL is preferable to reduce fishing pressures and allow more females to reach maturity.

Two alternatives to the 32 inches (81.3 cm) FL, minimum size limit for wahoo were considered but not selected. The first, the no-action alternative, would have no adverse impact on small businesses, but would not support proactive species management. The second, would establish a larger minimum size limit (40 inches; 101.6 cm, FL) and would reduce landings of wahoo by 37.7 percent instead of the 11.9 percent reduction that is expected from the size limit implemented by this final rule. As

such, this alternative would have a greater adverse impact on small businesses than the 32 inches FL minimum size limit.

St. Croix

An annual average of 15 small businesses harvest dolphinfish or wahoo from Federal and unknown waters around St. Croix. To avoid potential disclosure of confidential information, a comparison of the small businesses that land both dolphinfish and wahoo and impacts on them to businesses that land one of the species is not provided. An annual average of 14 small businesses in St. Croix land dolphinfish from Federal and unknown waters. The top 7 account for 95.4 percent of dolphinfish landings, while the bottom 7 account for the remaining 4.6 percent. On average, these 14 small businesses collectively land 34,038 lb (15,439.4 kg) of dolphinfish annually. For the top 7 small businesses, average dolphinfish landings are approximately 4,640 lb (2,104.7 kg) and average annual revenue from all landings is $98,803. For the bottom 7 small businesses, average dolphinfish landings are approximately 225 lb (102.1 kg) and average annual revenue from all landings is $8,711.

NMFS estimates that this final rule will reduce annual commercial landings of dolphinfish in St. Croix by 5 percent. On average, each of the top 7 of the small businesses that land dolphinfish from Federal and unknown waters is expected to have an annual reduction in dolphinfish landings of 234 lb (106.1 kg) worth $1,491, which represents 1.5 percent of their average annual revenue from all landings. Each of the bottom 7 that land dolphinfish from Federal and unknown waters is expected to have an average annual reduction in landings of about 9 lb (4.1 kg) worth $57, which represents 0.7 percent of their average annual revenue from all landings.

An annual average of 10 small businesses in St. Croix land wahoo from Federal and unknown waters. The top 5 account for 95.4 percent of wahoo landings, while the bottom 5 account for the remaining 4.6 percent. On average, these 10 small businesses collectively land 17,966 lb (8,149.2 kg) of wahoo annually. For the top 5 small businesses, average wahoo landings are approximately 3,692 lb (1,674.7 kg) and average annual revenue from all landings is $129,686. For the bottom 5 small businesses, average wahoo landings are approximately 140 lb (63.5 kg) and average annual revenue from all landings is $19,373.

NMFS estimates that this final rule will reduce annual commercial landings of wahoo in St. Croix by 2.2 percent. On average, each of the top 5 of the 10 small businesses that land wahoo from Federal and unknown waters is expected to have an annual reduction in wahoo landings of 76 lb (34.5 kg) worth $502, which represents 0.4 percent of their average annual revenue from all landings. Each of the bottom 5 that land wahoo from Federal and unknown waters is expected to have an average annual reduction in landings of 4 lb (1.8 kg) worth $26, which represents 0.1 percent of their average annual revenue from all landings.

Two alternatives to the 24 inches (61.0 cm) FL, minimum size limit for dolphinfish were considered but not selected. The first, the no-action alternative, would have no adverse impact on small businesses but would not support proactive species management. The second would have a smaller minimum size limit (20 inches; 50.8 cm, FL), and it would reduce dolphinfish landings by 3.9 percent instead of 5.0 percent, as expected from the size limit implemented by this final rule. However, this smaller minimum size limit would not be as effective for reducing fishing pressures on the species.

Two alternatives to the 32 inches (81.3 cm) FL, minimum size limit for wahoo were considered but not selected. The first, the no-action alternative, would have no adverse impact on small businesses but would not support proactive species management. The second would establish a larger minimum size limit (40 inches; 101.6 cm, FL) and would reduce annual wahoo landings by 44.6 percent as opposed to the 2.2 percent reduction that is expected from the size limit implemented by this final rule. As such, this alternative would have a greater adverse impact on small businesses than the 32 inches FL minimum size limit.

St. Thomas and St. John

An annual average of 12 small businesses in St. Thomas and St. John land dolphinfish from Federal and unknown waters. The top 6 account for 97.2 percent of dolphinfish landings, while the bottom 6 account for the remaining 2.8 percent. On average, these 12 small businesses collectively land 8,889 lb (4,032.0 kg) of dolphinfish annually. For the top 6 small businesses, average dolphinfish landings are approximately 1,440 lb (653.2 kg) and average annual revenue from all landings is $27,311. For the bottom 6 small businesses, average dolphinfish landings are approximately 41 lb (18.6 kg) and average annual revenue from all landings is $25,031.

NMFS estimates that this final rule will reduce annual commercial landings of dolphinfish in St. Thomas and St. John by 1 percent. On average, each of the top 6 of the 12 small businesses that land dolphinfish from Federal and unknown waters is expected to have an annual reduction in dolphinfish landings of about 15 lb (6.8 kg) worth $119, which represents 2.0 percent of their average annual revenue from all landings. Each of the bottom 6 that land dolphinfish from Federal and unknown waters is expected to have an average annual reduction in landings of less than 1 lb (0.5 kg) worth $3, which represents less than 0.1 percent of their average annual revenue from all landings.

An annual average of 8 small businesses in St. Thomas and St. John land wahoo from Federal and unknown waters. The top 4 account for 89.6 percent of wahoo landings, while the bottom 4 account for the remaining 10.4 percent. On average, these 8 small businesses collectively land 3,058 lb (1,387.1 kg) of wahoo annually. For the top 4 small businesses, average wahoo landings are approximately 685 lb (310.7 kg) and average annual revenue from all landings is $31,792. For the bottom 4 small businesses, average wahoo landings are approximately 80 lb (36.3 kg) and average annual revenue from all landings is $15,659.

It is estimated that the recommended minimum size limit for wahoo implemented by this final rule will reduce commercial landings of wahoo in St. Thomas and St. John by 12 percent, which would be a reduction of 367 lb (166.5 kg) annually. On average, each of the top 4 small businesses is expected to have an annual decrease in wahoo landings of 82 lb (37.2 kg) worth $622, which represents about 2 percent of their annual revenue from all landings. Each of the bottom 4 small businesses is expected to have an annual decrease of wahoo landings of 10 lb (4.4 kg) worth $76, which represents about 0.5 percent of annual revenue from all landings.

Two alternatives to the 24 inches (61.0 cm) FL, minimum size limit for dolphinfish were considered but not selected. The first, the no-action alternative, would have no adverse impact on small businesses, but would not support proactive species management. The second would have a smaller minimum size limit (20 inches; 50.8 cm, FL), and it would reduce dolphinfish landings by less than 1 percent, which is the same annual reduction in landings as expected from

the size limit implemented by this final rule. This smaller minimum size limit corresponds to the size at which only approximately 50 percent of females are mature. As such, the larger minimum size limit is preferable to reduce fishing pressures by allowing more females to reach maturity.

Two alternatives to the 32 inches (81.3 cm) FL, minimum size limit for wahoo were considered but not selected. The first, the no-action alternative, would have no adverse impact on small businesses. The second, would establish a larger minimum size limit (40 inches; 101.6 cm, FL), which would reduce wahoo landings by a larger percentage than the size limit implemented by this final rule. As such, this alternative would have a greater adverse impact on small businesses than the 32 inches FL minimum size limit.

Section 212 of the Small Business Regulatory Enforcement Fairness Act of 1996 states that, for each rule or group of related rules for which an agency is required to prepare a FRFA, the agency will publish one or more guides to assist small entities in complying with the rule and will designate such publications as ''small entity compliance guides.'' The agency will explain the actions a small entity is required to take to comply with a rule or group of rules. As part of this rulemaking process, a fishery bulletin to permit holders that also serves as a small entity compliance guide was prepared. This final rule and the guide (*i.e.,* bulletin) will be available on the website (see **ADDRESSES**). Hard copies of the guide and this final rule will be available upon request (see **ADDRESSES**).

No duplicative, overlapping, or conflicting Federal rules have been identified. In addition, no new reporting, recordkeeping, or other compliance requirements are introduced in this final rule. This final rule contains no information collection requirements under the Paperwork Reduction Act of 1995.

List of Subjects in 50 CFR Part 622

Caribbean, Dolphinfish, Fisheries, Fishing, Wahoo.

Authority: 16 U.S.C. 1801 *et seq.*

Dated: June 23, 2025.

Samuel D. Rauch, III,

Deputy Assistant Administrator for Regulatory Programs, National Marine Fisheries Service.

For the reasons set out in the preamble, NMFS amends 50 CFR part 622 as follows:

PART 622—FISHERIES OF THE CARIBBEAN, GULF OF MEXICO, AND SOUTH ATLANTIC

■ 1. The authority citation for part 622 continues to read as follows:

Authority: 16 U.S.C. 1801 *et seq.*

■ 2. In § 622.441, add paragraph (b) to read as follows:

§ 622.441 Size limits.

* * * * *

(b) *Pelagic fish.* (1) Dolphinfish—24 inches (61.0 cm), FL.

(2) Wahoo—32 inches (81.3 cm), FL.

* * * * *

■ 3. In § 622.444, add paragraph (b) to read as follows:

§ 622.444 Bag and possession limits.

* * * * *

(b) *Pelagic fish.* (1) Dolphinfish—5 per person per day, not to exceed 15 per vessel per day, whichever is less.

(2) Wahoo—5 per person per day, not to exceed 10 per vessel per day, whichever is less.

* * * * *

■ 4. In § 622.481, add paragraph (b) to read as follows:

§ 622.481 Size limits.

* * * * *

(b) *Pelagic fish.* (1) Dolphinfish—24 inches (61.0 cm), FL.

(2) Wahoo—32 inches (81.3 cm), FL.

* * * * *

■ 5. In § 622.484, add paragraph (b) to read as follows:

§ 622.484 Bag and possession limits.

* * * * *

(b) *Pelagic fish.* (1) Dolphinfish—10 per person per day, not to exceed 32 per vessel per day, whichever is less.

(2) Wahoo—2 per person per day, not to exceed 10 per vessel per day, whichever is less.

* * * * *

■ 6. In § 622.516, add paragraph (b) to read as follows:

§ 622.516 Size limits.

* * * * *

(b) *Pelagic fish.* (1) Dolphinfish—24 inches (61.0 cm), FL.

(2) Wahoo—32 inches (81.3 cm), FL.

* * * * *

■ 7. In § 622.519, add paragraph (b) to read as follows:

§ 622.519 Bag and possession limits.

* * * * *

(b) *Pelagic fish.* (1) Dolphinfish—10 per person per day, not to exceed 32 per vessel per day, whichever is less.

(2) Wahoo—2 per person per day, not to exceed 10 per vessel per day, whichever is less.

* * * * *

[FR Doc. 2025–11714 Filed 6–24–25; 8:45 am]

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DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 622

[Docket No. 250623–0107]

RIN 0648–BN22

Fishery Management Plan of Puerto Rico; Triggerfish Management Measures

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Final rule.

SUMMARY: NMFS issues this final rule to implement management measures described in Framework Action 3 under the Puerto Rico Fishery Management Plan (FMP) (Framework Action 3). Specifically, this final rule modifies the annual catch limits (ACLs) for the triggerfish stock complex in Federal waters off Puerto Rico. The purpose of this final rule and Framework Action 3 is to update management reference points for the triggerfish stock complex under the Puerto Rico FMP consistent with the most recent stock assessment to prevent overfishing and achieve optimum yield (OY).

DATES: This final rule is effective July 25, 2025.

ADDRESSES: Electronic copies of Framework Action 3, which includes an environmental assessment, a regulatory impact review, and a Regulatory Flexibility Act analysis, may be obtained from the Southeast Regional Office website at: *https://www.fisheries.noaa.gov/action/framework-action-3-puerto-rico-fishery-management-plan-modification-status-determination.*

FOR FURTHER INFORMATION CONTACT: Maria Lopez-Mercer, NMFS Southeast Regional Office, 727–824–5305, *maria.lopez@noaa.gov.*

SUPPLEMENTARY INFORMATION: The triggerfish stock complex in the Federal waters off Puerto Rico consists of ocean triggerfish, gray triggerfish and queen triggerfish, and is managed under the Puerto Rico FMP. The Puerto Rico FMP was prepared by the Caribbean Fishery

Management Council (Council), approved by the Secretary of Commerce, and is implemented by NMFS through regulations at 50 CFR part 622 under the authority of the Magnuson-Stevens Fishery Conservation and Management Act (Magnuson-Stevens Act). On December 17, 2024, NMFS published a proposed rule to implement Framework Action 3 and requested public comment (89 FR 102100). The proposed rule and Framework Action 3 outline the rationale for the actions contained in this final rule. A summary of the management measures described in Framework Action 3 and implemented by this final rule is described below.

Executive Order 14172, ''Restoring Names that Honor American Greatness'' (January 20, 2025), directs that the Gulf of Mexico be renamed the Gulf of America. Consistent with the order, NMFS uses Gulf of America to refer to the geographical area previously known as the Gulf of Mexico, except when a statute or existing regulations explicitly refer to the ''Gulf of Mexico.'' Relevant to this rulemaking, existing regulations contained in 50 CFR part 622, including the heading for that part, refer to the Gulf of Mexico, as well as the South Atlantic and Caribbean. Amending the heading of 50 CFR part 622 is beyond the scope of this rulemaking.

All weights described in this final rule are in round weight.

Background

The Magnuson-Stevens Act requires NMFS and regional fishery management councils to prevent overfishing and to achieve, on a continuing basis, the OY from federally managed fish stocks to ensure that fishery resources are managed for the greatest overall benefit to the nation, particularly with respect to providing food production and recreational opportunities, and protecting marine ecosystems.

This action is taken under the statutory authority of the Magnuson-Stevens Act section 303(a)(1) as necessary and appropriate for the conservation and management of the fishery to prevent overfishing and to promote the long-term health and stability of the fishery.

NMFS, with the advice of the Council, manages fisheries in Federal waters around Puerto Rico under the Puerto Rico FMP. On September 22, 2020, the Secretary of Commerce approved the Puerto Rico FMP under section 304(a)(3) of the Magnuson-Stevens Act. NMFS published the final rule in the **Federal Register** to implement the Puerto Rico FMP on September 13, 2022 (87 FR 56204), which, among other measures, included the current ACL values for the triggerfish stock complex in Puerto Rico. The Puerto Rico FMP contains management measures applicable for Federal waters off Puerto Rico, which extend seaward from 9 nautical miles (nm) (16.7 kilometers (km)) from shore to the offshore boundary of the U.S. Caribbean exclusive economic zone.

The Puerto Rico FMP established status determination criteria (SDC) and other management reference points for triggerfish species under Federal management off Puerto Rico. In the Puerto Rico FMP, the triggerfish stock complex contains queen triggerfish, ocean triggerfish, and gray triggerfish. Queen triggerfish is the indicator stock for the complex because of the limited information (*e.g.,* landings) available for ocean and gray triggerfish. Thus, management measures, SDC, and other reference points are based on landings of queen triggerfish only, but apply to the entire complex.

The Puerto Rico FMP applies a four-tiered acceptable biological catch (ABC) control rule depending on differing levels of data availability. Each tier specifies SDC, such as the maximum fishing mortality threshold (MFMT), minimum stock size threshold (MSST), and overfishing limit (OFL), or OFL proxy, and other reference points such as the maximum sustainable yield (MSY), or MSY proxy, and ABC. Under the ABC control rule, tier 1 applies to stocks with the most data available, and each subsequent tier operates with less available data than the preceding tier. Tier 4, the final tier, is the most data limited and applies when no accepted quantitative assessment is available. Tier 4 contains two sub-tiers, tier 4a and tier 4b, which are based on an understanding of the stock's vulnerability to fishing pressure. Tier 4a applies when the stock's vulnerability to fishing pressure is relatively low or moderate, while tier 4b applies to stocks with a high vulnerability to fishing pressure.

In the Puerto Rico FMP, the triggerfish stock complex is considered a tier 4a stock and the MSY proxy, MFMT, and MSST were defined, but as a result of data limitations, were not quantified. Similarly, the OFL for the triggerfish stock complex could not be quantified in the Puerto Rico FMP and a new reference point, the sustainable yield level (SYL), was quantified and used as the OFL proxy. The SYL is a level of landings that can be sustained by a stock over the long-term. For the triggerfish stock complex, the Council's Scientific and Statistical Committee (SSC) derived the ABC from the SYL, and the Council recommended an ACL for the triggerfish stock complex equal to 95 percent of the recommended ABC. The total ACL was set equal to OY. Under the Puerto Rico FMP, commercial and recreational data were available to establish sector-specific ACLs for the triggerfish stock complex, which were equal to 91.77 percent and 8.23 percent of the total ACL, respectively. For the triggerfish stock complex, the current total ACL is 90,552 pounds (lb) (41,073.6 kilograms (kg)), the commercial ACL is 83,099 lb (37,693 kg), and the recreational ACL is 7,453 lb (3,380.6 kg).

In 2022, the Southeast Data, Assessment, and Review (SEDAR) stock assessment was completed for queen triggerfish in Puerto Rico (SEDAR 80). SEDAR 80 was reviewed by the Council's SSC and determined to be suitable for short-term (*i.e.,* <5 years) management advice. The Council's SSC in consultation with NMFS' Southeast Fisheries Science Center (SEFSC) determined that SEDAR 80 represented the best scientific information available and recommended queen triggerfish (*i.e.,* the triggerfish stock complex) be reclassified from a tier 4a stock to a tier 3 stock (data limited, accepted assessment available) under the Puerto Rico FMP ABC control rule. Under tier 3, if the biomass of the stock goes below MSST, the stock would be determined to be overfished and the Council would then need to develop a rebuilding plan capable of returning the stock to a level that allows the stock to achieve MSY on a continuing basis. Additionally, under tier 3, in years when there is a stock assessment, the stock would be considered to be undergoing overfishing if fishing mortality exceeds the MFMT. This level of fishing mortality, if continued, would reduce the stock biomass to an overfished condition. In years in which there is no assessment, the stock complex would be considered to be undergoing overfishing if landings exceed the OFL.

Under tier 3, the ABC is derived by reducing the OFL by the Council's SSC scientific uncertainty buffer and reflecting the acceptable probability of overfishing determined by the Council (defined as P*). The Council's SSC coordinated with the SEFSC to provide OFLs and ABCs for the triggerfish stock complex. At the December 2022 Council meeting, the Council's SSC recommended both variable and constant OFLs and ABCs for years 2024 to 2026 for the triggerfish stock complex, with the ABCs across a range of P* values. NMFS agreed with the Council's recommendation to use a P* value of 0.4 and set a constant value OFL and ABC, which are equal to the 3-year average OFLs and ABCs from

years 2024 to 2026. The total ACL for the triggerfish stock complex is then derived by reducing the ABC by the Council's management uncertainty buffer.

Following the SEDAR 80 stock assessment and recommendations from the Council's SSC, NMFS and the Council developed Framework Action 3 to update management reference points to prevent overfishing of the triggerfish stock complex and achieve OY, consistent with the requirements of the Magnuson-Stevens Act. In Framework Action 3, the Council recommended a 5 percent management uncertainty buffer to set the total ACL for the stock complex equal to 95 percent of the ABC. The Council specified commercial and recreational ACLs for the triggerfish stock complex using the same sector allocation percentages used under the Puerto Rico FMP (91.77 percent of the total ACL for the commercial sector and 8.23 percent of the total ACL for the recreational sector). Currently, recreational landings in Puerto Rico are not being collected by the NMFS' Marine Recreational Information Program, which was disrupted by Hurricane Maria in 2017, and has not yet resumed operations in Puerto Rico. Therefore, Framework Action 3 did not consider any revisions to the sector allocations for the triggerfish complex.

Management Measures Contained in This Final Rule

This final rule revises the total, commercial, and recreational ACLs for the triggerfish stock complex in Federal waters off Puerto Rico. The total ACL for the triggerfish stock complex will decrease from 90,552 lb (41,073.6 kg) to 87,220 lb (39,562 kg). The commercial ACL for the complex will decrease from 83,099 lb (37,693 kg) to 80,041 lb (36,306 kg). The recreational ACL for the complex will decrease from 7,453 lb (3,380.6 kg) to 7,178 lb (3,256 kg).

The updated ACLs are expected to better protect the stock complex against the risk of overfishing in relation to the current ACLs, thus ensuring, to the greatest extent practicable, continued access to the resource in future years.

Measures Contained in Framework Action 3 Not Codified in This Final Rule

In addition to the ACL revisions described in this final rule and consistent with SEDAR 80, Framework Action 3 revises the MFMT, OFL, and ABC for the triggerfish stock complex under the Puerto Rico FMP. The MFMT, previously not quantified, will be 0.215. The OFL will decrease from the SYL (OFL proxy) of 190,636 lb (86,471 kg) to 118,283 lb (53,652 kg), and the ABC will decrease from 95,318 lb (45,236 kg) to 91,810 lb (41,644 kg). Because estimates of the long-term recruitment for queen triggerfish assessed in SEDAR 80 are unknown, values for the MSY and MSST were not quantified in Framework Action 3 and remain as defined under tier 3 of the ABC control rule. The MSY proxy is equal to 30 percent of the spawning potential ratio, and MSST is equal to 75 percent of the spawning stock biomass produced when fishing at MSY or MSY proxy. The updated management reference points are expected to better protect the stock complex against the risk of overfishing in relation to the current reference points, thus ensuring, to the greatest extent practicable, continued access to the resource in future years.

Comments and Responses

NMFS did not receive any comments on the proposed rule to implement management measures described in Framework Action 3. Therefore, no changes were made to this final rule based on public comment.

Classification

Pursuant to section 304(b)(3) of the Magnuson-Stevens Act, the NMFS Assistant Administrator has determined that this final rule is consistent with Framework Action 3, the Puerto Rico FMP, other provisions of the Magnuson-Stevens Act, and other applicable laws.

This final rule has been determined to be not significant for purposes of Executive Order 12866. This final rule is not an Executive Order 14192 regulatory action because this action is not significant under Executive Order 12866.

The Magnuson-Stevens Act provides the statutory basis for this final rule. No duplicative, overlapping, or conflicting Federal rules have been identified. In addition, no new reporting or recordkeeping compliance requirements are introduced in this final rule. This final rule contains no information collection requirements under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*). A description of this final rule, why it is being considered, and the purposes of this final rule are contained in the **SUMMARY** and **SUPPLEMENTARY INFORMATION** sections of this final rule.

The Chief Counsel for Regulation of the Department of Commerce certified to the Chief Counsel for Advocacy of the Small Business Administration during the proposed rule stage that this final rule would not have a significant economic impact on a substantial number of small entities. The factual basis for the certification was published in the proposed rule and is not repeated here. No comments from the public were received regarding this certification. As a result, a final regulatory flexibility analysis was not required and none was prepared.

NMFS has determined that this action would not have a substantial direct effect on one or more Indian Tribes, on the relationship between the Federal Government and Indian Tribes, or on the distribution of power and responsibilities between the Federal Government and Indian Tribes; therefore, consultation with Tribal officials under Executive Order 13175 is not required, and the requirements of sections (5)(b) and (5)(c) of Executive Order 13175 also do not apply. A Tribal summary impact statement under section (5)(b)(2)(B) and section (5)(c)(2)(B) of Executive Order 13175 is not required and has not been prepared.

List of Subjects in 50 CFR Part 622

Caribbean, Fisheries, Fishing, Reef fish, Triggerfish.

Authority: 16 U.S.C. 1801 *et seq.*

Dated: June 23, 2025.

Samuel D. Rauch, III,

Deputy Assistant Administrator for Regulatory Programs, National Marine Fisheries Service.

For the reasons set out in the preamble, NMFS amends 50 CFR part 622 as follows:

PART 622—FISHERIES OF THE CARIBBEAN, GULF OF MEXICO, AND SOUTH ATLANTIC

■ 1. The authority citation for part 622 continues to read as follows:

Authority: 16 U.S.C. 1801 *et seq.*

■ 2. In § 622.440, amend paragraphs (a)(1) through (3) by revising the table headings and the entries for Triggerfishes for Table 1 to § 622.440(a)(1), Table 2 to § 622.440(a)(2), and Table 3 to § 622.440(a)(3) to read as follows:

§ 622.440 Annual catch limits (ACLs), annual catch targets (ACTs), and accountability measures (AMs).

(a) * * *

(1) * * *

TABLE 1 TO PARAGRAPH (a)(1)

Family	Stock or stock complex and species composition	Commercial ACL
* *	* * * *	* *
Triggerfishes	Triggerfish—gray triggerfish, ocean triggerfish, queen triggerfish [1]	80,041 lb (36,306 kg).
* *	* * * *	* *

[1] Indicator stock.

* * * * * (2) * * *

TABLE 2 TO PARAGRAPH (a)(2)

Family	Stock or stock complex and species composition	Recreational ACL
* *	* * * *	* *
Triggerfishes	Triggerfish—gray triggerfish, ocean triggerfish, queen triggerfish [1]	7,178 lb (3,256 kg).
* *	* * * *	* *

[1] Indicator stock.

* * * * * (3) * * *

TABLE 3 TO PARAGRAPH (a)(3)

Family	Stock or stock complex and species composition	Total ACL
* *	* * * *	* *
Triggerfishes	Triggerfish—gray triggerfish, ocean triggerfish, queen triggerfish [1]	87,220 lb (39,562 kg).
* *	* * * *	* *

[1] Indicator stock.

* * * * *

[FR Doc. 2025–11712 Filed 6–24–25; 8:45 am]
BILLING CODE 3510–22–P

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 660

[Docket No. 250623–0110]

RIN 0648–BN19

Fisheries Off West Coast States; West Coast Salmon Fisheries; 2025 Specifications and Management Measures; Correction

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Final rule; correction.

SUMMARY: NMFS established fishery management measures for the ocean salmon fisheries off Washington, Oregon, and California for the season beginning May 16, 2025, and anticipated to end May 15, 2026 (the 2025 ocean salmon fishing season), under the authority of the Magnuson-Stevens Fishery Conservation and Management Act (MSA). The final rule, published in the **Federal Register** on May 16, 2025, included an error in the management measures for commercial ocean salmon fisheries in the area from Humbug Mountain, Oregon, to the U.S./Mexico border. This action edits formatting and corrects an error by adding the text that was unintentionally omitted from the May 16, 2025, rule.

DATES: Effective June 24, 2025.

FOR FURTHER INFORMATION CONTACT: Shannon Penna at 562–980–4239.

SUPPLEMENTARY INFORMATION: The final rule published May 16, 2025 (90 FR 20810), describes annual management measures for managing the harvest of salmon in the ocean waters under the jurisdiction of the Pacific Fishery Management Council (Council). This correcting amendment corrects an error in the May 16, 2025, rule, by adding the number ''4'' to ''2024'' under the management measures for the commercial troll ocean salmon fishery in the area from Humbug Mountain, Oregon, to the Oregon/California border. In addition, it corrects formatting for the recreational fishery from Point Arena, California, to the U.S./Mexico border as it may confuse the interpretation of the regulations.

Need for Correction

The 2025 salmon management measures (90 FR 20810, May 16, 2025), section 1, part A, describe the commercial ocean salmon fisheries in the area from the Oregon/California border to the U.S./Mexico border. Section 2, part A, describes the recreational ocean salmon fisheries in the area from the Oregon/California border to the U.S./Mexico border. There is a transcription error in section 2, part A, of the rule. The May 16, 2025, rule omitted text in the management measures for commercial salmon troll fisheries off the coast of Oregon set to occur during the 2026 ocean salmon fishing season for fisheries opening earlier than May 16, 2026. The omitted text is the reference year for the gear restrictions in that area. This correcting amendment would insert the reference year.

In section 2, part A, there is a formatting error in the titles for the area from Point Arena, California, to the U.S./Mexico border. Under the current format, the regulations for the areas from Point Arena to Pigeon Point and Pigeon Point to the U.S./Mexico border appear to apply to only the subareas from Point Reyes to Pigeon Point and Pigeon Point to Point Sur. However, the regulations apply to the entire area from Point Arena to the U.S. Mexico border and not just the subareas. This correcting amendment adjusts the formatting to accurately describe the applicability of the regulations.

Correction

In FR Doc. 2025–08741 appearing on pages 20816 and 20819, in the **Federal Register** of Friday, May 16, 2025, the following corrections are made:

On page 20816, in the first column, the description of the commercial ocean salmon troll fishery under ''Humbug Mountain to the Oregon/California Border'' is corrected to read as follows:

Closed.

In 2026, the season will open on March 15 for all salmon except coho salmon. Gear restrictions are the same as in 2024 (89 FR 44553, May 21, 2024; 89 FR 53529, June 27, 2024).

On page 20819, in the third column, the descriptions of the recreational ocean salmon fishery under ''Point Arena to Pigeon Point (San Francisco)'', ''Point Reyes to Pigeon Point Subarea'', ''Pigeon Point to U.S./Mexico border (Monterey)'', and ''Pigeon Point to Point Sur Subarea'' are corrected to read as follows:

Point Arena to Pigeon Point (San Francisco)
June 7–8
July 5–6
July 31–August 3
August 25–31.

Inseason action may be taken to close open days when total statewide harvest is approaching a statewide harvest guideline of 7,000 Chinook salmon for the summer (June–August) season.

Point Reyes to Pigeon Point Subarea:
September 4–7, 29–30;
October 1–5, 27–31.

Inseason action may be taken to close open days when total statewide harvest approaching a statewide harvest guideline of 7,500 Chinook salmon for the fall (September–October) season.

All salmon except coho salmon, two salmon per day.

In 2026, the season opens on April 4 for all salmon except coho salmon, two salmon per day. The same gear restrictions as in 2025. Inseason action to close fisheries, modify season dates, or modify the bag limit may be considered when harvest is approaching a harvest guideline.

Pigeon Point to U.S./Mexico border (Monterey)
June 7–8
July 5–6
July 31–August 3
August 25–31.

Inseason action may be taken to close open days when total statewide harvest is approaching a statewide harvest guideline of 7,000 Chinook salmon for the summer (June–August) season.

Pigeon Point to Point Sur Subarea:
September 4–7, 29–30.

Inseason action may be taken to close open days when total statewide harvest is approaching a guideline of 7,500 Chinook salmon for the fall (September–October) season.

All salmon except coho salmon, two salmon per day.

In 2026, the season opens on April 4 for all salmon except coho salmon, two salmon per day. The same gear restrictions as in 2025. Inseason action to close fisheries, modify season dates, or modify the bag limit may be considered when harvest is approaching a harvest guideline.

Classification

NMFS is issuing this rule pursuant to 305(d) of the MSA. The reason for using this regulatory authority is: In a previous action taken pursuant to section 304(b), the NMFS implemented through regulations the Council's Pacific Salmon Fishery Management Plan (FMP), authorizing NMFS to take this action pursuant to MSA section 305(d). See 50 CFR 660.408. These regulations are being promulgated under the authority of 16 U.S.C. 1855(d). The NMFS Assistant Administrator has determined that this final rule is consistent with the Pacific Coast Salmon FMP and regulations implementing the FMP, and other applicable law.

The Assistant Administrator for Fisheries, NOAA (AA) finds good cause under 5 U.S.C. 553(b)(B) to waive the requirement for prior notice and opportunity for additional public comment for this action as notice and comment would be unnecessary and contrary to the public interest. Notice and comment are unnecessary and contrary to the public interest because this action simply corrects an error in the final rule and avoids public confusion. This correction does not affect the results of analyses conducted to support management decisions in the salmon fishery nor change the total catch of salmon. In addition, it is important that the errors be corrected as quickly as possible. The correction affects fisheries that began on June 7, 2025, and corrects errors that may lead to confusion for the public and potentially impact the prosecution of fisheries. No aspect of this action is controversial and no change in operating practices in the fishery is required. For the same reasons, pursuant to 5 U.S.C. 553(d), the AA finds good cause to waive the 30-day delay in effective date.

Because prior notice and opportunity for public comment are not required for this rule by 5 U.S.C. 553, or any other law, the analytical requirements of the Regulatory Flexibility Act, 5 U.S.C. 601 *et seq.,* are inapplicable.

This final rule is exempt from review under Executive Order 12866.

Authority: 16 U.S.C. 773–773k; 1801 *et seq.*

Dated: June 23, 2025.

Samuel D. Rauch, III,

Deputy Assistant Administrator for Regulatory Programs, National Marine Fisheries Service.

[FR Doc. 2025–11713 Filed 6–24–25; 8:45 am]

BILLING CODE 3510–22–P

Proposed Rules

Federal Register
Vol. 90, No. 120
Wednesday, June 25, 2025

This section of the FEDERAL REGISTER contains notices to the public of the proposed issuance of rules and regulations. The purpose of these notices is to give interested persons an opportunity to participate in the rule making prior to the adoption of the final rules.

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. FAA–2025–1110; Project Identifier AD–2025–00166–T]

RIN 2120–AA64

Airworthiness Directives; The Boeing Company Airplanes

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Notice of proposed rulemaking (NPRM).

SUMMARY: The FAA proposes to adopt a new airworthiness directive (AD) for certain The Boeing Company Model 787–9 and 787–10 airplanes. This proposed AD was prompted by reports of multiple supplier notices of escapement (NOEs) indicating that multiple cargo barrier fitting links were possibly manufactured with an incorrect titanium alloy material. This proposed AD would require a high frequency eddy current (HFEC) or handheld X-ray fluorescence (XRF) spectrometer inspection of the cargo barrier fitting link to determine the titanium alloy material, and applicable on-condition actions. The FAA is proposing this AD to address the unsafe condition on these products.

DATES: The FAA must receive comments on this proposed AD by August 11, 2025.

ADDRESSES: You may send comments, using the procedures found in 14 CFR 11.43 and 11.45, by any of the following methods:

- *Federal eRulemaking Portal:* Go to *regulations.gov*. Follow the instructions for submitting comments.
- *Fax:* 202–493–2251.
- *Mail:* U.S. Department of Transportation, Docket Operations, M–30, West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue SE, Washington, DC 20590.
- *Hand Delivery:* Deliver to Mail address above between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays.

AD Docket: You may examine the AD docket at *regulations.gov* under Docket No. FAA–2025–1110; or in person at Docket Operations between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays. The AD docket contains this NPRM, any comments received, and other information. The street address for Docket Operations is listed above.

Material Incorporated by Reference:

- For Boeing material identified in this proposed AD, contact Boeing Commercial Airplanes, Attention: Contractual & Data Services (C&DS), 2600 Westminster Blvd., MC 110–SK57, Seal Beach, CA 90740–5600; telephone 562–797–1717; website *myboeingfleet.com*.
- You may view this material at the FAA, Airworthiness Products Section, Operational Safety Branch, 2200 South 216th St., Des Moines, WA. For information on the availability of this material at the FAA, call 206–231–3195. It is also available at *regulations.gov* under Docket No. FAA–2025–1110.

FOR FURTHER INFORMATION CONTACT: Joseph Hodgin, Aviation Safety Engineer, FAA, 2200 South 216th St., Des Moines, WA 98198; phone: 206–231–3962; email: *joseph.j.hodgin@faa.gov*.

SUPPLEMENTARY INFORMATION:

Comments Invited

The FAA invites you to send any written relevant data, views, or arguments about this proposal. Send your comments to an address listed under the **ADDRESSES** section. Include ''Docket No. FAA–2025–1110; Project Identifier AD–2025–00166–T'' at the beginning of your comments. The most helpful comments reference a specific portion of the proposal, explain the reason for any recommended change, and include supporting data. The FAA will consider all comments received by the closing date and may amend this proposal because of those comments.

Except for Confidential Business Information (CBI) as described in the following paragraph, and other information as described in 14 CFR 11.35, the FAA will post all comments received, without change, to *regulations.gov,* including any personal information you provide. The agency will also post a report summarizing each substantive verbal contact received about this NPRM.

Confidential Business Information

CBI is commercial or financial information that is both customarily and actually treated as private by its owner. Under the Freedom of Information Act (FOIA) (5 U.S.C. 552), CBI is exempt from public disclosure. If your comments responsive to this NPRM contain commercial or financial information that is customarily treated as private, that you actually treat as private, and that is relevant or responsive to this NPRM, it is important that you clearly designate the submitted comments as CBI. Please mark each page of your submission containing CBI as ''PROPIN.'' The FAA will treat such marked submissions as confidential under the FOIA, and they will not be placed in the public docket of this NPRM. Submissions containing CBI should be sent to Joseph Hodgin, Aviation Safety Engineer, FAA, 2200 South 216th St., Des Moines, WA 98198; phone: 206–231–3962; email: *joseph.j.hodgin@faa.gov.* Any commentary that the FAA receives that is not specifically designated as CBI will be placed in the public docket for this rulemaking.

Background

The FAA has received reports of multiple supplier NOEs indicating that multiple cargo barrier fitting links (both left and right) were possibly manufactured with an incorrect titanium alloy material. The titanium material that was possibly used is a Grade 1 or 2 commercially pure unalloyed titanium, which has significantly reduced strength and fatigue- and damage-tolerance properties compared to the type design Grade 5 Ti-6Al-4V alloy material. Cargo barrier fitting links manufactured with the incorrect titanium alloy material, if not addressed, could fail in the event of a rapid decompression in the aft fuselage and could result in damage to the aft electronic equipment bay and consequent loss of continued safe flight and landing.

FAA's Determination

The FAA is issuing this NPRM after determining that the unsafe condition described previously is likely to exist or develop on other products of the same type design.

Material Incorporated by Reference Under 1 CFR Part 51

The FAA reviewed Boeing Alert Requirements Bulletin B787–81205–SB530089–00 RB, dated February 7, 2025. This document specifies procedures for a HFEC or handheld XRF spectrometer inspection of the cargo barrier fitting link to determine the titanium alloy material type, and applicable on-condition actions. On-condition actions include replacing any affected fitting link with a new cargo barrier fitting link that is manufactured with Ti-6Al-4V alloy material. This document is reasonably available because the interested parties have access to it through their normal course of business or by the means identified in the **ADDRESSES** section.

Proposed AD Requirements in This NPRM

This proposed AD would require accomplishing the actions specified in the material already described, except for any differences identified as exceptions in the regulatory text of this proposed AD. For information on the procedures and compliance times, see this material at *regulations.gov* under Docket No. FAA–2025–1110.

Costs of Compliance

The FAA estimates that this AD, if adopted as proposed, would affect 23 airplanes of U.S. registry. The FAA estimates the following costs to comply with this proposed AD:

ESTIMATED COSTS

Action	Labor cost	Parts cost	Cost per product	Cost on U.S. operators
Inspection	1 work-hour × $85 per hour = $85	$0	$85	$1,955

The FAA estimates the following costs to do any replacements that would be required based on the results of the proposed inspection. The agency has no way of determining the number of aircraft that might need this replacement:

ON-CONDITION COSTS

Action	Labor cost	Parts cost	Cost per product
Replacement	1 work-hour × $85 per hour = $85	Up to $2,010	Up to $2,095.

The FAA has included all known costs in its cost estimate. According to the manufacturer, however, some or all of the costs of this proposed AD may be covered under warranty, thereby reducing the cost impact on affected operators.

Authority for This Rulemaking

Title 49 of the United States Code specifies the FAA's authority to issue rules on aviation safety. Subtitle I, section 106, describes the authority of the FAA Administrator. Subtitle VII: Aviation Programs, describes in more detail the scope of the Agency's authority.

The FAA is issuing this rulemaking under the authority described in Subtitle VII, Part A, Subpart III, Section 44701: General requirements. Under that section, Congress charges the FAA with promoting safe flight of civil aircraft in air commerce by prescribing regulations for practices, methods, and procedures the Administrator finds necessary for safety in air commerce. This regulation is within the scope of that authority because it addresses an unsafe condition that is likely to exist or develop on products identified in this rulemaking action.

Regulatory Findings

The FAA determined that this proposed AD would not have federalism implications under Executive Order 13132. This proposed AD would not have a substantial direct effect on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government.

For the reasons discussed above, I certify this proposed regulation:

(1) Is not a ''significant regulatory action'' under Executive Order 12866,

(2) Would not affect intrastate aviation in Alaska, and

(3) Would not have a significant economic impact, positive or negative, on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

List of Subjects in 14 CFR Part 39

Air transportation, Aircraft, Aviation safety, Incorporation by reference, Safety.

The Proposed Amendment

Accordingly, under the authority delegated to me by the Administrator, the FAA proposes to amend 14 CFR part 39 as follows:

PART 39—AIRWORTHINESS DIRECTIVES

■ 1. The authority citation for part 39 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40113, 44701.

§ 39.13 [Amended]

■ 2. The FAA amends § 39.13 by adding the following new airworthiness directive:

The Boeing Company: Docket No. FAA–2025–1110; Project Identifier AD–2025–00166–T.

(a) Comments Due Date

The FAA must receive comments on this airworthiness directive (AD) by August 11, 2025.

(b) Affected ADs

None.

(c) Applicability

This AD applies to The Boeing Company Model 787–9 and 787–10 airplanes, certificated in any category, as identified in Boeing Alert Requirements Bulletin B787–81205–SB530089–00 RB, dated February 7, 2025.

(d) Subject

Air Transport Association (ATA) of America Code 53, Fuselage.

(e) Unsafe Condition

This AD was prompted by reports of multiple supplier notices of escapement (NOEs) indicating that multiple cargo barrier fitting links were possibly manufactured with an incorrect titanium alloy material. The FAA is issuing this AD to address cargo barrier fitting links possibly manufactured with the incorrect titanium alloy material, which, if not addressed, could fail in the

event of a rapid decompression in the aft fuselage and could result in damage to the aft electronic equipment bay and consequent loss of continued safe flight and landing.

(f) Compliance

Comply with this AD within the compliance times specified, unless already done.

(g) Required Actions

Except as specified by paragraph (h) of this AD: At the applicable times specified in the ''Compliance'' paragraph of Boeing Alert Requirements Bulletin B787–81205–SB530089–00 RB, dated February 7, 2025, do all applicable actions identified in, and in accordance with, the Accomplishment Instructions of Boeing Alert Requirements Bulletin B787–81205–SB530089–00 RB, dated February 7, 2025.

Note 1 to paragraph (g): Guidance for accomplishing the actions required by this AD can be found in Boeing Alert Service Bulletin B787–81205–SB530089–00, dated February 7, 2025, which is referred to in Boeing Alert Requirements Bulletin B787–81205–SB530089–00 RB, dated February 7, 2025.

(h) Exception to Requirements Bulletin Specifications

Where the Compliance Time columns of the tables in the ''Compliance'' paragraph of Boeing Alert Requirements Bulletin B787–81205–SB530089–00 RB, dated February 7, 2025, refer to the Issue 001 date of Requirements Bulletin B787–81205–SB530089–00 RB, this AD requires using the effective date of this AD.

(i) Alternative Methods of Compliance (AMOCs)

(1) The Manager, AIR–520, Continued Operational Safety Branch, FAA, has the authority to approve AMOCs for this AD, if requested using the procedures found in 14 CFR 39.19. In accordance with 14 CFR 39.19, send your request to your principal inspector or responsible Flight Standards Office, as appropriate. If sending information directly to the manager of the certification office, send it to the attention of the person identified in paragraph (j)(1) of this AD. Information may be emailed to: *AMOC@faa.gov*.

(2) Before using any approved AMOC, notify your appropriate principal inspector, or lacking a principal inspector, the manager of the responsible Flight Standards Office.

(3) An AMOC that provides an acceptable level of safety may be used for any repair, modification, or alteration required by this AD if it is approved by The Boeing Company Organization Designation Authorization (ODA) that has been authorized by the Manager, AIR–520, Continued Operational Safety Branch, FAA, to make those findings. To be approved, the repair method, modification deviation, or alteration deviation must meet the certification basis of the airplane, and the approval must specifically refer to this AD.

(j) Related Information

(1) For more information about this AD, contact Joseph Hodgin, Aviation Safety Engineer, FAA, 2200 South 216th St., Des Moines, WA 98198; phone: 206–231–3962; email: *joseph.j.hodgin@faa.gov.*

(2) Material identified in this AD that is not incorporated by reference is available at the address specified in paragraph (k)(3) of this AD.

(k) Material Incorporated by Reference

(1) The Director of the Federal Register approved the incorporation by reference of the material listed in this paragraph under 5 U.S.C. 552(a) and 1 CFR part 51.

(2) You must use this material as applicable to do the actions required by this AD, unless the AD specifies otherwise.

(i) Boeing Alert Requirements Bulletin B787–81205–SB530089–00 RB, dated February 7, 2025.

(ii) [Reserved]

(3) For Boeing material identified in this AD, contact Boeing Commercial Airplanes, Attention: Contractual & Data Services (C&DS), 2600 Westminster Blvd., MC 110–SK57, Seal Beach, CA 90740–5600; telephone 562–797–1717; website *myboeingfleet.com*.

(4) You may view this material at the FAA, Airworthiness Products Section, Operational Safety Branch, 2200 South 216th St., Des Moines, WA. For information on the availability of this material at the FAA, call 206–231–3195.

(5) You may view this material at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, visit *www.archives.gov/federal-register/cfr/ibr-locations* or email *fr.inspection@nara.gov*.

Issued on June 13, 2025.

Peter A. White,

Deputy Director, Integrated Certificate Management Division, Aircraft Certification Service.

[FR Doc. 2025–11690 Filed 6–24–25; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. FAA–2025–1115; Project Identifier AD–2024–00797–E]

RIN 2120–AA64

Airworthiness Directives; CFM International, S.A. Engines

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Notice of proposed rulemaking (NPRM).

SUMMARY: The FAA proposes to adopt a new airworthiness directive (AD) for certain CFM International, S.A. (CFM) Model LEAP–1A23, LEAP–1A24, LEAP–1A24E1, LEAP–1A26, LEAP–1A26CJ, LEAP–1A26E1, LEAP–1A29, LEAP–1A29CJ, LEAP–1A30, LEAP–1A32, LEAP–1A33, LEAP–1A33B2, and LEAP–1A35A engines. This proposed AD was prompted by a report of multiple aborted takeoffs and air turn-backs (ATBs) caused by high-pressure compressor (HPC) stall, which was induced by high levels of non-synchronous vibration (NSV). Additional manufacturer investigation revealed that wear on the No. 3 bearing spring finger housing can lead to high levels of NSV. This proposed AD would require initial and repetitive calculations of the levels of NSV, inspection of the stage 2 high-pressure turbine (HPT) nozzle assembly honeycomb and HPT stator stationary seal honeycomb and, depending on the results of the calculations and inspections, replacement of certain parts. This AD also requires replacement of certain No. 3 bearing spring finger housings at a certain time. The FAA is proposing this AD to address the unsafe condition on these products.

DATES: The FAA must receive comments on this proposed AD by August 11, 2025.

ADDRESSES: You may send comments, using the procedures found in 14 CFR 11.43 and 11.45, by any of the following methods:

- *Federal eRulemaking Portal:* Go to *regulations.gov.* Follow the instructions for submitting comments.
- *Fax:* (202) 493–2251.
- *Mail:* U.S. Department of Transportation, Docket Operations, M–30, West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue SE, Washington, DC 20590.
- *Hand Delivery:* Deliver to Mail address above between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays.

AD Docket: You may examine the AD docket at *regulations.gov* under Docket No. FAA–2025–1115; or in person at Docket Operations between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays. The AD docket contains this NPRM, any comments received, and other information. The street address for Docket Operations is listed above.

Material Incorporated by Reference:

- For CFM material identified in this proposed AD, contact CFM, GE Aviation Fleet Support, 1 Neumann Way, M/D Room 285, Cincinnati, OH 45215; phone: (877) 432–3272; email: *aviation.fleetsupport@ge.com.*
- You may view this material at the FAA, Airworthiness Products Section, Operational Safety Branch, 1200 District Avenue, Burlington, MA 01803. For information on the availability of this

material at the FAA, call (817) 222–5110.

FOR FURTHER INFORMATION CONTACT: Mehdi Lamnyi, Aviation Safety Engineer, FAA, 2200 South 216th Street, Des Moines, WA 98198; phone: (781) 238–7743; email: *mehdi.lamnyi@faa.gov*.

SUPPLEMENTARY INFORMATION:

Comments Invited

The FAA invites you to send any written relevant data, views, or arguments about this proposal. Send your comments to an address listed under the **ADDRESSES** section. Include ''Docket No. FAA–2025–1115; Project Identifier AD–2024–00797–E'' at the beginning of your comments. The most helpful comments reference a specific portion of the proposal, explain the reason for any recommended change, and include supporting data. The FAA will consider all comments received by the closing date and may revise this proposal because of those comments.

Except for Confidential Business Information (CBI) as described in the following paragraph, and other information as described in 14 CFR 11.35, the FAA will post all comments received, without change, to *regulations.gov,* including any personal information you provide. The agency will also post a report summarizing each substantive verbal contact received about this NPRM.

Confidential Business Information

CBI is commercial or financial information that is both customarily and actually treated as private by its owner. Under the Freedom of Information Act (FOIA) (5 U.S.C. 552), CBI is exempt from public disclosure. If your comments responsive to this NPRM contain commercial or financial information that is customarily treated as private, that you actually treat as private, and that is relevant or responsive to this NPRM, it is important that you clearly designate the submitted comments as CBI. Please mark each page of your submission containing CBI as ''PROPIN.'' The FAA will treat such marked submissions as confidential under the FOIA, and they will not be placed in the public docket of this NPRM. Submissions containing CBI should be sent to Mehdi Lamnyi, Aviation Safety Engineer, FAA, 2200 South 216th Street, Des Moines, WA 98198. Any commentary that the FAA receives which is not specifically designated as CBI will be placed in the public docket for this rulemaking.

Background

The FAA was notified by the engine manufacturer of three aborted takeoffs and two ATBs caused by HPC stall on CFM Model LEAP–1A engines. Additional manufacturer investigation revealed that wear on the No. 3 bearing spring finger housing can lead to high levels of NSV, which could induce HPC stall. As a result of its investigation, the manufacturer published service material that specifies procedures for addressing this situation. The FAA previously published AD 2024–07–06, Amendment 39–22727 (89 FR 33211, April 29, 2024) to address this condition for parts from one specific supplier whose parts have shown increased susceptibility to premature wear. Since the publication of that AD, the manufacturer has identified another supplier whose parts are also susceptible to the same type of premature wear. This condition, if not addressed, could result in engine power loss at a critical phase of flight such as takeoff or climb, loss of engine thrust control, reduced controllability of the airplane, and loss of the airplane.

FAA's Determination

The FAA is issuing this NPRM after determining that the unsafe condition described previously is likely to exist or develop on other products of the same type design.

Material Incorporated by Reference Under 1 CFR Part 51

The FAA reviewed CFM Service Bulletin (SB) LEAP–1A–72–00–0536–01A–930A–D, Issue 001, dated July 22, 2024. This service material specifies procedures for replacing the No. 3 bearing spring finger housings, inspecting the stage 2 HPT nozzle assembly honeycomb, and inspecting the HPT stator stationary seal honeycomb. The FAA also reviewed CFM SB LEAP–1A–72–00–0562–01A–930A–D, Issue 001–00, dated April 30, 2025. This service material identifies the affected No. 3 bearing spring finger housings and specifies procedures for monitoring NSV during engine operation, replacing the stage 2 HPT nozzle assembly honeycomb, and replacing the HPT stator stationary seal. This material is reasonably available because the interested parties have access to it through their normal course of business or by the means identified in the **ADDRESSES** section.

Proposed AD Requirements in This NPRM

This proposed AD would require repetitive calculations of the levels of NSV and, depending on the results of the calculations, replacement of the No. 3 bearing spring finger housing. This proposed AD would require, following the removal and replacement of the No. 3 bearing spring finger housing, inspection of the stage 2 HPT nozzle assembly honeycomb and HPT stator stationary seal honeycomb for rubs and, depending on findings, replacement of the stage 2 HPT nozzle assembly honeycomb and HPT stator stationary seal. This proposed AD would also require replacement of the No. 3 bearing spring finger housing regardless of calculated level of NSV, at a certain time.

Costs of Compliance

The FAA estimates that this AD, if adopted as proposed, would affect three engines installed on airplanes of U.S. registry.

The FAA estimates the following costs to comply with this proposed AD:

ESTIMATED COSTS

Action	Labor cost	Parts cost	Cost per product	Cost on U.S. operators
Calculate NSV data	1 work-hours × $85 per hour = $85	$0	$85	$255
Inspect stage 2 HPT nozzle assembly honeycomb and HPT stator stationary seal honeycomb.	4 work-hours × $85 per hour = $340	0	340	1,020
Replace No. 3 bearing spring finger housing	17 work-hours × $85 per hour = $1,445	64,590	66,035	198,105

The FAA estimates the following costs to do any necessary replacements and inspections that would be required based on the results of the proposed calculation. The agency has no way of determining the number of engines that might need these replacements and inspections:

ON-CONDITION COSTS

Action	Labor cost	Parts cost	Cost per product
Replace stage 2 HPT nozzle assembly honeycomb	8 work-hours × $85 per hour = $680	$58,536	$59,216
Replace HPT stator stationary seal	8 work-hours × $85 per hour = $680	6,855	7,535

Authority for This Rulemaking

Title 49 of the United States Code specifies the FAA's authority to issue rules on aviation safety. Subtitle I, section 106, describes the authority of the FAA Administrator. Subtitle VII: Aviation Programs, describes in more detail the scope of the Agency's authority.

The FAA is issuing this rulemaking under the authority described in Subtitle VII, Part A, Subpart III, Section 44701: General requirements. Under that section, Congress charges the FAA with promoting safe flight of civil aircraft in air commerce by prescribing regulations for practices, methods, and procedures the Administrator finds necessary for safety in air commerce. This regulation is within the scope of that authority because it addresses an unsafe condition that is likely to exist or develop on products identified in this rulemaking action.

Regulatory Findings

The FAA determined that this proposed AD would not have federalism implications under Executive Order 13132. This proposed AD would not have a substantial direct effect on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government.

For the reasons discussed above, I certify this proposed regulation:

(1) Is not a ''significant regulatory action'' under Executive Order 12866,

(2) Would not affect intrastate aviation in Alaska, and

(3) Would not have a significant economic impact, positive or negative, on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

List of Subjects in 14 CFR Part 39

Air transportation, Aircraft, Aviation safety, Incorporation by reference, Safety.

The Proposed Amendment

Accordingly, under the authority delegated to me by the Administrator, the FAA proposes to amend 14 CFR part 39 as follows:

PART 39—AIRWORTHINESS DIRECTIVES

■ 1. The authority citation for part 39 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40113, 44701.

§ 39.13 [Amended]

■ 2. The FAA amends § 39.13 by adding the following new airworthiness directive:

CFM International, S.A.: Docket No. FAA–2025–1115; Project Identifier AD–2024–00797–E.

(a) Comments Due Date

The FAA must receive comments on this airworthiness directive (AD) by August 11, 2025.

(b) Affected ADs

None.

(c) Applicability

This AD applies to CFM International, S.A. (CFM) Model LEAP–1A23, LEAP–1A24, LEAP–1A24E1, LEAP–1A26, LEAP–1A26CJ, LEAP–1A26E1, LEAP–1A29, LEAP–1A29CJ, LEAP–1A30, LEAP–1A32, LEAP–1A33, LEAP–1A33B2, and LEAP–1A35A engines with an installed No. 3 bearing spring finger housing having part number (P/N) 2629M62G01 and a serial number identified in Table 1 of CFM Service Bulletin (SB) LEAP–1A–72–00–0562–01A–930A–D, Issue 001–00, dated April 30, 2025 (CFM SB LEAP–1A–72–00–0562–01A–930A–D, Issue 001–00).

(d) Subject

Joint Aircraft System Component (JASC) Code 7230, Turbine Engine Compressor Section.

(e) Unsafe Condition

This AD was prompted by a report of multiple aborted takeoffs and air turn-backs caused by high-pressure compressor (HPC) stall, which was induced by high levels of non-synchronous vibration (NSV), and an additional manufacturer investigation that revealed wear on the No. 3 bearing spring finger housing. The FAA is issuing this AD to prevent HPC stall. The unsafe condition, if not addressed, could result in engine power loss at a critical phase of flight such as takeoff or climb, loss of engine thrust control, reduced controllability of the airplane, and loss of the airplane.

(f) Compliance

Comply with this AD within the compliance times specified, unless already done.

(g) Required Actions

(1) Within 50 flight cycles (FCs) after the effective date of this AD and thereafter at intervals not to exceed 50 FCs, calculate the NSV data in accordance with the Accomplishment Instructions, paragraphs 5.A.(1) and 5.A.(3), or 5.B.(1) and 5.B.(3) of CFM SB LEAP–1A–72–00–0562–01A–930A–D, Issue 001–00.

(2) If, during any calculation required by paragraph (g)(1) of this AD, the NSV data exceeds the limits specified in the Accomplishment Instructions paragraph 5.A.(4)(a)1, 5.A.(4)(a)2, or 5.B.(4)(a)1 of CFM SB LEAP–1A–72–00–0562–01A–930A–D, Issue 001–00, discontinue the calculations required by paragraph (g)(1) of this AD and within 25 FCs or 5 FCs, as applicable, of the flight when these limits are exceeded:

(i) Remove from service the No. 3 bearing spring finger housing having P/N 2629M62G01 and a serial number identified in Table 1 of CFM SB LEAP–1A–72–00–0562–01A–930A–D, Issue 001–00, and replace with a part eligible for installation.

(ii) Inspect the stage 2 high-pressure turbine (HPT) nozzle assembly honeycomb for rubs in accordance with the Accomplishment Instructions, paragraphs 5.A.(4)(a)4b or 5.B.(4)(a)3b of CFM SB LEAP–1A–72–00–0562–01A–930A–D, Issue 001–00.

(iii) Inspect the HPT stator stationary seal honeycomb for rubs in accordance with the Accomplishment Instructions, paragraphs 5.A.(4)(a)4b or 5.B.(4)(a)3b of CFM SB LEAP–1A–72–00–0562–01A–930A–D, Issue 001–00.

(3) If, during the inspection required by paragraph (g)(2)(ii) of this AD, the stage 2 HPT nozzle assembly honeycomb fails to meet the serviceability criteria referenced in the Accomplishment Instructions, paragraphs 5.A.(4)(a)4b or 5.B.(4)(a)3b of CFM SB LEAP–1A–72–00–0562–01A–930A–D, Issue 001–00, before further flight, replace the stage 2 HPT nozzle assembly honeycomb.

(4) If, during the inspection required by paragraph (g)(2)(iii) of this AD, the HPT stator stationary seal honeycomb fails to meet the serviceability criteria referenced in the Accomplishment Instructions, paragraphs 5.A.(4)(a)4b or 5.B.(4)(a)3b of CFM SB LEAP–1A–72–00–0562–01A–930A–D, Issue 001–00, before further flight, replace the HPT stator stationary seal.

(5) At the next shop visit after the effective date of this AD, perform the following:

(i) Replace the No. 3 bearing spring finger housing having P/N 2629M62G01 and a serial number identified in Table 1 of CFM SB LEAP–1A–72–00–0562–01A–930A–D, Issue 001, with a part eligible for installation in accordance with paragraph 5.A.(1) of CFM SB LEAP–1A–72–00–0536–01A–930A–D, Issue 001–00 dated April 30, 2025 (CFM SB LEAP–1A–72–00–0536–01A–930A–D, Issue 001); and,

(ii) Inspect the stage 2 HPT nozzle assembly honeycomb and the HPT stator

stationary seal honeycomb for rubs and disposition in accordance with paragraph 5.B.(4) and 5.B.(5) of CFM SB LEAP–1A–72–00–0536–01A–930A–D, Issue 001.

(h) Terminating Action

Replacement of the No. 3 bearing spring finger housing having P/N 2629M62G01 and a serial number identified in Table 1 of CFM SB LEAP–1A–72–00–0562–01A–930A–D, Issue 001–00 with a part eligible for installation, as specified in paragraph (g)(2)(i) and (g)(5) of this AD, constitutes terminating action for the calculations required by paragraph (g)(1) of this AD.

(i) Definitions

(1) For the purpose of this AD, a ''part eligible for installation'' is a No. 3 bearing spring finger housing that does not have P/N 2629M62G01 and a serial number identified in Table 1 of CFM SB LEAP–1A–72–00–0562–01A–930A–D, Issue 001–00.

(2) For the purpose of this AD, a ''shop visit'' is the induction of an engine into the shop for maintenance involving the separation of pairs of major mating engine flanges, except that the separation of engine flanges solely for the purposes of transportation without subsequent engine maintenance does not constitute an engine shop visit.

(j) Alternative Methods of Compliance (AMOCs)

(1) The Manager, AIR–520 Continued Operational Safety Branch, FAA, has the authority to approve AMOCs for this AD, if requested using the procedures found in 14 CFR 39.19. In accordance with 14 CFR 39.19, send your request to your principal inspector or local Flight Standards District Office, as appropriate. If sending information directly to the Manager, AIR–520 Continued Operational Safety Branch, send it to the attention of the person identified in paragraph (k) of this AD and email to: *AMOC@faa.gov*.

(2) Before using any approved AMOC, notify your appropriate principal inspector, or lacking a principal inspector, the manager of the local flight standards district office/certificate holding district office.

(3) For service material that contains steps that are labeled as Required for Compliance (RC), the following provisions apply.

(i) The steps labeled as RC, including substeps under an RC step and any figures identified in an RC step, that are required by paragraph (g) of this AD must be done to comply with this AD. An AMOC is required for any deviations to RC steps required by paragraph (g) of this AD, including substeps and identified figures.

(ii) Steps not labeled as RC may be deviated from using accepted methods in accordance with the operator's maintenance or inspection program without obtaining approval of an AMOC, provided the RC steps, including substeps and identified figures, can still be done as specified, and the airplane can be put back in an airworthy condition.

(k) Additional Information

For more information about this AD, contact Mehdi Lamnyi, Aviation Safety Engineer, FAA, 2200 South 216th Street, Des Moines, WA 98198; phone: (781) 238–7743; email: *mehdi.lamnyi@faa.gov*.

(l) Material Incorporated by Reference

(1) The Director of the Federal Register approved the incorporation by reference (IBR) of the material listed in this paragraph under 5 U.S.C. 552(a) and 1 CFR part 51.

(2) You must use this material as applicable to do the actions required by this AD, unless the AD specifies otherwise.

(i) CFM International, S.A. (CFM) Service Bulletin (SB) LEAP–1A–72–00–0536–01A–930A–D, Issue 001–00, dated July 22, 2024.

(ii) CFM SB LEAP–1A–72–00–0562–01A–930A–D, Issue 001–00, dated April 30, 2025.

(3) For CFM material identified in this AD, contact CFM, GE Aviation Fleet Support, 1 Neumann Way, M/D Room 285, Cincinnati, OH 45215; phone: (877) 432–3272; email: *aviation.fleetsupport@ge.com*.

(4) You may view this material at the FAA, Airworthiness Products Section, Operational Safety Branch, 1200 District Avenue, Burlington, MA 01803. For information on the availability of this material at the FAA, call (817) 222–5110

(5) You may view this material at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, visit *www.archives.gov/federal-register/cfr/ibr-locations* or email *fr.inspection@nara.gov*.

Issued on June 18, 2025.

Peter A. White,

Deputy Director, Integrated Certificate Management Division, Aircraft Certification Service.

[FR Doc. 2025–11689 Filed 6–24–25; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. FAA–2025–0341; Product Identifier MCAI–2024–00679–E]

RIN 2120–AA64

Airworthiness Directives; Safran Helicopter Engines

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Notice of proposed rulemaking (NPRM); withdrawal.

SUMMARY: The FAA is withdrawing an NPRM that proposed to adopt a new airworthiness directive (AD) that would have applied to all Safran Helicopter Engines, S.A. (Safran) Model ARRIUS 2F and ARRIUS 2R engines. The NPRM was prompted by a manufacturer investigation that revealed certain high-pressure (HP) turbine blades may contain non-compliant porosity rates due to a change in the manufacturing process. The NPRM would have required replacement of affected HP turbine blades. Since the NPRM was issued, further investigation and tests demonstrated that the non-compliant rate of porosity has no impact on the use limit of the affected parts and the FAA has determined that the unsafe condition no longer exists. Accordingly, the NPRM is withdrawn.

DATES: As of June 25, 2025, the proposed rule, which was published in the **Federal Register** on March 13, 2025 (90 FR 11914), is withdrawn.

ADDRESSES: You may examine the AD docket at *regulations.gov* under Docket No. FAA–2025–0341; or in person at the Docket Operations between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays. The AD docket contains this AD action (withdrawal), the NPRM, the mandatory continuing airworthiness information, any comments received, and other information. The street address for Docket Operations is U.S. Department of Transportation, Docket Operations, M–30, West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue SE, Washington, DC 20590.

FOR FURTHER INFORMATION CONTACT: David Bergeron, Aerospace Engineer, FAA, 1600 Stewart Avenue, Suite 410, Westbury, NY 11590; phone: (781) 238–7157; email: *david.j.bergeron@faa.gov*.

SUPPLEMENTARY INFORMATION:

Discussion

Background

The FAA issued an NPRM that proposed to amend 14 CFR part 39 by adding an AD for all Safran Model ARRIUS 2F and ARRIUS 2R engines. The NPRM was published in the **Federal Register** on March 13, 2025 (90 FR 11914). The NPRM was prompted by a manufacturer investigation that revealed certain HP turbine blades may contain non-compliant porosity rates due to a change in the manufacturing process. The NPRM proposed to require replacement of affected HP turbine blades, as specified in European Union Aviation Safety Agency (EASA) AD 2024–0218R1, dated December 19, 2024 (EASA AD 2024–0218R1).

The proposed actions were intended to prevent the failure of the HP turbine blades. The unsafe condition, if not addressed, could result in an in-flight shutdown and a significant reduction in the control of the helicopter.

Actions Since the NPRM Was Issued

Since issuance of the NPRM, EASA, which is the Technical Agent for the Member States of the European Union, has issued EASA AD 2024–0218R1–CN, dated March 17, 2025 (EASA AD 2024–

0218R1–CN), which cancels EASA AD 2024–0218R1. EASA AD 2024–0218R1–CN states that since EASA AD 2024–0218R1 was issued, further investigation and tests demonstrated that the non-compliant rate of porosity has no impact on the use limit of the affected parts, and the subsequent risk re-assessment has shown that the safety issue addressed by the previous EASA AD does not qualify as an unsafe condition. Therefore, the FAA has determined that AD action is no longer appropriate.

Withdrawal of the NPRM constitutes only such action and does not preclude the FAA from further rulemaking on this issue, nor does it commit the FAA to any course of action in the future.

Comments

The FAA received comments from two commenters, including Summit Helicopters, Inc. and an anonymous commenter. The following presents the comments received on the NPRM and the FAA's response to each comment.

Request for Clarification Dependent on Issuance of New EASA AD

Summit Helicopers, Inc. requested that the FAA either cancel the NPRM or revise to remove reference to EASA AD 2024–0218R1. Summit Helicopters, Inc. pointed out that EASA has issued EASA AD 2024–0218R1–CN, which cancelled EASA AD 2024–0218R1.

The FAA agrees with the request and is withdrawing the NPRM.

Request for Greater Oversight of, and Transparency From, the Manufacturer

An anonymous commenter discussed numerous topics affecting the NPRM, especially requesting that the FAA require greater oversight of, and transparency from, the engine manufacturer. Additional topics included specialized training for technicians, environmental considerations, emergency preparedness, publication of root cause analysis reports, cost burden for operators, health and safety standards and equipment, and alignment of future oversight with international best practices and quality management standards.

The FAA agrees that all the discussed topics may have had an impact should the NPRM have continued to become a final rule. However, because the NPRM is withdrawn, the discussion and requests are no longer necessary.

FAA's Conclusions

Upon further consideration, the FAA has determined that the NPRM is unnecessary. Accordingly, the NPRM is withdrawn.

Regulatory Findings

Since this action only withdraws an NPRM, it is neither a proposed nor a final rule and therefore is not covered under Executive Order 12866, the Regulatory Flexibility Act, or DOT Regulatory Policies and Procedures (44 FR 11034, February 26, 1979).

List of Subjects in 14 CFR Part 39

Air transportation, Aircraft, Aviation safety, Incorporation by reference, Safety.

The Withdrawal

Accordingly, the notice of proposed rulemaking (Docket No. FAA–2025–0341), which was published in the **Federal Register** on March 13, 2025 (90 FR 11914), is withdrawn.

Issued on June 18, 2025.

Steven W. Thompson,

Acting Deputy Director, Compliance & Airworthiness Division, Aircraft Certification Service.

[FR Doc. 2025–11665 Filed 6–24–25; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. FAA–2025–0922; Project Identifier MCAI–2024–00650–R]

RIN 2120–AA64

Airworthiness Directives; Airbus Helicopters

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Notice of proposed rulemaking (NPRM).

SUMMARY: The FAA proposes to supersede Airworthiness Directive (AD) 2021–26–07, which applies to all Airbus Helicopters Model EC120B helicopters. AD 2021–26–07 requires performing repetitive inspections of the tail rotor (TR) hub body and, depending on the inspection results, replacing certain parts, and accomplishing further inspections. AD 2021–26–07 also requires for certain helicopters removing from service any bolt, washer, and nut installed on the TR hub body at certain life limits and replacing them with airworthy parts and accomplishing further inspections. Additionally, AD 2021–26–07 prohibits the installation of a certain part-numbered TR hub body unless certain requirements are met. Since the FAA issued AD 2021–26–07, it was determined that modifying the link of the TR hub body and splined flange by adding red paint marks is necessary to enable the detection of any loss of tightening torque. This proposed AD would require the same repetitive inspections and corrective actions as AD 2021–26–07 and would require modification of the link of the TR hub body, which would be a terminating action for the repetitive inspections. The proposed AD would also require repetitive inspections of the red paint line added during the modification of the link of the TR hub body for alignment. The FAA is proposing this AD to address the unsafe condition on these products.

DATES: The FAA must receive comments on this NPRM by August 11, 2025.

ADDRESSES: You may send comments, using the procedures found in 14 CFR 11.43 and 11.45, by any of the following methods:

- *Federal eRulemaking Portal:* Go to *regulations.gov*. Follow the instructions for submitting comments.
- *Fax:* (202) 493–2251.
- *Mail:* U.S. Department of Transportation, Docket Operations, M–30, West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue SE, Washington, DC 20590.
- *Hand Delivery:* Deliver to Mail address above between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays.

AD Docket: You may examine the AD docket at *regulations.gov* under Docket No. FAA–2025–0922; or in person at Docket Operations between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays. The AD docket contains this NPRM, the mandatory continuing airworthiness information (MCAI) any comments received, and other information. The street address for Docket Operations is listed above.

Material Incorporated by Reference:

- For Airbus Helicopters material identified in this proposed AD, contact Airbus Helicopters, 2701 North Forum Drive, Grand Prairie, TX 75052; phone: (972) 641–0000 or: (800) 232–0323; fax: (972) 641–3775; website: *airbus.com/en/products-services/helicopters/hcare-services/airbusworld*.
- You may view this material at the FAA, Office of the Regional Counsel, Southwest Region, 10101 Hillwood Parkway, Room 6N–321, Fort Worth, TX 76177. For information on the availability of this material at the FAA, call (817) 222–5110. It is also available at *regulations.gov* under Docket No. FAA–2025–0922.

FOR FURTHER INFORMATION CONTACT: Camille Seay, Aviation Safety Engineer, FAA, 1600 Stewart Avenue, Suite 410, Westbury, NY 11590; phone: (817) 222–5149; email: *camille.l.seay@faa.gov*.

SUPPLEMENTARY INFORMATION:

Comments Invited

The FAA invites you to send any written relevant data, views, or arguments about this proposal. Send your comments using a method listed under the **ADDRESSES** section. Include ''Docket No. FAA–2025–0922; Project Identifier MCAI–2024–00650–R'' at the beginning of your comments. The most helpful comments reference a specific portion of the proposal, explain the reason for any recommended change, and include supporting data. The FAA will consider all comments received by the closing date and may amend the proposal because of those comments.

Except for Confidential Business Information (CBI) as described in the following paragraph, and other information as described in 14 CFR 11.35, the FAA will post all comments received, without change, to *regulations.gov,* including any personal information you provide. The agency will also post a report summarizing each substantive verbal contact received about this NPRM.

Confidential Business Information

CBI is commercial or financial information that is both customarily and actually treated as private by its owner. Under the Freedom of Information Act (FOIA) (5 U.S.C. 552), CBI is exempt from public disclosure. If your comments responsive to this NPRM contain commercial or financial information that is customarily treated as private, that you actually treat as private, and that is relevant or responsive to this NPRM, it is important that you clearly designate the submitted comments as CBI. Please mark each page of your submission containing CBI as ''PROPIN.'' The FAA will treat such marked submissions as confidential under the FOIA, and they will not be placed in the public docket of this NPRM. Submissions containing CBI should be sent to Camille Seay, Aviation Safety Engineer, FAA, 1600 Stewart Avenue, Suite 410, Westbury, NY 11590. Any commentary that the FAA receives which is not specifically designated as CBI will be placed in the public docket for this rulemaking.

Background

The FAA issued AD 2021–26–07, Amendment 39–21866 (86 FR 72829, December 23, 2021) (AD 2021–26–07), for Airbus Helicopters Model EC120B helicopters. AD 2021–26–07 was prompted by European Union Aviation Safety Agency (EASA) AD 2021–0069, dated March 11, 2021 (EASA AD 2021–0069), issued by EASA, which is the Technical Agent for the Member States of the European Union, to address loss of tightening torque in the interface between the TR hub body and splined flange, which creates the risk of crack initiation from a fretting area located on the TR hub body and splined flange or on the TR hub body and flange bolts.

AD 2021–26–07 requires performing repetitive inspections of the TR hub body for a crack, and depending on the inspection results, removing the affected parts from service and inspecting the TR spline flange and, depending on those inspection results, removing an affected splined flange from service. AD 2021–26–07 also requires, for certain helicopters, removing from service any bolt, washer, and nut installed on the TR hub body that has exceeded a certain life limit, and thereafter removing these parts from service within specific intervals and accomplishing further inspections and corrective actions.

Additionally, AD 2021–26–07 prohibits installing a certain part-numbered TR hub body unless certain requirements are met. The FAA issued AD 2021–26–07 to detect cracking and fretting, which if not addressed, could result in potential loss of the TR drive and consequent loss of yaw control of the helicopter.

Actions Since AD 2021–26–07 Was Issued

Since the FAA issued AD 2021–26–07, EASA superseded EASA AD 2021–0069 with EASA AD 2024–0209, dated October 28, 2024 (EASA AD 2024–0209) (also referred to as the MCAI), to address an unsafe condition on all Airbus Helicopters Model EC 120 B helicopters. The MCAI states that, Airbus Helicopters developed a modification, which consists of adding a line of red paint on each bolt and each nut of the link between the TR hub and the splined flange. The MCAI further states that an Airworthiness Limitations Section task was published for checking alignment of the marks.

The FAA is proposing this AD to detect cracking and fretting of the TR hub body, which, if not addressed, could lead to loss of the TR drive, and consequent loss of yaw control of the helicopter.

You may examine the MCAI in the AD docket at *regulations.gov* under Docket No. FAA–2025–0922.

Material Incorporated by Reference Under 1 CFR Part 51

The FAA reviewed Airbus Helicopters Emergency Alert Service Bulletin 05A020, Revision 3, dated September 19, 2024 (EASB 05A0020 Rev 3), which specifies procedures for repetitive inspections of the TR hub body for cracks and the TR spline flange for cracks and fretting and the appropriate corrective actions to include replacing the hub body and the splined flange. EASB 05A0020 Rev 3 also excludes helicopters that have complied with Airbus Helicopters Alert Service Bulletin EC120–64–21–0001, Issue 001, dated September 19, 2024 (ASB EC120–64–21–0001) from its effectivity and limits the effectivity for ''non installed equipment or parts''.

The FAA also reviewed ASB EC120–64–21–0001, which specifies procedures for inspecting the torque applied on the nut of the link between the TR hub and the splined flange, and depending on the inspection results, applying torque and replacing parts. ASB EC120–64–21–0001 also specifies procedures for applying a red paint line on the screw, nut, washer, TR hub, and splined flange.

This material is reasonably available because the interested parties have access to it through their normal course of business or by the means identified in the **ADDRESSES** section.

FAA's Determination

These products have been approved by the aviation authority of another country and are approved for operation in the United States. Pursuant to the FAA's bilateral agreement with this State of Design Authority, it has notified the FAA of the unsafe condition described in the MCAI referenced above. The FAA is issuing this NPRM after determining that the unsafe condition described previously is likely to exist or develop on other products of the same type design.

Proposed AD Requirements in This NPRM

This proposed AD would require some of the same repetitive inspections and corrective actions as AD 2021–26–07 and would also require modifying the helicopter by applying torque and adding a red paint mark on each bolt and nut on the link between the TR hub and the splined flange after applying torque, which would be a terminating action for the repetitive inspection requirements. The proposed AD would also require repetitive inspections of the red paint line added during the modification of the link of the TR hub body for alignment.

Differences Between This Proposed AD and the MCAI

EASA AD 2024–0209 allows a non-cumulative tolerance of 100 FH [flight hours] to be applied to the compliance times to allow for synchronization of the required inspections with other

maintenance tasks, whereas this proposed AD would not allow a non-cumulative tolerance to be applied to the compliance times.

Costs of Compliance

The FAA estimates that this AD, if adopted as proposed, would affect 70 helicopters of U.S. registry. Labor rates are estimated at $85 per hour. Based on these numbers, the FAA estimates the following costs to comply with this proposed AD.

Visually inspecting a TR hub body for a crack would take 0.25 work-hour for an estimated cost of $22 per helicopter and $1,540 for the U.S. fleet.

Visually inspecting a TR spline flange for corrosion, impacts, fretting, wear, and a crack would take 0.25 work-hour for an estimated cost of $22 per helicopter and $1,540 for the U.S. fleet.

Replacing a T/R hub body bolt, washer, and nut would take 0.5 work-hour and parts would cost $25 (per hardware set) for an estimated cost of $68 per helicopter.

Inspecting torque and adding a red paint line on each bolt and each nut would take 4 work-hours for an estimated cost of $340 per helicopter and $23,800 for the U.S. fleet.

If required, replacing a TR hub body would take 2 work-hours and parts would cost $16,485 for an estimated cost of $16,655 per helicopter.

If required, replacing a TR spline flange would take 0.5 work-hour and parts would cost $2,950 for an estimated cost of $2,993 per helicopter.

Authority for This Rulemaking

Title 49 of the United States Code specifies the FAA's authority to issue rules on aviation safety. Subtitle I, section 106, describes the authority of the FAA Administrator. Subtitle VII, Aviation Programs, describes in more detail the scope of the Agency's authority.

The FAA is issuing this rulemaking under the authority described in Subtitle VII, Part A, Subpart III, Section 44701: General requirements. Under that section, Congress charges the FAA with promoting safe flight of civil aircraft in air commerce by prescribing regulations for practices, methods, and procedures the Administrator finds necessary for safety in air commerce. This regulation is within the scope of that authority because it addresses an unsafe condition that is likely to exist or develop on products identified in this rulemaking action.

Regulatory Findings

The FAA determined that this proposed AD would not have federalism implications under Executive Order 13132. This proposed AD would not have a substantial direct effect on the States, on the relationship between the national Government and the States, or on the distribution of power and responsibilities among the various levels of government.

For the reasons discussed above, I certify that the proposed regulation:

(1) Is not a ''significant regulatory action'' under Executive Order 12866,

(2) Would not affect intrastate aviation in Alaska, and

(3) Would not have a significant economic impact, positive or negative, on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

List of Subjects in 14 CFR Part 39

Air transportation, Aircraft, Aviation safety, Incorporation by reference, Safety.

The Proposed Amendment

Accordingly, under the authority delegated to me by the Administrator, the FAA proposes to amend 14 CFR part 39 as follows:

PART 39—AIRWORTHINESS DIRECTIVES

■ 1. The authority citation for part 39 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40113, 44701.

§ 39.13 [Amended]

■ 2. The FAA amends § 39.13 by:

■ a. Removing Airworthiness Directive 2021–26–07, Amendment 39–21866 (86 FR 72829, December 23, 2021); and

■ b. Adding the following new airworthiness directive:

Airbus Helicopters: Docket No. FAA–2025–0922; Project Identifier MCAI–2024–00650–R.

(a) Comments Due Date

The FAA must receive comments on this airworthiness directive (AD) by August 11, 2025.

(b) Affected ADs

This AD replaces AD 2021–26–07, Amendment 39–21866 (86 FR 72829, December 23, 2021).

(c) Applicability

This AD applies to Airbus Helicopters Model EC120B helicopters, certificated in any category.

(d) Subject

Joint Aircraft System Component (JASC) Code 6422, Tail rotor system.

(e) Unsafe Condition

This AD was prompted by analysis of recurrent loss of tightening torque on several attachment bolts on the tail rotor (TR) hub body. The FAA is issuing this AD to detect cracking and fretting of the TR hub body. The unsafe condition, if not addressed, could lead to loss of the TR drive, and consequent loss of yaw control of the helicopter.

(f) Compliance

Comply with this AD within the compliance times specified, unless already done.

(g) Required Actions

(1) Within 15 hours time-in-service (TIS) or 7 days, whichever occurs first after the effective date of this AD, and thereafter at intervals not to exceed 15 hours TIS, using a light source and mirror, visually inspect TR hub body part number (P/N) C642A0100103 for a crack in the entire inspection area depicted in Figure 1 of Airbus Helicopters Emergency Alert Service Bulletin 05A020 Revision 3, dated September 19, 2024. If any crack is found, before further flight, perform the actions in paragraphs (g)(1)(i) and (ii) of this AD.

(i) Remove the TR hub body and each bolt, washer, and nut installed on the TR hub body from service and replace with airworthy parts.

(ii) Inspect the TR splined flange for corrosion, impacts, fretting, wear, and a crack in the areas identified in Figure 2 to paragraph (g)(1)(ii) of this AD. If the condition of the part (including corrosion, impacts, fretting, wear, or cracks) exceeds the criteria as specified in Figure 1 to paragraph (g)(1)(ii) of this AD, before further flight, remove the splined flange from service and replace with an airworthy part.

Note 1 to paragraph (g)(1)(ii): You may refer to ''Detailed Check-Splined Flange,'' Task 64–21–00, 6–5, Airbus Aircraft Maintenance Manual (AMM), dated October 15, 2020, which pertains to the TR splined flange inspection.

Figure 1 to Paragraph (g)(1)(ii)—Inspection Criteria for TR Splined Flange

Location as specified in Figure 2 to paragraph (g)(1)(ii) of this AD	Maximum damage, which causes replacement (E1, Dia. 2, Dia. 3, and Dia. 4 are shown in Figure 2 to paragraph (g)(1)(ii) of this AD)
Zone A	Scratch depth >0.2 mm (0.008 in.). Crack. E1 <2.75 mm (0.108 in.). Dia. 3 >6.02 mm (0.2371 in.). Dia. 2 >33.03 mm (1.3004 in.).

Location as specified in Figure 2 to paragraph (g)(1)(ii) of this AD	Maximum damage, which causes replacement (E1, Dia. 2, Dia. 3, and Dia. 4 are shown in Figure 2 to paragraph (g)(1)(ii) of this AD)
Zone B	Touch-up depth >0.1 mm (0.004 in.). Crack.
Zone C	Crack. Scratch depth >0.2 mm (0.008 in.).
Zone D [Dia. 4 = 14 mm ±0.1 mm (0.548; 0.555in.)]	Touch-up depth >0.1 mm (0.004 in.). Crack. E1 <2.75 mm (0.108 in.).

Figure 2 to Paragraph (g)(1)(ii)—Inspection Areas of Tail Rotor Splined Flange

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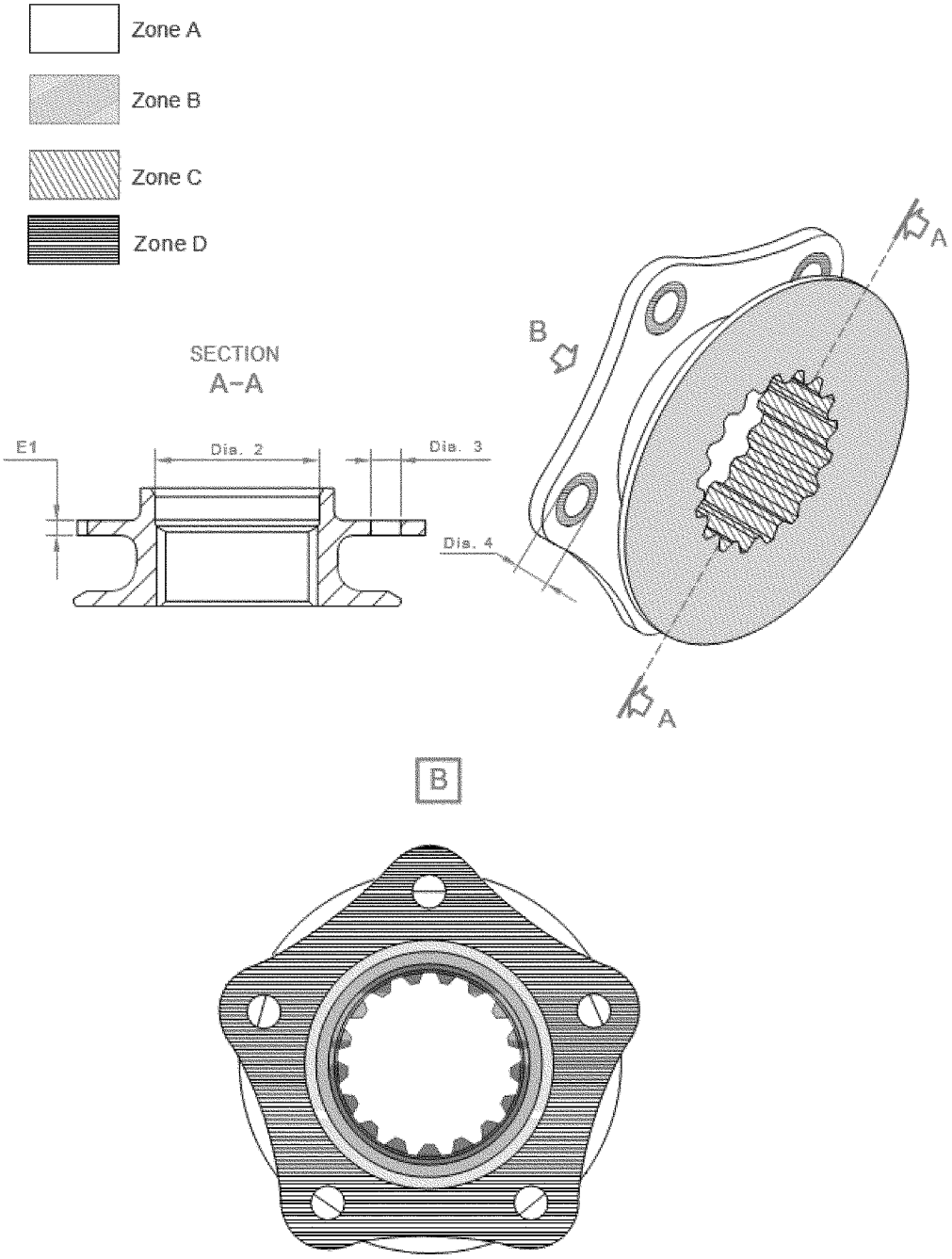

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(2) For helicopters with 9,000 or more total hours TIS or with unknown total hours TIS, within 15 hours TIS or 7 days, whichever occurs first after the effective date of this AD, and thereafter at intervals not to exceed 1,000 hours TIS, remove each bolt washer, and nut installed on the TR hub body from service and replace with airworthy parts and perform the actions in paragraph (g)(1)(ii) of this AD.

(3) For helicopters with less than 9,000 total hours TIS, within 1,000 hours TIS or before accumulating 9,000 total hours TIS, whichever occurs first after the effective date of this AD, and thereafter at intervals not to exceed 1,000 hours TIS, remove each bolt, washer, and nut installed on the TR hub body from service and replace with airworthy parts and perform the actions in paragraph (g)(1)(ii) of this AD.

(4) Within 24 months after the effective date of this AD, inspect the torque on the nut of the TR hub body in accordance with paragraph 4.1.2 of Airbus Helicopters Alert Service Bulletin ASB EC120–64–21–0001, dated September 19, 2024.

(i) If the torque is not within allowable limits, before further flight, remove the nut on the TR hub body from service and replace it with an airworthy nut; and accomplish the actions in paragraph (g)(4)(ii) of this AD.

(ii) If the torque is within allowable limits, before further flight, using polyurethane paint, apply a red paint line to the bolt and washer on the TR hub body; and apply a red paint line to the nut and washer on the splined flange. These actions terminate the repetitive inspections and replacements required by paragraphs (g)(1) through (3) of this AD.

(5) Within 100 hours TIS or 12 months, whichever occurs first after the action required in paragraph (g)(4)(ii) of this AD, and thereafter at intervals not to exceed 100 hours TIS or 12 months, whichever occurs first, inspect the red paint line for alignment. If the red paint line is misaligned, before further flight, perform the actions as specified in paragraphs (g)(4)(i) of this AD.

(h) Parts Installation Limitations

As of the effective date of this AD, do not install on any helicopter a TR hub body P/N C642A0100103 or a splined flange unless the part is new (zero hours TIS) or has passed the inspection requirements required by paragraph (g)(1) of this AD.

(i) Credit for Previous Actions

This paragraph provides credit for the initial instance of the actions required by paragraphs (g)(1) through (3) of this AD, if those actions were performed before the effective date of this AD in accordance with Airbus Helicopters Emergency Alert Service Bulletin 05A020 Revision 0, dated October 29, 2019; Revision 1, dated November 8, 2019; or Revision 2, dated February 8, 2021.

(j) Alternative Methods of Compliance (AMOCs)

(1) The Manager, International Validation Branch, FAA, has the authority to approve AMOCs for this AD, if requested using the procedures found in 14 CFR 39.19. In accordance with 14 CFR 39.19, send your request to your principal inspector or responsible Flight Standards Office, as appropriate. If sending information directly to the manager of the International Validation Branch, send it to the attention of the person identified in paragraph (k)(1) of this AD and email to: *AMOC@faa.gov.*

(2) Before using any approved AMOC, notify your appropriate principal inspector, or lacking a principal inspector, the manager of the responsible Flight Standards Office. The following provisions also apply to this AD.

(k) Additional Information

(1) For more information about this AD, contact Camille Seay, Aviation Safety Engineer, FAA, 1600 Stewart Avenue, Suite 410, Westbury, NY 11590; phone: (817) 222–5149; email: *camille.l.seay@faa.gov.*

(2) For Airbus Helicopters material identified in this AD that is not incorporated by reference, can be found at the contact information identified in paragraph (m)(3) of this AD.

(l) Material Incorporated by Reference

(1) The Director of the Federal Register approved the incorporation by reference of the material listed in this paragraph under 5 U.S.C. 552(a) and 1 CFR part 51.

(2) You must use this material as applicable to do the actions required by this AD, unless the AD specifies otherwise.

(i) Airbus Helicopters Emergency Alert Service Bulletin 05A020, Revision 3, dated September 19, 2024.

(ii) Airbus Helicopters Alert Service Bulletin EC120–64–21–0001, dated September 19, 2024.

(3) For Airbus Helicopters material identified in this AD, contact Airbus Helicopters, 2701 North Forum Drive, Grand Prairie, TX 75052; phone: (972) 641–0000 or: (800) 232–0323; fax: (972) 641–3775; website: *airbus.com/en/products-services/helicopters/hcare-services/airbusworld.*

(4) You may view this material at FAA, Office of the Regional Counsel, Southwest Region, 10101 Hillwood Parkway, Room 6N–321, Fort Worth, TX 76177. For information on the availability of this material at the FAA, call (817) 222–5110.

(5) You may view this material at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, visit *www.archives.gov/federal-register/cfr/ibr-locations* or email *fr.inspection@nara.gov.*

Issued on June 20, 2025.

Steven W. Thompson,

Acting Deputy Director, Compliance & Airworthiness Division, Aircraft Certification Service.

[FR Doc. 2025–11697 Filed 6–24–25; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 648

[Docket No. 250623–0104]

RIN 0648–BN40

Magnuson-Stevens Act Provisions; Fisheries of the Northeastern United States; Fisheries of the Northeastern United States; 2025–2027 Atlantic Herring Fishery Specifications

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Proposed specifications, request for comments.

SUMMARY: NMFS proposes new 2025 harvest specifications and river herring and shad catch caps for the Atlantic herring fishery, and projects specifications and catch caps for 2026 and 2027, as recommended by the New England Fishery Management Council. This action also proposes to update the target rebuilding date for Atlantic herring. This action is necessary to respond to updated scientific information from a 2024 management track assessment and to achieve the goals and objectives of the Atlantic Herring Fishery Management Plan, including preventing overfishing, helping rebuild an overfished stock, and achieving optimum yield on a continuing basis.

DATES: Public comments must be received by July 10, 2025.

ADDRESSES: A plain language summary of this proposed rule is available at *https://www.regulations.gov/docket/NOAA-NMFS-2025-0049.* You may submit comments on this document, identified by NOAA–NMFS–2025–0049 by the following method:

• *Electronic Submission:* Submit all electronic public comments via the Federal e-Rulemaking Portal. Visit *https://www.regulations.gov* and type NOAA–NMFS–2025–0049 in the Search box. Click on the ''Comment'' icon, complete the required fields, and enter or attach your comments.

Instructions: Comments sent by any other method, to any other address or individual, or received after the end of the comment period, may not be considered by NMFS. All comments received are a part of the public record and will generally be posted for public viewing on *https://www.regulations.gov* without change. All personal identifying information (*e.g.,* name, address, *etc.*),

confidential business information, or otherwise sensitive information submitted voluntarily by the sender will be publicly accessible. NMFS will accept anonymous comments (enter ''N/A'' in the required fields if you wish to remain anonymous).

Copies of the 2025–2027 herring specifications action, including the Supplemental Information Report (SIR) and the Regulatory Impact Review (RIR) prepared by the New England Fishery Management Council in support of this action, are available from Dr. Cate O'Keefe, Executive Director, New England Fishery Management Council, 50 Water Street, Mill 2, Newburyport, MA 01950. These documents are also accessible via the internet at *https://www.nefmc.org/management-plans/herring* or *http://www.regulations.gov.*

FOR FURTHER INFORMATION CONTACT: Carrie Nordeen, Fishery Policy Analyst, 978–281–9272.

SUPPLEMENTARY INFORMATION:

Background

NMFS and the New England Fishery Management Council manage the Atlantic herring fishery pursuant to the Atlantic Herring Fishery Management Plan (FMP). This action proposes to relieve a restriction by increasing herring harvest limits for 2025–2027 up to almost 240 percent compared to the current 2025 herring harvest limits. In 2023, the most recent year for which complete revenue data are available, the herring fishery generated $5.61 million in revenue. This action projects up to an additional $5.25 million in revenue available for 2026 and 2027 compared to revenue associated with the current 2025 harvest limits.

Regulations implementing the FMP appear at 50 CFR part 648, subpart K. The regulations at § 648.200 require the Council to recommend herring specifications for NMFS' review and proposal in the **Federal Register**, including: The overfishing limit (OFL); acceptable biological catch (ABC); annual catch limit (ACL); optimum yield (OY); domestic annual harvest (DAH); domestic annual processing (DAP); U.S. at-sea processing (USAP); border transfer (BT); the sub-ACL for each management area, including seasonal periods as allowed by § 648.201(d) and modifications to sub-ACLs as allowed by § 648.201(f); and the amount to be set aside for the research set aside (RSA) (3 percent of the sub-ACL from any management area) for up to 3 years. These regulations also provide the Council with the discretion to recommend river herring and shad catch caps as part of the specifications.

Under the Magnuson-Stevens Fishery Conservation and Management Act (Magnuson-Stevens Act), NMFS is required to publish proposed rules for comment after preliminarily determining whether they are consistent with applicable law. Consistent with herring regulations guiding the specifications process, NMFS reviews the Council's recommended specifications and develops proposed specifications based on its evaluation of the Council's recommendations. If the proposed specifications differ from those recommended by the Council, NMFS specifies the reasons for any differences. At this time, NMFS has reviewed and concurs with the Council's recommended 2025–2027 specifications for the herring fishery. Therefore, this action proposes and seeks comment on the Council's recommended herring specifications and river herring and shad catch caps and whether they are consistent with the FMP, the Magnuson-Stevens Act and its National Standards, and other applicable law. NMFS will make a final determination on specifications after considering public comment on the proposed specifications and will publish its responses to public comment and describe any differences from the Council's recommendations in its announcement of final specifications.

Amendment 8 to the FMP (86 FR 1810; January 11, 2021) implemented an ABC control rule for the herring fishery. The ABC control rule is a formulaic approach for setting a harvest limit and is designed to balance the goals and objectives of the FMP, including managing the fishery at long-term sustainable levels and accounting for herring's role as forage in the ecosystem. The ABC control rule states that when biomass is at or above 50 percent of the biomass associated with maximum sustainable yield (B_{MSY}) or its proxy, ABC is the catch associated with a maximum fishing mortality (F) of 80 percent of F associated maximum sustainable yield (F_{MSY}) or its proxy. When biomass falls below 50 percent of B_{MSY} or its proxy, the allowable F declines linearly to zero at 10 percent of B_{MSY} or its proxy.

On October 2, 2020, NMFS determined the Atlantic herring stock was overfished, but overfishing was not occurring. Framework 9 to the FMP (87 FR 42962; July 19, 2022) established a 5-year rebuilding plan for herring with an F consistent with the ABC control rule implemented in Amendment 8. The rebuilding plan was expected to rebuild the stock by 2026; however, the rebuilding target date was extended from 5 years (2026) to 7 years (2028) with implementation of the 2023–2025 herring specifications (88 FR 17397; March 23, 2023).

A 2024 herring management track stock assessment (2024 stock assessment) was completed in June 2024. According to the results of the 2024 stock assessment, the stock continues to be overfished with overfishing not occurring. Retrospective pattern adjustments were necessary because the model overestimated biomass and underestimated mortality. The adjusted spawning stock biomass was estimated to be 26 percent (47,955 metric tons (mt)) of B_{MSY} (186,367 mt) and the adjusted F was estimated to be 58 percent (0.263) of the overfishing threshold (F_{MSY} equals 0.45). Compared to the prior 2022 herring management track stock assessment, F_{MSY} is lower in the 2024 assessment than it was in the previous 2022 assessment (0.45 and 0.50, respectively) and projected biomass is much lower in the 2024 assessment than it was in the 2022 assessment (47,955 mt and 79,231 mt, respectively). The 2024 stock assessment was unable to explain a cause for the stock's historic and continued low recruitment and projected that continued poor recruitment of herring will likely result in a substantial decline in biomass.

Initial Specifications and 2025 In-Season Adjustment

At its September 2024 meeting, the Council reviewed the 2024 stock assessment and OFL and ABC recommendations from its Scientific and Statistical Committee (SSC). Short-term catch projections from the 2024 stock assessment indicated the need for an almost 90-percent reduction from the previously projected 2025 ACL (23,961 mt) (88 FR 17397; March 23, 2023) to the new 2025 ACL (2,710 mt). The Council acknowledged that herring harvest needed to be reduced to prevent overfishing and rebuild the stock and, accordingly, recommended new, reduced specifications for 2025 and projected specifications for 2026–2027. Because river herring and shad management is under consideration in Amendment 10 to the FMP, the Council recommended maintaining the current river herring and shad catch caps for 2025 and projected the current catch caps for 2026–2027. Additionally, the Council requested NMFS use its in-season adjustment authority described in the herring regulations at § 648.200(e) to reduce the 2025 specifications before the start of the fishing year on January 1 to prevent catch from exceeding new, lower limits. NMFS concurred with the Council's request to reduce herring

harvest to prevent overfishing and rebuild the stock and, therefore, implemented the reduced 2025 specifications on December 19, 2024 (89 FR 103695).

Updated Specifications

Notably, the catch projections from the 2024 stock assessment which indicated the need for a reduction from the previously projected 2025 specifications to the current, reduced 2025 specifications, were based on the assumption that the 2024 ABC (23,409 mt) would be fully harvested. However, in January 2025, preliminary 2024 herring catch data became available indicating that the amount of herring harvested in 2024 was much lower than what was assumed in the original projections. Based on preliminary herring catch, NMFS estimated only 51 percent of the 2024 herring ACL (10,315 mt of 20,141 mt) was harvested.

At its January 2025 meeting, the Council considered the potential impact of 2024 catch information on its prior recommendations for the 2025–2027 herring specifications. Updated catch projections suggest that less catch in 2024 may allow for higher catch limits in 2025 and beyond, while still achieving the FMP's goals of preventing overfishing and rebuilding the stock. The Council also noted the upcoming March peer review of the 2025 herring research track stock assessment (2025 stock assessment) may provide additional insights on the herring stock. For these reasons, the Council requested the SSC to provide updated herring OFL and ABC recommendations for 2025–2027 based on new information, including the 2024 catch data, March peer review of the 2025 stock assessment, and a risk assessment prepared by the Council's Herring Plan Development Team.

The SSC met on April 4, 2025, and recommended updated OFLs and ABCs for 2025–2027 based on the updated catch projections using preliminary 2024 catch data. The SSC's OFL and ABC recommendations are consistent with the best scientific information available and the herring ABC control rule. During its discussion, the SSC noted uncertainty around catch projection increases and that projected specifications for 2027 would likely be replaced following the currently scheduled 2026 stock assessment. The SSC considered whether lower than expected catch in 2024 was due to herring availability and/or lower fishing effort. Additionally, the SSC expressed concern that the fishery has not been achieving its catch limits and highlighted potential negative socioeconomic impacts of routinely increasing and decreasing catch limits.

At its April 2025 meeting, the Council reviewed and adopted the SSC's updated OFL and ABC recommendations for 2025 and projected limits for 2026–2027, with one exception. In response to the uncertainty around catch projection increases, especially in 2027, the Council recommended that the projected 2027 OFL remain consistent with catch projections, but that all other projected specification values for 2027 be held constant at 2026 levels. Similar to the Council's September 2024 recommendations, this approach uses the best information available, while acknowledging the uncertainty around catch projection increases.

Proposed Specifications

This action proposes new 2025 specifications and projected 2026–2027 specifications for the herring fishery, as recommended by the Council, intended to prevent overfishing, help rebuild an overfished stock, and achieve OY on a continuing basis, consistent with the best scientific information available. Pursuant to § 648.200(a)(2), the Council may annually review these specifications and recommend adjustments if necessary. The current 2025 specifications and the proposed 2025–2027 specifications are shown in table 1.

TABLE 1—CURRENT AND PROPOSED HERRING SPECIFICATIONS

Specifications	Current (mt)	Proposed (mt)		
	2025	2025	2026	2027
Overfishing Limit	18,273	20,802	23,491	31,075
Acceptable Biological Catch	6,741	8,587	13,165	13,165
Management Uncertainty	4,031	4,031	4,031	4,031
Annual Catch Limit/Optimum Yield	2,710	4,556	9,134	9,134
Domestic Annual Harvest	2,710	4,556	9,134	9,134
Border Transfer	0	0	0	0
Domestic Annual Processing	2,710	4,556	9,134	9,134
US At-Sea Processing	0	0	0	0
Area 1A Sub-ACL (28.9%)	783	1,317	2,640	2,640
Area 1B Sub-ACL (4.3%)	117	196	393	393
Area 2 Sub-ACL (27.8%)	753	1,267	2,539	2,539
Area 3 Sub-ACL (39%)	1,057	1,777	3,562	3,562
Fixed Gear Set-Aside	30	30	30	30
Research Set-Aside	0%	0%	0%	0%

If New Brunswick weir landings are less than 2,600 mt through October 1, then 1,000 mt will be subtracted from the management uncertainty and reallocated to the Area 1A sub-ACL and the ACL.

OFL

Both the OFL and ABC are set based on the ABC control rule established in Amendment 8 to the FMP. OFL is equal to catch resulting from applying F_{MSY} to a current estimate of stock size. This action proposes increasing the current OFL by 14 percent for 2025.

ABC

ABC must be less than the OFL. Under the ABC control rule, the target F that defines the ABC depends on the ratio of biomass to B_{MSY}. The larger or smaller the ratio, the larger or smaller the target F and ABC. This action proposes increasing the current ABC by 28 percent for 2025.

Management Uncertainty

The FMP states that sources of management uncertainty can include, but are not limited to, herring landings in the New Brunswick weir fishery and uncertainty around herring catch in

State waters and herring discard estimates in Federal waters. The juvenile herring (*i.e.,* ages 1 and 2) landed in the New Brunswick weir fishery are thought to come from the Gulf of Maine (GOM) herring stock complex. Since Framework Adjustment 6 to the FMP was implemented in 2020 (85 FR 26874; May 6, 2020), management uncertainty has been calculated as the average annual landings in the New Brunswick weir fishery over the most recent 10-year period. Recent herring stock assessments have also used the most recent 10-year period to calculate fixed gear herring harvest. Landings in the New Brunswick weir fishery are highly variable, fluctuating with herring availability and fishing effort. Using landings data from a 10-year period captures this variability. Because State-only catch and herring discards are tracked against catch limits and uncertainty around those estimates is low, the Council did not recommend any additional management uncertainty deductions. NMFS concurs. Therefore, this action proposes basing management uncertainty (4,031 mt) on New Brunswick weir fishery landings during the most recent 10 years (2014–2023).

Regulations at § 648.201(h) state that if NMFS determines that the New Brunswick weir fishery landed less than 2,722 mt through October 1, NMFS will subtract 1,000 mt from management uncertainty and reallocate that 1,000 mt to the ACL and Area 1A sub-ACL. The landings threshold amount (*i.e.,* currently 2,722 mt) for reallocation of a portion of the management uncertainty varies based on the amount of management uncertainty, and it has been calculated as 64.5 percent of management uncertainty since 2016. The December 2024 in-season adjustment that reduced the previously scheduled 2025 specifications to the current 2025 specifications did not similarly reduce the landings threshold amount. Therefore, this action proposes reducing the landings threshold amount from 2,722 mt to 2,600 mt to maintain the landings threshold amount at 64.5 percent of the amount of management uncertainty (4,031 mt).

ACL and OY

The ACL is less than or equal to ABC and is set by reducing the ABC by management uncertainty. As described previously, the Council recommended a 4,031-mt management uncertainty deduction for herring landed in the New Brunswick weir fishery. OY may not exceed OFL and may be reduced by social, economic, or ecological factors. The Council did not recommend any additional buffers for 2025–2027 and NMFS concurs, so this action proposes setting OY equal to the ACL.

DAH, BT, and DAP

The FMP specifies that DAH will be set less than or equal to OY and comprised of DAP and BT. DAH should reflect the actual and potential harvesting capacity of the U.S. herring fleet. Fishery catch in 2021 and 2022 was the lowest (7,865 mt and 7,866 mt, respectively) in the 1965–2023 time series, with the last 3 years (2021–2023) of catch as the lowest on record. Because the industry is capable of fully harvesting the OY, this action proposes setting DAH equal to the OY.

BT is a processing allocation available to Canadian vessels and dealers. The Magnuson-Stevens Act provides for the issuance of transshipment permits. These permits allow Canadian vessels to bring herring harvested from Area 1A to Canadian dealers for human consumption processing. Because incentives are currently low to transship herring to Canada for processing, BT been set at zero since 2021. Accordingly, this action proposes setting BT at zero.

DAP is the amount of herring that is processed domestically, as well as herring that is sold for bait. DAP is calculated by subtracting BT from DAH. Using this formula, this action proposes setting DAP equal to DAH.

USAP

A portion of DAP may be specified for the at-sea processing of herring in Federal waters. When determining the USAP specification, the Council considers availability of shore-side processing, status of the resource, and opportunities for vessels to participate in the herring fishery. During 2007–2009, the Council maintained a USAP specification of 20,000 mt (Management Areas ⅔ only) based on information received about a new at-sea processing vessel that intended to utilize a substantial amount of the USAP specification. However, this operation never materialized and, consequently, USAP has been set at zero since 2010. No new information supports revising this specification, therefore, this action proposes setting USAP at zero.

Sub-ACLs

The herring stock complex is managed as a single stock, but it is composed of inshore (GOM) and offshore (Georges Bank (GB)) stock components. These stock components segregate during spawning and mix during feeding and migration and herring management areas were developed in recognition of these different stock components. Area 1 is located in the GOM and is divided into an inshore section (Area 1A) and an offshore section (Area 1B). Area 2 is located in the coastal waters between Massachusetts and North Carolina, and Area 3 is on GB. The ACL for herring is divided into four management area sub-ACLs to minimize the risk of over-harvesting stock components while maximizing opportunities for the fishery to achieve OY. The percentage of the ACL allocated to each management area sub-ACL, (*i.e.,* Area 1A = 28.9 percent, Area 1B = 4.3 percent, Area 2 = 27.8 percent, Area 3 = 39 percent) has remained constant since 2013. No new information supports revising the sub-ACL percentages, therefore, this action proposes maintaining the current management area sub-ACL percentages.

Herring regulations at § 648.201(g) specify how to account for herring catch that exceeds herring management area sub-ACLs. Specifically, if NMFS determines that catch exceeded a herring sub-ACL by 10 percent or less and the ACL was not exceeded, then NMFS shall not deduct any amount of the overage from the applicable sub-ACL or ACL in the fishing year following total catch determination. In 2023, NMFS determined herring catch exceeded the Area 1A sub-ACL (4,345 mt) by 99 mt and exceeded the Area 3 sub-ACL (4,806 mt) by 314 mt, but total catch (10,228 mt) did not exceed the ACL (13,287 mt). Because 2023 catch overages were less than 10 percent of the sub-ACLs and total catch did not exceed the 2023 ACL, this action proposes no adjustments to the 2025 sub-ACLs or ACL to account for catch overages in 2023. In 2024, based on preliminary data, NMFS determined there were no catch overages in 2024, so this action proposes no adjustments to the 2026 sub-ACLs or ACL to account for catch overages in 2024.

Additionally, herring regulations at § 648.201(g) specify that unharvested catch in a herring management area in a fishing year (up to 10 percent of that area's sub-ACL) shall be carried over and added to the sub-ACL for that herring management area for the fishing year following the year when total catch is determined. Carryover is added to the applicable management area sub-ACL, but it is not added to the ACL. NMFS determined that catch levels were substantially lower than allowed in herring management areas 1B and 2 in 2023 and in all management areas during 2024. Thus, a percentage of unharvested catch from 2023 and 2024 is eligible for carryover in 2025 and 2026, respectively. From 2023, 54 mt for

Area 1B and 346 mt for Area 2 is eligible for carryover. From 2024, based on preliminary catch data, 518 mt for Area 1A, 83 mt for Area 1B, 534 mt for Area 2, and 748 mt for Area 3 is eligible for carryover. Based on these data, carryover has the potential to increase 2025 and 2026 sub-ACLs up to an additional 20 percent. In an effort to better support the FMP's conservation and management objectives, the Council recommended that no unharvested catch should be carried over and added to any management area sub-ACL for 2025 and 2026, and NMFS concurs. Therefore, this action proposes no adjustments to the 2025 and 2026 sub-ACLs to account for unharvested catch in 2023 or 2024, respectively.

Fixed Gear Set-Aside

Herring regulations (§ 648.201(f)) specify that up to 500 mt of the Area 1A sub-ACL shall be allocated for the fixed gear fisheries in Area 1A (weirs and stop seines) that occur west of 67°16.8 W long. (Cutler, Maine). This set-aside shall be available for harvest by the fixed gear within the specified area until November 1 of each year; any portion of the allocation that is unused after November 1 will be restored to the Area 1A sub-ACL. In recent years, the fixed gear set-aside has been proportionally reduced relative to the Area 1A sub-ACL, but it has been maintained at 30 mt since 2020 to recognize the historical importance of the Maine fishery. No new information supports revising the fixed gear set-aside; therefore, this action proposes setting the fixed gear set-aside at 30 mt.

RSA

Herring regulations (§ 648.200(a)) allow for up to 3 percent of management area sub-ACL to be set-aside to fund research. During 2019–2021, the herring RSA for each management area was set to 3 percent of each area's sub-ACL. Any unallocated or unused RSA is re-allocated to the sub-ACL and made available to the fleet before the end of the fishing year in accordance with the Administrative Procedure Act (APA), provided that the RSA can be available for harvest before the end of the fishing year for which the RSA is specified. However, with recent sub-ACL reductions, it has been difficult to harvest RSA, and the Council determined it was more beneficial to have that allocation applied directly to the herring fishery while catch limits are so low. Therefore, RSA has been set at zero since 2022. No new information supports revising RSA; therefore, this action proposes setting RSA at zero.

Status of Rebuilding Plan

As described previously, Framework 9 established a rebuilding plan for herring that became effective in August 2022. The rebuilding plan was expected to rebuild the stock by 2026, however, the target rebuilding date was extended from 5 years (2026) to 7 years (2028) with implementation of the 2023–2025 herring specifications. Projections from 2024 stock assessment indicate the herring stock is no longer likely to rebuild by 2028, but it could rebuild by 2031. Therefore, this action proposes revising the target rebuilding date for herring to 2031 to reflect the results of the 2024 stock assessment. This updated target rebuilding date falls within the 10-year rebuilding period required under the Magnuson-Stevens Act.

Proposed River Herring and Shad Catch Caps

Herring regulations (§ 648.200(b)(6)) provide for river herring and shad catch caps by gear and area. The current catch caps were originally set in the 2016–2018 specifications (FR 81 75731; November 1, 2016) and have been maintained since. In the absence of a biologically-based method to determine catch cap values, catch cap values were set based on river herring and shad catch during a ''reference period'' before catch caps were adopted (2008–2014). Catch is tracked against river herring and shad catch caps on trips landing more than 6,600 pounds (lb; 3,000 kilogram (kg)) of Atlantic herring. Once a catch cap is reached, the possession limit for herring vessels using that gear type and fishing in that area (or the corresponding catch cap closure area) is reduced to 2,000 lb (907 kg) of Atlantic herring for the remainder of the fishing year. Catch caps are intended to provide an incentive for the herring fleet to continue to reduce river herring and shad catch, while allowing the fleet to fully harvest the Atlantic herring OY. Because river herring and shad management is under consideration in Amendment 10 to the FMP, this action proposes maintaining the current river herring and shad catch caps for 2025 and projects the current catch caps for 2026–2027 (see table 2).

TABLE 2—CURRENT AND PROPOSED RIVER HERRING AND SHAD CATCH CAPS

Catch cap	2025 (mt)	2026 (mt)	2027 (mt)
Gulf of Maine Midwater Trawl	76.7	76.7	76.7
Cape Cod Midwater Trawl	32.4	32.4	32.4
Southern New England Midwater Trawl	129.6	129.6	129.6
Southern New England Bottom Trawl	122.3	122.3	122.3

Classification

NMFS is issuing this rule pursuant to section 305(d) of the Magnuson-Stevens Act. In a previous action taken pursuant to section 304(b), the regulations at 50 CFR 648.200 authorize NMFS to take this action under Magnuson-Stevens Act section 305(d). The NMFS Assistant Administrator has determined that this proposed rule is consistent with the Atlantic Herring FMP, National Standards and other provisions of the Magnuson-Stevens Act, and other applicable law, subject to further consideration after public comment.

Section 304(b) of the Magnuson-Stevens Act (16 U.S.C. 1854(b)) requires publication of proposed regulations in the **Federal Register** with a public comment period of 15 to 60 days. A 15-day comment period for this action provides a reasonable opportunity for public participation in this action pursuant to APA section 553(c) (5 U.S.C. 553(c)), while also helping to ensure that the final specifications are effective prior to the start of the summer fishery in July 2025. This is a routine specifications action that occurs every 2 years and are subject to ongoing Council review and public comment. Fishing industry members and stakeholders regularly participate in developing specifications actions, and they participated in public meetings to develop this action over the past year. Additionally, the action proposes to relieve a restriction by increasing 2025–2027 catch limits compared to current 2025 catch limits. A longer comment period would be contrary to the public interest, as it could further extend this proposed rulemaking into 2025,

potentially hindering the fishing industry's ability to fully harvest the higher OY in 2025.

This proposed rule has been determined to be not significant for purposes of Executive Order 12866.

This proposed rule is not an Executive Order 14192 regulatory action because this proposed rule is not significant under Executive Order 12866.

This proposed rule contains no information collection requirements under the Paperwork Reduction Act of 1995.

An initial regulatory flexibility analysis (IRFA) was prepared, as required by section 603 of the RFA (RFA). The IRFA describes the economic impact this proposed rule, if adopted, would have on small entities. A description of the action, why it is being considered, and the legal basis for this proposed action are contained at the beginning of this section in the preamble and in the **SUMMARY** section of the preamble. A summary of the analysis follows. A copy of this analysis is available from the Council (see **ADDRESSES**).

Description of the Reasons Why Action by the Agency Is Being Considered and Statement of the Objectives of, and Legal Basis for, the Proposed Rule

This action proposes 2025–2027 specifications for the Atlantic herring fishery. A complete description of the reasons why this action is being considered, and the objectives of and legal basis for this action, are contained in the preamble to this proposed rule and are not repeated here.

Description and Estimate of Number of Small Entities to Which This Proposed Rule Would Apply

The directly-regulated entities are the firms that currently hold at least one Atlantic herring permit (*i.e.,* Categories A, B, C, D, or E). The RFA recognizes three kinds of small entities: Small businesses; small organizations; and small governmental jurisdictions. A small entity is classified as a finfish firm if more than half of the firm's gross receipts are derived from finfish with receipts of up to $20.5 million of gross revenues annually. Herring-permitted vessels may hold permits for several fisheries, harvesting species of fish that are regulated by several different fishery management plans, even beyond those affected by the proposed action. Furthermore, multiple permitted vessels and/or permits may be owned by entities with various personal and business affiliations.

TABLE 3—NUMBER AND CHARACTERIZATION OF DIRECTLY-REGULATED ENTITIES AND AVERAGE REVENUE FROM 2019–2023

Size	Type	Firms	Vessels	Average gross receipts	Average herring receipts
Small	Fishing	739	1,174	$831,00	$7,000
Small	For Hire	138	178	215,000	0
Large	Fishing	10	135	19,094,000	98,000

Source: NMFS.

Table 3 indicates there are many small firms with herring permits, but that revenue from herring is only a small percentage of their total revenue. This may be because these firms only hold a Category D open access permit with a low herring possession limit (6,600 lb (3,000 kg)) or that these firms are not active in the herring fishery. The herring fishery has had historically low ACLs since 2018. Some firms have stopped participating in the fishery, but continue to hold herring permits to preserve the option to fish.

TABLE 4—NUMBER AND CHARACTERIZATION OF DIRECTLY-REGULATED, SMALL ENTITIES ACTIVE IN THE ATLANTIC HERRING FISHERY AND AVERAGE REVENUE FROM 2019–2023

Size	Type	Firms	Vessels	Average gross receipts	Average herring receipts
Small	Fishing	29	61	$1,510,000	$171,000

Source: NMFS.

Table 4 describes a subset of the directly-regulated, small entities that hold a Limited Access Permit (*i.e.,* Categories A, B, C) or an Open Access Areas 2/3 Permit (*i.e.,* Category E) and participated in the herring fishery between 2019 and 2023. The small firms identified in table 4 are the firms most likely to be affected by the proposed action. Because there are fewer than three directly-regulated, large entities, data confidentiality requirements prevent those data from being included.

Description of Projected Reporting, Recordkeeping, and Other Compliance Requirements

This action contains no new collection-of-information, reporting, or recordkeeping requirements.

Federal Rules Which May Duplicate, Overlap, or Conflict With the Proposed Rule

This action does not duplicate, overlap, or conflict with any other Federal rules.

Description of Significant Alternatives to the Proposed Action Which Accomplish the Stated Objectives of Applicable Statues and Which Minimize Any Significant Economic Impact on Small Entities

For the 2025–2027 herring specifications, the proposed action would relieve a restriction by allowing higher catch limits than would maintaining the current ACL. The current 2025 ACL (2,710 mt) is the lowest ACL on record for the herring fishery. In comparison, the proposed ACL for 2025 (4,556 mt) is 68 percent

higher than the current ACL and the projected ACLs for 2026–2027 (9,134 mt) are 237 percent higher than the current ACL. There is no significant alternative to the proposed action to accomplish the objectives of applicable statutes and minimize any significant economic impact on small entities.

TABLE 5—PROJECTED LANDINGS, PRICES, AND REVENUE UNDER THE PROPOSED ACTION FOR 2025–2027

Year	Landings (mt)	Price *	Revenue **	
			Proposed ACL	Amount of increase compared to current ACL
2025	4,556	$862	$3,925,000	$1,560,000
2026	9,134	834	7,618,000	5,253,000
2027	9,134	834	7,618,000	5,253,000

* Price is based on real 2023 U.S. dollars per mt.
** Revenue is based on real 2023 U.S. dollars.
Source: NMFS.

In general, table 5 projects increased landings and revenue under the proposed action compared to the current 2025 ACL. The increase in landings results in modestly lower herring prices. As described previously, it is likely that the projected 2027 specifications would be replaced following the 2026 stock assessment.

Despite proposed increases to the ACLs, the SIR for the 2025–2027 herring specifications concluded the impacts of the proposed action on herring fishery-related businesses and communities would likely remain *negative.* Despite moderate ACL increases, the proposed action would continue the period of substantially reduced catch limits implemented in 2019. The low ACL and corresponding sub-ACLs would likely lead to continued low fishing effort, which could have negative social and economic impacts in fishing communities and for stakeholders directly or indirectly reliant on the herring fishery. Users of fresh herring as bait may need to switch to an alternative supply (*e.g.,* frozen herring bait or menhaden). Additionally, the proposed action could prevent larger vessels from participating in the fishery altogether, resulting in a potential loss of jobs for crew and adverse community impacts (*e.g.,* reduced spending on ice, fuel, cold storage, other supplies).

For the 2025–2027 river herring and shad catch caps, the proposed action would maintain the values, gears, and areas for the catch caps that were originally implemented in 2016. There is no significant alternative to the proposed action to accomplish the objectives of applicable statutes and minimize any significant economic impact on small entities.

NMFS has determined that this proposed action would not have a substantial direct effect on one or more Indian Tribes, on the relationship between the Federal Government and Indian Tribes, or on the distribution of power and responsibilities between the Federal Government and Indian Tribes; therefore, consultation with Tribal officials under E.O. 13175 is not required, and the requirements of sections (5)(b) and (5)(c) of E.O. 13175 also do not apply. A Tribal summary impact statement under section (5)(b)(2)(B) and section (5)(c)(2)(B) of E.O. 13175 is not required and has not been prepared.

List of Subjects in 50 CFR Part 648

Fisheries, Fishing, Recordkeeping and reporting requirements.

Dated: June 23, 2025.

Samuel D. Rauch, III,

Deputy Assistant Administrator for Regulatory Programs, National Marine Fisheries Service.

For the reasons set out in the preamble, 50 CFR part 648 is proposed to be amended as follows:

PART 648—FISHERIES OF THE NORTHEASTERN UNITED STATES

■ 1. The authority citation for part 648 continues to read as follows:

Authority: 16 U.S.C. 1801 *et seq.*

■ 2. In § 648.201, revise paragraphs (g)(2) and (h) to read as follows:

§ 648.201 AMs and harvest controls.

* * * * *

(g)(2). No unharvested catch will be carried over and added to any management area sub-ACL for the 2025 and 2026 fishing years.

(h) If NMFS determines that the New Brunswick weir fishery landed less than 2,600 mt of herring through October 1, NMFS will subtract 1,000 mt from management uncertainty and reallocate that 1,000 mt to the ACL and Area 1A sub-ACL. NMFS will notify the Council of this adjustment and publish the adjustment in the **Federal Register**.

[FR Doc. 2025–11711 Filed 6–24–25; 8:45 am]

BILLING CODE 3510–22–P

Notices

Federal Register
Vol. 90, No. 120
Wednesday, June 25, 2025

This section of the FEDERAL REGISTER contains documents other than rules or proposed rules that are applicable to the public. Notices of hearings and investigations, committee meetings, agency decisions and rulings, delegations of authority, filing of petitions and applications and agency statements of organization and functions are examples of documents appearing in this section.

DEPARTMENT OF AGRICULTURE

Animal and Plant Health Inspection Service

[Docket No. APHIS–2025–0014]

General Conference Committee of the National Poultry Improvement Plan

AGENCY: Animal and Plant Health Inspection Service, USDA.

ACTION: Notice of public meeting.

SUMMARY: We are giving notice that the General Conference Committee of the National Poultry Improvement Plan will be holding a public meeting.

DATES: The General Conference Committee public meeting will be held on Thursday, July 17, 2025, beginning at 7:30 a.m. and end no later than 1:30 p.m.

ADDRESSES: The meeting will be held at the DoubleTree by Hilton Bloomington-Minneapolis South Hotel, 7800 Normandale Blvd., Minneapolis, MN 55439.

FOR FURTHER INFORMATION CONTACT: Dr. Savannah Busby, Acting Senior Coordinator, National Poultry Improvement Plan, VS, APHIS, USDA, 1506 Klondike Road, Suite 301, Conyers, GA 30094; (770) 922–3496; email: *Savannah.Busby@usda.gov.*

SUPPLEMENTARY INFORMATION: The General Conference Committee (the Committee) of the National Poultry Improvement Plan (NPIP), representing cooperating State agencies and poultry industry members, serves an essential function by acting as liaison between the poultry industry and the Department in matters pertaining to poultry health.

Topics for discussion at the upcoming meeting include:

1. Avian Influenza Update.
2. Salmonella Update.
3. Mycoplasma Update.
4. New Diagnostic Tests Seeking NPIP Approval.

The meeting will be open to the public; however, APHIS will be unable to allow public participation in session discussions due to time constraints. Written statements may be filed with the Committee before or after the meeting. Statements filed with the Committee must include the name of the Agency contact as listed under **FOR FURTHER INFORMATION CONTACT**. Please refer to Docket No. APHIS–2025–0014 when submitting your statements.

Reasonable Accommodations

If needed, please request reasonable accommodations by contacting the person listed under **FOR FURTHER INFORMATION CONTACT**. Requests made after that date may be considered, but it may not be possible to fulfill them.

This notice of meeting is given pursuant to section 10 of the Federal Advisory Committee Act (5 U.S.C. 10).

Equal opportunity practices, in line with U.S. Department of Agriculture (USDA) policies and consistent with applicable law, will be followed in all membership appointments to the Committee.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, religion, sex, disability, age, marital status, family/parental status, income derived from a public assistance program, political beliefs, or reprisal or retaliation for prior civil rights activity, in any program or activity conducted or funded by USDA (not all bases apply to all programs). Remedies and complaint filing deadlines vary by program or incident.

Persons with disabilities who require alternative means for communication of program information (Braille, large print, audiotape, etc.) should contact USDA's TARGET center at (202) 720–2600 (voice and TDD). Determinations for reasonable accommodation will be made on a case-by-case basis.

Dated: June 17, 2025.

Cikena Reid,

USDA Committee Management Officer.

[FR Doc. 2025–11686 Filed 6–24–25; 8:45 am]

BILLING CODE 3410–34–P

DEPARMENT OF AGRICULTURE

Natural Resources Conservation Service

[Docket No. NRCS–2025–0003]

Notice of Intent To Prepare an Environmental Impact Statement for the Shortfoot Creek Watershed Plan, North Dakota

AGENCY: Natural Resources Conservation Service, U.S. Department of Agriculture (USDA).

ACTION: Notice of Intent (NOI) to prepare an Environmental Impact Statement (EIS).

SUMMARY: The Natural Resources Conservation Service (NRCS), North Dakota State Office, announces its intent to prepare an EIS for the Shortfoot Creek Watershed located within Sargent and Richland Counties, and North Dakota, Marshall and Roberts Counties, South Dakota. The proposed EIS will examine alternative solutions to provide flood damage reduction and watershed protection. NRCS is requesting comments to identify significant issues, potential alternatives, information, and analyses relevant to the proposed action from all interested individuals, Federal and State agencies, and Tribes.

DATES: We will consider comments that we receive by August 11, 2025. We will consider comments received after the close of the comment period to the extent possible.

ADDRESSES: We invite you to submit comments in response to this notice. You may submit your comments through one of the methods below:

- *Federal eRulemaking Portal:* Go to *http://www.regulations.gov* and search for docket ID NRCS–2025–0003. Follow the online instructions for submitting comments.
- *Mail or Hand Delivery:* Jonathan Petersen, USDA–NRCS, 220 E Rosser Ave., Bismarck, ND 58502–1458. In your comments, specify the docket ID–NRCS–2025–0003.

All comments received will be posted without change and made publicly available on *www.regulations.gov.*

FOR FURTHER INFORMATION CONTACT: Jonathan Petersen; telephone: (701) 530–2082; email: *jonathan.petersen@usda.gov.*

Individuals who require alternative means of communication should contact

USDA Target Center at (202) 720–2600 (voice and text telephone (TTY] mode) or dial 711 for Telecommunications Relay service (both voice and text telephone users can initiate this call from any telephone).

SUPPLEMENTARY INFORMATION:

Purpose and Need

The primary purpose of the proposed action is flood damage reduction and watershed protection. Watershed planning is authorized under the Watershed Protection and Flood Prevention Act of 1954 (Pub. L. 83–566), as amended, and the Flood Control Act of 1944 (Pub. L. 78–534).

The U.S. Army Corps of Engineers (USACE) and U.S. Fish and Wildlife Service (USFWS) are cooperating federal agencies in the watershed planning effort. NRCS is the lead federal agency implementing the National Environmental Policy Act (NEPA) and the National Historic Preservation Act (NHPA). The following agencies have been consulted and their input requested in this planning effort: U.S. Environmental Protection Agency; U.S. Federal Emergency Management Agency; North Dakota Department of Water Resources (ND DWR); North Dakota Department of Environmental Quality; North Dakota Game and Fish Department; North Dakota Department of Transportation; Sargent County Water Resource District (local project Sponsor); Sargent County Highway Department; Sargent County Sheriff's Office; Sargent County Commission; and Sargent County Emergency Management. NRCS is consulting on both NEPA and section 106 of the NHPA with the North Dakota State Historical Preservation Office and Tribal Nations.

This action is needed because the Shortfoot Creek watershed experiences $677,800 in average annual flood damages due to cropland inundation and damage to roads. Approximately 78 percent of the watershed is farmed for row crops consisting predominantly of corn, soybeans, and spring wheat. Flooding causes disruptions to transportation by overtopping and washing out roads, bridges, and culverts.

Long duration inundation of cropland, particularly in spring floods, results in high transfer of nutrients from soil and residue back to Shortfoot Creek, the Wild Rice River, and Red River downstream. At the 2-year recurrence interval flood, 1,118 acres of cropland are flooded, at the 5-year 4,268 acres are flooded, at the 10-year 5,214 acres are flooded, and at the 100-year 7,293 acres are flooded. The Shortfoot Creek watershed contributes an average annual volume of 15,548 pounds of phosphorus and 70,176 pounds of nitrogen to downstream waterways.

Agricultural non-point source pollution from the U.S. portion of the Red River Basin is a major contributor to the ongoing eutrophication of Lake Winnipeg, the 10th largest freshwater lake in the world, which is degrading a $102 million a year recreational fishing industry, $25 million a year commercial fishing industry, and subsistence fishing by 14 First Nation communities along the lakeshore. Between 1994 and 2007, annual phosphorus loads to Lake Winnipeg increased 71 percent and nitrogen loads increased 18 percent. While the Red River contributes only 15 to 20 percent of overall annual runoff to the lake by volume, from 1994 through 2007 it contributed 70 percent of the total phosphorus load, largely in the form of inorganic dissolved phosphorus, and 78 percent of the annual total nitrogen load. The Wild Rice Watershed is rated within the top 20 percent of Red River Basin sub-watersheds for phosphorus delivery and the top 40 percent for nitrogen delivery. In total, 65 percent of total nitrogen and 75 percent of total phosphorus originates from cropland within the North Dakota portion of the Basin.

Federal investment in nutrient reduction within the Red River Basin is an important contribution to the Boundary Waters Treaty (BWT) obligation of the United States. Article IV of the BWT specifies that boundary waters or waters flowing across the boundary are not to be polluted to the injury of health and property to the other. The International Joint Commission (IJC) acts as the mediator for BWT, with International Red River Board (IRRB) established as the IJC sub entity for the Red River Basin. In 2019, IRRB recommended nutrient concentration and load target objectives for the international border crossing of the Red River to IJC, which were formally adopted in 2022 with the concurrence from the U.S. State Department and Global Affairs Canada. The reported average nutrient load for phosphorus in 2017 through 2021 was 170 percent of the standard and for nitrogen was 125 percent. The annual flow-averaged concentration of phosphorus exceeds the standard by 300 to 400 percent.

The Prairie Pothole Region (PPR) in the northcentral Great Plains is one of the most threatened waterfowl habitats in the United States. The Red River Valley is one of the largest artificially drained landscapes in the world, with hundreds of miles of publicly owned drainage ditches, privately owned lateral ditches, and thousands of acres of surface tile drains. The remaining wetlands and grasslands of the PPR are one of the most productive areas in the world for breeding waterfowl and are important habitat for migratory grassland and shore birds. It is estimated that only 3 percent of tallgrass prairie in the Red River Basin remains unplowed and that 85 percent of wetlands were drained as of 1980. Drainage of remaining wetlands continues at a high rate as precipitation has continued to increase, from 1997 to 2009 more than 50,000 individual wetlands were lost within North Dakota alone, a −3.3 percent overall change.

Preliminary Proposed Action and Alternatives, Including a No Action

The EIS objective is to formulate and evaluate alternatives that would provide flood damage reduction and watershed protection. The EIS is expected to evaluate two alternatives: one no action alternative and one action alternative.

The alternatives that may be considered for detailed analysis include:

- *Alternative 1—No Action Alternative:* Taking no action would mean that no Federal action would be taken in the Shortfoot Creek Watershed and implementation of significant flood damage reduction, nutrient reduction, and large-scale wetland and wildlife habitat improvement projects would not occur. The watershed will continue to contribute an average of 19,841 pounds of phosphorus and 50,223 pounds of nitrogen annually to the Maple River, and the downstream Red River and Lake Winnipeg.
- *Alternative 2—Proposed Action Alternative—Shortfoot Creek Site 7:* The proposed action would construct the Shortfoot Creek Site 7 as a multi-purpose dry dam with interior features designed and operated for the purpose of flood damage reduction, nutrient reduction, and wetland/upland wildlife habitat. The dam would provide 1,250 acre-feet of temporary (less than 10 days inundation at the 10-year recurrence interval flood) floodwater retention for a 32.7 square mile drainage area. It would consist of a 1-mile embankment with a maximum height of 20 feet, 48-inch principal spillway conduit, and structural concrete auxiliary spillway. Reduction of dissolved inorganic phosphorus (DP) will be through two primary means. The first involves construction and operation of two constructed wetlands, totaling 130 acres, on the interior of the dry dam to which water during flood events would be routed with pump and pipelines, held to depths of 2 to 3 feet through the

growing season. Low flows will continue down the creek to avoid impacts to aquatic species. Vegetation would uptake DP as it grows and in the early fall the cells would be drained via automated control structures and tile drains below the cells to allow vegetation to be cut, baled, and removed from the floodplain prior to the first frost in 2 out of 3 years. The second primary means of DP reduction occurs through reducing the extents, frequency, and duration of cropland inundation downstream of the dam through modification of the peak flow hydrograph. The project also involves restoring natural sinuosity and channel dimensions to 2.6-miles of straightened or channelized creek upstream of the dam, which will result in restoration of 17.8 acres of riverine wetlands. A ditch plug will be installed to restore 2.8 acres of pothole wetlands. The 130 acres of constructed treatment wetlands will also provide wildlife habitat. Currently 203.4 acres of existing wetlands are hayed throughout the year and improvement to vegetation management to benefit wildlife will provide functional enhancement on those wetlands. In total, a 363-acre mosaic of 354 acres of enhanced, restored, and constructed wetlands and 9 acres of uplands along 2.6-miles of restored creek will be placed in a 50-year conservation easement and managed for wildlife habitat and nutrient reduction.

Summary of Expected Impacts

The EIS will be prepared as required by section 102(2)(C) of NEPA and NRCS regulations that implement NEPA in 7 CFR part 650.

An NRCS evaluation of this federally assisted action indicates that the proposed alternative may have a significant positive local, regional, national, or international impact on the environment. The project would reduce average annual cropland flood damages by $130,400 and road damages by $1,400 per year. Average annual loads of total phosphorus transported out of the Shortfoot Creek watershed would be reduced by 3,997 lbs. and total nitrogen would be reduced by 19,863 lbs. Restoration of natural riverine conditions and vegetation on 2.6-miles of Shortfoot Creek and its adjacent floodplain will improve wildlife habitat. Construction of embankments will cause a loss of 4.1 acres of existing wetlands. The project would generate a net increase of 354 acres of enhanced, restored, and constructed wetlands and 9 acres of uplands along 2.6-miles of restored creek for the benefit of migratory birds and other wildlife species. Short term negative impacts during construction are anticipated regarding traffic, dust, vegetation, and noise.

Anticipated Permits and Authorizations

The following permits and other authorizations are anticipated to be required:

- *Clean Water Act (CWA) Section 404 permit.* Implementation of the proposed action would require a CWA section 404 permit from the USACE, which is a cooperating federal agency on the planning effort. Consultation is ongoing and no significant challenges are anticipated given the overall environmental benefits of the project.
- *CWA and National Pollutant Discharge Elimination System (NPDES).* The project would also require water quality certification under section 401 of CWA and permitting under Section 402 of NPDES, both of which would be issued by the North Dakota Department of Environmental Quality, which is participating on the interagency team for the watershed plan. Consultation is ongoing and no significant challenges are anticipated given the overall environmental benefits of the project.
- *Permit To Construct or Modify a Dam.* The project will require authorization from ND DWR for construction of a dam. ND DWR is participating on the interagency team for the watershed plan and has also provided funding for the planning effort. No significant challenges are anticipated given the project is being designed to meet State of North Dakota dam safety standards.
- *Water Appropriation Permit.* The project may require a conditional water use permit from ND DWR for construction of a dam that will temporarily retain water during flood events. ND DWR is participating on the interagency team for the watershed plan and has also provided funding for the planning effort.
- *Floodplain Permit.* The project will require a floodplain development permit from Sargent County. Sargent County is participating on the interagency team for the watershed plan and no significant challenges are expected given the beneficial flood damage reduction effects of the project.
- *NHPA Section 106.* Consultation with Tribal Nations and the North Dakota State Historical Society are ongoing, as required by NHPA. The NRCS Class III Cultural Resources report recommendation for the alternative is ''No Historic Properties Affected.'' To date no concerns have been raised by any entities, however consultation under NHPA is ongoing.

Schedule of Decision-Making Process

A Draft EIS (DEIS) will be prepared and circulated for review and comment by agencies, Tribes, consulting parties, and the public for at least 45 days as required by the regulations in 7 CFR 650.13. The DEIS is anticipated to be published in the **Federal Register**, approximately 6 months after publication of this NOI. A Final EIS is anticipated to be published within 6 months of completion of the public comment period for the DEIS.

NRCS will decide whether to implement one of the action alternatives as evaluated in the EIS. A Record of Decision will be completed after the required 30-day waiting period and will be publicly available. The responsible Federal official and decision maker for NRCS is Dan Hovland, North Dakota State Conservationist.

Public Scoping Process

Public scoping meetings will be held to further develop the scope of the DEIS. An initial scoping meeting was held on June 15, 2016, at the Sargent County Courthouse in Forman, ND. An additional public scoping meeting was held March 27, 2025, Sargent County Courthouse (2nd floor), 355 Main Street South. The meeting was both in-person and may be accessed virtually at *https://tinyurl.com/Shortfoot-Creek-Dam-Meeting.* A recording of the meeting may be accessed at: *https://www.nrcs.usda.gov/conservation-basics/conservation-by-state/north-dakota/shortfoot-creek-watershed-plan.*

NRCS will coordinate the scoping process as provided in 36 CFR 800.2(d)(3) and 800.8 (54 U.S.C. 306108) to help fulfill the NHPA review process, as amended. The USACE and USFWS have declined to participate in the NRCS led NHPA process and instead intend to use their agency specific NHPA processes.

Identification of Potential Alternatives, Information, and Analyses

NRCS invites agencies, Tribes, consulting parties, and individuals that have special expertise, legal jurisdiction, or interest in the Shortfoot Creek Watershed and the Red River Basin to provide comments concerning the scope of the analysis and identification of potential alternatives, information, and analyses relevant to the Proposed Action.

The information about historic and cultural resources within the area potentially affected by the proposed project will assist NRCS in identifying and evaluating impacts to such resources in the context of both NEPA and NHPA.

NRCS will consult with Native American Tribes on a government-to-government basis in accordance with the regulations in 36 CFR 800.2 and 800.3, Executive Order 13175, and other policies. Tribal concerns, including impacts on Indian trust assets and potential impacts to cultural resources and historic properties, will be given due consideration.

Authorities

This document is published as specified by the NEPA regulations regarding publication of an NOI to issue an EIS (7 CFR part 650). Watershed planning is authorized under the Watershed Protection and Flood Prevention Act of 1954, as amended and the Flood Control Act of 1944.

Federal Assistance Program

The title and number of the Federal Assistance Programs, as found in the Assistance Listing,[1] to which this document applies is 10.904, Watershed Protection and Flood Prevention.

Executive Order 12372

Executive Order 12372, ''Intergovernmental Review of Federal Programs,'' requires consultation with State and local officials that would be directly affected by proposed Federal financial assistance. The objectives of the Executive Order are to foster an intergovernmental partnership and a strengthened federalism, by relying on State and local processes for State and local government coordination and review of proposed Federal financial assistance and direct Federal development. This program is subject to the provisions of Executive Order 12372, which requires intergovernmental consultation with State and local officials.

USDA Non-Discrimination Policy

In accordance with Federal civil rights law and USDA civil rights regulations and policies, USDA, its agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, religion, sex, disability, age, marital status, family or parental status, income derived from a public assistance program, political beliefs, or reprisal or retaliation for prior civil rights activity, in any program or activity conducted or funded by USDA (not all bases apply to all programs). Remedies and complaint filing deadlines vary by program or incident.

[1] See *https://sam.gov/content/assistance-listings.*

Individuals who require alternative means of communication for program information (for example, braille, large print, audiotape, American Sign Language, etc.) should contact the responsible Agency or USDA TARGET Center at (202) 720–2600 (voice and text telephone) or dial 711 for Telecommunications Relay Service (both voice and text telephone users can initiate this call from any phone). Additionally, program information may be made available in languages other than English.

To file a program discrimination complaint, complete the USDA Program Discrimination Complaint Form, AD–3027, found online at *https://www.usda.gov/oascr/how-to-file-program-discrimination-complaint* and at any USDA office or write a letter addressed to USDA and provide in the letter all the information requested in the form. To request a copy of the complaint form, call (866) 632–9992. Submit your completed form or letter to USDA by mail: (1) mail to: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue SW, Washington, DC 20250–9410; (2) Fax: (202) 690–7442; or (3) email: *program.intake@usda.gov.*

USDA is an equal opportunity provider, employer, and lender.

Daniel Hovland,

North Dakota State Conservationist, Natural Resources Conservation Service.

[FR Doc. 2025–11671 Filed 6–24–25; 8:45 am]

BILLING CODE 3410–16–P

DEPARTMENT OF COMMERCE

Foreign-Trade Zones Board

[B–3–2025]

Foreign-Trade Zone (FTZ) 41; Authorization of Production Activity; Zebra Technologies Corporation; (Computer Printing Products); Kenosha, Wisconsin

On January 13, 2025, Zebra Technologies Corporation submitted a notification of proposed production activity to the FTZ Board for its facility within FTZ 41, in Kenosha, Wisconsin.

The notification was processed in accordance with the regulations of the FTZ Board (15 CFR part 400), including notice in the **Federal Register** inviting public comment (90 FR 8007–8008, January 23, 2025). On June 20, 2025, the applicant was notified of the FTZ Board's decision that no further review of the activity is warranted at this time. The production activity described in the notification was authorized, subject to the FTZ Act and the FTZ Board's regulations, including section 400.14.

Dated: June 23, 2025.

Elizabeth Whiteman,

Executive Secretary.

[FR Doc. 2025–11698 Filed 6–24–25; 8:45 am]

BILLING CODE 3510–DS–P

DEPARTMENT OF COMMERCE

International Trade Administration

Notice of Scope Ruling Applications Filed in Antidumping Duty and Countervailing Duty Proceedings

AGENCY: Enforcement and Compliance, International Trade Administration, Department of Commerce.

SUMMARY: The U.S. Department of Commerce (Commerce) received scope ruling applications, requesting that scope inquiries be conducted to determine whether identified products are covered by the scope of antidumping duty (AD) and/or countervailing duty (CVD) orders and that Commerce issue scope rulings pursuant to those inquiries. In accordance with Commerce's regulations, we are notifying the public of the filing of the scope ruling applications listed below in the month of May 2025.

DATES: Applicable June 25, 2025.

FOR FURTHER INFORMATION CONTACT: Yasmin Bordas, AD/CVD Operations, Customs Liaison Unit, Enforcement and Compliance, International Trade Administration, U.S. Department of Commerce, 1401 Constitution Avenue NW, Washington, DC 20230, telephone: (202) 482–3813.

Notice of Scope Ruling Applications

In accordance with 19 CFR 351.225(d)(3), we are notifying the public of the following scope ruling applications related to AD and CVD orders and findings filed in or around the month of May 2025. This notification includes, for each scope application: (1) identification of the AD and/or CVD orders at issue (19 CFR 351.225(c)(1)); (2) concise public descriptions of the products at issue, including the physical characteristics (including chemical, dimensional and technical characteristics) of the products (19 CFR 351.225(c)(2)(ii)); (3) the countries where the products are produced and the countries from where the products are exported (19 CFR 351.225(c)(2)(i)(B)); (4) the full names of the applicants; and (5) the dates that the scope applications were filed with Commerce and the name of the ACCESS

scope segment where the scope applications can be found.[1] This notice does not include applications which have been rejected and not properly resubmitted. The scope ruling applications listed below are available on Commerce's online e-filing and document management system, Antidumping and Countervailing Duty Electronic Service System (ACCESS), at *https://access.trade.gov.*

Scope Ruling Applications

Printed Fashion File Folder from the People's Republic of China (China) (A–570–147); Paper File Folders; [2] produced in and exported from China; submitted A2V Trade Limited (A2V); May 13, 2025; ACCESS scope segment ''Fashion File Folder''

Certain Forged Steel Fittings from China (A–570–067/C–570–068); Certain Automotive Brake Hose Fittings; [3] produced and exported from China; submitted by AGS Company Automotive Solutions (AGS); May 20, 2025; ACCESS scope segment ''Brake Hose Fittings''

Certain Forged Steel Wheels from China (A–570–090/C–570–091); Steel Wheels; [4] produced in and exported from China; submitted by Vision Wheel, Inc. (Vision Wheel); May 21, 2025; ACCESS scope segment ''Vision Wheel''

[1] *See Regulations to Improve Administration and Enforcement of Antidumping and Countervailing Duty Laws,* 86 FR 52300, 52316 (September 20, 2021) (*Final Rule*) (''It is our expectation that the **Federal Register** list will include, where appropriate, for each scope application the following data: (1) identification of the AD and/or CVD orders at issue; (2) a concise public summary of the product's description, including the physical characteristics (including chemical, dimensional and technical characteristics) of the product; (3) the country(ies) where the product is produced and the country from where the product is exported; (4) the full name of the applicant; and (5) the date that the scope application was filed with Commerce.'').

[2] The products are produced using CMYK offset printing on 250gsm paper, followed by full plastic lamination of the exterior. Sheets are then die-cut, folded, glued, and assembled into finished folders.

[3] The products are certain automotive brake hose fittings. The fittings are composed of 12L14 steel. The material composition of the alloying elements, by weight percent, are: carbon, 0.15% maximum; manganese, 0.85 to 1.15%; phosphorus, 0.04 to 0.09%; sulfur, 0.26 to 0.35%; lead, 0.15 to 0.35%; aluminum, 0.02% max; niobium, 0.025% max; and vanadium, 0.05% max. Dimensions are similar for each part but threading dimensions vary by part and the length ranges from 3/16'' to 1/4''.

[4] The products are described ranging from 14 to 18 inches in diameter, and four and ten inches in width, with bolt hole patterns ranging from four to eight holes, bolt pattern spacing ranging from 4.5 to 6.69 inches, center holes (*i.e.,* hub bore sizes) ranging 81.7 to 130.8 mm, offset from −39 to 50 mm, and load capacity ranging from 1,210 to 3,650 lbs.

Notification to Interested Parties

This list of scope ruling applications is not an identification of scope inquiries that have been initiated. In accordance with 19 CFR 351.225(d)(1), if Commerce has not rejected a scope ruling application nor initiated the scope inquiry within 30 days after the filing of the application, the application will be deemed accepted and a scope inquiry will be deemed initiated the following day—day 31.[5] Commerce's practice generally dictates that where a deadline falls on a weekend, Federal holiday, or other non-business day, the appropriate deadline is the next business day.[6] Accordingly, if the 30th day after the filing of the application falls on a non-business day, the next business day will be considered the ''updated'' 30th day, and if the application is not rejected or a scope inquiry initiated by or on that particular business day, the application will be deemed accepted and a scope inquiry will be deemed initiated on the next business day which follows the ''updated'' 30th day.[7]

In accordance with 19 CFR 351.225(m)(2), if there are companion AD and CVD orders covering the same merchandise from the same country of origin, the scope inquiry will be conducted on the record of the AD proceeding. Further, please note that pursuant to 19 CFR 351.225(m)(1), Commerce may either apply a scope ruling to all products from the same country with the same relevant physical characteristics, (including chemical, dimensional, and technical characteristics) as the product at issue, on a country-wide basis, regardless of the producer, exporter, or importer of those products, or on a company-specific basis.

For further information on procedures for filing information with Commerce through ACCESS and participating in scope inquiries, please refer to the Filing Instructions section of the Scope Ruling Application Guide, at *https://access.trade.gov/help/Scope_Ruling_Guidance.pdf.* Interested parties, apart from the scope ruling applicant, who wish to participate in a scope inquiry and be added to the public service list for that segment of the proceeding must file an entry of appearance in accordance with 19 CFR 351.103(d)(1) and 19 CFR 351.225(n)(4). Interested parties are advised to refer to the case segment in ACCESS as well as 19 CFR 351.225(f) for further information on the scope inquiry procedures, including the timelines for the submission of comments.

Please note that this notice of scope ruling applications filed in AD and CVD proceedings may be published before any potential initiation, or after the initiation, of a given scope inquiry based on a scope ruling application identified in this notice. Therefore, please refer to the case segment on ACCESS to determine whether a scope ruling application has been accepted or rejected and whether a scope inquiry has been initiated.

Interested parties who wish to be served scope ruling applications for a particular AD or CVD order may file a request to be included on the annual inquiry service list during the anniversary month of the publication of the AD or CVD order in accordance with 19 CFR 351.225(n) and Commerce's procedures.[8]

Interested parties are invited to comment on the completeness of this monthly list of scope ruling applications received by Commerce. Any comments should be submitted to Scot Fullerton, Acting Deputy Assistant Secretary for AD/CVD Operations, Enforcement and Compliance, International Trade Administration, via email to *CommerceCLU@trade.gov.*

This notice of scope ruling applications filed in AD and CVD proceedings is published in accordance with 19 CFR 351.225(d)(3).

Dated: June 20, 2025.

Abdelali Elouaradia,

Deputy Assistant Secretary for Enforcement & Compliance.

[FR Doc. 2025–11705 Filed 6–24–25; 8:45 am]

BILLING CODE 3510–DS–P

[5] In accordance with 19 CFR 351.225(d)(2), within 30 days after the filing of a scope ruling application, if Commerce determines that it intends to address the scope issue raised in the application in another segment of the proceeding (such as a circumvention inquiry under 19 CFR 351.226 or a covered merchandise inquiry under 19 CFR 351.227), it will notify the applicant that it will not initiate a scope inquiry, but will instead determine if the product is covered by the scope at issue in that alternative segment.

[6] *See Notice of Clarification: Application of* ''*Next Business Day*'' *Rule for Administrative Determination Deadlines Pursuant to the Tariff Act of 1930, As Amended,* 70 FR 24533 (May 10, 2005).

[7] This structure maintains the intent of the applicable regulation, 19 CFR 351.225(d)(1), to allow day 30 and day 31 to be separate business days.

[8] *See Scope Ruling Application; Annual Inquiry Service List; and Informational Sessions,* 86 FR 53205 (September 27, 2021).

DEPARTMENT OF COMMERCE

International Trade Administration

[A–570–168, C–570–169]

Certain Alkyl Phosphate Esters From the People's Republic of China: Antidumping and Countervailing Duty Orders; Correction

AGENCY: Enforcement and Compliance, International Trade Administration, Department of Commerce.

SUMMARY: The U.S. Department of Commerce (Commerce) published a notice in the **Federal Register** on June 11, 2025, in which Commerce announced the antidumping and countervailing duty orders on certain alkyl phosphate esters from the People's Republic of China (China). This notice corrects the ending date of the antidumping duty provisional measures.

FOR FURTHER INFORMATION CONTACT: Dennis McClure, AD/CVD Operations, Office VIII, Enforcement and Compliance, International Trade Administration, U.S. Department of Commerce, 1401 Constitution Avenue NW, Washington, DC 20203; telephone: (202) 482–5973.

SUPPLEMENTARY INFORMATION:

Background

On June 11, 2025, Commerce published in the **Federal Register**, *Certain Alkyl Phosphate Esters from the People's Republic of China: Antidumping and Countervailing Duty Orders*.[1] In that notice, we incorrectly stated that the date for the end of provisional measures in the less-than-fair-value (LTFV) investigation was June 2, 2025, rather than June 1, 2025.

Correction

In the **Federal Register** of June 11, 2025, in FR Doc 2025–10630 on page 24581, in the first column, in the second paragraph under the heading ''Provisional Measures—AD,'' correct the first two sentences to read as follows:

The provisional measures period, beginning on the date of publication of the *LTFV Preliminary Determination,*{[2]} ended on June 1, 2025. Therefore, in accordance with section 733(d) of the Act and our practice,[3] Commerce will instruct CBP to terminate the suspension of liquidation and to liquidate, without regard to antidumping duties, unliquidated entries of alkyl phosphate esters from China entered, or withdrawn from warehouse, for consumption after June 1, 2025, the final day on which the provisional measures were in effect, until and through the day preceding the date of publication of the ITC's final affirmative injury determination in the **Federal Register**.

Notification to Interested Parties

This notice is issued and published in accordance with section 516A(c) and (e) and 777(i)(1) of the Tariff Act of 1930, as amended.

Dated: June 20, 2025.

Christopher Abbott,

Deputy Assistant Secretary for Policy and Negotiations, performing the non-exclusive functions and duties of the Assistant Secretary for Enforcement and Compliance.

[FR Doc. 2025–11706 Filed 6–24–25; 8:45 am]

BILLING CODE 3510–DS–P

[1] *See Certain Alkyl Phosphate Esters from the People's Republic of China: Antidumping and Countervailing Duty Orders,* 90 FR 24579 (June 11, 2025).

[2] *See Certain Alkyl Phosphate Esters from the People's Republic of China: Preliminary Affirmative Determination of Sales at Less Than Fair Value, Postponement of Final Determination and Extension of Provisional Measures,* 89 FR 96223 (December 4, 2024) (*LTFV Preliminary Determination*).

[3] *See, e.g., Certain Corrosion-Resistant Steel Products from India, Italy, the People's Republic of China, the Republic of Korea and Taiwan: Amended Final Affirmative Antidumping Determination for India and Taiwan, and Antidumping Duty Orders,* 81 FR 48390, 48392 (July 25, 2016).

DEPARTMENT OF COMMERCE

International Trade Administration

Initiation of Antidumping and Countervailing Duty Administrative Reviews

AGENCY: Enforcement and Compliance, International Trade Administration, Department of Commerce.

SUMMARY: The U.S. Department of Commerce (Commerce) has received requests to conduct administrative reviews of various antidumping duty (AD) and countervailing duty (CVD) orders with May anniversary dates. In accordance with Commerce's regulations, we are initiating those administrative reviews.

DATES: Applicable June 25, 2025.

FOR FURTHER INFORMATION CONTACT: Brenda E. Brown, AD/CVD Operations, Customs Liaison Unit, Enforcement and Compliance, International Trade Administration, U.S. Department of Commerce, 1401 Constitution Avenue NW, Washington, DC 20230, telephone: (202) 482–4735.

SUPPLEMENTARY INFORMATION:

Background

Commerce has received timely requests, in accordance with 19 CFR 351.213(b), for administrative reviews of various AD and CVD orders with May anniversary dates.

All deadlines for the submission of various types of information, certifications, comments, or actions by Commerce discussed below refer to the number of calendar days from the applicable starting time.

Respondent Selection

In the event that Commerce limits the number of respondents for individual examination for administrative reviews initiated pursuant to requests made for the orders identified below, Commerce intends to select respondents based either on U.S. Customs and Border Protection (CBP) data for U.S. imports during the period of review (POR) or questionnaires in which we request the quantity and value (Q&V) of sales, shipments, or exports during the POR. Where Commerce selects respondents based on CBP data, we intend to place the CBP data on the record within five days of publication of the initiation notice. Where Commerce selects respondents based on Q&V data, Commerce intends to place the Q&V questionnaire on the record of the review within five days of publication of the initiation notice. In either case, we intend to make our decision regarding respondent selection within 35 days of publication of the initiation notice in the **Federal Register**. Comments regarding the CBP data (and/or Q&V data (where applicable)) and respondent selection should be submitted within seven days after the placement of the CBP data/submission of the Q&V data on the record of the review. Parties wishing to submit rebuttal comments should submit those comments within five days after the deadline for the initial comments.

In the event that Commerce decides it is necessary to limit individual examination of respondents and conduct respondent selection under section 777A(c)(2) of the Tariff Act of 1930, as amended (the Act), the following guidelines regarding collapsing of companies for purposes of respondent selection will apply. In general, Commerce has found that determinations concerning whether particular companies should be ''collapsed'' (*e.g.,* treated as a single entity for purposes of calculating AD rates) require a substantial amount of detailed information and analysis, which often require follow-up questions and analysis. Accordingly, Commerce

will not conduct collapsing analyses at the respondent selection phase of the review and will not collapse companies at the respondent selection phase unless there has been a determination to collapse certain companies in a previous segment of the AD proceeding (*e.g.,* investigation, administrative review, new shipper review, or changed circumstances review). For any company subject to the review, if Commerce determined, or continued to treat, that company as collapsed with others, Commerce will assume that such companies continue to operate in the same manner and will collapse them for respondent selection purposes. Otherwise, Commerce will not collapse companies for purposes of respondent selection.

Parties are requested to (a) identify which companies subject to review previously were collapsed, and (b) provide a citation to the proceeding in which they were collapsed. Further, if companies are requested to complete the Q&V questionnaire for purposes of respondent selection, in general, each company must report volume and value data separately for itself. Parties should not include data for any other party, even if they believe they should be treated as a single entity with that other party. If a company was collapsed with another company or companies in the most recently completed segment of the proceeding where Commerce considered collapsing that entity, complete Q&V data for that collapsed entity must be submitted.

Notice of No Sales

With respect to AD administrative reviews, we intend to rescind the review where there are no suspended entries for a company or entity under review and/or where there are no suspended entries under the company-specific case number for that company or entity. Where there may be suspended entries, if a producer or exporter named in this notice of initiation had no exports, sales, or entries during the POR, it may notify Commerce of this fact within 30 days of publication of this initiation notice in the **Federal Register** for Commerce to consider how to treat suspended entries under that producer's or exporter's company-specific case number.

Deadline for Withdrawal of Request for Administrative Review

Pursuant to 19 CFR 351.213(d)(1), a party that has requested a review may withdraw that request within 90 days of the date of publication of the notice of initiation of the requested review. The regulation provides that Commerce may extend this time if it is reasonable to do so. Determinations by Commerce to extend the 90-day deadline will be made on a case-by-case basis.

Deadline for Particular Market Situation Allegation

Section 504 of the Trade Preferences Extension Act of 2015 amended the Act by adding the concept of a particular market situation (PMS) for purposes of constructed value under section 773(e) of the Act.[1] Section 773(e) of the Act states that ''if a particular market situation exists such that the cost of materials and fabrication or other processing of any kind does not accurately reflect the cost of production in the ordinary course of trade, the administering authority may use another calculation methodology under this subtitle or any other calculation methodology.'' When an interested party submits a PMS allegation pursuant to section 773(e) of the Act, Commerce will respond to such a submission consistent with 19 CFR 351.301(c)(2)(v). If Commerce finds that a PMS exists under section 773(e) of the Act, then it will modify its dumping calculations appropriately.

Neither section 773(e) of the Act nor 19 CFR 351.301(c)(2)(v) set a deadline for the submission of PMS allegations and supporting factual information. However, in order to administer section 773(e) of the Act, Commerce must receive PMS allegations and supporting factual information with enough time to consider the submission. Thus, should an interested party wish to submit a PMS allegation and supporting new factual information pursuant to section 773(e) of the Act, it must do so no later than 20 days after submission of initial responses to section D of the questionnaire.

Separate Rates

In proceedings involving non-market economy (NME) countries, Commerce begins with a rebuttable presumption that all companies within the country are subject to government control and, thus, should be assigned a single AD deposit rate. It is Commerce's policy to assign all exporters of merchandise subject to an administrative review in an NME country this single rate unless an exporter can demonstrate that it is sufficiently independent so as to be entitled to a separate rate.

To establish whether a firm is sufficiently independent from government control of its export activities to be entitled to a separate rate, Commerce analyzes each entity exporting the subject merchandise. In accordance with the separate rates criteria, Commerce assigns separate rates to companies in NME cases only if respondents can demonstrate the absence of both *de jure* and *de facto* government control over export activities.

All firms listed below that wish to qualify for separate rate status in the administrative reviews involving NME countries must complete, as appropriate, either a Separate Rate Application or Certification, as described below. In addition, all firms that wish to qualify for separate rate status in the administrative reviews of AD orders in which a Q&V questionnaire is issued must complete, as appropriate, either a Separate Rate Application or Certification, and respond to the Q&V questionnaire.

For these administrative reviews, in order to demonstrate separate rate eligibility, Commerce requires entities for whom a review was requested, that were assigned a separate rate in the most recent segment of this proceeding in which they participated, to certify that they continue to meet the criteria for obtaining a separate rate. The Separate Rate Certification form will be available on Commerce's website at *https://access.trade.gov/Resources/nme/nme-sep-rate.html* on the date of publication of this **Federal Register** notice. In responding to the certification, please follow the ''Instructions for Filing the Certification'' in the Separate Rate Certification. Separate Rate Certifications are due to Commerce no later than 14 calendar days after publication of this **Federal Register** notice. In addition to filing a Separate Rate Certification with Commerce no later than 14 calendar days after publication of this **Federal Register** notice. The deadline and requirement for submitting a Separate Rate Certification applies equally to NME-owned firms, wholly foreign-owned firms, and foreign sellers who purchase and export subject merchandise to the United States.

Entities that currently do not have a separate rate from a completed segment of the proceeding[2] should timely file a Separate Rate Application to

[1] *See* Trade Preferences Extension Act of 2015, Public Law 114–27, 129 Stat. 362 (2015).

[2] Such entities include entities that have not participated in the proceeding, entities that were preliminarily granted a separate rate in any currently incomplete segment of the proceeding (*e.g.,* an ongoing administrative review, new shipper review, *etc.*) and entities that lost their separate rate in the most recently completed segment of the proceeding in which they participated.

demonstrate eligibility for a separate rate in this proceeding. In addition, companies that received a separate rate in a completed segment of the proceeding that have subsequently made changes, including, but not limited to, changes to corporate structure, acquisitions of new companies or facilities, or changes to their official company name,[3] should timely file a Separate Rate Application to demonstrate eligibility for a separate rate in this proceeding. The Separate Rate Application will be available on Commerce's website at *https://access.trade.gov/Resources/nme/nme-sep-rate.html* on the date of publication of this **Federal Register** notice. In responding to the Separate Rate Application, refer to the instructions contained in the application. Separate Rate Applications are due to Commerce no later than 14 calendar days after publication of this **Federal Register** notice. The deadline and requirement for submitting a Separate Rate Application applies equally to NME-owned firms, wholly foreign-owned firms, and foreign sellers that purchase and export subject merchandise to the United States.

Exporters and producers must file a timely Separate Rate Application or Certification if they want to be considered for individual examination. Furthermore, exporters and producers who submit a Separate Rate Application or Certification and subsequently are selected as mandatory respondents will no longer be eligible for separate rate status unless they respond to all parts of the questionnaire as mandatory respondents.

Certification Eligibility

Commerce may establish a certification process for companies whose exports to the United States could contain both subject and non-subject merchandise. Companies under review that were deemed to not be eligible to participate in the certification program of that proceeding may submit a Certification Eligibility Application to establish that they maintain the necessary systems to track their sales to the United States of subject and non-subject goods.

All firms listed below that are not currently eligible to certify but wish to establish certification eligibility are required to submit a Certification Eligibility Application. The Certification Eligibility Application will be available on Commerce's website at *https://access.trade.gov/Resources/Certification-Eligibility-Application.pdf.*

Certification Eligibility Applications must be filed according to Commerce's regulations and are due to Commerce no later than 30 calendar days after the publication of the **Federal Register** notice.

Exporters and producers that are not currently eligible to certify, who submit a Certification Eligibility Application, and are subsequently selected as mandatory respondents must respond to all parts of the questionnaire as mandatory respondents for Commerce to consider their Certification Eligibility Application.

Initiation of Reviews

In accordance with 19 CFR 351.221(c)(1)(i), we are initiating administrative reviews of the following AD and CVD orders and findings. We intend to issue the final results of these reviews not later than May 31, 2026.

	Period to be reviewed
AD Proceedings	
BELGIUM: Certain Carbon and Alloy Steel Cut-To-Length Plate, A–423–812	5/1/24–4/30/25
Industeel Belgium S.A.	
NLMK Clabecq S.A.	
NLMK Plate Sales S.A.	
NLMK Sales Europe S.A.	
NLMK Manage Steel Center S.A.	
NLMK La Louviere S.A.	
NLMK Dansteel A.S	
Nialco SA.	
BELGIUM: Stainless Steel Plate in Coils, A–423–808	5/1/24–4/30/25
Aperam Stainless Belgium NV	
CANADA: Large Diameter Welded Pipe, A–122–863	5/1/24–4/30/25
Aciers Lague Steels Inc	
Acier Profile SBB Inc	
Amdor Inc	
BPC Services Group	
Bri-Steel Manufacturing	
CFI Metal Inc	
Canada Culvert	
Canadian National Steel Corp	
Canam (St Gedeon)	
Cappco Tubular Products Canada Inc	
Dominion Pipe & Piling	
Enduro Canada Pipeline Services	
Evraz Inc. NA	
Fi Oilfield Services Canada	
Forterra	
Gchem Ltd	
Graham Construction	
Groupe Fordia Inc	
Hodgson Custom Rolling	
Hyprescon Inc	
Interpipe Inc	
K K Recycling Services	

[3] Only changes to the official company name, rather than trade names, need to be addressed via a Separate Rate Application. Information regarding new trade names may be submitted via a Separate Rate Certification.

	Period to be reviewed
Kobelt Manufacturing Co	
Labrie Environment	
Les Aciers Sofatec	
Lorenz Conveying Products	
MBI Produits De Forge	
Matrix Manufacturing	
Nor Arc	
Peak Drilling Ltd.	
Pipe & Piling Supplies Ltd.; 1045761 Ontario Ltd.; Spiralco Inc.	
Prudential	
Shaw Pipe Protection	
Tenaris Algoma Tubes Facility	
Tenaris Prudential	
Welded Tube of Can Ltd	
FRANCE: Carbon and Alloy Steel Cut-To-Length Plate, A–427–828	5/1/24–4/30/25
Dillinger France S.A.	
GERMANY: Certain Carbon and Alloy Steel Cut-To-Length Plate, A–428–844	5/1/24–4/30/25
AG der Dillinger Hüttenwerke	
GREECE: Large Diameter Welded Pipe, A–484–803	5/1/24–4/30/25
Corinth Pipeworks Pipe Industry S.A.	
INDIA: Certain New Pneumatic Off-The-Road Tires,[4] A–533–869	3/1/24–2/28/25
JK Tyres & Industries Ltd.	
Sun Tyres And Wheel Systems	
INDIA: Organic Soybean Meal, A–533–901	5/1/24–4/30/25
Aashiyana Foodstuffs	
ABC Fruits	
Adani Wilmar Ltd.	
Agrawal Oil & Biocheam	
Aia Engineering Ltd.	
Al Quresh Exp.	
Alembic Pharmaceuticals Ltd.	
Allana Consumer Products Pvt. Ltd.	
Apac Sourcing Solutions Ltd.	
Arctal India International	
Arn Designs 12. Artevet India LLP	
Artevet Therapeutics Pvt. Ltd.	
Asa Agrotech Pvt., Ltd.	
Aurobindo Pharma Ltd.	
Avi Agri Business Ltd.	
Avt Natural Products Ltd.	
Axis India International	
B.H. Handicrafts	
Basillia Organics Pvt. Ltd.	
Bawa Fishmeal and Oil Co.	
Bergwerff Organic (India) Pvt., Ltd.; Suminter India Organic Pvt., Ltd.	
Bharat Cereals Pvt., Ltd.	
BNS Agro Industries Sarl	
Capital Ventures Pvt. Ltd.	
Cardolite Speciality Chemicals India LLP	
Cloves Inc.	
Craft Home	
Crest Container Lines Pvt., Ltd.	
Dhanay Logistics Pvt., Ltd.	
Deccan Fine Chemicals (India) Pvt. Ltd.	
Delhi Haat Craft Cottage Industries	
Dighvijay Overseas	
Divi's Laboratories Ltd.	
Eco Gold Nutri and Organics LLP	
Ecopure Specialities Ltd.	
Euroasias Organics Pvt., Ltd.	
Exp. Freight Pvt., Ltd.	
Eyeconic Indian Handicraft	
Fair Exp. India Pvt., Ltd.	
Fermenta Biotech Ltd.	
Flex Foods Ltd.	
Frigorifico Allana Pvt. Ltd.	
Gate Foods Pvt. Ltd.	
Gateway Exim	
Gee Pee Overseas	
Gharda Chemicals Ltd.	
Goglocal Pvt. Ltd.	
GRS Agritech	
HBNT Packaging and Manufacturing Pvt., Ltd.	

	Period to be reviewed
Healthline Pvt. Ltd.	
HK. Exp.	
Indauto Filters	
Indrani Automotive & Engineering	
Infinite Bioscience	
Interport Global Logistics Pvt., Ltd.	
Issgf India Pvt., Ltd.	
ITC Ltd.	
J.B. Overseas	
Jaeger Products Pvt., Ltd.	
Jairaj Adi Global Food Products LLP	
Janatha Fish Meal and Oil Product	
Jay Keshav Exp. Pvt., Ltd.	
JSM Foods	
Kamal & Sons	
Kemin Industries South Asia Pvt., Ltd.	
King Exp.	
Krishna Corncob Industries	
Lamtuf Ltd.	
Larsen & Toubro	
Levon Chemicals India Pvt., Ltd.	
Lophius	
Lupin Ltd.	
Luxmi Tea	
Magnuss Enterprizes	
Makwell Organics Pvt., Ltd.	
Makwell Plastisizers Pvt., Ltd.	
Manisha Pharmo Pvt., Ltd.	
Marinetrans India Pvt., Ltd.	
Marksans Pharma Ltd.	
Medikonda Nutrients	
Menon Renewable Resources (India) Pvt. Ltd.	
Molhadeen International Nigeria	
Mukka Proteins Ltd.	
Natural Remedies Pvt., Ltd.	
Noble Shipping	
Novel Nutrients Pvt. Ltd.	
Nutech Biosciences India Pvt. Ltd.	
Orchid Exim India Pvt. Ltd.	
Orgonew Pvt. Ltd.	
Pachranga Foods	
Parikh Enterprises Pvt. Ltd.	
Patel Retail Pvt., Ltd.	
Pck Agri Ventures Pvt. Ltd.	
Pfizer Healthcare India Pvt. Ltd.	
Pisces Fashions	
Pots and Grains Pvt. Ltd.	
Prima Chemicals	
Propelor India Pvt., Ltd.	
R.P.M. Exim Pvt., Ltd.	
R.M. Trading Co.	
Radhakrishna Agro Industries Pvt. Ltd.	
Radhika Textiles & Handicrafts	
Rayban Organics Pvt., Ltd.	
Reindeer Organics LLP	
Repast Dietary Lifesciences Pvt., Ltd.	
Rishabh Gupta Corp. Pvt., Ltd.	
Ritz Creations	
Rohlig India Pvt., Ltd.	
Saastha Warehousing Ltd.	
Safewater Lines India Pvt.	
Samruddhi Organic Farm (India) Pvt., Ltd.	
Samsung Data Systems India Pvt., Ltd.	
Sap Oleochemicals Pvt., Ltd.	
Sayaji Industries Ltd.	
Sethi International	
SGR (777) Foods Pvt., Ltd.	
Shah Precicast Pvt., Ltd.	
Shakti Exim Co.	
Shikhar Logistics Pvt., Ltd.	
Shreeram Fibres India Pvt. Ltd.	
Shree Uday Oil and Foods Industries	
Shri Sumati Oil Industries Pvt., Ltd.	

	Period to be reviewed
Shubhangay Exim Pvt. Ltd.	
Singh Agritech Pvt. Ltd.	
Soliflex Packaging Pvt., Ltd.	
Speciality Indian Food Parks & Exp. Pvt., Ltd.	
S.S. India Foods Pvt. Ltd.	
Star India Container Line Pvt., Ltd.	
Sukhvarsha Projects Pvt., Ltd.	
Sunrise Seafoods India Pvt. Ltd.	
Suryamitra Exim Pvt., Ltd.	
Swaranimakash Life Sciences Pvt. Ltd.	
Teamglobal Logistics Pvt., Ltd.	
Tejawat Organic Foods	
Tex Biosciences Pvt. Ltd.	
The Vantage Tradelink	
Triveni Interchem Pvt., Ltd.	
Unique Fragrances	
United Magnetic System	
Uno Vetchem	
Vahdam Teas Pvt., Ltd.	
Veesure Animal Health	
Vippy Industries Ltd.	
Vishnu Barium Pvt., Ltd.	
Vista Processed Foods Pvt. Ltd.	
Wellcome Fisheries Ltd.	
INDIA: Silicomanganese, A–533–823	5/1/24–4/30/25
Alloys and Metals India	
Maithan Alloys Ltd.	
Shyam Sel and Power Ltd.	
INDONESIA: Mattresses,[5] A–560–836	5/1/24–4/30/25
PT Ecos Jaya Indonesia	
PT Grantec Jaya Indonesia	
PT. Zinus Global Indonesia	
ITALY: Certain Carbon and Alloy Steel Cut-To-Length Plate, A–475–834	5/1/24–4/30/25
NLMK Verona S.p.A.	
Officine Technosider s.r.l.	
F.A.R. Fonderie Acciaierie S.p.A.	
Ferriera Valsider SpA	
Metinvest Trametal SpA.	
Pro Form S.R.L.	
JAPAN: Diffusion-Annealed Nickel-Plated Flat-Rolled Steel Products, A–588–869	5/1/24–4/30/25
Higuchi Manufacturing Co., Ltd.	
IHI Corporation	
JFE Shoji Corporation	
Kohan Shoji Co., Ltd.	
Marubeni-Itochu Steel, Inc.	
Nichias Corporation	
Nikken Lath Kogyo Co., Ltd.	
Nippon Steel Trading Co., Ltd.; Nippon Steel Trading Corporation	
Oneda Electric Corporation	
Panasonic Operational Excellence Co., Ltd.	
Rinnai Corporation	
Sumisho Metalex Corporation	
Tokyo Metal Resources Co., Ltd.	
Tomiyasu & Co., Ltd.	
Toyo Kohan Co., Ltd.	
MALAYSIA: Mattresses, A–557–818	5/1/24–4/30/25
APM Auto Parts Marketing	
Comfort Coil Technology SDN BHD	
CS Vision Supplly SDN BHD	
Delandis Furniture (M) SDN BHD	
Ever Want (M) SDN BHD	
Far East Foam Industries SDN BHD	
GGC Global	
Hestart Venture	
Irama Furniture SDN BHD	
Kin Heng Furniture SDN BHD	
Lion YTT	
Maxmatt Industries SDN BHD	
Orient GIC Global	
Oyxen Ventures	
Perniagaan Jaya Nokkorn	
Pinnacle Salute SDN BHD	
Premier High Ventures	

	Period to be reviewed
Vision Foam Ind. SDN BHD	
Weld Tack Industries	
NETHERLANDS: Certain Preserved Mushrooms, A–421–815	5/1/24–4/30/25
Okechamp B.V.	
POLAND: Certain Preserved Mushrooms, A–455–806	5/1/24–4/30/25
Okechamp S.A.	
REPUBLIC OF KOREA: Carbon and Alloy Steel Cut-To-Length Plate, A–580–887	5/1/24–4/30/25
POSCO	
POSCO International Corporation	
REPUBLIC OF KOREA: Carbon and Alloy Steel Wire Rod, A–580–891	5/1/24–4/30/25
POSCO; POSCO International Corporation	
REPUBLIC OF KOREA: Large Diameter Welded Pipe, A–580–897	5/1/24–4/30/25
AJU Besteel Co., Ltd	
Chang Won Bending Co., Ltd.	
Daiduck Piping Co., Ltd.	
Dong Yang Steel Pipe Co., Ltd.	
Dongbu Incheon Steel Co., Ltd.	
EEW KHPC Co., Ltd.	
EEW Korea Co., Ltd.	
Geumok Tech. Co., Ltd.	
Hansol Metal Co. Ltd.	
Histeel Co., Ltd.	
Husteel Co., Ltd.	
Hyundai RB Co., Ltd	
Hyundai Steel Company	
Hyundai Steel Pipe Co., Ltd.	
Il Jin Nts Co. Ltd.	
Kiduck Industries Co., Ltd.	
Kum Kang Kind. Co., Ltd.]	
Kumsoo Connecting Co., Ltd.	
Nexteel Co., Ltd.	
SeAH Steel Corporation	
Seonghwa Industrial Co., Ltd.	
SIN-E B&P Co., Ltd.	
Steel Flower Co., Ltd.	
WELTECH Co., Ltd.	
REPUBLIC OF KOREA: Polyester Staple Fiber, A–580–839	5/1/24–4/30/25
Huvis Corporation	
Toray Advanced Materials Korea, Inc.	
REPUBLIC OF TÜRKIYE: Common Alloy Aluminum Sheet,[6] A–489–839	4/1/24–3/31/24
ASAS Aluminyum Sanayi ve Ticaret A.S	
Assan Aluminyum Sanayi ve Ticaret A.S.	
Kibar Americas, Inc.	
Kibar Dis Ticaret A.S	
Teknik Aluminyum Sanayi A.S.	
REPUBLIC OF TÜRKIYE: Circular Welded Carbon Steel Pipes and Tubes, A–489–501	5/1/24–4/30/25
Borusan Birleşik Boru Fabrikalari Sanayi ve Ticaret A.Ş.	
REPUBLIC OF TÜRKIYE: Large Diameter Welded Pipe, A–489–833	5/1/24–4/30/25
Cagil Makina San ve Tic A.S. AKA Cagil Makina A.S.	
Çimtaş Boru Imalatiral Ticaret Ltd.	
HDM Celik Boru Sanayi ve Ticaret A.S.; HDM Spiral Kaynakli Boru A.S.[7]	
Emek Boru Makina Sanayi ve Ticaret A.S.	
Erciyas Celik Boru Sanayi A.S.	
Mazlum Mangtay Boru Son. Ins. Tar.Urn.San.ve Tic. A.S.	
Noksel Celik Boru Sanayi A.S.	
Ozbal Celik Boru San. Tic. Ve TAAH A.S.	
Spirally Welded Steel Pipe Inc.	
Toscelik Profil ve Sac End. A.S.[8]	
Toscelik Spiral Boru Uretim A.S.	
Umran Celik Boru Sanayii A.S.	
SULTANATE OF: Polyethylene Terephthalate Resin, A–523–810	5/1/24–4/30/25
OCTAL SAOC–FZC	
TAIWAN: Certain Stainless Steel Plate in Coils, A–583–830	5/1/24–4/30/25
Alpha Metal International Co., Ltd.	
Aurora Metal International Co., Ltd.	
Best Win International Co., Ltd.	
Build Up Hardware Co., Ltd.	
Chain Chon Industrial Co., Ltd.	
Chang Mien Industries Co., Ltd.	
Chia Far Industries Factory Co., Ltd.	
Chien Shing Stainless Co., Ltd.	
China Steel Corporation	
China Steel Global Trading Corp.	

	Period to be reviewed
China Tah Lee Special Steel Co., Ltd.	
Chung Hung Steel Co., Ltd.	
Da Song Enterprise Co., Ltd.	
Da Tsai Stainless Steel Co., Ltd.	
East Track Enterprise Co., Ltd.	
Froch Enterprise Co., Ltd.	
Fu Sheng Rubber & Plastic Industries Co.	
Gifull Enterprise Co., Ltd.	
Goang Jau Shing Enterprise Co., Ltd.	
Goldioceans International Co., Ltd.	
High Point Steel Mfg. Co., Ltd.	
Hoka Elements Co., Ltd.	
Huang-Yi Steel Coil Co., Ltd.	
Hwa Yang Stainless Steel Ind Corp.	
JJSE Co., Ltd.	
JK Industrial Development Corp.	
Jye Chi Corporation	
Kunn Chuan Enterprise Co., Ltd.	
Lien Chy Laminated Metal Co., Ltd.	
Lien Kuo Metal Industries Co., Ltd.	
Lung An Stainless Ind. Co., Ltd.	
Meglobe Co., Ltd.	
Omen Bright Co., Ltd.	
PFP Taiwan Co., Ltd.	
Po Chwen Metal Industrial Co., Ltd.	
Pyramid Metal Technology Co., Ltd.	
Shang Chen Steel Co., Ltd.	
Shiner Steel International Ltd.	
Shing Shong Ta Metal Co., Ltd.	
Shye Yao Steel Co., Ltd.	
Sinkang Industries Co., Ltd.	
S-More Steel Materials Co., Ltd.	
Stanch Stainless Steel Co., Ltd.	
Sun Chun Stainless Co., Ltd.	
Sunmax Industrial Inc.	
Ta Chen International, Inc.	
Ta Chen Stainless Pipe Co., Ltd.	
Ta Fong Steel Co., Ltd.	
Taiwan Nippon Steel Stainless	
Tang Eng Iron Works	
Ton Yi Industrial Corp.	
Top Sunny Group Corp.	
Tsung Yui Enterprise Co., Ltd.	
Tung Mung Development Co., Ltd.	
Tzong Ji Metals Co., Ltd.	
Unity Special Steel Co., Ltd.	
Vasteel Enterprises Co., Ltd.	
Walsin Lihwa Corp.	
Wu Fu Jin	
Wuu Jing Enterprise Co., Ltd.	
Yc Inox Co., Ltd.	
Yeou Ting Industries Co., Ltd.	
Yeou Yih Steel Co., Ltd.	
Yes Stainless International Co.	
Yi Shuenn Enterprise Co., Ltd.	
Yieh Corp.	
Yieh Loong Enterprise Co., Ltd.	
Yieh Mau Corporation	
Yuan Long Stainless Steel Corp.	
Yue Send Industrial Co., Ltd.	
Yuen Chang Stainless Steel Co., Ltd.	
Yuh Sheng Stainless Steel Co., Ltd.	
TAIWAN: Stilbenic Optical Brightening Agents, A–583–848	5/1/24–4/30/25
Teh Fong Min International Co., Ltd.	
THE PEOPLE'S REPUBLIC OF CHINA: Aluminum Extrusions, A–570–967	5/1/24–4/30/25
AD Solutions	
Anji Chang Hong Chain Manufacturing Co., Ltd.	
Anji Dingze Technology Co., Ltd.	
Assa Abloy (Zhongshan) Security Technology	
Assa Abloy Entrance Systems Suzhou	
Assa Abloy Global Solutions (Shanghai)	
Baolida Window & Door Accessories	
Beijing Hongyi Denon International	

	Period to be reviewed
Beijing Kangtengwei International Trade Co.	
Cargo Services Group Limited	
Changchun Tianlong Automotive Components Co., Ltd	
Chengde Greenlife Home Product Co., Ltd.	
Chengdu Metalware Trading Co., Ltd.	
Chongqing Chaoli Electric Appliance	
Chongqing Millison Technologies Inc	
Citic Dicastal Co., Ltd.	
CMECH Ltd.	
Damco China Limited Ningbo Branch	
Dezhou Huamei Windows and Doors Co., Ltd.	
Dongguan Kowin Metal Precision Fabrication Co., Ltd.	
Ener Technology Co. Limited	
Ewellix Motion Technologies (Pinghu)	
Foshan Kinghorn Machinery Co., Ltd.	
Foshan Zhongfeixin Technology Co., Ltd.	
Green & Light Automotive Components	
Guangdong Xiongjin Metal Products	
Guangzhou Valeo Engine Cooling Co. Ltd.	
Hangzhou Douhao Import and Export Co. Ltd.	
Hangzhou Susan I E Co., Ltd.	
Hangzhou Xline Machinery & Equipment Co., Ltd.	
Hebei Jinshi Industrial Metal Co., Ltd	
Huzhou Minghua Auto Parts and Co., Ltd.	
IKD Co., Ltd.	
Jiangsu Tongshun Power Technology Co., Ltd.	
Jiangsu Wenhui Steel Engineering	
Jianxin Zhao's Technology Co., Ltd.	
JOC Machinery Co., Ltd.	
KECO Metal Manufacturing (HK) Co., Limited	
Lancham International Trade Co., Ltd.	
Liberty Lift Solution Shandong Oilfield Equipment Manufacturing Co., Ltd.	
Lifestyle Metal Co., Ltd.	
Maxwell China Technology Co., Ltd.	
Modine Thermal Systems (Changzhou)	
Nantong Jianghua Machinery Co., Ltd.	
Ningbo Allart International Trade Co.	
Ningbo Best Hardware Products Co., Ltd.	
Ningbo Daye Garden Industry Co., Ltd.	
Ningbo Dungyi & Yulian Casting Co., Ltd.	
Ningbo Harsco Machinery Co., Ltd.	
Ningbo Lianda Winch Co., Ltd.	
Ningbo Mogb Machinery Import & Export Co., Ltd.	
Ningbo Wubian Rubber and Plastic Co., Ltd.	
Ningbo Yesheng Precision Technical	
Ningbo Yongsheng Metal Manufacturing Co., Ltd.	
Ningbo Zhenlong Auto Parts Co., Ltd.	
Oubao Security Technology Co., Ltd.	
Pan Jack Industrial Co., Ltd.	
Puhui Home and Leisure Goods Company	
Pxi Auto Components (Suzhou) Co., Ltd.	
Qingdao Hisense Mould Co., Ltd.	
Qingdao Sanheshan Precision Casting	
Rainbird Irrigation Equipment Shanghai	
Relux Products Ltd.	
SAIC Volkswagen Automotive Co., Ltd	
Shanghai Homeland Info Tech Co., Ltd.	
Shanghai Hongji Metal Products Co., Ltd.	
Shanghai Shinekin Automotive Technology Co., Ltd.	
Shanghai Zesheng Automotive Technology Co., Ltd.	
Shenzhen Wulup S.C.M. Co., Ltd.	
Shunde Native Produce Import & Export Co. Ltd.	
Sunrise Machinery Co., Ltd.	
Suzhou Quality Import and Export Co.	
Suzhou Shida Tongtai Automotive Components Co., Ltd.	
Synergy Architectural Hardware Limited	
Techno Precision (Shen Zhen) Co., Ltd.	
Tianjin Wanda Tyre Group Co., Ltd.	
United Precision Casting Development Co., Ltd.	
Usual Material Group Limited	
Via Asia Supply Chain Management Co., Ltd	
Wisdom Electronics (Huizhou) Co., Ltd.	
Wuxi Bangde Machine Co., Ltd.	

	Period to be reviewed
Wuxi Dongpeng Metal Products Co., Ltd.	
Wuxi Huaguang Car Parts Co., Ltd.	
Xiamen Xianghao Trading Co., Ltd.	
Yakima (Najing) Precison Industry Co	
Yuhuan Huachao Machine Co., Ltd.	
Yuyao Nuohai Metalwork Co., Ltd.	
Zenith Industry (Shanghai) Co., Ltd.	
Zhangqiu Copper and Aluminum Casting	
Zhaoqing City Zhisheng Door Control	
Zhejiang Dongfeng Refrigeration Components Co., Ltd.	
Zhejiang Rongtai Electric Material Co., Ltd.	
Zhongce Rubber Group Co., Ltd.	
Zhongnan Aluminum Wheel	
Zhongnan Industrial Group Limited	
Zhongshan Huaguan Hardware Co., Ltd.	
ZZF Fence Technology Co., Ltd.	
THE PEOPLE'S REPUBLIC OF CHINA: Certain Vertical Shaft Engines between 99cc and up to 225cc, and parts thereof, A–570–124	5/1/24–4/30/25
Changzhou Kawasaki and Kwang Yang Engine Co., Ltd.	
ChongQing AM Pride Power & Machinery Co., Ltd.	
Chongqing Chen Hui Electric Machinery Co., Ltd	
Chongqing Dinking Power Machinery Co., Ltd.	
Chongqing Ducar Power Equipment Co., Ltd.	
Chongqing Hwasdan Power Technology Co., Ltd.	
Chongqing Kohler Engines, Ltd.	
Chongqing Kohler Motors Co., Ltd.	
Chongqing Rato Technology Co., Ltd.	
Chongqing Senci Import & Export Trade Co., Ltd	
Chongqing Shineray Agricultural Machinery Co., Ltd.	
Chongqing Zongshen General Power Machine Co., Ltd.; Chongqing Dajiang Power Equipment Co., Ltd.; Chongqing Zongshen Power Machinery Co., Ltd.[9]	
Fujian Everstrong Lega Power Equipments Co., Ltd.	
Kawasaki Heavy Industries, Ltd.	
Lifan Technology (Group) Co., Ltd.	
Loncin Motor Co., Ltd.	
Qianjiang Group Wenling Jennfeng Industry Inc.	
Taizhou Sabo Electronics Co., Ltd.	
Wenling Qianjiang Imp. & Exp. Co., Ltd.	
Zhejiang Amerisun Technology Co., Ltd.	
Zhejiang Dobest Power Tools Co., Ltd.	
THE PEOPLE'S REPUBLIC OF CHINA: Non-refillable Steel Cylinders, A–570–126	5/1/24–4/30/25
Ningbo Eagle Machinery & Technology Co., Ltd.	
Sanjiang Kai Yuan Co. Ltd.	
Wuyi Xilinde Machinery Manufacture Co., Ltd.	
Zhejiang KIN–SHINE Technology Co., Ltd	
THE PEOPLE'S REPUBLIC OF CHINA: Stilbenic Optical Brightening Agents, A–570–972	5/1/24–4/30/25
Beijing Odyssey Chemical Ind. Co. Ltd.	
CSFC Taiwan Enterprise Corporation	
Dongguan Tangxia Kong Fung	
Hebei Dianchang Chemicals Co. Ltd.	
Jiangsu Glory Chemical Co., Ltd.	
Jinan Subang Fine Chemical Co., Ltd.	
Zhejiang Hongda Chemicals Co., Ltd.	
Zhejiang Transfar Whyyon Chemical Co., Ltd.	
THE PEOPLE'S REPUBLIC OF CHINA: Citric Acid and Certain Citrate Salts, A–570–937	5/1/24–4/30/25
RZBC Group Co., Ltd.	
RZBC Co., Ltd.	
RZBC Import & Export Co., Ltd.	
RZBC (Juxian) Co., Ltd.	
UNITED ARAB EMIRATES: Certain Steel Nails, A–520–804	5/1/24–4/30/25
Al Falaq Building Materials	
Al Khashab Building Materials Co., LLC	
Al Rafaa Star Building Materials Est	
Al Sabbah Trading and Importing, Est	
All Ferro Building Materials, LLC	
Asgarali Yousuf Trading Co., LLC	
Azymuth Consulting, LLC	
Burj Al Tasmeem, Tr	
Dubai Wire FZE	
Gheewala Hardware Trading Company, LLC	
Madar UAE	
Master Nails and Pins Manufacturing, LLC/Middle East Manufacturing Steel, LLC	
Mustafa Building Materials Co. (LLC)	

	Period to be reviewed
New World International, LLC	
Okzeela Star Building Materials Trading, LLC	
Rich Well Steel Industries LLC	
Rishi International, FZCO	
Samrat Wire Industry, LLC	
Sea Land Contracting Trade Circle Enterprises, LLC	
SK Metal International DMCC	
CVD Proceedings	
INDIA: Organic Soybean Meal, C–533–902	1/1/24–12/31/24
Aashiyana Foodstuffs	
Agrawal Oil & Biocheam	
Aia Engineering Ltd.	
Ajanta Pharma Ltd.	
Al Quresh Exp.	
Allana Consumer Products Pvt. Ltd.	
Artevet India LLP	
Asa Agrotech Pvt., Ltd.	
Avi Agri Business Ltd.	
Avt Natural Products Ltd.	
Basillia Organics Pvt. Ltd.	
Bawa Fishmeal and Oil Co.	
Bergwerff Organic (India) Pvt., Ltd.; Suminter India Organics Private Limited	
Bharat Cereals Pvt., Ltd.	
BNS Agro Industries Sarl	
Cardolite Specialty Chemicals India LLP	
Craft Home	
Dahnay Logistics Pvt., Ltd.	
Divi's Laboratories Ltd.	
Dr. Reddys Laboratories Ltd.	
Ecopure Specialities Ltd.	
Epsilon Carbon Pvt., Ltd.	
Euroasias Organics Pvt., Ltd.	
Exp. Freight Pvt., Ltd.	
Expeditors International (India) Pvt., Ltd.	
Fair Exp. India Pvt., Ltd.	
Flex Foods Ltd.	
Frigorifico Allana Pvt. Ltd.	
Gate Foods Pvt. Ltd.	
Gharda Chemicals Ltd.	
Indauto Filters	
Indo Gulf Co.	
Indrani Automotive & Engineering	
Infinite Bioscience	
Interport Global Logistics Pvt., Ltd.	
J.R. Roadlines Pvt., Ltd	
Janatha Fish Meal and Oil Products	
Januz Universal	
Jay Keshav Exp. Pvt., Ltd.	
JSM Foods	
Kemin Industries South Asia Pvt., Ltd.	
Khanal Foods Pvt., Ltd.	
King Exp.	
Krishna Corncob Industries	
Larsen & Toubro	
LG Balakrishnan Bros.	
Lupin Ltd.	
Luxmi Tea	
Magnichem Industries	
Medikonda Nutrients	
MRL Tyres Ltd.	
Mukka Proteins Ltd.	
N M Coating	
Natural Herbs & Formulations	
Natural Remedies Pvt., Ltd.	
Noble Shipping	
Novel Nutrients Pvt. Ltd.	
Nutrivin Agro Pvt., Ltd.	
Pachranga Foods	
Patel Retail Pvt., Ltd.	
Prima Chemicals	
Quality Spices and Food Exp. Pvt., Ltd	
R.M. Trading Co.	

	Period to be reviewed
Rayban Organics Pvt., Ltd.	
Rohlig India Pvt., Ltd.	
Rupen Marketing Pvt., Ltd.	
Safewater Lines (India) Pvt., Ltd.	
Samruddhi Organic Farm (India) Pvt., Ltd.	
Satyendra Fibc Pvt., Ltd.	
Sethi International	
SGR (777) Foods Pvt., Ltd.	
Shah Precicast Pvt., Ltd.	
Shikhar Logistics Pvt., Ltd.	
Shree Uday Oil and Foods Industries	
Shri Sumati Oil Industries Pvt., Ltd.	
Soliflex Packaging Pvt., Ltd.	
Sona Sunehri Exp.	
Speciality Indian Food Parks & Exp. Pvt., Ltd.	
Sunrise Seafoods India Pvt. Ltd.	
Suprajit Engineering Ltd.	
Suryamitra Exim Pvt., Ltd.	
TCG Lifesciences Pvt. Ltd.	
Tejawat Organic Foods	
The Vantage Tradelink	
Unichem Laboratories Ltd.	
Unique Fragrances	
Unovel Industries Pvt., Ltd.	
Vippy Industries Ltd.	
Vishnu Barium Pvt., Ltd.	
REPUBLIC OF KOREA: Certain Carbon and Alloy Steel Cut-To-Length Plate, C–580–888	1/1/24–12/31/24
Ajin Industrial Co., Ltd.	
BDP International	
Blue Track Equipment	
Boxco	
Boxco, Inc.	
Bukook Steel Co., Ltd.	
Buma CE Co., Ltd.	
China Chengdu International Techno-Economic Cooperation Co., Ltd.	
Daehan I.M. Co., Ltd.	
Daehan Tex Co., Ltd.	
Daeik Eng Co. Ltd.	
Daelim Industrial Co., Ltd.	
Daesam Industrial Co., Ltd.	
Daesin Lighting Co., Ltd.	
Daewoo International Corp.	
Dong Yang Steel Pipe	
DKC	
DK Corporation	
DK Dongshin Co., Ltd.	
Dongbu Steel Co., Ltd.	
Dongkuk Industries Co., Ltd.	
Dongkuk Steel Mill Co., Ltd.	
EAE Automotive Equipment	
EEW KHPC Co., Ltd.	
Eplus Expo Inc.	
GS Global Corp.	
Haem Co., Ltd.	
Han Young Industries	
Hyeon Dae Jong Hap Gong Gu Co. Ltd.	
Hyosung Corp.	
Hyundai Steel Co.	
Jinmyung Frictech Co., Ltd.	
Khana Marine Ltd.	
Kindus Inc.	
Korean Iron and Steel Co., Ltd.	
Kyoungil Precision Co., Ltd.	
LG Electronics Inc	
Menics	
POSCO	
POSCO International Corp.	
POSCO International Corporation	
Qian'an Rentai Metal Products Co., Ltd.	
Samjin Lnd Co., Ltd	
Samsun C&T Corp.	
Samsung	
Samsung Electronics Co., Ltd.	

	Period to be reviewed
Shinko	
Shipping Imperial Co., Ltd.	
Sinchang Eng Co., Ltd.	
SK Networks Co., Ltd.	
SNP Ltd.	
Seogio O/A	
Steel N People Ltd.	
Summit Industry	
Sungjin Co., Ltd.	
Wonbang Tech Co., Ltd.	
Young Sun Steel.	
REPUBLIC OF KOREA: Large Diameter Welded Pipe, C–580–898	1/1/24–12/31/24
AJU Besteel Co., Ltd	
Chang Won Bending Co., Ltd.	
Daiduck Piping Co., Ltd.	
Dongbu Incheon Steel Co., Ltd.	
Dong Yang Steel Pipe Co., Ltd.	
EEW KHPC Co., Ltd.	
EEW Korea Co., Ltd.	
Hansol Metal Co. Ltd.	
Histeel Co., Ltd.	
Husteel Co., Ltd.[10]	
Hyundai RB Co., Ltd.; Shinchang Construction Co., Ltd.	
Hyundai Steel Company[11]	
Hyundai Steel Pipe Co., Ltd.	
Il Jin Nts Co. Ltd.	
Iljin Nts Co. Ltd.	
Kem Solutions Co., Ltd.	
Kiduck Industries Co., Ltd.	
Kum Kang Kind. Co., Ltd.	
Kumsoo Connecting Co., Ltd.	
Nexteel Co., Ltd.	
POSCO International Corporation	
Samkang M&T Co., Ltd.	
SeAH Steel Corporation; SeAH Steel Holdings Corporation.	
Seonghwa Industrial Co., Ltd.	
SIN-E B&P Co., Ltd.	
Steel Flower Co., Ltd.	
WELTECH Co., Ltd	
REPUBLIC OF TÜRKIYE: Large Diameter Welded Pipe, C–489–834	1/1/24–12/31/24
Cagil Makina San ve Tic A.S. AKA Cagil Makina A.S.	
Çimtaş Boru Imalatiral Ticaret Ltd.	
HDM Celik Boru Sanayi ve Ticaret A.S.; HDM Spiral Kaynakli Boru A.S.[12]	
Emek Boru Makina Sanayi ve Ticaret A.S.	
Erciyas Celik Boru Sanayi A.S.	
Mazlum Mangtay Boru Son. Ins. Tar.Urn.San.ve Tic. A.S.	
Noksel Celik Boru Sanayi A.S.	
Ozbal Celik Boru San. Tic. Ve TAAH A.S.	
Spirally Welded Steel Pipe Inc.	
Toscelik Profil ve Sac End. A.S.[13]	
Toscelik Spiral Boru Uretim A.S.	
Umran Celik Boru Sanayii A.S.	
REPUBLIC OF TÜRKIYE: Common Alloy Aluminum Sheet,[14] C–489–840	1/1/24–12/31/24
ASAS Aluminyum Sanayi ve Ticaret A.S.	
Teknik Aluminyum Sanayi A.S.; TAC Metal Ticaret A.S.	
Assan Aluminyum Sanayi ve Ticaret A.S.; Kibar Dis Ticaret A.S.; Kibar Holding A.S. Kibar Americas, Inc.	
P.M.S. Metal Profil Aluminyum Sanayi Ve Ticaret A.S.	
THE PEOPLE'S REPUBLIC OF CHINA: Non-refillable Steel Cylinders, C–570–127	1/1/24–12/31/24
Sanjiang Kai Yuan Co. Ltd	
THE PEOPLE'S REPUBLIC OF CHINA: Aluminum Extrusions, C–570–968	1/1/24–12/31/24
AD Solutions	
Anji Chang Hong Chain Manufacturing Co., Ltd.	
Anji Dingze Technology Co., Ltd.	
Assa Abloy (Zhongshan) Security Technology	
Assa Abloy Entrance Systems Suzhou	
Assa Abloy Global Solutions (Shanghai)	
Baolida Window & Door Accessories	
Beijing Hongyi Denon International	
Beijing Kangtengwei International Trade Co.	
Cargo Services Group Limited	
Changchun Tianlong Automotive Components Co., Ltd	
Chengde Greenlife Home Product Co., Ltd.	
Chengdu Metalware Trading Co., Ltd.	

	Period to be reviewed
Chongqing Chaoli Electric Appliance	
Chongqing Millison Technologies Inc	
Citic Dicastal Co., Ltd.	
CMECH Ltd.	
Damco China Limited Ningbo Branch	
Dezhou Huamei Windows and Doors Co., Ltd.	
Dongguan Kowin Metal Precision Fabrication Co., Ltd.	
Ener Technology Co. Limited	
Ewellix Motion Technologies (Pinghu)	
Foshan Kinghorn Machinery Co., Ltd.	
Foshan Zhongfeixin Technology Co., Ltd.	
Green & Light Automotive Components	
Guangdong Xiongjin Metal Products	
Guangzhou Valeo Engine Cooling Co. Ltd.	
Hangzhou Douhao Import and Export Co. Ltd.	
Hangzhou Susan I E Co., Ltd.	
Hangzhou Xline Machinery & Equipment Co., Ltd.	
Hebei Jinshi Industrial Metal Co., Ltd	
Huzhou Minghua Auto Parts and Co., Ltd.	
IKD Co., Ltd.	
Jiangsu Tongshun Power Technology Co., Ltd.	
Jiangsu Wenhui Steel Engineering	
Jianxin Zhao's Technology Co., Ltd.	
JOC Machinery Co., Ltd.	
KECO Metal Manufacturing (HK) Co., Limited	
Lancham International Trade Co., Ltd.	
Liberty Lift Solution Shandong Oilfield Equipment Manufacturing Co., Ltd.	
Lifestyle Metal Co., Ltd.	
Maxwell China Technology Co., Ltd.	
Modine Thermal Systems (Changzhou)	
Nantong Jianghua Machinery Co., Ltd.	
Ningbo Allart International Trade Co.	
Ningbo Best Hardware Products Co., Ltd.	
Ningbo Daye Garden Industry Co., Ltd.	
Ningbo Dungyi & Yulian Casting Co., Ltd.	
Ningbo Harsco Machinery Co., Ltd.	
Ningbo Lianda Winch Co., Ltd.	
Ningbo Mogb Machinery Import & Export Co., Ltd.	
Ningbo Wubian Rubber and Plastic Co., Ltd.	
Ningbo Yesheng Precision Technical	
Ningbo Yongsheng Metal Manufacturing Co., Ltd.	
Ningbo Zhenlong Auto Parts Co., Ltd.	
Oubao Security Technology Co., Ltd.	
Pan Jack Industrial Co., Ltd.	
Puhui Home and Leisure Goods Company	
Pxi Auto Components (Suzhou) Co., Ltd.	
Qingdao Hisense Mould Co., Ltd.	
Qingdao Sanheshan Precision Casting	
Rainbird Irrigation Equipment Shanghai	
Relux Products Ltd.	
SAIC Volkswagen Automotive Co., Ltd	
Shanghai Homeland Info Tech Co., Ltd.	
Shanghai Hongji Metal Products Co., Ltd.	
Shanghai Shinekin Automotive Technology Co., Ltd.	
Shanghai Zesheng Automotive Technology Co., Ltd.	
Shenzhen Wulup S.C.M. Co., Ltd.	
Shunde Native Produce Import & Export Co. Ltd.	
Sunrise Machinery Co., Ltd.	
Suzhou Quality Import and Export Co.	
Suzhou Shida Tongtai Automotive Components Co., Ltd.	
Synergy Architectural Hardware Limited	
Techno Precision (Shen Zhen) Co., Ltd.	
Tianjin Wanda Tyre Group Co., Ltd.	
United Precision Casting Development Co., Ltd.	
Usual Material Group Limited	
Via Asia Supply Chain Management Co., Ltd	
Wisdom Electronics (Huizhou) Co., Ltd.	
Wuxi Bangde Machine Co., Ltd.	
Wuxi Dongpeng Metal Products Co., Ltd.	
Wuxi Huaguang Car Parts Co., Ltd.	
Xiamen Xianghao Trading Co., Ltd.	
Yakima (Najing) Precison Industry Co	
Yuhuan Huachao Machine Co., Ltd.	

	Period to be reviewed
Yuyao Nuohai Metalwork Co., Ltd. Zenith Industry (Shanghai) Co., Ltd. Zhangqiu Copper and Aluminum Casting Zhaoqing City Zhisheng Door Control Zhejiang Dongfeng Refrigeration Components Co., Ltd. Zhejiang Rongtai Electric Material Co., Ltd. Zhongce Rubber Group Co., Ltd. Zhongnan Aluminum Wheel Zhongnan Industrial Group Limited Zhongshan Huaguan Hardware Co., Ltd. ZZF Fence Technology Co., Ltd.	

Suspension Agreements

None.

[4] In the initiation notice published on April 28, 2025 (90 FR 17568), we listed two company names with incorrect spellings. We are correcting those errors in this notice.

[5] We received requests for reviews of the listed companies for this POR, however, this Order has been revoked due to litigation. *See Mattresses from Indonesia: Notice of Court Decision Not in Harmony with the Final Determination of Antidumping Duty Investigation; Notice of Amended Final Determination; and Notice of Revocation of Antidumping Order.* Should the order be reinstated as a result of pending litigation, we will initiate on these requests at that time.

[6] The initiation notice that published on May 20, 2025 (90 FR 21459) did not include this case. We are correcting this error in this initiation notice, effective May 20, 2025.

[7] In English, the name HDM Spiral Kaynakli Celik Boru A.S. is HDM Spirally Welded Steel Pipe Inc.

[8] In English, the name Toscelik Profil ve Sac End. A.S. is Toscelik Profile and Sheet Ind. Co.

[9] In the investigation, Commerce treated these companies as a single entity. *See Certain Vertical Shaft Engines Between 99cc and Up to 225cc, and Parts Thereof, From the People's Republic of China: Final Affirmative Determination of Sales at Less Than Fair Value and Final Affirmative Determination of Critical Circumstances, in Part,* 86 FR 14077 (March 12, 2021). Absent information to the contrary, we intend to continue to treat these companies as a single entity for the purpose of this administrative review.

[10] Subject merchandise both produced and exported by Husteel Co., Ltd. (Husteel) is excluded from the countervailing duty order. *See Large Diameter Welded Pipe from the Republic of Korea: Countervailing Duty Order,* 84 FR 18773 (May 2, 2019). Thus, Husteel's inclusion in this administrative review is limited to entries for which Husteel was not both the producer and exporter of the subject merchandise.

[11] Subject merchandise both produced and exported by Hyundai Steel Company (Hyundai Steel) and subject merchandise produced by Hyundai Steel and exported by Hyundai Corporation are excluded from the countervailing duty order. *See Large Diameter Welded Pipe from the Republic of Korea: Countervailing Duty Order,* 84 FR 18773 (May 2, 2019). Thus, Hyundai Steel's inclusion in this administrative review is limited to entries for which Hyundai Steel was not both the producer and exporter of subject merchandise.

[12] In English, the name HDM Spiral Kaynakli Celik Boru A.S. is HDM Spirally Welded Steel Pipe Inc.

[13] In English, the name Toscelik Profil ve Sac End. A.S. is Toscelik Profile and Sheet Ind. Co.

[14] The initiation notice that published on May 20, 2025 (90 FR 21459) did not include this case. We are correcting this error in this initiation notice, effective May 20, 2025.

Duty Absorption Reviews

During any administrative review covering all or part of a period falling between the first and second or third and fourth anniversary of the publication of an AD order under 19 CFR 351.211 or a determination under 19 CFR 351.218(f)(4) to continue an order or suspended investigation (after sunset review), Commerce, if requested by a domestic interested party within 30 days of the date of publication of the notice of initiation of the review, will determine whether antidumping duties have been absorbed by an exporter or producer subject to the review if the subject merchandise is sold in the United States through an importer that is affiliated with such exporter or producer. The request must include the name(s) of the exporter or producer for which the inquiry is requested.

Gap Period Liquidation

For the first administrative review of any order, there will be no assessment of antidumping or countervailing duties on entries of subject merchandise entered, or withdrawn from warehouse, for consumption during the relevant ''gap'' period of the order (*i.e.,* the period following the expiry of provisional measures and before definitive measures were put into place), if such a gap period is applicable to the POR.

Administrative Protective Orders and Letters of Appearance

Interested parties must submit applications for disclosure under administrative protective orders in accordance with the procedures outlined in Commerce's regulations at 19 CFR 351.305. Those procedures apply to administrative reviews included in this notice of initiation. Parties wishing to participate in any of these administrative reviews should ensure that they meet the requirements of these procedures (*e.g.,* the filing of separate letters of appearance as discussed at 19 CFR 351.103(d)).

Factual Information Requirements

Commerce's regulations identify five categories of factual information in 19 CFR 351.102(b)(21), which are summarized as follows: (i) evidence submitted in response to questionnaires; (ii) evidence submitted in support of allegations; (iii) publicly available information to value factors under 19 CFR 351.408(c) or to measure the adequacy of remuneration under 19 CFR 351.511(a)(2); (iv) evidence placed on the record by Commerce; and (v) evidence other than factual information described in (i)–(iv). These regulations require any party, when submitting factual information, to specify under which subsection of 19 CFR 351.102(b)(21) the information is being submitted and, if the information is submitted to rebut, clarify, or correct factual information already on the record, to provide an explanation identifying the information already on the record that the factual information seeks to rebut, clarify, or correct. The regulations, at 19 CFR 351.301, also provide specific time limits for such factual submissions based on the type of factual information being submitted. Please review the *Final Rule,*[15] available at *https://www.govinfo.gov/content/pkg/FR-2013-07-17/pdf/2013-17045.pdf,* prior to submitting factual information in this segment. Note that Commerce has amended certain of its requirements pertaining to the service of documents in 19 CFR 351.303(f).[16]

Any party submitting factual information in an AD or CVD proceeding must certify to the accuracy and completeness of that information using the formats provided at the end of

[15] *See Certification of Factual Information To Import Administration During Antidumping and Countervailing Duty Proceedings,* 78 FR 42678 (July 17, 2013) (*Final Rule*); *see also* the frequently asked questions regarding the *Final Rule,* available at *https://enforcement.trade.gov/tlei/notices/factual_info_final_rule_FAQ_07172013.pdf.*

[16] *See Administrative Protective Order, Service, and Other Procedures in Antidumping and Countervailing Duty Proceedings; Final Rule,* 88 FR 67069 (September 29, 2023).

the *Final Rule.*[17] Commerce intends to reject factual submissions in any proceeding segments if the submitting party does not comply with applicable certification requirements.

Extension of Time Limits Regulation

Parties may request an extension of time limits before a time limit established under Part 351 expires, or as otherwise specified by Commerce.[18] In general, an extension request will be considered untimely if it is filed after the time limit established under Part 351 expires. For submissions which are due from multiple parties simultaneously, an extension request will be considered untimely if it is filed after 10:00 a.m. on the due date. Examples include, but are not limited to: (1) case and rebuttal briefs, filed pursuant to 19 CFR 351.309; (2) factual information to value factors under 19 CFR 351.408(c), or to measure the adequacy of remuneration under 19 CFR 351.511(a)(2), filed pursuant to 19 CFR 351.301(c)(3) and rebuttal, clarification and correction filed pursuant to 19 CFR 351.301(c)(3)(iv); (3) comments concerning the selection of a surrogate country and surrogate values and rebuttal; (4) comments concerning CBP data; and (5) Q&V questionnaires. Under certain circumstances, Commerce may elect to specify a different time limit by which extension requests will be considered untimely for submissions which are due from multiple parties simultaneously. In such a case, Commerce will inform parties in the letter or memorandum setting forth the deadline (including a specified time) by which extension requests must be filed to be considered timely. This policy also requires that an extension request must be made in a separate, standalone submission, and clarifies the circumstances under which Commerce will grant untimely-filed requests for the extension of time limits. Please review the *Final Rule,* available at *https://www.gpo.gov/fdsys/pkg/FR-2013-09-20/html/2013-22853.htm,* prior to submitting factual information in these segments.

Notification to Interested Parties

These initiations and this notice are in accordance with section 751(a) of the Act (19 U.S.C. 1675(a)) and 19 CFR 351.221(c)(1)(i).

[17] *See* section 782(b) of the Act; *see also Final Rule;* and the frequently asked questions regarding the *Final Rule,* available at *https://enforcement.trade.gov/tlei/notices/factual_info_final_rule_FAQ_07172013.pdf.*

[18] *See* 19 CFR 351.302.

Dated: June 18, 2025.

Abdelali Elouaradia,

Deputy Assistant Secretary for Enforcement and Compliance.

[FR Doc. 2025–11704 Filed 6–24–25; 8:45 am]

BILLING CODE 3510–DS–P

DEPARTMENT OF COMMERCE

National Institute of Standards and Technology

Information Collection Activities; Submission to the Office of Management and Budget (OMB) for Review and Approval; Comment Request; Generic Clearance for Usability Data Collections

The Department of Commerce will submit the following information collection request to the Office of Management and Budget (OMB) for review and clearance in accordance with the Paperwork Reduction Act of 1995, on or after the date of publication of this notice. We invite the general public and other Federal agencies to comment on proposed and continuing information collections, which helps us assess the impact of our information collection requirements and minimize the public's reporting burden. Public comments were previously requested via the **Federal Register** on April 15, 2025, during a 60-day comment period. This notice allows for an additional 30 days for public comments.

Agency: National Institute of Standards and Technology (NIST), Commerce.

Title: Generic Clearance for Usability Data Collections.

OMB Control Number: 0693–0043.

Form Number(s): None.

Type of Request: Regular submission, extension of a current information collection.

Number of Respondents: 150,000.

Average Hours per Response: Varied, dependent upon the data collection method used. The possible response time to complete a questionnaire may be 15 minutes or 2 hours to participate in an empirical study.

Burden Hours: 100,000.

Needs and Uses: NIST will conduct information collections to evaluate the usability and utility of NIST research for measurement and standardization work. These data collections efforts may include, but may not be limited to electronic methodologies, empirical studies, video and audio collections, interviews, and questionnaires.

Affected Public: Individual or households; State, Local or Tribal Government; Federal Government.

Frequency: On occasion.

Respondent's Obligation: Voluntary.

This information collection request may be viewed at *www.reginfo.gov.* Follow the instructions to view the Department of Commerce collections currently under review by OMB.

Written comments and recommendations for the proposed information collection should be submitted within 30 days of the publication of this notice on the following website *www.reginfo.gov/public/do/PRAMain.* Find this particular information collection by selecting ''Currently under 30-day Review—Open for Public Comments'' or by using the search function and entering either the title of the collection or the OMB Control Number 0693–0043.

Sheleen Dumas,

Departmental PRA Compliance Officer, Office of the Under Secretary for Economic Affairs, Commerce Department.

[FR Doc. 2025–11664 Filed 6–24–25; 8:45 am]

BILLING CODE 3510–13–P

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

[RTID 0648–XF010]

Endangered Species; File No. 28467

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Notice; issuance of permit.

SUMMARY: Notice is hereby given that the University of North Carolina Wilmington (Responsible Party: Frederick Scharf, Ph.D.) has been issued a permit to take Atlantic sturgeon (*Acipenser oxyrinchus*) and shortnose sturgeon (*A. brevirostrum*) for purposes of scientific research.

ADDRESSES: The permit and related documents are available for review upon written request via email to *NMFS.Pr1Comments@noaa.gov.*

FOR FURTHER INFORMATION CONTACT: Erin Markin, Ph.D., or Shasta McClenahan, Ph.D., (301) 427–8401.

SUPPLEMENTARY INFORMATION: On April 14, 2025, notice was published in the **Federal Register** (90 FR 15563) that a request for a scientific research permit to take Atlantic and shortnose sturgeon had been submitted by the above-named organization. The requested permit has been issued under the authority of the Endangered Species Act of 1973, as amended (ESA; 16 U.S.C. 1531 *et seq.*) and the regulations governing the

taking, importing, and exporting of endangered and threatened species (50 CFR parts 222–226).

The permit was issued on June 17, 2025, and authorizes the applicant to continue research on Atlantic and shortnose sturgeon to determine their abundance, distribution, habitat use, and migration dynamics in the coastal rivers and estuaries of North Carolina basins (Cape Fear, Neuse, Tar/Pamlico, Roanoke/Chowan). Atlantic and shortnose sturgeon may be captured using gill nets, trammel nets, or trawls, measured, weighed, tagged (PIT, Floy, T-bar), biologically sampled (tissue), and photographed/videoed. A subset of Atlantic sturgeon may be anesthetized and receive an internal acoustic tag. In addition, these same research procedures may be conducted on Atlantic sturgeon captured under other authority in the Frying Pan Shoals area of North Carolina to determine habitat use. Early life stages of Atlantic sturgeon may be lethally collected. The permit is valid through June 30, 2035.

Issuance of this permit, as required by the ESA, was based on a finding that such permit (1) was applied for in good faith, (2) will not operate to the disadvantage of such endangered or threatened species, and (3) is consistent with the purposes and policies set forth in section 2 of the ESA.

Dated: June 23, 2025.

Shannon Bettridge,

Chief, Marine Mammal and Sea Turtle Conservation Division, Office of Protected Resources, National Marine Fisheries Service.

[FR Doc. 2025–11715 Filed 6–24–25; 8:45 am]

BILLING CODE 3510–22–P

CONSUMER PRODUCT SAFETY COMMISSION

Commission Agenda and Priorities; Notice of Hearing

AGENCY: U.S. Consumer Product Safety Commission.

ACTION: Notice of public hearing.

SUMMARY: The U.S. Consumer Product Safety Commission (Commission or CPSC) will conduct a public hearing to receive views from interested parties about the Commission's agenda and priorities for fiscal year (FY) 2026, which begins on October 1, 2025, and for FY 2027, which begins on October 1, 2026. We invite members of the public to participate.

DATES: The hybrid hearing will be held in person at CPSC's headquarters and remotely via webinar on July 16, 2025, beginning at 10:00 a.m. Eastern Daylight Time (EDT).

ADDRESSES: This year's hearing will be held as a hybrid meeting—in person at CPSC's headquarters and remotely via webinar. For individuals attending in person, the meeting will be held at CPSC's headquarters, located at 4330 East-West Highway, 4th Floor—Hearing Room, Bethesda, MD 20814. Individuals who plan to attend the meeting remotely should use the following link to access the meeting: *https://events.gcc.teams.microsoft.com/event/0a0f4c40-f6e3-4465-8bc4-14cf2e840e76@7f5de26c-a63d-475c-9b6c-4126a914e132.* Requests to make oral presentations (in person or remotely) and the text of oral presentations and written comments should be sent by email to *cpsc-os@cpsc.gov* with the subject line, ''Agenda and Priorities FY 2026 and/or 2027.'' Requests to make oral presentations—in person or remotely—and the written text of any oral presentations must be received by the Office of the Secretary not later than 5:00 p.m. EDT on July 9, 2025. The Commission will accept written comments as well. These also must be received by the Office of the Secretary not later than 5:00 p.m. EDT on July 9, 2025.

FOR FURTHER INFORMATION CONTACT: For information about the hearing, or to request an opportunity to make an oral presentation, whether in person or remotely, please send an email to CPSC's Office of the Secretary at *cpsc-os@cpsc.gov.* If you have any questions about the hearing, you may contact Alberta E. Mills, Office of the Secretary, U.S. Consumer Product Safety Commission, 4330 East-West Highway, Bethesda, MD 20814, telephone (301) 504–7479.

SUPPLEMENTARY INFORMATION:

I. Background

Section 4(j) of the Consumer Product Safety Act (CPSA), 15 U.S.C. 2053(j), requires the Commission to establish an agenda for action under the laws the Commission administers and, to the extent feasible, select priorities for action at least 30 days before the beginning of each fiscal year. Section 4(j) of the CPSA provides further that when establishing its agenda and priorities, the Commission shall conduct a public hearing and provide an opportunity for the submission of comments.

II. Instructions for Remote Attendees

The hybrid public hearing will be held on July 16, 2025, at 10:00 a.m. EDT in person at CPSC's headquarters and remotely via webinar. The notice for the hearing will also be made available on the CPSC website on the public calendar: *https://www.cpsc.gov/Newsroom/Public-Calendar.* Individuals who plan to attend the meeting remotely should use the following link to access the meeting: *https://events.gcc.teams.microsoft.com/event/0a0f4c40-f6e3-4465-8bc4-14cf2e840e76@7f5de26c-a63d-475c-9b6c-4126a914e132.*[1]

III. Oral Presentations (Both in Person at CPSC's Headquarters and Remotely via Webinar) and Submission of Written Comments

The Commission is preparing the agency's fiscal year 2026 Operating Plan and fiscal year 2027 Congressional Budget Request. Fiscal year 2026 begins on October 1, 2025, and fiscal year 2027 begins on October 1, 2026. Through this notice, the Commission invites the public to comment on the Commission's agenda and priorities that will be established in the fiscal year 2026 Operating Plan and the fiscal year 2027 Congressional Budget Request. Proposed priorities should be aligned with the agency's Strategic Plan for fiscal years 2023–2026, which is available at *http://www.cpsc.gov/about-cpsc/agency-reports/performance-and-budget.*

Persons who desire to make oral presentations at the hearing on July 16, 2025—in person or remotely—should send an email to the Office of the Secretary, U.S. Consumer Product Safety Commission at *cpsc-os@cpsc.gov* not later than 5:00 p.m. EDT on July 9, 2025. Texts of intended oral presentations should be captioned ''Agenda and Priorities FY 2026 and/or 2027'' and must be received not later than 5:00 p.m. EDT on July 9, 2025. Oral presentations—in person or remotely—should be limited to approximately 5 minutes. The Commission reserves the right to impose further time limitations or other restrictions on presentations.

If you do not want to make an oral presentation but would like to provide written comments, you may do so. Written comments should be captioned, ''Agenda and Priorities FY 2026 and/or 2027,'' and sent to Office of the Secretary, U.S. Consumer Product Safety Commission at *cpsc-os@cpsc.gov* no later than 5 p.m. EDT on July 9, 2025. There is no length restriction for written comments.

Alberta E. Mills,

Secretary, U.S. Consumer Product Safety Commission.

[FR Doc. 2025–11657 Filed 6–24–25; 8:45 am]

BILLING CODE 6355–01–P

[1] On June 20, 2025, the Commission voted 3–0–2 to approve publication of this document.

DEPARTMENT OF DEFENSE

Office of the Secretary

[Docket ID: DOD–2024–OS–0152]

Submission for OMB Review; Comment Request; Correction

AGENCY: Office of the Under Secretary of Defense for Personnel and Readiness (OUSD (P&R)), Department of Defense (DoD).

ACTION: 30-Day information collection notice; correction.

SUMMARY: On June 18, 2025, the DoD published a notice with the wrong *Title; Associated Form; and OMB Number* text in the **SUPPLEMENTARY INFORMATION** section. This notice corrects the error. Everything else in the original notice remains the same.

DATES: This correction is effective June 25, 2025.

FOR FURTHER INFORMATION CONTACT: Aaron Siegel, 571–372–0488.

SUPPLEMENTARY INFORMATION: On June 18, 2025, the DoD published 2025–11195 at 90 FR 26038. Subsequent to publication of the notice in the **Federal Register**, DoD realized the *Title; Associated Form; and OMB Number* text in the **SUPPLEMENTARY INFORMATION** section was not correct.

On page 26038, in the first column, in the **SUPPLEMENTARY INFORMATION** section, the *Title; Associated Form; and OMB Number* text is corrected to read as follows:

Title; Associated Form; and OMB Number: Department of Defense (DoD) Voluntary Education Partnership Memorandum of Understanding (MOU) Institutional Compliance Program (ICP); OMB Control Number 0704–VEPP.

Dated: June 23, 2025.

Aaron T. Siegel,

Alternate OSD Federal Register Liaison Officer, Department of Defense.

[FR Doc. 2025–11709 Filed 6–24–25; 8:45 am]

BILLING CODE 6001–FR–P

DEPARTMENT OF EDUCATION

Applications for New Awards; Educational Technology, Media, and Materials for Individuals With Disabilities—National Center To Improve Faculty Capacity To Use Educational Technology in Special Education Personnel and Leadership Preparation Programs

AGENCY: Office of Special Education and Rehabilitative Services, Department of Education.

ACTION: Notice.

SUMMARY: The Department of Education (Department) is issuing a notice inviting applications for new awards for fiscal year (FY) 2025 for Educational Technology, Media, and Materials for Individuals with Disabilities—National Center to Improve Faculty Capacity to Use Educational Technology in Special Education Personnel and Leadership Preparation Programs.

DATES:

Applications Available: June 25, 2025.

Deadline for Transmittal of Applications: July 25, 2025.

Deadline for Intergovernmental Review: August 25, 2025.

Pre-Application Webinar Information: No later than June 30, 2025, the Office of Special Education and Rehabilitative Services (OSERS) will post pre-recorded informational webinars designed to provide technical assistance (TA) to interested applicants. Links to the webinars may be found at *www.ed.gov/about/ed-offices/osers/osep/new-osep-grant-competitions.*

ADDRESSES: For the addresses for obtaining and submitting an application, please refer to our Common Instructions for Applicants to Department of Education Discretionary Grant Programs, published in the **Federal Register** on December 23, 2024 (89 FR 104528) and available at *www.federalregister.gov/documents/2024/12/23/2024-30488/common-instructions-for-applicants-to-department-of-education-discretionary-grant-programs.*

FOR FURTHER INFORMATION CONTACT: Tina Diamond, U.S. Department of Education, 400 Maryland Avenue SW, Room 4A10, Washington, DC 20202. Telephone: (202) 245–6723. Email: *christina.diamond@ed.gov.*

If you are deaf, hard of hearing, or have a speech disability and wish to access telecommunications relay services, please dial 7–1–1.

SUPPLEMENTARY INFORMATION:

Full Text of Announcement

I. Funding Opportunity Description

Purpose of Program: The Educational Technology, Media, and Materials for Individuals with Disabilities Program is designed to improve results for children with disabilities by: (1) promoting the development, demonstration, and use of technology; (2) supporting educational activities designed to be of educational value in the classroom for children with disabilities; (3) providing support for captioning and video description that is appropriate for use in the classroom; and (4) providing accessible educational materials to children with disabilities in a timely manner.

Assistance Listing Number (ALN): 84.327F.

OMB Control Number: 1820–0028.

Priority: This competition includes one absolute priority. In accordance with 34 CFR 75.105(b)(2)(v), this priority is from allowable activities specified in the statute (see sections 674(b) and 681(d) of the Individuals with Disabilities Education Act (IDEA); 20 U.S.C. 1474(b) and 1481(d)).

Absolute Priority: For FY 2025 and any subsequent year in which we make awards from the list of unfunded applications from this competition, this priority is an absolute priority. Under 34 CFR 75.105(c)(3), we consider only applications that meet this priority.

This priority is:

National Center to Improve Faculty Capacity to Use Educational Technology in Special Education Personnel and Leadership Preparation Programs.

Background:

Educational technology includes a range of technologies, from those that are universally designed to support all learners to highly customized assistive technology (AT) devices designed to support the needs of individual learners with disabilities.

To realize the power of educational technology, educators must be adequately prepared, have confidence in their ability to integrate and implement educational technology in their teaching, and understand emerging technologies such as artificial intelligence (AI) (Anderson & Putman, 2020).

For educators to effectively implement educational technology, institutions of higher education (IHEs) that prepare and provide continuing education must integrate educational and assistive technologies into their programs of study so that special education personnel and leadership program graduates have experienced effective educational technology integration. IHE faculty vary in their content expertise, experiences in course design, and technological knowledge and skills for teaching and learning, and this variability influences their use of educational technology (Hughes et al., 2016; Vogel et al., 2024). Challenges for faculty at IHEs include the time commitment needed to change instructional approaches and lack of access to sustained professional development to support the continued use of educational technology (Polly et al., 2021; See also Case Studies by the Center for Innovation, Design, and Digital Learning available at *https://ciddl.org/case-studies/*). Additional challenges exist when IHEs move special education personnel preparation

programs or leadership preparation programs that have historically operated on campus and in-person to virtual programs that operate exclusively online (Karchmer-Klein, 2020). Competencies needed by faculty at IHEs to effectively prepare future educators and leaders have been proposed, and approaches to the acquisition of these competencies need to be explored (Foulger et al., 2017). Institutional incentives to increase faculty knowledge and use of educational technology exist (*e.g.,* reduced teaching load, financial compensation) but often are not offered (Kolb et al., 2018). In addition, educational technology continues to rapidly expand and evolve, which presents challenges for faculty at IHEs to stay up to date on innovative tools and strategies. Keeping current on educational technology is critical, as advances in AI and educational technology have the potential to significantly impact special education practices (Center for Innovation, Design, and Digital Learning, 2024; National Academies of Sciences, Engineering, and Medicine, 2024; Waterfield et al., 2024).

Priority:

The purpose of this priority is to fund a cooperative agreement to establish and operate a National Center to Improve Faculty Capacity to Use Educational Technology in Special Education Personnel and Leadership Preparation Programs. For the purposes of this priority, educational technology includes AT devices [1] and AI.[2] This project will support faculty at IHEs by improving their knowledge and use of educational technology, and their capacity to sustain its use in special education personnel and leadership preparation programs.

The project must achieve, at a minimum, the following expected outcomes:

(a) Increased knowledge of faculty at IHEs about the range of educational technologies that can be used within special education personnel and leadership preparation programs;

(b) Increased capacity of faculty at IHEs to use a range of educational technologies within special education personnel and leadership preparation programs;

(c) Increased capacity of faculty within and across IHEs to establish and sustain professional learning networks related to the use of educational technologies within special education personnel and leadership preparation programs to keep up with technological innovations;

(d) Increased integration of educational technologies and practices throughout special education personnel and leadership preparation programs; and

(e) Increased number of special education personnel and leadership preparation program graduates who enter the field well-prepared to integrate educational technologies and innovative technology practices, especially evidence-based technology and practices that improve literacy outcomes, to better serve children with disabilities and their families.

In addition, to be considered for funding under this priority, applicants must meet the following requirements:

(a) Describe, in the narrative section of the application under ''Significance,'' how the proposed project will address faculty needs at IHEs to identify, select, use, and integrate educational technology into their special education personnel and leadership preparation programs. To meet this requirement the applicant must—

(1) Present information on the types of educational technology that can be used in special education personnel and leadership preparation programs that support both in-person and distance learning;

(2) Present information on the extent to which special education personnel and leadership preparation programs have currently integrated educational technology, including AT, into their courses and content; and

(3) Identify systemic barriers, gaps, or challenges to integrating educational technology in special education personnel and leadership preparation programs.

(b) Describe, in the narrative section of the application under ''Quality of the project design,'' how the proposed project will—

(1) Achieve its goals, objectives, and intended outcomes. To meet this requirement, the applicant must provide—

(i) Measurable intended project outcomes; and

(ii) In Appendix A, the logic model (as defined in 34 CFR 77.1) by which the proposed project will achieve its intended outcomes that depicts, at a minimum, the goals, activities, outputs, and intended outcomes of the proposed project;

Note: The following website provides more information on logic models: *https://ies.ed.gov/use-work/resource-library/resource/tooltoolkit/program-evaluation-toolkit.*

(2) Use a conceptual framework (and provide a copy in Appendix A) to develop project plans and activities, describing any underlying concepts, assumptions, expectations, beliefs, or theories, as well as the presumed relationships or linkages among these variables, and any empirical support for this framework;

(3) Be based on current research and make use of evidence-based [3] practices (EBPs) on educational technology for special education personnel and leadership preparation programs. To meet this requirement, the applicant must describe—

(i) The current literature and research on—

(A) Educational technology, including technologies that support distance learning, for special education personnel and leadership preparation programs; the evidence base related to its effectiveness; and the effective use of such technologies;

(B) How to support faculty at IHEs in the use of educational technology to prepare future special educators and leaders; and

(C) Factors associated with the integration of educational technology, including technologies that support distance learning, into courses and components of special education personnel and leadership preparation programs, and how to address those factors;

(ii) How the proposed project will incorporate current literature and research in the development and refinement of frameworks for integrating technology in preparation programs and engaging in sustained professional learning networks;

(iii) How the proposed project will identify faculty at IHEs or preparation programs that have promising approaches and practices for integrating educational technology in its special

[1] The term ''assistive technology device'' or ''AT device'' has the meaning set forth in 20 U.S.C. 1401(1): Any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain, or improve the functional capabilities of a child with a disability. The term does not include a medical device that is surgically implanted, or the replacement of such device.

[2] The term ''artificial intelligence'' or ''AI'' has the meaning set forth in 15 U.S.C. 9401(3): A machine-based system that can, for a given set of human-defined objectives, make predictions, recommendations, or decisions influencing real or virtual environments. AI systems use machine- and human-based inputs to perceive real and virtual environments; abstract such perceptions into models through analysis in an automated manner; and use model inference to formulate options for information or action.

[3] For the purposes of this priority, ''evidence-based'' means the proposed project component is supported by one or more of strong evidence, moderate evidence, promising evidence, or evidence that demonstrates a rationale (34 CFR 77.1).

education personnel and leadership preparation programs, and incorporate that information into the development and refinement of the framework;

(iv) The current research about adult learning principles and implementation science that will inform the proposed TA to IHE faculty within special education personnel and leadership preparation programs; and

(v) How the proposed project will incorporate current research and EBPs in the development and delivery of its products and services;

(4) Develop products and provide TA services that are of high quality and sufficient intensity and duration to achieve the intended outcomes of the proposed project. To address this requirement, the applicant must describe—

(i) How it proposes to identify or develop the knowledge base related to educational technology for special education personnel and leadership preparation programs, its effectiveness, and how to use the technologies; and

(ii) How it proposes to engage constituents in the development and refinement of a framework for—

(A) How to support IHE faculty to acquire needed competencies for integrating educational technology within special education personnel and leadership preparation programs; and

(B) Increasing capacity of faculty within and across IHEs to create and sustain professional learning networks related to educational technology and its integration in special education personnel and leadership preparation programs;

(iii) The proposed approach to universal, general TA,[4] which must describe—

(A) The intended recipients, including the type and number of recipients, that will receive the products and services;

(B) The products and services that the project proposes to make available;

(C) The development and maintenance of a high-quality website, with an easy-to-navigate design, that meets or exceeds government- or industry-recognized standards for accessibility; and

(D) The expected reach and impact of universal, general TA;

(iv) The proposed approach to targeted, specialized TA,[5] which must describe—

(A) The intended recipients, including the type and number of recipients, that will receive the products and services;

(B) The products and services that the project proposes to make available;

(C) The proposed approach to measure the readiness of potential TA recipients to work with the project, including, at a minimum, an assessment of potential recipients' current infrastructure, available resources, and ability to build capacity at the local level;

(D) How the proposed project will ensure continuity of TA services to special education personnel and leadership preparation programs to implement previously developed technology integration plans; and

(E) The expected impact of targeted, specialized TA;

(v) The proposed approach to intensive, sustained TA,[6] which must describe—

(A) The intended recipients, including the type and number of recipients from a variety of settings and geographic distribution, that will receive the products and services designed to increase the integration of educational technologies in special education personnel and leadership preparation programs;

(B) The proposed approach to supporting faculty at IHEs in implementing the frameworks for integrating technology in preparation programs and engaging in sustained professional learning networks, which must include a plan to measure the readiness of potential recipients to work with the project, assessing, at a minimum, their current use of educational technology in the delivery of coursework, technology resources at the IHE, and ability to build educational technology capacity at the institutional level; and

(C) The expected impact of intensive, sustained TA;

(5) Develop products and implement services that maximize efficiency. To address this requirement, the applicant must describe—

(i) How the proposed project will use technology to achieve the intended project outcomes;

(ii) With whom the proposed project will collaborate and the intended outcomes of this collaboration; and

(iii) How the proposed project will use non-project resources, such as non-Federal funds and in-kind contributions, to achieve the intended project outcomes; and

(6) Systematically disseminate information, products, and services to varied intended audiences. To address this requirement the applicant must describe—

(i) The variety of dissemination strategies the project will use throughout the five years of the project to promote awareness and use of its products and services;

(ii) How the project will tailor dissemination strategies across all planned levels of TA to ensure that products and services reach intended recipients, and those recipients can access and use those products and services;

(iii) How the project's dissemination plan is connected to the proposed outcomes of the project; and

(iv) How the project will evaluate and correct all digital products and external communications to ensure they meet or exceed government or industry-recognized standards for accessibility.

(c) In the narrative section of the application under ''Quality of the project evaluation or other evidence-building,'' describe how the project will develop an evaluation plan in consultation with, and to be implemented by, a third-party [7] evaluator. The evaluation plan must—

(1) Articulate formative and summative evaluation questions across all planned levels of TA, including important process and outcome evaluation questions. These questions must be related to the project's proposed logic model required under paragraph (b)(2)(ii);

[4] ''Universal, general TA'' means TA and information provided to independent users through their own initiative, resulting in minimal interaction with TA project staff and including one-time, invited or offered conference presentations by TA project staff. This category of TA also includes information or products, such as newsletters, guidebooks, or research syntheses, downloaded from the TA project's website by independent users. Brief communications by TA project staff with recipients, either by telephone or email, are also considered universal, general TA.

[5] ''Targeted, specialized TA'' means TA services based on needs common to multiple recipients and not extensively individualized. A relationship is established between the TA recipient and one or more TA project staff. This category of TA includes one-time, labor-intensive events, such as facilitating strategic planning or hosting regional or national conferences. It can also include episodic, less labor-intensive events that extend over a period of time, such as facilitating a series of conference calls on single or multiple topics that are designed around the needs of the recipients. Facilitating communities of practice can also be considered targeted, specialized TA.

[6] ''Intensive, sustained TA'' means TA services often provided on-site and requiring a stable, ongoing relationship between the TA project staff and the TA recipient. ''TA services'' are defined as negotiated series of activities designed to reach a valued outcome. This category of TA should result in changes to policy, program, practice, or operations that support increased recipient capacity or improved outcomes at one or more systems levels.

[7] A ''third-party'' evaluator is an independent and impartial program evaluator who is contracted by the grantee to conduct an objective evaluation of the project. This evaluator must not have participated in the development or implementation of any project activities, except for the evaluation activities, nor have any financial interest in the outcome of the evaluation.

(2) Describe how progress in and fidelity of implementation, as well as project outcomes, will be measured to answer the evaluation questions. In measuring progress of implementation across all levels of TA, the plan should include criteria for determining the extent to which the project's products and services reached intended recipients; data, including feedback from recipients, on how recipients used the products and services; and the impact of the products and services. The plan should also specify sources for data, and measures and instruments appropriate to the evaluation questions, including information on reliability and validity of the measures and associated instruments where appropriate;

(3) Describe strategies for analyzing data and how data collected as part of this plan will be used to inform and improve service delivery over the course of the project and to refine the proposed logic model and evaluation plan, including subsequent data collection;

(4) Provide a timeline for conducting the evaluation and include staff assignments for completing the plan. The timeline must indicate that the data will be available annually for the annual performance report (APR); and

(5) Dedicate sufficient funds in each budget year to cover the costs of developing or refining the evaluation plan in consultation with a third-party evaluator, as well as the costs associated with the implementation of the evaluation plan by the third-party evaluator.

(d) Describe, in the narrative section of the application under ''Adequacy of resources,'' how—

(1) The project will make positive efforts to employ and advance in employment qualified individuals with disabilities;

(2) The applicant and any key partners have adequate resources to carry out the proposed activities;

(3) The applicant will ensure adequacy of resources for the proposed project and the quality of the personnel who will carry out the proposed project by addressing all aspects of the selection criteria for this section;

(4) The proposed project will have processes, resources, and funds in place to provide equitable access for project staff, contractors, and partners, who require digital accessibility accommodations; [8] and

(5) The proposed costs are reasonable in relation to the anticipated results and benefits, and funds will be spent in a way that increases their efficiency and cost-effectiveness, including by reducing waste or achieving better outcomes.

(d) Describe, in the narrative section of the application under ''Quality of the management plan,'' how—

(1) The proposed key project personnel, consultants, and subcontractors have the qualifications and experience to carry out the proposed activities and achieve the project's intended outcomes;

(2) The proposed project will implement project management techniques to ensure the project's intended outcomes will be achieved on time and within budget. To address this requirement, the applicant must describe how the management plan for the proposed project addresses all aspects of the selection criteria for this section; and

(3) The proposed management plan will ensure that the products and services provided are of high quality, relevant, and useful to recipients.

(f) Address the following application requirements. The applicant must—

(1) Include, in Appendix A, personnel-loading charts and timelines, as applicable, to illustrate the management plan described in the narrative;

(2) Include, in the budget, attendance at the following:

(i) A one and one-half day kick-off meeting in Washington, DC, after receipt of the award, and an annual planning meeting in Washington, DC, with the OSEP project officer and other relevant staff during each subsequent year of the project period.

Note: Within 30 days of receipt of the award, a post-award teleconference must be held between the OSEP project officer and the grantee's project director or other authorized representative;

(ii) A two-day project directors' conference in Washington, DC, during each year of the project period; and

(iii) Two annual two-day trips to attend Department briefings, Department-sponsored conferences, and other meetings, as requested by OSEP;

(3) Provide an assurance that the project will reallocate unused travel funds no later than the end of the third quarter if the kick-off or planning meetings are conducted virtually;

(4) Include, in the budget, a line item for an annual set-aside of 5 percent of the grant amount to support emerging needs that are consistent with the proposed project's intended outcomes, as those needs are identified in consultation with, and approved by, the OSEP project officer. With approval from the OSEP project officer, the project must reallocate any remaining funds from this annual set-aside no later than the end of the third quarter of each budget period;

(5) Provide an assurance that the project will engage doctoral students or post-doctoral fellows in the project to increase the number of future leaders in the field who are knowledgeable about integration of educational technology in special education personnel and leadership preparation programs;

(6) Ensure that annual project progress toward meeting project goals is posted on the project website; and

(7) Include, in Appendix A, an assurance to assist OSEP with the transfer of pertinent resources and products and to maintain the continuity of services to States during the transition to a new award at the end of this award period, as appropriate.

Fourth and Fifth Years of the Project:

In deciding whether to continue funding the project for the fourth and fifth years, the Secretary will consider the requirements of 34 CFR 75.253(a), including—

(a) The timeliness with which, and how well, the requirements of the negotiated cooperative agreement have been or are being met by the project; and

(b) The quality, relevance, and usefulness of the project's products and services and the extent to which the project's products and services are aligned with the project's objectives and likely to result in the project achieving its intended outcomes.

Under 34 CFR 75.253, the Secretary may reduce continuation awards or discontinue awards in any year of the project period for excessive carryover balances, a failure to make substantial progress, or where grantees have not maintained financial and administrative management systems that meet requirements in 2 CFR 200.302, Financial management, and 2 CFR 200.303, Internal controls. The Department intends to closely monitor unobligated balances and substantial progress under this program and may reduce or discontinue funding accordingly.

[8] For information about digital accessibility and accessibility standards, visit *https://sites.ed.gov/idea/topic-areas/#Accessibility-Creating-Content* and Section 504 and Technology Accessibility (*www.ed.gov/laws-and-policy/civil-rights-laws/disability-discrimination/disability-discrimination-key-issues/disability-discrimination-technology-accessibility*). Starting in either April 2026 or April 2027 (depending on the size of the school district), Title II of the Americans with Disabilities Act will require that public entities, including public schools, ensure that web content and mobile apps made available by the public entities are accessible in compliance with the Web Content Accessibility Guidelines (WCAG) 2.1, level AA. New Rule on the Accessibility of Web Content and Mobile Apps Provided by State and Local Governments (*ada.gov*).

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Waterfield, D.A., Watson, L., & Day, J. (2024). Applying artificial intelligence in special education: Exploring availability and functionality of AI platforms for special educators. *Journal of Special Education Technology, 39*(3), 448–454. *https://doi.org/10.1177/01626434241257237.*

Waiver of Proposed Rulemaking: Under the Administrative Procedure Act (APA) (5 U.S.C. 553), the Department generally offers interested parties the opportunity to comment on proposed priorities. Section 681(d) of IDEA, however, makes the public comment requirements of the APA inapplicable to the priority in this notice.

Program Authority: 20 U.S.C. 1474, 1481, and 1482.

Note: Projects will be awarded and must be operated in a manner consistent with the nondiscrimination requirements contained in Federal civil rights laws.

Applicable Regulations: (a) The Education Department General Administrative Regulations in 34 CFR parts 75, 77, 79, 81, 82, 84, 86, 97, 98, 99, and 100. (b) The Office of Management and Budget (OMB) Guidelines to Agencies on Governmentwide Debarment and Suspension (Nonprocurement) in 2 CFR part 180, as adopted and amended as regulations of the Department in 2 CFR part 3485. (c) The Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards in 2 CFR part 200 (Uniform Guidance), as adopted and amended as regulations of the Department in 2 CFR part 3474.

Note: The regulations in 34 CFR part 79 apply to all applicants except federally recognized Indian Tribes.

Note: The regulations in 34 CFR part 86 apply to IHEs only.

II. Award Information

Type of Award: Cooperative agreement.

Estimated Available Funds: $700,000.

Contingent upon the availability of funds and the quality of applications, we may make additional awards in FY 2026 from the list of unfunded applications from this competition.

Maximum Award: We will not make an award exceeding $700,000 for a single budget period of 12 months.

Estimated Number of Awards: 1.

Note: The Department is not bound by any estimates in this notice.

Project Period: Up to 60 months.

III. Eligibility Information

1. *Eligible Applicants:* State educational agencies; local educational agencies (LEAs), including public charter schools that are considered LEAs under State law; IHEs; other public agencies; private nonprofit organizations; freely associated States and outlying areas; Indian Tribes or Tribal organizations; and for-profit organizations.

Note: If you are a nonprofit organization, under 34 CFR 75.51, you may demonstrate your nonprofit status by providing: (1) proof that the Internal Revenue Service currently recognizes the applicant as an organization to which contributions are tax deductible under section 501(c)(3) of the Internal Revenue Code; (2) a statement from a State taxing body or the State attorney general certifying that the organization is a nonprofit organization operating within the State and that no part of its net earnings may lawfully benefit any private shareholder or individual; (3) a certified copy of the applicant's certificate of incorporation or similar document if it clearly establishes the nonprofit status of the applicant; or (4) any item described above if that item applies to a State or national parent organization, together with a statement by the State or parent organization that the applicant is a local nonprofit affiliate.

2. a. *Cost Sharing or Matching:* This competition does not require cost sharing or matching.

b. *Indirect Cost Rate Information:* This program uses an unrestricted indirect cost rate. For more information regarding indirect costs, or to obtain a negotiated indirect cost rate, please see *www.ed.gov/about/ed-offices/ofo#Indirect-Cost-Division.*

c. *Administrative Cost Limitation:* This program does not include any program-specific limitation on administrative expenses. All administrative expenses must be reasonable and necessary and conform to Cost Principles described in 2 CFR part 200 subpart E of the Uniform Guidance.

3. *Subgrantees:* Under 34 CFR 75.708(b) and (c), a grantee under this competition may award subgrants—to directly carry out project activities described in its application—to the following types of entities: IHEs, nonprofit organizations suitable to carry out the activities proposed in the application, and other public agencies. The grantee may award subgrants to entities it has identified in an approved application or that it selects through a competition under procedures established by the grantee, consistent with 34 CFR 75.708(b)(2).

4. *Other General Requirements:*

(a) Recipients of funding under this competition must make positive efforts to employ and advance in employment qualified individuals with disabilities (see section 606 of IDEA).

(b) Applicants for, and recipients of, funding must, with respect to the aspects of their proposed project relating to the absolute priority, involve individuals with disabilities, or parents of individuals with disabilities ages

birth through 26, in planning, implementing, and evaluating the project (see section 682(a)(1)(A) of IDEA).

IV. Application and Submission Information

1. *Application Submission Instructions:* Applicants are required to follow the Common Instructions for Applicants to Department of Education Discretionary Grant Programs, published in the **Federal Register** on December 23, 2024 (89 FR 104528), and available at *www.federalregister.gov/documents/2024/12/23/2024-30488/common-instructions-for-applicants-to-department-of-education-discretionary-grant-programs,* which contain requirements and information on how to submit an application.

2. *Intergovernmental Review:* This competition is subject to Executive Order 12372 and the regulations in 34 CFR part 79. Information about Intergovernmental Review of Federal Programs under Executive Order 12372 is in the application package for this competition. Please note that, under 34 CFR 79.8(a), we have shortened the standard 60-day intergovernmental review period in order to make awards by the end of FY 2025.

3. *Funding Restrictions:* We reference regulations outlining funding restrictions in the *Applicable Regulations* section of this notice.

4. *Recommended Page Limit:* The application narrative is where you, the applicant, address the selection criteria that reviewers use to evaluate your application. We recommend that you (1) limit the application narrative to no more than 70 pages and (2) use the following standards:

- A ''page'' is 8.5″ x 11″, on one side only, with 1″ margins at the top, bottom, and both sides.
- Double-space (no more than three lines per vertical inch) all text in the application narrative, including titles, headings, footnotes, quotations, reference citations, and captions, as well as all text in charts, tables, figures, graphs, and screen shots.
- Use a font that is 12 point or larger.
- Use one of the following fonts: Times New Roman, Courier, Courier New, or Arial.

The recommended page limit does not apply to the cover sheet; the budget section, including the narrative budget justification; the assurances and certifications; or the abstract (follow the guidance provided in the application package for completing the abstract), the table of contents, the list of priority requirements, the resumes, the reference list, the letters of support, or the appendices. However, the recommended page limit does apply to all of the application narrative, including all text in charts, tables, figures, graphs, and screen shots.

V. Application Review Information

1. *Selection Criteria:* The selection criteria for this competition are from 34 CFR 75.210 and are as follows:

(a) *Significance (15 points).*

The Secretary considers the significance of the proposed project. In determining the significance of the proposed project, the Secretary considers the following factors:

(1) The extent to which the specific nature and magnitude of gaps or challenges are identified and the extent to which these gaps or challenges will be addressed by the services, supports, infrastructure, or opportunities described in the proposed project.

(2) The extent to which the resources, tools, and implementation lessons of the proposed project will be disseminated in ways to the target population and local community that will enable them and others (including practitioners, researchers, education leaders, and partners) to implement similar strategies.

(b) *Quality of the project design (30 points).*

The Secretary considers the quality of the design of the proposed project. In determining the quality of the design of the proposed project, the Secretary considers the following factors:

(1) The extent to which the goals, objectives, and outcomes to be achieved by the proposed project are clearly specified, measurable, and ambitious yet achievable within the project period, and aligned with the purposes of the grant program.

(2) The quality of the logic model or other conceptual framework underlying the proposed project, including how inputs are related to outcomes.

(3) The extent to which the services to be provided by the proposed project reflect up-to-date knowledge and an evidence-based project component.

(4) The extent to which the training or professional development services to be provided by the proposed project are of sufficient quality, intensity, and duration to build recipient and project capacity in ways that lead to improvements in practice among the recipients of those services.

(5) The extent to which the services to be provided by the proposed project involve the use of efficient strategies, including the use of technology, as appropriate, and the leveraging of non-project resources.

(c) *Quality of the project evaluation or other evidence-building (20 points).*

The Secretary considers the quality of the evaluation or other evidence-building of the proposed project. In determining the quality of the evaluation or other evidence-building, the Secretary considers the following factors:

(1) The extent to which the methods of evaluation or other evidence-building are thorough, feasible, relevant, and appropriate to the goals, objectives, and outcomes of the proposed project.

(2) The extent to which the methods of evaluation or other evidence-building are designed to measure the fidelity of implementation of the project.

(3) The extent to which the methods of evaluation or other evidence-building will provide performance feedback and provide formative, diagnostic, or interim data that is a periodic assessment of progress toward achieving intended outcomes.

(4) The extent to which the methods of evaluation or other evidence-building include the use of objective performance measures that are clearly related to the intended outcomes of the project and will produce quality data that are quantitative and qualitative.

(5) The extent to which the evaluation plan includes a dissemination strategy that is likely to promote others' learning from the project.

(d) *Adequacy of resources (20 points).*

The Secretary considers the adequacy of resources for the proposed project. In determining the adequacy of resources for the proposed project, the Secretary considers the following factors:

(1) The qualifications, including relevant training and experience, of project consultants or subcontractors.

(2) The extent to which the evaluator has the qualifications, including the relevant training, experience, and independence, required to conduct an evaluation of the proposed project, including experience conducting evaluations of similar methodology as proposed and with evaluations for the proposed population and setting.

(3) The adequacy of support for the project, including facilities, equipment, supplies, and other resources, from the applicant or the lead applicant organization.

(4) The relevance and demonstrated commitment of each partner in the proposed project to the implementation and success of the project.

(5) The extent to which the budget is adequate to support the proposed project and the costs are reasonable in relation to the objectives, design, and potential significance of the proposed project.

(e) *Quality of the management plan (15 points).*

The Secretary considers the quality of the management plan for the proposed project. In determining the quality of the management plan for the proposed project, the Secretary considers the following factors:

(1) The feasibility of the management plan to achieve project objectives and goals on time and within budget, including clearly defined responsibilities, timelines, and milestones for accomplishing project tasks.

(2) The extent to which the time commitments of the project director and principal investigator and other key project personnel are appropriate and adequate to meet the objectives of the proposed project.

(3) The extent to which the key personnel in the project, when hired, have the qualifications required for the proposed project, including formal training or work experience in fields related to the objectives of the project, and represent or have lived experiences of the target population.

(4) The adequacy of mechanisms for ensuring high-quality and accessible products and services from the proposed project for the target population.

2. *Review and Selection Process:* We remind potential applicants that in reviewing applications in any discretionary grant competition, the Secretary may consider, under 34 CFR 75.217(d)(3), the past performance of the applicant in carrying out a previous award, such as the applicant's use of funds, achievement of project objectives, and compliance with grant conditions. The Secretary may also consider whether the applicant failed to submit a timely performance report or submitted a report of unacceptable quality.

In addition, in making a competitive grant award, the Secretary requires various assurances, including those applicable to Federal civil rights laws that prohibit discrimination in programs or activities receiving Federal financial assistance from the Department (34 CFR 100.4, 104.5, 106.4, 108.8, and 110.23).

In the event there are two or more applications with the same final score, and there are insufficient funds to fully support each of these applications, the scores under selection criterion (b) *Quality of the project design* will be used as a tiebreaker. If the scores remain tied, then the scores under selection criterion (d) *Adequacy of resources* will be used to break the tie.

3. *Additional Review and Selection Process Factors:* In the past, the Department has had difficulty finding peer reviewers for certain competitions because so many individuals who are eligible to serve as peer reviewers have conflicts of interest. The standing panel requirements under section 682(b) of IDEA also have placed additional constraints on the availability of reviewers. Therefore, the Department has determined that for some discretionary grant competitions, applications may be separated into two or more groups and ranked and selected for funding within specific groups. This procedure will make it easier for the Department to find peer reviewers by ensuring that greater numbers of individuals who are eligible to serve as reviewers for any particular group of applicants will not have conflicts of interest. It also will increase the quality, independence, and fairness of the review process.

4. *Risk Assessment and Specific Conditions:* Consistent with 2 CFR 200.206, before awarding grants under this competition the Department conducts a review of the risks posed by applicants. Under 2 CFR 200.208, the Secretary may impose specific conditions and, under 2 CFR 3474.10, in appropriate circumstances, high-risk conditions on a grant if the applicant or grantee is not financially stable; has a history of unsatisfactory performance; has a financial or other management system that does not meet the standards in 2 CFR part 200, subpart D; has not fulfilled the conditions of a prior grant; or is otherwise not responsible.

5. *Integrity and Performance System:* If you are selected under this competition to receive an award that over the course of the project period may exceed the simplified acquisition threshold (currently $250,000), we must make a judgment about your integrity, business ethics, and record of performance under Federal awards—that is, the risk posed by you as an applicant—before we make an award. In doing so, we must consider any information about you that is in the System for Award Management's (SAM) Responsibility/Qualification reports (formerly referred to as the Federal Awardee Performance and Integrity Information System (FAPIIS). You may review and comment on any information about yourself that a Federal agency previously entered and that is currently in the Responsibility/Qualification reports in SAM.

If the total value of your currently active grants, cooperative agreements, and procurement contracts from the Federal Government exceeds $10,000,000, the reporting requirements in 2 CFR part 200, Appendix XII, require you to report certain integrity information to SAM semiannually. Please review these requirements if this grant plus all the other Federal funds you receive exceed $10,000,000.

VI. Award Administration Information

1. *Award Notices:* If your application is successful, we notify your U.S. Representative and U.S. Senators and send you a Grant Award Notification (GAN), or we may send you an email containing a link to access an electronic version of your GAN.

If your application is not evaluated or not selected for funding, we notify you.

2. *Administrative and National Policy Requirements:* We identify administrative and national policy requirements in the application package and reference these and other requirements in the *Applicable Regulations* section of this notice.

We reference the regulations outlining the terms and conditions of an award in the *Applicable Regulations* section of this notice and include these and other specific conditions in the GAN. The GAN also incorporates your approved application as part of your binding commitments under the grant.

3. *Open Licensing Requirements:* Unless an exception applies, if you are awarded a grant under this competition, you will be required to openly license to the public grant deliverables created in whole, or in part, with Department grant funds. When the deliverable consists of modifications to pre-existing works, the license extends only to those modifications that can be separately identified and only to the extent that open licensing is permitted under the terms of any licenses or other legal restrictions on the use of pre-existing works. Additionally, a grantee that is awarded competitive grant funds must have a plan to disseminate these public grant deliverables. This dissemination plan can be developed and submitted after your application has been reviewed and selected for funding. For additional information on the open licensing requirements please refer to 2 CFR 3474.20.

4. *Reporting:* (a) If you apply for a grant under this competition, you must ensure that you have in place the necessary processes and systems to comply with the reporting requirements in 2 CFR part 170 should you receive funding under the competition. See the standards in 2 CFR 170.105 to determine whether you are covered by 2 CFR part 170.

(b) At the end of your project period, you must submit a final performance report, including financial information, as directed by the Secretary. If you

receive a multiyear award, you must submit an APR that provides the most current performance and financial expenditure information as directed by the Secretary under 34 CFR 75.118. The Secretary may also require more frequent performance reports under 34 CFR 75.720(c). For specific requirements on reporting, please go to *www.ed.gov/fund/grant/apply/appforms/appforms.html.*

5. *Performance Measures:* For the purposes of Department reporting under 34 CFR 75.110, the Department has established a set of performance measures that are designed to yield information on various aspects of the effectiveness and quality of the Educational Technology, Media, and Materials for Individuals with Disabilities program. These measures are:

- *Program Performance Measure #1:* The percentage of Educational Technology, Media, and Materials Program products and services judged to be of high quality by an independent review panel of experts qualified to review the substantial content of the products and services.
- *Program Performance Measure #2:* The percentage of Educational Technology, Media, and Materials Program products and services judged to be of high relevance to improving outcomes for infants, toddlers, children, and youth with disabilities.
- *Program Performance Measure #3:* The percentage of Educational Technology, Media, and Materials Program products and services judged to be useful in improving results for infants, toddlers, children, and youth with disabilities.

The measures apply to projects funded under this competition, and grantees are required to submit data on these measures as directed by OSEP.

Grantees will be required to report information on their project's performance in annual and final performance reports to the Department (34 CFR 75.590).

The Department will also closely monitor the extent to which the products and services provided by the project meet needs identified by stakeholders and may require the project to report on such alignment in its annual and final performance reports.

6. *Continuation Awards:* In making a continuation award, the Secretary considers, among other things: whether a grantee has made substantial progress in achieving the goals and objectives of the project; whether the grantee has expended funds in a manner that is consistent with its approved application and budget; if the Secretary has established performance measurement requirements, whether the grantee has made substantial progress in achieving the performance targets in the grantee's approved application; and whether the continuation of the project is in the best interest of the Federal Government.

In making a continuation award, the Secretary also considers whether the grantee is operating in compliance with the assurances in its approved application, including those applicable to Federal civil rights laws that prohibit discrimination in programs or activities receiving Federal financial assistance from the Department (34 CFR 100.4, 104.5, 106.4, 108.8, and 110.23).

VII. Other Information

Accessible Format: On request to the program contact person listed under **FOR FURTHER INFORMATION CONTACT**, individuals with disabilities can obtain this document and a copy of the application package in an accessible format. The Department will provide the requestor with an accessible format that may include Rich Text Format (RTF) or text format (txt), a thumb drive, an MP3 file, braille, large print, audiotape, compact disc, or other accessible format.

Electronic Access to This Document: The official version of this document is the document published in the **Federal Register**. You may access the official edition of the **Federal Register** and the Code of Federal Regulations at *www.govinfo.gov.* At this site you can view this document, as well as all other Department documents published in the **Federal Register,** in text or Portable Document Format (PDF). To use PDF you must have Adobe Acrobat Reader, which is available free at the site.

You may also access Department documents published in the **Federal Register** by using the article search feature at *www.federalregister.gov.* Specifically, through the advanced search feature at this site, you can limit your search to documents published by the Department.

Diana Diaz,

Deputy Assistant Secretary and Acting Assistant Secretary for Special Education and Rehabilitative Services.

[FR Doc. 2025–11612 Filed 6–24–25; 8:45 am]

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DEPARTMENT OF EDUCATION

Applications for New Awards; Technical Assistance on State Data Collection—Technical Assistance on State Data Collection—National Technical Assistance Center To Improve State Capacity To Collect, Report, Analyze, and Use Accurate IDEA Part B and Part C Fiscal Data

AGENCY: Office of Special Education and Rehabilitative Services, Department of Education.

ACTION: Notice.

SUMMARY: The Department of Education (Department) is issuing a notice inviting applications for new awards for fiscal year (FY) 2025 for a Technical Assistance on State Data Collection—Technical Assistance on State Data Collection—National Technical Assistance Center to Improve State Capacity to Collect, Report, Analyze, and Use Accurate IDEA Part B and Part C Fiscal Data.

DATES:

Applications Available: June 25, 2025.

Deadline for Transmittal of Applications: July 25, 2025.

Deadline for Intergovernmental Review: August 25, 2025.

ADDRESSES: For the addresses for obtaining and submitting an application, please refer to our Common Instructions for Applicants to Department of Education Discretionary Grant Programs, published in the **Federal Register** on December 23, 2024 (89 FR 104528) and available at *www.federalregister.gov/documents/2024/12/23/2024-30488/common-instructions-for-applicants-to-department-of-education-discretionary-grant-programs.*

FOR FURTHER INFORMATION CONTACT: Charles D. Kniseley, U.S. Department of Education, 400 Maryland Avenue SW, Room 4A127, Washington, DC 20202. Telephone: (202) 245–6313. Email: *Charles.Kniseley@ed.gov.*

If you are deaf, hard of hearing, or have a speech disability and wish to access telecommunications relay services, please dial 7–1–1.

SUPPLEMENTARY INFORMATION:

Full Text of Announcement

I. Funding Opportunity Description

Purpose of Program: The purpose of the Technical Assistance on State Data Collection program is to improve the capacity of States to meet the Individuals with Disabilities Education Act (IDEA) data collection and reporting requirements. Funding for the program is authorized under section 611(c)(1) of

IDEA, which gives the Secretary the authority to reserve not more than one-half of one percent of the amounts appropriated under Part B for each fiscal year to provide technical assistance (TA) activities authorized under section 616(i), where needed, to improve the capacity of States to meet the data collection and reporting requirements under Parts B and C of IDEA. The maximum amount the Secretary may reserve under this set-aside for fiscal year 2025 is $42,657,297, cumulatively adjusted by the rate of inflation. For fiscal year 2025 the Secretary plans to reserve $27,500,000. Section 616(i) of IDEA requires the Secretary to review the data collection and analysis capacity of States to ensure that data and information determined necessary for implementation of sections 616 and 642 of IDEA are collected, analyzed, and accurately reported to the Secretary. It also requires the Secretary to provide TA, where needed, to improve the capacity of States to meet the data collection requirements, which include the data collection and reporting requirements in sections 616 and 618 of IDEA. In addition, the Further Consolidated Appropriations Act, 2024, Public Law 118–47, gives the Secretary authority to use funds reserved under section 611(c) of IDEA to ''administer and carry out other services and activities to improve data collection, coordination, quality, and use under Parts B and C of the IDEA.'' Further Consolidated Appropriations Act, 2024, Public Law 118–47, Division D, Title III, 138 Stat. 460, 685 (2024).

Assistance Listing Number (ALN): 84.373F.

OMB Control Number: 1820–0028.

Priority: This competition includes one absolute priority. This priority is from the notice of final priority (NFP) for this program published elsewhere in this issue of the **Federal Register**.

Absolute Priority: For FY 2025 and any subsequent year in which we make awards from the list of unfunded applications from this competition, this priority is an absolute priority. Under 34 CFR 75.105(c)(3), we consider only applications that meet this priority.

This priority is:

National Technical Assistance Center to Improve State Capacity to Collect, Report, Analyze, and Use Accurate IDEA Part B and Part C Fiscal Data.

Background:

The Department prioritizes supporting States in meeting the requirements of IDEA to collect, report, analyze, and use valid and reliable IDEA fiscal data; and assisting them in ensuring that funds are used consistent with IDEA requirements to implement effective programs and services that improve outcomes for infants, toddlers, children, and youth with disabilities and their families. While States have identified benefits to effectively collecting and using their fiscal data to meet the requirements under IDEA and ensure that they do not experience monetary consequences because of inaccurate data, they have expressed the need for support in building their knowledge and expertise to help ensure compliance with IDEA's fiscal data requirements, and to use the data to identify issues and improve State systems.

The Department has found that because of the complex nature and high-stakes need for meeting IDEA fiscal requirements, changes in Federal fiscal reporting requirements, modifications in State funding formulas, turnover in State staff, and organizational changes, States request and readily take advantage of TA activities devoted to the development and operationalization of IDEA fiscal policies and procedures, systems to collect and report complex IDEA fiscal data to improve IDEA programs, and strategies to address fiscal system needs.

Priority:

The purpose of this priority is to fund a cooperative agreement to establish and operate the National Technical Assistance Center to Improve State Capacity to Collect, Report, Analyze, and Use Accurate IDEA Part B and Part C Fiscal Data (Fiscal Data Center).

The Fiscal Data Center will provide TA to improve the capacity of States to meet the IDEA Part B and Part C fiscal data collection requirements under IDEA sections 618 and 642 and increase States' knowledge of the underlying IDEA fiscal requirements and calculations necessary to submit valid and reliable data for the following collections: (1) Maintenance of State Financial Support (MFS) in Section V of the IDEA Part B Annual State Application; (2) local educational agency (LEA) Maintenance of Effort (MOE) Reduction and Coordinated Early Intervening Services (CEIS); (3) Description of Use of IDEA Part B Section 611 Funds reserved for State administration and other State-level activities in Section III of the IDEA Part B Annual State Application; (4) Description of Use of Federal IDEA Part C Funds for the Lead Agency (LA) and the Interagency Coordinating Council in Section III of the IDEA Part C Annual State Application; (5) IDEA Part C MOE requirements; (6) Restricted Indirect Cost Rate/Cost Allocation Plan Information in Sections III and IV of the IDEA Part C Annual State Application; and (7) Part C Subgranting, in Section III.F. of the Part C Annual State Application.

The Fiscal Data Center must be designed to achieve, at a minimum, the following expected outcomes:

(a) Increased capacity of States to collect, report, analyze, and use high-quality IDEA Part B and Part C fiscal data;

(b) Increased capacity of States to accurately perform calculations related to IDEA Part B and Part C statutory and regulatory fiscal requirements, and submit valid and reliable fiscal data under IDEA Part B and Part C;

(c) Improved State fiscal infrastructure to communicate and coordinate effective IDEA Part B and Part C fiscal data collections and reporting strategies among relevant State offices, including State educational agencies (SEAs), LAs and other State agencies, LEAs, schools, public charter schools that are LEAs, and early intervention services (EIS) programs or providers;

(d) Increased capacity of States to submit accurate and timely IDEA Part B and Part C fiscal data, and enhance State validation procedures to prevent errors in State-reported IDEA fiscal data;

(e) Increased capacity of States to train personnel to meet the IDEA Part B and Part C fiscal data collection and reporting requirements under sections 616, 618, and 642 of IDEA; and

(f) Increased capacity of SEAs and LAs to work with LEAs, including public charter schools that are LEAs, and EIS programs or providers to analyze and use IDEA fiscal data to identify issues and address those issues through monitoring, TA, and partner involvement.

In addition to these programmatic requirements, to be considered for funding under this priority, applicants must meet the application and administrative requirements in this priority, which are:

(a) Describe, in the narrative section of the application under ''Significance,'' how the proposed project will—

(1) Address the current and emerging needs of States and local systems to collect, report, analyze, and use high-quality IDEA Part B and Part C fiscal data. To meet this requirement, the applicant must—

(i) Demonstrate knowledge of how SEAs, LAs, LEAs, including public charter schools that are LEAs, and EIS programs and providers are meeting IDEA Part B and Part C fiscal data collection and reporting requirements and the underlying statutory and regulatory fiscal requirements, as well

as knowledge of State and local data collection systems, as appropriate; and

(ii) Present applicable national, State, and local data to show the current capacity needs of SEAs, LAs, LEAs, including public charter schools that are LEAs, and EIS programs and providers to meet IDEA Part B and Part C fiscal data collection and reporting requirements; and

(2) Improve how SEAs and LAs use IDEA section 618 fiscal data as a means of both improving data quality and identifying programmatic strengths and areas for improvement, and indicate the likely magnitude or importance of the improvements.

(b) Describe, in the narrative section of the application under ''Quality of the project design,'' how the proposed project will—

(1) Achieve its goals, objectives, and intended outcomes. To meet this requirement, the applicant must provide—

(i) Measurable intended project outcomes; and

(ii) In Appendix A, the logic model (as defined in 34 CFR 77.1) by which the proposed project will achieve its intended outcomes that depicts, at a minimum, the goals, activities, outputs, and intended outcomes of the proposed project;

(2) Use a conceptual framework (and provide a copy in Appendix A) to develop project plans and activities, describing any underlying concepts, assumptions, expectations, beliefs, or theories, as well as the presumed relationships or linkages among these variables, and any empirical support for this framework;

(3) Be based on current research and make use of evidence-based [1] practices (EBPs). To meet this requirement, the applicant must describe—

(i) The current research on the capacity of SEAs, LEAs, including public charter schools that are LEAs, LAs, and EIS providers to report and use IDEA Part B and Part C data submitted under section 616 and section 618, as a means of both improving data quality and identifying strengths and areas for improvement; and

(ii) How the proposed project will incorporate current research and EBPs in the development and delivery of its products and services;

(4) Develop products and provide services that are of high quality and sufficient intensity and duration to achieve the intended outcomes of the proposed project. To address this requirement, the applicant must describe—

(i) How it proposes to expand the knowledge base for States on—

(A) Fiscal data management and data system integration needed for IDEA Part B and Part C data collection and reporting;

(B) IDEA fiscal data validation that leads to improvements in the validity and reliability of fiscal data required by IDEA; and

(C) Effective ways to communicate fiscal data to local consumers (*e.g.,* parents, LEAs, including public charter schools that are LEAs, EIS programs or providers, the general public);

(ii) Its proposed approach to universal, general TA,[2] which must describe—

(A) The intended recipients, including the type and number of recipients, that will receive the products and services;

(B) The products and services that the project proposes to make available;

(C) The development and maintenance of a high-quality website, with an easy-to-navigate design, that meets or exceeds government- or industry-recognized standards for accessibility; and

(D) The expected reach and impact of universal, general TA;

(iii) Its proposed approach to targeted, specialized TA,[3] which must describe—

(A) The intended recipients, including the type and number of recipients, that will receive the products and services;

(B) The products and services that the project proposes to make available; and

(C) The proposed approach to measure the readiness of potential TA recipients to work with the project, including, at a minimum, an assessment of potential recipients' current infrastructure, available resources, and ability to build capacity at the local level;

(iv) Its proposed approach to intensive, sustained TA,[4] which must describe—

(A) The intended recipients, including the type and number of recipients from a variety of settings and geographic distribution, that will receive the products and services;

(B) Its proposed approach to addressing States' challenges reporting high-quality IDEA fiscal data to the Department and the public, which should, at a minimum, include providing virtual and on-site consultation to the SEA or LA to—

(*1*) Implement model practices for the management of IDEA data and data system integration policies, procedures, processes, and activities within the State;

(*2*) Develop, use, or adapt tools to meet State-specific IDEA data needs;

(*3*) Develop a sustainability plan for the State to continue the management of IDEA data and data system integration work in the future; and

(*4*) Implement a cybersecurity plan to ensure a secure IDEA fiscal data system;

(C) Its proposed approach to measure the readiness of SEAs and LAs to work with the project, including their commitment to the initiative, alignment of the initiative to their needs, current infrastructure, available resources, and ability to build capacity at the State and local levels;

(D) Its proposed plan to prioritize States with the greatest need for intensive TA to receive products and services;

(E) Its proposed plan for assisting SEAs and LAs to build or enhance training systems that include professional development based on adult learning principles and coaching;

(F) Its proposed plan for working with appropriate levels of the education system (*e.g.,* SEAs, LAs, regional TA providers, LEAs, including public charter schools that are LEAs, local EIS programs and providers, and families) to ensure that there is communication between each level and that there are systems in place to support the collection, reporting, analysis, and use

[1] For the purposes of these requirements, ''evidence-based'' means the proposed project component is supported by one or more of strong evidence, moderate evidence, promising evidence, or evidence that demonstrates a rationale (as such terms are defined in 34 CFR 77.1).

[2] ''Universal, general TA'' means TA and information provided to independent users through their own initiative, resulting in minimal interaction with TA center staff and including one-time, invited or offered conference presentations by TA center staff. This category of TA also includes information or products, such as newsletters, guidebooks, or research syntheses, downloaded from the TA center's website by independent users. Brief communications by TA center staff with recipients, either by telephone or email, are also considered universal, general TA.

[3] ''Targeted, specialized TA'' means TA services based on needs common to multiple recipients and not extensively individualized. A relationship is established between the TA recipient and one or more TA center staff. This category of TA includes one-time, labor-intensive events, such as facilitating strategic planning or hosting regional or national conferences. It can also include episodic, less labor-intensive events that extend over a period of time, such as facilitating a series of conference calls on single or multiple topics that are designed around the needs of the recipients. Facilitating communities of practice can also be considered targeted, specialized TA.

[4] ''Intensive, sustained TA'' means TA services often provided on-site and requiring a stable, ongoing relationship between the TA center staff and the TA recipient. ''TA services'' are defined as negotiated series of activities designed to reach a valued outcome. This category of TA should result in changes to policy, program, practice, or operations that support increased recipient capacity or improved outcomes at one or more systems levels.

of high-quality IDEA fiscal data as well as IDEA fiscal data management and data system integration; and

(G) The expected impact of intensive, sustained TA; and

(v) How the proposed project will intentionally engage families of children with disabilities and individuals with disabilities in the development, implementation, and evaluation of its products and services across all levels of TA;

(5) Develop products and implement services that maximize efficiency. To address this requirement, the applicant must describe—

(i) How the proposed project will use technology to achieve the intended project outcomes;

(ii) With whom the proposed project will collaborate and the intended outcomes of this collaboration, including the process by which the proposed project will collaborate with Department-funded centers (including privacy TA centers such as the DaSy Center that provides Department-funded TA on early childhood data privacy, and the Privacy Technical Assistance Center) and other federally funded TA centers to develop and implement a coordinated TA plan when they are involved in a State; and

(iii) How the proposed project will use non-project resources, such as non-Federal funds and in-kind contributions, to achieve the intended project outcomes, to achieve the intended project outcomes; and

(6) Systematically disseminate information, products, and services to varied intended audiences. To address this requirement the applicant must describe—

(i) The variety of dissemination strategies the project will use throughout the five years of the project to promote awareness and use of its products and services;

(ii) How the project will tailor dissemination strategies across all planned levels of TA to ensure that products and services reach intended recipients, and those recipients can access and use those products and services;

(iii) How the project's dissemination plan is connected to the proposed outcomes of the project; and

(iv) How the project will evaluate and correct all digital products and external communications to ensure they meet or exceed government or industry-recognized standards for accessibility.

(c) In the narrative section of the application under ''Quality of the project evaluation or other evidence-building,'' describe how the project will develop an evaluation plan in consultation with, and to be implemented by, a third-party evaluator.[5] The evaluation plan must—

(1) Articulate formative and summative evaluation questions, including important process and outcome evaluation questions. These questions must be related to the project's proposed logic model required under paragraph (b)(1)(ii) of these application and administrative requirements;

(2) Describe how progress in and fidelity of implementation, as well as project outcomes, will be measured to answer the evaluation questions. In measuring progress of implementation across all levels of TA, the plan must include criteria for determining the extent to which the project's products and services reached intended recipients; data, including feedback from recipients, on how recipients used the products and services; and the impact of the products and services. The plan must also specify sources for data, and measures and instruments appropriate to the evaluation questions, including information on reliability and validity of the measures and associated instruments where appropriate;

(3) Describe strategies for analyzing data and how data collected as part of this plan will be used to inform and improve service delivery over the course of the project and to refine the proposed logic model and evaluation plan, including subsequent data collection;

(4) Provide a timeline for conducting the evaluation and include staff assignments for completing the plan. The timeline must indicate that the data will be available annually for the Annual Performance Report and at the end of Year 2; and

(5) Dedicate sufficient funds in each budget year to cover the costs of developing or refining the evaluation plan in consultation with a third-party evaluator, as well as the costs associated with the implementation of the evaluation plan by the third-party evaluator.

(d) Describe, in the narrative section of the application under ''Adequacy of resources,'' how—

(1) The project will make positive efforts to employ and advance in employment qualified individuals with disabilities;

(2) The applicant and any key partners have adequate resources to carry out the proposed activities;

(3) The proposed project will have processes, resources, and funds in place to provide access for project staff, contractors, and partners, who require digital accessibility accommodations;[6] and

(4) The proposed costs are reasonable in relation to the anticipated results and benefits, and funds will be spent in a way that increases their efficiency and cost-effectiveness.

(e) Describe, in the narrative section of the application under ''Quality of the management plan,''—

(1) How the proposed management plan will ensure that the project's intended outcomes will be achieved on time and within budget. To address this requirement, the applicant must describe—

(i) Clearly defined responsibilities for key project personnel, consultants, and subcontractors, as applicable; and

(ii) Timelines and milestones for accomplishing the project tasks;

(2) Allocations of key project personnel and any consultants and subcontractors and how these allocations are appropriate and adequate to achieve the project's intended outcomes;

(3) How the proposed key project personnel, consultants, and subcontractors have the qualifications and experience to carry out the proposed activities and achieve the project's intended outcomes;

(4) How the proposed management plan will ensure that the products and services provided are of high quality, relevant, and useful to recipients; and

(5) How the proposed project will benefit from a variety of perspectives, including those of families, educators, TA providers, researchers, and policy makers, among others, in its development and operation.

(f) Address the following application requirements. The applicant must—

(1) Include, in Appendix A, personnel-loading charts and timelines, as applicable, to illustrate the management plan described in the narrative;

(2) Include, in the budget, attendance at the following:

(i) A one and one-half day kick-off meeting in Washington, DC, after receipt of the award, and an annual planning meeting in Washington, DC, with the OSEP project officer and other relevant

[5] A ''third-party'' evaluator is an independent and impartial program evaluator who is contracted by the grantee to conduct an objective evaluation of the project. This evaluator must not have participated in the development or implementation of any project activities, except for the evaluation activities, nor have any financial interest in the outcome of the evaluation.

[6] For information about digital accessibility and accessibility standards from Section 508 of the Rehabilitation Act, visit *https://sites.ed.gov/idea/topic-areas/#Accessibility-Creating-Content.*

staff during each subsequent year of the project period.

Note: Within 30 days of receipt of the award, a post-award teleconference must be held between the OSEP project officer and the grantee's project director or other authorized representative;

(ii) A three-day project directors' conference in Washington, DC, during each year of the project periods, provided that, if the meeting is conducted virtually, the project must reallocate unused travel funds no later than the end of the third quarter of each budget period; and

(iii) Three annual two-day trips to attend Department briefings, Department-sponsored conferences, and other meetings, as requested by OSEP; and

(3) Include, in the budget, a line item for an annual set-aside of five percent of the grant amount to support emerging needs that are consistent with the proposed project's intended outcomes, as those needs are identified in consultation with, and approved by, the OSEP project officer. With approval from the OSEP project officer, the project must reallocate any remaining funds from this annual set-aside no later than the end of the third quarter of each budget period;

(4) Budget at least 50 percent of the grant award for providing targeted and intensive TA to States; and

(5) Include, in Appendix A, an assurance to assist OSEP with the transfer of pertinent resources and products and to maintain the continuity of services to States during the transition to a new award at the end of this award period, as appropriate.

Program Authority: 20 U.S.C. 1411(c), 1416(i), 1418(c), 1418(d), 1442, 1482; Further Consolidated Appropriations Act, 2024, Public Law 118–47, Division D, Title III, 138 Stat. 460, 685 (2024).

Note: Projects will be awarded and must be operated in a manner consistent with the nondiscrimination requirements contained in Federal civil rights laws.

Applicable Regulations: (a) The Education Department General Administrative Regulations in 34 CFR parts 75, 77, 79, 81, 82, 84, 86, 97, 98, and 99. (b) The Office of Management and Budget (OMB) Guidelines to Agencies on Governmentwide Debarment and Suspension (Nonprocurement) in 2 CFR part 180, as adopted and amended as regulations of the Department in 2 CFR part 3485. (c) The Guidance for Federal Financial Assistance in 2 CFR part 200, as adopted and amended as regulations of the Department in 2 CFR part 3474. (d) 34 CFR 300.702. (e) The NFP.

Note: The regulations in 34 CFR part 79 apply to all applicants except federally recognized Indian Tribes.

Note: The regulations in 34 CFR part 86 apply to institutions of higher education (IHEs) only.

II. Award Information

Type of Award: Cooperative agreement.

Estimated Available Funds: $3,900,000 in year one and $4,200,000 in years two through five.

Contingent upon the availability of funds and the quality of applications, we may make additional awards in FY 2026 from the list of unfunded applications from this competition.

Maximum Award: We will not make an award exceeding $3,900,000 for a single budget period of 12 months in year one and $4,200,000 for a single budget period of 12 months in years two through five.

Estimated Number of Awards: 1.

Note: The Department is not bound by any estimates in this notice.

Project Period: Up to 60 months.

III. Eligibility Information

1. *Eligible Applicants:* SEAs; State lead agencies under Part C of the IDEA; LEAs, including public charter schools that are considered LEAs under State law; IHEs; other public agencies; private nonprofit organizations; freely associated States and outlying areas; Indian Tribes or Tribal organizations; and for-profit organizations.

2. a. *Cost Sharing or Matching:* This competition does not require cost sharing or matching.

b. *Indirect Cost Rate Information:* This program uses an unrestricted indirect cost rate. For more information regarding indirect costs, or to obtain a negotiated indirect cost rate, please see *www.ed.gov/about/ed-offices/ofo#Indirect-Cost-Division.*

c. *Administrative Cost Limitation:* This program does not include any program-specific limitation on administrative expenses. All administrative expenses must be reasonable and necessary and conform to Cost Principles described in 2 CFR part 200 subpart E of the Guidance for Federal Financial Assistance.

3. *Subgrantees:* Under 34 CFR 75.708(b) and (c), a grantee under this competition may award subgrants—to directly carry out project activities described in its application—to the following types of entities: IHEs, nonprofit organizations suitable to carry out the activities proposed in the application, and other public agencies. The grantee may award subgrants to entities it has identified in an approved application or that it selects through a competition under procedures established by the grantee, consistent with 34 CFR 75.708(b)(2).

4. *Other General Requirements:*

(a) Recipients of funding under this competition must make positive efforts to employ and advance in employment qualified individuals with disabilities (see section 606 of IDEA).

(b) Applicants for, and recipients of, funding must, with respect to the aspects of their proposed project relating to the absolute priority, involve individuals with disabilities, or parents of individuals with disabilities ages birth through 26, in planning, implementing, and evaluating the project (see section 682(a)(1)(A) of IDEA).

IV. Application and Submission Information

1. *Application Submission Instructions:* Applicants are required to follow the Common Instructions for Applicants to Department of Education Discretionary Grant Programs, published in the **Federal Register** on December 23, 2024 (89 FR 104528), and available at *www.federalregister.gov/documents/2024/12/23/2024-30488/common-instructions-for-applicants-to-department-of-education-discretionary-grant-programs,* which contain requirements and information on how to submit an application.

2. *Intergovernmental Review:* This competition is subject to Executive Order 12372 and the regulations in 34 CFR part 79. Information about Intergovernmental Review of Federal Programs under Executive Order 12372 is in the application package for this competition. Please note that, under 34 CFR 79.8(a), we have shortened the standard 60-day intergovernmental review period in order to make awards by the end of FY 2025.

3. *Funding Restrictions:* We reference regulations outlining funding restrictions in the *Applicable Regulations* section of this notice.

4. *Recommended Page Limit:* The application narrative is where you, the applicant, address the selection criteria that reviewers use to evaluate your application. We recommend that you (1) limit the application narrative to no more than 70 pages and (2) use the following standards:

- A ''page'' is 8.5″ x 11″, on one side only, with 1″ margins at the top, bottom, and both sides.
- Double-space (no more than three lines per vertical inch) all text in the application narrative, including titles, headings, footnotes, quotations, reference citations, and captions, as well

as all text in charts, tables, figures, graphs, and screen shots.

- Use a font that is 12 point or larger.
- Use one of the following fonts: Times New Roman, Courier, Courier New, or Arial.

The recommended page limit does not apply to the cover sheet; the budget section, including the narrative budget justification; the assurances and certifications; or the abstract (follow the guidance provided in the application package for completing the abstract), the table of contents, the list of priority requirements, the resumes, the reference list, the letters of support, or the appendices. However, the recommended page limit does apply to all of the application narrative, including all text in charts, tables, figures, graphs, and screen shots.

V. Application Review Information

1. *Selection Criteria:* The selection criteria for this competition are from 34 CFR 75.210 and are as follows:

(a) *Significance (10 points).*

The Secretary considers the significance of the proposed project. In determining the significance of the proposed project, the Secretary considers the following factors:

(1) The extent to which the specific nature and magnitude of gaps or challenges are identified and the extent to which these gaps or challenges will be addressed by the services, supports, infrastructure, or opportunities described in the proposed project.

(2) The likelihood that the proposed project will result in systemic change that supports continuous, sustainable, and measurable improvement.

(b) *Quality of the project design (35 points).*

The Secretary considers the quality of the design of the proposed project. In determining the quality of the design of the proposed project, the Secretary considers the following factors:

(1) The extent to which the goals, objectives, and outcomes to be achieved by the proposed project are clearly specified, measurable, and ambitious yet achievable within the project period, and aligned with the purposes of the grant program.

(2) The quality of the logic model or other conceptual framework underlying the proposed project, including how inputs are related to outcomes.

(3) The extent to which the services to be provided by the proposed project reflect up-to-date knowledge and an evidence-based project component.

(4) The extent to which the training or professional development services to be provided by the proposed project are of sufficient quality, intensity, and duration to build recipient and project capacity in ways that lead to improvements in practice among the recipients of those services.

(5) The extent to which the services to be provided by the proposed project involve the use of efficient strategies, including the use of technology, as appropriate, and the leveraging of non-project resources.

(c) *Quality of the project evaluation or other evidence-building (20 points).*

The Secretary considers the quality of the evaluation or other evidence-building of the proposed project. In determining the quality of the evaluation or other evidence-building, the Secretary considers the following factors:

(1) The extent to which the methods of evaluation or other evidence-building are thorough, feasible, relevant, and appropriate to the goals, objectives, and outcomes of the proposed project.

(2) The extent to which the methods of evaluation or other evidence-building are designed to measure the fidelity of implementation of the project.

(3) The extent to which the methods of evaluation or other evidence-building will provide performance feedback and provide formative, diagnostic, or interim data that is a periodic assessment of progress toward achieving intended outcomes.

(4) The extent to which the methods of evaluation or other evidence-building include the use of objective performance measures that are clearly related to the intended outcomes of the project and will produce quality data that are quantitative and qualitative.

(d) *Adequacy of resources (15 points).*

The Secretary considers the adequacy of resources for the proposed project. In determining the adequacy of resources for the proposed project, the Secretary considers the following factors:

(1) The adequacy of support for the project, including facilities, equipment, supplies, and other resources, from the applicant or the lead applicant organization.

(2) The relevance and demonstrated commitment of each partner in the proposed project to the implementation and success of the project.

(3) The extent to which the budget is adequate to support the proposed project and the costs are reasonable in relation to the objectives, design, and potential significance of the proposed project.

(e) *Quality of the management plan (20 points).*

The Secretary considers the quality of the management plan for the proposed project. In determining the quality of the management plan for the proposed project, the Secretary considers the following factors:

(1) The feasibility of the management plan to achieve project objectives and goals on time and within budget, including clearly defined responsibilities, timelines, and milestones for accomplishing project tasks.

(2) The extent to which the time commitments of the project director and principal investigator and other key project personnel are appropriate and adequate to meet the objectives of the proposed project.

(3) The extent to which the key personnel in the project, when hired, have the qualifications required for the proposed project, including formal training or work experience in fields related to the objectives of the project, and represent or have lived experiences of the target population.

(4) The adequacy of mechanisms for ensuring high-quality and accessible products and services from the proposed project for the target population.

2. *Review and Selection Process:* We remind potential applicants that in reviewing applications in any discretionary grant competition, the Secretary may consider, under 34 CFR 75.217(d)(3), the past performance of the applicant in carrying out a previous award, such as the applicant's use of funds, achievement of project objectives, and compliance with grant conditions. The Secretary may also consider whether the applicant failed to submit a timely performance report or submitted a report of unacceptable quality.

In addition, in making a competitive grant award, the Secretary requires various assurances, including those applicable to Federal civil rights laws that prohibit discrimination in programs or activities receiving Federal financial assistance from the Department (34 CFR 100.4, 104.5, 106.4, 108.8, and 110.23).

In the event there are two or more applications with the same final score, and there are insufficient funds to fully support each of these applications, the scores under selection criterion (b) *Quality of the project design* will be used as a tiebreaker. If the scores remain tied, then the scores under selection criterion (d) *Adequacy of resources* will be used to break the tie.

3. *Additional Review and Selection Process Factors:* In the past, the Department has had difficulty finding peer reviewers for certain competitions because so many individuals who are eligible to serve as peer reviewers have conflicts of interest. The standing panel requirements under section 682(b) of

IDEA also have placed additional constraints on the availability of reviewers. Therefore, the Department has determined that for some discretionary grant competitions, applications may be separated into two or more groups and ranked and selected for funding within specific groups. This procedure will make it easier for the Department to find peer reviewers by ensuring that greater numbers of individuals who are eligible to serve as reviewers for any particular group of applicants will not have conflicts of interest. It also will increase the quality, independence, and fairness of the review process, while permitting panel members to review applications under discretionary grant competitions for which they also have submitted applications.

4. *Risk Assessment and Specific Conditions:* Consistent with 2 CFR 200.206, before awarding grants under this competition the Department conducts a review of the risks posed by applicants. Under 2 CFR 200.208, the Secretary may impose specific conditions and, under 2 CFR 3474.10, in appropriate circumstances, high-risk conditions on a grant if the applicant or grantee is not financially stable; has a history of unsatisfactory performance; has a financial or other management system that does not meet the standards in 2 CFR part 200, subpart D; has not fulfilled the conditions of a prior grant; or is otherwise not responsible.

5. *Integrity and Performance System:* If you are selected under this competition to receive an award that over the course of the project period may exceed the simplified acquisition threshold (currently $250,000), we must make a judgment about your integrity, business ethics, and record of performance under Federal awards—that is, the risk posed by you as an applicant—before we make an award. In doing so, we must consider any information about you that is in the System for Award Management's (SAM) Responsibility/Qualification reports (formerly referred to as the Federal Awardee Performance and Integrity Information System (FAPIIS)). You may review and comment on any information about yourself that a Federal agency previously entered and that is currently in the Responsibility/Qualification reports in SAM.

If the total value of your currently active grants, cooperative agreements, and procurement contracts from the Federal Government exceeds $10,000,000, the reporting requirements in 2 CFR part 200, Appendix XII, require you to report certain integrity information to SAM semiannually. Please review these requirements if this grant plus all the other Federal funds you receive exceed $10,000,000.

6. *In General:* In accordance with the Guidance for Federal Financial Assistance located at 2 CFR part 200, all applicable Federal laws, and relevant Executive guidance, the Department will review and consider applications for funding pursuant to this notice inviting applications in accordance with—

(a) Selecting recipients most likely to be successful in delivering results based on the program objectives through an objective process of evaluating Federal award applications (2 CFR 200.205);

(b) Prohibiting the purchase of certain telecommunication and video surveillance services or equipment in alignment with section 889 of the National Defense Authorization Act of 2019 (Pub. L. 115–232) (2 CFR 200.216);

(c) Providing a preference, to the extent permitted by law, to maximize use of goods, products, and materials produced in the United States (2 CFR 200.322); and

(d) Terminating agreements in whole or in part to the greatest extent authorized by law if an award no longer effectuates the program goals or agency priorities (2 CFR 200.340).

VI. Award Administration Information

1. *Award Notices:* If your application is successful, we notify your U.S. Representative and U.S. Senators and send you a Grant Award Notification (GAN), or we may send you an email containing a link to access an electronic version of your GAN. We also may notify you informally.

If your application is not evaluated or not selected for funding, we notify you.

2. *Administrative and National Policy Requirements:* We identify administrative and national policy requirements in the application package and reference these and other requirements in the *Applicable Regulations* section of this notice.

We reference the regulations outlining the terms and conditions of an award in the *Applicable Regulations* section of this notice and include these and other specific conditions in the GAN. The GAN also incorporates your approved application as part of your binding commitments under the grant.

3. *Open Licensing Requirements:* Unless an exception applies, if you are awarded a grant under this competition, you will be required to openly license to the public grant deliverables created in whole, or in part, with Department grant funds. When the deliverable consists of modifications to pre-existing works, the license extends only to those modifications that can be separately identified and only to the extent that open licensing is permitted under the terms of any licenses or other legal restrictions on the use of pre-existing works. Additionally, a grantee that is awarded competitive grant funds must have a plan to disseminate these public grant deliverables. This dissemination plan can be developed and submitted after your application has been reviewed and selected for funding. For additional information on the open licensing requirements please refer to 2 CFR 3474.20.

4. *Reporting:* (a) If you apply for a grant under this competition, you must ensure that you have in place the necessary processes and systems to comply with the reporting requirements in 2 CFR part 170 should you receive funding under the competition. This does not apply if you have an exception under 2 CFR 170.110(b).

(b) At the end of your project period, you must submit a final performance report, including financial information, as directed by the Secretary. If you receive a multiyear award, you must submit an annual performance report that provides the most current performance and financial expenditure information as directed by the Secretary under 34 CFR 75.118. The Secretary may also require more frequent performance reports under 34 CFR 75.720(c). For specific requirements on reporting, please go to *www.ed.gov/fund/grant/apply/appforms/appforms.html.*

5. Performance Measures: Performance Measures: For the purposes of Department reporting under 34 CFR 75.110, the Department has established a set of performance measures that are designed to yield information on various aspects of the effectiveness and quality of the Technical Assistance on State Data Collection program. These measures are:

- *Program Performance Measure #1:* The percentage of TA and dissemination products and services deemed to be of high quality by an independent review panel of experts qualified or individuals with appropriate expertise to review the substantive content of the products and services.
- *Program Performance Measure #2:* The percentage of TA and dissemination products and services deemed by an independent review panel of qualified experts or members of the target audiences to be of high relevance to educational and early intervention policy or practice.
- *Program Performance Measure #3:* The percentage of TA and dissemination products and services deemed by an

independent review panel of qualified experts or members of the target audiences to be useful in improving educational or early intervention policy or practice.

• *Program Performance Measure #4:* The cost efficiency of the Technical Assistance on State Data Collection Program includes the percentage of milestones achieved in the current annual performance report period and the percentage of funds spent during the current fiscal year.

The measures apply to projects funded under this competition, and grantees are required to submit data on these measures as directed by OSEP.

Grantees will be required to report information on their project's performance in annual and final performance reports to the Department (34 CFR 75.590).

The Department will also closely monitor the extent to which the products and services provided by the project meet needs identified by stakeholders and may require the project to report on such alignment in its annual and final performance reports.

6. *Continuation Awards:* In making a continuation award under 34 CFR 75.253, the Secretary considers, among other things: whether a grantee has made substantial progress in achieving the goals and objectives of the project; whether the grantee has expended funds in a manner that is consistent with its approved application and budget; if the Secretary has established performance measurement requirements, whether the grantee has made substantial progress in achieving the performance targets in the grantee's approved application; and whether the continuation of the project is in the best interest of the Federal Government.

In making a continuation award, the Secretary also considers whether the grantee is operating in compliance with the assurances in its approved application, including those applicable to Federal civil rights laws that prohibit discrimination in programs or activities receiving Federal financial assistance from the Department (34 CFR 100.4, 104.5, 106.4, 108.8, and 110.23).

VII. Other Information

Accessible Format: On request to the program contact person listed under **FOR FURTHER INFORMATION CONTACT**, individuals with disabilities can obtain this document and a copy of the application package in an accessible format. The Department will provide the requestor with an accessible format that may include Rich Text Format (RTF) or text format (txt), a thumb drive, an MP3 file, braille, large print, audiotape, compact disc, or other accessible format.

Electronic Access to This Document: The official version of this document is the document published in the **Federal Register**. You may access the official edition of the **Federal Register** and the Code of Federal Regulations at *www.govinfo.gov.* At this site you can view this document, as well as all other Department documents published in the **Federal Register**, in text or Portable Document Format (PDF). To use PDF you must have Adobe Acrobat Reader, which is available free at the site.

You may also access Department documents published in the **Federal Register** by using the article search feature at *www.federalregister.gov.* Specifically, through the advanced search feature at this site, you can limit your search to documents published by the Department.

Diana Diaz,

Deputy Assistant Secretary and Acting Assistant Secretary for Special Education and Rehabilitative Services.

[FR Doc. 2025–11607 Filed 6–24–25; 8:45 am]

BILLING CODE 4000–01–P

DEPARTMENT OF EDUCATION

Applications for New Awards; Educational Technology, Media, and Materials for Individuals With Disabilities Program—Stepping-Up Technology Implementation

AGENCY: Office of Special Education and Rehabilitative Services, Department of Education.

ACTION: Notice.

SUMMARY: The Department of Education (Department) is issuing a notice inviting applications for new awards for fiscal year (FY) 2025 for Stepping-up Technology Implementation.

DATES:

Applications Available: June 25, 2025.

Application Deadline: July 25, 2025.

Deadline for Intergovernmental Review: August 25, 2025.

Pre-Application Webinar Information: The Office of Special Education Programs and Rehabilitative Services will record a pre-application webinar for this competition, available at *www.ed.gov/about/ed-offices/osers/osep/new-osep-grant-competitions,* within five days after publication of this notice. In addition, applicants may view information on this competition at *www.ed.gov/about/ed-offices/osers/osep/new-osep-grant-competitions.*

ADDRESSES: For the addresses for obtaining and submitting an application, please refer to the *Application Submission Instructions* section.

FOR FURTHER INFORMATION CONTACT: Anita Vermeer, U.S. Department of Education, 400 Maryland Avenue SW, Room 4A208, Washington, DC 20202. Telephone: (202) 987–0155. Email: *anita.vermeer@ed.gov.*

If you are deaf, hard of hearing, or have a speech disability and wish to access telecommunications relay services, please dial 7–1–1.

SUPPLEMENTARY INFORMATION:

Full Text of Announcement

Funding Opportunity Description

Purpose of Program:

The purpose of the Educational Technology, Media, and Materials for Individuals with Disabilities Program (ETechM2 Program) is to improve results for children with disabilities by (1) promoting the development, demonstration, and use of technology; (2) supporting educational activities designed to be of educational value in the classroom for children with disabilities; (3) providing support for captioning and video description that is appropriate for use in the classroom; and (4) providing accessible educational materials to children with disabilities in a timely manner.

Assistance Listing Number (ALN): 84.327S.

OMB Control Number: 1820–0028.

Eligible Applicants:

State educational agencies (SEAs); local educational agencies (LEAs), including public charter schools that operate as LEAs under State law; institutions of higher education (IHEs); other public agencies; private nonprofit organizations; freely associated States and outlying areas; Indian Tribes or Tribal organizations; and for-profit organizations.

Type of Award: Cooperative Agreements.

Estimated Available Funds: $2,000,000.

Contingent upon the availability of funds and the quality of applications, we may make additional awards in FY 2026 from the list of unfunded applications from this competition.

Estimated Range of Awards: $375,000 to $400,000 per year.

Estimated Average Size of Awards: $385,000 per year.

Maximum Award: We will not make an award exceeding $400,000 for a single budget period of 12 months.

Estimated Number of Awards: 5.

Note: The Department is not bound by any estimates in this notice.

Project Period: Up to 60 months.

Priority: This competition includes one absolute priority. In accordance

with 34 CFR 75.105(b)(2)(v), the absolute priority is from allowable activities specified in sections 674(b)(2) and 681(d) of the Individuals with Disabilities Education Act (IDEA); 20 U.S.C. 1474(b)(2) and 1481(d).

Absolute Priority: For FY 2025 this priority is an absolute priority. The absolute priority is from the allowable activities in, or otherwise authorized under, the statute.[1] We consider only applications that meet this priority.

This priority is:

Use of Evidence-based Technology-based Tools or Approaches that Improve Reading Outcomes for Children with, or At Risk for, Disabilities.

Background:

The 2024 National Assessment of Educational Progress (NAEP)[2] indicates that only one in 10 students with disabilities in fourth or eighth grade reads at NAEP proficient[3] levels or above. Evidence-based reading instruction and interventions that utilize technology provide opportunities to further support the delivery of services to children with disabilities.

Priority:

The purpose of this priority is to support the implementation of evidence-based technology-based tools or approaches that improve reading outcomes for children with, or at risk for, disabilities (hereafter referred to as ''children with disabilities'') in pre-kindergarten (PK), elementary, middle, or high school instructional settings;

Through this priority, the Department intends to fund five cooperative agreements to establish and operate projects that achieve, at a minimum, the following expected outcomes:

(a) Improved reading outcomes for children with disabilities in PK–12 instructional settings using an evidence-based technology-based tool or approach;[4]

(b) Improved educator[5] implementation of an evidence-based technology-based tool or approach to deliver evidence-based instruction and interventions to improve reading outcomes for children with disabilities;

(c) Improved educator and family engagement regarding the use of an evidence-based technology-based tool or approach to improve reading outcomes for children with disabilities; and

(d) Sustained use of the evidence-based technology-based tool or approach within the instructional setting.

Application Requirements:

At a minimum, to be considered for funding under this priority in the application, applicants must describe the—

(a) Evidence-based technology-based tool or approach that improves reading outcomes and is ready to use at the time of the application;

(b) Reading outcomes of children with disabilities that will be improved by implementing the technology-based tool or approach;

(c) Approach to increase educators' implementation of the technology-based tool or approach to improve the reading outcomes of children with disabilities in an instructional setting; and

(d) Accessible products and resources[6] that will help educators and families to effectively use and implement the technology-based tool or approach.

In addition to these application requirements, to be considered for funding under this priority, applicants must meet the following requirements:

(a) In the narrative section of the application under ''Significance'' describe how the proposed project will address the need for a technology-based tool or approach to improve reading outcomes for children with disabilities. To meet this requirement applicants must—

(1) Describe the developed technology-based tool or approach and core components that improve reading outcomes that are based on at least promising evidence;

(2) Describe the educators who will implement the technology-based tool or approach and the population of children with disabilities who will benefit from the technology-based tool or approach;

(3) Describe how the technology-based tool or approach is currently being implemented and has improved reading outcomes for children with disabilities, if applicable;

(4) Describe any Federal funding, if applicable, within the last five years related to this technology-based tool or approach, how the funding has supported development and current implementation, and demonstrated improved outcomes for children with disabilities;

(5) Describe how the technology-based tool or approach will improve educators' implementation of evidence-based reading instruction to improve outcomes for children with disabilities in PK–12 instructional settings; and

(6) Present applicable national, State, regional, or local data demonstrating the need for the identified technology-based tool or approach to enhance the reading outcomes for children with disabilities.

(b) Demonstrate, in the narrative section of the application under ''Quality of the project design'' how the proposed project will—

(1) Develop and refine products and resources that incorporate principles of

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[1] See sections 20 U.S.C. 1474(b)(2) and 1481(d) of the Individuals with Disabilities Education Act.

[2] The National Assessment of Educational Progress (2024). *National Achievement-Level Results.* The Nation's Report Card. *www.nationsreportcard.gov/reading/nation/achievement/?grade=4.*

[3] ''*NAEP Proficient* does not signifiy being on grade level, like State assessments, which align to state grade-level expectations, and NAEP achievement levels generally are distinct from those used on State assessments.'' The Nation's Report Card/NAEP Achievement Levels (nd). *www.nagb.gov/naep/NAEP-achievement-levels.html.*

[4] For the purpose of this priority, projects must meet at least the definition of ''promising evidence,'' which means that there is evidence of the effectiveness of a key project component in improving a relevant outcome, based on a relevant finding from one of the following: (a) A practice guide prepared by the What Works Clearinghouse (WWC) reporting ''strong evidence'' ''moderate evidence'', or ''promising evidence'' for the corresponding practice recommendation; (b) An intervention report prepared by the WWC reporting ''Tier 1 strong evidence'' of effectiveness, or ''Tier 2 moderate evidence'' of effectiveness, or ''Tier 3 promising evidence'' of effectiveness, or a ''positive effect,'' or ''potentially positive effect'' on a relevant outcome, with no reporting of a ''negative effect'' or ''potentially negative effect'' on a relevant outcome; or (c) A single study assessed by the Department, as appropriate, that—(1) Is an experimental study, a quasi-experimental design study, or a well-designed and well-implemented correlational study with statistical controls for selection bias (such as a study using regression methods to account for differences between a treatment group and a comparison group); (2) Includes at least one statistically significant and positive (*i.e.,* favorable) effect on a relevant outcome; and (3) Includes no overriding statistically significant and negative effects on relevant outcomes reported in the study or in a corresponding WWC intervention report. See 34 CFR 77.1 for definitions of ''project component,'' ''promising evidence,'' ''experimental study,'' ''moderate evidence,'' ''quasi-experimental design study,'' ''relevant outcome,'' and ''strong evidence.''

[5] For the purpose of this priority, ''educators'' include teachers, early childhood providers, related services providers, administrators, paraprofessionals, and others providing services to childen with disabilities.

[6] Applicants should note that other laws, including the Americans with Disabilities Act of 1990 (42 U.S.C. 12101 *et seq.;* 28 CFR part 35) and section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. 794; 34 CFR part 104), may require that SEAs and LEAs provide captioning, video description, and other accessible educational materials to students with disabilities when these materials are necessary to provide equally integrated and equally effective access to the benefits of the educational program or activity, or as part of a ''free appropriate public education'' as defined in 34 CFR 104.33. Starting in either April 2026 or April 2027 (depending on the size of the school district), Title II of the Americans with Disabilities Act will require that public entities, including public schools, ensure that web content and mobile apps made available by the public entities are accessible in compliance with the Web Content Accessibility Guidelines (WCAG) 2.1, level AA. *www.ada.gov/resources/2024-03-08-web-rule/#top.*

universal design for learning [7] to support full implementation and use of the technology tool or approach to improve reading outcomes for children with disabilities;

(2) Recruit and engage educators and children with disabilities who are intended to benefit from the technology-based tool or approach; and

(3) Address barriers or challenges of implementation and utilize stages of implementation science with a variety of sites, such as public or private school buildings or early childhood settings, to support, sustain, and scale the evidence-based technology-based tool or approach.

To address this requirement, the applicant must include the following—

(i) Two product and resource development sites. Applicants must describe at least two proposed product and resource development sites, where the project would conduct iterative development of the products and resources intended to support the implementation of the technology-based tool or approach and produce, by the end of year one, preliminary feasibility and usability data. Applicants must include a letter in Appendix A from at least one site that indicates agreement to serve as a product and resource development site, at a minimum, in year one of the project.

(ii) Three pilot sites, one of which must be a site that is eligible for Title I funds under Part A of the Elementary and Secondary Education Act (ESEA). Pilot sites are the sites in which ongoing refinement of the developed products and resources, and the continued collection of feasibility and usability data, will occur. Applicants must describe how they would work with a minimum of three pilot sites no later than year two of the project, where the project would continue to refine the developed products and resources; collect feasibility and usability data; and demonstrate that the educational technology-based tool or approach is improving reading outcomes for children with disabilities.

(iii) Ten dissemination study sites, three of which must be sites that are eligible for Title I funds under Part A of the ESEA. Applicants must describe and complete work with a minimum of five dissemination sites by the end of year three and another five by the end of year four of the project period, to evaluate the performance of the technology-based tool or approach on educators' implementation and reading outcomes for children with disabilities. Dissemination sites would receive less implementation support from the project than development and pilot sites.

Note: A site may not serve in more than one category (*i.e.,* development, pilot, dissemination).

(iv) A plan to systematically disseminate information about the technology-based tool or approach to varied audiences throughout the five-year project period that extends beyond conference presentations and articles to reach intended audiences, support implementation. This plan must describe—

(A) How the project will utilize the fifth year of the project to scale the use of the technology-based tool or approach by educators and children with disabilities to improve reading outcomes; and

(B) How the project will ensure that all digital products and all external communications are routinely evaluated for and, if necessary, remediated to meet or exceed government or industry-recognized standards for accessibility.

(c) Demonstrate, in the narrative section of the application under ''Adequacy of resources,'' how—

(1) The applicant and any key partners or sites have adequate resources and demonstrated commitment to carry out the proposed activities; and

(2) Proposed costs are reasonable in relation to the anticipated results and benefits.

(d) Demonstrate, in the narrative section of the application under ''Quality of the management plan,'' how—

(1) The proposed project personnel, consultants, and subcontractors have the qualifications and experience to carry out the proposed activities and achieve the project's intended outcomes and how the proposed project team will include qualified experts on topics such as technology, education theory, practice, research methods, and scale-up or commercialization to support sustainability and dissemination;

(2) The proposed management plan will ensure that the project's intended outcomes will be achieved on time and within budget. To address this requirement, the applicant must describe—

(i) Clearly defined responsibilities for key project personnel, consultants, and subcontractors, as applicable; and

(ii) Timelines and milestones for accomplishing the project tasks;

(3) Key project personnel and any consultants and subcontractors will be allocated and how these allocations are appropriate and adequate to achieve the project's intended outcomes;

(4) The proposed management plan will ensure that the products and resources provided are of high quality, and are relevant and useful to educators and children with disabilities; and

(5) The proposed project will integrate feedback from a variety of perspectives, including families, educators and those from the intended users.

(e) Include a plan in the narrative section of the application under ''Quality of project evaluation or other evidence-building'' that describes—

(1) A logic model (as defined in 34 CFR 77.1) or conceptual framework that depicts, at a minimum, the goals, activities, project evaluation, methods, performance measures, outputs, and intended outcomes of the proposed project;

(2) The formative evaluation of the proposed project's activities and how the formative evaluation will use clear performance objectives to ensure continuous improvement in the operation of the proposed project;

(3) A method for assessing—

(i) The formative and summative data from the development sites that informs the implementation support needs;

(ii) The readiness of pilot sites to pilot the technology-based tool or approach, including, at a minimum, their current practices, technology or instructional alignment, available resources, and ability to build capacity;

(iii) The formative and summative data collected from the pilot sites to refine and evaluate the products and resources to support full implementation;

(iv) The training and ongoing professional learning needs of educators to implement the technology-based tool or approach with fidelity;

(v) The dissemination and scale up efforts to spread the use of the technology-based tool or approach by educators to improve reading outcomes for children with disabilities;

(4) How the project will collect summative data to report on the quality, relevance, usefulness, and efficacy of the products and resources developed to support implementation of the technology-based tool or approach to improve reading outcomes for children with disabilities; and

[7] Multiple means of representation so that information can be delivered in more than one way (*e.g.,* specialized software and websites, customizing display for visual or physical modalities); multiple means of expression that allow knowledge to be exhibited through options (*e.g.,* writing, online concept mapping, or speech-to-text programs, where appropriate); and multiple means of engagement to stimulate interest in and motivation for learning (*e.g.,* individual or group learning experiences or activities, learner choice).

(5) How, by the end of the project period, the project will provide—

(i) Information supported by the project evaluation on the products and resources, including accessibility features, that will enable other sites to implement and sustain implementation of the technology-based tool or approach;

(ii) Information in the project's final performance report, including implementation data, on how educators utilized the technology-based tool or approach; how the technology-based tool or approach was implemented with fidelity; and the effectiveness of the technology-based tool or approach in improving reading outcomes for children with disabilities;

(iii) Data on how the technology-based tool or approach changed educators' practices to improve reading outcomes for children with disabilities; and

(iv) A dissemination plan that includes scaling up the technology-based tool or approach and accompanying products beyond the sites directly involved in the project.

(f) Address the following application requirements. The applicant must include—

(1) In Appendix A, personnel-loading charts and timelines, as applicable, to illustrate the management plan described in the narrative;

(2) In Appendix A, the logic model by which the proposed project will develop project plans and activities and achieve its intended outcomes. The logic model must depict, at a minimum, the goals, activities, project evaluation, methods, and intended outcomes of the proposed project; and

Note: The following website provides more information on logic models: *https://ies.ed.gov/use-work/resource-library/resource/tooltoolkit/program-evaluation-toolkit.*

(3) In the budget, attendance at the following:

(i) A two-day project directors' conference in Washington, DC, during each year of the project period.

(ii) One annual trip, to attend Department briefings, Department-sponsored conferences, and other meetings, as requested by OSEP. Provide an assurance that the project will reallocate unused travel funds no later than the end of the third quarter if the meetings are conducted virtually.

Cohort Collaboration and Support:

OSEP project officers will provide coordination support among the projects. Each project funded under this priority must—

(a) Participate in monthly conference-call discussions to collaborate on implementation and project issues; and

(b) Provide annual information to OSEP using a template that captures descriptive data on project site selection and the processes for implementation and use of the technology-based tool or approach.

Selection Criteria: The selection criteria for this competition are from 34 CFR 75.210 and are as follows:

(a) *Significance* (15 points).

The Secretary considers the significance of the proposed project. In determining the significance of the proposed project, the Secretary considers the following factors:

(1) The extent to which findings from the project's implementation will contribute new knowledge to the field by increasing knowledge or understanding of educational challenges, including the underlying or related challenges, and effective strategies for addressing educational challenges and their effective implementation (up to 4 points);

(2) The potential effective replicability of the proposed project or strategies, including, as appropriate, the potential for implementation by a variety of populations or settings (up to 5 points).

(3) The extent to which the resources, tools, and implementation lessons of the proposed project will be disseminated in ways to the target population and local community that will enable them and others (including practitioners, researchers, education leaders, and partners) to implement similar strategies (up to 6 points).

(b) *Quality of the project design* (30 points).

The Secretary considers the quality of the design of the proposed project. In determining the quality of the design of the proposed project, the Secretary considers the following factors:

(1) The extent to which the services to be provided by the proposed project reflect up-to-date knowledge and an evidence-based project component (up to 5 points);

(2) The likely benefit to the intended recipients, as indicated by the logic model or other conceptual framework, of the services to be provided (up to 7 points);

(3) The extent to which the training or professional development services to be provided by the proposed project are of sufficient quality, intensity, and duration to build recipient and project capacity in ways that lead to improvements in practice among the recipients of those services (up to 10 points); and

(4) The extent to which the services to be provided by the proposed project involve the use of efficient strategies, including the use of technology, as appropriate, and the leveraging of non-project resources (up to 8 points).

(c) *Adequacy of resources* (15 points).

The Secretary considers the adequacy of resources for the proposed project. In determining the adequacy of resources for the proposed project, the Secretary considers the following factors:

(1) The adequacy of support for the project, including facilities, equipment, supplies, and other resources, from the applicant or the lead applicant organization (up to 5 points);

(2) The relevance and demonstrated commitment of each partner in the proposed project to the implementation and success of the project (up to 5 points); and

(3) The extent to which the budget is adequate to support the proposed project and the costs are reasonable in relation to the objectives, design, and potential significance of the proposed project (up to 5 points).

(d) *Quality of the management plan* (20 points).

The Secretary considers the quality of the management plan for the proposed project. In determining the quality of the management plan for the proposed project, the Secretary considers the following factors:

(1) The feasibility of the management plan to achieve project objectives and goals on time and within budget, including clearly defined responsibilities, timelines, and milestones for accomplishing project tasks (up to 5 points);

(2) The adequacy of mechanisms for ensuring high-quality and accessible products and services from the proposed project for the target population (up to 4 points);

(3) The extent to which the time commitments of the project director and principal investigator and other key project personnel are appropriate and adequate to meet the objectives of the proposed project (up to 3 points);

(4) The extent to which the key personnel in the project, when hired, have the qualifications required for the proposed project, including formal training or work experience in fields related to the objectives of the project, and represent or have lived experiences of the target population (up to 6 points); and

(5) The qualifications, including relevant training and experience, of project consultants or subcontractors (up to 2 points).

(e) *Quality of the project evaluation or other evidence-building* (20 points).

The Secretary considers the quality of the evaluation or other evidence-building of the proposed project. In determining the quality of the evaluation or other evidence-building, the Secretary considers the following factors:

(1) The extent to which the methods of evaluation or other evidence-building are thorough, feasible, relevant, and appropriate to the goals, objectives, and outcomes of the proposed project (up to 5 points);

(2) The extent to which the methods of evaluation or other evidence-based building are designed to measure the fidelity of implementation of the project (up to 5 points);

(3) The extent to which the methods of evaluation or other evidence-building will provide performance feedback and provide formative, diagnostic, or interim data that is a periodic assessment of progress toward achieving intended outcomes (up to 5 points); and

(4) The extent to which the evaluation will provide guidance about effective strategies suitable for replication or testing and potential implementation in other settings (up to 5 points).

Performance Measures:

For the purposes of Department reporting under 34 CFR 75.110, the Department has established a set of performance measures including long-term measures, that are designed to yield information on various aspects of the effectiveness and quality of the ETechM2 Program. These measures are:

- *Program Performance Measure 1:* The percentage of ETechM2 Program products and services judged to be of high quality by an independent review panel of experts qualified to review the substantial content of the products and services.
- *Program Performance Measure 2:* The percentage of ETechM2 Program products and services judged to be of high relevance to improving outcomes for infants, toddlers, children, and youth with disabilities.
- *Program Performance Measure 3:* The percentage of ETechM2 Program products and services judged to be useful in improving results for infants, toddlers, children, and youth with disabilities.
- *Program Performance Measure 4.1:* The Federal cost per unit of accessible educational materials funded by the ETechM2 Program.
- *Program Performance Measure 4.2:* The Federal cost per unit of accessible educational materials from the National Instructional Materials Access Center funded by the ETechM2 Program.
- *Program Performance Measure 4.3:* The Federal cost per unit of video description funded by the ETechM2 Program.

Program Performance Measures 1, 2, and 3 apply to projects funded under this competition, and grantees are required to submit data on Program Performance Measures 1, 2, and 3 as directed by OSEP.

Grantees will be required to report information on their project's performance in annual performance reports and additional performance data to the Department (34 CFR 75.590 and 75.591).

Waiver of Proposed Rulemaking: Under the Administrative Procedure Act (5 U.S.C. 553), the Department generally offers interested parties the opportunity to comment on proposed priorities and requirements. Section 681(d) of IDEA, however, makes the public comment requirements of the APA inapplicable to the priority in this notice.

Program Authority: 20 U.S.C. 1471, 1481, 1482.

Applicable Regulations: (a) The Education Department General Administrative Regulations in 34 CFR parts 75, 77, 79, 81, 82, 84, 86, 97, 98, and 99. (b) The Office of Management and Budget Guidelines to Agencies on Governmentwide Debarment and Suspension (Nonprocurement) in 2 CFR part 180, as adopted and amended as regulations of the Department in 2 CFR part 3485. (c) The Guidance for Federal Financial Assistance in 2 CFR part 200, as adopted and amended as regulations of the Department in 2 CFR part 3474.

Cost Sharing or Matching: This program does not require cost sharing or matching.

Indirect Cost Rate Information: This program uses an unrestricted indirect cost rate. For more information regarding indirect costs, or to obtain a negotiated indirect cost rate, please see *www.ed.gov/about/ed-offices/ofo#Indirect-Cost-Division.*

Administrative Cost Limitation: This program includes administrative cost limitations under 20 U.S.C. 1482(b)(3)(B).

Subgrantees: A grantee under this competition may award subgrants—to directly carry out project activities described in its application—to the following types of entities: IHEs and private nonprofit organizations suitable to carry out the activities proposed in the application.

The grantee may award subgrants to entities it has identified in an approved application.

Other General Requirements:

1. Recipients of funding under this program must make positive efforts to employ and advance in employment qualified individuals with disabilities (see section 606 of IDEA).

2. Each applicant for, and recipient of, funding under this program must involve individuals with disabilities, or parents of individuals with disabilities ages birth through 26, in planning, implementing, and evaluating the project (see section 682(a)(1)(A) of IDEA).

Application and Submission Information:

1. *Application Submission Instructions:* Applicants are required to follow the Common Instructions for Applicants to Department of Education Discretionary Grant Programs available at *www.federalregister.gov/d/2024-30488* (89 FR 104528, December 23, 2024).

2. *Intergovernmental Review:* This competition is subject to intergovernmental review under Executive Order 12372 and the regulations in 34 CFR part 79. Information about this process is in the application package. Please note that, under 34 CFR 79.8(a), we have shortened the standard 60-day intergovernmental review period in order to make awards by the end of FY 2025.

3. *Recommended Page Limit:* The application narrative is where you, the applicant, address the selection criteria that reviewers use to evaluate your application. We recommend that you (1) limit the application narrative to no more than 50 pages and (2) use the following standards:

- A ''page'' is 8.5″ x 11″, on one side only, with 1″ margins at the top, bottom, and both sides.
- Double space (no more than three lines per vertical inch) all text in the application narrative, including titles, headings, footnotes, quotations, reference citations, and captions, as well as all text in charts, tables, figures, graphs, and screen shots.
- Use a font that is 12 point or larger.
- Use one of the following fonts: Times New Roman, Courier, Courier New, or Arial.

The recommended page limit does not apply to the cover sheet; the budget section, including the narrative budget justification; the assurances and certifications; or the abstract (follow the guidance provided in the application package for completing the abstract), the table of contents, the list of priority requirements, the resumes, the reference list, the letters of support, or the appendices. However, the recommended page limit does apply to all of the application narrative, including all text in charts, tables, figures, graphs, and screen shots.

4. *Review and Selection Process:* We remind potential applicants that in reviewing applications in any discretionary grant competition, the Secretary may consider the past performance of the applicant in carrying out a previous award, such as the applicant's use of funds, achievement of project objectives, and compliance with grant conditions. The Secretary may also consider whether the applicant failed to submit a timely performance report or submitted a report of unacceptable quality.

In addition, in making a competitive grant award, the Secretary requires various assurances, including those applicable to Federal civil rights laws that prohibit discrimination in programs or activities receiving Federal financial assistance from the Department.

In the event there are two or more applications with the same final score, and there are insufficient funds to fully support each of these applications, the scores under selection criterion (b) *Quality of the project design* will be used as a tiebreaker. If the scores remain tied, then the scores under selection criterion (c) *Adequacy of resources* will be used to break the tie.

5. *Additional Review and Selection Process Factors:* In the past, the Department has had difficulty finding peer reviewers for certain competitions because so many individuals who are eligible to serve as peer reviewers have conflicts of interest. The standing panel requirements under section 682(b) of IDEA also have placed additional constraints on the availability of reviewers. Therefore, the Department has determined that for some discretionary grant competitions, applications may be separated into two or more groups and ranked and selected for funding within specific groups. This procedure will make it easier for the Department to find peer reviewers by ensuring that greater numbers of individuals who are eligible to serve as reviewers for any particular group of applicants will not have conflicts of interest. It also will increase the quality, independence, and fairness of the review process.

6. *Risk Assessment and Specific Conditions:* Before awarding grants under this competition, the Department conducts a review of the risks posed by applicants. The Secretary may impose specific conditions and, in appropriate circumstances, high-risk conditions on a grant if the applicant or grantee is not financially stable; has a history of unsatisfactory performance; has a financial or other management system that does not meet the standards in 2 CFR part 200, subpart D; has not fulfilled the conditions of a prior grant; or is otherwise not responsible.

7. *Integrity and Performance System:* If you are selected under this competition to receive an award that over the course of the project period may exceed the simplified acquisition threshold (currently $250,000), we must make a judgment about your integrity, business ethics, and record of performance under Federal awards—that is, the risk posed by you as an applicant—before we make an award. In doing so, we must consider any information about you that is in the System for Award Management's (SAM) Responsibility/Qualification reports (formerly referred to as the Federal Awardee Performance and Integrity Information System (FAPIIS)). You may review and comment on any information about yourself that a Federal agency previously entered and that is currently in the Responsibility/Qualification reports in SAM.

If the total value of your currently active grants, cooperative agreements, and procurement contracts from the Federal Government exceeds $10,000,000, the reporting requirements in 2 CFR part 200, Appendix XII, require you to report certain integrity information to SAM semiannually. Please review these requirements if this grant plus all the other Federal funds you receive exceed $10,000,000.

Award Administration Information:

1. *Award Notices:* If your application is successful, we notify your U.S. Representative and U.S. Senators and send you a Grant Award Notification (GAN), or we may send you an email containing a link to access an electronic version of your GAN.

If your application is not evaluated or not selected for funding, we notify you.

2. *Administrative and National Policy Requirements:* We identify administrative and national policy requirements in the application package and reference these and other requirements in the *Applicable Regulations* section of this notice.

We reference the regulations outlining the terms and conditions of an award in the *Applicable Regulations* section of this notice and include these and other specific conditions in the GAN. The GAN also incorporates your approved application as part of your binding commitments under the grant.

3. *Open Licensing Requirements:* Unless an exception applies, if you are awarded a grant under this competition, you will be required to openly license to the public grant deliverables created in whole, or in part, with Department grant funds. When the deliverable consists of modifications to pre-existing works, the license extends only to those modifications that can be separately identified and only to the extent that open licensing is permitted under the terms of any licenses or other legal restrictions on the use of pre-existing works. Additionally, a grantee that is awarded competitive grant funds must have a plan to disseminate these public grant deliverables. This dissemination plan can be developed and submitted after your application has been reviewed and selected for funding. For additional information on the open licensing requirements please refer to 2 CFR 3474.20.

4. *Reporting:* (a) If you apply for a grant under this competition, you must ensure that you have in place the necessary processes and systems to comply with the reporting requirements should you receive funding under the competition. This does not apply if you have an exception.

(b) At the end of your project period, you must submit a final performance report, including financial information, as directed by the Secretary. If you receive a multiyear award, you must submit an annual performance report that provides the most current performance and financial expenditure information as directed by the Secretary. The Secretary may also require more frequent performance reports. For specific requirements on reporting, please go to *www.ed.gov/fund/grant/apply/appforms/appforms.html.*

(c) The Secretary may provide a grantee with additional funding for data collection analysis and reporting. In this case the Secretary establishes a data collection period.

5. *Continuation Awards:* In making a continuation award, the Secretary considers, among other things: whether a grantee has made substantial progress in achieving the goals and objectives of the project; whether the grantee has expended funds in a manner that is consistent with its approved application and budget; if the Secretary has established performance measurement requirements, whether the grantee has made substantial progress in achieving the performance targets in the grantee's approved application; and whether the continuation of the project is in the best interest of the Federal Government.

In making a continuation award, the Secretary also considers whether the grantee is operating in compliance with the assurances in its approved application, including those applicable to Federal civil rights laws that prohibit discrimination in programs or activities receiving Federal financial assistance from the Department.

Accessible Format: On request to the program contact person listed under **FOR FURTHER INFORMATION CONTACT**, individuals with disabilities can obtain this document and a copy of the application package in an accessible format. The Department will provide the requestor with an accessible format that may include Rich Text Format (RTF) or text format (txt), a thumb drive, an MP3 file, braille, large print, audiotape, compact disc, or other accessible format.

Diana Diaz,

Deputy Assistant Secretary and Acting Assistant Secretary for Special Education and Rehabilitative Services.

[FR Doc. 2025–11614 Filed 6–24–25; 8:45 am]

BILLING CODE 4000–01–P

DEPARTMENT OF EDUCATION

Applications for New Awards; Technical Assistance on State Data Collection—IDEA Data Management Center

AGENCY: Office of Special Education and Rehabilitative Services, Department of Education.

ACTION: Notice.

SUMMARY: The Department of Education (Department) is issuing a notice inviting applications for new awards for fiscal year (FY) 2025 for a Technical Assistance on State Data Collection—IDEA Data Management Center.

DATES:

Applications Available: June 25, 2025.

Deadline for Transmittal of Applications: July 25, 2025.

Deadline for Intergovernmental Review: August 25, 2025.

ADDRESSES: For the addresses for obtaining and submitting an application, please refer to our Common Instructions for Applicants to Department of Education Discretionary Grant Programs, published in the **Federal Register** on December 23, 2024 (89 FR 104528) and available at *www.federalregister.gov/documents/2024/12/23/2024-30488/common-instructions-for-applicants-to-department-of-education-discretionary-grant-programs.*

FOR FURTHER INFORMATION CONTACT: Amy Bae, U.S. Department of Education, 400 Maryland Avenue SW, Room 4A224, Washington, DC 20202. Telephone: (202) 987–1557. Email: *Amy.Bae@ed.gov.*

If you are deaf, hard of hearing, or have a speech disability and wish to access telecommunications relay services, please dial 7–1–1.

SUPPLEMENTARY INFORMATION:

Full Text of Announcement

I. Funding Opportunity Description

Purpose of Program: The purpose of the Technical Assistance on State Data Collection program is to improve the capacity of States to meet the Individuals with Disabilities Education Act (IDEA) data collection and reporting requirements. Funding for the program is authorized under section 611(c)(1) of IDEA, which provides the Secretary with the authority to reserve not more than one-half of one percent of the amounts appropriated under Part B for each fiscal year to provide technical assistance (TA) activities authorized under section 616(i), where needed, to improve the capacity of States to meet the data collection and reporting requirements under Parts B and C of IDEA. The maximum amount the Secretary may reserve under this set-aside for fiscal year 2025 is $42,657,297, cumulatively adjusted by the rate of inflation. For fiscal year 2025 the Secretary plans to reserve $27,500,000. Section 616(i) of IDEA requires the Secretary to review the data collection and analysis capacity of States to ensure that data and information determined necessary for implementation of sections 616 and 642 of IDEA are collected, analyzed, and accurately reported to the Secretary. It also requires the Secretary to provide TA, where needed, to improve the capacity of States to meet the data collection requirements, which include the data collection and reporting requirements in sections 616 and 618 of IDEA. In addition, the Further Consolidated Appropriations Act, 2024, Public Law 118–47, Division D, Title III, 138 Stat. 460, 685 gives the Secretary authority to use funds reserved under section 611(c) of IDEA to ''administer and carry out other services and activities to improve data collection, coordination, quality, and use under Parts B and C of the IDEA.''

Assistance Listing Number (ALN): 84.373M.

OMB Control Number: 1820–0028.

Priority: This competition includes one priority. This priority is from the notice of final priority (NFP) for this program published elsewhere in this issue of the **Federal Register**.

Absolute Priority: For FY 2025 and any subsequent year in which we make awards from the list of unfunded applications from this competition, this priority is an absolute priority. Under 34 CFR 75.105(c)(3), we consider only applications that meet this priority.

This priority is:

IDEA Data Management Center.

Background:

The Department prioritizes supporting States in meeting the requirements of IDEA to collect, report, analyze, and use high-quality IDEA data (including data reported under IDEA sections 616, 618, and 642), and assisting them in meeting their needs to enhance, streamline, and integrate IDEA data into other data systems such as their State longitudinal data systems (SLDS) and early childhood integrated data systems (ECIDS). States have identified several benefits to having more integrated data systems including, more standardized and streamlined data collection and reporting across programs serving children; better tracking of child level outcomes in areas such as math, literacy, and science; better tracking of system level outcomes such as developmental screening and referral; and more support for program improvement. Data integration across systems allows States to provide administrators, parents, and policymakers more accurate and comprehensive data to evaluate and improve special education and early intervention programs and services.

While States have recognized the benefits of data integration, despite some progress over the past decade, many States indicate that they still struggle to link IDEA data into K–12 and early childhood data systems often because they do not have the expertise, resources, or staffing to develop integrated data systems. States have requested TA to support stronger linkages between SLDS and ECIDS as a way to better respond to IDEA reporting requirements and improve coordination and access to actionable data that they can use to better evaluate program effectiveness, guide policy decisions, refine instructional and intervention strategies, and provide parents with the information they need to support their children's educational and developmental progress.

Priority:

The purpose of this priority is to fund a cooperative agreement to establish and operate an IDEA Data Management Center (Data Management Center). The Data Management Center will respond to State needs as States determine whether and how to coordinate and integrate their IDEA Part B and Part C data required to meet the data collection requirements in sections 616 and 618 of IDEA into their longitudinal data systems (including SLDS and ECIDS) while ensuring applicable IDEA and Family Educational Rights and Privacy Act (FERPA) privacy protections are met. This integration will improve the capacity of States to collect, report, analyze, and use high-quality IDEA Part

B and Part C data to establish and meet high expectations for each child with a disability. The Data Management Center will help States address challenges with data management procedures and data systems architecture and better meet current and future IDEA Part B and Part C data collection and reporting requirements. The Data Management Center's work will comply with the privacy and confidentiality protections under IDEA and FERPA. The Data Management Center will not provide the Department with access to child-level data and will further ensure that such data is de-identified, as defined in 34 CFR 99.31(b)(1).

The Data Management Center must be designed to achieve, at a minimum, the following expected outcomes:

(a) Increased capacity of States to use interagency agreements or other mechanisms to coordinate and integrate IDEA Part B and IDEA Part C data required under sections 616 and 618 of IDEA within their SLDS while meeting the applicable privacy requirements under Parts B and C of the IDEA and FERPA (which may include developing or disseminating TA resources on privacy, interagency agreements on data sharing and/or data coordination, and integration);

(b) Increased use of IDEA Part B and IDEA Part C data within States by developing products to allow States to report their special education, preschool special education, and early intervention data to various partners (*e.g.,* other State agencies, policymakers, school and early care and education program personnel, local and State school boards, local educational agency (LEA) administrators, early care and education childhood administrators, researchers, charter school authorizers, parents and advocates, Indian Tribes, and Tribal organizations) through their longitudinal data systems;

(c) Increased number of States that use data governance and data management procedures to increase their capacity to meet the IDEA Part B and IDEA Part C reporting requirements under sections 616 and 618 of IDEA;

(d) Increased capacity of States to utilize their SLDS and ECIDS to collect, report, analyze, and use high-quality IDEA Part B and IDEA Part C data (including data required under sections 616, 618, and 642 of IDEA);

(e) Increased capacity of States to use their SLDS and ECIDS to analyze high-quality data on the participation and outcomes of children with disabilities who receive services under IDEA and under Title I of the Elementary and Secondary Education Act of 1965, as amended (ESEA), to improve IDEA and ESEA programs and the outcomes of children with disabilities; and

(f) Increased capacity of States to coordinate and use available IDEA Part C early intervention data with IDEA Part B preschool special education data (and to integrate or link such data with ECIDS, if applicable) to analyze high-quality data on the participation and outcomes of infants, toddlers, and children with disabilities served under IDEA who may also participate in other programs and services (*e.g.,* child care, Early Head Start, Head Start, publicly funded preschool, and home visiting programs).

In addition to these programmatic requirements, to be considered for funding under this priority, applicants must meet the application and administrative requirements in this priority, which are:

(a) Describe, in the narrative section of the application under ''Significance,'' how the proposed project will—

(1) Address State challenges associated with State data management procedures, data systems architecture, and building ED*Facts* data files and reports for timely reporting of the IDEA Part B and IDEA Part C data to the Department and the public. To meet this requirement the applicant must—

(i) Present applicable national, State, or local data demonstrating the difficulties that States have encountered in the collection and submission of valid and reliable IDEA Part B and IDEA Part C data;

(ii) Demonstrate knowledge of current educational and technical issues and policy initiatives relating to IDEA Part B data and IDEA Part C collections and ED*Facts* file specifications for the IDEA Part B and IDEA Part C data collections; and

(iii) Present information about the current level of implementation of integrating IDEA Part B data within SLDS and IDEA Part C and IDEA Part B preschool special education data within ECIDs, and the reporting of high-quality IDEA Part B and IDEA Part C data to the Department and the public.

(b) Describe, in the narrative section of the application under ''Quality of the project design,'' how the proposed project will—

(1) Achieve its goals, objectives, and intended outcomes. To meet this requirement, the applicant must provide—

(i) Measurable intended project outcomes; and

(ii) In Appendix A, the logic model (as defined in 34 CFR 77.1) by which the proposed project will achieve its intended outcomes that depicts, at a minimum, the goals, activities, outputs, and intended outcomes of the proposed project;

(2) Use a conceptual framework (and provide a copy in Appendix A) to develop project plans and activities, describing any underlying concepts, assumptions, expectations, beliefs, or theories, as well as the presumed relationships or linkages among these variables, and any empirical support for this framework.

Note: The following website provides more information on logic models and conceptual frameworks: *https://ies.ed.gov/ncee/rel/Products/Region/central/Resource/100644.*

(3) Be based on current research and make use of evidence-based [1] practices (EBPs). To meet this requirement, the applicant must describe—

(i) The current research on data collection strategies, data management procedures, and data systems architecture; and

(ii) How the proposed project will incorporate current research and EBPs in the development and delivery of its products and services;

(4) Develop products and provide services that are of high quality and sufficient intensity and duration to achieve the intended outcomes of the proposed project. To address this requirement, the applicant must describe—

(i) How it proposes to identify or develop the knowledge base on States' data management processes and data systems architecture;

(ii) A plan to provide a range of products and services to—

(A) Improve States' capacity to report high-quality IDEA Part B and Part C data required under sections 616, 618, and 642 of IDEA through their SLDS and other applicable data systems; and

(B) Improve States' capacity to link and integrate (where determined appropriate by States) their IDEA Part C early intervention and IDEA Part B preschool special education data with data/data systems associated with other Federal programs and services that support infants, toddlers, and young children and their families in order to report high-quality IDEA Part C data and IDEA Part B preschool special education data required under sections 616 and 618 of IDEA. The plan must include, at a minimum, how the project will—

(*1*) In Years 1 through 5—

(*i*) Support, in partnership with the Department, the implementation of an

[1] For the purposes of these requirements, ''evidence-based'' means the proposed project component is supported by one or more of strong evidence, moderate evidence, promising evidence, or evidence that demonstrates a rationale (as such terms are defined in 34 CFR 77.1).

existing open-source electronic tool to assist States in building ED*Facts* data files and reports that can be submitted to the Department and made available to the public. The tool must utilize Common Education Data Standards (CEDS) and meet all States' needs associated with reporting the IDEA Part B and Part C data required under sections 616, 618, and 642 of IDEA;

(*ii*) Provide maintenance to support the appropriate functionality of the open-source electronic tool as changes are made to data collections, reporting requirements, file specifications, and CEDS (such as links within the system to include TA products developed by other Office of Special Education Programs (OSEP) and Department-funded centers or contractors);

(*iii*) Provide TA focused on data governance to facilitate the use of the open-source electronic tool and training to State staff to implement the open-source electronic tool;

(*iv*) Revise the CEDS ''Connections'' to calculate metrics needed to report the IDEA Part B and Part C data required under sections 616 and 618 of IDEA;

(*v*) Develop other outputs (*e.g.,* reports, Application Programming Interface, new innovations) of an open-source electronic tool that can support reporting by States of IDEA Part B data to different partner groups (*e.g.,* LEAs, charter schools, legislative branch, parents);

(*vi*) Implement strategies to support the inclusion of other OSEP and Department-funded TA centers' products within the open-source electronic tool or build connections that allow the SEAs to pull IDEA Part B data efficiently into the other TA products;

(*vii*) Support a user group of States that are using an open-source electronic tool for reporting IDEA Part B data required under sections 616 and 618 of IDEA; and

(*viii*) Develop products and presentations that include tools and solutions to challenges in data management procedures and data system architecture for reporting the IDEA Part B and Part C data required under sections 616 and 618 of IDEA;

(*2*) In Years 2 through 5—

(*i*) Develop, in partnership with the Department, an open-source electronic tool to assist States with linking and integrating their IDEA Part C early intervention and IDEA Part B preschool special education data with other data/data systems associated with other Federal programs and services that support infants, toddlers, and young children and their families, in order to provide high-quality reporting of the IDEA Part C data and IDEA Part B preschool special education data required under sections 616 and 618 of IDEA; drive program improvement; improve results for children with disabilities; and improve compliance accountability. The tool must utilize CEDS and meet States' needs associated with linking or integrating their Part C early intervention and Part B preschool special education data with other data/data systems associated with other Federal programs that support infants, toddlers, and young children and their families;

(*ii*) Develop the CEDS ''Connections'' to ensure the electronic tool is built for States to conduct analyses related to reporting the IDEA Part C data and IDEA Part B preschool special education data required under sections 616 and 618 of IDEA, driving program improvement, improving results for children with disabilities and their families, and improving compliance accountability;

(*iii*) Provide maintenance to support the appropriate functionality of the open-source electronic tool as changes are made to data reporting requirements and CEDS;

(*iv*) Provide TA on data governance to facilitate the use of the open-source electronic tool and training to State staff to implement the open-source electronic tool; and

(*v*) Support a user group of States that are using an open-source electronic tool for reporting the IDEA Part C data and IDEA Part B preschool special education data required under sections 616, 618, and 642 of IDEA;

(iii) Its proposed approach to universal, general TA,[2] which must identify the intended recipients, including the type and number of recipients, that will receive the products and services, a description of the products and services that the Center proposes to make available, and the expected impact of those products and services under this approach;

(iv) Its proposed approach to targeted, specialized TA,[3] which must identify—

(A) The intended recipients, including the type and number of recipients, that will receive the products and services, a description of the products and services that the Center proposes to make available, and the expected impact of those products and services under this approach; and

(B) Its proposed approach to measure the readiness of potential TA recipients to work with the project, assessing, at a minimum, their current infrastructure, available resources, and ability to build capacity at the local level; and

(C) The process by which the proposed project will collaborate with Department-funded centers (including TA centers such as the DaSy Center that provides Department-funded TA on early childhood data privacy, and the Privacy Technical Assistance Center) and other federally funded TA centers to develop and implement a coordinated TA plan when they are involved in a State;

(v) Its proposed approach to intensive, sustained TA,[4] which must identify—

(A) The intended recipients, including the type and number of recipients from a variety of settings and geographic distribution, that will receive the products and services under this approach;

(B) Its proposed approach to address States' challenges associated with integrating IDEA Part B data within SLDS and IDEA Part C and IDEA Part B preschool special education data within ECIDS and to report high-quality IDEA Part B and IDEA Part C data to the Department and the public, which should, at a minimum, include providing on-site consultants to SEAs and Part C lead agencies to—

(*1*) Model and document data management and data system integration policies, procedures, processes, and activities within the State;

(*2*) Support the State's use of an open-source electronic tool and provide technical solutions to meet State-specific data needs;

[2] ''Universal, general TA'' means TA and information provided to independent users through their own initiative, resulting in minimal interaction with TA center staff and including one-time, invited or offered conference presentations by TA center staff. This category of TA also includes information or products, such as newsletters, guidebooks, or research syntheses, downloaded from the TA center's website by independent users. Brief communications by TA center staff with recipients, either by telephone or email, are also considered universal, general TA.

[3] ''Targeted, specialized TA'' means TA services based on needs common to multiple recipients and not extensively individualized. A relationship is established between the TA recipient and one or more TA center staff. This category of TA includes one-time, labor-intensive events, such as facilitating strategic planning or hosting regional or national conferences. It can also include episodic, less labor-intensive events that extend over a period of time, such as facilitating a series of conference calls on single or multiple topics that are designed around the needs of the recipients. Facilitating communities of practice can also be considered targeted, specialized TA.

[4] ''Intensive, sustained TA'' means TA services often provided on-site and requiring a stable, ongoing relationship between the TA center staff and the TA recipient. ''TA services'' are defined as negotiated series of activities designed to reach a valued outcome. This category of TA should result in changes to policy, program, practice, or operations that support increased recipient capacity or improved outcomes at one or more systems levels.

(*3*) Develop a sustainability plan for the State to maintain the data management and data system integration work in the future; and

(*4*) Support the State's cybersecurity plan in collaboration, to the extent appropriate, with the Department's Student Privacy Policy Office and its Privacy Technical Assistance Center;

(*5*) Develop products and implement services that maximize efficiency. To address this requirement, the applicant must describe—

(i) How the proposed project will use technology to achieve the intended project outcomes;

(ii) With whom the proposed project will collaborate and the intended outcomes of this collaboration; and

(iii) How the proposed project will use non-project resources, such as non-Federal funds and in-kind contributions, to achieve the intended project outcomes; and

(*6*) Develop a dissemination plan that describes how the applicant will systematically distribute information, products, and services to varied intended audiences, using a variety of dissemination strategies, to promote awareness and use of the Center's products and services.

(c) In the narrative section of the application under ''Quality of the project evaluation or other evidence-building,'' describe how the project will develop an evaluation plan in consultation with, and to be implemented by, a third-party evaluator.[5] The evaluation plan must—

(1) Articulate formative and summative evaluation questions, including important process and outcome evaluation questions. These questions must be related to the project's proposed logic model required under paragraph (b)(2)(ii);

(2) Describe how progress in and fidelity of implementation, as well as project outcomes, will be measured to answer the evaluation questions. Specify the measures and associated instruments or sources for data appropriate to the evaluation questions. Include information regarding reliability and validity of measures where appropriate;

(3) Describe strategies for analyzing data and how data collected as part of this plan will be used to inform and improve service delivery over the course of the project and to refine the proposed logic model and evaluation plan, including subsequent data collection;

(4) Provide a timeline for conducting the evaluation and include staff assignments for completing the plan. The timeline must indicate that the data will be available annually for the Annual Performance Report (APR) and at the end of Year 2; and

(5) Dedicate sufficient funds in each budget year to cover the costs of developing or refining the evaluation plan in consultation with a third-party evaluator, as well as the costs associated with the implementation of the evaluation plan by the third-party evaluator.

(d) Demonstrate, in the narrative section of the application under ''Adequacy of resources,'' how—

(1) The project will make positive efforts to employ and advance in employment qualified individuals with disabilities;

(2) The applicant and any key partners have adequate resources to carry out the proposed activities; and

(3) The proposed costs are reasonable in relation to the anticipated results and benefits, and funds will be spent in a way that increases their efficiency and cost-effectiveness, including by reducing waste or achieving better outcomes.

(e) Describe, in the narrative section of the application under ''Quality of the management plan,'' how—

(1) The proposed management plan will ensure that the project's intended outcomes will be achieved on time and within budget. To address this requirement, the applicant must describe—

(i) Clearly defined responsibilities for key project personnel, consultants, and subcontractors, as applicable; and

(ii) Timelines and milestones for accomplishing the project tasks;

(2) Key project personnel and any consultants and subcontractors will be allocated and how these allocations are appropriate and adequate to achieve the project's intended outcomes;

(3) The proposed key project personnel, consultants, and subcontractors have the qualifications and experience to carry out the proposed activities and achieve the project's intended outcomes; and

(4) The proposed management plan will ensure that the products and services provided are of high quality, relevant, and useful to recipients.

(f) Address the following application requirements. The applicant must—

(1) Include, in Appendix A, personnel-loading charts and timelines, as applicable, to illustrate the management plan described in the narrative;

(2) Include, in the budget, attendance at the following:

(i) A one and one-half day kick-off meeting in Washington, DC, after receipt of the award, and an annual planning meeting in Washington, DC, with the OSEP project officer and other relevant staff during each subsequent year of the project period.

Note: Within 30 days of receipt of the award, a post-award teleconference must be held between the OSEP project officer and the grantee's project director or other authorized representative.

(ii) A three-day project directors' conference in Washington, DC, during each year of the project periods, provided that, if the meeting is conducted virtually, the project must reallocate unused travel funds no later than the end of the third quarter of each budget period;

(iii) Three annual two-day trips to attend Department briefings, Department-sponsored conferences, and other meetings, as requested by OSEP; and

(3) Include, in the budget, a line item for an annual set-aside of five percent of the grant amount to support emerging needs that are consistent with the proposed project's intended outcomes, as those needs are identified in consultation with, and approved by, the OSEP project officer. With approval from the OSEP project officer, the project must reallocate any remaining funds from this annual set-aside no later than the end of the third quarter of each budget period;

(4) Provide an assurance that it will maintain a high-quality website, with an easy-to-navigate design, that meets government or industry-recognized standards for accessibility;

(5) Include, in Appendix A, an assurance to assist OSEP with the transfer of pertinent resources and products and to maintain the continuity of services to States during the transition to a new award at the end of this award period, as appropriate; and

(6) Budget at least 50 percent of the grant award, in years three through five, for providing targeted and intensive TA to States.

Program Authority: 20 U.S.C. 1411(c), 1416(i), 1418(c), 1418(d), 1442, 1482; Further Consolidated Appropriations Act, 2024, Public Law 118–47, Division D, Title III, 138 Stat. 460, 685 (2024).

Note: Projects will be awarded and must be operated in a manner consistent with the nondiscrimination requirements contained in Federal civil rights laws.

[5] A ''third-party'' evaluator is an independent and impartial program evaluator who is contracted by the grantee to conduct an objective evaluation of the project. This evaluator must not have participated in the development or implementation of any project activities, except for the evaluation activities, nor have any financial interest in the outcome of the evaluation.

Applicable Regulations: (a) The Education Department General Administrative Regulations in 34 CFR parts 75, 77, 79, 81, 82, 84, 86, 97, 98, and 99. (b) The Office of Management and Budget (OMB) Guidelines to Agencies on Governmentwide Debarment and Suspension (Nonprocurement) in 2 CFR part 180, as adopted and amended as regulations of the Department in 2 CFR part 3485. (c) The Guidance for Federal Financial Assistance in 2 CFR part 200, as adopted and amended as regulations of the Department in 2 CFR part 3474. (d) 34 CFR 300.702. (e) The NFP.

Note: The regulations in 34 CFR part 79 apply to all applicants except federally recognized Indian Tribes.

Note: The regulations in 34 CFR part 86 apply to institutions of higher education (IHEs) only.

II. Award Information

Type of Award: Cooperative agreement.

Estimated Available Funds: $2,700,000.

Contingent upon the availability of funds and the quality of applications, we may make additional awards in FY 2026 from the list of unfunded applications from this competition.

Maximum Award: We will not make an award exceeding $2,700,000 for a single budget period of 12 months.

Estimated Number of Awards: 1.

Note: The Department is not bound by any estimates in this notice.

Project Period: Up to 60 months.

III. Eligibility Information

1. *Eligible Applicants:* SEAs; State lead agencies under Part C of the IDEA; LEAs, including public charter schools that are considered LEAs under State law; IHEs; other public agencies; private nonprofit organizations; freely associated States and outlying areas; Indian Tribes or Tribal organizations; and for-profit organizations.

2. a. *Cost Sharing or Matching:* This competition does not require cost sharing or matching.

b. *Indirect Cost Rate Information:* This program uses an unrestricted indirect cost rate. For more information regarding indirect costs, or to obtain a negotiated indirect cost rate, please see *www.ed.gov/about/ed-offices/ofo#Indirect-Cost-Division.*

c. *Administrative Cost Limitation:* This program does not include any program-specific limitation on administrative expenses. All administrative expenses must be reasonable and necessary and conform to Cost Principles described in 2 CFR part 200 subpart E of the Guidance for Federal Financial Assistance.

3. *Subgrantees:* Under 34 CFR 75.708(b) and (c), a grantee under this competition may award subgrants—to directly carry out project activities described in its application—to the following types of entities: IHEs, nonprofit organizations suitable to carry out the activities proposed in the application, and other public agencies. The grantee may award subgrants to entities it has identified in an approved application or that it selects through a competition under procedures established by the grantee, consistent with 34 CFR 75.708(b)(2).

4. *Other General Requirements:*

(a) Recipients of funding under this competition must make positive efforts to employ and advance in employment qualified individuals with disabilities (see section 606 of IDEA).

(b) Applicants for, and recipients of, funding must, with respect to the aspects of their proposed project relating to the absolute priority, involve individuals with disabilities, or parents of individuals with disabilities ages birth through 26, in planning, implementing, and evaluating the project (see section 682(a)(1)(A) of IDEA).

IV. Application and Submission Information

1. *Application Submission Instructions:* Applicants are required to follow the Common Instructions for Applicants to Department of Education Discretionary Grant Programs, published in the **Federal Register** on December 23, 2024 (89 FR 104528), and available at *www.federalregister.gov/documents/2024/12/23/2024-30488/common-instructions-for-applicants-to-department-of-education-discretionary-grant-programs,* which contain requirements and information on how to submit an application.

2. *Intergovernmental Review:* This competition is subject to Executive Order 12372 and the regulations in 34 CFR part 79. Information about Intergovernmental Review of Federal Programs under Executive Order 12372 is in the application package for this competition. Please note that, under 34 CFR 79.8(a), we have shortened the standard 60-day intergovernmental review period in order to make awards by the end of FY 2025.

3. *Funding Restrictions:* We reference regulations outlining funding restrictions in the *Applicable Regulations* section of this notice.

4. *Recommended Page Limit:* The application narrative is where you, the applicant, address the selection criteria that reviewers use to evaluate your application. We recommend that you (1) limit the application narrative to no more than 70 pages and (2) use the following standards:

- A ''page'' is 8.5″ x 11″, on one side only, with 1″ margins at the top, bottom, and both sides.
- Double-space (no more than three lines per vertical inch) all text in the application narrative, including titles, headings, footnotes, quotations, reference citations, and captions, as well as all text in charts, tables, figures, graphs, and screen shots.
- Use a font that is 12 point or larger.
- Use one of the following fonts: Times New Roman, Courier, Courier New, or Arial.

The recommended page limit does not apply to the cover sheet; the budget section, including the narrative budget justification; the assurances and certifications; or the abstract (follow the guidance provided in the application package for completing the abstract), the table of contents, the list of priority requirements, the resumes, the reference list, the letters of support, or the appendices. However, the recommended page limit does apply to all of the application narrative, including all text in charts, tables, figures, graphs, and screen shots.

V. Application Review Information

1. *Selection Criteria:* The selection criteria for this competition are from 34 CFR 75.210 and are as follows:

(a) *Significance (10 points).*

The Secretary considers the significance of the proposed project. In determining the significance of the proposed project, the Secretary considers the following factors:

(1) The extent to which the specific nature and magnitude of gaps or challenges are identified and the extent to which these gaps or challenges will be addressed by the services, supports, infrastructure, or opportunities described in the proposed project.

(2) The importance or magnitude of the results or outcomes likely to be attained by the proposed project, especially contributions toward improving teaching practice and student learning and achievement.

(b) *Quality of the project design (35 points).*

The Secretary considers the quality of the design of the proposed project. In determining the quality of the design of the proposed project, the Secretary considers the following factors:

(1) The extent to which the goals, objectives, and outcomes to be achieved by the proposed project are clearly specified, measurable, and ambitious yet achievable within the project period,

and aligned with the purposes of the grant program.

(2) The quality of the logic model or other conceptual framework underlying the proposed project, including how inputs are related to outcomes.

(3) The extent to which the services to be provided by the proposed project reflect up-to-date knowledge and an evidence-based project component.

(4) The extent to which the training or professional development services to be provided by the proposed project are of sufficient quality, intensity, and duration to build recipient and project capacity in ways that lead to improvements in practice among the recipients of those services.

(5) The extent to which the services to be provided by the proposed project involve the use of efficient strategies, including the use of technology, as appropriate, and the leveraging of non-project resources.

(c) *Quality of the project evaluation or other evidence-building (20 points).*

The Secretary considers the quality of the evaluation or other evidence-building of the proposed project. In determining the quality of the evaluation or other evidence-building, the Secretary considers the following factors:

(1) The extent to which the methods of evaluation or other evidence-building are thorough, feasible, relevant, and appropriate to the goals, objectives, and outcomes of the proposed project.

(2) The extent to which the methods of evaluation or other evidence-building are designed to measure the fidelity of implementation of the project.

(3) The extent to which the methods of evaluation or other evidence-building will provide performance feedback and provide formative, diagnostic, or interim data that is a periodic assessment of progress toward achieving intended outcomes.

(4) The extent to which the methods of evaluation or other evidence-building include the use of objective performance measures that are clearly related to the intended outcomes of the project and will produce quality data that are quantitative and qualitative.

(d) *Adequacy of resources (15 points).*

The Secretary considers the adequacy of resources for the proposed project. In determining the adequacy of resources for the proposed project, the Secretary considers the following factors:

(1) The qualifications, including relevant training and experience, of project consultants or subcontractors.

(2) The extent to which the evaluator has the qualifications, including the relevant training, experience, and independence, required to conduct an evaluation of the proposed project, including experience conducting evaluations of similar methodology as proposed and with evaluations for the proposed population and setting.

(3) The adequacy of support for the project, including facilities, equipment, supplies, and other resources, from the applicant or the lead applicant organization.

(4) The relevance and demonstrated commitment of each partner in the proposed project to the implementation and success of the project.

(5) The extent to which the budget is adequate to support the proposed project and the costs are reasonable in relation to the objectives, design, and potential significance of the proposed project.

(e) *Quality of the management plan (20 points).*

The Secretary considers the quality of the management plan for the proposed project. In determining the quality of the management plan for the proposed project, the Secretary considers the following factors:

(1) The feasibility of the management plan to achieve project objectives and goals on time and within budget, including clearly defined responsibilities, timelines, and milestones for accomplishing project tasks.

(2) The extent to which the time commitments of the project director and principal investigator and other key project personnel are appropriate and adequate to meet the objectives of the proposed project.

(3) The extent to which the project director or principal investigator, when hired, has the qualifications required for the project, including formal training or work experience in fields related to the objectives of the project and experience in designing, managing, or implementing similar projects for the target population to be served by the project.

(4) The extent to which the key personnel in the project, when hired, have the qualifications required for the proposed project, including formal training or work experience in fields related to the objectives of the project, and represent or have lived experiences of the target population.

(5) The adequacy of mechanisms for ensuring high-quality and accessible products and services from the proposed project for the target population.

2. *Review and Selection Process:* We remind potential applicants that in reviewing applications in any discretionary grant competition, the Secretary may consider, under 34 CFR 75.217(d)(3), the past performance of the applicant in carrying out a previous award, such as the applicant's use of funds, achievement of project objectives, and compliance with grant conditions. The Secretary may also consider whether the applicant failed to submit a timely performance report or submitted a report of unacceptable quality.

In addition, in making a competitive grant award, the Secretary requires various assurances, including those applicable to Federal civil rights laws that prohibit discrimination in programs or activities receiving Federal financial assistance from the Department (34 CFR 100.4, 104.5, 106.4, 108.8, and 110.23).

In the event there are two or more applications with the same final score, and there are insufficient funds to fully support each of these applications, the scores under selection criterion (b) *Quality of the project design* will be used as a tiebreaker. If the scores remain tied, then the scores under selection criterion (d) *Adequacy of resources* will be used to break the tie.

3. *Additional Review and Selection Process Factors:* In the past, the Department has had difficulty finding peer reviewers for certain competitions because so many individuals who are eligible to serve as peer reviewers have conflicts of interest. The standing panel requirements under section 682(b) of IDEA also have placed additional constraints on the availability of reviewers. Therefore, the Department has determined that for some discretionary grant competitions, applications may be separated into two or more groups and ranked and selected for funding within specific groups. This procedure will make it easier for the Department to find peer reviewers by ensuring that greater numbers of individuals who are eligible to serve as reviewers for any particular group of applicants will not have conflicts of interest. It also will increase the quality, independence, and fairness of the review process, while permitting panel members to review applications under discretionary grant competitions for which they also have submitted applications.

4. *Risk Assessment and Specific Conditions:* Consistent with 2 CFR 200.206, before awarding grants under this competition the Department conducts a review of the risks posed by applicants. Under 2 CFR 200.208, the Secretary may impose specific conditions and, under 2 CFR 3474.10, in appropriate circumstances, high-risk conditions on a grant if the applicant or grantee is not financially stable; has a history of unsatisfactory performance;

has a financial or other management system that does not meet the standards in 2 CFR part 200, subpart D; has not fulfilled the conditions of a prior grant; or is otherwise not responsible.

5. *Integrity and Performance System:* If you are selected under this competition to receive an award that over the course of the project period may exceed the simplified acquisition threshold (currently $250,000), we must make a judgment about your integrity, business ethics, and record of performance under Federal awards—that is, the risk posed by you as an applicant—before we make an award. In doing so, we must consider any information about you that is in the System for Award Management's (SAM) Responsibility/Qualification reports (formerly referred to as the Federal Awardee Performance and Integrity Information System (FAPIIS)). You may review and comment on any information about yourself that a Federal agency previously entered and that is currently in the Responsibility/Qualification reports in SAM.

If the total value of your currently active grants, cooperative agreements, and procurement contracts from the Federal Government exceeds $10,000,000, the reporting requirements in 2 CFR part 200, Appendix XII, require you to report certain integrity information to SAM semiannually. Please review these requirements if this grant plus all the other Federal funds you receive exceed $10,000,000.

6. *In General:* In accordance with the Guidance for Federal Financial Assistance located at 2 CFR part 200, all applicable Federal laws, and relevant Executive guidance, the Department will review and consider applications for funding pursuant to this notice inviting applications in accordance with—

(a) Selecting recipients most likely to be successful in delivering results based on the program objectives through an objective process of evaluating Federal award applications (2 CFR 200.205);

(b) Prohibiting the purchase of certain telecommunication and video surveillance services or equipment in alignment with section 889 of the National Defense Authorization Act of 2019 (Pub. L. 115–232) (2 CFR 200.216);

(c) Providing a preference, to the extent permitted by law, to maximize use of goods, products, and materials produced in the United States (2 CFR 200.322); and

(d) Terminating agreements in whole or in part to the greatest extent authorized by law if an award no longer effectuates the program goals or agency priorities (2 CFR 200.340).

VI. Award Administration Information

1. *Award Notices:* If your application is successful, we notify your U.S. Representative and U.S. Senators and send you a Grant Award Notification (GAN), or we may send you an email containing a link to access an electronic version of your GAN. We also may notify you informally.

If your application is not evaluated or not selected for funding, we notify you.

2. *Administrative and National Policy Requirements:* We identify administrative and national policy requirements in the application package and reference these and other requirements in the *Applicable Regulations* section of this notice.

We reference the regulations outlining the terms and conditions of an award in the *Applicable Regulations* section of this notice and include these and other specific conditions in the GAN. The GAN also incorporates your approved application as part of your binding commitments under the grant.

3. *Open Licensing Requirements:* Unless an exception applies, if you are awarded a grant under this competition, you will be required to openly license to the public grant deliverables created in whole, or in part, with Department grant funds. When the deliverable consists of modifications to pre-existing works, the license extends only to those modifications that can be separately identified and only to the extent that open licensing is permitted under the terms of any licenses or other legal restrictions on the use of pre-existing works. Additionally, a grantee that is awarded competitive grant funds must have a plan to disseminate these public grant deliverables. This dissemination plan can be developed and submitted after your application has been reviewed and selected for funding. For additional information on the open licensing requirements please refer to 2 CFR 3474.20.

4. *Reporting:* (a) If you apply for a grant under this competition, you must ensure that you have in place the necessary processes and systems to comply with the reporting requirements in 2 CFR part 170 should you receive funding under the competition. This does not apply if you have an exception under 2 CFR 170.110(b).

(b) At the end of your project period, you must submit a final performance report, including financial information, as directed by the Secretary. If you receive a multiyear award, you must submit an annual performance report that provides the most current performance and financial expenditure information as directed by the Secretary under 34 CFR 75.118. The Secretary may also require more frequent performance reports under 34 CFR 75.720(c). For specific requirements on reporting, please go to *www.ed.gov/fund/grant/apply/appforms/appforms.html*.

5. *Performance Measures:* For the purposes of Department reporting under 34 CFR 75.110, the Department has established a set of performance measures that are designed to yield information on various aspects of the effectiveness and quality of the Technical Assistance on State Data Collection program. These measures are:

- *Program Performance Measure #1:* The percentage of TA and dissemination products and services deemed to be of high quality by an independent review panel of experts qualified or individuals with appropriate expertise to review the substantive content of the products and services.
- *Program Performance Measure #2:* The percentage of TA and dissemination products and services deemed by an independent review panel of qualified experts or members of the target audiences to be of high relevance to educational and early intervention policy or practice.
- *Program Performance Measure #3:* The percentage of TA and dissemination products and services deemed by an independent review panel of qualified experts or members of the target audiences to be useful in improving educational or early intervention policy or practice.
- *Program Performance Measure #4:* The cost efficiency of the Technical Assistance on State Data Collection Program includes the percentage of milestones achieved in the current annual performance report period and the percentage of funds spent during the current fiscal year.

The measures apply to projects funded under this competition, and grantees are required to submit data on these measures as directed by OSEP.

Grantees will be required to report information on their project's performance in annual and final performance reports to the Department (34 CFR 75.590).

The Department will also closely monitor the extent to which the products and services provided by the project meet needs identified by stakeholders and may require the project to report on such alignment in its annual and final performance reports.

6. *Continuation Awards:* In making a continuation award under 34 CFR 75.253, the Secretary considers, among other things: whether a grantee has

made substantial progress in achieving the goals and objectives of the project; whether the grantee has expended funds in a manner that is consistent with its approved application and budget; if the Secretary has established performance measurement requirements, whether the grantee has made substantial progress in achieving the performance targets in the grantee's approved application; and whether the continuation of the project is in the best interest of the Federal Government.

In making a continuation award, the Secretary also considers whether the grantee is operating in compliance with the assurances in its approved application, including those applicable to Federal civil rights laws that prohibit discrimination in programs or activities receiving Federal financial assistance from the Department (34 CFR 100.4, 104.5, 106.4, 108.8, and 110.23).

VII. Other Information

Accessible Format: On request to the program contact person listed under **FOR FURTHER INFORMATION CONTACT**, individuals with disabilities can obtain this document and a copy of the application package in an accessible format. The Department will provide the requestor with an accessible format that may include Rich Text Format (RTF) or text format (txt), a thumb drive, an MP3 file, braille, large print, audiotape, compact disc, or other accessible format.

Electronic Access to This Document: The official version of this document is the document published in the **Federal Register**. You may access the official edition of the **Federal Register** and the Code of Federal Regulations at *www.govinfo.gov.* At this site you can view this document, as well as all other Department documents published in the **Federal Register**, in text or Portable Document Format (PDF). To use PDF you must have Adobe Acrobat Reader, which is available free at the site.

You may also access Department documents published in the **Federal Register** by using the article search feature at *www.federalregister.gov.* Specifically, through the advanced search feature at this site, you can limit your search to documents published by the Department.

Diana Diaz,

Deputy Assistant Secretary and Acting Assistant Secretary for Special Education and Rehabilitative Services.

[FR Doc. 2025–11610 Filed 6–24–25; 8:45 am]

BILLING CODE 4000–01–P

DEPARTMENT OF ENERGY

Agency Information Collection Extension

AGENCY: Office of Science, Department of Energy.

ACTION: Notice of request for comments.

SUMMARY: The Department of Energy (DOE) invites public comment on a proposed collection of certain information that DOE is developing for submission to the Office of Management and Budget (OMB) pursuant to the Paperwork Reduction Act (PRA) of 1995.

DATES: Comments regarding this proposed information collection must be received on or before July 25, 2025. If you anticipate that you will be submitting comments but find it difficult to do so within the period of time allowed by this notice, please advise the DOE Desk Officer at OMB of your intention to make a submission as soon as possible. The Desk Officer may be contacted at (202) 395–4718.

ADDRESSES: Written comments may be sent to the Office of Workforce Development for Teachers and Scientists (WDTS), U.S. Department of Energy, 1000 Independence Avenue SW, Washington, DC 20585, or by email at *sc.wdts@science.doe.gov.*

FOR FURTHER INFORMATION CONTACT: Dr. Ping Ge, Office of Workforce Development for Teachers and Scientists (WDTS), U.S. Department of Energy, 1000 Independence Avenue SW, Washington, DC 20585; (202) 287–6490; *sc.wdts@science.doe.gov.*

SUPPLEMENTARY INFORMATION: Under the PRA of 1995 (Pub. L. 104–13; 44 U.S.C. 3501–3521), Federal agencies must obtain approval from OMB for each collection of information they conduct or sponsor. This request for comment is being made pursuant to Section 3506(c)(2)(A) of the PRA. With respect to the following collection of information, DOE invites comments are invited on: (a) Whether the extended collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used; (c) ways to enhance the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology.

This information collection request contains:

(1) OMB No.: 1910–NEW;

(2) Information Collection Request Title: Office of Workforce Development for Teachers and Scientists (WDTS) Science Undergraduate Laboratory Internship (SULI) Program Longer-Term Follow-up Study;

(3) Type of Request: New;

(4) Purpose: The WDTS SULI Longer-Term Follow-up Study will examine the longer-term impact of SULI on participants' educational and career outcomes. This will allow for program development based on longer-term outcomes. Respondents include SULI participants and a comparison group of eligible applicants who did not participate in the SULI internship.

(5) Annual Estimated Number of Respondents: 2,400;

(6) Annual Estimated Number of Total Responses: 2,400;

(7) Annual Estimated Number of Burden Hours: 1,400;

(8) Annual Estimated Reporting and Recordkeeping Cost Burden: $93,115.

Statutory Authority: Energy and Water Development and Related Agencies Appropriations Act, 2024, continued through Full-Year Continuing Appropriations and Extensions Act, 2025 (Pub. L. 119–4, March 15, 2025).

Signing Authority

This document of the Department of Energy was signed on June 18, 2025, by Harriet Kung, Acting Director, Office of Science, pursuant to delegated authority from the Secretary of Energy. The document with the original signature and date is maintained by DOE. For administrative purposes only, and in compliance with requirements of the Office of the Federal Register, the undersigned DOE Federal Register Liaison Officer has been authorized to sign and submit the document in electronic format for publication, as an official document of the Department of Energy. This administrative process in no way alters the legal effect of this document upon publication in the **Federal Register**.

Signed in Washington, DC, on June 23, 2025.

Jennifer Hartzell,

Alternate Federal Register Liaison Officer, U.S. Department of Energy.

[FR Doc. 2025–11707 Filed 6–24–25; 8:45 am]

BILLING CODE 6450–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

Combined Notice of Filings #2

Take notice that the Commission received the following electric rate filings:

Docket Numbers: ER24–792–002.
Applicants: PJM Interconnection, L.L.C.
Description: Tariff Amendment: Amendment of WMPA, SA No. 6731; AE2–248 in Docket No. er24–792 to be effective 8/20/2025.
Filed Date: 6/20/25.
Accession Number: 20250620–5379.
Comment Date: 5 p.m. ET 7/11/25.

Docket Numbers: ER25–2559–000.
Applicants: Alabama Power Company, Georgia Power Company, Mississippi Power Company.
Description: 205(d) Rate Filing: Alabama Power Company submits tariff filing per 35.13(a)(2)(iii: Peach Grove BESS LGIA Filing to be effective 6/10/2025.
Filed Date: 6/20/25.
Accession Number: 20250620–5308.
Comment Date: 5 p.m. ET 7/11/25.

Docket Numbers: ER25–2560–000.
Applicants: American Transmission Systems, Incorporated.
Description: 205(d) Rate Filing: ATSI submits revised SA No. 3995 to be effective 8/20/2025.
Filed Date: 6/20/25.
Accession Number: 20250620–5310.
Comment Date: 5 p.m. ET 7/11/25.

Docket Numbers: ER25–2561–000.
Applicants: IP Energy Marketing, LLC.
Description: Initial Rate Filing: Application for MBR Authorization to be effective 8/20/2025.
Filed Date: 6/20/25.
Accession Number: 20250620–5324.
Comment Date: 5 p.m. ET 7/11/25.

The filings are accessible in the Commission's eLibrary system (*https://elibrary.ferc.gov/idmws/search/fercgensearch.asp*) by querying the docket number.

Any person desiring to intervene, to protest, or to answer a complaint in any of the above proceedings must file in accordance with Rules 211, 214, or 206 of the Commission's Regulations (18 CFR 385.211, 385.214, or 385.206) on or before 5:00 p.m. Eastern time on the specified comment date. Protests may be considered, but intervention is necessary to become a party to the proceeding.

eFiling is encouraged. More detailed information relating to filing requirements, interventions, protests, service, and qualifying facilities filings can be found at:

http://www.ferc.gov/docs-filing/efiling/filing-req.pdf. For other information, call (866) 208–3676 (toll free). For TTY, call (202) 502–8659.

The Commission's Office of Public Participation (OPP) supports meaningful public engagement and participation in Commission proceedings. OPP can help members of the public, including landowners, community organization, Tribal members and others, access publicly available information and navigate Commission processes. For public inquiries and assistance with making filings such as interventions, comments, or requests for rehearing, the public is encouraged to contact OPP at (202) 502–6595 or *OPP@ferc.gov.*

Dated: June 20, 2025.

Debbie-Anne A. Reese,

Secretary.

[FR Doc. 2025–11680 Filed 6–24–25; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

Combined Notice of Filings

Take notice that the Commission has received the following Natural Gas Pipeline Rate and Refund Report filings:

Filings Instituting Proceedings

Docket Numbers: RP25–956–000.
Applicants: Mountain Valley Pipeline, LLC.
Description: 4(d) Rate Filing: Negotiated Rate Agreement—6/19/2025 to be effective 6/19/2025.
Filed Date: 6/20/25.
Accession Number: 20250620–5025.
Comment Date: 5 p.m. ET 7/2/25.

Docket Numbers: RP25–957–000.
Applicants: Equitrans, L.P.
Description: 4(d) Rate Filing: Negotiated Rate Agreement—07/01/2025 to be effective 7/1/2025.
Filed Date: 6/20/25.
Accession Number: 20250620–5036.
Comment Date: 5 p.m. ET 7/2/25.

Docket Numbers: RP25–958–000.
Applicants: B–R Pipeline, LLC.
Description: Compliance filing: B–R Pipeline NAESB Order No. 587–AA Compliance Filing to be effective 8/1/2025.
Filed Date: 6/20/25.
Accession Number: 20250620–5039.
Comment Date: 5 p.m. ET 7/2/25.

Docket Numbers: RP25–959–000.
Applicants: USG Pipeline Company, LLC.
Description: Compliance filing: USG Pipeline Order No. 587–AA Compliance Filing to be effective 8/1/2025.
Filed Date: 6/20/25.
Accession Number: 20250620–5040.
Comment Date: 5 p.m. ET 7/2/25.

Docket Numbers: RP25–960–000.
Applicants: Texas Eastern Transmission, LP.
Description: Compliance filing: TETLP June 2025 Penalty Disbursement Report to be effective N/A.
Filed Date: 6/20/25.
Accession Number: 20250620–5261.
Comment Date: 5 p.m. ET 7/2/25.

Any person desiring to intervene, to protest, or to answer a complaint in any of the above proceedings must file in accordance with Rules 211, 214, or 206 of the Commission's Regulations (18 CFR 385.211, 385.214, or 385.206) on or before 5:00 p.m. Eastern time on the specified comment date. Protests may be considered, but intervention is necessary to become a party to the proceeding.

Filings in Existing Proceedings

Docket Numbers: RP24–514–000.
Applicants: Great Basin Gas Transmission Company.
Description: Refund Report: Rate Case Refund Report to be effective N/A.
Filed Date: 6/20/25.
Accession Number: 20250620–5037.
Comment Date: 5 p.m. ET 7/2/25.

Docket Numbers: RP24–780–008.
Applicants: Maritimes & Northeast Pipeline, L.L.C.
Description: Compliance filing: MNUS Settlement Compliance Filing—Docket No. RP24–780 to be effective 6/1/2025.
Filed Date: 6/20/25.
Accession Number: 20250620–5243.
Comment Date: 5 p.m. ET 7/2/25.

Docket Numbers: RP24–781–010.
Applicants: Algonquin Gas Transmission, LLC.
Description: Compliance filing: AGT Settlement Compliance Filing—Docket No. RP24–781 to be effective 6/1/2025.
Filed Date: 6/20/25.
Accession Number: 20250620–5042.
Comment Date: 5 p.m. ET 7/2/25.

Docket Numbers: RP25–844–003.
Applicants: East Tennessee Natural Gas, LLC.
Description: Compliance filing: Revised Rate Case Ministerial Filing (RP25–844) to be effective 6/1/2025.
Filed Date: 6/20/25.
Accession Number: 20250620–5024.
Comment Date: 5 p.m. ET 7/2/25.

Any person desiring to protest in any the above proceedings must file in accordance with Rule 211 of the Commission's Regulations (18 CFR

385.211) on or before 5:00 p.m. Eastern time on the specified comment date.

The filings are accessible in the Commission's eLibrary system (*https://elibrary.ferc.gov/idmws/search/fercgensearch.asp*) by querying the docket number.

eFiling is encouraged. More detailed information relating to filing requirements, interventions, protests, service, and qualifying facilities filings can be found at: *http://www.ferc.gov/docs-filing/efiling/filing-req.pdf.* For other information, call (866) 208–3676 (toll free). For TTY, call (202) 502–8659.

The Commission's Office of Public Participation (OPP) supports meaningful public engagement and participation in Commission proceedings. OPP can help members of the public, including landowners, community organizations, Tribal members and others, access publicly available information and navigate Commission processes.

For public inquiries and assistance with making filings such as interventions, comments, or requests for rehearing, the public is encouraged to contact OPP at (202) 502–6595 or *OPP@ferc.gov.*

Dated: June 20, 2025.

Debbie-Anne A. Reese,

Secretary.

[FR Doc. 2025–11681 Filed 6–24–25; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. EL25–93–000]

Hillcrest Solar I, LLC; Notice of Institution of Section 206 Proceeding and Refund Effective Date

On June 18, 2025, the Commission issued an order in Docket No. EL25–93–000, pursuant to section 206 of the Federal Power Act (FPA), 16 U.S.C. 824e, instituting an investigation to determine whether Hillcrest Solar I, LLC's Rate Schedule is unjust, unreasonable, unduly discriminatory or preferential, or otherwise unlawful. *Hillcrest Solar I, LLC,* 191 FERC ¶ 61,210 (2025).

The refund effective date in Docket No. EL25–93–000 established pursuant to section 206(b) of the FPA, will be the date of publication of this notice in the **Federal Register**.

Any interested person desiring to be heard in Docket No. EL25–93–000 must file a notice of intervention or motion to intervene, as appropriate, with the Federal Energy Regulatory Commission, in accordance with Rule 214 of the Commission's Rules of Practice and Procedure, 18 CFR 385.214 (2024), within 21 days of the date of issuance of the order.

In addition to publishing the full text of this document in the **Federal Register**, the Commission provides all interested persons an opportunity to view and/or print the contents of this document via the internet through the Commission's Home Page (*http://www.ferc.gov*) using the ''eLibrary'' link. Enter the docket number excluding the last three digits in the docket number field to access the document. From FERC's Home Page on the internet, this information is available on eLibrary. The full text of this document is available on eLibrary in PDF and Microsoft Word format for viewing, printing, and/or downloading. To access this document in eLibrary, type the docket number excluding the last three digits of this document in the docket number field. User assistance is available for eLibrary and the FERC's website during normal business hours from FERC Online Support at 202–502–6652 (toll free at 1–866–208–3676) or email at *ferconlinesupport@ferc.gov,* or the Public Reference Room at (202) 502–8371, TTY (202) 502–8659. Email the Public Reference Room at *public.referenceroom@ferc.gov.*

The Commission strongly encourages electronic filings of comments, protests and interventions in lieu of paper using the ''eFile'' link at *http://www.ferc.gov.* In lieu of electronic filing, you may submit a paper copy. Submissions sent via the U.S. Postal Service must be addressed to: Debbie-Anne A. Reese, Secretary, Federal Energy Regulatory Commission, 888 First Street NE, Room 1A, Washington, DC 20426. Submissions sent via any other carrier must be addressed to: Debbie-Anne A. Reese, Secretary, Federal Energy Regulatory Commission, 12225 Wilkins Avenue, Rockville, Maryland 20852.

The Commission's Office of Public Participation (OPP) supports meaningful public engagement and participation in Commission proceedings. OPP can help members of the public, including landowners, community organizations, Tribal members and others, access publicly available information and navigate Commission processes. For public inquiries and assistance with making filings such as interventions, comments, or requests for rehearing, the public is encouraged to contact OPP at (202) 502–6595 or *OPP@ferc.gov.*

Dated: June 20, 2025.

Debbie-Anne A. Reese,

Secretary.

[FR Doc. 2025–11676 Filed 6–24–25; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

Combined Notice of Filings #1

Take notice that the Commission received the following electric corporate filings:

Docket Numbers: EC25–97–000.

Applicants: Beaver Falls, L.L.C., Fairless Energy, L.L.C., Garrison Energy Center LLC, Greenleaf Energy Unit 2 LLC, Hazleton Generation LLC, Manchester Street, L.L.C., Syracuse, L.L.C., Vistra Corp.

Description: Joint Application for Authorization Under Section 203 of the Federal Power Act of Beaver Falls, L.L.C., et al.

Filed Date: 6/6/25.

Accession Number: 20250606–5249.

Comment Date: 5 p.m. ET 8/5/25.

Take notice that the Commission received the following electric rate filings:

Docket Numbers: ER22–2303–002.

Applicants: Black Hills Power, Inc.

Description: Compliance filing: Amended Order No. 881 Compliance Filing to be effective 9/1/2026.

Filed Date: 6/20/25.

Accession Number: 20250620–5256.

Comment Date: 5 p.m. ET 7/11/25.

Docket Numbers: ER22–2306–002.

Applicants: Black Hills Colorado Electric, LLC.

Description: Compliance filing: Amended Order No. 881 Compliance Filing to be effective 9/1/2026.

Filed Date: 6/20/25.

Accession Number: 20250620–5238.

Comment Date: 5 p.m. ET 7/11/25.

Docket Numbers: ER22–2307–002.

Applicants: Cheyenne Light, Fuel and Power Company.

Description: Compliance filing: Amended Order No. 881 Compliance Filing to be effective 9/1/2026.

Filed Date: 6/20/25.

Accession Number: 20250620–5259.

Comment Date: 5 p.m. ET 7/11/25.

Docket Numbers: ER24–2567–003.

Applicants: Northern States Power Company, a Minnesota corporation.

Description: Tariff Amendment: 2025–06–19 CapX Brookings OMA—537—Errata to be effective 6/21/2024.

Filed Date: 6/20/25.

Accession Number: 20250620–5033.

Comment Date: 5 p.m. ET 7/11/25.

Docket Numbers: ER25–2025–001.

Applicants: Great Basin Transmission, LLC.

Description: Tariff Amendment: GBT Amended Tariff Filing to be effective 8/20/2025.

Filed Date: 6/20/25.

Accession Number: 20250620–5045.

Comment Date: 5 p.m. ET 7/11/25.

Docket Numbers: ER25–2544–000.

Applicants: Puget Sound Energy, Inc.

Description: 205(d) Rate Filing: BP Products North America—NITSA, NOA, IA to be effective 6/1/2025.

Filed Date: 6/18/25.

Accession Number: 20250618–5239.

Comment Date: 5 p.m. ET 7/9/25.

Docket Numbers: ER25–2545–000.

Applicants: PJM Interconnection, L.L.C.

Description: Tariff Amendment: Notice of Cancellation of WMPA, SA No. 6107; Queue No. AG1–318 to be effective 7/29/2025.

Filed Date: 6/18/25.

Accession Number: 20250618–5248.

Comment Date: 5 p.m. ET 7/9/25.

Docket Numbers: ER25–2546–000.

Applicants: Public Service Company of Colorado.

Description: 205(d) Rate Filing: 2025–06–19—PSC–HLYCRS–T–2023–3–SISA–781–0.0.0 to be effective 6/5/2025.

Filed Date: 6/20/25.

Accession Number: 20250620–5020.

Comment Date: 5 p.m. ET 7/11/25.

Docket Numbers: ER25–2547–000.

Applicants: Public Service Company of Colorado.

Description: 205(d) Rate Filing: 2025–06–19—WAPA—Att K1 SISA—Mt. Elbert Daytime Pum—882 0.0.0 to be effective 6/10/2025.

Filed Date: 6/20/25.

Accession Number: 20250620–5021.

Comment Date: 5 p.m. ET 7/11/25.

Docket Numbers: ER25–2548–000.

Applicants: McFarland Solar A, LLC.

Description: 205(d) Rate Filing: Second SFA amendment 2025 to be effective 6/23/2025.

Filed Date: 6/20/25.

Accession Number: 20250620–5043.

Comment Date: 5 p.m. ET 7/11/25.

Docket Numbers: ER25–2549–000.

Applicants: McFarland Solar A, LLC.

Description: 205(d) Rate Filing: Second LGIA Co-Tenancy Agreement 2025 to be effective 6/23/2025.

Filed Date: 6/20/25.

Accession Number: 20250620–5044.

Comment Date: 5 p.m. ET 7/11/25.

Docket Numbers: ER25–2550–000.

Applicants: McFarland Solar B, LLC.

Description: 205(d) Rate Filing: COC Shared Facilities Agreement 2025 to be effective 6/23/2025.

Filed Date: 6/20/25.

Accession Number: 20250620–5046.

Comment Date: 5 p.m. ET 7/11/25.

Docket Numbers: ER25–2551–000.

Applicants: McFarland Solar B, LLC.

Description: 205(d) Rate Filing: COC LGIA Co-Tenancy 2025 to be effective 6/23/2025.

Filed Date: 6/20/25.

Accession Number: 20250620–5047.

Comment Date: 5 p.m. ET 7/11/25.

Docket Numbers: ER25–2552–000.

Applicants: McFarland Storage C, LLC.

Description: 205(d) Rate Filing: COC Shared Facilities Agreement 2025 to be effective 6/23/2025.

Filed Date: 6/20/25.

Accession Number: 20250620–5048.

Comment Date: 5 p.m. ET 7/11/25.

Docket Numbers: ER25–2553–000.

Applicants: McFarland Storage C, LLC.

Description: 205(d) Rate Filing: COC LGIA Co-Tenancy 2025 to be effective 6/23/2025.

Filed Date: 6/20/25.

Accession Number: 20250620–5049.

Comment Date: 5 p.m. ET 7/11/25.

Docket Numbers: ER25–2554–000.

Applicants: PJM Interconnection, L.L.C.

Description: 205(d) Rate Filing: Amendment to ISA, Service Agreement No. 6116; Queue Position No. AE1–129 to be effective 8/20/2025.

Filed Date: 6/20/25.

Accession Number: 20250620–5094.

Comment Date: 5 p.m. ET 7/11/25.

Docket Numbers: ER25–2555–000.

Applicants: PJM Interconnection, L.L.C.

Description: 205(d) Rate Filing: NSA, Original Service Agreement No. 7707; Queue No. AE2–074 to be effective 8/20/2025.

Filed Date: 6/20/25.

Accession Number: 20250620–5151.

Comment Date: 5 p.m. ET 7/11/25.

Docket Numbers: ER25–2556–000.

Applicants: PJM Interconnection, L.L.C.

Description: Tariff Amendment: Notice of Cancellation of ISA, SA No. 7200; Queue No. AF1–114 to be effective 2/10/2025.

Filed Date: 6/20/25.

Accession Number: 20250620–5217.

Comment Date: 5 p.m. ET 7/11/25.

Docket Numbers: ER25–2557–000.

Applicants: Dunns Bridge Energy Storage, LLC.

Description: Tariff Amendment: Notice of Cancellation of Market-Based Rate Tariff to be effective 6/21/2025.

Filed Date: 6/20/25.

Accession Number: 20250620–5252.

Comment Date: 5 p.m. ET 7/11/25.

The filings are accessible in the Commission's eLibrary system (*https://elibrary.ferc.gov/idmws/search/fercgensearch.asp*) by querying the docket number.

Any person desiring to intervene, to protest, or to answer a complaint in any of the above proceedings must file in accordance with Rules 211, 214, or 206 of the Commission's Regulations (18 CFR 385.211, 385.214, or 385.206) on or before 5:00 p.m. Eastern time on the specified comment date. Protests may be considered, but intervention is necessary to become a party to the proceeding.

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The Commission's Office of Public Participation (OPP) supports meaningful public engagement and participation in Commission proceedings. OPP can help members of the public, including landowners, community organization, Tribal members and others, access publicly available information and navigate Commission processes. For public inquiries and assistance with making filings such as interventions, comments, or requests for rehearing, the public is encouraged to contact OPP at (202) 502–6595 or *OPP@ferc.gov.*

Dated: June 20, 2025.

Debbie-Anne A. Reese,

Secretary.

[FR Doc. 2025–11677 Filed 6–24–25; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Project No. 2614–042]

City of Hamilton, Ohio, American Municipal Power, Inc.; Notice Soliciting Scoping Comments

Take notice that the following hydroelectric application has been filed with the Commission and is available for public inspection.

a. *Type of Application:* New Major License.

b. *Project No.:* P–2614–042.

c. *Date filed:* February 21, 2024.

d. *Applicants:* City of Hamilton, Ohio (City of Hamilton) and American Municipal Power, Inc. (American Municipal).

e. *Name of Project:* Greenup Hydroelectric Project (Greenup Project).

f. *Location:* The Greenup Project is located at the U.S. Army Corps of Engineers' (Corps) Greenup Locks and Dam on the Ohio River near the Town of Franklin Furnace in Scioto County, Ohio and Greenup County, Kentucky. The project occupies 12.74 acres of federal land administered by the Corps.

g. *Filed Pursuant to:* Federal Power Act 16 U.S.C. 791(a)–825(r).

h. *Applicant Contact:* Jeff Martin, City of Hamilton, Ohio, 9505 West Mary Ingles Highway (KY Route 8), Foster, KY 41043; (606) 747–6103; *greenuplicensing@hamilton-oh.gov* and John McGreevy, American Municipal Power, Inc., 1111 Schrock Road, Columbus, OH 43229; (614) 540–1111; *greenuplicensing@hamilton-oh.gov.*

i. *FERC Contact:* Twyla Cheatwood, Project Coordinator, Midwest Branch, Division of Hydropower Licensing; telephone at (202) 502–8066; email at *Twyla.cheatwood@ferc.gov*.

j. *Deadline for filing scoping comments:* July 21, 2025 by 5 p.m. Eastern Time.

The Commission strongly encourages electronic filing. Please file motions to intervene and protests and requests for cooperating status using the Commission's eFiling system at *https://ferconline.ferc.gov/FERCOnline.aspx.* For assistance, please contact FERC Online Support at *FERCOnlineSupport@ferc.gov,* (866) 208–3676 (toll free), or (202) 502–8659 (TTY). In lieu of electronic filing, you may submit a paper copy. Submissions sent via the U.S. Postal Service must be addressed to: Debbie-Anne A. Reese, Secretary, Federal Energy Regulatory Commission, 888 First Street NE, Room 1A, Washington, DC 20426. Submissions sent via any other carrier must be addressed to: Debbie-Anne A. Reese, Secretary, Federal Energy Regulatory Commission, 12225 Wilkins Avenue, Rockville, Maryland 20852. All filings must clearly identify the project name and docket number on the first page: Greenup Hydroelectric Project (P–2614–042).

The Commission's Rules of Practice require all intervenors filing documents with the Commission to serve a copy of that document on each person on the official service list for the project. Further, if an intervenor files comments or documents with the Commission relating to the merits of an issue that may affect the responsibilities of a particular resource agency, they must also serve a copy of the document on that resource agency.

k. This application is not ready for environmental analysis at this time.

l. *Project Description:* The Greenup Project is located at the Corps' existing Greenup Locks and Dam and consist of the following existing facilities: (1) a 125-foot-long, 145-foot-wide reinforced concrete intake channel with sloped bottom and vertical left and right bank concrete walls; (2) three 39-foot-wide intakes equipped with trashracks having a clear bar spacing of 5.9 inches; (3) a 145-foot-wide and 190-foot-long powerhouse consisting of a steel-plate enclosure with concrete filled bulkhead walls located on the east (right) end of the dam, with a combined capacity of 70.27 megawatts; (4) a 125-foot-long and 145-foot-wide reinforced concrete tailrace channel with sloped bottom and vertical left and right bank concrete walls; (5) a 10-foot-wide gravity dam between the left wall of the intake channel and gated spillway which acts as an uncontrolled spillway during open river (flood) conditions; and (6) a steel sheet pile wall that stabilizes the right (east) bank.

The Greenup Project currently operates in a run-of-release mode with releases made in accordance with the Operating Agreement between the licensees and the Corps. The project has an estimated average annual energy production of 263,596 megawatt-hours. City of Hamilton and American Power do not propose any new construction and propose to continue operating the project in a run-of-release mode.

m. The application can be viewed on the Commission's website at *https://www.ferc.gov* using the ''eLibrary'' link. Enter the project's docket number, excluding the last three digits in the docket number field to access the document (P–8315). For assistance, contact FERC Online Support at *FERCOnlineSupport@ferc.gov,* or call (866) 208–3676 (toll-free) or (202) 502 8659 (TTY).

You may also register online at *http://www.ferc.gov/docs-filing/esubscription.asp* to be notified via email of new filings and issuances related to this or other pending projects. For assistance, contact FERC Online Support.

n. The Commission's Office of Public Participation (OPP) supports meaningful public engagement and participation in Commission proceedings. OPP can help members of the public, including landowners, community organizations, Tribal members and others, access publicly available information and navigate Commission processes. For public inquiries and assistance with making filings such as interventions, comments, or requests for rehearing, the public is encouraged to contact OPP at (202) 502–6595, or *OPP@ferc.gov.*

o. *Scoping Process:* Pursuant to the National Environmental Policy Act (NEPA), Commission staff intends to prepare either an environmental assessment (EA) or an environmental impact statement (EIS) (collectively referred to as the ''NEPA document'') that describes and evaluates the probable effects, including an assessment of the site-specific and cumulative effects, if any, of the proposed action and alternatives. The Commission's scoping process will help determine the required level of analysis and satisfy the NEPA scoping requirements, irrespective of whether the Commission issues an EA or an EIS. At this time, we do not anticipate holding an on-site scoping meeting. Instead, we are soliciting written comments and suggestions on the preliminary list of issues and alternatives to be addressed in the NEPA document, as described in scoping document 1 (SD1), issued June 20, 2025.

Copies of the SD1 outlining the subject areas to be addressed in the NEPA document were distributed to the parties on the Commission's mailing list and the applicant's distribution list. Copies of SD1 may be viewed on the web at *http://www.ferc.gov* using the ''eLibrary'' link. Enter the docket number excluding the last three digits in the docket number field to access the document. For assistance, call 1–866–208–3676 or for TTY, (202) 502–8659.

Dated: June 20, 2025.

Debbie-Anne A. Reese,

Secretary.

[FR Doc. 2025–11678 Filed 6–24–25; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Project No. 4679–050]

New York Power Authority; Notice of Reasonable Period of Time for Water Quality Certification Application

On June 18, 2025, the New York State Department of Environmental Conservation (New York DEC) submitted to the Federal Energy Regulatory Commission (Commission) notice that it received a request for a Clean Water Act section 401(a)(1) water quality certification as defined in 40 CFR 121.5, from the New York Power Authority, in conjunction with the above captioned project on May 12, 2025. Pursuant to the Commission's

regulations,[1] we hereby notify New York DEC of the following:

Date of Receipt of the Certification Request: May 12, 2025.

Reasonable Period of Time to Act on the Certification Request: One year, May 12, 2026.

If New York DEC fails or refuses to act on the water quality certification request on or before the above date, then the certifying authority is deemed waived pursuant to section 401(a)(1) of the Clean Water Act, 33 U.S.C. 1341(a)(1).

Dated: June 20, 2025.

Debbie-Anne A. Reese,

Secretary.

[FR Doc. 2025–11675 Filed 6–24–25; 8:45 am]

BILLING CODE 6717–01–P

[1] 18 CFR 5.23(b)(2).

ENVIRONMENTAL PROTECTION AGENCY

[EPA–HQ–OPPT–2017–0318; FRL–12684–01–OCSPP]

Agency Information Collection Activities; Proposed Renewal Collection and Request for Comment; Request for Contractor Access to TSCA Confidential Business Information (CBI)

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice.

SUMMARY: In compliance with the Paperwork Reduction Act (PRA), this document announces the availability of and solicits public comment on the following Information Collection Request (ICR) that EPA is planning to submit to the Office of Management and Budget (OMB): Request for Contractor Access to TSCA Confidential Business Information (CBI) (EPA ICR No. 1250.13 and OMB Control No. 2070–0075). This ICR represents a renewal of an existing ICR that is currently approved through April 30, 2026. Before submitting the ICR to OMB for review and approval under the PRA, EPA is soliciting comments on specific aspects of the information collection that is summarized in this document. The ICR and accompanying material are available in the docket for public review and comment.

DATES: Comments must be received on or before August 25, 2025.

ADDRESSES: Submit your comments, identified by docket identification (ID) number Docket ID No, EPA–HQ–OPPT–2017–0318 online at *https://www.regulations.gov.* Follow the online instructions for submitting comments. Do not submit electronically any information you consider to be Confidential Business Information (CBI) or other information whose disclosure is restricted by statute. Additional instructions on commenting or visiting the docket, along with more information about dockets generally, is available at *https://www.epa.gov/dockets.*

FOR FURTHER INFORMATION CONTACT: Katherine Sleasman, Office of Program Support (Mail Code 7602M), Office of Chemical Safety and Pollution Prevention, Environmental Protection Agency, 1200 Pennsylvania Ave. NW, Washington, DC 20460–0001; telephone number: (202) 566–1204; email address: *Sleasman.Katherine@epa.gov.*

SUPPLEMENTARY INFORMATION:

I. What information is EPA particularly interested in?

Pursuant to PRA section 3506(c)(2)(A) (44 U.S.C. 3506(c)(2)(A)), EPA specifically solicits comments and information to enable it to:

1. Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the Agency, including whether the information will have practical utility.

2. Evaluate the accuracy of the Agency's estimates of the burden of the proposed collection of information, including the validity of the methodology and assumptions used.

3. Enhance the quality, utility, and clarity of the information to be collected.

4. Minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated electronic, mechanical, or other technological collection techniques or other forms of information technology, *e.g.,* permitting electronic submission of responses. In particular, EPA is requesting comments from very small businesses (those that employ less than 25) on examples of specific additional efforts that EPA could make to reduce the paperwork burden for very small businesses affected by this collection.

II. What information collection activity or ICR does this action apply to?

Title: Request for Contractor Access to TSCA Confidential Business Information (CBI).

EPA ICR No.: 1250.13.

OMB Control No.: 2070–0075.

ICR Status: This ICR is currently approved through April 30,2026. Under the PRA, an agency may not conduct or sponsor, and a person is not required to respond to, a collection of information, unless it displays a currently valid OMB control number. The OMB control numbers for EPA's regulations in title 40 of the Code of Federal Regulations (CFR), after appearing in the **Federal Register** when approved, are displayed either by publication in the **Federal Register** or by other appropriate means, such as on the related collection instrument or form, if applicable. The display of OMB control numbers for certain EPA regulations is consolidated in 40 CFR part 9.

Abstract: EPA procures contract support to facilitate the performance of certain duties. EPA may require contractors to handle Toxic Substances Control Act (TSCA) Confidential Business Information (CBI). Each contractor employee who will use TSCA CBI in the performance of his or her duties must be authorized for access to TSCA CBI through a multi-step process. The TSCA CBI Protection Manual (EPA Publication 7700 A2, revised October 2003) provides Federal and contractor employees with guidelines and operating procedures for handling TSCA CBI while performing their official duties, as well as the procedures to obtain authorization for access to TSCA CBI.

Specifically, for purposes of this information collection, contractor personnel must submit to EPA the EPA form titled ''TSCA CBI Access Request, Agreement, and Approval'' (EPA Form 7740–6). The Office of Pollution Prevention and Toxics (OPPT), uses EPA Form 7740–6 to collect information about contractor personnel so that the Agency can evaluate their suitability for access to TSCA CBI. EPA stores the information on the OPPT Chemical Information System (CIS).

The ICR, which is available in the docket along with other related materials, provides a detailed explanation of the collection activities and the burden estimate that is only briefly summarized here:

Form number(s): 7740–6.

Respondents/affected entities: Entities potentially affected by this ICR include North American Industrial Classification System (NAICS) codes 514 Information Services and 561 Administrative and Support Services.

Respondent's obligation to respond: Mandatory, per TSCA section 14 (15 U.S.C. 2613).

Estimated number of potential respondents: 288.

Frequency of response: On occasion.

Total estimated average number of responses for each respondent: 1.

Total estimated burden: 461 hours (per year). Burden is defined at 5 CFR 1320.3(b).

Total estimated costs: $25,220 (per year), includes $0 annualized capital investment or maintenance and operational costs.

III. Are there changes in the estimates from the last approval?

There is an increase of 120 hours in the total estimated respondent burden compared with that identified in the ICR currently approved by OMB. This increase reflects the increase in the number of contractors requesting CBI access from 214 to 288. This change is an adjustment.

IV. What is the next step in the process for this ICR?

EPA will consider the comments received and amend the ICR as appropriate. The final ICR package will then be submitted to OMB for review and approval pursuant to 5 CFR 1320.12. EPA will issue another **Federal Register** document pursuant to 5 CFR 1320.5(a)(1)(iv) to announce the submission of the ICR to OMB and the opportunity to submit additional comments to OMB. If you have any questions about this ICR or the approval process, please contact the person listed under **FOR FURTHER INFORMATION CONTACT**.

Authority: 44 U.S.C. 3501 *et seq.*

Dated: June 19, 2025.

Nancy B. Beck,

Principal Deputy Assistant Administrator, Office of Chemical Safety and Pollution Prevention.

[FR Doc. 2025–11672 Filed 6–24–25; 8:45 am]

BILLING CODE 6560–50–P

FEDERAL DEPOSIT INSURANCE CORPORATION

Guidance on Referrals for Potential Criminal Enforcement

AGENCY: Federal Deposit Insurance Corporation.

ACTION: Notice of general policy.

SUMMARY: This document describes the Federal Deposit Insurance Corporation's (FDIC) plans to address criminally liable regulatory offenses under the recent executive order on fighting overcriminalization in Federal regulations.

FOR FURTHER INFORMATION CONTACT: Andrew Kim, Senior Attorney, 1776 F St. NW, F–2016, Washington, DC 20429.

SUPPLEMENTARY INFORMATION: On May 9, 2025, the President issued Executive Order (E.O.) 14294, Fighting Overcriminalization in Federal Regulations (90 FR 20363; May 14, 2025). Section 7 of E.O. 14294 provides that within 45 days of the order, and in consultation with the Attorney General, each agency should publish guidance in the **Federal Register** describing its plan to address criminally liable regulatory offenses.

Consistent with that requirement, the FDIC advises the public that by May 9, 2026, the agency, in consultation with the Attorney General, will provide to the Director of the Office of Management and Budget (OMB) a report containing (1) a list of all criminal regulatory offenses [1] enforceable by the FDIC or the Department of Justice (DOJ); and (2) for each such criminal regulatory offense, the range of potential criminal penalties for a violation and the applicable mens rea standard [2] for the criminal regulatory offense.

As a practical matter, the FDIC does not generally make referrals of criminal regulatory offenses to the DOJ. To the extent that information is uncovered during the agency's supervisory activities that could suggest potential violations of criminal laws, the FDIC's practice is to refer such information to the Office of the Inspector General for the FDIC (FDIC–OIG). The FDIC–OIG then evaluates the information and determines whether a criminal referral to DOJ may be warranted. Where warranted, the FDIC–OIG's office makes referrals to DOJ based upon violations of Federal criminal statutes; the FDIC is not aware of the FDIC–OIG having made any referral to DOJ based upon a criminal regulatory offense in the past 10 years. Nonetheless, the FDIC commits to establishing procedures consistent with the E.O. for any future referral to DOJ involving a potential criminal regulatory offense.

This document announces a general policy, subject to appropriate exceptions and to the extent consistent with law, that when the FDIC is deciding whether to refer alleged violations of criminal regulatory offenses to DOJ, officers and employees of the FDIC should consider the following factors:

- the harm or risk of harm, pecuniary or otherwise, caused by the alleged offense;
- the potential gain to the putative defendant that could result from the offense;
- whether the putative defendant held specialized knowledge or expertise, or was licensed in an industry related to the rule or regulation at issue; and
- evidence, if any is available, of the putative defendant's general awareness of the unlawfulness of his conduct as well as his knowledge or lack thereof of the regulation at issue.

This general policy is not intended to, and does not, create any right or benefit, substantive or procedural, enforceable at law or in equity by any party against the United States, its departments, agencies, or entities, its officers, employees, or agents, or any other person.

Federal Deposit Insurance Corporation.

Dated at Washington, DC, on June 23, 2025.

Matthew P. Reed,

Acting General Counsel.

[FR Doc. 2025–11691 Filed 6–24–25; 8:45 am]

BILLING CODE 6714–01–P

[1] ''Criminal regulatory offense'' means a Federal regulation that is enforceable by a criminal penalty. E.O. 14294, sec. 3(b).

[2] ''Mens rea'' means the state of mind that by law must be proven to convict a particular defendant of a particular crime. E.O. 14294, sec. 3(c).

FEDERAL RESERVE SYSTEM

Formations of, Acquisitions by, and Mergers of Bank Holding Companies

The companies listed in this notice have applied to the Board for approval, pursuant to the Bank Holding Company Act of 1956 (12 U.S.C. 1841 *et seq.*) (BHC Act), Regulation Y (12 CFR part 225), and all other applicable statutes and regulations to become a bank holding company and/or to acquire the assets or the ownership of, control of, or the power to vote shares of a bank or bank holding company and all of the banks and nonbanking companies owned by the bank holding company, including the companies listed below.

The public portions of the applications listed below, as well as other related filings required by the Board, if any, are available for immediate inspection at the Federal Reserve Bank(s) indicated below and at the offices of the Board of Governors. This information may also be obtained on an expedited basis, upon request, by contacting the appropriate Federal Reserve Bank and from the Board's Freedom of Information Office at *https://www.federalreserve.gov/foia/request.htm.* Interested persons may express their views in writing on the standards enumerated in the BHC Act (12 U.S.C. 1842(c)).

Comments received are subject to public disclosure. In general, comments received will be made available without change and will not be modified to remove personal or business information including confidential, contact, or other identifying information. Comments should not include any information such as

confidential information that would not be appropriate for public disclosure.

Comments regarding each of these applications must be received at the Reserve Bank indicated or the offices of the Board of Governors, Ann E. Misback, Secretary of the Board, 20th Street and Constitution Avenue NW, Washington, DC 20551–0001, not later than July 25, 2025.

A. Federal Reserve Bank of Kansas City (Jeffrey Imgarten, Assistant Vice President) 1 Memorial Drive, Kansas City, Missouri 64198–0001. Comments can also be sent electronically to *KCApplicationComments@kc.frb.org:*

1. *Bancfirst Corporation, Oklahoma City, Oklahoma;* to merge with AmeriBank Holding Company, and thereby indirectly acquire American Bank of Oklahoma, both of Collinsville, Oklahoma.

Board of Governors of the Federal Reserve System.

Michele Taylor Fennell,

Associate Secretary of the Board.

[FR Doc. 2025–11695 Filed 6–24–25; 8:45 am]

BILLING CODE 6210–01–P

FEDERAL RESERVE SYSTEM

Change in Bank Control Notices; Acquisitions of Shares of a Bank or Bank Holding Company

The notificants listed below have applied under the Change in Bank Control Act (Act) (12 U.S.C. 1817(j)) and § 225.41 of the Board's Regulation Y (12 CFR 225.41) to acquire shares of a bank or bank holding company. The factors that are considered in acting on the applications are set forth in paragraph 7 of the Act (12 U.S.C. 1817(j)(7)).

The public portions of the applications listed below, as well as other related filings required by the Board, if any, are available for immediate inspection at the Federal Reserve Bank(s) indicated below and at the offices of the Board of Governors. This information may also be obtained on an expedited basis, upon request, by contacting the appropriate Federal Reserve Bank and from the Board's Freedom of Information Office at *https://www.federalreserve.gov/foia/request.htm.* Interested persons may express their views in writing on the standards enumerated in paragraph 7 of the Act.

Comments received are subject to public disclosure. In general, comments received will be made available without change and will not be modified to remove personal or business information including confidential, contact, or other identifying information. Comments should not include any information such as confidential information that would not be appropriate for public disclosure.

Comments regarding each of these applications must be received at the Reserve Bank indicated or the offices of the Board of Governors, Ann E. Misback, Secretary of the Board, 20th Street and Constitution Avenue NW, Washington, DC 20551–0001, not later than July 10, 2025.

A. Federal Reserve Bank of Kansas City (Jeffrey Imgarten, Assistant Vice President) 1 Memorial Drive, Kansas City, Missouri 64198–0001. Comments can also be sent electronically to *KCApplicationComments@kc.frb.org:*

1. *Mollie Morrow, Albion, Nebraska;* to become a member of the Sullivan/Morrow Family Control Group, a group acting in concert, to retain voting shares of Cedar Rapids State Company, and thereby indirectly retain voting shares of Cedar Rapids State Bank, both of Cedar Rapids, Nebraska.

Board of Governors of the Federal Reserve System.

Michele Taylor Fennell,

Associate Secretary of the Board.

[FR Doc. 2025–11693 Filed 6–24–25; 8:45 am]

BILLING CODE P

FEDERAL RESERVE SYSTEM

Formations of, Acquisitions by, and Mergers of Savings and Loan Holding Companies

The companies listed in this notice have applied to the Board for approval, pursuant to the Home Owners' Loan Act (12 U.S.C. 1461 *et seq.*) (HOLA), Regulation LL (12 CFR part 238), and Regulation MM (12 CFR part 239), and all other applicable statutes and regulations to become a savings and loan holding company and/or to acquire the assets or the ownership of, control of, or the power to vote shares of a savings association.

The public portions of the applications listed below, as well as other related filings required by the Board, if any, are available for immediate inspection at the Federal Reserve Bank(s) indicated below and at the offices of the Board of Governors. This information may also be obtained on an expedited basis, upon request, by contacting the appropriate Federal Reserve Bank and from the Board's Freedom of Information Office at *https://www.federalreserve.gov/foia/request.htm.* Interested persons may express their views in writing on whether the proposed transaction complies with the standards enumerated in the HOLA (12 U.S.C. 1467a(e)).

Comments received are subject to public disclosure. In general, comments received will be made available without change and will not be modified to remove personal or business information including confidential, contact, or other identifying information. Comments should not include any information such as confidential information that would not be appropriate for public disclosure.

Comments regarding each of these applications must be received at the Reserve Bank indicated or the offices of the Board of Governors, Ann E. Misback, Secretary of the Board, 20th Street and Constitution Avenue NW, Washington, DC 20551–0001, not later than July 25, 2025.

A. Federal Reserve Bank of Chicago (Colette A. Fried, Assistant Vice President) 230 South LaSalle Street, Chicago, Illinois 60690–1414. Comments can also be sent electronically to *Comments.applications@chi.frb.org:*

1. *Hoyne Savings, MHC, Chicago, Illinois;* to convert from mutual to stock form. As part of the conversion, Hoyne Savings, MHC, and Hoyne Financial Corporation, also of Chicago, Illinois, an existing mid-tier savings and loan holding company, will cease to exist and Hoyne Savings Bank, Chicago, Illinois, will become a wholly-owned subsidiary of Hoyne Bancorp, Inc., Chicago, Illinois, a newly-formed Delaware corporation, which has applied to become a savings and loan holding company, pursuant to section 10(e) of the HOLA, by acquiring Hoyne Savings Bank.

Board of Governors of the Federal Reserve System.

Michele Taylor Fennell,

Associate Secretary of the Board.

[FR Doc. 2025–11694 Filed 6–24–25; 8:45 am]

BILLING CODE P

GENERAL SERVICES ADMINISTRATION

[OMB Control No. 3090–0321; Docket No. 2025–0001; Sequence No. 14]

Information Collection; Improving Customer Experience—Implementation of Section 280 of OMB Circular A–11

AGENCY: General Services Administration (GSA).

ACTION: Notice; request for comment.

SUMMARY: The GSA, as part of its continuing effort to reduce paperwork and respondent burden, is announcing

an opportunity for public comment on a proposed extension of a collection of information by the Agency. Under the Paperwork Reduction Act of 1995 (PRA), Federal agencies are required to publish notice in the **Federal Register** concerning each proposed collection of information, and to allow 60 days for public comment in response to the notice. This notice solicits comments on an extension of an existing collection proposed by the Agency.

DATES: Submit comments on or before August 25, 2025.

ADDRESSES: Submit comments identified by Information Collection 3090–0321, Improving Customer Experience (OMB Circular A–11, Section 280 Implementation), by any of the following methods:

- *Federal eRulemaking portal: https://www.regulations.gov.* Follow the instructions for submitting comments. Comments submitted electronically, including attachments to *https://www.regulations.gov,* will be posted to the docket unchanged.

Instructions: Please submit comments only and cite Information Collection 3090–0321, Improving Customer Experience (OMB Circular A–11, Section 280 Implementation), in all correspondence related to this collection. To confirm receipt of your comment(s), please check *regulations.gov,* approximately 2–3 business days after submission to verify posting.

FOR FURTHER INFORMATION CONTACT: Requests for additional information should be directed to Nicole Bynum, Regulatory Program Specialist, at 202–501–4755, or email to *GSARegSec@gsa.gov.*

SUPPLEMENTARY INFORMATION:

A. Purpose

Under the PRA, (*44 U.S.C. 3501–3520*) Federal agencies must obtain approval from the Office of Management and Budget (OMB) for each collection of information they conduct or sponsor. ''Collection of information'' is defined in *44 U.S.C. 3502(3)* and *5 CFR 1320.3(c)* and includes Agency requests or requirements that members of the public submit reports, keep records, or provide information to a third party. Section 3506(c)(2)(A) of the PRA requires Federal agencies to provide a 60-day notice in the **Federal Register** concerning each proposed collection of information, including each proposed extension of an existing collection of information, before submitting the collection to OMB for approval. To comply with this requirement, the agency is publishing notice of the proposed collection of information set forth in this document.

Under the Government Service Delivery Improvement Act and the 21st Century Integrated Digital Experience Act, along with OMB guidance, agencies are obligated to continually improve the services they provide the public and to collect qualitative and quantitative data from the public to do so.

The purpose of this request is to facilitate the agency's ability to collect feedback from the public to continue to improve its services, thereby facilitating its compliance with statutory requirements and general principles of good governance.

The agency will only submit collections if they meet the following criteria.

- The collections are voluntary;
- The collections are low-burden for respondents (based on considerations of total burden hours or burden-hours per respondent) and are low-cost for both the respondents and the Federal Government;
- The collections are non-controversial;
- Any collection is targeted to the solicitation of opinions from respondents who have experience with the program or may have experience with the program in the near future;
- Personally identifiable information (PII) is collected only to the extent necessary and the agency will comply with applicable legal and policy requirements to ensure its protection;
- Information gathered is intended to be used for general service improvement and program management purposes;
- The agency will follow the procedures specified in any relevant OMB guidance for the required reporting to OMB of data from surveys;
- Outside of the reporting mentioned in the bullet immediately above, if the agency intends to release journey maps, user personas, reports, or other data-related summaries stemming from this collection, the agency must include appropriate caveats around those summaries, noting that conclusions should not be generalized beyond the sample, considering the sample size and response rates. The agency must submit the data summary itself (*e.g.,* the report) and the caveat language mentioned above to OMB before it releases them outside the agency. OMB will engage in a passback process with the agency.

Method of Collection

The agency will collect this information by electronic means, when possible, as well as by mail, fax, telephone, technical discussions, and in-person interviews. The agency may also utilize observational techniques to collect this information.

Data

Form Number(s): OMB Control No. 3090–0321.

Type of Review: Extension of an existing collection.

B. Annual Reporting Burden

Affected Public: Collections will be targeted to the solicitation of opinions from respondents who have experience with the program or may have experience with the program in the near future. For the purposes of this request, ''customers'' are individuals, businesses, and organizations that interact with a Federal Government agency or program, either directly or via a Federal contractor. This could include individuals or households; businesses or other for-profit organizations; not-for-profit institutions; State, local or tribal governments; Federal government; and universities.

Estimated Number of Respondents: 1,101,500.

Estimated Time per Response: Varied, dependent upon the data collection method used. The possible response time to complete a questionnaire or survey may be 3 minutes or up to 1.5 hours to participate in an interview.

Estimated Total Annual Burden Hours: 100,800.

C. Public Comments

The agency invites comments on: (a) Whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility; (b) the accuracy of the agency's estimate of the burden of the proposed collection of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology. Comments submitted in response to this notice will be summarized and/or included in the request for OMB approval of this information collection; they also will become a matter of public record.

William F. Clark,

Director, Office of Government-wide Acquisition Policy, Office of Acquisition Policy, Office of Government-wide Policy.

[FR Doc. 2025–11667 Filed 6–24–25; 8:45 am]

BILLING CODE 6820–34–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–3473–PN]

Medicare and Medicaid Programs: Application From the Accreditation Commission for Health Care (ACHC) for Continued Approval of Its Hospice Accreditation Program

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Notice with request for comment.

SUMMARY: This proposed notice acknowledges the receipt of an application from the Accreditation Commission for Health Care, for continued recognition as a national accrediting organization for hospices that wish to participate in the Medicare or Medicaid programs.

DATES: To be assured consideration, comments must be received at one of the addresses discussed later in this section, no later than 5 p.m. on July 25, 2025.

ADDRESSES: In commenting, refer to file code CMS–3473–PN.

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 *http://www.regulations.gov.* 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–3473–PN, P.O. Box 8010, Baltimore, MD 21244–8010.

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–3473–PN, 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:

Annette Snyder, (410) 786–0807.

Lillian Williams, (410) 786–8636.

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 at *http://www.regulations.gov.* Follow the search instructions on that website to view public comments. CMS 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. CMS continues 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.

I. Background

Under the Medicare program, eligible beneficiaries may receive covered services from a hospice, provided that certain requirements are met by the hospice. Section 1861(dd) of the Social Security Act (the Act) establishes distinct criteria for an agency or organization seeking designation as a hospice. Regulations concerning provider agreements are at 42 CFR part 489 and those pertaining to activities relating to the survey and certification of an agency or organization are at 42 CFR part 488. The regulations at 42 CFR part 418 specify the conditions that a hospice must meet in order to participate in the Medicare program, the scope of covered services and the conditions for Medicare payment for hospice services.

Generally, to enter into an agreement, a hospice must first be certified by a state survey agency (SA) as complying with the conditions or requirements set forth in part 418. Thereafter, the hospice is subject to regular surveys by an SA agency to determine whether it continues to meet these requirements.

However, section 1865(a)(1) of the Act provides that, if a provider entity demonstrates through accreditation by a Centers for Medicare & Medicaid Services (CMS) approved national Accrediting Organization (AO) that all applicable Medicare conditions are met or exceeded, we will deem those provider entities as having met the requirements. Accreditation by an AO is voluntary and is not required for Medicare participation.

If an AO is recognized by the Secretary of the Department of Health and Human Services (the Secretary) as having standards for accreditation that meet or exceed Medicare requirements, any provider entity accredited by the national accrediting body's approved program would be deemed to meet the Medicare conditions. A national AO applying for approval of its accreditation program under part 488, subpart A, must provide CMS with reasonable assurance that the AO requires the accredited provider entities to meet requirements that are at least as stringent as the Medicare conditions. Our regulations concerning the approval of AOs are set forth at §§ 488.4 and 488.5. The regulations at § 488.5(e)(2)(i) require AOs to reapply for continued approval of its accreditation program every 6 years or sooner as determined by CMS. The Accreditation Commission for Health Care's (ACHC's) current term of approval for their hospice accreditation program expires November 27, 2025.

II. Approval of Deeming Organizations

Section 1865(a)(2) of the Act and our regulations at § 488.5 require that our findings concerning review and approval of a national AO's requirements consider, among other factors, the applying AO's requirements for accreditation; survey procedures; resources for conducting required surveys; capacity to furnish information for use in enforcement activities; monitoring procedures for provider entities found not in compliance with the conditions or requirements; and ability to provide CMS with the necessary data for validation.

Section 1865(a)(3)(A) of the Act further requires that we publish, within 60 days of receipt of an organization's complete application, a notice identifying the national accrediting body making the request, describing the nature of the request, and providing at least a 30-day public comment period. We have 210 days from the receipt of a complete application to publish notice of approval or denial of the application.

The purpose of this proposed notice is to inform the public of ACHC's request for continued approval of its hospice accreditation program. This notice also solicits public comment on whether the ACHC's requirements meet or exceed the Medicare conditions of participation (CoPs) for hospices.

III. Evaluation of Deeming Authority Request

ACHC submitted all the necessary materials to enable us to make a determination concerning its request for continued approval of its hospice accreditation program. This application was determined to be complete on May 1, 2025. Under section 1865(a)(2) of the

Act and our regulations at § 488.5 (Application and re-application procedures for national accrediting organizations), our review and evaluation of ACHC will be conducted in accordance with, but not necessarily limited to, the following factors:

- The equivalency of ACHC's standards for hospices as compared with CMS' hospice CoPs.
- ACHC's survey process to determine the following:

++ The composition of the survey team, surveyor qualifications, and the ability of the organization to provide continuing surveyor training.

++ The comparability of ACHC's processes to those of state agencies, including survey frequency, and the ability to investigate and respond appropriately to complaints against accredited facilities.

++ ACHC's processes and procedures for monitoring hospices which are found out of compliance with ACHC's program requirements. These monitoring procedures are used only when ACHC identifies noncompliance. If noncompliance is identified through validation reviews or complaint surveys, the SA monitors corrections as specified at § 488.9.

++ ACHC's capacity to report deficiencies to the surveyed facilities and respond to the facility's plan of correction in a timely manner.

++ ACHC's capacity to provide CMS with electronic data and reports necessary for effective validation and assessment of the organization's survey process.

++ The adequacy of ACHC's staff and other resources, and its financial viability.

++ ACHC's capacity to adequately fund required surveys.

++ ACHC's policies with respect to whether surveys are announced or unannounced, to ensure that surveys are unannounced.

++ ACHC's policies and procedures to avoid conflicts of interest, including the appearance of conflicts of interest, involving individuals who conduct surveys or participate in accreditation decisions.

++ ACHC's agreement to provide CMS with a copy of the most current accreditation survey, together with any other information related to the survey as we may require (including corrective action plans).

IV. Collection of Information Requirements

This document does not impose information collection requirements, that is, reporting, recordkeeping or third-party disclosure requirements. Consequently, there is no need for review by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

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.

The Administrator of the Centers for Medicare & Medicaid Services (CMS), Mehmet Oz, having reviewed and approved this document, authorizes Vanessa Garcia to electronically sign this document for purposes of publication in the **Federal Register**.

Vanessa Garcia,

Federal Register Liaison, Centers for Medicare & Medicaid Services.

[FR Doc. 2025–11701 Filed 6–24–25; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. FDA–2024–E–0205]

Determination of Regulatory Review Period for Purposes of Patent Extension; FILSPARI

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA or the Agency) has determined the regulatory review period for FILSPARI and is publishing this notice of that determination as required by law. FDA has made the determination because of the submission of an application to the Director of the U.S. Patent and Trademark Office (USPTO), Department of Commerce, for the extension of a patent which claims that human drug product.

DATES: Anyone with knowledge that any of the dates as published (see **SUPPLEMENTARY INFORMATION**) are incorrect may submit either electronic or written comments and ask for a redetermination by August 25, 2025. Furthermore, any interested person may petition FDA for a determination regarding whether the applicant for extension acted with due diligence during the regulatory review period by December 22, 2025. See ''Petitions'' in the **SUPPLEMENTARY INFORMATION** section for more information.

ADDRESSES: You may submit comments as follows. Please note that late, untimely filed comments will not be considered. The *https://www.regulations.gov* electronic filing system will accept comments until 11:59 p.m. Eastern Time at the end of August 25, 2025. Comments received by mail/hand delivery/courier (for written/paper submissions) will be considered timely if they are received on or before that date.

Electronic Submissions

Submit electronic comments in the following way:

- *Federal eRulemaking Portal: https://www.regulations.gov.* Follow the instructions for submitting comments. Comments submitted electronically, including attachments, to *https://www.regulations.gov* will be posted to the docket unchanged. Because your comment will be made public, you are solely responsible for ensuring that your comment does not include any confidential information that you or a third party may not wish to be posted, such as medical information, your or anyone else's Social Security number, or confidential business information, such as a manufacturing process. Please note that if you include your name, contact information, or other information that identifies you in the body of your comments, that information will be posted on *https://www.regulations.gov.*
- If you want to submit a comment with confidential information that you do not wish to be made available to the public, submit the comment as a written/paper submission and in the manner detailed (see ''Written/Paper Submissions'' and ''Instructions'').

Written/Paper Submissions

Submit written/paper submissions as follows:

- *Mail/Hand Delivery/Courier (for written/paper submissions):* Dockets Management Staff (HFA–305), Food and Drug Administration, 5630 Fishers Lane, Rm. 1061, Rockville, MD 20852.
- For written/paper comments submitted to the Dockets Management Staff, FDA will post your comment, as well as any attachments, except for information submitted, marked and identified, as confidential, if submitted as detailed in ''Instructions.''

Instructions: All submissions received must include the Docket No. FDA–2024–E–0205 for ''Determination of Regulatory Review Period for Purposes

of Patent Extension; FILSPARI.'' Received comments, those filed in a timely manner (see **ADDRESSES**), will be placed in the docket and, except for those submitted as ''Confidential Submissions,'' publicly viewable at *https://www.regulations.gov* or at the Dockets Management Staff between 9 a.m. and 4 p.m., Monday through Friday, 240–402–7500.

• Confidential Submissions—To submit a comment with confidential information that you do not wish to be made publicly available, submit your comments only as a written/paper submission. You should submit two copies total. One copy will include the information you claim to be confidential with a heading or cover note that states ''THIS DOCUMENT CONTAINS CONFIDENTIAL INFORMATION.'' The Agency will review this copy, including the claimed confidential information, in its consideration of comments. The second copy, which will have the claimed confidential information redacted/blacked out, will be available for public viewing and posted on *https://www.regulations.gov.* Submit both copies to the Dockets Management Staff. If you do not wish your name and contact information to be made publicly available, you can provide this information on the cover sheet and not in the body of your comments and you must identify this information as ''confidential.'' Any information marked as ''confidential'' will not be disclosed except in accordance with § 10.20 (21 CFR 10.20) and other applicable disclosure law. For more information about FDA's posting of comments to public dockets, see 80 FR 56469, September 18, 2015, or access the information at: *https://www.govinfo.gov/content/pkg/FR-2015-09-18/pdf/2015-23389.pdf.*

Docket: For access to the docket to read background documents or the electronic and written/paper comments received, go to *https://www.regulations.gov* and insert the docket number, found in brackets in the heading of this document, into the ''Search'' box and follow the prompts and/or go to the Dockets Management Staff, 5630 Fishers Lane, Rm. 1061, Rockville, MD 20852, 240–402–7500.

FOR FURTHER INFORMATION CONTACT: Jack Dan, Office of Regulatory Policy, Food and Drug Administration, 10903 New Hampshire Ave., Bldg. 51, Rm. 6200, Silver Spring, MD 20993, 240–402–6940.

SUPPLEMENTARY INFORMATION:

I. Background

The Drug Price Competition and Patent Term Restoration Act of 1984 (Pub. L. 98–417) and the Generic Animal Drug and Patent Term Restoration Act (Pub. L. 100–670) generally provide that a patent may be extended for a period of up to 5 years so long as the patented item (human drug or biological product, animal drug product, medical device, food additive, or color additive) was subject to regulatory review by FDA before the item was marketed. Under these acts, a product's regulatory review period forms the basis for determining the amount of extension an applicant may receive.

A regulatory review period consists of two periods of time: a testing phase and an approval phase. For human drug products, the testing phase begins when the exemption to permit the clinical investigations of the drug becomes effective and runs until the approval phase begins. The approval phase starts with the initial submission of an application to market the human drug product and continues until FDA grants permission to market the drug product. Although only a portion of a regulatory review period may count toward the actual amount of extension that the Director of USPTO may award (for example, half the testing phase must be subtracted as well as any time that may have occurred before the patent was issued), FDA's determination of the length of a regulatory review period for a human drug product will include all of the testing phase and approval phase as specified in 35 U.S.C. 156(g)(1)(B).

FDA has approved for marketing the human drug product, FILSPARI (sparsentan). FILSPARI is indicated to reduce proteinuria in adults with primary immunoglobulin A nephropathy (IgAN) at risk of rapid disease progression, generally a urine protein-to-creatinine ratio ≥1.5 g/g. This indication is approved under accelerated approval based on reduction of proteinuria. It has not been established whether FILSPARI slows kidney function decline in patients with IgAN. Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory clinical trial. Subsequent to this approval, the USPTO received a patent term restoration application for FILSPARI (U.S. Patent No. 9,993,461) from Ligand Pharmaceuticals Inc., and the USPTO requested FDA's assistance in determining the patent's eligibility for patent term restoration. In a letter dated January 30, 2024, FDA advised the USPTO that this human drug product had undergone a regulatory review period and that the approval of FILSPARI represented the first permitted commercial marketing or use of the product. Thereafter, the USPTO requested that FDA determine the product's regulatory review period.

II. Determination of Regulatory Review Period

FDA has determined that the applicable regulatory review period for FILSPARI is 5,867 days. Of this time, 5,529 days occurred during the testing phase of the regulatory review period, while 338 days occurred during the approval phase. These periods of time were derived from the following dates:

1. *The date an exemption under section 505(i) of the Federal Food, Drug, and Cosmetic Act (FD&C Act) (21 U.S.C. 355(i)) became effective:* January 27, 2007. The applicant claims November 21, 2018, as the date the investigational new drug application (IND) became effective. However, FDA records indicate that the IND effective date was January 27, 2007, which was 30 days after FDA receipt of an earlier IND.

2. *The date the application was initially submitted with respect to the human drug product under section 505 of the FD&C Act:* March 17, 2022. FDA has verified the applicant's claim that the new drug application (NDA) for FILSPARI (NDA 216403) was initially submitted on March 17, 2022.

3. *The date the application was approved:* February 17, 2023. FDA has verified the applicant's claim that NDA 216403 was approved on February 17, 2023.

This determination of the regulatory review period establishes the maximum potential length of a patent extension. However, the USPTO applies several statutory limitations in its calculations of the actual period for patent extension. In its application for patent extension, this applicant seeks 945 days of patent term extension.

III. Petitions

Anyone with knowledge that any of the dates as published are incorrect may submit either electronic or written comments and, under 21 CFR 60.24, ask for a redetermination (see **DATES**). Furthermore, as specified in § 60.30 (21 CFR 60.30), any interested person may petition FDA for a determination regarding whether the applicant for extension acted with due diligence during the regulatory review period. To meet its burden, the petition must comply with all the requirements of § 60.30, including but not limited to: must be timely (see **DATES**), must be

filed in accordance with § 10.20, must contain sufficient facts to merit an FDA investigation, and must certify that a true and complete copy of the petition has been served upon the patent applicant. (See H. Rept. 857, part 1, 98th Cong., 2d sess., pp. 41–42, 1984.) Petitions should be in the format specified in 21 CFR 10.30.

Submit petitions electronically to *https://www.regulations.gov* at Docket No. FDA–2013–S–0610. Submit written petitions (two copies are required) to the Dockets Management Staff (HFA–305), Food and Drug Administration, 5630 Fishers Lane, Rm. 1061, Rockville, MD 20852.

Dated: June 18, 2025.

Grace R. Graham,

Deputy Commissioner for Policy, Legislation, and International Affairs.

[FR Doc. 2025–11604 Filed 6–24–25; 8:45 am]

BILLING CODE 4164–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. FDA–FDA–2025–N–0008]

Request for Nominations for Voting Members on the Tobacco Products Scientific Advisory Committee

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA) is requesting nominations for members to serve on the Tobacco Products Scientific Advisory Committee (TPSAC), in the Center for Tobacco Products. FDA seeks to include the views of qualified individuals on its advisory committees, and therefore encourages nominations of appropriately qualified candidates. Specifically, TPSAC is seeking to fill 5 vacancies with physicians, dentists, scientists, or health care professionals practicing in the area of oncology, pulmonology, cardiology, toxicology, pharmacology, addiction, engineering, or any other relevant specialty. Included in the 5 vacancies is 1 vacancy for a representative of the general public, and 1 vacancy for an employee of a state or local government or of the Federal Government.

DATES: Nominations received on or before June 25, 2025 will be given first consideration for membership on the Tobacco Products Scientific Advisory Committee. Nominations received after August 25, 2025 will be considered for nomination to the committee as later vacancies occur.

ADDRESSES: All nominations for membership should be sent electronically by logging into the FDA Advisory Nomination Portal: *http://www.accessdata.fda.gov/scripts/FACTRSPortal/FACTRS/index.cfm* or by mail to Advisory Committee Oversight and Management Staff, Food and Drug Administration, 10903 New Hampshire Ave., Bldg. 32, Rm. 5103, Silver Spring, MD 20993–0002.

FOR FURTHER INFORMATION CONTACT:

Regarding all nomination questions for membership, the primary contact is:

Rachel Jang, PharmD, Office of Science, Center for Tobacco Products, Food and Drug Administration, Center for Tobacco Products, Document Control Center, 10903 New Hampshire Ave., Bldg. 71, Rm. G335, Silver Spring, MD 20993–0002, 1–877–287–1373 (choose Option 5), *email: TPSAC@fda.hhs.gov*. Information about becoming a member on an FDA advisory committee can also be obtained by visiting FDA's website at: *http://www.fda.gov/AdvisoryCommittees/default.htm*.

SUPPLEMENTARY INFORMATION: FDA is requesting nomination for voting members on the Tobacco Products Scientific Advisory Committee.

I. General Description of the Committee Duties

The Tobacco Products Scientific Advisory Committee advises the Commissioner of FDA or designee in discharging responsibilities related to the regulation of tobacco products. The Tobacco Products Scientific Advisory Committee reviews and evaluates safety, dependence, and health issues relating to tobacco products and provides appropriate advice, information and recommendations to the Commissioner of Food and Drugs.

II. Criteria for Voting Members

The Committee consists of 12 members including the Chair. Members and the Chair are selected by the Commissioner or designee from among individuals knowledgeable in the fields of medicine, medical ethics, science, or technology involving the manufacture, evaluation, or use of tobacco products. Almost all non-Federal members of this committee serve as Special Government Employees. The Committee includes nine technically qualified voting members, selected by the Commissioner or designee. The nine voting members include seven members who are physicians, dentists, scientists, or health care professionals practicing in the area of oncology, pulmonology, cardiology, toxicology, pharmacology, addiction, or any other relevant specialty. The nine voting members also include one member who is an officer or employee of a state or local government or of the Federal Government, and one member who is a representative of the general public. Members will be invited to serve for terms of up to 4 years.

III. Nomination Procedures

Any interested person may nominate one or more qualified individuals for membership on the advisory committee. Self-nominations are also accepted. Nominations must include a current, complete résumé or curriculum vitae for each nominee, including current business address and/or home address, telephone number, and email address if available. Nominations must also specify the advisory committee for which the nominee is recommended. Nominations must also acknowledge that the nominee is aware of the nomination unless self-nominated. FDA will ask potential candidates to provide detailed information concerning such matters related to financial holdings, employment, and research grants and/or contracts to permit evaluation of possible sources of conflicts of interest.

This notice is issued under the Federal Advisory Committee Act (5 U.S.C. app. 2) and 21 CFR part 14, relating to advisory committees.

Dated: June 18, 2025.

Grace R. Graham,

Deputy Commissioner for Policy, Legislation, and International Affairs.

[FR Doc. 2025–11600 Filed 6–24–25; 8:45 am]

BILLING CODE 4164–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket Nos. FDA–2022–E–2187; FDA–2022–E–2190; FDA–2022–E–2191; FDA–2022–E–2192; FDA–2022–E–2193]

Determination of Regulatory Review Period for Purposes of Patent Extension; [EDWARDS SAPIEN 3 TRANSCATHETER PULMONARY VALVE]

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA or the Agency) has determined the regulatory review period for EDWARDS SAPIEN 3 TRANSCATHETER PULMONARY VALVE and is publishing this notice of

that determination as required by law. FDA has made the determination because of the submission of applications to the Director of the U.S. Patent and Trademark Office (USPTO), Department of Commerce, for the extension of patents which claim that medical device.

DATES: Anyone with knowledge that any of the dates as published (see **SUPPLEMENTARY INFORMATION**) are incorrect may submit either electronic or written comments and ask for a redetermination by August 25, 2025. Furthermore, any interested person may petition FDA for a determination regarding whether the applicant for extension acted with due diligence during the regulatory review period by December 22, 2025. See ''Petitions'' in the **SUPPLEMENTARY INFORMATION** section for more information.

ADDRESSES: You may submit comments as follows. Please note that late, untimely filed comments will not be considered. The *https://www.regulations.gov* electronic filing system will accept comments until 11:59 p.m. Eastern Time at the end of August 25, 2025. Comments received by mail/hand delivery/courier (for written/paper submissions) will be considered timely if they are received on or before that date.

Electronic Submissions

Submit electronic comments in the following way:

- *Federal eRulemaking Portal: https://www.regulations.gov*. Follow the instructions for submitting comments. Comments submitted electronically, including attachments, to *https://www.regulations.gov* will be posted to the docket unchanged. Because your comment will be made public, you are solely responsible for ensuring that your comment does not include any confidential information that you or a third party may not wish to be posted, such as medical information, your or anyone else's Social Security number, or confidential business information, such as a manufacturing process. Please note that if you include your name, contact information, or other information that identifies you in the body of your comments, that information will be posted on *https://www.regulations.gov*.
- If you want to submit a comment with confidential information that you do not wish to be made available to the public, submit the comment as a written/paper submission and in the manner detailed (see ''Written/Paper Submissions'' and ''Instructions'').

Written/Paper Submissions

Submit written/paper submissions as follows:

- *Mail/Hand Delivery/Courier (for written/paper submissions):* Dockets Management Staff (HFA–305), Food and Drug Administration, 5630 Fishers Lane, Rm. 1061, Rockville, MD 20852.
- For written/paper comments submitted to the Dockets Management Staff, FDA will post your comment, as well as any attachments, except for information submitted, marked and identified, as confidential, if submitted as detailed in ''Instructions.''

Instructions: All submissions received must include the Docket Nos. FDA–2022–E–2187; FDA–2022–E–2190; FDA–2022–E–2191; FDA–2022–E–2192; and FDA–2022–E–2193 for Determination of Regulatory Review Period for Purposes of Patent Extension; EDWARDS SAPIEN 3 TRANSCATHETER PULMONARY VALVE. Received comments, those filed in a timely manner (see **ADDRESSES**), will be placed in the docket and, except for those submitted as ''Confidential Submissions,'' publicly viewable at *https://www.regulations.gov* or at the Dockets Management Staff between 9 a.m. and 4 p.m., Monday through Friday, 240–402–7500.

- Confidential Submissions—To submit a comment with confidential information that you do not wish to be made publicly available, submit your comments only as a written/paper submission. You should submit two copies total. One copy will include the information you claim to be confidential with a heading or cover note that states ''THIS DOCUMENT CONTAINS CONFIDENTIAL INFORMATION.'' The Agency will review this copy, including the claimed confidential information, in its consideration of comments. The second copy, which will have the claimed confidential information redacted/blacked out, will be available for public viewing and posted on *https://www.regulations.gov*. Submit both copies to the Dockets Management Staff. If you do not wish your name and contact information to be made publicly available, you can provide this information on the cover sheet and not in the body of your comments and you must identify this information as ''confidential.'' Any information marked as ''confidential'' will not be disclosed except in accordance with § 10.20 (21 CFR 10.20) and other applicable disclosure law. For more information about FDA's posting of comments to public dockets, see 80 FR 56469, September 18, 2015, or access the information at: *https://www.govinfo.gov/content/pkg/FR-2015-09-18/pdf/2015-23389.pdf*.

Docket: For access to the docket to read background documents or the electronic and written/paper comments received, go to *https://www.regulations.gov* and insert the docket number, found in brackets in the heading of this document, into the ''Search'' box and follow the prompts and/or go to the Dockets Management Staff, 5630 Fishers Lane, Rm. 1061, Rockville, MD 20852, 240–402–7500.

FOR FURTHER INFORMATION CONTACT: Jack Dan, Office of Regulatory Policy, Food and Drug Administration, 10903 New Hampshire Ave., Bldg. 51, Rm. 6250, Silver Spring, MD 20993, 240–402–6940.

SUPPLEMENTARY INFORMATION:

I. Background

The Drug Price Competition and Patent Term Restoration Act of 1984 (Pub. L. 98–417) and the Generic Animal Drug and Patent Term Restoration Act (Pub. L. 100–670) generally provide that a patent may be extended for a period of up to 5 years so long as the patented item (human drug or biological product, animal drug product, medical device, food additive, or color additive) was subject to regulatory review by FDA before the item was marketed. Under these acts, a product's regulatory review period forms the basis for determining the amount of extension an applicant may receive.

A regulatory review period consists of two periods of time: a testing phase and an approval phase. For medical devices, the testing phase begins with a clinical investigation of the device and runs until the approval phase begins. The approval phase starts with the initial submission of an application to market the device and continues until permission to market the device is granted. Although only a portion of a regulatory review period may count toward the actual amount of extension that the Director of USPTO may award (half the testing phase must be subtracted as well as any time that may have occurred before the patent was issued), FDA's determination of the length of a regulatory review period for a medical device will include all of the testing phase and approval phase as specified in 35 U.S.C. 156(g)(3)(B).

FDA has approved for marketing the medical device EDWARDS SAPIEN 3 TRANSCATHETER PULMONARY VALVE. EDWARDS SAPIEN 3 TRANSCATHETER PULMONARY VALVE is indicated for use in the management of pediatric and adult

patients with severe pulmonary regurgitation as measured by echocardiography who have a native or surgically-repaired right ventricular outflow tract and are clinically indicated for pulmonary valve replacement. Subsequent to this approval, the USPTO received patent term restoration applications for EDWARDS SAPIEN 3 TRANSCATHETER PULMONARY VALVE (U.S. Patent Nos. 9,119,716; 9,393,110; 10,179,047; 10,413,407; and 10,537,423 from Edwards Lifesciences Corporation, and the USPTO requested FDA's assistance in determining the patents' eligibility for patent term restoration. In a letter dated January 18, 2023, FDA advised the USPTO that this medical device had undergone a regulatory review period and that the approval of EDWARDS SAPIEN 3 TRANSCATHETER PULMONARY VALVE represented the first permitted commercial marketing or use of the product. Thereafter, the USPTO requested that FDA determine the product's regulatory review period.

II. Determination of Regulatory Review Period

FDA has determined that the applicable regulatory review period for EDWARDS SAPIEN 3 TRANSCATHETER PULMONARY VALVE is 1,725 days. Of this time, 1,546 days occurred during the testing phase of the regulatory review period, while 179 days occurred during the approval phase. These periods of time were derived from the following dates:

1. *The date an exemption under section 520(g) of the Federal Food, Drug, and Cosmetic Act (FD&C Act) (21 U.S.C. 360j(g)) involving this device became effective:* March 29, 2017. The applicant claims that the investigational device exemption (IDE) required under section 520(g) of the FD&C Act for human tests to begin became effective on February 27, 2017. However, FDA records indicate that the IDE was determined substantially complete for clinical studies to have begun on March 29, 2017, which represents the IDE effective date.

2. *The date an application was initially submitted with respect to the device under section 515 of the FD&C Act (21 U.S.C. 360e):* June 21, 2021. FDA has verified the applicant's claim that the premarket approval application (PMA) for EDWARDS SAPIEN 3 TRANSCATHETER PULMONARY VALVE (PMA P200015/Supplement (S011) was initially submitted June 21, 2021.

3. *The date the application was approved:* December 16, 2021. FDA has verified the applicant's claim that PMA P200015/S011 was approved on December 16, 2021.

This determination of the regulatory review period establishes the maximum potential length of a patent extension. However, the USPTO applies several statutory limitations in its calculations of the actual period for patent extension. In its applications for patent extension, this applicant seeks 436 days, 499 days, 622 days or 965 days of patent term extensions.

III. Petitions

Anyone with knowledge that any of the dates as published are incorrect may submit either electronic or written comments and, under 21 CFR 60.24, ask for a redetermination (see **DATES**). Furthermore, as specified in § 60.30 (21 CFR 60.30), any interested person may petition FDA for a determination regarding whether the applicant for extension acted with due diligence during the regulatory review period. To meet its burden, the petition must comply with all the requirements of § 60.30, including but not limited to: must be timely (see **DATES**), must be filed in accordance with § 10.20, must contain sufficient facts to merit an FDA investigation, and must certify that a true and complete copy of the petition has been served upon the patent applicant. (See H. Rept. 857, part 1, 98th Cong., 2d sess., pp. 41–42, 1984.) Petitions should be in the format specified in 21 CFR 10.30.

Submit petitions electronically to *https://www.regulations.gov* at Docket No. FDA–2013–S–0610. Submit written petitions (two copies are required) to the Dockets Management Staff (HFA–305), Food and Drug Administration, 5630 Fishers Lane, Rm. 1061, Rockville, MD 20852.

Dated: June 18, 2025.

Grace R. Graham,

Deputy Commissioner for Policy, Legislation, and International Affairs.

[FR Doc. 2025–11601 Filed 6–24–25; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. FDA–2023–E–2803; FDA–2023–E–2804; FDA–2023–E–2805; FDA–2023–E–2806]

Determination of Regulatory Review Period for Purposes of Patent Extension; [EDWARDS SAPIEN 3 ULTRA RESILIA—PMA 140031 S–141]

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA or the Agency) has determined the regulatory review period for EDWARDS SAPIEN 3 ULTRA RESILIA premarket approval application (PMA) 140031 supplement (S–141) and is publishing this notice of that determination as required by law. FDA has made the determination because of the submission of applications to the Director of the U.S. Patent and Trademark Office (USPTO), Department of Commerce, for the extension of a patent which claims that medical device.

DATES: Anyone with knowledge that any of the dates as published (see **SUPPLEMENTARY INFORMATION**) are incorrect may submit either electronic or written comments and ask for a redetermination by August 25, 2025. Furthermore, any interested person may petition FDA for a determination regarding whether the applicant for extension acted with due diligence during the regulatory review period by December 22, 2025. See ''Petitions'' in the **SUPPLEMENTARY INFORMATION** section for more information.

ADDRESSES: You may submit comments as follows. Please note that late, untimely filed comments will not be considered. The *https://www.regulations.gov* electronic filing system will accept comments until 11:59 p.m. Eastern Time at the end of August 25, 2025. Comments received by mail/hand delivery/courier (for written/paper submissions) will be considered timely if they are received on or before that date.

Electronic Submissions

Submit electronic comments in the following way:

- *Federal eRulemaking Portal: https://www.regulations.gov.* Follow the instructions for submitting comments. Comments submitted electronically, including attachments, to *https://www.regulations.gov* will be posted to the docket unchanged. Because your

comment will be made public, you are solely responsible for ensuring that your comment does not include any confidential information that you or a third party may not wish to be posted, such as medical information, your or anyone else's Social Security number, or confidential business information, such as a manufacturing process. Please note that if you include your name, contact information, or other information that identifies you in the body of your comments, that information will be posted on *https://www.regulations.gov*.

- If you want to submit a comment with confidential information that you do not wish to be made available to the public, submit the comment as a written/paper submission and in the manner detailed (see ''Written/Paper Submissions'' and ''Instructions'').

Written/Paper Submissions

Submit written/paper submissions as follows:

- Mail/Hand Delivery/Courier (for written/paper submissions): Dockets Management Staff (HFA–305), Food and Drug Administration, 5630 Fishers Lane, Rm. 1061, Rockville, MD 20852.
- For written/paper comments submitted to the Dockets Management Staff, FDA will post your comment, as well as any attachments, except for information submitted, marked and identified, as confidential, if submitted as detailed in ''Instructions.''

Instructions: All submissions received must include the Docket Nos. FDA–2023–E–2803 FDA–2023–E–2804; FDA–2023–E–2805; and FDA–2023–E–2806 for Determination of Regulatory Review Period for Purposes of Patent Extension; EDWARDS SAPIEN 3 ULTRA RESILIA. Received comments, those filed in a timely manner (see **ADDRESSES**), will be placed in the dockets and, except for those submitted as ''Confidential Submissions,'' publicly viewable at *https://www.regulations.gov* or at the Dockets Management Staff between 9 a.m. and 4 p.m., Monday through Friday, 240–402–7500.

- Confidential Submissions—To submit a comment with confidential information that you do not wish to be made publicly available, submit your comments only as a written/paper submission. You should submit two copies total. One copy will include the information you claim to be confidential with a heading or cover note that states ''THIS DOCUMENT CONTAINS CONFIDENTIAL INFORMATION.'' The Agency will review this copy, including the claimed confidential information, in its consideration of comments. The second copy, which will have the claimed confidential information redacted/blacked out, will be available for public viewing and posted on *https://www.regulations.gov*. Submit both copies to the Dockets Management Staff. If you do not wish your name and contact information to be made publicly available, you can provide this information on the cover sheet and not in the body of your comments and you must identify this information as ''confidential.'' Any information marked as ''confidential'' will not be disclosed except in accordance with § 10.20 (21 CFR 10.20) and other applicable disclosure law. For more information about FDA's posting of comments to public dockets, see 80 FR 56469, September 18, 2015, or access the information at: *https://www.govinfo.gov/content/pkg/FR-2015-09-18/pdf/2015-23389.pdf*.

Docket: For access to the docket to read background documents or the electronic and written/paper comments received, go to *https://www.regulations.gov* and insert the docket number, found in brackets in the heading of this document, into the ''Search'' box and follow the prompts and/or go to the Dockets Management Staff, 5630 Fishers Lane, Rm. 1061, Rockville, MD 20852, 240–402–7500.

FOR FURTHER INFORMATION CONTACT: Jack Dan, Office of Regulatory Policy, Food and Drug Administration, 10903 New Hampshire Ave., Bldg. 51, Rm. 6200, Silver Spring, MD 20993, 240–402–6940.

SUPPLEMENTARY INFORMATION:

I. Background

The Drug Price Competition and Patent Term Restoration Act of 1984 (Pub. L. 98–417) and the Generic Animal Drug and Patent Term Restoration Act (Pub. L. 100–670) generally provide that a patent may be extended for a period of up to 5 years so long as the patented item (human drug or biological product, animal drug product, medical device, food additive, or color additive) was subject to regulatory review by FDA before the item was marketed. Under these acts, a product's regulatory review period forms the basis for determining the amount of extension an applicant may receive.

A regulatory review period consists of two periods of time: a testing phase and an approval phase. For medical devices, the testing phase begins with a clinical investigation of the device and runs until the approval phase begins. The approval phase starts with the initial submission of an application to market the device and continues until permission to market the device is granted. Although only a portion of a regulatory review period may count toward the actual amount of extension that the Director of USPTO may award (half the testing phase must be subtracted as well as any time that may have occurred before the patent was issued), FDA's determination of the length of a regulatory review period for a medical device will include all of the testing phase and approval phase as specified in 35 U.S.C. 156(g)(3)(B).

FDA has approved for marketing the medical device EDWARDS SAPIEN 3 ULTRA RESILIA. The EDWARDS SAPIEN 3 ULTRA RESILIA Transcatheter Heart Valve system is indicated (1) for relief of aortic stenosis in patients with symptomatic heart disease due to severe native calcific aortic stenosis who are judged by a Heart Team, including a cardiac surgeon, to be appropriate for the transcatheter heart valve replacement therapy and (2) for patients with symptomatic heart disease due to failing (stenosed, insufficient, or combined) of a surgical or transcatheter bioprosthetic aortic valve, a surgical bioprosthetic mitral valve, or a native mitral valve with an annuloplasty ring who are judged by a Heart team, including a cardiac surgeon, to be at high or greater risk for open surgical therapy (*i.e.,* predicted risk of surgical mortality 8% at 30 days, based on the Society of Thoracic Surgeons (STS) risk score and other clinical co-morbidities unmeasured by the STS risk calculator). Subsequent to this approval, the USPTO received patent term restoration applications for EDWARDS SAPIEN 3 ULTRA RESILIA (U.S. Patent Nos. 10,413,407; 10,433,958; 10,849,741; and 11,213,388) from Edwards Lifesciences Corporation, and the USPTO requested FDA's assistance in determining the patents' eligibility for patent term restoration. In a letter dated January 18, 2024, FDA advised the USPTO that this medical device had undergone a regulatory review period and that the approval of EDWARDS SAPIEN 3 ULTRA RESILIA represented the first permitted commercial marketing or use of the product. Thereafter, the USPTO requested that FDA determine the product's regulatory review period.

II. Determination of Regulatory Review Period

FDA has determined that the applicable regulatory review period for EDWARDS SAPIEN 3 ULTRA RESILIA is 88 days. Of this time, zero (0) days occurred during the testing phase of the regulatory review period, while 88 days occurred during the approval phase.

These periods of time were derived from the following dates:

1. *The date an exemption under section 520(g) of the Federal Food, Drug, and Cosmetic Act (FD&C Act) (21 U.S.C. 360j(g)) involving this device became effective: not applicable.* The applicant claims that the length of the testing phase of the regulatory review period is 0 days.

2. *The date an application was initially submitted with respect to the device under section 515 of the FD&C Act (21 U.S.C. 360e):* May 2, 2022. FDA has verified the applicant's claim that the premarket approval application (PMA) for EDWARDS SAPIEN 3 ULTRA RESILIA (PMA P140031/Supplement (S141)) was initially submitted May 2, 2022.

3. *The date the application was approved:* July 28, 2022. FDA has verified the applicant's claim that PMA P140031/S141 was approved on July 28, 2022.

This determination of the regulatory review period establishes the maximum potential length of a patent extension. However, the USPTO applies several statutory limitations in its calculations of the actual period for patent extension. In its application for patent extension, this applicant seeks 87 days of patent term extension.

III. Petitions

Anyone with knowledge that any of the dates as published are incorrect may submit either electronic or written comments and, under 21 CFR 60.24, ask for a redetermination (see **DATES**). Furthermore, as specified in § 60.30 (21 CFR 60.30), any interested person may petition FDA for a determination regarding whether the applicant for extension acted with due diligence during the regulatory review period. To meet its burden, the petition must comply with all the requirements of § 60.30, including but not limited to: must be timely (see **DATES**), must be filed in accordance with § 10.20, must contain sufficient facts to merit an FDA investigation, and must certify that a true and complete copy of the petition has been served upon the patent applicant. (See H. Rept. 857, part 1, 98th Cong., 2d sess., pp. 41–42, 1984.) Petitions should be in the format specified in 21 CFR 10.30.

Submit petitions electronically to *https://www.regulations.gov* at Docket No. FDA–2013–S–0610. Submit written petitions (two copies are required) to the Dockets Management Staff (HFA–305), Food and Drug Administration, 5630 Fishers Lane, Rm. 1061, Rockville, MD 20852.

Dated: June 18, 2025.

Grace R. Graham,

Deputy Commissioner for Policy, Legislation, and International Affairs.

[FR Doc. 2025–11603 Filed 6–24–25; 8:45 am]

BILLING CODE 4164–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket Nos. FDA–2024–E–0423; FDA–2024–E–0424; and FDA–2024–E–0426]

Determination of Regulatory Review Period for Purposes of Patent Extension; AGAMREE

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA or the Agency) has determined the regulatory review period for AGAMREE and is publishing this notice of that determination as required by law. FDA has made the determination because of the submission of applications to the Director of the U.S. Patent and Trademark Office (USPTO), Department of Commerce, for the extension of a patent which claims that human drug product.

DATES: Anyone with knowledge that any of the dates as published (see **SUPPLEMENTARY INFORMATION**) are incorrect may submit either electronic or written comments and ask for a redetermination by August 25, 2025. Furthermore, any interested person may petition FDA for a determination regarding whether the applicant for extension acted with due diligence during the regulatory review period by December 22, 2025. See ''Petitions'' in the **SUPPLEMENTARY INFORMATION** section for more information.

ADDRESSES: You may submit comments as follows. Please note that late, untimely filed comments will not be considered. The *https://www.regulations.gov* electronic filing system will accept comments until 11:59 p.m. Eastern Time at the end of August 25, 2025. Comments received by mail/hand delivery/courier (for written/paper submissions) will be considered timely if they are received on or before that date.

Electronic Submissions

Submit electronic comments in the following way:

- *Federal eRulemaking Portal: https://www.regulations.gov.* Follow the instructions for submitting comments. Comments submitted electronically, including attachments, to *https://www.regulations.gov* will be posted to the docket unchanged. Because your comment will be made public, you are solely responsible for ensuring that your comment does not include any confidential information that you or a third party may not wish to be posted, such as medical information, your or anyone else's Social Security number, or confidential business information, such as a manufacturing process. Please note that if you include your name, contact information, or other information that identifies you in the body of your comments, that information will be posted on *https://www.regulations.gov.*
- If you want to submit a comment with confidential information that you do not wish to be made available to the public, submit the comment as a written/paper submission and in the manner detailed (see ''Written/Paper Submissions'' and ''Instructions'').

Written/Paper Submissions

Submit written/paper submissions as follows:

- *Mail/Hand Delivery/Courier (for written/paper submissions):* Dockets Management Staff (HFA–305), Food and Drug Administration, 5630 Fishers Lane, Rm. 1061, Rockville, MD 20852.
- For written/paper comments submitted to the Dockets Management Staff, FDA will post your comment, as well as any attachments, except for information submitted, marked and identified, as confidential, if submitted as detailed in ''Instructions.''

Instructions: All submissions received must include the Docket Nos. FDA–2024–E–0423; FDA–2024–E–0424; and FDA–2024–E–0426, for ''Determination of Regulatory Review Period for Purposes of Patent Extension; AGAMREE.'' Received comments, those filed in a timely manner (see **ADDRESSES**), will be placed in the docket and, except for those submitted as ''Confidential Submissions,'' publicly viewable at *https://www.regulations.gov* or at the Dockets Management Staff between 9 a.m. and 4 p.m., Monday through Friday, 240–402–7500.

- Confidential Submissions—To submit a comment with confidential information that you do not wish to be made publicly available, submit your comments only as a written/paper submission. You should submit two copies total. One copy will include the information you claim to be confidential with a heading or cover note that states ''THIS DOCUMENT CONTAINS CONFIDENTIAL INFORMATION.'' The Agency will review this copy, including the claimed confidential information, in

its consideration of comments. The second copy, which will have the claimed confidential information redacted/blacked out, will be available for public viewing and posted on *https://www.regulations.gov.* Submit both copies to the Dockets Management Staff. If you do not wish your name and contact information to be made publicly available, you can provide this information on the cover sheet and not in the body of your comments and you must identify this information as ''confidential.'' Any information marked as ''confidential'' will not be disclosed except in accordance with § 10.20 (21 CFR 10.20) and other applicable disclosure law. For more information about FDA's posting of comments to public dockets, see 80 FR 56469, September 18, 2015, or access the information at: *https://www.govinfo.gov/content/pkg/FR-2015-09-18/pdf/2015-23389.pdf.*

Docket: For access to the docket to read background documents or the electronic and written/paper comments received, go to *https://www.regulations.gov* and insert the docket number, found in brackets in the heading of this document, into the ''Search'' box and follow the prompts and/or go to the Dockets Management Staff, 5630 Fishers Lane, Rm. 1061, Rockville, MD 20852, 240–402–7500.

FOR FURTHER INFORMATION CONTACT: Jack Dan, Office of Regulatory Policy, Food and Drug Administration, 10903 New Hampshire Ave., Bldg. 51, Rm. 6200, Silver Spring, MD 20993, 240–402–6940.

SUPPLEMENTARY INFORMATION:

I. Background

The Drug Price Competition and Patent Term Restoration Act of 1984 (Pub. L. 98–417) and the Generic Animal Drug and Patent Term Restoration Act (Pub. L. 100–670) generally provide that a patent may be extended for a period of up to 5 years so long as the patented item (human drug or biological product, animal drug product, medical device, food additive, or color additive) was subject to regulatory review by FDA before the item was marketed. Under these acts, a product's regulatory review period forms the basis for determining the amount of extension an applicant may receive.

A regulatory review period consists of two periods of time: a testing phase and an approval phase. For human drug products, the testing phase begins when the exemption to permit the clinical investigations of the drug becomes effective and runs until the approval phase begins. The approval phase starts with the initial submission of an application to market the human drug product and continues until FDA grants permission to market the drug product. Although only a portion of a regulatory review period may count toward the actual amount of extension that the Director of USPTO may award (for example, half the testing phase must be subtracted as well as any time that may have occurred before the patent was issued), FDA's determination of the length of a regulatory review period for a human drug product will include all of the testing phase and approval phase as specified in 35 U.S.C. 156(g)(1)(B).

FDA has approved for marketing the human drug product, AGAMREE (vamorolone) indicated for the treatment of Duchenne muscular dystrophy in patients 2 years of age and older. Subsequent to this approval, the USPTO received patent term restoration applications for AGAMREE (U.S. Patent Nos. 8,344,279; 10,857,161; and 11,690,853) from Catalyst Pharmaceuticals, Inc. and the USPTO requested FDA's assistance in determining the patents' eligibility for patent term restoration. In a letter dated May 8, 2024, FDA advised the USPTO that this human drug product had undergone a regulatory review period and that the approval of AGAMREE represented the first permitted commercial marketing or use of the product. Thereafter, the USPTO requested that FDA determine the product's regulatory review period.

II. Determination of Regulatory Review Period

FDA has determined that the applicable regulatory review period for AGAMREE is 3,215 days. Of this time, 2,849 days occurred during the testing phase of the regulatory review period, while 366 days occurred during the approval phase. These periods of time were derived from the following dates:

1. *The date an exemption under section 505(i) of the Federal Food, Drug, and Cosmetic Act (FD&C Act) (21 U.S.C. 355(i)) became effective:* January 8, 2015. The applicant claims January 11, 2015, as the date the investigational new drug application (IND) became effective. However, FDA records indicate that the IND effective date was January 8, 2015, which was the first date after receipt of the IND that the investigational studies were allowed to proceed.

2. *The date the application was initially submitted with respect to the human drug product under section 505 of the FD&C Act:* October 26, 2022. FDA has verified the applicant's claim that the new drug application (NDA) for AGAMREE (NDA 215239) was initially submitted on October 26, 2022.

3. *The date the application was approved:* October 26, 2023. FDA has verified the applicant's claim that NDA 215239 was approved on October 26, 2023.

This determination of the regulatory review period establishes the maximum potential length of a patent extension. However, the USPTO applies several statutory limitations in its calculations of the actual period for patent extension. In its applications for patent extension, this applicant seeks 115 days, 710 days, or 1,789 days of patent term extension.

III. Petitions

Anyone with knowledge that any of the dates as published are incorrect may submit either electronic or written comments and, under 21 CFR 60.24, ask for a redetermination (see **DATES**). Furthermore, as specified in § 60.30 (21 CFR 60.30), any interested person may petition FDA for a determination regarding whether the applicant for extension acted with due diligence during the regulatory review period. To meet its burden, the petition must comply with all the requirements of § 60.30, including but not limited to: must be timely (see **DATES**), must be filed in accordance with § 10.20, must contain sufficient facts to merit an FDA investigation, and must certify that a true and complete copy of the petition has been served upon the patent applicant. (See H. Rept. 857, part 1, 98th Cong., 2d sess., pp. 41–42, 1984.) Petitions should be in the format specified in 21 CFR 10.30.

Submit petitions electronically to *https://www.regulations.gov* at Docket No. FDA–2013–S–0610. Submit written petitions (two copies are required) to the Dockets Management Staff (HFA–305), Food and Drug Administration, 5630 Fishers Lane, Rm. 1061, Rockville, MD 20852.

Dated: June 18, 2025.

Grace R. Graham,

Deputy Commissioner for Policy, Legislation, and International Affairs.

[FR Doc. 2025–11602 Filed 6–24–25; 8:45 am]

BILLING CODE 4164–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. FDA–2024–N–5468]

Agency Information Collection Activities; Submission for Office of Management and Budget Review; Comment Request; Food and Drug Administration's Adverse Event and Product Experience Reporting Program

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA) is announcing that a proposed collection of information has been submitted to the Office of Management and Budget (OMB) for review and clearance under the Paperwork Reduction Act of 1995.

DATES: Submit written comments (including recommendations) on the collection of information by July 25, 2025.

ADDRESSES: To ensure that comments on the information collection are received, OMB recommends that written comments be submitted to *https://www.reginfo.gov/public/do/PRAMain*. Find this particular information collection by selecting ''Currently under Review—Open for Public Comments'' or by using the search function. The OMB control number for this information collection is 0910–0291. Also include the FDA docket number found in brackets in the heading of this document.

FOR FURTHER INFORMATION CONTACT: Domini Bean, Office of Operations, Food and Drug Administration, Three White Flint North, 10A–12M, 11601 Landsdown St., North Bethesda, MD 20852, 301–796–5733, *PRAStaff@fda.hhs.gov*.

SUPPLEMENTARY INFORMATION: In compliance with 44 U.S.C. 3507, FDA has submitted the following proposed collection of information to OMB for review and clearance.

FDA's Adverse Event and Product Experience Reporting Program

OMB Control Number 0910–0291—Revision

This information collection supports FDA laws and regulations governing adverse event reports and product experience reports for FDA-regulated products. The Federal Food, Drug, and Cosmetic Act (FD&C Act) (21 U.S.C. 353b, 355, 360i, 360l, 379aa, and 393) and the Public Health Service Act (42 U.S.C. 262) authorize FDA to collect adverse event reports and product experience reports from regulated industry and to monitor the safety of drugs, biologics, medical devices, and dietary supplements. These reporting and recordkeeping requirements are found in FDA regulations, discussed in Agency guidance, and included in Agency forms. Although not all respondents to the information collection are required to submit reports, we encourage voluntary reporting of adverse experiences associated with any FDA-regulated product.

To facilitate both consumer and industry reporting of adverse events and experiences with FDA-regulated products, we developed the MedWatch program. The MedWatch program allows anyone to submit reports to FDA on adverse events, including injuries and/or deaths, as well as other product experiences associated with the products we regulate. Requirements regarding mandatory reporting of adverse events or product problems have been codified in parts 310, 314, 329, 600, and 803 (21 CFR 310, 314, 600, and 803), and specified in sections 503B, 760, and 761 of the FD&C Act (21 U.S.C. 353b, 379aa, and 379aa–1). Mandatory reporting of adverse events for human cells, tissues, and cellular- and tissue-based products (HCT/Ps) have been codified in Sec. 1271.350 (21 CFR 1271.350). Other postmarketing reporting associated with requirements found in sections 201, 502, 505, and 701 (21 U.S.C. 321, 352, 355, and 371) of the FD&C Act and applicable to certain drug products with and without approved applications are accounted for in OMB control number 0910–0230. Mandatory reporting under 21 CFR part 803, associated with medical device products, using form FDA 3500a, is accounted for in OMB control number 0910–0437.

Since 1993, mandatory adverse event reporting has been supplemented by voluntary reporting by healthcare professionals, patients, and consumers via the MedWatch reporting process. To carry out its responsibilities, the Agency needs to be informed when an adverse event, product problem, error with use of a human medical product, or evidence of therapeutic failure is suspected or identified in clinical use. When FDA receives this information from healthcare professionals, patients, or consumers, the report becomes data that will be used to assess and evaluate the risk associated with the product. FDA will take any necessary action to reduce, mitigate, or eliminate the public's exposure to the risk through regulatory and public health interventions.

To implement these reporting provisions for FDA-regulated products (except vaccines) during their post-approval and marketed lifetimes, we developed the following three forms, available for download from our website or upon request to the Agency: (1) Form FDA 3500 may be used for voluntary (*i.e.,* not mandated by law or regulation) reporting by healthcare professionals; (2) Form FDA 3500A is used for mandatory reporting (*i.e.,* required by law or regulation); and (3) Form FDA 3500B, available in English and Spanish, is written in plain language and may be used for voluntary reporting (*i.e.,* not mandated by law or regulation) by consumers (*i.e.,* patients and their caregivers). Respondents to the information collection are healthcare professionals, medical care organizations and other user facilities (*e.g.,* extended care facilities, ambulatory surgical centers), consumers, manufacturers of biological, food products including dietary supplements and special nutritional products (*e.g.,* infant formula and medical foods), cosmetics, drug products or medical devices, and importers.

Use of Form FDA 3500, MedWatch—The Safety Information and Adverse Event Reporting Program (Voluntary Reporting)

This voluntary version of the form may be used by health care professionals to submit all reports not mandated by Federal law or regulation. Individual health care professionals are not required by law or regulation to submit reports to the Agency or the manufacturer, with the exception of certain adverse events following immunization with vaccines as mandated by the National Childhood Vaccine Injury Act of 1986. Reports for vaccines are not submitted via MedWatch or MedWatch forms but are submitted to the Vaccines Adverse Event Reporting System (VAERS; see *http://vaers.hhs.gov*), which is jointly administered by FDA and the Centers for Disease Control and Prevention.

Hospitals are not required by Federal law or regulation to submit reports associated with drug products, biological products, or special nutritional products. However, hospitals and other user facilities are required to report medical device-related deaths and serious injuries (accounted for in OMB control number 0910–0437).

Under Federal law and regulation (section 761(b)(1) of the FD&C Act), a

dietary supplement manufacturer, packer, or distributor whose name appears on the label of a dietary supplement marketed in the United States is required to submit to FDA any serious adverse event report it receives regarding use of the dietary supplement in the United States. However, FDA bears the burden to gather and review evidence that a dietary supplement may be adulterated under section 402 of the FD&C Act after that product is marketed. Therefore, the Agency depends on the voluntary reporting by healthcare professionals and especially by consumers of suspected serious adverse events and product quality problems associated with the use of dietary supplements. All dietary supplement reports were originally received by the Agency on paper versions of Form FDA 3500 (by mail or fax). Today, electronic reports may be sent to the Agency via an online submission route called the Safety Reporting Portal at *http://www.safetyreporting.fda.gov/*. In that case, the Form FDA 3500 is not used.

Form FDA 3500 may be used to report to the Agency adverse events, product problems, product use errors, and therapeutic failures. The form is provided in both paper and electronic formats. Reporters may mail or fax paper forms to the Agency. A fillable .pdf version of the form is available at *https://www.accessdata.fda.gov/scripts/medwatch/* or electronically submit a report via the MedWatch Online Voluntary Reporting Form at *https://www.accessdata.fda.gov/scripts/medwatch/*.

Reporting using Form FDA 3500 in paper form is supported for drugs, non-vaccine biologicals, medical devices, food products, special nutritional products, cosmetics, and non-prescription human drug products marketed without an approved application, and dietary supplements. Electronic reports for FDA products, may be submitted to the Agency via an online submission route called the Safety Reporting Portal at *http://www.safetyreporting.fda.gov/*.

Electronic reports for tobacco products may be submitted to the Agency via the tobacco questionnaire within the online Safety Reporting Portal at *http://www.safetyreporting.fda.gov/*.

Use of Form FDA 3500A, MedWatch for use by User-Facilities, Importers, Distributors, and Manufacturers (Mandatory Reporting)

Drug and Biological Products

Sections 503B, 505(j), and 704 of the FD&C Act (21 U.S.C. 374) require that important safety information relating to all human prescription drug products be made available to FDA in the event it becomes necessary to take appropriate action to ensure protection of the public health. Mandatory reporting of adverse events for HCT/Ps is codified in Sec. 1271.350. Consistent with statutory requirements, information is required to be submitted electronically and therefore we account for most all reports under OMB control number 0910–0230 to support electronic reporting to our MedWatch program. At the same time, regulations are provided for waivers from the electronic submission requirements and we therefore account for paper-based reporting in this information collection.

Medical Device Products

Section 519 of the FD&C Act (21 U.S.C. 360i) requires manufacturers and importers, of devices intended for human use to establish and maintain records, make reports, and provide information as the Secretary of Health and Human Services may by regulation reasonably require to assure that such devices are not adulterated or misbranded and to otherwise assure its safety and effectiveness. The Safe Medical Device Act of 1990, signed into law on November 28, 1990, amends section 519 of the FD&C Act. The amendment requires that user facilities such as hospitals, nursing homes, ambulatory surgical facilities, and outpatient treatment facilities report deaths related to medical devices to FDA and to the manufacturer, if known. Serious illnesses and injuries are to be reported to the manufacturer or to FDA if the manufacturer is not known. These statutory requirements regarding mandatory reporting have been codified by FDA under 21 CFR part 803 (part 803). Part 803 mandates the use of the Form FDA 3500A for reporting to FDA on medical devices. Mandatory reporting associated with medical device products using form FDA 3500A is accounted for in OMB control number 0910–0437.

Dietary Supplements

Section 502(x) in the FD&C Act implements the requirements of The Dietary Supplement and Nonprescription Drug Consumer Protection Act, which became law (Pub. L. 109–462) on December 22, 2006. These requirements apply to manufacturers, packers, and distributors of nonprescription human drug products marketed without an approved application. The law requires reports of serious adverse events to be submitted to the Agency by manufacturers of dietary supplements.

Electronic reports for dietary supplements may be submitted using the Safety Reporting Portal at *http://www.safetyreporting.fda.gov/*. Paper-based dietary supplement reports may be submitted using the MedWatch Form FDA 3500A.

Use of Form FDA 3500B, MedWatch Consumer Voluntary Reporting

This voluntary version of the form may be used by consumers, patients, or caregivers to submit reports not mandated by Federal law or regulation. Individual consumers, patients, or caregivers are not required by law or regulation to submit reports to the Agency or the manufacturer. FDA supports and encourages direct reporting to the Agency by consumers of suspected adverse events and other product problems associated with human medical products, food, dietary supplements, and cosmetic products and invite these respondents to visit our website at *https://www.fda.gov/safety/report-problem-fda* for more information. Since the inception of the MedWatch program in July 1993, the program has been promoting and facilitating voluntary reporting by both the public and healthcare professionals. FDA has further encouraged voluntary reporting by requiring inclusion of the MedWatch toll-free phone number or the MedWatch internet address on all outpatient drug prescriptions dispensed, as mandated by section 17 of the Best Pharmaceuticals for Children Act (Pub. L. 107–109).

Section 906 of the FDA Amendments Act amended section 502(n) of the FD&C Act, mandating that published direct-to-consumer advertisements for prescription drugs include the following statement printed in conspicuous text (this includes vaccine products): ''You are encouraged to report negative side effects of prescription drugs to the FDA. Visit *https://www.fda.gov/medwatch,* or call 1–800–FDA–1088.'' Most private vendors of consumer medication information, the drug product-specific instructions dispensed to consumers at outpatient pharmacies, remind patients to report ''side effects'' to FDA and provide contact information to permit MedWatch reporting.

Form FDA 3500B, since it was first made available in 2013 was tailored for

consumers and written in plain language in conformance with the Plain Writing Act of 2010 (*https://www.govinfo.gov/content/pkg/PLAW-111publ274/pdf/PLAW-111publ274.pdf*) and has evolved with input from human factors experts, from other regulatory agencies and with extensive input from consumer advocacy groups and the public. It is used to report adverse events, product problems, product use errors and problems after switching from one product maker to another maker to the Agency. The form is available in Spanish at *https://www.fda.gov/safety/medwatch-fda-safety-information-and-adverse-event-reporting-program/reporting-serious-problems-fda* and available to upload electronically since 2021 at *https://www.accessdata.fda.gov/scripts/medwatch/index.cfm?action=reporting.spanish* and provided in both paper and electronic formats. Respondents may submit reports by mail or fax paper forms to the Agency or electronically submit a report via the MedWatch Online Voluntary Reporting Form at *https://www.accessdata.fda.gov/scripts/medwatch/*. A fillable.pdf version of the form, available at *http://www.fda.gov/downloads/AboutFDA/ReportsManualsForms/Forms/UCM349464.pdf* may be downloaded, completed, and mailed or faxed to the Agency. Reporting is supported for drugs, non-vaccine biologicals, medical devices, food products, special nutritional products, cosmetics, and non-prescription human drug products marketed without an approved application. The paper form may also be used to submit reports about dietary supplements. Electronic reports for dietary supplements may be submitted to the Agency via an online submission route called the Safety Reporting Portal at *http://www.safetyreporting.fda.gov/*.

Use of Form FDA 3800, Safety Reporting Portal

The Safety Reporting Portal (SRP) streamlines the process of reporting product safety issues to the FDA. Organizations and people in certain professional roles, such as the following, may be required by law to submit safety reports under some circumstances. Food Manufacturers, processors, packers, and holders, researchers, an applicant of an approved drug product or a manufacturer, distributor or packer listed on the label of any marketed drug product, drug manufacturers, sponsors, sponsor-investigators of investigational drugs and biologics, dietary supplement manufacturers, packers, and distributors, tobacco product manufacturers.

Others, including healthcare providers, public health officials, and other professionals, as well as consumers and concerned citizens, may voluntarily submit reports if they encounter safety issues with a product and/or harmful effects that they believe are related to a product.

The information collection includes the following agency forms, available electronically via the Safety Reporting Portal:

Center for Veterinary Medicine—Voluntary reporting of adverse events and product problems involving Pet Food or Livestock Food. Section 1002(b) of the FDAAA directed the Secretary to establish an early warning and surveillance system to identify adulteration of the pet food supply and outbreaks of illness associated with pet food. We developed the Pet Food Early Warning System rational questionnaire as a user-friendly data collection tool, as well as a questionnaire for collecting voluntary adverse event reports associated with pet and livestock food. Information collected in these voluntary adverse event reports contribute to CVM's ability to identify adulteration of the pet and livestock food supply and outbreaks of illness associated with pet and livestock food. We use the information collected to help ensure that such products are quickly and efficiently removed from the market to prevent foodborne illnesses.

Center for Tobacco Products—Voluntary Tobacco Product Health Problem or Product Problem Reports (*i.e.,* Adverse experience reports). Voluntary adverse experience reports have been collected from consumers/concerned citizens and healthcare professionals via the Safety Reporting Portal's (SRP) Tobacco Problem Report (TPR) questionnaire since January 10, 2014, from tobacco product manufacturers via the SRP TPR since June 10, 2016, and from researchers engaged in clinical trials using investigational or legally marketed tobacco products via the SRP Tobacco Investigator Report (TIR) questionnaire since June 10, 2016. For efficiency of Agency operations, we have consolidated activities associated with adverse event reporting previously approved under OMB control number 0910–0879 into this collection.

Mandatory Tobacco Product Health Problem or Product Problem Reports (*i.e.,* Adverse experience reports). On October 5, 2021 (86 FR 55300), FDA published a rule titled ''Premarket Tobacco Product Applications and Recordkeeping Requirements (PMTA)''. The rule establishes regulatory definitions (§ 1114.3) for adverse experience, serious adverse experience and unexpected adverse experience associated with tobacco product use. The Final Rule, in effect since November 4, 2021, requires premarket applicants (manufacturers of new tobacco products) who receive marketing granted orders to report all serious and unexpected adverse experiences associated with the tobacco product (§ 1114.41(a)(2)) that have been reported to the applicant or of which the applicant is aware, to the SRP or in another manner designated by FDA, within 15 calendar days of their awareness.

Proposed Modifications to Existing Forms 3500, 3500A and 3500B

General Changes

The proposed modifications to Form FDA 3500, 3500A and Form FDA 3500B (English and Spanish) reflect changes that will bring the forms into conformation, since the previous authorization in 2022, with current regulations, rules, and guidances. The proposed extension to Form FDA 3500, Form FDA 3500A, and Form FDA 3500B will only have changes in the form instructions to provide clarity of reporting. The proposed changes fall into one of three categories (1) regulatory driven revisions (2) work improvements for the Center and (3) report processing improvements. Formatting modifications are being proposed to several fields to enhance the quality, utility and clarity of the information. We also propose to update the mailing address add mailing address to Attn: MedWatch Program, White Oak Campus, Building 22, G0207, 10903 New Hampshire Ave., Silver Spring, MD 20993.

Changes Proposed for Form FDA 3500

Throughout the form, we propose to:

- add calendar functionality to all date fields for uniformity and standardization of date format.

In the header, we propose to specify the intended reporters at the top of form (*i.e.,* Health Professional Voluntary Reporting).

In Section A, we propose to:

- based on the executive order, Defending Women from Gender Ideology Extremism and Restoring Biological Truth to the Federal Government, signed by President Donald J. Trump on January 20, 2025, revise the Sex field to include two options, Male and Female. and remove the Gender field. combine the Ethnicity (Field A5) and Race (Field A6) fields as

outlined in the Statistical Policy Directive No. 15: Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity (SPD 15) issued on March 29, 2024. Add new text—''What is your race and/or ethnicity? Select all that apply.'' The data fields include:

- American Indian or Alaska Native
- Asian
- Black or African American
- Hispanic or Latino
- Middle Eastern or North African
- Native Hawaiian or Pacific Islander
- White

In Section B, we propose to:

• re-order the outcomes attributed to adverse events list so that ''Other Serious or Important Medical Events'' appears as the last choice of the outcomes listed in Field B2.

• Add field for reference ranges in the Relevant Test/Laboratory Data section (Field B6)

In Section C, we propose to:

• Add field for Where (*e.g.,* website, pharmacy/store/state of purchase) was the suspect product obtained and When (date) was the suspect product obtained

In section D, we propose to:

• Remove 'This report involves cosmetic, dietary supplement, food/medical food and other.'' Cosmetic will now be captured under the ''Product Type'' section Field D5.)

• add ''Usage Dates'' after ''Treatment Dates/Therapy Dates'' and add ''Usage'' after ''treatment'' and ''Therapy'' in Field D3.

• revise the ''Product Type'' section (Field D5) as follows: (Note: Dietary supplement and Food/medical food selections will be removed. Adverse events involving these products should be submitted through the Safety Reporting Portal)

- Drug or Biologic
  - Brand
  - Generic or Biosimilar
  - Over-the Counter (OTC)
  - Compounded product (by a Pharmacy or an Outsourcing Facility)
- Cosmetic
  - Cosmetic for professional use only
  - Cosmetic sold on a retail basis
- Cannabinoid Hemp Products (such as products containing CBD)
- Other

In section E, we propose to interchange the fields 2a and 2b. ''Procode'' will now appear in field 2a and ''Common Device Name'' will appear in field 2b.

In section G, we propose to add a field ''Packer'' to the list under ''Also Reported to'' in Field G4.

In the Advice about Voluntary Reporting section, we propose to:

• remove:
- Special nutritional products (dietary supplements, medical foods, infant formulas)
- Food (including beverages and ingredients added to foods)

• add:
- If your report involves a health problem or product problem with foods or special nutritional products such as infant formulas, dietary supplements, or medical foods, go to *https://www.safetyreporting.fda.gov* or call 1–888–723–3366 to report.

• revise:
- ''If your report involves a health problem or a product problem with a tobacco product, go to *https://www.safetyreporting.fda.gov* or call 1–877–287–1363 to report.'' to ''If your report involves a health problem or a product problem with a tobacco product, including e-cigarettes (nicotine-containing vapes) or nicotine pouches, go to *https://www.safetyreporting.fda.gov* or call 1–877–287–1363 to report.''

Changes Proposed for Form FDA 3500A

Throughout the form, we propose to:

• add calendar functionality to all date fields for uniformity and standardization of date format.

In the header, we propose to:

• revise ''For use by user-facilities, importers, distributors and manufacturers'' to ''For use by user-facilities, importers, distributors, manufacturers and packers.''

• remove the header ''FDA USE ONLY''

• revise ''Exemption/Variance #'' field to ''Exemption/Variance/Alternative #.''

In Section A, we propose to:

• based on the executive order, Defending Women from Gender Ideology Extremism and Restoring Biological Truth to the Federal Government, signed by President Donald J. Trump on January 20, 2025, revise the Sex field to include two options, Male and Female. and remove the Gender field.

• combine the Ethnicity (Field A5) and Race (Field A6) fields as outlined in the Statistical Policy Directive No. 15: Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity (SPD 15) issued on March 29, 2024. Add new text—''What is your race and/or ethnicity?'' Select all that apply.

- The data fields include:

• combine the Ethnicity (Field A5) and Race (Field A6) fields as outlined in the Statistical Policy Directive No. 15: Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity (SPD 15) issued on March 29, 2024. Add new text—''What is your race and/or ethnicity? Select all that apply.''

- The data fields include:
  - *American Indian or Alaska Native*
  - *Asian*
  - *Black or African American*
  - *Hispanic or Latino*
  - *Middle Eastern or North African*
  - *Native Hawaiian or Pacific Islander*
  - *White*

In Section B, we propose to:

• re-order the outcomes attributed to adverse events list so that ''Other Serious or Important Medical Events'' appears as the last choice of the outcomes listed in Field B2.

• add language on page 1 ''Describe Event or Problem'' and on page 2 ''Describe Event or Problem (continued)'' (Field B5)

• add field for reference ranges in the Relevant Test/Laboratory Data section (Field B6)

In Section C, we propose to:

• revise the ''Name, Strength, Manufacturer/Compounder'' field under ''Manufacturer/Compounder Name'' '' to include a new field for ''FEI # for cosmetics'' '' This revision applies to Suspect Product #1 and Suspect Product #2. (Field C1)

• add ''Usage Dates'' after ''Treatment Dates/Therapy Dates'' and add ''Usage'' after ''treatment'' and ''Therapy.'' (Field C4)

• revise the ''Product Type'' section (Field C6) as follows (applies to Suspect Product #1 and Suspect Product #2):

- Drug or Biologic
  - Brand
  - Generic or Biosimilar
  - Over-the Counter (OTC)
  - Compounded product (by a Pharmacy or an Outsourcing Facility)
- Cosmetic
  - Cosmetic for professional use only
  - Cosmetic sold on a retail basis
- Other

In section D, we propose to interchange the fields 2a and 2b. ''Procode'' will now appear in field 2a and ''Common Device Name'' will appear in field 2b.

In Section F, we propose to:

- revise to ''User Facility or Importer Name/Address'' field to ''User Facility or Importer Name/Address/Email'' (Field F3)

• add the following two selections with checkboxes, ''Initial'' and ''Follow-up #_.'' in the Type of Report field (Field F7)

• delete ''Date of This Report (01–JAN–1900)'' field (Field F8). This information is requested in ''Report Sent to FDA?'' (Field F11) or ''Report Sent to Manufacturer?'' (Field F13).

In Section G, we propose to:

- revise ''Contact Office (and Manufacturing Site for Devices) or Compounding Outsourcing Facility'' to ''Contact Office (and Manufacturing Site for Devices) or Compounding Outsourcing Facility or Responsible Person'' (Field G1)
- revise ''Use Facility'' to ''User Facility'' in the Report Source field (Field G2)
- revise ''Date Received by Manufacturer (01–JAN–1900)'' to ''Date Received by Manufacturer (01–JAN–1900) or Responsible Person'' (Field G3)
- revise ''ANDA #'' to ''ANDA/Pre-ANDA #.'' (Field G4)
- revise ''Periodic'' to ''Non-expedited (periodic)'' under ''Type of Report'' field (Field G6)
- revise ''If action reported to FDA under 21 U.S.C. 360i(g), list correction/removal reporting number:'' to ''If action reported to FDA under 21 U.S.C. 360i(g), list FDA-assigned recall number or include a statement:'' (Field H9)

Changes Proposed for Form FDA 3500A Instructional Supplement

- The FDA Form 3500A instructional supplement will be revised to correct grammatical errors and to clarify reporting instructions.
- In addition to these changes, the FDA Form 3500A instructional supplement will include revisions based on the Modernization of Cosmetics Registration Act of 2022 (MoCRA). The instructional supplement will include the following revisions specifically pertaining to cosmetics:

General Instructions

- Add the text '', or cosmetic product'' to ''If no suspect medical device is involved in a reported adverse event (*i.e.,* when reporting ONLY a suspect drug or, biologic) ONLY sections A, B, C, E, and G are to be filled out:
- Remove the text ''or,'' between drug and biologic
- Add the text ''When reporting ONLY a cosmetic product, the sections and/or subsections/blocks that are not relevant to cosmetics should be left blank.''
- Add the text ''Cosmetic Products: Responsible persons submitting serious adverse event reports for cosmetic products using Form FDA 3500A should include a copy of the label on or within the retail packaging of the cosmetic product, along with any information that can be provided to support the report, such as scans of labels and images of the serious adverse event. This may be submitted to FDA:''
- Add the text ''via email at: *CosmeticAERS@fda.hhs.gov*''
- Add the text ''Or by mail to: FDA CDER Mail Center, Attn: Cosmetics MedWatch Reports. White Oak Campus, Building 22, G0207, 10903 New Hampshire Ave., Silver Spring, MD 20993''

Front Page

- Add the text ''For cosmetic products, the User Facility/Importer Report # and Exemption/Variance # should be left blank in this section.''
- Add the text ''(mfr report #): after ''Manufacturer report #''
- Revise the text ''The manufacturer report number is also entered in block G9 on the back of the form'' to ''The manufacturer report number is also entered in block G8 on the back of the form.''
- Add the text ''and for responsible persons for cosmetic products:'' to ''For drug and biologics manufacturers''
- Add the text ''that'' and ''or the responsible person to ''The ''mfr report #'' is the number the manufacturer chooses to uniquely identify the report, and should conform to any applicable regulations or guidances.''

Section B: Adverse Event or Product Problem

- B1: Type of Report
  - Adverse event: Include the text ''or cosmetic product'' to ''Any incident where the use of a product (drug or biologic, including human cell, tissue, or cellular or tissue-based product (HCT/P), at any dose, or a medical device (including in vitro diagnostic products), is suspected to have resulted in an adverse outcome in a patient.
- B2: Outcomes attributed to adverse event
- Add ''and Cosmetic Products'' to'' Drugs and Biologics''
- Include the regulatory reference ''21 CFR and Section 605 of the FD&C Act, respectively.''
- Under Disability or Permanent Damage, add the following text:
  - For cosmetic products, check if the adverse event resulted in a persistent or significant disability or incapacity.
- Under Congenital Anomaly/Birth Defect, remove the text ''medical.''
- Under Other Serious (Important Medical Events), add the following text:
  - Cosmetic Products: Check if the other categories are not applicable, such as when the adverse event results in an infection or significant disfigurement (including serious and persistent rashes, second- or third-degree burns, significant hair loss, or persistent or significant alteration of appearance) other than as intended, under conditions of use that are customary or usual. Describe the outcomes in the actual narrative of the event in block B5.
- B4: Date of this Report
  - Add the text '', and Cosmetic Products'' to ''For all mandatory reports filed for Medical Devices, Drugs, and Biologics, including Human Cells, Tissues, and Cellular and Tissue- Based Products enter the date the report is submitted to the FDA.''
- B5: Describe Event or Problem

Add the text ''For cosmetics, please indicate whether the product was for professional use only; describe the amount and frequency used; for which body parts the cosmetic product was used; and outcomes.'' Section C: Suspect Product(s)

- Add the text ''For cosmetic products, fill out ONLY the blocks that are relevant to cosmetic products.''
- C1: Add the following text after the ''Name, Strength, Manufacturer/Compounder'' instruction—''For cosmetics: In the product name field, enter the statement of identity as such name appears on the label. If the product names in the listing are not unique, then also include distinguishing information for identification purposes. For example, please include a brand name or a code that the responsible person uses to distinguish the product. Such information may also be included, in addition to the product name, even when product names in the listing are unique. If you believe certain distinguishing information is confidential, please include that distinguishing information in parentheses''.
- C1: Add the following text after the ''NDC# or Unique ID'' instruction—''For cosmetic product(s), if available, the FDA Establishment Identifier (FEI) number obtained by the owner or operator of a facility(ies), of the facility that manufactured or processed the affected cosmetic product(s). FEI is also known as the Firm or Facility Establishment Identifier.''
- C2: List Medical Products and Treatment Given at the Same time of the Event and Date
- Add the text ''For cosmetic reports include all related cosmetic products used at the same time.''
- C3: Dose, Frequency & Route Used
- Add the text ''or the consumer'' after ''Describe how the product was used by the patient''
- Add the words ''or number of applications, area of application)'' after ''(*e.g.,* 500 mg QID orally or 10 mg every other day IV.''
- C4: Treatment/Therapy Start and Stop Dates
- Add the text ''Usage'' to the C4: Treatment/Therapy Start and Stop Dates heading

- Add the text ''treatment/therapy'' and ''or usage'' to the following sentence. ''Provide the date of administration was started (or best estimate) and the date stopped (or best estimate).''
- C6: Add the text ''Cosmetics for Professional Use Only, Cosmetics Sold on a Retail Basis,'' after ''Biosimilar,'' and before ''please check the best option that best fits this medical product.''
- C7: Add the text ''For cosmetic products, if available, include best by/use by date'' to the ''Expiration date'' after the current instruction.

Section G: All Manufacturers

- Add the text ''AND RESPONSIBLE PERSONS'' to the Section G: ALL MANUFACTURERS heading
- Add the text ''or responsible persons (in case of cosmetic products)'' to the sentence, ''This section is to be filled out by all manufacturers.''
- Add the text ''or cosmetic product'' to ''NOTE: If a drug, biologic, including human cell, tissue, and cellular and tissue-based product (HCT/P),''
- Add the text ''(or responsible person in case of cosmetic product)'' to the ''manufacturer is reporting an adverse event in which no suspect medical device is involved, section G may be identically reproduced in place of Section D on the front of the form so that a one-page form may be submitted.''
- Add the following text, ''For cosmetic products, fill out ONLY the blocks that are relevant to cosmetic products.''
- G1: Contact Office (and manufacturing site for devices) or Compounding Outsourcing Facility
  - Add ''or Responsible Person (in case of cosmetic products)'' to ''Contact Office (and manufacturing site for devices) or Compounding Outsourcing Facility'' heading
  - Add this text as the last sentence ''For cosmetic products, enter the information of the responsible person, which means the manufacturer, packer, or distributor of a cosmetic product whose name appears on the label of the cosmetic product.''
- G2: Report Source:
  - Add the text ''and Cosmetic Products'' to the sentence ''Drugs and Biologics, including HCT/Ps: A separate 3500A form must be completed for each identifiable patient described in the article or manuscript.'' Remove the text '', and'' between ''Drugs and Biologics.''
- G3: Date received by manufacturer:
  - Add the text ''or responsible person (in case of cosmetic product)'' to the heading
  - Add the text ''responsible person,'' to the following sentence, ''This means the date when the applicant, manufacturer, corporate affiliate, etc. receives information that an adverse event or medical device malfunction has occurred.''
- G6: Type of Report:
  - Under 15-day, add the following text '', and cosmetic products'' to ''As specified in the drug, biologic, including human cell, tissue, and cellular and tissue- based product (HCT/P),''
  - Under 15-day, add the following text ''or requirements,'' to ''regulations for reports of serious and unexpected adverse events.''
  - Change the ''Periodic'' label to ''Non-expedited (Periodic)'' and add ''For Cosmetic products, use this option for non-serious adverse event.''
  - Under Follow-up, add the text ''and cosmetic products'' to ''Follow-up reports on drugs, biologics, including HCT/Ps, should contain information that was submitted in the original report if the information is still correct.''
- G7: Adverse Event Term(s):
  - Add the text '', and cosmetic products'' to ''[for use by drug, biologic, including human cell, tissue, and cellular and tissue-based product (HCT/P),''
  - Add the text ''(or responsible persons, in case of cosmetic products)'' to ''manufacturers only]''
  - Remove the text ''or WHOART'' from the list of accepted standards.
- G8: Manufacturer Report Number
  - Remove the following text that refers to the MedWatch to Manufacturer program. ''If submitting a follow-up to a report originally obtained from FDA through a MedWatch to Manufacturer program transmission of a serious direct report, check the ''Other'' box in block G2 and enter the FDA-assigned report number there.''
  - Add ''For cosmetics: The manufacturer report number is the number the responsible person chooses to uniquely identify the report, and should conform to any applicable regulations or guidances. The submission will not be considered complete without this information. While FDA currently does not have a mandatory format for the Manufacturer Report Number for reporting cosmetic adverse events, we strongly encourage you to use a numbering system that provides unique information of the adverse event reported, such as the year, company name, and the case report number.

Changes Proposed for Form FDA 3500B

In the instructions section, we propose to make the following revisions:

- Under ''When do I use this form?''
  - Revise the first bullet to ''You were hurt or had a bad side effect (including new or worsening symptoms) after taking a drug or using a medical device or product to ''You were hurt or had a bad side effect (including new or worsening symptoms) after using a product, drug, cosmetic or a medical device.''
  - Add the word ''cosmetic'' after the word ''drug'' in the following bullets:
    - You used a product, drug, cosmetic, or medical device incorrectly which could have or led to unsafe use.
    - You noticed a problem with the quality of the product, drug, cosmetic, or medical device.
- Under ''Don't use this form to report:''
  - Add the hyperlink for the Vaccine Adverse Event Reporting System (VAERS), add descriptive language under tobacco products about e-cigarettes and nicotine pouches, remove the word cosmetic from the safety reporting portal language and revise the hyperlink to the Safety Reporting Portal.
  - Vaccines—report problems to the Vaccine Adverse Event Reporting System (VAERS) *http://vaers.hhs.gov.*
  - Tobacco products, including e-cigarettes (nicotine-containing vapes) and nicotine pouches—report health or product problems to the Safety Reporting Portal (SRP) *https://www.safetyreporting.fda.gov/* or call 1–877–287–1363.
  - Remove the word ''cosmetic'' from the last bullet—Food or dietary supplement products—report problems to the SRP *https://www.safetyreporting.fda.gov/.*
- Under ''What types of products should I use this form for?''
  - In the first bullet, add a comma between ''bone), allergenics''
  - In the third bullet, remove the word ''makeup.''
  - Add bullet for ''Cannabinoid Hemp Products (such as products containing CBD''
  - Remove last bullet: Foods (including beverages and ingredients added to foods)
- Under ''Are there specific instructions for filling out the form?''
  - The first two bullets in this section will remain unchanged.
  - New text will be added for the third and fourth bullet.
    - Including or attaching images of all sides of the product will help FDA review your report but is not required. Please do not send the products to the FDA.
    - The Global Unique Device Identification Database (GUDID) contains key device identification information submitted to the FDA about medical devices that have Unique Device Identifiers (UDI). In

collaboration with the National Library of Medicine, the FDA has created a portal, called Access GUDID, to make device identification information in the GUDID available for everyone. For more information regarding the UDI#, refer to the UDI web page, *https://www.fda.gov/medical-devices/device-advice-comprehensive-regulatory-assistance/unique-device-identification-system-udi-system.*

- Under ''How can I contact the FDA if I have questions?'' add a phone number for cosmetics.
  - For Cosmetics: Toll-free line: 1–888–723–3366
- Add language to match that of the MedWatch Online application
  - If this is a medical emergency, please call 911.
  - If you have a mental health crisis, please call 988.

In Section A—About the Problem, we propose to:

- Add field for reference ranges in the Relevant Test/Laboratory Data section (Field A5)

In Section B—Product Availability, we propose to:

- Revise the question in Field B2 from ''Do you have a picture of the product? (check yes if you are including a picture)'' to ''2. Do you have a picture of the product including product labels if reporting cosmetics? While not required, pictures of all sides of the product will help FDA review your report. (check yes if you are including pictures)
- Under the section, ''For a problem with a product, including''
  - Remove the language ''or make-up products'' from the fourth bullet.
  - Remove bullets 3 and 5:
- nutrition products, such as vitamins and minerals, herbal remedies, infant formulas, and medical foods
- foods (including beverages and ingredients added to foods)
- Under the section ''For a health or product problem with a food, cosmetic, dietary supplement or tobacco product''
  - Remove the word ''cosmetic.''
  - Revise the hyperlink to the Safety Reporting Portal to *https://www.safetyreporting.fda.gov/*

In Section C: About the Products, we propose to:

- Remove ''This report is about'' or field C1. Product type field will be updated.
- Add a section for a second suspect product and design the two sections for suspect product on the same page to facilitate the addition of another page if the reporter needs to report more than two products.
- For field C3, add the word ''usage'' after ''therapy.'' Revised language will be ''Check if therapy/usage is on-going.''
- Revise the field ''Product Type'' (Field C5) as follows: (Note: Dietary supplement and Food/Medical Food selections will be removed. Adverse events involving these products should be submitted through the Safety Reporting Portal)
  - Drug or Biologic
    - Brand
    - Generic or Biosimilar
    - Over-the Counter (OTC)
    - Compounded product (by a Pharmacy or an Outsourcing Facility)
  - Cosmetic
    - Cosmetic for professional use only
    - Cosmetic sold on a retail basis
  - Cannabinoid Hemp Products (such as products containing CBD
  - Other
- For Field C12, revise instructions from ''How was it taken or used (for example, by mouth, injection, or on the skin)?'' to ''How was it taken or used (for example, by mouth, injection, inhaled, or on the skin)?'' to add the word ''inhaled.''
- Add a field for ''Purchase Date.''
- Add a field for Where (*e.g.,* website, pharmacy/store/state of purchase) was the suspect product obtained and When (date) was the suspect product obtained. Propose addition of fields to capture ''Place of Purchase Name,'' ''web page/URL (if purchased online),'' and ''Place of Purchase City and State/Province''

Under Section D—About the Medical Device, we propose to:

- For field D7, add Text to read as ''Unique Device Identifier (UDI) number—Please record all symbols, letters and numbers located under the barcode. An example of a UDI number can be found at *https://accessgudid.nlm.nih.gov/about-gudid#what-is-udi.*''

Under Section E—About the Person Who Had the Problem, we propose to:

- based on the executive order, Defending Women from Gender Ideology Extremism and Restoring Biological Truth to the Federal Government, signed by President Donald J. Trump on January 20, 2025, revise the Sex field to include two options, Male and Female. and remove the Gender field.
- Add calendar functionality to Field E4 (Date of Birth) for uniformity in reporting and to ensure correct reporting of date format.
  - Combine the Ethnicity (Field E6) and Race (Field E7) fields as outlined in the Statistical Policy Directive No. 15: Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity (SPD 15) issued on March 29, 2024. Add new text—''What is your race and/or ethnicity? Select all that apply.'' The data fields include:
    - *American Indian or Alaska Native*
    - *Asian*
    - *Black or African American*
    - *Hispanic or Latino*
    - *Middle Eastern or North African*
    - *Native Hawaiian or Pacific Islander*
    - *White*

Under Section F—About the Person Filling Out This Form, we propose to:

- For Field F4, change the title of the field from ''City and State/Province'' to ''City and State/Province (including your State/Province will help FDA review your report).''

Under ''Send This Report by Mail or Fax,'' revise the mailing address to Attn: MedWatch Program, White Oak Campus, Building 22, G0207, 10903 New Hampshire Ave., Silver Spring, MD 20993.

Changes Proposed for Form FDA 3800, Safety Reporting Portal

The Center for Tobacco Products (CTP) proposes to make non-substantive changes to the Tobacco Product Report (TPR) and Tobacco Investigator Report (TIR) questionnaires in the Safety Reporting Portal. The proposed changes clarify the instructions, clarify existing questions, and simplify certain response fields.

CTP also proposes to modify the instructions in response to findings in a user experience study that was completed in 2024. For example, participants wanted the instructions to indicate how long the report typically takes to complete. CTP proposes to replace some structured answer lists with free text boxes to shorten the questionnaire and better align with the MedWatch forms. CTP proposes to remove structured answer choices that have been rarely or never used, while maintaining the current functionality that allows uncommon responses to be provided in free-text boxes. CTP proposes to replace certain free-text or structured answer choices with searchable drop-down menus to assist in answer selection.

The proposed changes do not change the breadth or depth of data collected in the questionnaires or the number of required questions. The proposed changes aim to reduce the burden on the reporter by shortening the questionnaire and streamlining the questions and instructions. The proposed changes are supported by the results of a user experience study that was completed in 2024.

In the **Federal Register** of January 17, 2025 (90 FR 5900), we published a 60-day notice soliciting public comment on the proposed collection of information.

Two comments were received supporting FDA's addition of a ''cannabinoid hemp product'' category for reporting adverse events, but encouraged FDA to include additional categories as well that would allow for specific data as it pertained to a wider variety of individual products. A third comment was received encouraging the enhancement of FDA's MAUDE system using automated technologies that would allow for easier input by respondents. FDA appreciates each comment and although we continue to modify applicable forms to increase the utility of the information collection as our limited resources allow, we are proposing no other modifications at this time and have made no changes in the estimated burden based on these public comments.

We estimate the burden of this collection of information as follows:

TABLE 1—ESTIMATED ANNUAL REPORTING BURDEN [1]

FDA Center or 21 CFR Section and/or FDA Form	Number of respondents	Number of responses per respondent	Total annual responses	Average burden per response	Total hours
CBER/CDER, FDA 3500 (voluntary reporting)	58,711	1	58,711	0.66 (40 minutes)	38,749
CBER, FDA 3500A; 600.80; 1271.350 (mandatory reporting)	599	98	58,702	1.21	71,029
CBER, FDA 3500B	13,750	1	13,750	0.46 (28 minutes)	6,325
CDER, FDA 3500B	18,961	1	18,961	0.46 (28 minutes)	8,722
CDRH, FDA 3500 and FDA 3500B	15,304	1	15,304	0.46 (28 minutes)	7,040
CTP, FDA 3500	39	1	39	0.66 (40 minutes)	26
HFP, FDA 3500	7,442	1.061	7,895	0.66 (40 minutes)	5,211
HFP, FDA 3500A	1,659	1	1,659	1.21	2,007
Written requests for temporary waiver under § 329.100(c)(2)	1	1	1	1	1
Total					139,110

[1] There are no capital costs or operating and maintenance costs associated with this collection of information.
CBER—Center for Biologics Evaluation and Research.
CDER—Center for Drug Evaluation and Research.
CDRH—Center for Devices and Radiological Health.
HFP—Human Foods Program.
CTP—Center for Tobacco Products.

The estimates in Table 1 are based on current agency data and our experience with the information collection.

TABLE 2—ESTIMATED ANNUAL REPORTING BURDEN E-SUBMISSIONS INCLUDING VIA SRP [1]

FDA Form 3800	Number of respondents	Number of responses per respondent	Total annual responses	Average burden per response	Total hours
Reportable Foods Registry (mandatory reports)	875	1	875	0.6 (36 minutes)	525
Reportable Foods Registry (voluntary reports)	5	1	5	0.6 (36 minutes)	3
Food, Infant Formula, and Cosmetic Adverse Event Reports	1,165	1.2	1,398	0.6 (36 minutes)	839
Voluntary Dietary Supplement Adverse Event Reports	360	1.2	432	0.6 (36 minutes)	259
Mandatory Dietary Supplement Adverse Event Reports	80	12	960	1	960
Animal Food: Voluntary Pet Food Reports	1,401	1	1,401	0.6 (36 minutes)	841
Animal Food: Voluntary Livestock Food Reports	23	1	23	0.6 (36 minutes)	14
Voluntary Tobacco Product Health Problem or Product Problem (*i.e.,* adverse experience) Reports to SRP (both questionnaires)	176	1	176	0.6 (36 minutes)	106
Mandatory Tobacco Product Health Problem or Product Problem (*i.e.,* adverse experience) Reports 1114.41(a)(2)	3	6	18	0.6 (36 minutes)	11

TABLE 2—ESTIMATED ANNUAL REPORTING BURDEN E-SUBMISSIONS INCLUDING VIA SRP [1]—Continued

FDA Form 3800	Number of respondents	Number of responses per respondent	Total annual responses	Average burden per response	Total hours
Total			5,924		3,961

[1] There are no capital costs or operating and maintenance costs associated with this collection of information.

The number of respondents for the Voluntary Tobacco Product Health Problem or Product Problem Reports e-submissions has decreased from 204 to 176, according to an updated analysis.

Based on burden estimates associated with the Premarket Tobacco Product applications and Recordkeeping Requirements regulation we have decreased the average burden per response from 1 hour to 36 minutes for 1114.41(a)(2); Mandatory Tobacco Product Health Problem or Product Problem Reports.

CVM reports a decrease in the number of submissions received over the last few years.

CDER/CBER has increased the number of direct safety reports from healthcare providers and consumers. Additionally, CDER mandatory reports, Form FDA 3500A previously included in this information collection, are now reported in the approved information collection, OMB control number 0910–0230. However, increases in receipts of CBER mandatory reports have obscured any decrease in burden. Adverse event reports related 21 CFR 310.305 from outsourcing facilities are also included in 0910–0230 and decreases the total burden of this collection.

Based on updated data, CDRH has revised our estimate for forms FDA 3500 and FDA 3500B. Additionally, we have determined that the estimate previously reported in this information collection for mandatory reporting under 21 CFR part 803, associated with medical device products, using form FDA 3500A, is redundant with our approved burden estimates in OMB control number 0910–0437 *Medical Device Reporting* (under 21 CFR part 803). We have therefore removed CDRH reporting via FDA 3500A from this information collection request and continue to account for its burden in OMB control number 0910–0437.

Based on agency experience HFP's estimated burden for the information collection reflects an overall increase. We attribute this adjustment to an increase in the number of submissions we received over the last few years, due primarily to changes in the infant formula industry.

Therefore, the cumulative changes, both program changes which include form revisions, and adjustments reflecting fluctuations in submissions, as well as removing double-counted burden reflects and overall increase of 116,014 hours to the total burden for this information collection.

Dated: June 18, 2025.

Grace R. Graham,

Deputy Commissioner for Policy, Legislation, and International Affairs.

[FR Doc. 2025–11605 Filed 6–24–25; 8:45 am]

BILLING CODE P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

Agency Information Collection Activities: Submission to OMB for Review and Approval; Public Comment Request; Data System for Organ Procurement and Transplantation Network

AGENCY: Health Resources and Services Administration (HRSA), Department of Health and Human Services (HHS).

ACTION: Notice.

SUMMARY: In compliance with the Paperwork Reduction Act of 1995, HRSA submitted an Information Collection Request (ICR) to the Office of Management and Budget (OMB) for review and approval. Comments submitted during the first public review of this ICR will be provided to OMB. OMB will accept further comments from the public during the review and approval period. OMB may act on HRSA's ICR only after the 30-day comment period for this notice has closed.

DATES: Comments on this ICR should be received no later than July 25, 2025.

ADDRESSES: Written comments and recommendations for the proposed information collection should be sent within 30 days of publication of this notice to *www.reginfo.gov/public/do/PRAMain.* Find this particular information collection by selecting ''Currently under Review—Open for Public Comments'' or by using the search function.

FOR FURTHER INFORMATION CONTACT: To request a copy of the clearance requests submitted to OMB for review, email Samantha Miller, HRSA Information Collection Clearance Officer, at *paperwork@hrsa.gov* or call (301) 443–3983.

SUPPLEMENTARY INFORMATION:

Information Collection Request Title: Data System for Organ Procurement and Transplantation Network, OMB No. 0915–0157—Revision.

Abstract: Section 372 of the Public Health Service Act requires that the Secretary of HHS, by award, provide for the establishment and operation of the Organ Procurement and Transplantation Network (OPTN), which, under oversight of the HRSA, operates the U.S. Organ Procurement and Transplantation system. HRSA, in alignment with the Paperwork Reduction Act of 1995, submits OPTN Board of Directors (BOD)-approved data elements for collection to OMB for approval.

A 60-day notice was published in the **Federal Register** on November 1, 2024, Vol. 89, No. 212, pp. 87380–85. There were six comments, including feedback from OPTN Members and Transplant Centers. Public comments raised concerns about the financial burden of additional data collection. The commenters called for greater collaboration between transplant professionals, HRSA, and the Scientific Registry of Transplant Recipients to eliminate redundancies and improve efficiency. Commenters expressed concern that changes were communicated via the **Federal Register** instead of the OPTN public comment process, limiting input from the transplant community. Additionally, the commenters sought clarification on discrepancies regarding which forms were designated as new, and they requested access to the data collection plans and draft instruments.

HRSA carefully reviewed all public feedback submitted during the 60-day comment period. Through its policy development process, OPTN had previously solicited input on each of the data collection instruments through four channels:

(1) Targeted outreach to relevant stakeholder organizations, including

transplant professionals and patient groups.

(2) Comments submitted by other OPTN committees.

(3) In-person meetings across 11 OPTN regions.

(4) An online OPTN public comment forum open to all on the OPTN website.

HRSA welcomes participation from all interested individuals. HRSA seeks input from transplant candidates directly affected by policy changes and strongly encourages transplant professionals to provide input on the potential financial impacts of proposals. HRSA values all feedback and remains committed to reviewing and refining data collection efforts in collaboration with the OPTN.

Finally, in response to commenter concerns regarding potential burden, the OPTN contract requires the OPTN Contractor to implement a direct electronic data submission plan and supplement official OPTN data with external sources. This approach aims to reduce the burden of data collection on OPTN members.

Need and Proposed Use of the Information: HRSA and the OPTN BOD use data to develop transplant, procurement, and allocation policies; to determine whether institutional members are complying with policy; to determine member-specific performance; to ensure patient safety; and to fulfill the requirements of the OPTN Final Rule. The regulatory authority in 42 CFR 121.11 (*https://www.ecfr.gov/current/title-42/section-121.11*) of the OPTN Final Rule requires the OPTN data to be made available, consistent with applicable laws, for use by OPTN members, the Scientific Registry of Transplant Recipients, HHS, and members of the public for evaluation, research, patient information, and other important purposes.

This is a request to revise the current OPTN data collection, which includes time-sensitive, life-critical data on transplant candidates and potential organ donors, the organ matching process, histocompatibility results, organ labeling and packaging, and pre- and post-transplantation data on recipients and donors. This revision also includes OPTN BOD-approved changes to the existing OMB data collection forms. OPTN collects these specific data elements from transplant hospitals, organ procurement organizations, and histocompatibility laboratories.

HRSA and the OPTN use this information to (1) facilitate organ placement and match donor organs with recipients; (2) monitor compliance of member organizations with federal laws and regulations and with OPTN requirements; (3) review and report periodically to the public on the status of organ donation, procurement, and transplantation in the United States; (4) provide data to researchers and government agencies to study the scientific and clinical status of organ transplantation; and (5) perform transplantation-related public health surveillance, including the possible transmission of donor disease.

HRSA is requesting to make the following changes to improve the OPTN organ matching and allocation process and improve OPTN member compliance with OPTN requirements:

(1) Adding data collection forms for candidates listed in the OPTN organ transplant waiting list to the existing OMB-approved information collection. These forms allow a transplant center to add, change, or remove candidates from the OPTN waiting list after a transplant center completes the patient evaluation. These forms contain information that the OPTN electronic organ matching system uses to match potential organ recipients with available deceased donor organs. There are 83 new data collection forms: candidate listing registration forms of all organs, candidate status justification forms of all applicable organs, Model for End-Stage Liver Disease or Pediatric End-Stage Liver Disease (MELD/PELD) score exception and extension forms, and other forms.

(2) OPTN BOD-approved revisions to existing data collection forms to improve organ matching, allocation, and OPTN policy compliance.

Likely Respondents: Transplant Centers, Organ Procurement Organizations (OPO), and Histocompatibility Laboratories.

Burden Statement: Burden in this context means the time expended by persons to generate, maintain, retain, disclose, or provide the information requested. This includes the time needed to review instructions; to develop, acquire, install, and utilize technology and systems for the purpose of collecting, validating, and verifying information, processing and maintaining information, and disclosing and providing information; to train personnel and to be able to respond to a collection of information; to search data sources; to complete and review the collection of information; and to transmit or otherwise disclose the information. The total annual burden hours estimated for this ICR are summarized in the table below.

The estimated burden hours for this collection increased by 203,937.21 hours from the currently approved ICR package. This increase includes 96,148.84 hours due to adding 83 new data collection forms for the OPTN waiting list and 107,788.37 hours due to OPTN BOD-approved data collection changes to existing forms and the number of respondents.

TOTAL ESTIMATED ANNUALIZED BURDEN—HOURS

Form No.	Form name	Number of respondents	Number of responses per respondent * ****	Total responses	Average burden per response (in hours)	Total burden hours
1	Deceased Donor Registration	56	414.71	23,223.76	0.48	11,147.40
2	Living Donor Registration	207	33.42	6,917.94	2.19	15,150.29
3	Living Donor Follow-up	207	94.86	19,636.02	1.52	29,846.75
4	Donor Histocompatibility	138	173.31	23,916.78	0.20	4,783.36
5	Recipient Histocompatibility	138	307.09	42,378.42	0.40	16,951.37
6	Heart Transplant Candidate Registration	149	38.50	5,736.50	0.90	5,162.85
7	Heart Transplant Recipient Registration	149	30.50	4,544.50	1.96	8,907.22
8	Heart Transplant Recipient Follow Up (6-month)	149	27.79	4,140.71	0.40	1,656.28
9	Heart Transplant Recipient Follow Up (1–5 year)	149	109.21	16,272.29	0.90	14,645.06
10	Heart Transplant Recipient Follow Up (Post 5 year).	149	183.73	27,375.77	0.50	13,687.89
11	Heart Post-Transplant Malignancy Form	149	12.21	1,819.29	0.90	1,637.36
12	Lung Transplant Candidate Registration	74	45.36	3,356.64	0.95	3,188.81
13	Lung Transplant Recipient Registration	74	40.85	3,022.90	1.14	3,446.11

TOTAL ESTIMATED ANNUALIZED BURDEN—HOURS—Continued

Form No.	Form name	Number of respondents	Number of responses per respondent*****	Total responses	Average burden per response (in hours)	Total burden hours
14	Lung Transplant Recipient Follow Up (6-month)	74	35.96	2,661.04	0.50	1,330.52
15	Lung Transplant Recipient Follow Up (1–5 year)	74	135.61	10,035.14	1.10	11,038.65
16	Lung Transplant Recipient Follow Up (Post 5 year).	74	148.09	10,958.66	0.60	6,575.20
17	Lung Post-Transplant Malignancy Form	74	18.39	1,360.86	0.40	544.34
18	Heart/Lung Transplant Candidate Registration	72	1.03	74.16	1.16	86.03
19	Heart/Lung Transplant Recipient Registration	72	0.75	54.00	2.09	112.86
20	Heart/Lung Transplant Recipient Follow Up (6-month).	72	0.64	46.08	0.80	36.86
21	Heart/Lung Transplant Recipient Follow Up (1–5 year).	72	2.46	177.12	1.10	194.83
22	Heart/Lung Transplant Recipient Follow Up (Post 5 year).	72	3.35	241.20	0.60	144.72
23	Heart/Lung Post-Transplant Malignancy Form	72	0.22	15.84	0.40	6.34
24	Liver Transplant Candidate Registration	142	103.39	14,681.38	0.80	11,745.10
25	Liver Transplant Recipient Registration	142	75.08	10,661.36	1.20	12,793.63
26	Liver Transplant Recipient Follow Up (6-month–5 year).	142	344.55	48,926.10	1.00	48,926.10
27	Liver Transplant Recipient Follow Up (Post 5 year).	142	427.56	60,713.52	0.50	30,356.76
28	Liver Recipient Explant Pathology Form	142	7.17	1,018.14	0.60	610.88
29	Liver Post-Transplant Malignancy Form	142	21.21	3,011.82	0.80	2,409.46
30	Intestine Transplant Candidate Registration	18	7.50	135.00	1.30	175.50
31	Intestine Transplant Recipient Registration	18	5.28	95.04	1.80	171.07
32	Intestine Transplant Recipient Follow Up (6-month–5 year).	18	21.50	387.00	1.50	580.50
33	Intestine Transplant Recipient Follow Up (Post 5 year).	18	49.61	892.98	0.40	357.19
34	Intestine Post-Transplant Malignancy Form	18	0.94	16.92	1.00	16.92
35	Kidney Transplant Candidate Registration	228	203.12	46,311.36	0.80	37,049.09
36	Kidney Transplant Recipient Registration	228	119.89	27,334.92	1.20	32,801.90
37	Kidney Transplant Recipient Follow Up (6-month–5 year).	228	571.22	130,238.16	0.90	117,214.34
38	Kidney Transplant Recipient Follow Up (Post 5 year).	228	565.59	128,954.52	0.50	64,477.26
39	Kidney Post-Transplant Malignancy Form	228	25.60	5,836.80	0.80	4,669.44
40	Pancreas Transplant Candidate Registration	123	2.63	323.49	0.60	194.09
41	Pancreas Transplant Recipient Registration	123	0.84	103.32	1.20	123.98
42	Pancreas Transplant Recipient Follow Up (6-month–5 year).	123	5.05	621.15	0.50	310.58
43	Pancreas Transplant Recipient Follow Up (Post 5 year).	123	17.11	2,104.53	0.50	1,052.27
44	Pancreas Post-Transplant Malignancy Form	123	0.76	93.48	0.60	56.09
45	Kidney/Pancreas Transplant Candidate Registration.	123	12.94	1,591.62	0.60	954.97
46	Kidney/Pancreas Transplant Recipient Registration.	123	6.59	810.57	1.20	972.68
47	Kidney/Pancreas Transplant Recipient Follow Up (6-month–5 year).	123	38.12	4,688.76	0.50	2,344.38
48	Kidney/Pancreas Transplant Recipient Follow Up (Post 5 year).	123	66.63	8,195.49	0.60	4,917.29
49	Kidney/Pancreas Post-Transplant Malignancy Form.	123	2.24	275.52	0.40	110.21
50	VCA Transplant Candidate Registration	23	1.00	23.00	0.40	9.20
51	VCA Transplant Recipient Registration	23	0.39	8.97	1.36	12.20
52	VCA Transplant Recipient Follow Up	23	2.30	52.90	1.31	69.30
53	Organ Labeling and Packaging	56	298.27	16,703.12	0.18	3,006.56
54	Organ Tracking and Validating	304	20.36	6,189.44	0.08	495.16
55	Kidney Paired Donation Candidate Registration	156	0.34	53.04	0.26	13.79
56	Kidney Paired Donation Donor Registration	156	0.99	154.44	1.08	166.80
57	Kidney Paired Donation Match Offer Management.	156	0.59	92.04	0.67	61.67
58	Disease Transmission Event	304	2.33	708.32	0.60	424.99
59	Living Donor Event	207	0.15	31.05	0.56	17.39
60	Safety Situation	442	0.93	411.06	0.24	98.65
61	Potential Disease Transmission Report	56	11.09	621.04	1.27	788.72
62	Request to Unlock Form	442	174.67	77,204.14	0.02	1,544.08
63	Initial Donor Registration	56	414.71	23,223.76	4.61	107,061.53
64	OPO Notification Limit Administration	56	9.52	533.12	0.17	90.63

TOTAL ESTIMATED ANNUALIZED BURDEN—HOURS—Continued

Form No.	Form name	Number of respondents	Number of responses per respondent*****	Total responses	Average burden per response (in hours)	Total burden hours
65	Potential Transplant Recipient	304	6,017.74	1,829,392.96	0.05	91,469.65
66	Death Notification Registration**	56	289.70	16,223.20	0.42	6,813.74
67	Deceased Donor Death Referral**	56	58.11	3,254.16	0.50	1,627.08
68	Donor Hospital Registration	56	0.04	2.24	0.08	0.18
69	Donor Organ Disposition	56	414.71	23,223.76	0.17	3,948.04
70	Transplant Center Contact Management	248	808.10	200,408.80	0.06	12,024.53
71	Adult Kidney Candidate Listing Registration***	228	204.93	46,724.04	0.52	24,296.50
72	Pediatric Kidney Candidate Listing Registration***.	101	11.66	1,177.66	0.47	553.50
73	Adult Kidney Pancreas Candidate Listing Registration***.	123	12.93	1,590.39	0.37	588.44
74	Pediatric Kidney Pancreas Candidate Listing Registration***.	29	0.07	2.03	0.30	0.61
75	Adult Pancreas Candidate Listing Registration***	123	15.29	1,880.67	0.38	714.65
76	Pediatric Pancreas Candidate Listing Registration***.	30	1.13	33.90	0.38	12.88
77	Adult Pancreas Islet Listing Registration***	16	2.06	32.96	0.38	12.52
78	Pediatric Pancreas Islet Listing Registration***	16	0.00	0.00	0.33	0.00
79	Adult Liver Candidate Listing Registration***	142	98.43	13,977.06	0.32	4,472.66
80	Pediatric Liver Candidate Listing Registration***	57	12.37	705.09	0.40	282.04
81	Adult Intestine Candidate Listing Registration***	18	4.94	88.92	0.38	33.79
82	Pediatric Intestine Candidate Listing Registration***.	18	2.56	46.08	0.43	19.81
83	Adult Heart Candidate Listing Registration***	149	33.58	5,003.42	0.83	4,152.84
84	Pediatric Heart Candidate Listing Registration***	64	11.47	734.08	0.58	425.77
85	Adult HeartLung Candidate Listing Registration***.	72	0.97	69.84	0.85	59.36
86	Pediatric HeartLung Candidate Listing Registration***.	27	0.15	4.05	0.93	3.77
87	Adult Lung Candidate Listing Registration***	74	44.85	3,318.90	1.00	3,318.90
88	Pediatric Lung Candidate Listing Registration***	45	0.84	37.80	0.83	31.37
89	Candidate Registration Listing Removal***	248	289.27	71,738.96	0.18	12,913.01
90	VCA Abdominal Wall Candidate Listing Registration***.	8	0.38	3.04	0.33	1.00
91	VCA External Male Genitalia Candidate Listing Registration***.	2	0.00	0.00	0.33	0.00
92	VCA Head and Neck Candidate Listing Registration***.	10	0.50	5.00	0.33	1.65
93	VCA Lower Limb Candidate Listing Registration***.	4	0.00	0.00	0.33	0.00
94	VCA Musculoskeletal Composite Graft Segment Candidate Listing Registration***.	2	0.00	0.00	0.33	0.00
95	VCA Other Genitourinary Organ Candidate Listing Registration***.	3	0.00	0.00	0.33	0.00
96	VCA Spleen Candidate Listing Registration***	0	0.00	0.00	0.33	0.00
97	VCA Upper Limb Candidate Listing Registration***.	11	0.27	2.97	0.33	0.98
98	VCA Uterus Candidate Listing Registration***	6	2.00	12.00	0.33	3.96
99	VCA Vascularized Gland Candidate Listing Registration***.	8	0.00	0.00	0.33	0.00
100	Organ Export Verification Form***	56	0.46	25.76	0.03	0.77
101	OPTN Waiting Time Transfer Form***	248	5.54	1,373.92	0.23	316.00
102	OPTN Waiting Time Modification Form***	248	59.40	14,731.20	0.22	3,240.86
103	OPTN Renal Waiting Time Reinstatement Form***.	228	1.21	275.88	0.27	74.49
104	OPTN Pancreas Waiting Time Reinstatement Form***.	123	0.03	3.69	0.20	0.74
105	Intestinal Waiting Time Reinstatement Form*** ...	18	0.00	0.00	0.25	0.00
106	Prior Living Donor Priority***	228	0.25	57.00	0.27	15.39
107	Kidney Minimum Acceptance Criteria***	228	0.47	107.16	0.30	32.15
108	Adult Liver Status 1A Initial Justification and Extension Form***.	142	2.31	328.02	0.57	186.97
109	Pediatric Liver Status 1A Initial Justification and Extension Form***.	57	2.30	131.10	0.57	74.73
110	Pediatric Liver Status 1B Initial Justification and Extension Form***.	57	5.61	319.77	0.47	150.29
111	Liver Cholangiocarcinoma (CCA) Initial MELD/PELD Score Exception Form***.	142	0.42	59.64	0.43	25.65

TOTAL ESTIMATED ANNUALIZED BURDEN—HOURS—Continued

Form No.	Form name	Number of respondents	Number of responses per respondent*****	Total responses	Average burden per response (in hours)	Total burden hours
112	Liver Cholangiocarcinoma (CCA) MELD/PELD Score Exception Extension Form***.	142	0.34	48.28	0.32	15.45
113	Liver Cystic Fibrosis (CF) Initial MELD/PELD Score Exception and Extension Form***.	142	0.10	14.20	0.33	4.69
114	Liver Familial Amyloid Polyneuropathy (FAP) Initial MELD/PELD Score Exception Form***.	142	0.04	5.68	0.40	2.27
115	Liver Familial Amyloid Polyneuropathy (FAP) MELD/PELD Score Exception Extension Form***.	142	0.05	7.10	0.30	2.13
116	Liver Hepatic Artery Thrombosis (HAT) Initial MELD/PELD Score Exception and Extension Form***.	142	0.69	97.98	0.35	34.29
117	Liver Hepatocellular Carcinoma (HCC) Initial MELD/PELD Score Exception Form***.	142	23.30	3,308.60	0.47	1,555.04
118	Liver Hepatocellular Carcinoma (HCC) MELD/PELD Score Exception Extension Form***.	142	33.21	4,715.82	0.35	1,650.54
119	Liver Hepatopulmonary Syndrome (HPS) Initial MELD/PELD Score Exception Form***.	142	1.39	197.38	0.32	63.16
120	Liver Hepatopulmonary Syndrome (HPS) MELD/PELD Score Exception Extension Form***.	142	0.99	140.58	0.25	35.15
121	Liver Metabolic Disease Initial MELD/PELD Score Exception and Extension Form***.	142	0.77	109.34	0.28	30.62
122	Liver Portopulmonary Hypertension Initial MELD/PELD Score Exception Form***.	142	0.51	72.42	0.42	30.42
123	Liver Portopulmonary Hypertension MELD/PELD Score Exception Extension Form***.	142	0.36	51.12	0.33	16.87
124	Liver Primary Hyperoxaluria Initial MELD/PELD Score Exception and Extension Form***.	142	0.13	18.46	0.35	6.46
125	Liver Other Diagnosis Initial MELD/PELD Score Exception and Extension Form***.	142	12.03	1,708.26	0.35	597.89
126	Pediatric Heart and HeartLung Status 1A Initial Justification Form***.	64	16.06	1,027.84	0.52	534.48
127	Pediatric Heart and HeartLung Status 1A Extension and Appeal Justification Forms***.	64	54.61	3,495.04	0.47	1,642.67
128	Pediatric Heart and HeartLung Status 1B Initial Justification Form***.	64	7.31	467.84	0.42	196.49
129	Adult Heart and HeartLung Status 1–6 Justification Form Demographic Data***.	149	135.78	20,231.22	0.32	6,473.99
130	Adult Heart and HeartLung Status 1–6 Justification Form Risk Stratification Data***.	149	135.78	20,231.22	0.72	14,566.48
131	Adult Heart and HeartLung Status 1 Initial Justification Form Medical Urgency Data***.	149	5.69	847.81	0.58	491.73
132	Adult Heart and HeartLung Status 1 Exception Extension Justification Form Medical Urgency Data***.	149	0.46	68.54	0.33	22.62
133	Adult Heart and HeartLung Status 1 Criteria 1 Extension Justification Form Medical Urgency Data***.	149	0.43	64.07	0.53	33.96
134	Adult Heart and HeartLung Status 2 Initial Justification Form Medical Urgency Data***.	149	25.91	3,860.59	0.80	3,088.47
135	Adult Heart and HeartLung Status 2 Exception Extension Justification Form Medical Urgency Data***.	149	9.87	1,470.63	0.33	485.31
136	Adult Heart and HeartLung Status 2 Criteria 1 Extension Justification Form Medical Urgency Data***.	149	0.03	4.47	0.42	1.88
137	Adult Heart and HeartLung Status 2 Criteria 4 Extension Justification Form Medical Urgency Data***.	149	3.05	454.45	0.63	286.30
138	Adult Heart and HeartLung Status 2 Criteria 5 Extension Justification Form Medical Urgency Data***.	149	1.70	253.30	0.60	151.98
139	Adult Heart and HeartLung Status 3 Initial Justification Form Medical Urgency Data***.	149	11.91	1,774.59	0.63	1,117.99
140	Adult Heart and HeartLung Status 3 Exception Extension Justification Form Medical Urgency Data***.	149	6.88	1,025.12	0.33	338.29

TOTAL ESTIMATED ANNUALIZED BURDEN—HOURS—Continued

Form No.	Form name	Number of respondents	Number of responses per respondent * ****	Total responses	Average burden per response (in hours)	Total burden hours
141	Adult Heart and HeartLung Status 3 Criteria 2 Extension Justification Form Medical Urgency Data ***.	149	0.64	95.36	0.32	30.52
142	Adult Heart and HeartLung Status 3 Criteria 5 Extension Justification Form Medical Urgency Data ***.	149	0.11	16.39	0.48	7.87
143	Adult Heart and HeartLung Status 4 Initial Justification Form Medical Urgency Data ***.	149	23.51	3,502.99	0.50	1,751.50
144	Adult Heart and HeartLung Status 4 Exception Extension Justification Form Medical Urgency Data ***.	149	1.73	257.77	0.25	64.44
145	Adult Heart and HeartLung Status 4 Criteria 2 Extension Justification Form Medical Urgency Data ***.	149	0.56	83.44	0.40	33.38
146	Adult and Pediatric Lung and HeartLung Goal Exception Form ***.	149	3.72	554.28	0.75	415.71
147	Pediatric Lung Priority 1 Status Justification Form ***.	45	1.16	52.20	0.33	17.23
148	Review Board Voter Form ***	248	22.46	5,570.08	0.23	1,281.12
149	Living Donor Feedback Form ***	207	37.73	7,810.11	0.13	1,015.31
150	Extra Vessels Reporting Form ***	248	53.71	13,320.08	0.03	399.60
151	Non-US Transplants Reporting Form ***	228	0.00	0.00	0.03	0.00
152	Discrepant HLA Typings Reporting Form ***	138	0.78	107.64	5.17	556.50
153	Interim Event Reporting Form ***	248	72.58	17,999.84	0.06	1,079.99
	Total	18,697	.....	3,184,247.26	.....	851,565.51

* The numbers of respondents and total responses in the burden table were updated with 2023 OPTN data and reflect increases in the number of organ transplants and changes in the number of respondents (Transplant Centers, OPOs, and Histocompatibility Labs).

** These two forms will not be used once the OPTN Process Data OMB package is approved and implemented. The OPTN Process Data OMB package is new and will be considered separate from this package. We are including these forms in this collection to avoid any lapse in approval of these forms while the OPTN Process Data package is being approved.

*** These are new forms.

**** If a form has 0.00 under average number of responses, this indicates no submissions in calendar year 2023.

Maria G. Button,

Director, Executive Secretariat.

[FR Doc. 2025–11668 Filed 6–24–25; 8:45 am]

BILLING CODE 4165–15–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

Center for Scientific Review; Notice of Closed Meetings

Pursuant to section 1009 of the Federal Advisory Committee Act, as amended, notice is hereby given of the following meetings.

The meetings will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: Center for Scientific Review Special Emphasis Panel; RFA Panel: Supporting the next generation of researchers for ADRD research.

Date: July 23, 2025.

Time: 9:30 a.m. to 8:30 p.m.

Agenda: To review and evaluate grant applications.

Address: National Institutes of Health, Rockledge II, 6701 Rockledge Drive, Bethesda, MD 20892.

Meeting Format: Virtual Meeting.

Contact Person: Sue Andersen, Ph.D., Scientific Review Officer, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Bethesda, MD 20892, (301) 480–5404, *sue.andersen-navalta@nih.gov*.

Name of Committee: Center for Scientific Review Special Emphasis Panel; Special Topics in Biodata Management and Computational Modeling.

Date: July 23–24, 2025.

Time: 9:30 a.m. to 6:30 p.m.

Agenda: To review and evaluate grant applications.

Address: National Institutes of Health, Rockledge II, 6701 Rockledge Drive, Bethesda, MD 20892.

Meeting Format: Virtual Meeting.

Contact Person: Christopher Ryan Mahone, Ph.D., Scientific Review Officer, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Dr., Room 710F, Bethesda, MD 20892, (443) 224–3992, *mahonecr@csr.nih.gov*.

Name of Committee: Center for Scientific Review Special Emphasis Panel; NIAID Virology Quality Assurance Program.

Date: July 23, 2025.

Time: 10:00 a.m. to 1:00 p.m.

Agenda: To review and evaluate contract proposals.

Address: National Institutes of Health, Rockledge II, 6701 Rockledge Drive, Bethesda, MD 20892.

Meeting Format: Virtual Meeting.

Contact Person: Barry Joseph Margulies, Ph.D., Primary is AI, 5601 Fishers Lane, Room 3G11, Rockville, MD 20852, (301) 761–7956, *barry.margulies@nih.gov*.

Name of Committee: Center for Scientific Review Special Emphasis Panel; PAR24–258: Research Resource for Human Organs and Tissues.

Date: July 23, 2025.

Time: 10:00 a.m. to 2:00 p.m.

Agenda: To review and evaluate grant applications.

Address: National Institutes of Health, Rockledge II, 6701 Rockledge Drive, Bethesda, MD 20892.

Meeting Format: Virtual Meeting.

Contact Person: David Balasundaram, Ph.D., Scientific Review Officer, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 5189,

MSC 7840, Bethesda, MD 20892, 301–435–1022, *balasundaramd@csr.nih.gov*.

Name of Committee: Center for Scientific Review Special Emphasis Panel; PAR: Topics on Biomarkers, neurotherapeutics and BRAIN Armamentarium Special emphasis panel.

Date: July 23, 2025.

Time: 10:00 a.m. to 6:00 p.m.

Agenda: To review and evaluate grant applications.

Address: National Institutes of Health, Rockledge II, 6701 Rockledge Drive, Bethesda, MD 20892.

Meeting Format: Virtual Meeting.

Contact Person: Marta Veronica Hamity, Ph.D., Scientific Review Officer, Office of Scientific Review, Division of Extramural Activities, NCCIH/NIH, 6707 Democracy Boulevard, Suite 401, Bethesda, MD 20892, *marta.hamity@nih.gov*.

Name of Committee: Center for Scientific Review Special Emphasis Panel; Member Conflict: Transmission of Vector-Borne and Zoonotic Diseases.

Date: July 23, 2025.

Time: 10:00 a.m. to 6:00 p.m.

Agenda: To review and evaluate grant applications.

Address: National Institutes of Health, Rockledge II, 6701 Rockledge Drive, Bethesda, MD 20892.

Meeting Format: Virtual Meeting.

Contact Person: Hailey P. Weerts, Ph.D., Scientific Review Officer, BG 5601 Fishers Lane, Room 3G74, 5601 Fishers Ln., Rockville, MD 20852, (240) 669–5931, *hailey.weerts@nih.gov*.

Name of Committee: Center for Scientific Review Special Emphasis Panel; RFA–DA–25–062: HEAL Initiative: JCOIN Phase II Innovation Hubs (R01).

Date: July 23, 2025.

Time: 11:00 a.m. to 3:00 p.m.

Agenda: To review and evaluate grant applications.

Address: National Institutes of Health, Rockledge II, 6701 Rockledge Drive, Bethesda, MD 20892.

Meeting Format: Virtual Meeting.

Contact Person: Trinh T. Tran, Ph.D., Scientific Review Officer, Scientific Review Branch, Office of Extramural Policy, National Institute on Drug Abuse, National Institutes of Health, Bethesda, MD 20892, (301) 827–5843, *trinh.tran@nih.gov*.

Name of Committee: Center for Scientific Review Special Emphasis Panel; Member Conflict: Topics in Bacterial-Host Interactions, Hypersensitivity and Allergy.

Date: July 23, 2025.

Time: 12:00 p.m. to 6:00 p.m.

Agenda: To review and evaluate grant applications.

Address: National Institutes of Health, Rockledge II, 6701 Rockledge Drive, Bethesda, MD 20892,

Meeting Format: Virtual Meeting,

Contact Person: Marci Scidmore, Ph.D., Scientific Review Officer, Scientific Review Program, Natl Institute of Allergy & Infectious Diseases, National Institutes of Health, 5601 Fishers Lane, Room 3G76, Bethesda, MD 20892, (240) 627–3255, *marci.scidmore@nih.gov*.

Name of Committee: Center for Scientific Review Special Emphasis Panel; AREA/REAP: Cardiovascular and Respiratory Sciences.

Date: July 23, 2025.

Time: 12:30 p.m. to 4:30 p.m.

Agenda: To review and evaluate grant applications.

Address: National Institutes of Health, Rockledge II, 6701 Rockledge Drive, Bethesda, MD 20892.

Meeting Format: Virtual Meeting.

Contact Person: Rupali Das, Ph.D., Scientific Review Officer, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Bethesda, MD 20892, (301) 594–0023, *rupali.das@nih.gov*.

(Catalogue of Federal Domestic Assistance Program Nos. 93.306, Comparative Medicine; 93.333, Clinical Research, 93.306, 93.333, 93.337, 93.393–93.396, 93.837–93.844, 93.846–93.878, 93.892, 93.893, National Institutes of Health, HHS)

Dated: June 20, 2025.

Sterlyn H. Gibson,

Program Specialist, Office of Federal Advisory Committee Policy.

[FR Doc. 2025–11651 Filed 6–24–25; 8:45 am]

BILLING CODE 4140–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

Center for Scientific Review; Notice of Closed Meetings

Pursuant to section 1009 of the Federal Advisory Committee Act, as amended, notice is hereby given of the following meetings.

The meetings will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: Center for Scientific Review Special Emphasis Panel; PAR–25–357: Vision-Related Secondary Data Analysis.

Date: July 23, 2025.

Time: 1:00 p.m. to 4:00 p.m.

Agenda: To review and evaluate grant applications.

Address: National Institutes of Health, Rockledge II, 6701 Rockledge Drive, Bethesda, MD 20892.

Meeting Format: Virtual Meeting.

Contact Person: Aurea D. De Sousa, Ph.D., Scientific Review Officer, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 5186, Bethesda, MD 20892, (301) 827–6829, *aurea.desousa@nih.gov*.

Name of Committee: Center for Scientific Review Special Emphasis Panel; PAR Panel: Musculoskeletal, Skin and Oral Sciences Clinical Studies/Trials.

Date: July 24–25, 2025.

Time: 8:30 a.m. to 7:00 p.m.

Agenda: To review and evaluate grant applications.

Address: National Institutes of Health, Rockledge II, 6701 Rockledge Drive, Bethesda, MD 20892.

Meeting Format: Virtual Meeting.

Contact Person: Sushmita Purkayastha, Ph.D., Scientific Review Officer, NIH NIAMS, 6701 Democracy Blvd., 1 Dem Plaza, Rm. 814, Bethesda, MD 20817, *sushmita.purkayastha@nih.gov.*

Name of Committee: Center for Scientific Review Special Emphasis Panel; Immunology-Oncology.

Date: July 24–25, 2025.

Time: 8:30 a.m. to 7:00 p.m.

Agenda: To review and evaluate grant applications.

Address: National Institutes of Health, Rockledge II, 6701 Rockledge Drive, Bethesda, MD 20892.

Meeting Format: Virtual Meeting.

Contact Person: Jing Chen, Ph.D., Scientific Review Officer, Office of Scientific Review, National Center for Advancing Translational Sciences (NCATS), National Institutes of Health, 6701 Democracy Blvd., Democracy 1, Room 1080, Bethesda, MD 20892–4874, *chenjing@mail.nih.gov.*

Name of Committee: Center for Scientific Review Special Emphasis Panel; Fellowships Panel 2: Neurodevelopment, Oxidative Stress and Synaptic Plasticity.

Date: July 24–25, 2025.

Time: 9:00 a.m. to 2:00 p.m.

Agenda: To review and evaluate grant applications.

Address: National Institutes of Health, Rockledge II, 6701 Rockledge Drive, Bethesda, MD 20892.

Meeting Format: Virtual Meeting.

Contact Person: Beata Buzas, Ph.D., Scientific Review Officer, Extramural Project Review Branch, Office of Extramural Activities, 6700B Rockledge Drive, Room 2116, MSC 6902, National Institute on Alcohol Abuse and Alcoholism, Bethesda, MD 20892, (301) 443–0800, *bbuzas@mail.nih.gov*.

Name of Committee: Center for Scientific Review Special Emphasis Panel; Member Conflict: Topics in Hepatology, Pharmacology and Toxicology.

Date: July 24–25, 2025.

Time: 9:30 a.m. to 8:00 p.m.

Agenda: To review and evaluate grant applications.

Address: National Institutes of Health, Rockledge II, 6701 Rockledge Drive, Bethesda, MD 20892.

Meeting Format: Virtual Meeting.

Contact Person: Stephanie Nicole Hicks, Ph.D., Scientific Review Officer, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Bethesda, MD 20892, (301) 480–5710, *hickssn@mail.nih.gov*.

Name of Committee: Center for Scientific Review Special Emphasis Panel; Mechanisms of Autoimmunity and Inflammation.

Date: July 24, 2025.
Time: 9:30 a.m. to 6:00 p.m.
Agenda: To review and evaluate grant applications.
Address: National Institutes of Health, Rockledge II, 6701 Rockledge Drive, Bethesda, MD 20892.
Meeting Format: Virtual Meeting.
Contact Person: Lindsey M. Pujanandez, Ph.D., Scientific Review Officer, Immunology Review Branch, Scientific Review Program, DEA/NIAID/NIH, Rockville, MD 20852, (240) 627–3206, *lindsey.pujanandez@nih.gov.*

Name of Committee: Infectious Diseases and Immunology A Integrated Review Group; HIV Molecular Virology, Cell Biology, and Drug Development Study Section.
Date: July 24–25, 2025.
Time: 10:00 a.m. to 7:00 p.m.
Agenda: To review and evaluate grant applications.
Address: National Institutes of Health, Rockledge II, 6701 Rockledge Drive, Bethesda, MD 20892.
Meeting Format: Virtual Meeting.
Contact Person: Kenneth A. Roebuck, Ph.D., Scientific Review Officer, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 5214, MSC 7852, Bethesda, MD 20892, (301) 435–1166, *roebuckk@csr.nih.gov.*

Name of Committee: Center for Scientific Review Special Emphasis Panel; PAR Panel: Clinical and Translational Exploratory/Developmental Studies.
Date: July 24–25, 2025.
Time: 10:00 a.m. to 5:00 p.m.
Agenda: To review and evaluate grant applications.
Address: National Institutes of Health, Rockledge II, 6701 Rockledge Drive, Bethesda, MD 20892.
Meeting Format: Virtual Meeting.
Contact Person: Shuli Xia, Ph.D., NCI, National Institutes of Health, Rockville, MD 20850, 2402765256, *shuli.xia@nih.gov.*

Name of Committee: Center for Scientific Review Special Emphasis Panel; RFA Panel: Review of CTSA K12/T32 Applications and TURTLE UE5 Applications.
Date: July 24, 2025.
Time: 10:00 a.m. to 6:00 p.m.
Agenda: To review and evaluate grant applications.
Address: National Institutes of Health, Rockledge II, 6701 Rockledge Drive, Bethesda, MD 20892.
Meeting Format: Virtual Meeting.
Contact Person: Lee Warren Slice, MS, BA, Ph.D., Scientific Review Officer, Office of Scientific Review, National Institute of General Medical Sciences, National Institutes of Health, 1 Democracy Plaza, 6701 Democracy Blvd., Room 1068, Bethesda, MD 20892, *slicelw@mail.nih.gov.*

Name of Committee: Center for Scientific Review Special Emphasis Panel; Behavioral Neuroendocrinology, Neuroimmunology, Rhythms, and Sleep.
Date: July 24, 2025.
Time: 1:00 p.m. to 3:00 p.m.
Agenda: To review and evaluate grant applications.
Address: National Institutes of Health, Rockledge II, 6701 Rockledge Drive, Bethesda, MD 20892.
Meeting Format: Virtual Meeting.
Contact Person: Simon Peter Peron, Ph.D., Scientific Review Officer, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Dr., Room 1009K, Bethesda, MD 20892, (301) 594–6236, *peronsp@csr.nih.gov.*

Name of Committee: Center for Scientific Review Special Emphasis Panel; Member Conflict: Basic and Translational Cancer Research Review.
Date: July 24, 2025.
Time: 12:00 p.m. to 4:00 p.m.
Agenda: To review and evaluate grant applications.
Address: National Institutes of Health, Rockledge II, 6701 Rockledge Drive, Bethesda, MD 20892.
Meeting Format: Virtual Meeting.
Contact Person: David G. Ransom, Ph.D., BS, Scientific Review Officer, Special Review Branch, Division of Extramural Activities, 9609 Medical Center Drive, Room 7W124, National Cancer Institute, NIH, Rockville, MD 20850, (240) 276–6351, *david.ransom@nih.gov.*

(Catalogue of Federal Domestic Assistance Program Nos. 93.306, Comparative Medicine; 93.333, Clinical Research, 93.306, 93.333, 93.337, 93.393–93.396, 93.837–93.844, 93.846–93.878, 93.892, 93.893, National Institutes of Health, HHS)

Dated: June 23, 2025.

Sterlyn H. Gibson,

Program Specialist, Office of Federal Advisory Committee Policy.

[FR Doc. 2025–11723 Filed 6–24–25; 8:45 am]

BILLING CODE 4140–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health,

Center for Scientific Review; Notice of Closed Meetings

Pursuant to section 1009 of the Federal Advisory Committee Act, as amended, notice is hereby given of the following meetings.

The meetings will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: Center for Scientific Review Special Emphasis Panel; Small Business: Health Services and Systems B.
Date: July 17–18, 2025.
Time: 9:00 a.m. to 6:00 p.m.
Agenda: To review and evaluate grant applications.
Address: National Institutes of Health, Rockledge II, 6701 Rockledge Drive, Bethesda, MD 20892.
Meeting Format: Virtual Meeting.
Contact Person: Preethy Nayar, Ph.D., Section Chief, Scientific Review Branch, National Institute on Drug Abuse, NIH, 301 North Stonestreet Avenue, 3WFN, MSC 6021, Bethesda, MD 20892, (301) 594–3087, *preethy.nayar@nih.gov.*

Name of Committee: Center for Scientific Review Special Emphasis Panel; Mentored Career Development Award Applications.
Date: July 17, 2025.
Time: 10:00 a.m. to 6:00 p.m.
Agenda: To review and evaluate grant applications.
Address: National Institutes of Health, Rockledge II, 6701 Rockledge Drive, Bethesda, MD 20892.
Meeting Format: Virtual Meeting.
Contact Person: Srihari Seshadri, Ph.D., Scientific Review Officer, Scientific Review Program, DEA/NIAID/NIH/DHHS, 5601 Fishers Lane, MSC–9823, Rockville, MD 20852, (240) 236–9279, *srihari.seshadri@nih.gov.*

Name of Committee: Center for Scientific Review Special Emphasis Panel; Small Business: Social and Community Influences on Substance and Alcohol Use.
Date: July 18, 2025.
Time: 1:30 p.m. to 5:00 p.m.
Agenda: To review and evaluate grant applications.
Address: National Institutes of Health, Rockledge II, 6701 Rockledge Drive, Bethesda, MD 20892.
Meeting Format: Virtual Meeting.
Contact Person: Keary A. Cope, Ph.D., MPH, Scientific Review Officer, Office of Scientific Review/DERA, National Heart, Lung, and Blood Institute, 6705 Rockledge Drive, Room 209–A, Bethesda, MD 20892–7924, 301–827–7912, *copeka@mail.nih.gov.*

Name of Committee: Center for Scientific Review Special Emphasis Panel; Fellowships: HIV/AIDS Behavioral.
Date: July 21, 2025,
Time: 9:00 a.m. to 2:30 p.m.
Agenda: To review and evaluate grant applications,
Address: National Institutes of Health, Rockledge II, 6701 Rockledge Drive, Bethesda, MD 20892.
Meeting Format: Virtual Meeting.
Contact Person: Xinli Nan, MD, Ph.D., Scientific Review Officer, National Institute on Minority Health and Health Disparities, National Institutes of Health, Scientific Review Branch, OERA, 6707 Democracy Boulevard, Suite 800, Bethesda, MD 20892, (301) 594–7784, *Xinli.Nan@nih.gov.*

Name of Committee: Center for Scientific Review Special Emphasis Panel; Member Conflict: Cardiac, Hematopoietic, Vascular Biology and Diseases.
Date: July 21, 2025,
Time: 9:00 a.m. to 6:00 p.m.
Agenda: To review and evaluate grant applications,
Address: National Institutes of Health, Rockledge II, 6701 Rockledge Drive, Bethesda, MD 20892.
Meeting Format: Virtual Meeting.

Contact Person: Devaiah Nanjappa Ballachanda, Ph.D., Scientific Review Officer, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 801F, Bethesda, MD 20892, (301) 480–0576, *ballachandad@mail.nih.gov.*

Name of Committee: Center for Scientific Review Special Emphasis Panel; Fellowships: Learning, Memory, Language, Communication and Related Neuroscience.

Date: July 21–22, 2025.

Time: 9:30 a.m. to 7:00 p.m.

Agenda: To review and evaluate grant applications.

Address: National Institutes of Health, Rockledge II, 6701 Rockledge Drive, Bethesda, MD 20892.

Meeting Format: Virtual Meeting.

Contact Person: Kausik Ray, Ph.D. Scientific Review Officer, National Institute on Deafness and Other Communication Disorders, National Institutes of Health, 6001 Executive Blvd., Rockville, MD 20852, (301) 402–3587, *rayk@mail.nih.gov.*

Name of Committee: Center for Scientific Review Special Emphasis Panel; PAR Panel: CTSA Collaboration, Innovation and Small Grant Programs.

Date: July 21, 2025

Time: 10:00 a.m. to 6:00 p.m.

Agenda: To review and evaluate grant applications

Address: National Institutes of Health, Rockledge II, 6701 Rockledge Drive, Bethesda, MD 20892.

Meeting Format: Virtual Meeting.

Contact Person: Birgit Neuhuber, Ph.D., Scientific Review Officer, Scientific Review Branch, National Institute on Aging, Gateway Building, Suite 2W–200, 7201 Wisconsin Avenue, Bethesda, MD 20892, 301–827–6548, *birgit.neuhuber@nih.gov.*

Name of Committee: Center for Scientific Review Special Emphasis Panel; Special topics in Health Promotion and Community Influences on Behavior.

Date: July 21, 2025.

Time: 10:45 a.m. to 1:30 p.m.

Agenda: To review and evaluate grant applications.

Address: National Institutes of Health, Rockledge II, 6701 Rockledge Drive, Bethesda, MD 20892.

Meeting Format: Virtual Meeting.

Contact Person: Kimberly L. Houston, MD, Scientific Review Officer, Scientific Review Branch, Eunice Kennedy Shriver National Institute of Child Health and Human Development, NIH, 6710B Rockledge Drive, Room 2137C, Bethesda, MD 20892, (301) 827–4902, *Kimberly.Houston@nih.gov.*

Name of Committee: Center for Scientific Review Special Emphasis Panel; PAR 25–242: Mobile Health: Technology and Outcomes in Low- and Middle-Income Countries.

Date: July 21, 2025.

Time: 1:30 p.m. to 5:00 p.m.

Agenda: To review and evaluate grant applications

Address: National Institutes of Health, Rockledge II, 6701 Rockledge Drive, Bethesda, MD 20892.

Meeting Format: Virtual Meeting.

Contact Person: Kimberly L. Houston, MD, Scientific Review Officer, Scientific Review Branch, Eunice Kennedy Shriver National Institute of Child Health and Human Development, NIH, 6710B Rockledge Drive, Room 2137C, Bethesda, MD 20892, (301) 827–4902, *Kimberly.Houston@nih.gov.*

Name of Committee: Center for Scientific Review Special Emphasis Panel; PAR Panel: HIV/AIDS Health Interventions, Prevention, Clinical Care, and Treatment.

Date: July 21, 2025.

Time: 2:30 p.m. to 6:00 p.m.

Agenda: To review and evaluate grant applications.

Address: National Institutes of Health, Rockledge II, 6701 Rockledge Drive, Bethesda, MD 20892.

Meeting Format: Virtual Meeting.

Contact Person: Xinli Nan, MD, Ph.D., Scientific Review Officer, National Institute on Minority Health and Health Disparities, National Institutes of Health, Scientific Review Branch, OERA, 6707 Democracy Boulevard, Suite 800, Bethesda, MD 20892, (301) 594–7784, *Xinli.Nan@nih.gov.*

(Catalogue of Federal Domestic Assistance Program Nos. 93.306, Comparative Medicine; 93.333, Clinical Research, 93.306, 93.333, 93.337, 93.393–93.396, 93.837–93.844, 93.846–93.878, 93.892, 93.893, National Institutes of Health, HHS)

Dated: June 23, 2025.

Sterlyn H. Gibson,

Program Specialist, Office of Federal Advisory Committee Policy.

[FR Doc. 2025–11722 Filed 6–24–25; 8:45 am]

BILLING CODE 4140–01–P

DEPARTMENT OF HOMELAND SECURITY

U.S. Customs and Border Protection

Accreditation and Approval of Saybolt LP (Nederland, TX) as a Commercial Gauger and Laboratory

AGENCY: U.S. Customs and Border Protection, Department of Homeland Security.

ACTION: Notice of accreditation and approval of Saybolt LP (Nederland, TX), as a commercial gauger and laboratory.

SUMMARY: Notice is hereby given, pursuant to CBP regulations, that Saybolt LP (Nederland, TX), has been approved to gauge petroleum and certain petroleum products and accredited to test petroleum and certain petroleum products for customs purposes for the next three years as of August 14, 2024.

DATES: Saybolt LP (Nederland, TX) was approved and accredited as a commercial gauger and laboratory as of August 14, 2024. The next triennial inspection date will be scheduled for August 2027.

FOR FURTHER INFORMATION CONTACT: Mr. Robert P. Munivez, Laboratories and Scientific Services, U.S. Customs and Border Protection, 4150 Interwood South Parkway, Houston, TX 77032, tel. 281–560–2937.

SUPPLEMENTARY INFORMATION: Notice is hereby given pursuant to 19 CFR 151.12 and 19 CFR 151.13, that Saybolt LP, 4144 N Twin City Hwy, Nederland, TX 77627, has been approved to gauge petroleum and certain petroleum products and accredited to test petroleum and certain petroleum products for customs purposes, in accordance with the provisions of 19 CFR 151.12 and 19 CFR 151.13.

Saybolt LP (Nederland, TX) is approved for the following gauging procedures for petroleum and certain petroleum products from the American Petroleum Institute (API):

API chapters	Title
3	Tank Gauging.
7	Temperature Determination.
8	Sampling.
12	Calculation of Petroleum Quantities.
17	Marine Measurement.

Saybolt LP (Nederland, TX) is accredited for the following laboratory analysis procedures and methods for petroleum and certain petroleum products set forth by the U.S. Customs and Border Protection Laboratory Methods (CBPL) and American Society for Testing and Materials (ASTM):

CBPL No.	ASTM	Title
27–03	D4006	Standard Test Method for Water in Crude Oil by Distillation.
27–05	D4928	Standard Test Method for Water in Crude Oils by Coulometric Karl Fischer Titration.
27–06	D473	Standard Test Method for Sediment in Crude Oils and Fuel Oils by the Extraction Method.
27–13	D4294	Standard Test Method for Sulfur in Petroleum and Petroleum Products by Energy-Dispersive X-ray Fluorescence Spectrometry.
27–48	D4052	Standard Test Method for Density, Relative Density, and API Gravity of Liquids by Digital Density Meter.
N/A	D4007	Standard Test Method for Water and Sediment in Crude Oil by the Centrifuge Method (Laboratory Procedure).

Anyone wishing to employ this entity to conduct laboratory analyses and gauger services should request and receive written assurances from the entity that it is accredited or approved by the U.S. Customs and Border Protection to conduct the specific test or gauger service requested. Alternatively, inquiries regarding the specific test or gauger service this entity is accredited or approved to perform may be directed to the U.S. Customs and Border Protection by calling (202) 344–1060. The inquiry may also be sent to *CBPGaugersLabs@cbp.dhs.gov.* Please reference the website listed below for a complete listing of CBP approved gaugers and accredited laboratories. *http://www.cbp.gov/about/labs-scientific/commercial-gaugers-and-laboratories.*

Lina M. Acosta,

Acting Laboratory Director, Houston, Laboratories and Scientific Services.

[FR Doc. 2025–11702 Filed 6–24–25; 8:45 am]

BILLING CODE 9111–14–P

DEPARTMENT OF HOMELAND SECURITY

U.S. Customs and Border Protection

Accreditation of Seahawk Services (West Deptford, NJ) as a Commercial Laboratory

AGENCY: U.S. Customs and Border Protection, Department of Homeland Security.

ACTION: Notice of accreditation of Seahawk Services (West Deptford, NJ), as a commercial laboratory.

SUMMARY: Notice is hereby given, pursuant to CBP regulations, that Seahawk Services (West Deptford, NJ), has been accredited to test petroleum and certain petroleum products for customs purposes for the next three years as of March 8, 2023.

DATES: Seahawk Services (West Deptford, NJ) was accredited as a commercial laboratory as of March 8, 2023. The next triennial inspection date will be scheduled for March 2026.

FOR FURTHER INFORMATION CONTACT: Dr. Justin Shey, Laboratories and Scientific Services, U.S. Customs and Border Protection, 1331 Pennsylvania Avenue NW, Suite 1501A North, Washington, DC 20004, tel. 202–344–1060.

SUPPLEMENTARY INFORMATION: Notice is hereby given pursuant to 19 CFR 151.12, that Seahawk Services, 1501 Grandview Ave., West Deptford, NJ 08066, has been accredited to test petroleum and certain petroleum products for customs purposes, in accordance with the provisions of 19 CFR 151.12.

Seahawk Services (West Deptford, NJ) is accredited for the following laboratory analysis procedures and methods for petroleum and certain petroleum products set forth by the U.S. Customs and Border Protection Laboratory Methods (CBPL) and American Society for Testing and Materials (ASTM):

CBPL No.	ASTM	Title
27–01	D287	Standard Test Method for API Gravity of Crude Petroleum and Petroleum Products (Hydrometer Method).
27–03	D4006	Standard Test Method for Water in Crude Oil by Distillation.
27–04	D95	Standard Test Method for Water in Petroleum Products and Bituminous Materials by Distillation.
27–06	D473	Standard Test Method for Sediment in Crude Oils and Fuel Oils by the Extraction Method.
27–08	D86	Standard Test Method for Distillation of Petroleum Products at Atmospheric Pressure.
27–11	D445	Standard Test Method for Kinematic Viscosity of Transparent and Opaque Liquids (and Calculation of Dynamic Viscosity).
27–13	D4294	Standard Test Method for Sulfur in Petroleum and Petroleum Products by Energy-Dispersive X-ray Fluorescence Spectrometry.
27–48	D4052	Standard Test Method for Density, Relative Density, and API Gravity of Liquids by Digital Density Meter.

Anyone wishing to employ this entity to conduct laboratory analyses should request and receive written assurances from the entity that it is accredited by the U.S. Customs and Border Protection to conduct the specific test requested. Alternatively, inquiries regarding the specific test this entity is accredited to perform may be directed to the U.S. Customs and Border Protection by calling (202) 344–1060. The inquiry may also be sent to *CBPGaugersLabs@cbp.dhs.gov.* Please reference the website listed below for a complete listing of CBP approved gaugers and accredited laboratories. *http://www.cbp.gov/about/labs-scientific/commercial-gaugers-and-laboratories.*

Lina M. Acosta,

Acting Laboratory Director, Houston, Laboratories and Scientific Services.

[FR Doc. 2025–11699 Filed 6–24–25; 8:45 am]

BILLING CODE 9111–14–P

DEPARTMENT OF HOMELAND SECURITY

U.S. Customs and Border Protection

Accreditation and Approval of Product Quality Management, LLC (Carteret, NJ) as a Commercial Gauger and Laboratory

AGENCY: U.S. Customs and Border Protection, Department of Homeland Security.

ACTION: Notice of accreditation and approval of Product Quality Management, LLC (Carteret, NJ), as a commercial gauger and laboratory.

SUMMARY: Notice is hereby given, pursuant to CBP regulations, that Product Quality Management, LLC (Carteret, NJ), has been approved to gauge petroleum and certain petroleum products and accredited to test petroleum and certain petroleum products for customs purposes for the next three years as of September 27, 2024.

DATES: Product Quality Management, LLC (Carteret, NJ) was approved and accredited as a commercial gauger and laboratory as of September 27, 2024. The next triennial inspection date will be scheduled for September 2027.

FOR FURTHER INFORMATION CONTACT: Dr. Justin Shey, Laboratories and Scientific Services, U.S. Customs and Border Protection, 1331 Pennsylvania Avenue NW, Suite 1501A North, Washington, DC 20004, tel. 202–344–1060.

SUPPLEMENTARY INFORMATION: Notice is hereby given pursuant to 19 CFR 151.12 and 19 CFR 151.13, that Product Quality Management, LLC, 2 Terminal Road KMI Building OB2, Carteret, NJ 07008 has been approved to gauge petroleum and certain petroleum products and accredited to test petroleum and certain petroleum products for customs purposes, in accordance with the provisions of 19 CFR 151.12 and 19 CFR 151.13.

Product Quality Management, LLC (Carteret, NJ) is approved for the following gauging procedures for petroleum and certain petroleum products from the American Petroleum Institute (API):

API chapters	Title
3	Tank Gauging.
7	Temperature Determination.
8	Sampling.
11	Physical Properties Data.
12	Calculation of Petroleum Quantities.
17	Marine Measurement.

Product Quality Management, LLC (Carteret, NJ) is accredited for the following laboratory analysis procedures and methods for petroleum and certain petroleum products set forth by the U.S. Customs and Border Protection Laboratory Methods (CBPL) and American Society for Testing and Materials (ASTM):

CBPL No.	ASTM	Title
27–01	D287	Standard Test Method for API Gravity of Crude Petroleum and Petroleum Products (Hydrometer Method).
27–04	D95	Standard Test Method for Water in Petroleum Products and Bituminous Materials by Distillation.
27–05	D4928	Standard Test Method for Water in Crude Oils by Coulometric Karl Fischer Titration.
27–06	D473	Standard Test Method for Sediment in Crude Oils and Fuel Oils by the Extraction Method.
27–08	D86	Standard Test Method for Distillation of Petroleum Products at Atmospheric Pressure.
27–11	D445	Standard Test Method for Kinematic Viscosity of Transparent and Opaque Liquids (and Calculation of Dynamic Viscosity).
27–13	D4294	Standard Test Method for Sulfur in Petroleum and Petroleum Products by Energy-Dispersive X-ray Fluorescence Spectrometry.
27–14	D2622	Standard Test Method for Sulfur in Petroleum Products by Wavelength Dispersive X-Ray Fluorescence Spectrometry.
27–46	D5002	Standard Test Method for Density, Relative Density, and API Gravity of Crude Oils by Digital Density Analyzer.
27–48	D4052	Standard Test Method for Density, Relative Density, and API Gravity of Liquids by Digital Density Meter.
27–50	D93	Standard Test Methods for Flash Point by Pensky-Martens Closed Cup Tester.
27–53	D2709	Standard Test Method for Water and Sediment in Middle Distillate Fuels by Centrifuge.
27–58	D5191	Standard Test Method for Vapor Pressure of Petroleum Products and Liquid Fuels (Mini Method).
N/A	D130	Standard Test Method for Corrosiveness to Copper from Petroleum Products by Copper Strip Test.
N/A	D2699	Standard Test Method for Research Octane Number of Spark-Ignition Engine Fuel.
N/A	D2700	Standard Test Method for Motor Octane Number of Spark-Ignition Engine Fuel.
N/A	D3606	Standard Test Method for Determination of Benzene and Toluene in Spark Ignition Fuels by Gas Chromatography.
N/A	D5769	Standard Test Method for Determination of Benzene, Toluene, and Total Aromatics in Finished Gasolines by Gas Chromatography/Mass Spectrometry.

Anyone wishing to employ this entity to conduct laboratory analyses and gauger services should request and receive written assurances from the entity that it is accredited or approved by the U.S. Customs and Border Protection to conduct the specific test or gauger service requested. Alternatively, inquiries regarding the specific test or gauger service this entity is accredited or approved to perform may be directed to the U.S. Customs and Border Protection by calling (202) 344–1060. The inquiry may also be sent to *CBPGaugersLabs@cbp.dhs.gov*. Please reference the website listed below for a complete listing of CBP approved gaugers and accredited laboratories. *http://www.cbp.gov/about/labs-scientific/commercial-gaugers-and-laboratories*.

Lina M. Acosta,

Acting Laboratory Director, Houston, Laboratories and Scientific Services.

[FR Doc. 2025–11703 Filed 6–24–25; 8:45 am]

BILLING CODE 9111–14–P

DEPARTMENT OF HOMELAND SECURITY

U.S. Customs and Border Protection

Approval of Seahawk Services (West Deptford, NJ) as a Commercial Gauger

AGENCY: U.S. Customs and Border Protection, Department of Homeland Security.

ACTION: Notice of approval of Seahawk Services (West Deptford, NJ), as a commercial gauger.

SUMMARY: Notice is hereby given, pursuant to CBP regulations, that Seahawk Services (West Deptford, NJ), has been approved to gauge petroleum and certain petroleum products for customs purposes for the next three years as of March 8, 2023.

DATES: Seahawk Services (West Deptford, NJ) was approved as a commercial gauger as of March 8, 2023. The next triennial inspection date will be scheduled for March 2026.

FOR FURTHER INFORMATION CONTACT: Dr. Justin Shey, Laboratories and Scientific Services, U.S. Customs and Border Protection, 1331 Pennsylvania Avenue NW, Suite 1501A North, Washington, DC 20004, tel. 202–344–1060.

SUPPLEMENTARY INFORMATION: Notice is hereby given pursuant to 19 CFR 151.13, that Seahawk Services, 1501 Grandview Ave., West Deptford, NJ 08066, has been approved to gauge petroleum and certain petroleum products for customs purposes, in accordance with the provisions of 19 CFR 151.13.

Seahawk Services (West Deptford, NJ) is approved for the following gauging procedures for petroleum and certain petroleum products from the American Petroleum Institute (API):

API chapters	Title
3	Tank Gauging.
7	Temperature Determination.
8	Sampling.
11	Physical Properties Data.
12	Calculation of Petroleum Quantities.
17	Marine Measurement.

Anyone wishing to employ this entity to conduct gauger services should request and receive written assurances from the entity that it is approved by the U.S. Customs and Border Protection to conduct the specific gauger service requested. Alternatively, inquiries regarding the specific gauger service this entity is approved to perform may be directed to the U.S. Customs and Border Protection by calling (202) 344–1060. The inquiry may also be sent to *CBPGaugersLabs@cbp.dhs.gov*. Please

reference the website listed below for a complete listing of CBP approved gaugers and accredited laboratories. *http://www.cbp.gov/about/labs-scientific/commercial-gaugers-and-laboratories.*

Lina M. Acosta,

Acting Laboratory Director, Houston, Laboratories and Scientific Services.

[FR Doc. 2025–11700 Filed 6–24–25; 8:45 am]

BILLING CODE 9111–14–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Docket ID: FEMA–2025–0011; OMB No. 1660–0138]

Agency Information Collection Activities: Proposed Collection; Comment Request; Direct Housing Assistance Forms

AGENCY: Federal Emergency Management Agency, Department of Homeland Security.

ACTION: 60-Day notice of revision and request for comments.

SUMMARY: The Federal Emergency Management Agency (FEMA), as part of its continuing effort to reduce paperwork and respondent burden, invites the general public to take this opportunity to comment on a revision of a currently approved information collection. In accordance with the Paperwork Reduction Act of 1995, this notice seeks comments concerning information collected by FEMA to provide temporary housing units, including manufactured housing units, recreational vehicles and other readily fabricated dwellings to eligible applicants who, as a direct result of a major disaster or emergency, are unable to occupy their primary residence or obtain adequate alternate housing, and therefore require temporary housing.

DATES: Comments must be submitted on or before August 25, 2025.

ADDRESSES: To avoid duplicate submissions to the docket, please submit comments at *www.regulations.gov* under Docket ID: FEMA–2025–0011. Follow the instructions for submitting comments.

All submissions received must include the agency name and Docket ID. Regardless of the method used for submitting comments or material, all submissions will be posted, without change, to the Federal eRulemaking Portal at *http://www.regulations.gov,* and will include any personal information you provide. Therefore, submitting this information makes it public. You may wish to read the Privacy and Security Notice that is available via a link on the homepage of *www.regulations.gov.*

FOR FURTHER INFORMATION CONTACT: Nicole Dunne, Supervisory Emergency Management Specialist, FEMA, Recovery Directorate, 202–646–3297, and *Nicole.Dunne@fema.dhs.gov.* You may contact the Information Management Division for copies of the proposed collection of information at email address: *FEMA-Information-Collections-Management@fema.dhs.gov.*

SUPPLEMENTARY INFORMATION: The Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5174, as amended by the Disaster Mitigation Act of 2000 (Pub. L. 106–390), authorizes the President to provide temporary housing units, including manufactured housing units, recreational vehicles and other readily fabricated dwellings to eligible applicants who, as a direct result of a major disaster or emergency, are unable to occupy their primary residence or obtain adequate alternate housing, and therefore require temporary housing. Requirements for disaster-related housing needs of individuals and households who are eligible for temporary housing assistance may be found in 44 CFR 206.117—Housing Assistance. The information collected is used to determine the feasibility of a potential site for placement of temporary housing units (THUs) to ensure the THUs are ready for applicant occupancy, and to confirm applicant understanding of the requirements of occupancy of the THUs. The information will also provide FEMA with access to place the THUs, to document the installation and maintenance of the THUs, and to retrieve the THUs at the end of their use.

FEMA is revising this collection to add two instruments that are currently approved under 1660–0002—Disaster Assistance Registration, FEMA Form FF–104–FY–21–127 (formerly 009–0–5), Direct Temporary Housing Assistance Revocable License and Receipt for Government Property (Revocable License) and its Spanish translation FF–104–FY–21–127–A (formerly 009–0–6), Asistencia Directa para Vivienda Temporal Licencia Revocable y Recibo de Propiedad Gubernamental (Licencia Revocable). These instruments will be better aligned for their use in this collection.

FEMA is also adding a new instrument, FEMA Form FF–104–FY–25–101, Right of Entry. This instrument is used to obtain the landowner consent to inspect and determine feasibility of their property for the placement of Transportable Temporary Housing Unit (TTHUs).

Collection of Information

Title: Direct Housing Assistance Forms.

Type of Information Collection: Revision of a currently approved information collection.

OMB Number: 1660–0138.

FEMA Forms (12 in total): FEMA Form FF–104–FY–21–109 (formerly 010–0–9), Direct Housing Assistance Request for Site Inspection; FF–104–FY–21–110 (formerly 010–0–10)/FF–104–FY–21–110–A (formerly 010–0–10S), Landowner Authorization and Ingress-Egress Agreement; FF–104–FY–21–111 (formerly 009–0–138), THU Inspection (formerly TTHU Inspection Report); FF–104–FY–21–112 (formerly 009–0–136), TTHU Installation Work Order; FF–104–FY–21–113 (formerly 009–0–130), TTHU Maintenance Work Order; FF–104–FY–21–127 (formerly 009–0–5)/FF–104–FY–21–127–A Revocable License Agreement (formerly Revocable License and Receipt for Government Property); FF–104–FY–21–191 (formerly 009–0–129), TTHU Ready for Occupancy Status; FF–104–FY–21–192 (formerly 009–0–131), Conditions of Sale (formerly Sales Calculation Worksheet); FF–104–FY–21–193 (formerly 009–0–134), Recertification Worksheet (formerly Direct Temporary Housing Assistance Recertification Worksheet); FF–104–FY–21–194 (formerly 009–0–135)/FF–104–FY–21–194–A, Temporary Housing Agreement (formerly Direct Temporary Housing Assistance Temporary Housing Agreement); FF–104–FY–21–195 (009–0–137), Commercial Park Requirements Checklist (formerly Commercial Park Unit Pad Requirements Information Checklist); and FF–104–FY–25–101, Right of Entry.

Abstract: The information collected within this information collection is necessary for eligible applicant's use of THUs provided by FEMA, including all occupancy requirements, and to ensure FEMA has the required information to establish, maintain, or conclude use of a THU. The information will also provide FEMA with access to place the THUs, to document the installation and maintenance of the THUs, and to retrieve the THUs at the end of their use.

Affected Public: Individuals or households, business or other for-profit.

Estimated Number of Respondents: 30,401.

Estimated Number of Responses: 30,401.

Estimated Total Annual Burden Hours: 4,501.

Estimated Total Annual Respondent Cost: $245,262.

Estimated Respondents' Operation and Maintenance Costs: $0.

Estimated Respondents' Capital and Start-Up Costs: $0.

Estimated Total Annual Cost to the Federal Government: $11,864,348.

Comments

Comments may be submitted as indicated in the **ADDRESSES** caption above. Comments are solicited to (a) evaluate whether the proposed data collection is necessary for the proper performance of the Agency, including whether the information shall have practical utility; (b) evaluate the accuracy of the Agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used; (c) enhance the quality, utility, and clarity of the information to be collected; and (d) minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, *e.g.,* permitting electronic submission of responses.

Russell R. Bard,

Acting Senior Director for Information Management, Office of the Chief Administrative Officer, Mission Support, Federal Emergency Management Agency, Department of Homeland Security.

[FR Doc. 2025–11688 Filed 6–24–25; 8:45 am]

BILLING CODE 9111–23–P

DEPARTMENT OF THE INTERIOR

Geological Survey

[GX24EN05ESK0000]

Agency Information Collection Activities; The Impact and Potential of "Co-Production" in Addressing Climate Adaptation Across the Pacific Islands

AGENCY: U.S. Geological Survey, Interior.

ACTION: Notice of information collection; request for comment.

SUMMARY: The U.S. Geological Survey (USGS) is proposing a new information collection in accordance with the Paperwork Reduction Act (PRA) of 1995.

DATES: Interested persons are invited to submit comments. To be considered, USGS must receive your comments on or before July 25, 2025.

ADDRESSES: You may submit comments by one of the following methods:

- *Internet: https://www.regulations.gov.* Search for and submit comments on Docket No. USGS–2025–0011.
- *U.S. Mail:* USGS, Information Collections Clearance Officer, 12201 Sunrise Valley Drive, MS 159, Reston, VA 20192.

FOR FURTHER INFORMATION CONTACT: Mari-Vaughn Johnson by email at *mvjohnson@usgs.gov* or by telephone at 808–208–3142. Individuals in the United States who are deaf, deafblind, hard of hearing, or have a speech disability may dial 711 (TTY, TDD, or TeleBraille) to access telecommunications relay services. Individuals outside the United States should use the relay services offered within their country to make international calls to the point-of-contact in the United States.

SUPPLEMENTARY INFORMATION: In accordance with the PRA (44 U.S.C. 3501 *et seq.*) and 5 CFR 1320.8(d)(1), all information collections require approval under the PRA. We may not conduct or sponsor, nor are you required to respond to a collection of information unless it displays a currently valid OMB control number.

As part of our continuing effort to reduce paperwork and respondent burdens, we invite the public and other federal agencies to comment on new, proposed, revised, and continuing collections of information. This helps us assess the impact of our information collection requirements and minimize the public's reporting burden. It also helps the public understand our information collection requirements and provide the requested data in the desired format.

We are especially interested in public comment addressing the following:

(1) Whether or not the collection of information is necessary for the proper performance of the functions of the agency, including whether or not the information will have practical utility;

(2) The accuracy of our estimate of the burden for this collection of information, including the validity of the methodology and assumptions used;

(3) Ways to enhance the quality, utility, and clarity of the information to be collected; and

(4) How the agency might minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, *e.g.,* permitting electronic submission of response.

Comments that you submit in response to this notice are a matter of public record. Before including your address, phone number, email address, or other personally identifiable information (PII) in your comment, you should be aware that your entire comment—including your PII—may be made publicly available at any time. While you can ask us in your comment to withhold your PII from public review, we cannot guarantee that we will be able to do so.

Project A

Abstract: The Pacific Islands Climate Adaptation Science Center (PI–CASC) involves a partnership between the USGS and a university consortium, including the University of Hawai'i at Mānoa, the University of Hawai'i at Hilo, and the University of Guam. PI–CASC aims to support a portfolio of research projects that foster long-lasting partnerships between researchers, natural and cultural resource stewards and managers, and community leaders. While building local capacities, PI–CASC endeavors to co-develop the science/knowledge bases informing our current understanding of climate change and its impacts, as well as how we might take steps to adapt to those impacts across the Pacific Islands. PI–CASC is seeking to conduct surveys and interviews with project leaders, collaborators, and community members to better understand the state of co-production across the portfolio and how such cooperative efforts may be improved moving forward. The proposed survey and interviews will collect the following information:

- The state of collaborative relationships between project partners, the community, and others since project completion.
- Status of products developed via PI–CASC funding (*e.g.,* new grant awards, research articles, presentations, workshops, visualization tools, assessments, guidance documents, etc.).
- PI–CASCs influence on approaches taken in other projects.

The information collected in this effort will be used to improve the approach to developing climate adaptation science/knowledge production and concomitant management/stewardship plans in future PI–CASC work.

Title of Collection: The Impact and Potential of ''Co-Production'' in Addressing Climate Adaptation across the Pacific Islands.

OMB Control Number: 1028–NEW.

Form Number: None.

Type of Review: New.

Respondents/Affected Public: Respondents will include PI–CASC funded projects' principal investigators, co-investigators, and collaborators; graduate scholars and postdocs; and community members. These include individuals from Federal organizations, State organizations (including academic institutions), non-governmental organizations (NGOs), and Tribal entities.

Total Estimated Number of Annual Respondents: PI–CASC expects to request surveys from a maximum of 330 respondents (Approximately 85 Federal employees, 20 State or local government employees, 150 university/college researchers, 45 NGO leaders, and 30 international respondents that have been involved and/or impacted by PI–CASC project work). Of these 330 requests, we hope to have a response rate near half, to get an estimated 150 survey responses. We also plan to request interviews with 50 participants from a subset of PI–CASC project case studies. There is likely to be overlap in the participants that complete the surveys and are requested for interviews.

Total Estimated Number of Annual Responses: An estimated 150 surveys and 50 interviews are expected to be completed.

Estimated Completion Time per Response: Each survey is expected to take a respondent approximately 10 minutes to complete. For those that agree to an interview, an additional 1 hour is expected to be used per interview.

Total Estimated Number of Annual Burden Hours: An estimated 75 burden hours per year is expected (10 min × 150) + (60 min × 50) = 4500 min → 75 hours.

Respondent's Obligation: Voluntary.

Frequency of Collection: The information collection needed to reach the described 150–330 surveys and 50 interviews may take place over multiple years (splitting up the described annual burden hours), and the overall collection process may be potentially repeated every five years to gather information about changes over time.

Total Estimated Annual Nonhour Burden Cost: None.

Project B

Abstract: The USGS PI–CASC and U.S. Fish and Wildlife Service (USFWS) support the coordinator of the Pacific Regional Invasive Species and Climate Change Management Network (Pacific RISCC), a community of practice that includes partnerships with PI–CASC, USGS, USFWS, the University of Hawai'i at Mānoa, the State of Hawai';i Department of Land and Natural Resources Division of Forestry & Wildlife, the Coordinating Group on Alien Pest Species, and representatives from all of the U.S. affiliated Pacific islands. Pacific RISCC aims to support research and management efforts addressing the individual and interacting impacts of climate change and invasive species in the U.S. Pacific, with the goal of increasing the effectiveness of management and reducing the impacts of climate change and invasive species. Pacific RISCC would like to assess the effectiveness of hosted workshops by surveying attendees.

The proposed surveys and interviews will collect the following types of information:

- Demographic characteristics of workshop attendees (field, role/position, location, etc.).
- Pacific RISCC events, products, communications, or tools that are most used by and/of interest to attendees.
- Outstanding invasive species and climate change related challenges and associated research needs.
- Response to workshop in terms of topical relevance, effectiveness, accessibility, and capacity building in a regional context.

The information collected in this effort will be used to better align the future goals and objectives of Pacific RISCC, including future workshops, with the needs of respondants across the Pacific RISCC region.

Respondents/Affected Public: Respondents will include individuals from county, State, and Federal organizations, including land management agencies and academic institutions, individuals from non-profits and NGOs, students, and community members.

Total Estimated Number of Annual Respondents: Pacific RISCC expects to request annual survey completion via the RISCC Listservs containing approximately 800 respondents (approximately 120 Federal employees, 220 State or local government employees, 200 university/college researchers (including students)), 100 NGO leaders, 100 community members, and 60 international respondents. Additionally, Pacific RISCC expects to request post-workshop surveys twice a year from a maximum of 60 respondents per workshop (affiliations will depend on who signs up, but will likely include Federal, State, and county agency resource managers and scientists from State and Federal institutions).

Total Estimated Number of Annual Responses: An estimated 400 surveys and 15 interviews are expected to be completed from the annual listserv inquiry, and an additional 120 post-workshop survey responses are expected to be returned, for a combined total of 535 survey and interview responses. This estimate is based on a 50% survey response rate.

Estimated Completion Time per Response: Each survey is expected to take a respondent approximately 10 minutes to complete. For those that agree to a follow-up interview, an additional 1 hour is expected to be taken per interview.

Total Estimated Number of Annual Burden Hours: Based on a 50% response rate, an estimated 65 hours are expected to be taken for annual listserv surveys, with another 15 hours for the interviews, and an estimated 20 hours for the two post-workshop surveys. The total maximum estimated burden hours is 102 hours for Project B.

Respondent's Obligation: Voluntary.

Frequency of Collection: Information will be collected annually.

Total Estimated Annual Nonhour Burden Cost: None.

The authority for this action is the PRA (44 U.S.C. 3501 *et seq.*).

Mari-Vaughn Johnson,

Regional Administrator, PI–CASC, USGS.

[FR Doc. 2025–11720 Filed 6–24–25; 8:45 am]

BILLING CODE 4388–11–P

DEPARTMENT OF THE INTERIOR

Office of the Solicitor

Guidance on Referrals for Potential Criminal Enforcement

AGENCY: Office of the Solicitor, Interior.

ACTION: Notice.

SUMMARY: This notice describes the Department of the Interior's (''Department'' or ''DOI'') plans to address criminally liable regulatory offenses under the Executive Order 14294, ''Fighting Overcriminalization in Federal Regulations.''

FOR FURTHER INFORMATION CONTACT: Kasie Durkit, Office of the Solicitor, 1849 C Street NW, Washington, DC 20240; telephone 202–208–4423.

SUPPLEMENTARY INFORMATION: On May 9, 2025, the President issued Executive Order (''E.O.'') 14294, ''Fighting Overcriminalization in Federal Regulations.'' 90 FR 20363 (published May 14, 2025). Section 7 of E.O. 14294 provides that within 45 days of the order, and in consultation with the Attorney General, each agency should

publish guidance in the **Federal Register** describing its plan for how it will address its regulations that provide for criminal liability for regulatory offenses.

Consistent with that requirement, the Department advises the public that by May 9, 2026, the Department, in consultation with the Attorney General, will provide to the Director of the Office of Management and Budget (''OMB'') a report containing: (1) a list of all criminal regulatory offenses [1] in DOI's regulations that are enforceable by DOI or the Department of Justice (''DOJ''); and (2) for each such criminal regulatory offense, the range of potential criminal penalties for a violation, and the applicable *mens rea* standard [2] for the criminal regulatory offense.

This notice also announces a general policy, subject to appropriate exceptions and to the extent consistent with law, that when the Department is deciding whether to refer alleged violations of criminal regulatory offenses to DOJ, officers and employees of the Department should consider, among other factors:

- the harm or risk of harm, pecuniary or otherwise, caused by the alleged offense;
- the potential gain to the putative defendant that could result from the offense;
- whether the putative defendant held specialized knowledge, expertise, or was licensed in an industry related to the rule or regulation at issue; and
- evidence, if any is available, of the putative defendant's general awareness of the unlawfulness of his conduct as well as his or her knowledge or lack thereof of the regulation at issue.

Department-Specific Implementation Plan

Consistent with E.O. 14294 and the general policy set forth above, the following actions will be undertaken:

a. The Department will review its regulations for all criminal regulatory offenses enforceable by the agency or the DOJ, including the applicable statutory authorities, the range of potential criminal penalties for a violation, and the applicable mens rea standard for each criminal regulatory offense.

b. The Department will review the identified regulatory offenses and associated processes for compliance with the principles articulated in E.O. 14294. The Department will evaluate whether regulatory or procedural changes are necessary to ensure the public has adequate notice of the offenses and that the mens rea identified for each regulatory offense is appropriate.

c. The Department will make recommendations to the Secretary on actions to further the principles articulated in E.O. 14294 and the general policy set forth above, as well as take all measures legally permissible and procedurally appropriate to implement such actions.

This general policy is not intended to, and does not, create any right or benefit, substantive or procedural, enforceable at law or in equity by any party against the United States, its departments, agencies, or entities, its officers, employees, or agents, or any other person.

Damon A. Hagan,

Deputy Solicitor for General Law.

[FR Doc. 2025–11721 Filed 6–23–25; 4:15 pm]

BILLING CODE 4334–CC–P

[1] ''Criminal regulatory offense'' means a Federal regulation that is enforceable by a criminal penalty. E.O. 14294, sec. 3(b).

[2] ''Mens rea'' means the state of mind that by law must be proven to convict a particular defendant of a particular crime. E.O. 14294, sec. 3(c).

INTERNATIONAL TRADE COMMISSION

[Investigation No. 337–TA–1403]

Certain Sensors With Pixels and Products Containing the Same; Notice of a Commission Determination Not To Review an Initial Determination Terminating the Investigation Based on Settlement; Termination of Investigation

AGENCY: U.S. International Trade Commission.

ACTION: Notice.

SUMMARY: Notice is hereby given that the U.S. International Trade Commission (''Commission'') has determined not to review an initial determination (''ID'') (Order No. 60) of the presiding administrative law judge (''ALJ'') granting the complainant's motion to terminate the above-captioned investigation based on settlement. The investigation is terminated.

FOR FURTHER INFORMATION CONTACT: Lynde Herzbach, Office of the General Counsel, U.S. International Trade Commission, 500 E Street SW, Washington, DC 20436, telephone (202) 205–3228. Copies of non-confidential documents filed in connection with this investigation may be viewed on the Commission's electronic docket (EDIS) at *https://edis.usitc.gov.* For help accessing EDIS, please email *EDIS3Help@usitc.gov.* General information concerning the Commission may also be obtained by accessing its internet server at *https://www.usitc.gov.* Hearing-impaired persons are advised that information on this matter can be obtained by contacting the Commission's TDD terminal on (202) 205–1810.

SUPPLEMENTARY INFORMATION: The Commission instituted this investigation on June 5, 2024, based on a complaint filed by SiOnyx, LLC of Beverly, Massachusetts (''SiOnyx''). *See* 89 FR 48191–48192 (June 5, 2024). The complaint, as supplemented, alleges violations of section 337 of the Tariff Act of 1930, as amended, 19 U.S.C. 1337, in the importation into the United States, the sale for importation, or the sale within the United States after importation of certain sensors with pixels and products containing same by reason of the infringement of certain claims of U.S. Patent Nos. 9,064,764 (''the '764 patent''); 9,905,599 (''the '599 patent''); 10,224,359 (''the '359 patent''); 11,069,737 (''the '737 patent''); and 11,721,714 (''the '714 patent''). *Id.* The complaint further alleges that a domestic industry exists. *Id.* The Commission's notice of investigation named as respondents Samsung Electronics Co., Ltd. of Suwon, Republic of Korea; Samsung Electronics America, Inc. of Ridgefield Park, New Jersey; and Samsung Semiconductor, Inc. of San Jose, California (collectively, ''Respondents''). *Id.* The Office of Unfair Import Investigations is not participating in the investigation. *Id.*

The Commission previously terminated the investigation as to claims 1–7, 12, 13, 19, 22, and 24 of the '764 patent; claims 2, 3, 10, 12–17, 20, 21, 25, 27, 29, 34, and 35 of the '599 patent; claims 2–4, 9, 10, 22, 25, 27, 30, 34, 38–40, 42–47, 49–53, 56–59, 62, 63, 65–67, 71–73, 76, 81, and 83 of the '359 patent; claims 1, 8, 9, 11, 14, 15, 17, 23, 25, 27, 31, 32, 34, 37, 40, 42, 46, 47, and 53 of the '737 patent; and claims 7, 8, and 14–16 of the '714 patent based on partial withdrawal of the complaint. Order No. 31 (Dec. 10, 2024), *unreviewed by* Comm'n Notice (Dec. 23, 2024). The Commission also previously terminated the investigation as to claims 9, 10, 11, 14, 15, and 25 of the '764 patent; claims 4, 5, 7, 22, 23, 26, and 30 of the '599 patent; claims 5, 6, 7, 8, 12, 13, 14, 19, 41, 44, 48, 54, 55, 60, 61, 64, 68, 69, 70, 74, 75, 80, and 82 of the '359 patent; claims 3, 5, 6, 7, 12, 13, 16, 18, 19, 20, 21, 22, 24, 26, 28, 29, 30, 35, 36, 38, 39, 43, 44, 45, 48, 49, 50, 51, 52, and 54 of the '737 patent; and claims 2, 3, 4, 5, 6, 9, 10, and 11 of the '714 patent based on withdrawal of the complaint as to those claims. Order No. 43 (June 9,

2025), *unreviewed by* Comm'n Notice (Mar. 24, 2025).

On May 29, 2025, SiOnyx moved for termination of this investigation in its entirety based on settlement. ID at 1 (citing Mot. at 1). The motion notes that it is ''based on a Patent License Agreement between SiOnyx and [non-party] RPX Corporation ('RPX') and a Release Agreement between SiOnyx and Respondents Samsung Electronics Co., Ltd. ('SEC') on behalf of all Respondents.'' *Id.* at 1 (citing Mot. at 1). The motion notes that Respondents do not oppose the motion. No responses to the motion were filed.

On June 9, 2025, the presiding ALJ issued the subject ID granting the motion to terminate the investigation and a Notice of Errata to the subject ID. *See* Order No. 60 (June 9, 2025); Notice of Errata to Order No. 60 (June 9, 2025) (identifying Order No. 60 as an initial determination). The subject ID finds that the motion complies with Commission Rule 210.21(b)(1) (19 CFR 210.21(b)) and that no extraordinary circumstances prevent granting the motion. The ID also finds that termination of the investigation based on settlement would not be contrary to the public interest.

No petitions for review of the ID were filed.

The Commission has determined not to review the subject ID (Order No. 60). The investigation is terminated.

The Commission vote for this determination took place on June 20, 2025.

The authority for the Commission's determination is contained in section 337 of the Tariff Act of 1930, as amended (19 U.S.C. 1337), and in Part 210 of the Commission's Rules of Practice and Procedure (19 CFR part 210).

By order of the Commission.

Issued: June 20, 2025.

Lisa Barton,

Secretary to the Commission.

[FR Doc. 2025–11658 Filed 6–24–25; 8:45 am]

BILLING CODE 7020–02–P

INTERNATIONAL TRADE COMMISSION

[Investigation Nos. 701–TA–742–745 and 731–TA–1720–1723 (Final)]

Hard Empty Capsules From Brazil, China, India, and Vietnam; Scheduling of the Final Phase of Countervailing Duty and Antidumping Duty Investigations

AGENCY: United States International Trade Commission.

ACTION: Notice.

SUMMARY: The Commission hereby gives notice of the scheduling of the final phase of antidumping and countervailing duty investigation Nos. 701–TA–742–745 and 731–TA–1720–1723 (Final) pursuant to the Tariff Act of 1930 (''the Act'') to determine whether an industry in the United States is materially injured or threatened with material injury, or the establishment of an industry in the United States is materially retarded, by reason of imports of hard empty capsules from Brazil, China, India, and Vietnam, provided for in subheadings 9602.00.10 and 9602.00.50 of the Harmonized Tariff Schedule of the United States, preliminarily determined by the Department of Commerce (''Commerce'') to be subsidized and sold at less-than-fair-value.

DATES: May 29, 2025.

FOR FURTHER INFORMATION CONTACT: Julie Duffy ((202) 708–2579), Office of Investigations, U.S. International Trade Commission, 500 E Street SW, Washington, DC 20436. Hearing-impaired persons can obtain information on this matter by contacting the Commission's TDD terminal on 202–205–1810. Persons with mobility impairments who will need special assistance in gaining access to the Commission should contact the Office of the Secretary at 202–205–2000. General information concerning the Commission may also be obtained by accessing its internet server (*https://www.usitc.gov*). The public record for these investigations may be viewed on the Commission's electronic docket (EDIS) at *https://edis.usitc.gov.*

SUPPLEMENTARY INFORMATION:

Scope.—For purposes of these investigations, Commerce has defined the subject merchandise as ''The merchandise subject to the scope of the investigation is hard empty capsules, which are comprised of two prefabricated, hollowed cylindrical sections (cap and body). The cap and body pieces each have one closed and rounded end and one open end, and are constructed with different or equal diameters at their open ends.

Hard empty capsules are unfilled cylindrical shells composed of at least 80 percent by weight of a water soluble polymer that is considered non-toxic and appropriate for human or animal consumption by the United States Pharmacopeia—National Formulary (USP–NF), Food Chemical Codex (FCC), or equivalent standards. The most common polymer materials in hard empty capsules are gelatin derived from animal collagen (including, but not limited to, pig, cow, or fish collagen), hydroxypropyl methylcellulose (HPMC), and pullulan.

Hard empty capsules may also contain water and additives, such as opacifiers, colorants, processing aids, controlled release agents, plasticizers, and preservatives. Hard empty capsules may also be imprinted or otherwise decorated with markings.

Hard empty capsules are covered by the scope of the investigation regardless of polymer material, additives, transparency, opacity, color, imprinting, or other markings.

Hard empty capsules are also covered by the scope of the investigation regardless of their size, weight, length, diameter, thickness, and filling capacity.

Cap and body pieces of hard empty capsules are covered by the scope of the investigation regardless of whether they are imported together or separately, and regardless of whether they are imported in attached or detached form.

Hard empty capsules covered by the scope of the investigation are those that disintegrate in water within 2 hours under tests specified in Chapter 701 of the USP–NF, or equivalent disintegration tests.

Hard empty capsules are classifiable under subheadings 9602.00.1040 and 9602.00.5010 of the Harmonized Tariff Schedule of the United States (HTSUS). In addition, hard empty capsules may be imported under HTSUS subheading 1905.90.9090; gelatin hard empty capsules may be imported under HTSUS subheading 3503.00.5510; HPMC hard empty capsules may be imported under HTSUS subheading 3923.90.0080; and pullulan hard empty capsules may be imported under HTSUS subheading 2106.90.9998. Although the HTSUS subheadings are provided for convenience and customs purposes, the written description of the merchandise covered by the investigation is dispositive.

Background.—The final phase of these investigations is being scheduled pursuant to sections 705(b) and 731(b) of the Tariff Act of 1930 (19 U.S.C. 1671d(b) and 1673d(b)), as a result of affirmative preliminary determinations by Commerce that certain benefits which constitute subsidies within the meaning of § 703 of the Act (19 U.S.C. 1671b) are being provided to manufacturers, producers, or exporters in Brazil, China, India, and Vietnam of hard empty capsules, and that such products are being sold in the United States at less than fair value within the meaning of § 733 of the Act (19 U.S.C. 1673b). The investigations were requested in petitions filed on October 24, 2024, by Lonza Greenwood LLC, Greenwood, South Carolina.

For further information concerning the conduct of this phase of the investigations, hearing procedures, and rules of general application, consult the Commission's Rules of Practice and Procedure, part 201, subparts A and B (19 CFR part 201), and part 207, subparts A and C (19 CFR part 207).

Participation in the investigations and public service list.—Persons, including industrial users of the subject merchandise and, if the merchandise is sold at the retail level, representative consumer organizations, wishing to participate in the final phase of these investigations as parties must file an entry of appearance with the Secretary to the Commission, as provided in § 201.11 of the Commission's rules, no later than 21 days prior to the hearing date specified in this notice. A party that filed a notice of appearance during the preliminary phase of the investigations need not file an additional notice of appearance during this final phase. The Secretary will maintain a public service list containing the names and addresses of all persons, or their representatives, who are parties to the investigations.

Please note the Secretary's Office will accept only electronic filings during this time. Filings must be made through the Commission's Electronic Document Information System (EDIS, *https://edis.usitc.gov*). No in-person paper-based filings or paper copies of any electronic filings will be accepted until further notice.

Limited disclosure of business proprietary information (BPI) under an administrative protective order (APO) and BPI service list.—Pursuant to § 207.7(a) of the Commission's rules, the Secretary will make BPI gathered in the final phase of these investigations available to authorized applicants under the APO issued in the investigations, provided that the application is made no later than 21 days prior to the hearing date specified in this notice. Authorized applicants must represent interested parties, as defined by 19 U.S.C. 1677(9), who are parties to the investigations. A party granted access to BPI in the preliminary phase of the investigations need not reapply for such access. A separate service list will be maintained by the Secretary for those parties authorized to receive BPI under the APO.

Staff report.—The prehearing staff report in the final phase of these investigations will be placed in the nonpublic record on October 1, 2025, and a public version will be issued thereafter, pursuant to § 207.22 of the Commission's rules.

Hearing.—The Commission will hold a hearing in connection with the final phase of these investigations beginning at 9:30 a.m. on Thursday, October 16, 2025. Requests to appear at the hearing should be filed in writing with the Secretary to the Commission on or before Thursday, October 9, 2025. Any requests to appear as a witness via videoconference must be included with your request to appear. Requests to appear via videoconference must include a statement explaining why the witness cannot appear in person; the Chairman, or other person designated to conduct the investigation, may in their discretion for good cause shown, grant such a request. Requests to appear as remote witness due to illness or a positive COVID–19 test result may be submitted by 3pm the business day prior to the hearing. Further information about participation in the hearing will be posted on the Commission's website at *https://www.usitc.gov/calendarpad/calendar.html.*

A nonparty who has testimony that may aid the Commission's deliberations may request permission to present a short statement at the hearing. All parties and nonparties desiring to appear at the hearing and make oral presentations should attend a prehearing conference, if deemed necessary, to be held at 9:30 a.m. on Tuesday, October 14, 2025. Parties shall file and serve written testimony and presentation slides in connection with their presentation at the hearing by no later than noon on October 15, 2025. Oral testimony and written materials to be submitted at the public hearing are governed by sections 201.6(b)(2), 201.13(f), and 207.24 of the Commission's rules. Parties must submit any request to present a portion of their hearing testimony *in camera* no later than 7 business days prior to the date of the hearing.

Written submissions.—Each party who is an interested party shall submit a prehearing brief to the Commission. Prehearing briefs must conform with the provisions of § 207.23 of the Commission's rules; the deadline for filing is October 8, 2025. Parties shall also file written testimony in connection with their presentation at the hearing, and posthearing briefs, which must conform with the provisions of § 207.25 of the Commission's rules. The deadline for filing posthearing briefs is October 23, 2025. In addition, any person who has not entered an appearance as a party to the investigations may submit a written statement of information pertinent to the subject of the investigations, including statements of support or opposition to the petition, on or before October 23, 2025. On November 5, 2025, the Commission will make available to parties all information on which they have not had an opportunity to comment. Parties may submit final comments on this information on or before November 7, 2025, but such final comments must not contain new factual information and must otherwise comply with § 207.30 of the Commission's rules. All written submissions must conform with the provisions of § 201.8 of the Commission's rules; any submissions that contain BPI must also conform with the requirements of §§ 201.6, 207.3, and 207.7 of the Commission's rules. The Commission's *Handbook on Filing Procedures,* available on the Commission's website at *https://www.usitc.gov/documents/handbook_on_filing_procedures.pdf,* elaborates upon the Commission's procedures with respect to filings.

Additional written submissions to the Commission, including requests pursuant to § 201.12 of the Commission's rules, shall not be accepted unless good cause is shown for accepting such submissions, or unless the submission is pursuant to a specific request by a Commissioner or Commission staff.

In accordance with §§ 201.16(c) and 207.3 of the Commission's rules, each document filed by a party to the investigations must be served on all other parties to the investigations (as identified by either the public or BPI service list), and a certificate of service must be timely filed. The Secretary will not accept a document for filing without a certificate of service.

Authority: These investigations are being conducted under authority of title VII of the Tariff Act of 1930; this notice is published pursuant to § 207.21 of the Commission's rules.

By order of the Commission.

Issued: June 23, 2025.

Lisa Barton,

Secretary to the Commission.

[FR Doc. 2025–11708 Filed 6–24–25; 8:45 am]

BILLING CODE 7020–02–P

INTERNATIONAL TRADE COMMISSION

[Investigation No. 337–TA–1382]

Certain Electronic Computing Devices and Components Thereof; Notice of a Final Determination Finding No Violation of Section 337; Termination of Investigation

AGENCY: U.S. International Trade Commission.

ACTION: Notice.

SUMMARY: Notice is hereby given that the U.S. International Trade Commission (''Commission'') has determined that the respondents have not violated section 337 of the Tariff Act of 1930, as amended, by importing into the United States, selling for importation, or selling within the United States after importation certain electronic computing devices and components thereof by reason of infringement of certain claims of U.S. Patent No. 7,792,066 (''the '066 patent''); U.S. Patent No. 8,687,354 (''the '354 patent''); and U.S. Patent No. 10,952,203 (''the '203 patent''). This investigation is terminated.

FOR FURTHER INFORMATION CONTACT: Benjamin S. Richards, Esq., Office of the General Counsel, U.S. International Trade Commission, 500 E Street SW, Washington, DC 20436, telephone (202) 708–5453. Copies of non-confidential documents filed in connection with this investigation may be viewed on the Commission's electronic docket (EDIS) at *https://edis.usitc.gov.* For help accessing EDIS, please email *EDIS3Help@usitc.gov.* General information concerning the Commission may also be obtained by accessing its internet server at *https://www.usitc.gov.* Hearing-impaired persons are advised that information on this matter can be obtained by contacting the Commission's TDD terminal on (202) 205–1810.

SUPPLEMENTARY INFORMATION: The Commission instituted this investigation based on a complaint filed on behalf of Lenovo (United States) Inc. of Morrisville, North Carolina (''Lenovo''). 88 FR 88110 (Dec. 20, 2023). The complaint, as amended and supplemented, alleged violations of section 337 of the Tariff Act of 1930, as amended, 19 U.S.C. 1337, in the importation into the United States, the sale for importation, or the sale within the United States after importation of certain electronic computing devices and components thereof by reason of infringement of claims 1, 3, 5, 7, 9, 11, 13, and 15 of U.S. Patent No. 7,760,189 (''the '189 patent''); claims 1–21 of the '066 patent; claims 1–11 of the '354 patent; and claims 1–18 of the '203 patent. *Id.* The complaint further alleged that a domestic industry exists. *Id.* The Commission's notice of investigation named as respondents ASUSTeK Computer Inc., of Taipei, Taiwan and ASUS Computer International of Fremont, CA (''ASUS''). *Id.* at 88111. The Office of Unfair Import Investigations did not participate in the investigation. *Id.*

The presiding administrative law judge (''ALJ'') held a claim construction hearing on May 16, 2024, and issued a claim construction order on July 15, 2024. Order No. 32 (July 15, 2024).

The following claims were terminated from the investigation at Lenovo's request: all asserted claims of the '189 patent; claims 6, 8–15, and 19–21 of the '066 patent; claims 2, 3, 8 and 10 of the '354 patent; and claims 1–7, 9–16, and 18 of the '203 patent. Order No. 33 (July 16, 2024), *unreviewed,* Comm'n Notice, EDIS Doc. ID 828374 (Aug. 5, 2024); Order No. 38 (Aug. 8, 2024), *unreviewed,* Comm'n Notice, EDIS Doc. ID 831494 (Sept. 5, 2024); Order No. 60 (Sept. 12, 2024), *unreviewed,* Comm'n Notice, EDIS Doc. ID 834090 (Oct. 4, 2024).

The ALJ conducted an evidentiary hearing from September 16, 2024, through September 20, 2024. Lenovo and ASUS filed initial post-hearing briefs on October 4, 2024, and filed post-hearing reply briefs on October 18, 2024.

On February 7, 2025, the ALJ issued the final initial determination (''ID'') on violation of section 337. Lenovo filed a petition for review of that ID, and ASUS filed a contingent petition for review, on February 21, 2025. The parties filed respective replies to each others' petitions on March 3, 2025.

On April 9, 2025, the Commission extended the date by which it must determine whether to review the final ID to May 1, 2025.

On May 1, 2025, the Commission determined to review the ID in its entirety and sought briefing from the parties on certain issues, including remedy, bonding, and the public interest. The parties filed opening and reply submissions in response to that request on May 15, 2025, and May 22, 2025, respectively.

On June 9, 2025, the Commission extended the target date for completion of this investigation to June 20, 2025.

Having considered the record of the investigation, including the final ID, the parties' submissions to the ALJ, the parties' petitions and responses thereto, and the parties' responses to the Commission's notice of review, the Commission has determined to affirm the ID's finding of no violation, make supplemental findings in support of that determination, and take no position on certain subsidiary findings in the ID as detailed in the concurrently issued Commission opinion. Specifically, the Commission has determined that claims 8 and 17 of the '203 patent, claims 1–5, 7, and 16–18 of the '066 patent, and claims 1 and 4–6 of the '354 patent are not infringed and claims 7, 9, and 11 of the '354 patent are invalid. The Commission has determined to take no position on the following issues: whether ASUS demonstrated the knowledge and intent necessary to be liable for inducing infringement of the '203 patent, whether the term ''resource block'' requires both time and frequency components, whether the asserted claims of the '203 patent are invalid, whether claims 1 and 4–6 of the '354 patent are invalid, and whether the domestic industry requirement is satisfied for the '354 patent. This investigation is terminated.

The Commission vote for this determination took place on June 20, 2025.

The authority for the Commission's determination is contained in section 337 of the Tariff Act of 1930, as amended (19 U.S.C. 1337), and in Part 210 of the Commission's Rules of Practice and Procedure (19 CFR part 210).

By order of the Commission.

Issued: June 20, 2025.

Lisa Barton,

Secretary to the Commission.

[FR Doc. 2025–11661 Filed 6–24–25; 8:45 am]

BILLING CODE 7020–02–P

INTERNATIONAL TRADE COMMISSION

[Investigation No. 337–TA–1398]

Certain Smart Wearable Devices, Systems, and Components Thereof; Notice of a Commission Determination To Review in Part a Final Initial Determination; Request for Written Submissions on Remedy, the Public Interest, and Bonding

AGENCY: U.S. International Trade Commission.

ACTION: Notice.

SUMMARY: Notice is hereby given that the U.S. International Trade Commission (''Commission'') has determined to review in part a final initial determination (''FID'') of the presiding administrative law judge (''ALJ''). The Commission requests written submissions from the parties, interested government agencies, and other interested persons on the issues of remedy, the public interest, and bonding, under the schedule set forth below.

FOR FURTHER INFORMATION CONTACT: Paul Lall, Office of the General Counsel, U.S. International Trade Commission, 500 E Street SW, Washington, DC 20436,

telephone (202) 205–2043. Copies of non-confidential documents filed in connection with this investigation may be viewed on the Commission's electronic docket (EDIS) at *https://edis.usitc.gov.* For help accessing EDIS, please email *EDIS3Help@usitc.gov.* General information concerning the Commission may also be obtained by accessing its internet server at *https://www.usitc.gov.* Hearing-impaired persons are advised that information on this matter can be obtained by contacting the Commission's TDD terminal, telephone (202) 205–1810.

SUPPLEMENTARY INFORMATION: The Commission instituted this investigation on April 17, 2024, based on a complaint filed on behalf of Ouraring, Inc. of San Francisco, California, and Ōura Health Oy of Finland (collectively, ''Oura,'' or ''Complainants''). 89 FR 27452–53 (Apr. 17, 2024). The complaint, as amended, alleged violations of section 337, based upon the importation into the United States, the sale for importation, and the sale within the United States after importation of certain smart wearable devices, systems, and components thereof by reason of the infringement of certain claims of U.S. Patent Nos. 11,868,178 (''the '178 patent''); 10,842,429 (''the '429 patent''); and 11,868,179 (''the '179 patent''). The Commission's notice of investigation named as respondents Ultrahuman Healthcare Pvt. Ltd. of Karnataka, India; Ultrahuman Healthcare SP LLC of Abu Dhabi, UAE; Ultrahuman Healthcare Ltd. of London, United Kingdom (collectively ''Ultrahuman''); Guangdong Jiu Zhi Technology Co. Ltd. of Guangdong, China; RingConn LLC of Wilmington, Delaware; and Circular SAS of Paris, France. The Office of Unfair Import Investigations (''OUII'') is also a party in this investigation.

Subsequently, the ALJ issued an ID granting Oura's motion to amend its first amended complaint and the notice of investigation to change the name of respondent Guangdong Jiu Zhi Technology Co. Ltd. to Shenzhen Ninenovo Technology Limited because of a corporate name change, and to amend the address for RingConn LLC (collectively, ''RingConn''). Order No. 8 (May 3, 2024), *unreviewed by* Comm'n Notice, 89 FR 48686–87 (June 7, 2024).

The ALJ also issued an ID granting a joint motion for partial termination of the investigation as to respondent Circular SAS based on settlement. Order No. 12 (July 9, 2024), *unreviewed by* Comm'n Notice (Aug. 6, 2024).

Moreover, the ALJ issued three IDs granting the complainants' unopposed motions for partial termination as to certain claims, including all claims of the '429 and '179 patents. Order No. 13 (July 30, 2024), *unreviewed by* Comm'n Notice (Aug. 22, 2024); Order No. 15 (Sept. 16, 2024), *unreviewed by* Comm'n Notice (Oct. 7, 2024); Order No. 21 (Dec. 9, 2024), *unreviewed by* Comm'n Notice (Dec. 23, 2024).

On August 15, 2024, the ALJ held a hearing on claim construction, and on October 13, 2024, the ALJ issued a claim construction order. Order No.17 (Oct. 23, 2024).

The ALJ held an evidentiary hearing on December 11–13 and 16–17, 2024. As of the hearing, Oura only asserted claims 1, 2, and 12–14 of the '178 patent (the ''Asserted Claims'') against the RingConn's accused Smart Ring and associated applications and the Ultrahuman Ring AIR and its associated application. FID at 7–8. Oura also asserted that its domestic industry products practice claims 1, 2, and 12–14 of the '178 patent for purposes of the domestic industry requirement. *Id.*

On April 18, 2025, the presiding ALJ issued the FID, finding that there has been a violation of section 337 in the importation into the United States, the sale for importation, and/or the sale in the United States after importation of certain smart ring wearable devices, systems, and components thereof with respect to certain claims of the '178 patent. Specifically, the FID found that: (1) The importation requirement was satisfied for the accused products; (2) claims 1, 2, and 12–14 of the '178 patent were shown to be infringed; (3) the technical prong of the domestic industry requirement was satisfied with respect to the '178 patent; (4) claims 1, 2, and 12–14 of the '178 patent were not shown to be invalid; and (5) the economic prong of the domestic industry requirement was satisfied with respect to the '178 patent. *Id.* at 130.

The FID included a Recommended Determination on Remedy and Bonding (''RD''). *Id.* at 136–41. It recommended that the Commission issue a limited exclusion order and cease and desist orders in the event the Commission finds a violation of section 337 and impose a bond of zero percent (0%) during the period of Presidential Review. *Id.* The ALJ also issued a Recommended Determination on the Public Interest pursuant to the Commission's delegation of public interest to the ALJ in the notice of investigation.

On May 2, 2025, RingConn and Ultrahuman (collectively, ''Respondents'') filed a joint petition for review of several of the FID's findings. On May 12, 2025, Oura and OUII filed separate responses to Respondents' petition.

Having reviewed the record of the investigation, including the parties' petitions for review and related submissions, the Commission has determined to review the final initial determination in part. Specifically, the Commission has determined to review the economic prong of the domestic industry requirement for the '178 patent.

In connection with the final disposition of this investigation, the statute authorizes issuance of, *inter alia,* (1) an exclusion order that could result in the exclusion of the subject articles from entry into the United States; and/or (2) cease and desist orders that could result in the respondents being required to cease and desist from engaging in unfair acts in the importation and sale of such articles. Accordingly, the Commission is interested in receiving written submissions that address the form of remedy, if any, that should be ordered. If a party seeks exclusion of an article from entry into the United States for purposes other than entry for consumption, the party should so indicate and provide information establishing that activities involving other types of entry either are adversely affecting it or likely to do so. For background, see *Certain Devices for Connecting Computers via Telephone Lines,* Inv. No. 337–TA–360, USITC Pub. No. 2843, Comm'n Op. at 7–10 (Dec. 1994). In connection with these findings, the Commission requests responses from the parties to the following questions:

(1) To the extent that any party seeks an exemption from any proposed remedy for customer service and warranty obligations, please explain:

a. What is the rationale for providing an exemption, including under the public interest factors (in particular, U.S. consumers)? Please identify and describe specific evidence supporting this rationale and where in the record such evidence was first submitted to the ALJ. If such evidence was not submitted to the ALJ, please explain why the Commission should give such evidence any weight at this stage in the investigation.

b. What are the warranty terms, if any, for the merchandise in question? Should the exemption apply only to merchandise under warranty, or to all needed service and repair?

c. Should the exemption cover only parts for service/repair, or should it also allow complete replacement of merchandise?

d. What should the temporal cutoff be for the exemption, *e.g.,* (1) should the

operative date be the issuance of the Commission's final determination or the end of the Presidential review period, and (2) should it apply to merchandise sold prior to such date or to merchandise imported prior to such date?

The parties are invited to brief only the discrete issues requested above. The parties are not to brief other issues on review, which are adequately presented in the parties' existing filings.

The statute requires the Commission to consider the effects of that remedy upon the public interest. The public interest factors the Commission will consider include the effect that an exclusion order and cease and desist orders would have on: (1) the public health and welfare, (2) competitive conditions in the U.S. economy, (3) U.S. production of articles that are like or directly competitive with those that are subject to investigation, and (4) U.S. consumers. To the extent that any party in this investigation asserts that the proposed remedy would adversely impact the public interest, please identify and describe specific evidence supporting this assertion and where in the record such evidence was first submitted to the ALJ. If such evidence was not submitted to the ALJ, please explain what weight, if any, the Commission should give such evidence at this stage in the investigation.

In connection with the consideration of the public interest, the Commission requests responses from the parties to the following questions:

(1) Please identify whether any reasonable substitutes for the infringing devices are available to consumers, researchers, or other professionals, for example those participating in the uses described in the third-party public interest submissions, and whether they are capable of meeting any public health and welfare concerns raised by any remedial relief in this investigation. Is or would there be sufficient supply of any such reasonable substitutes for the infringing devices?

(2) With respect to the medical, health, and wellness studies using the accused products referenced during the hearing, please provide documents sufficient to show:

a. What is the goal of the study?

b. When did the study start?

c. How long is the study planned for?

d. How many devices are being used?

e. How many participants are involved in the study?

f. Are there reasonable substitutes for the accused product currently used in the study? Are Complainants' domestic industry products reasonable substitutes?

(3) Please explain why the parties failed to develop the evidentiary record in the hearing before the ALJ to include specific documents and statements from third party researchers that use the accused products.

If the Commission orders some form of remedy, the U.S. Trade Representative, as delegated by the President, has 60 days to approve, disapprove, or take no action on the Commission's determination. *See* Presidential Memorandum of July 21, 2005, 70 FR 43251 (July 26, 2005). During this period, the subject articles would be entitled to enter the United States under bond, in an amount determined by the Commission and prescribed by the Secretary of the Treasury. The Commission is therefore interested in receiving submissions concerning the amount of the bond that should be imposed if a remedy is ordered.

Written Submissions: The parties to the investigation are requested to file written submissions on the issues identified in this notice. Parties to the investigation, interested government agencies, and any other interested parties are encouraged to file written submissions on the issues of remedy, the public interest, and bonding. Such submissions should address the RD by the ALJ on remedy and bonding.

In their initial submission, Complainants are also requested to identify the remedy sought, and Complainants and OUII are requested to submit proposed drafts of remedial orders for the Commission's consideration. Complainants are further requested to provide the HTSUS subheadings under which the accused products are imported and to supply the identification information for all known importers of the products at issue in this investigation. All initial written submissions, from the parties and/or third parties/interested government agencies, and proposed remedial orders from the parties must be filed no later than close of business on July 7, 2025. All reply submissions must be filed no later than the close of business on July 14, 2025. Opening submissions from the parties are limited to 50 pages. Reply submissions from the parties are limited to 25 pages. All submission from third parties and/or interested government agencies are limited to 10 pages. No further submissions on any of these issues will be permitted unless otherwise ordered by the Commission.

Persons filing written submissions must file the original document electronically on or before the deadlines stated above. The Commission's paper filing requirements in 19 CFR 210.4(f) are currently waived. 85 FR 15798 (Mar. 19, 2020). Submissions should refer to the investigation number (''Inv. No. 337–TA–1398'') in a prominent place on the cover page and/or the first page. (*See* Handbook for Electronic Filing Procedures, *https://www.usitc.gov/documents/handbook_on_filing_procedures.pdf*). Persons with questions regarding filing should contact the Secretary, (202) 205–2000.

Any person desiring to submit a document to the Commission in confidence must request confidential treatment by marking each document with a header indicating that the document contains confidential information. This marking will be deemed to satisfy the request procedure set forth in Rules 201.6(b) and 210.5(e)(2) (19 CFR 201.6(b) & 210.5(e)(2)). Documents for which confidential treatment by the Commission is properly sought will be treated accordingly. Any non-party wishing to submit comments containing confidential information must serve those comments on the parties to the investigation pursuant to the applicable Administrative Protective Order. A redacted non-confidential version of the document must also be filed with the Commission and served on any parties to the investigation within two business days of any confidential filing. All information, including confidential business information and documents for which confidential treatment is properly sought, submitted to the Commission for purposes of this investigation may be disclosed to and used: (i) by the Commission, its employees and Offices, and contract personnel (a) for developing or maintaining the records of this or a related proceeding, or (b) in internal investigations, audits, reviews, and evaluations relating to the programs, personnel, and operations of the Commission including under 5 U.S.C. Appendix 3; or (ii) by U.S. government employees and contract personnel, solely for cybersecurity purposes. All contract personnel will sign appropriate nondisclosure agreements. All nonconfidential written submissions will be available for public inspection on EDIS.

The Commission's vote on this determination took place on June 20, 2025.

The authority for the Commission's determination is contained in section 337 of the Tariff Act of 1930, as amended (19 U.S.C. 1337), and in part 210 of the Commission's Rules of Practice and Procedure (19 CFR part 210).

By order of the Commission.

Issued: June 20, 2025.

Lisa Barton,

Secretary to the Commission.

[FR Doc. 2025–11659 Filed 6–24–25; 8:45 am]

BILLING CODE 7020–02–P

DEPARTMENT OF LABOR

Guidance on Referrals for Potential Criminal Enforcement

ACTION: Notice.

SUMMARY: This notice describes the Department of Labor's plans to address criminally liable regulatory offenses under the recent executive order on Fighting Overcriminalization in Federal Regulations.

FOR FURTHER INFORMATION CONTACT: Edmund C. Baird, Acting Deputy Solicitor for Regional Enforcement, Office of the Solicitor; telephone (202) 693–5460; email: *contact-sol@dol.gov*

SUPPLEMENTARY INFORMATION: On May 9, 2025, the President issued Executive Order (''E.O.'') 14294, Fighting Overcriminalization in Federal Regulations. 90 FR 20363 (published May 14, 2025). Section 7 of E.O. 14294 provides that within 45 days of the order, and in consultation with the Attorney General, each agency should publish guidance in the **Federal Register** describing its plan to address criminally liable regulatory offenses.

Consistent with that requirement, the Department of Labor (''DOL'') advises the public that by May 9, 2026, the Department, in consultation with the Attorney General, will provide to the Director of the Office of Management and Budget (''OMB'') a report containing: (1) a list of all criminal regulatory offenses [1] enforceable by DOL or the Department of Justice (''DOJ''); and (2) for each such criminal regulatory offense, the range of potential criminal penalties for a violation and the applicable mens rea standard [2] for the criminal regulatory offense.

This notice also announces a general policy, subject to appropriate exceptions and to the extent consistent with law, that when DOL is deciding whether to refer alleged violations of criminal regulatory offenses to DOJ, officers and employees of DOL should consider, among other factors:

- whether an employee has died or was seriously injured as a result of a violation of one of the laws that DOL enforces;
- whether the putative defendant's conduct is particularly egregious, such as where the employer has a history of similar violations;
- whether the putative defendant has deliberately impeded Department of Labor investigative efforts;
- whether workers were physically or mentally coerced, such as in cases involving trafficking or extortion;
- the harm or risk of harm, pecuniary or otherwise, caused by the alleged offense;
- the potential gain to the putative defendant that could result from the offense;
- whether the putative defendant held specialized knowledge, expertise, or was licensed in an industry related to the rule or regulation at issue; and
- evidence, if any is available, of the putative defendant's general awareness of the unlawfulness of his conduct as well as his knowledge or lack thereof of the regulation at issue.

This general policy is not intended to, and does not, create any right or benefit, substantive or procedural, enforceable at law or in equity by any party against the United States, its departments, agencies, or entities, its officers, employees, or agents, or any other person.

Jonathan Snare,

Acting Solicitor of Labor.

[FR Doc. 2025–11679 Filed 6–24–25; 8:45 am]

BILLING CODE 4510–HX–P

[1] ''Criminal regulatory offense'' means a Federal regulation that is enforceable with a criminal penalty. E.O. 14294, sec. 3(b).

[2] ''Mens rea'' means the state of mind that by law must be proven to convict a particular defendant of a particular crime. E.O. 14294, sec. 3(c).

OFFICE OF SPECIAL COUNSEL

Information Collection Request; Request for Comment

AGENCY: U.S. Office of Special Counsel (OSC).

ACTION: Notice of request for comments.

SUMMARY: In accordance with the Paperwork Reduction Act of 1995 (44 U.S.C. chapter 35), the U.S. Office of Special Counsel (OSC) is seeking public comment on an extension of a currently approved information collection activity for its Alternative Dispute Resolution (ADR) Program, approved under OMB Control Number 3255–0008. OSC has revised its survey approach and now administers a single survey to mediation participants immediately following the conclusion of their ADR session. This updated format replaces the prior two-part survey process (initial and follow-up). The survey is used to assess program effectiveness, gather participant feedback, and identify areas for improvement. Participation is voluntary and responses are submitted anonymously.

DATES: Written comments must be received on or before August 25, 2025.

ADDRESSES: You may submit comments by any of the following methods:

- *Mail:* Barbara Wheeler Jones, U.S. Office of Special Counsel, 1730 M Street NW, Suite 218, Washington, DC 20036.
- *Email: frliaison@osc.gov.*

FOR FURTHER INFORMATION CONTACT: Nicole Courtney, Records and Information Manager, at (202) 804–7000 or via email at *frliaison@osc.gov.*

SUPPLEMENTARY INFORMATION: OSC's ADR Survey is administered electronically to individuals who participate in the agency's voluntary mediation program for prohibited personnel practice complaints. To improve efficiency and enhance response quality, OSC now issues a single consolidated survey immediately after the mediation concludes. The information collected will help OSC evaluate the overall success of its ADR process and improve service delivery. Participation remains voluntary and anonymous.

- *Title of Collection:* OSC Alternative Dispute Resolution (ADR) Program Survey.
- *OMB Control Number:* 3255–0008.
- *Type of Review:* An amendment of a currently approved information collection. OSC has submitted an extension request to OMB for this collection (Control No. 3255–0008), which is currently under review. This notice initiates a separate review process for a proposed revision to that collection, which will be submitted to OMB following the conclusion of the public comment period.
- *Affected Public:* Individuals who participate in OSC's ADR process (*e.g.,* federal employees, agency representatives, legal counsel).
- *Estimated Number of Respondents:* 80 annually.
- *Estimated Time per Response:* 35 minutes.
- *Total Estimated Annual Burden:* Approximately 46.64.

Abstract: The ADR Program at OSC provides a confidential and informal process to resolve prohibited personnel practice complaints through mediation and facilitated discussions. To assess participant satisfaction, OSC administers a short, singular survey following each mediation session. This revised format replaces the former two-survey model. Responses are used to evaluate the effectiveness of the ADR process, identify trends, and inform program enhancements. The survey is

voluntary and responses are kept anonymous.

Request for Comments: OSC invites written comments on:

1. Whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;

2. The accuracy of OSC's estimate of the burden of the proposed collection of information;

3. Ways to enhance the quality, utility, and clarity of the information to be collected; and

4. Ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology.

All comments received will be included in the public record. Comments will be summarized and/or included in the request for Office of Management and Budget (OMB) approval.

Dated: April 4, 2025.

Barbara Wheeler Jones,

Chief, Case Review Division, U.S. Office of Special Counsel.

[FR Doc. 2025–11663 Filed 6–24–25; 8:45 am]

BILLING CODE 7405–01–P

OFFICE OF PERSONNEL MANAGEMENT

Submission for Review: Renewal of an Existing Information Collection, CAHPS Enrollee Survey; OMB Control No. 3206–0274

AGENCY: Office of Personnel Management.

ACTION: 60-Day Notice and request for comments.

SUMMARY: Healthcare and Insurance, Office of Personnel Management (OPM) offers the general public and other federal agencies the opportunity to comment on the administration of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey for the Federal Employees Health Benefits (FEHB) and the Postal Service Health Benefits (PSHB) Programs. CAHPS® surveys ask consumers and patients to report on and evaluate their experiences with health care. These surveys cover topics that are important to consumers and focus on aspects of quality that consumers are best qualified to assess, such as the communication skills of providers and ease of access to health care services.

DATES: Comments are encouraged and will be accepted until August 25, 2025. This process is conducted in accordance with 5 CFR 1320.1.

ADDRESSES: Interested persons are invited to submit written comments on the proposed information collection by the following means:

Federal Rulemaking Portal: http://www.regulations.gov All submissions received must include the agency name and OMB Control Number for this collection. The general policy for comments and other submissions from members of the public is to make these submissions available for public viewing on the internet at *http://www.regulations.gov* as they are received without change, including any personal identifiers or contact information.

FOR FURTHER INFORMATION CONTACT: A copy of this information collection request, with applicable supporting documentation, may be obtained by contacting Meredith Gitangu, Office of Personnel Management, (202) 606–2678 or via electronic mail to *FEHBPerformance@OPM.gov.*

SUPPLEMENTARY INFORMATION: As required by the Paperwork Reduction Act (44 U.S.C. chapter 35) as amended, OPM is soliciting comments for this collection that:

1. Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;

2. Evaluate the accuracy of the agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used;

3. Enhance the quality, utility, and clarity of the information to be collected; and

4. Minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, *e.g.,* permitting electronic submissions of responses.

Program Description

OPM uses the CAHPS results as part of the FEHB and PSHB Plan Performance Assessment (PPA). The PPA enables a consistent, objective evaluation of carrier performance and also provides more transparency for enrollees. This assessment uses a discrete set of quantifiable measures to examine key aspects of performance in the areas of clinical quality, customer service, and resource use. Six CAHPS measures are part of this discrete set of quantifiable measures.

Taken together with more traditional assessments of contract administration, these measures help ensure that enrollees receive high quality, affordable healthcare and a positive customer experience. The PPA is linked to carrier profit and adjustment factors. FEHB and PSHB contracts include language to incorporate the PPA as a determinant of the Service Charge or Performance Adjustment.

Analysis

Agency: Office of Personnel Management.

Title: CAHPS Survey.

OMB Number: 3206–0274.

Frequency: Annually

Affected Public: Federal Employees and Retirees (Including Postal employees and Retirees).

Number of Respondents: 48,829.

Estimated Time per Respondent: 15 Minutes.

Total Burden Hours: 12,207.

Office of Personnel Management.

Alexys Stanley,

Federal Register Liaison.

[FR Doc. 2025–11696 Filed 6–24–25; 8:45 am]

BILLING CODE 6325–63–P

POSTAL REGULATORY COMMISSION

[Docket Nos. CP2024–638; K2024–1; K2025–224; K2025–225; K2025–436; MC2025–1531 and K2025–1526; MC2025–1532 and K2025–1527; MC2025–1534 and K2025–1528]

New Postal Products

AGENCY: Postal Regulatory Commission.

ACTION: Notice.

SUMMARY: The Commission is noticing a recent Postal Service filing for the Commission's consideration concerning a negotiated service agreement. This notice informs the public of the filing, invites public comment, and takes other administrative steps.

DATES: *Comments are due:* June 30, 2025.

ADDRESSES: Submit comments electronically via the Commission's Filing Online system at *https://www.prc.gov.* Those who cannot submit comments electronically should contact the person identified in the **FOR FURTHER INFORMATION CONTACT** section by telephone for advice on filing alternatives.

FOR FURTHER INFORMATION CONTACT: David A. Trissell, General Counsel, at 202–789–6820.

SUPPLEMENTARY INFORMATION:

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I. Introduction
II. Public Proceeding(s)
III. Summary Proceeding(s)

I. Introduction

Pursuant to 39 CFR 3041.405, the Commission gives notice that the Postal Service filed request(s) for the Commission to consider matters related to Competitive negotiated service agreement(s). The request(s) may propose the addition of a negotiated service agreement from the Competitive product list or the modification of an existing product currently appearing on the Competitive product list.

The public portions of the Postal Service's request(s) can be accessed via the Commission's website (*http://www.prc.gov*). Non-public portions of the Postal Service's request(s), if any, can be accessed through compliance with the requirements of 39 CFR 3011.301.[1]

Section II identifies the docket number(s) associated with each Postal Service request, if any, that will be reviewed in a public proceeding as defined by 39 CFR 3010.101(p), the title of each such request, the request's acceptance date, and the authority cited by the Postal Service for each request. For each such request, the Commission appoints an officer of the Commission to represent the interests of the general public in the proceeding, pursuant to 39 U.S.C. 505 and 39 CFR 3000.114 (Public Representative). The Public Representative does not represent any individual person, entity or particular point of view, and, when Commission attorneys are appointed, no attorney-client relationship is established. Section II also establishes comment deadline(s) pertaining to each such request.

The Commission invites comments on whether the Postal Service's request(s) identified in Section II, if any, are consistent with the policies of title 39. Applicable statutory and regulatory requirements include 39 U.S.C. 3632, 39 U.S.C. 3633, 39 U.S.C. 3642, 39 CFR part 3035, and 39 CFR part 3041. Comment deadline(s) for each such request, if any, appear in Section II.

Section III identifies the docket number(s) associated with each Postal Service request, if any, to add a standardized distinct product to the Competitive product list or to amend a standardized distinct product, the title of each such request, the request's acceptance date, and the authority cited by the Postal Service for each request. Standardized distinct products are negotiated service agreements that are variations of one or more Competitive products, and for which financial models, minimum rates, and classification criteria have undergone advance Commission review. *See* 39 CFR 3041.110(n); 39 CFR 3041.205(a). Such requests are reviewed in summary proceedings pursuant to 39 CFR 3041.325(c)(2) and 39 CFR 3041.505(f)(1). Pursuant to 39 CFR 3041.405(c)–(d), the Commission does not appoint a Public Representative or request public comment in proceedings to review such requests.

II. Public Proceeding(s)

1. *Docket No(s).:* CP2024–638; *Filing Title:* USPS Request Concerning Amendment One to Priority Mail Express, Priority Mail & USPS Ground Advantage Contract 305, with Materials Filed Under Seal; *Filing Acceptance Date:* June 20, 2025; *Filing Authority:* 39 CFR 3035.105 and 39 CFR 3041.505; *Public Representative:* Arif Hafiz; *Comments Due:* June 30, 2025.

2. *Docket No(s).:* K2024–1; *Filing Title:* USPS Request Concerning Amendment One to Priority Mail Express, Priority Mail & USPS Ground Advantage Contract 359, with Materials Filed Under Seal; *Filing Acceptance Date:* June 20, 2025; *Filing Authority:* 39 CFR 3035.105 and 39 CFR 3041.505; *Public Representative:* Almaroof Agoro; *Comments Due:* June 30, 2025.

3. *Docket No(s).:* K2025–224; *Filing Title:* USPS Request Concerning Amendment One to Priority Mail Express, Priority Mail & USPS Ground Advantage Contract 587, with Materials Filed Under Seal; *Filing Acceptance Date:* June 20, 2025; *Filing Authority:* 39 CFR 3035.105 and 39 CFR 3041.505; *Public Representative:* Almaroof Agoro; *Comments Due:* June 30, 2025.

4. *Docket No(s).:* K2025–225; *Filing Title:* USPS Request Concerning Amendment One to Priority Mail Express, Priority Mail & USPS Ground Advantage Contract 589, with Materials Filed Under Seal; *Filing Acceptance Date:* June 20, 2025; *Filing Authority:* 39 CFR 3035.105 and 39 CFR 3041.505; *Public Representative:* Samuel Robinson; *Comments Due:* June 30, 2025.

5. *Docket No(s).:* K2025–436; *Filing Title:* USPS Request Concerning Amendment One to Priority Mail Express, Priority Mail & USPS Ground Advantage Contract 750, with Materials Filed Under Seal; *Filing Acceptance Date:* June 20, 2025; *Filing Authority:* 39 CFR 3035.105 and 39 CFR 3041.505; *Public Representative:* Samuel Robinson; *Comments Due:* June 30, 2025.

6. *Docket No(s).:* MC2025–1531 and K2025–1526; *Filing Title:* USPS Request to Add Priority Mail & USPS Ground Advantage Contract 785 to the Competitive Product List and Notice of Filing Materials Under Seal; *Filing Acceptance Date:* June 20, 2025; *Filing Authority:* 39 U.S.C. 3642, 39 CFR 3035.105, and 39 CFR 3041.310; *Public Representative:* Alain Brou; *Comments Due:* June 30, 2025.

7. *Docket No(s).:* MC2025–1532 and K2025–1527; *Filing Title:* USPS Request to Add Priority Mail & USPS Ground Advantage Contract 786 to the Competitive Product List and Notice of Filing Materials Under Seal; *Filing Acceptance Date:* June 20, 2025; *Filing Authority:* 39 U.S.C. 3642, 39 CFR 3035.105, and 39 CFR 3041.310; *Public Representative:* Alain Brou; *Comments Due:* June 30, 2025.

8. *Docket No(s).:* MC2025–1534 and K2025–1528; *Filing Title:* USPS Request to Add Priority Mail & USPS Ground Advantage Contract 787 to the Competitive Product List and Notice of Filing Materials Under Seal; *Filing Acceptance Date:* June 20, 2025; *Filing Authority:* 39 U.S.C. 3642, 39 CFR 3035.105, and 39 CFR 3041.310; *Public Representative:* Arif Hafiz; *Comments Due:* June 30, 2025.

III. Summary Proceeding(s)

None. See Section II for public proceedings.

This Notice will be published in the **Federal Register**.

Erica A. Barker,

Secretary.

[FR Doc. 2025–11717 Filed 6–24–25; 8:45 am]

BILLING CODE 7710–FW–P

[1] *See* Docket No. RM2018–3, Order Adopting Final Rules Relating to Non-Public Information, June 27, 2018, Attachment A at 19–22 (Order No. 4679).

POSTAL REGULATORY COMMISSION

[Docket Nos. CP2024–572; CP2024–632; MC2025–1528 and K2025–1523; MC2025–1529 and K2025–1524; MC2025–1530 and K2025–1525]

New Postal Products

AGENCY: Postal Regulatory Commission.

ACTION: Notice.

SUMMARY: The Commission is noticing a recent Postal Service filing for the Commission's consideration concerning a negotiated service agreement. This notice informs the public of the filing, invites public comment, and takes other administrative steps.

DATES: *Comments are due:* June 27, 2025.

ADDRESSES: Submit comments electronically via the Commission's Filing Online system at *https://www.prc.gov*. Those who cannot submit comments electronically should contact the person identified in the **FOR FURTHER INFORMATION CONTACT** section by telephone for advice on filing alternatives.

FOR FURTHER INFORMATION CONTACT: David A. Trissell, General Counsel, at 202–789–6820.

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Pursuant to 39 CFR 3041.405, the Commission gives notice that the Postal Service filed request(s) for the Commission to consider matters related to Competitive negotiated service agreement(s). The request(s) may propose the addition of a negotiated service agreement from the Competitive product list or the modification of an existing product currently appearing on the Competitive product list.

The public portions of the Postal Service's request(s) can be accessed via the Commission's website (*http://www.prc.gov*). Non-public portions of the Postal Service's request(s), if any, can be accessed through compliance with the requirements of 39 CFR 3011.301.[1]

Section II identifies the docket number(s) associated with each Postal Service request, if any, that will be reviewed in a public proceeding as defined by 39 CFR 3010.101(p), the title of each such request, the request's acceptance date, and the authority cited by the Postal Service for each request. For each such request, the Commission appoints an officer of the Commission to represent the interests of the general public in the proceeding, pursuant to 39 U.S.C. 505 and 39 CFR 3000.114 (Public Representative). The Public Representative does not represent any individual person, entity or particular point of view, and, when Commission attorneys are appointed, no attorney-client relationship is established. Section II also establishes comment deadline(s) pertaining to each such request.

The Commission invites comments on whether the Postal Service's request(s) identified in Section II, if any, are consistent with the policies of title 39. Applicable statutory and regulatory requirements include 39 U.S.C. 3632, 39 U.S.C. 3633, 39 U.S.C. 3642, 39 CFR part 3035, and 39 CFR part 3041. Comment deadline(s) for each such request, if any, appear in Section II.

Section III identifies the docket number(s) associated with each Postal Service request, if any, to add a standardized distinct product to the Competitive product list or to amend a standardized distinct product, the title of each such request, the request's acceptance date, and the authority cited by the Postal Service for each request. Standardized distinct products are negotiated service agreements that are variations of one or more Competitive products, and for which financial models, minimum rates, and classification criteria have undergone advance Commission review. *See* 39 CFR 3041.110(n); 39 CFR 3041.205(a). Such requests are reviewed in summary proceedings pursuant to 39 CFR 3041.325(c)(2) and 39 CFR 3041.505(f)(1). Pursuant to 39 CFR 3041.405(c)–(d), the Commission does not appoint a Public Representative or request public comment in proceedings to review such requests.

II. Public Proceeding(s)

1. *Docket No(s).:* CP2024–572; *Filing Title:* USPS Request Concerning Amendment One to Priority Mail Express, Priority Mail & USPS Ground Advantage Contract 256, with Materials Filed Under Seal; *Filing Acceptance Date:* June 18, 2025; *Filing Authority:* 39 CFR 3035.105 and 39 CFR 3041.505; *Public Representative:* Arif Hafiz; *Comments Due:* June 27, 2025.

2. *Docket No(s).:* CP2024–632; *Filing Title:* USPS Request Concerning Amendment One to Priority Mail Express, Priority Mail & USPS Ground Advantage Contract 302, with Materials Filed Under Seal; *Filing Acceptance Date:* June 18, 2025; *Filing Authority:* 39 CFR 3035.105 and 39 CFR 3041.505; *Public Representative:* Arif Hafiz; *Comments Due:* June 27, 2025.

3. *Docket No(s).:* MC2025–1528 and K2025–1523; *Filing Title:* USPS Request to Add Priority Mail Contract 892 to the Competitive Product List and Notice of Filing Materials Under Seal; *Filing Acceptance Date:* June 18, 2025; *Filing Authority:* 39 U.S.C. 3642, 39 CFR 3035.105, and 39 CFR 3041.310; *Public Representative:* Jennaca Upperman; *Comments Due:* June 27, 2025.

4. *Docket No(s).:* MC2025–1529 and K2025–1524; *Filing Title:* USPS Request to Add Priority Mail Contract 893 to the Competitive Product List and Notice of Filing Materials Under Seal; *Filing Acceptance Date:* June 18, 2025; *Filing Authority:* 39 U.S.C. 3642, 39 CFR 3035.105, and 39 CFR 3041.310; *Public Representative:* Samuel Robinson; *Comments Due:* June 27, 2025.

5. *Docket No(s).:* MC2025–1530 and K2025–1525; *Filing Title:* USPS Request to Add Priority Mail & USPS Ground Advantage Contract 784 to the Competitive Product List and Notice of Filing Materials Under Seal; *Filing Acceptance Date:* June 18, 2025; *Filing Authority:* 39 U.S.C. 3642, 39 CFR 3035.105, and 39 CFR 3041.310; *Public Representative:* Samuel Robinson; *Comments Due:* June 27, 2025.

III. Summary Proceeding(s)

None. See Section II for public proceedings.

This Notice will be published in the **Federal Register**.

Erica A. Barker,

Secretary.

[FR Doc. 2025–11660 Filed 6–24–25; 8:45 am]

BILLING CODE 7710–FW–P

[1] *See* Docket No. RM2018–3, Order Adopting Final Rules Relating to Non-Public Information, June 27, 2018, Attachment A at 19–22 (Order No. 4679).

POSTAL SERVICE

Product Change—Priority Mail Express, Priority Mail, and USPS Ground Advantage Negotiated Service Agreements; Priority Mail, and USPS Ground Advantage Negotiated Service Agreements; Priority Mail Negotiated Service Agreements

AGENCY: Postal Service.

ACTION: Notice.

SUMMARY: The Postal Service gives notice of filing a request with the Postal Regulatory Commission to add a domestic shipping services contract to the list of Negotiated Service Agreements in the Mail Classification Schedule's Competitive Products List.

DATES: *Date of required notice:* June 25, 2025.

FOR FURTHER INFORMATION CONTACT: Sean C. Robinson, 202–268–8405.

SUPPLEMENTARY INFORMATION: The United States Postal Service hereby gives notice that, pursuant to 39 U.S.C. 3642 and 3632(b)(3), it filed with the Postal Regulatory Commission the following requests:

Date filed with Postal Regulatory Commission	Negotiated service agreement product category and No.	MC docket No.	K docket No.
6/9/2025	PM 875	MC2025–1500	K2025–1495
6/9/2025	PM 876	MC2025–1501	K2025–1496
6/10/2025	PM 877	MC2025–1502	K2025–1497
6/10/2025	PM 878	MC2025–1503	K2025–1498
6/10/2025	PME–PM–GA 1379	MC2025–1504	K2025–1499
6/11/2025	PM 879	MC2025–1505	K2025–1500
6/11/2025	PM 880	MC2025–1506	K2025–1501
6/11/2025	PM 881	MC2025–1507	K2025–1502
6/11/2025	PM 882	MC2025–1508	K2025–1503
6/11/2025	PME–PM–GA 1380	MC2025–1509	K2025–1504
6/12/2025	PM–GA 778	MC2025–1510	K2025–1505
6/12/2025	PM–GA 779	MC2025–1511	K2025–1506
6/12/2025	PM–GA 780	MC2025–1512	K2025–1507
6/12/2025	PM–GA 781	MC2025–1513	K2025–1508
6/12/2025	PME–PM–GA 1381	MC2025–1514	K2025–1509
6/12/2025	PM 883	MC2025–1515	K2025–1510
6/12/2025	PM–GA 782	MC2025–1516	K2025–1511
6/12/2025	PM 884	MC2025–1517	K2025–1512
6/13/2025	PM 885	MC2025–1519	K2025–1514
6/13/2025	PM 886	MC2025–1520	K2025–1515
6/13/2025	PM 887	MC2025–1521	K2025–1516
6/13/2025	PM–GA 783	MC2025–1522	K2025–1517
6/16/2025	PM 888	MC2025–1523	K2025–1518
6/16/2025	PME–PM–GA 1382	MC2025–1524	K2025–1519
6/16/2025	PM 889	MC2025–1525	K2025–1520
6/17/2025	PM 890	MC2025–1526	K2025–1521
6/17/2025	PM 891	MC2025–1527	K2025–1522
6/18/2025	PM 892	MC2025–1528	K2025–1523
6/18/2025	PM 893	MC2025–1529	K2025–1524
6/18/2025	PM–GA 784	MC2025–1530	K2025–1525
6/20/2025	PM–GA 785	MC2025–1531	K2025–1526
6/20/2025	PM–GA 786	MC2025–1532	K2025–1527
6/20/2025	PM–GA 787	MC2025–1534	K2025–1528

Documents are available at *www.prc.gov.*

Sean C. Robinson,

Attorney, Corporate and Postal Business Law.

[FR Doc. 2025–11649 Filed 6–24–25; 8:45 am]

BILLING CODE 7710–12–P

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–103294; File No. SR–IEX–2025–12]

Self-Regulatory Organizations; Investors Exchange LLC; Notice of Filing and Immediate Effectiveness of a Proposed Rule Change To Amend IEX Rule 11.660 of the Exchange's Consolidated Audit Trail Compliance Rule Regarding the National Market System Plan Governing the Consolidated Audit Trail To Be Consistent With the Exemptive Relief Granted by the Commission From Certain Provisions Related to Timestamp Granularity

June 20, 2025.

Pursuant to Section 19(b)(1) of the Securities Exchange Act of 1934 (''Act''),[1] and Rule 19b–4 thereunder,[2] notice is hereby given that on June 17, 2025, Investors Exchange LLC (''IEX'' or the ''Exchange'') filed with the Securities and Exchange Commission (''Commission'') the proposed rule change as described in Items I and II below, which Items have been prepared by the Exchange. The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

Pursuant to the provisions of Section 19(b)(1) under the Act,[3] and Rule 19b–4 thereunder,[4] IEX is filing with the Commission a proposed rule change to amend IEX Rule 11.660 of the Exchange's compliance rule (''CAT Compliance Rule'') regarding the National Market System Plan Governing the Consolidated Audit Trail (the ''CAT NMS Plan'' or ''Plan'') [5] to be consistent with the exemptive relief granted by the Commission from certain provisions of the CAT NMS Plan related to timestamp granularity (''2025 Timestamp Granularity Exemption'').[6] Specifically, the Exchange proposes to update the expiration date of the exemption in Rule 11.660(a)(2) from April 8, 2025 to April 8, 2030. The Exchange has designated this proposal as non-controversial and provided the Commission with the notice required by Rule 19b–4(f)(6)(iii) under the Act.[7]

The text of the proposed rule change is available at the Exchange's website at *https://www.iexexchange.io/resources/regulation/rule-filings,* at the principal office of the Exchange, and at the Commission's Public Reference Room.

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, the self-regulatory organization included statements concerning the purpose of and basis for the proposed rule change and discussed any comments it received on the proposed rule change. The text

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

[3] 15 U.S.C. 78s(b)(1).

[4] 17 CFR 240.19b–4.

[5] Unless otherwise specified, capitalized terms used in this rule filing are defined as set forth in the CAT Compliance Rule.

[6] Securities Exchange Act Rel. No. 102980 (May 2, 2025), 90 FR 19334 (May 7, 2025).

[7] 17 CFR 240.19b–4(f)(6)(iii).

of these statements may be examined at the places specified in Item IV below. The self-regulatory organization has prepared summaries, set forth in Sections A, B, and C below, of the most significant aspects of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

1. Purpose

The purpose of this proposed rule change is to amend Rule 11.660 of the CAT Compliance Rule to be consistent with the 2025 Timestamp Granularity Exemption. Under the 2025 Timestamp Granularity Exemption, the Commission extended the existing exemptive relief pursuant to which Industry Members that capture timestamps in increments more granular than nanoseconds must truncate the timestamps after the nanosecond level for submission to CAT, rather than rounding such timestamps up or down, from April 8, 2025 to April 8, 2030. Accordingly, the Exchange proposes to update the expiration date of the exemption in Rule 11.660(a)(2) from April 8, 2025 to April 8, 2030.

On February 3, 2020, the Participants filed with the Commission a request for exemptive relief from the requirement in Section 6.8(b) of the CAT NMS Plan for each Participant, through its CAT Compliance Rule, to require that, to the extent that its Industry Members utilize timestamps in increments finer than nanoseconds in their order handling or execution systems, such Industry Members utilize such finer increment when reporting CAT Data to the Central Repository.[8] On April 8, 2020, the Participants received the requested exemptive relief.[9] As a condition to this exemption, the Participants, through their CAT Compliance Rules, required Industry Members that capture timestamps in increments more granular than nanoseconds to truncate the timestamps after the nanosecond level for submission to CAT, rather than rounding up or down in such circumstances. The exemption was to remain in effect for five years, until April 8, 2025.

In 2020, the Exchange amended paragraph (a)(2) of Rule 11.660 to reflect this exemptive relief.[10] Specifically, the Exchange amended Rule 11.660(a)(2) to state the following:

Subject to paragraph (b), to the extent that any Industry Member's order handling or execution systems utilize time stamps in increments finer than milliseconds, such Industry Member shall record and report Industry Member Data to the Central Repository with time stamps in such finer increment up to nanoseconds; provided, that Industry Members that capture timestamps in increments more granular than nanoseconds must truncate the timestamps after the nanosecond level for submission to CAT, rather than rounding such timestamps up or down, until April 8, 2025.

The language of Rule 11.660(a)(2) has not been changed since that time.

The exemption granted in 2020, however would no longer be in effect after April 8, 2025, unless the period the exemption is in effect is extended by the SEC. Accordingly, on March 24, 2025, the Participants filed with the Commission a request to extend the existing exemptive relief for another five years, until April 8, 2030.[11] On May 2, 2025, the Participants received the requested exemptive relief from the Commission via the 2025 Timestamp Granularity Exemption. As a condition to this exemption, the Participants, through their CAT Compliance Rules, are required to require Industry Members that capture timestamps in increments more granular than nanoseconds to truncate the timestamps after the nanosecond level for submission to CAT, rather than rounding up or down in such circumstances. The SEC granted the 2025 Timestamp Granularity Exemption for a period of five years, until April 8, 2030.

Accordingly, the Exchange proposes to amend its CAT Compliance Rule to reflect the extended period set forth in the 2025 Timestamp Granularity Exemption, replacing the reference to April 8, 2025 with April 8, 2030. Specifically, the Exchange proposes to amend paragraph (a)(2) of Rule 11.660 to state:

Subject to paragraph (b), to the extent that any Industry Member's order handling or execution systems utilize time stamps in increments finer than milliseconds, such Industry Member shall record and report Industry Member Data to the Central Repository with time stamps in such finer increment up to nanoseconds; provided, that Industry Members that capture timestamps in increments more granular than nanoseconds must truncate the timestamps after the nanosecond level for submission to CAT, rather than rounding such timestamps up or down, until April 8, 2030.

2. Statutory Basis

The Exchange believes that the proposed rule change is consistent with the provisions of Section 6(b)(5) of the Act,[12] which require, among other things, that the Exchange's rules must be designed to prevent fraudulent and manipulative acts and practices, to promote just and equitable principles of trade, and, in general, to protect investors and the public interest, and Section 6(b)(8) of the Act,[13] which requires that the Exchange's rules not impose any burden on competition that is not necessary or appropriate.

The Exchange believes that this proposal is consistent with the Act because it is consistent with the exemptive relief that has been in place for five years, is consistent with the 2025 Timestamp Granularity Exemption, and is designed to assist the Exchange and its Industry Members in meeting regulatory obligations pursuant to the Plan. In approving the Plan, the SEC noted that the Plan ''is necessary and appropriate in the public interest, for the protection of investors and the maintenance of fair and orderly markets, to remove impediments to, and perfect the mechanism of a national market system, or is otherwise in furtherance of the purposes of the Act.'' [14] To the extent that this proposal implements the Plan, including the exemptive relief related thereto, and applies specific requirements to Industry Members, the Exchange believes that this proposal furthers the objectives of the Plan, as identified by the SEC, and is therefore consistent with the Exchange Act.

B. Self-Regulatory Organization's Statement on Burden on Competition

The Exchange does not believe that the proposed rule change will result in any burden on competition that is not necessary or appropriate in furtherance of the purposes of the Exchange Act. The Exchange notes that the proposed rule change is consistent with the exemptive relief that has been in place for five years, is consistent with the 2025 Timestamp Granularity Exemption, and is designed to assist the Exchange in meeting its regulatory

[8] *See* Letter to Vanessa Countryman, Secretary, SEC, from Michael Simon, CAT NMS Plan Operating Committee Chair, re: Request for Exemption from Certain Provisions of the National Market System Plan Governing the Consolidated Audit Trail related to Granularity of Timestamps and Relationship Identifiers (Feb. 3, 2020).

[9] See Securities Exchange Act Release No. 88608 (Apr. 8, 2020), 85 FR 20743 (Apr. 14, 2020).

[10] *See* Securities Exchange Act Release No. 89118 (June 19, 2020), 85 FR 38421 (June 22, 2020).

[11] *See* Letter to Vanessa Countryman, Secretary, SEC, from Brandon Becker, CAT NMS Plan Operating Committee Chair, re: Request for Exemption from Certain Provisions of the National Market System Plan Governing the Consolidated Audit Trail related to Timestamp Granularity (Mar. 24, 2025).

[12] 15 U.S.C. 78f(b)(6).

[13] 15 U.S.C. 78f(b)(8).

[14] *See* Securities Exchange Act Release No. 79318 (Nov. 15, 2016), 81 FR 84696, 84697 (Nov. 23, 2016).

obligations pursuant to the Plan. The Exchange also notes that the amendment to the CAT Compliance Rule will apply equally to all Industry Members that trade NMS Securities and OTC Equity Securities. In addition, all national securities exchanges and FINRA are proposing these amendments to their CAT Compliance Rules. Therefore, this is not a competitive rule filing, and, therefore, it does not impose a burden on competition.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

Written comments were neither solicited nor received.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

The Exchange has filed the proposed rule change pursuant to Section 19(b)(3)(A) of the Act [15] and Rule 19b–4(f)(6) [16] thereunder. Because the foregoing proposed rule change does not: (i) significantly affect the protection of investors or the public interest; (ii) impose any significant burden on competition; or (iii) become operative for 30 days from the date on which it was filed, or such shorter time as the Commission may designate, it has become effective pursuant to Section 19(b)(3)(A) of the Act [17] and Rule 19b–4(f)(6) [18] thereunder.

A proposed rule change filed under Rule 19b–4(f)(6) [19] normally does not become operative prior to 30 days after the date of the filing. However, pursuant to Rule 19b–4(f)(6)(iii),[20] the Commission may designate a shorter time if such action is consistent with protection of investors and the public interest. The Exchange has asked the Commission to waive the 30-day operative delay so that the proposed rule change may become operative immediately upon filing. The Commission believes that waiving the 30-day operative delay is consistent with the protection of investors and the public interest because the proposal seeks to amend the Exchange's CAT Compliance Rule to reflect the expiration date for exemptive relief relating to timestamp granularity approved by the Commission on May 2, 2025, and the proposal does not introduce any novel regulatory issues. Accordingly, the Commission designates the proposed rule change to be operative upon filing.[21]

At any time within 60 days of the filing of the proposed rule change, the Commission summarily may temporarily suspend such rule change if it appears to the Commission that such action is necessary or appropriate in the public interest, for the protection of investors, or otherwise in furtherance of the purposes of the Act. If the Commission takes such action, the Commission will institute proceedings to determine whether the proposed rule change should be approved or disapproved.

IV. Solicitation of Comments

Interested persons are invited to submit written data, views and arguments concerning the foregoing, including whether the proposed rule change is consistent with the Act. Comments may be submitted by any of the following methods:

Electronic Comments

- Use the Commission's internet comment form (*https://www.sec.gov/rules/sro.shtml*); or
- Send an email to *rule-comments@sec.gov.* Please include file number SR–IEX–2025–12 on the subject line.

Paper Comments

- Send paper comments in triplicate to Secretary, Securities and Exchange Commission, 100 F Street NE, Washington, DC 20549–1090.

All submissions should refer to file number SR–IEX–2025–12. This file number should be included on the subject line if email is used. To help the Commission process and review your comments more efficiently, please use only one method. The Commission will post all comments on the Commission's internet website (*https://www.sec.gov/rules/sro.shtml*). Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for website viewing and printing in the Commission's Public Reference Room, 100 F Street NE, Washington, DC 20549, on official business days between the hours of 10 a.m. and 3 p.m. Copies of the filing also will be available for inspection and copying at the principal office of the Exchange. Do not include personal identifiable information in submissions; you should submit only information that you wish to make available publicly. We may redact in part or withhold entirely from publication submitted material that is obscene or subject to copyright protection. All submissions should refer to file number SR–IEX–2025–12 and should be submitted on or before July 16, 2025.

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.[22]

Stephanie J. Fouse,

Assistant Secretary.

[FR Doc. 2025–11609 Filed 6–24–25; 8:45 am]

BILLING CODE 8011–01–P

[15] 15 U.S.C. 78s(b)(3)(A).

[16] 17 CFR 240.19b–4(f)(6).

[17] 15 U.S.C. 78s(b)(3)(A).

[18] 17 CFR 240.19b–4(f)(6). In addition, Rule 19b–4(f)(6)(iii) requires the Exchange to give the Commission written notice of its intent to file the proposed rule change, along with a brief description and text of the proposed rule change, at least five business days prior to the date of filing of the proposed rule change, or such shorter time as designated by the Commission. The Exchange has satisfied this requirement.

[19] 17 CFR 240.19b–4(f)(6).

[20] 17 CFR 240.19b–4(f)(6)(iii).

[21] For purposes only of waiving the 30-day operative delay, the Commission also has considered the proposed rule's impact on efficiency, competition, and capital formation. *See* 15 U.S.C. 78c(f).

[22] 17 CFR 200.30–3(a)(12) and (59).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–103293; File No. SR–NYSEARCA–2024–112]

Self-Regulatory Organizations; NYSE Arca, Inc.; Notice of Designation of a Longer Period for Commission Action on Proceedings To Determine Whether To Approve or Disapprove a Proposed Rule Change To Amend Rule 7.31–E To Adopt the Selective Midpoint Order

June 20, 2025.

On December 18, 2024, NYSE Arca, Inc. (the ''Exchange'') filed with the Securities and Exchange Commission (''Commission''), pursuant to Section 19(b)(1) of the Securities Exchange Act of 1934 (''Act'') [1] and Rule 19b–4 thereunder,[2] a proposed rule change to amend Exchange Rule 7.31–E to adopt the Selective Midpoint Order. The proposed rule change was published for comment in the **Federal Register** on December 30, 2024.[3] The Commission received comment on the proposal.[4] On February 11, 2025, pursuant to Section

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

[3] *See* Securities Exchange Act Release No. 102005 (Dec. 19, 2024), 89 FR 106630 (''Notice'').

[4] Comments received on the proposed rule change are available at: *https://www.sec.gov/comments/sr-nysearca-2024-112/srnysearca2024112.htm.*

19(b)(2) of the Act,[5] the Commission designated a longer period within which to approve the proposed rule change, disapprove the proposed rule change, or institute proceedings to determine whether to disapprove the proposed rule change.[6] On March 13, 2025, the Commission instituted proceedings under Section 19(b)(2)(B) of the Act[7] to determine whether to approve or disapprove the proposed rule change.[8]

Section 19(b)(2) of the Act[9] provides that, after initiating proceedings, the Commission shall issue an order approving or disapproving the proposed rule change not later than 180 days after the date of publication of the notice of filing of the proposed rule change. The Commission may extend the period for issuing an order approving or disapproving the proposed rule change, however, by not more than 60 days if the Commission determines that a longer period is appropriate and publishes the reasons for such determination. The proposed rule change was published for comment in the **Federal Register** on December 30, 2024.[10] The 180th day after publication of the Notice is June 28, 2025. The Commission is extending the time period for approving or disapproving the proposed rule change for an additional 60 days.

The Commission finds that it is appropriate to designate a longer period within which to issue an order approving or disapproving the proposed rule change so that it has sufficient time to consider the proposed rule change and the comments received. Accordingly, the Commission, pursuant to Section 19(b)(2) of the Act,[11] designates August 27, 2025, as the date by which the Commission shall either approve or disapprove the proposed rule change (File No. SR–NYSEARCA–2024–112).

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.[12]

Stephanie J. Fouse,

Assistant Secretary.

[FR Doc. 2025–11611 Filed 6–24–25; 8:45 am]

BILLING CODE 8011–01–P

[5] 15 U.S.C. 78s(b)(2).

[6] *See* Securities Exchange Act Release No. 102401, 90 FR 9782 (Feb. 18, 2025) (designating Mar. 30, 2025, as the date by which the Commission shall either approve, disapprove, or institute proceedings to determine whether to disapprove the proposed rule change).

[7] 15 U.S.C. 78s(b)(2)(B).

[8] *See* Securities Exchange Act Release No. 102657, 90 FR 12835 (Mar. 19, 2025).

[9] 15 U.S.C. 78s(b)(2).

[10] *See supra* note 3.

[11] 15 U.S.C. 78s(b)(2).

[12] 17 CFR 200.30–3(a)(57).

SECURITIES AND EXCHANGE COMMISSION

[Investment Company Act Release No. 35648; File No. 812–15791]

LAGO Evergreen Credit, et al.

June 23, 2025.

AGENCY: Securities and Exchange Commission (''Commission'' or ''SEC'').

ACTION: Notice.

Notice of application for an order under sections 17(d) and 57(i) of the Investment Company Act of 1940 (the ''Act'') and rule 17–1 under the Act to permit certain joint transactions otherwise prohibited by sections 17(d) and 57(a)(4) of the Act and rule 17–1 under the Act.

SUMMARY OF APPLICATION: Applicants request an order to permit certain business development companies (''BDCs'') and closed-end management investment companies to co-invest in portfolio companies with each other and with certain affiliated investment entities.

APPLICANTS: LAGO Evergreen Credit, LAGO Asset Management, LLC, LAGO Innovation Fund I, LP, LAGO Innovation Fund I–QP, LP, LAGO Innovation Fund, LLC, LAGO Innovation Fund II–AI, LP, LAGO Innovation Fund II–QP, LP, LAGO Innovation Fund II, LLC, LAGO Delta Nine Fund, LP, LAGO Delta Nine Fund QP, LP, LAGO Delta Nine, LLC, LAGO D9 Equity Fund I, LP, LAGO D9 Equity Fund I–QP, LP, LAGO Innovation Fund III–AI, LP, LAGO Innovation Fund III–QP, LP, LAGO Innovation Fund III, LLC, LAGO Acceleration Fund I, LP, LAGO Acceleration Fund I–QP, LP, LAGO Apex Credit Corporation.

FILING DATES: The application was filed on May 9, 2025.

HEARING OR NOTIFICATION OF HEARING: An order granting the requested relief will be issued unless the Commission orders a hearing. Interested persons may request a hearing on any application by emailing the SEC's Secretary at *Secretarys-Office@sec.gov* and serving the Applicants with a copy of the request by email, if an email address is listed for the relevant Applicant below, or personally or by mail, if a physical address is listed for the relevant Applicant below. Hearing requests should be received by the Commission by 5:30 p.m. on July 18, 2025, and should be accompanied by proof of service on the Applicants, in the form of an affidavit or, for lawyers, a certificate of service. Pursuant to rule 0–5 under the Act, hearing requests should state the nature of the writer's interest, any facts bearing upon the desirability of a hearing on the matter, the reason for the request, and the issues contested. Persons who wish to be notified of a hearing may request notification by emailing the Commission's Secretary at *Secretarys-Office@sec.gov.*

ADDRESSES: The Commission: *Secretarys-Office@sec.gov.* Applicants: Tim Gottfried, LAGO Asset Management LLC, *tim@lagoinnovation.com,* and Anne G. Oberndorf, Esq., Eversheds Sutherland (US) LLP, *anneoberndorf@eversheds-sutherland.com.*

FOR FURTHER INFORMATION CONTACT: Adam Large, Senior Special Counsel, Stephan N. Packs, Senior Counsel, or Daniele Marchesani, Assistant Chief Counsel, at (202) 551–6825 (Division of Investment Management, Chief Counsel's Office).

SUPPLEMENTARY INFORMATION: For Applicants' representations, legal analysis, and conditions, please refer to Applicants' Application, dated May 9, 2025, which may be obtained via the Commission's website by searching for the file number at the top of this document, or for an Applicant using the Company name search field, on the SEC's EDGAR system. The SEC's EDGAR system may be searched at *www.sec.gov/edgar/searchedgar/companysearch.*

You may also call the SEC's Office of Investor Education and Advocacy at (202) 551–8090.

For the Commission, by the Division of Investment Management, under delegated authority.

Sherry R. Haywood,

Assistant Secretary.

[FR Doc. 2025–11718 Filed 6–24–25; 8:45 am]

BILLING CODE 8011–01–P

SURFACE TRANSPORTATION BOARD

[Docket No. AB 290 (Sub-No. 418X); Docket No. AB 1257 (Sub-No.1X)]

Norfolk Southern Railway Company—Abandonment Exemption—in Cuyahoga, Geauga, and Portage Counties, Ohio; Cleveland & Cuyahoga Railway, LLC—Discontinuance of Service Exemption—in Cuyahoga, Geauga, and Portage Counties, Ohio.

Norfolk Southern Railway Company (NSR) and Cleveland & Cuyahoga Railway, LLC (CCRL) (collectively, Applicants), have jointly filed a verified notice of exemption under 49 CFR part 1152 subpart F—*Exempt Abandonments and Discontinuances of Service* for NSR to abandon, and for CCRL to discontinue service over, an

approximately 7.0-mile rail line extending between milepost RH 15.0 ± in Cuyahoga County, Ohio, and milepost RH 22.0 ± in Portage County, Ohio (the Line). The Line traverses U.S. Postal Service Zip Codes 44139, 44023, and 44202.

Applicants have certified that: (1) no local traffic has moved over the Line for at least two years; (2) any overhead traffic on the Line can be rerouted over other lines; (3) no formal complaint filed by a user of rail service on the Line (or by a state or local government entity acting on behalf of such user) regarding cessation of service over the Line is pending with either the Surface Transportation Board (Board) or with any U.S. District Court or has been decided in favor of a complainant within the two-year period; and (4) the requirements at 49 CFR 1105.7(b) and 1105.8(c) (notice of environmental and historic reports), 49 CFR 1105.12 (newspaper publication), and 49 CFR 1152.50(d)(1) (notice to government agencies) have been met.

As a condition to these exemptions, any employee adversely affected by the abandonment or discontinuance of service shall be protected under *Oregon Short Line Railroad—Abandonment Portion Goshen Branch Between Firth & Ammon, in Bingham & Bonneville Counties, Idaho,* 360 I.C.C. 91 (1979). To address whether this condition adequately protects affected employees, a petition for partial revocation under 49 U.S.C. 10502(d) must be filed.

Provided no formal expression of intent to file an offer of financial assistance (OFA) has been received,[1] these exemptions will be effective on July 25, 2025, unless stayed pending reconsideration. Petitions to stay that do not involve environmental issues,[2] must be filed by July 3, 2025. Formal expressions of intent to file an OFA under 49 CFR 1152.27(c)(2) and interim trail use/railbanking requests under 49 CFR 1152.29 must be filed by July 7, 2025.[3] Petitions to reopen or requests for public use conditions under 49 CFR 1152.28 must be filed by July 15, 2025.

All pleadings, referring to Docket Nos. AB 290 (Sub-No. 418X) and AB 1257 (Sub-No. 1X), must be filed with the Surface Transportation Board either via e-filing on the Board's website or in writing addressed to 395 E Street SW, Washington, DC 20423–0001. In addition, a copy of each pleading must be served on Applicants' representative, Crystal M. Zorbaugh, Mullins Law Group PLLC, 2001 L St. NW, Suite 720, Washington, DC 20036.

If the verified notice contains false or misleading information, the exemptions are void ab initio.

NSR has filed a combined environmental and historic report that addresses the potential effects, if any, of the abandonment on the environment and historic resources. OEA will issue a Draft Environmental Assessment (Draft EA) by June 30, 2025. The Draft EA will be available to interested persons on the Board's website, by writing to OEA, or by calling OEA at (202) 245–0294. If you require an accommodation under the Americans with Disabilities Act, please call (202) 245–0245. Comments on environmental and historic preservation matters must be filed within 15 days after the Draft EA becomes available to the public.

Environmental, historic preservation, public use, or interim trail use/railbanking conditions will be imposed, where appropriate, in a subsequent decision.

Pursuant to the provisions of 4 CFR 1152.29(e)(2), NSR shall file a notice of consummation with the Board to signify that it has exercised the authority granted and fully abandoned the Line. If consummation has not been effected by NSR filing of a notice of consummation by June 25, 2026, and there are no legal or regulatory barriers to consummation, the authority to abandon will automatically expire.

Board decisions and notices are available at *www.stb.gov*.

Decided: June 18, 2025.

By the Board, Scott M. Zimmerman, Acting Director, Office of Proceedings.

Brendetta Jones,

Clearance Clerk.

[FR Doc. 2025–11591 Filed 6–24–25; 8:45 am]

BILLING CODE 4915–01–P

[1] Persons interested in submitting an OFA must first file a formal expression of intent to file an offer, indicating the type of financial assistance they wish to provide (*i.e.,* subsidy or purchase) and demonstrating that they are preliminarily financially responsible. *See* 49 CFR 1152.27(c)(2)(i).

[2] The Board will grant a stay if an informed decision on environmental issues (whether raised by a party or by the Board's Office of Environmental Analysis (OEA) in its independent investigation) cannot be made before the effective date of the exemptions. *See Exemption of Out-of-Serv. Rail Lines,* 5 I.C.C.2d 377 (1989). Any request to stay should be filed as soon as possible so that the Board may take appropriate action before the effective date of the exemptions.

[3] Filing fees for OFAs and trail use requests can be found at 49 CFR 1002.2(f)(25) and (27), respectively.

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

[Docket Number 2025–0771]

Agency Information Collection Activities: Requests for Comments; Clearance of Renewed Approval of Information Collection: Automatic Dependent Surveillance—Broadcast (ADS–B) Out Performance Requirements To Support Air Traffic Control (ATC)

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Notice and request for comments.

SUMMARY: In accordance with the Paperwork Reduction Act of 1995, FAA invites public comments about our intention to request the Office of Management and Budget (OMB) approval to renew an information collection. The **Federal Register** Notice with a 60-day comment period soliciting comments on the following collection of information was published on 23 April 2025. The collection involves Automatic Dependent Surveillance-Broadcast (ADS–B) Out equipage and subsequent maintenance post-installation recordkeeping. The information to be collected will be used to and/or is necessary for continued aircraft certification and recordkeeping.

DATES: Written comments should be submitted by 23 July 2025.

ADDRESSES: Written comments and recommendations for the proposed information collection should be sent within 30 days of publication of this notice to *www.reginfo.gov/public/do/PRAMain.* Find this particular information collection by selecting ''Currently under 30-day Review—Open for Public Comments'' or by using the search function.

FOR FURTHER INFORMATION CONTACT: Jamal A. Wilson by email at: *jamal.wilson@faa.gov;* phone: (202) 267–4301.

SUPPLEMENTARY INFORMATION:

Public Comments Invited: You are asked to comment on any aspect of this information collection, including (a) Whether the proposed collection of information is necessary for FAA's performance; (b) the accuracy of the estimated burden; (c) ways for FAA to enhance the quality, utility and clarity of the information collection; and (d) ways that the burden could be minimized without reducing the quality of the collected information.

OMB Control Number: 2120–0728.

Title: Automatic Dependent Surveillance—Broadcast (ADS–B) Out

Performance Requirements to Support Air Traffic Control (ATC).

Form Numbers: FAA Form 337.

Type of Review: Clearance of a renewal of an information collection.

Background: The **Federal Register** Notice with a 60-day comment period soliciting comments on the following collection of information was published on 23 April 2025 (75 FR 30193). Title 49 of the United States Code, Subtitle VII, Aviation Programs, described in detail the scope of the Federal Aviation Administration (FAA) Administrator's authority. Rulemaking for Automatic Dependent Surveillance-Broadcast (ADS–B) Out was promulgated under the authority described Subtitle VII, Part A, Subpart I, Section 40103, Sovereignty and use of the Airspace, and Subpart III, Section 44701, General requirements. Under Section 40103, the FAA is charged with prescribing regulations on: (1) the flight of aircraft, including regulations on safe altitudes; (2) the navigation, protection, and identification of aircraft; and (3) the safe and efficient use of the navigable airspace. Under Section 44701, the FAA is charged with promoting safe flight of civil aircraft in air commerce by prescribing regulations for practices, methods and procedures the Administrator finds necessary for safety in air commerce and national security.

On May 28, 2010, the FAA published the final rule entitled *Automatic Dependent Surveillance-Broadcast (ADS–B) Out Performance Requirements to Support Air Traffic Control (ATC) Service.*[1] As of January 2, 2020, when operating in the airspace designated in 14 CFR 91.225(a) and (d), operators must be equipped with ADS–B Out avionics that meet the performance requirements of 14 CFR 91.227. In short, ADS–B rule airspace consists of the entirety of a Class B airport's airspace and the surrounding Mode C veil, Class C airspace and the airspace above Class C up to 10,000 ft, all U.S. sovereign airspace above 10,000 ft, and all Class A airspace. Basic elements of the ADS–B Out transmission include aircraft position, velocity, and identification information. Per Appendix A of FAR Part 43, installation of ADS–B Out avionics on certificated aircraft includes the completion of a Form 337 by the maintenance personnel accomplishing or supervising the installation. This form is submitted to document major alterations to an aircraft and is received by the Aircraft Registration Branch in Oklahoma City, OK for recordkeeping. This constitutes the only collection of information related to ADS–B Out equipage, although all information collected on Form 337 and its associated burden is already covered by OMB Control 2120–0020.

Respondents: Maintenance or inspecting personnel responsible for ADS–B installation on an aircraft.

Frequency: N/A.

Estimated Average Burden per Response: 15 minutes per installation.

Estimated Total Annual Burden: Dependent on number of ADS–B installations conducted in a given period.

Issued in Washington, DC, on 23 June 2025.

Jamal Abdul Wilson,

Project Manager, AJM–42, ADS–B Program Office, PMO Surveillance Services, Air Traffic Organization, FAA.

[FR Doc. 2025–11673 Filed 6–24–25; 8:45 am]

BILLING CODE 4910–13–P

[1] 75 FR 30193.

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

[Docket No. FAA–2025–1118]

Notice of Intent To Designate as Abandoned Edward L. Soncrant Supplemental Type Certificate No. SA4289WE

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Notice of intent to designate supplemental type certificate as abandoned; request for comments.

SUMMARY: This notice announces the FAA's intent to designate Edward L. Soncrant Supplemental Type Certificate (STC) No. SA4289WE as abandoned and make the related engineering data available upon request. The FAA has received a request to provide engineering data concerning this STC. The FAA has been unsuccessful in contacting Edward L. Soncrant concerning the STC. This action is intended to enhance aviation safety.

DATES: The FAA must receive all comments by December 22, 2025.

ADDRESSES: You may send comments on this notice by any of the following methods:

- *Federal eRulemaking Portal:* Go to *regulations.gov*. Follow the instructions for submitting comments.
- *Mail:* Ed Mills, AIR–771, Federal Aviation Administration, West Certification Branch, 2200 216th Street, Des Moines, WA 98189.
- *Email: Ed.Mills@faa.gov.* Include ''Docket No. FAA–2025–1118'' in the subject line of the message.
- *Hand Delivery:* Deliver to Mail address above between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays.

FOR FURTHER INFORMATION CONTACT: Ed Mills, Program Manager, AIR–771, FAA; telephone: 206–231–3515; email: *Ed.Mills@faa.gov.*

SUPPLEMENTARY INFORMATION:

Comments Invited

The FAA invites interested parties to provide comments, written data, views, or arguments relating to this notice. Send your comments using a method listed under the **ADDRESSES** section. Include ''Docket No. FAA–2025–1118'' at the beginning of your comments. The FAA will consider all comments received on or before the closing date. All comments received will be available in the docket for examination by interested persons.

Background

The FAA is posting this notice to inform the public that the FAA intends to designate Edward L. Soncrant STC No. SA4289WE as abandoned and subsequently release the related engineering data. Edward L. Soncrant STC No. SA4289WE is for installation of a Continental 0–200–A engine and McCauley 1A100 propeller; modified trim system; modified wheels and disc brakes; relocated fuel tank, battery, and instrument panel; and installation of a heated pitot tube, Cessna 50-amp alternator, and associated changes.

The FAA has received a third-party request for the release of the aforementioned engineering data under the provisions of the Freedom of Information Act (FOIA), 5 U.S.C. 552. The FAA cannot release commercial or financial information under FOIA without the permission of the data owner. However, in accordance with title 49 of the United States Code § 44704(a)(5), the FAA can provide STC ''engineering data'' it possesses for STC maintenance or improvement, upon request, if the following conditions are met:

1. The FAA determines the STC has been inactive for 3 years or more;
2. Using due diligence, the FAA is unable to locate the owner of record or the owner of record's heir; and
3. The availability of such data will enhance aviation safety.

There has been no activity on this STC for more than 3 years.

On April 29, 2025, the FAA sent a certified letter to Edward L. Soncrant at his last known address: 4103 Jacinto Way, Long Beach, California 90815. The letter was returned, unclaimed, and unable to be forwarded. The letter informed Edward L. Soncrant that the

FAA had received a request for engineering data related to STC No. SA4289WE and was conducting a due diligence search to determine whether the STC was inactive and may be considered abandoned. The letter further requested that Edward L. Soncrant respond in writing within 60 days and state whether he is the holder of the STC. The FAA also attempted to make contact with Edward L. Soncrant by other means, including telephone communication, without success.

Information Requested

If you are the owner or heir or a transferee of STC No. SA4289WE or have any knowledge regarding who may now hold STC No. SA4289WE, please contact Ed Mills using a method described in this notice under **FOR FURTHER INFORMATION CONTACT**. If you are the heir of the owner, or the owner by transfer, of STC No. SA4289WE, you must provide a notarized copy of your government-issued identification with a letter and background establishing your ownership of the STC and, if applicable, your relationship as the heir to the deceased holder of the STC.

Conclusion

If the FAA does not receive any response by December 22, 2025, the FAA will consider STC No. SA4289WE abandoned, and the FAA will proceed with the release of the requested data. This action is for the purpose of maintaining the airworthiness of an aircraft and enhancing aviation safety.

Issued on June 18, 2025.

Steven W. Thompson,

Acting Deputy Director, Compliance & Airworthiness Division, Aircraft Certification Service.

[FR Doc. 2025–11692 Filed 6–24–25; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Motor Carrier Safety Administration

[Docket No. FMCSA–2025–0003]

Agency Information Collection Activities; Renewal of an Approved Information Collection Request: Transportation of Household Goods; Consumer Protection

AGENCY: Federal Motor Carrier Safety Administration (FMCSA), Department of Transportation (DOT).

ACTION: Notice and request for comments.

SUMMARY: In accordance with the Paperwork Reduction Act of 1995, FMCSA announces its plan to submit the Information Collection Request (ICR) described below to the Office of Management and Budget (OMB) for review and approval. FMCSA requests OMB's renewed approval of the ICR titled ''Transportation of Household Goods; Consumer Protection,'' which applies to household goods motor carriers who are procured by the public (household goods shippers) to transport their household goods. This renewal revises the previous information collection's number of respondents, total respondent hours, and cost burden. No comments were received in response to the 60-day **Federal Register** notice.

DATES: Comments on this notice must be received on or before July 25, 2025.

ADDRESSES: Written comments and recommendations for the proposed information collection should be submitted within 30 days of publication of this notice to *www.reginfo.gov/public/do/PRAMain.* Find this information collection by selecting ''Currently under 30-day Review—Open for Public Comments'' or by using the search function.

FOR FURTHER INFORMATION CONTACT: Eduardo Suarez, Commercial Enforcement Division, DOT, FMCSA, 1200 New Jersey Avenue SE, Washington, DC 20590–0001; (760) 693–6646; *Eduardo.Suarez@dot.gov.*

SUPPLEMENTARY INFORMATION:

Title: Transportation of Household Goods; Consumer Protection.

OMB Control Number: 2126–0025.

Type of Request: Renewal of a currently approved collection.

Respondents: Household goods motor carriers.

Estimated Number of Respondents: 7,861.

Estimated Time per Response: Varies.

Expiration Date: July 31, 2025.

Frequency of Response: On occasion.

Estimated Total Annual Burden: 3,722,704 hours. The estimated total annual burden was calculated using the hourly burden for each of the five Information Collections.

Background

On July 12, 2005, FMCSA published a final rule titled ''Transportation of Household Goods; Consumer Protection Regulations,'' (70 FR 39949), which specified how motor carriers transporting household goods by motor vehicle in interstate commerce must assist their individual customers who ship household goods. The collected information encompasses that which is generated, maintained, and provided to, or for, the Agency under 49 CFR part 375.

On August 10, 2005, the President signed into law the Safe, Accountable, Flexible, Efficient Transportation Equity Act: A Legacy for Users ((SAFETEA–LU), Pub. L. 109–59, 119 Stat. 1144, Aug. 10, 2005). The Agency consequently revised this ICR to address these statutory impacts in a final rule titled ''Amendments to Implement Certain Provisions of the Safe, Accountable, Flexible, Efficient Transportation Act: A Legacy for Users (SAFETEA–LU)'' (72 FR 36760, July 5, 2007). Section 4205 of SAFETEA–LU amended 49 U.S.C. 14104(b) by requiring the household goods motor carrier to conduct a physical survey of the household goods to be transported on behalf of the individual shipper. The carrier must then provide the shipper with a written estimate, based on the physical survey, of charges for the transportation and all related services.

On July 16, 2012, FMCSA published a direct final rule titled ''Transportation of Household Goods in Interstate Commerce; Consumer Protection Regulations: Household Goods Motor Carrier Record Retention Requirements'' (77 FR 41699) that amended the regulations governing the period during which household goods motor carriers must retain documentation of an individual shipper's waiver of receipt of printed copies of consumer protection materials. In the rulemaking, FMCSA reduced the 3-year required retention period for those receipts to 1 year. This change harmonized the retention period with other document retention requirements applicable to household goods motor carriers. FMCSA also amended the regulations to clarify that a household goods motor carrier is not required to retain waiver documentation from any individual shippers for whom the carrier does not actually provide services.

On April 26, 2022, FMCSA updated the regulations at 49 CFR parts 371 and 375 in a final rule titled ''Implementation of Household Goods Working Group Recommendations'' (87 FR 24431). The final rule made various changes to the household goods regulations that the Household Goods Consumer Protection Working Group recommended to FMCSA. These changes, which are incorporated in Appendix A to 49 CFR part 375, include further revisions to streamline FMCSA's publication ''Your Rights and Responsibilities When You Move.'' Household goods motor carriers are required to provide consumers with the ''Your Rights and Responsibilities When You Move'' pamphlet along with the estimate and to provide new binding or non-binding estimates instead of the

previously-allowed revised estimates when an individual shipper tenders more goods or requests additional service. The final rule also allowed motor carriers to provide a virtual survey and removed the 50-mile radius for when a survey is required, removed the requirement for an order for service and incorporated that document into the bill of lading, and made other minor updates to increase the clarity of the regulations. These changes were intended to reduce the paperwork burden on household goods motor carriers and reduce confusion for individual shippers.

The complete information collection required by the referenced final rules assists household goods shippers in their business dealings with interstate household goods motor carriers. The information collected is used by prospective household goods shippers to make informed decisions about contracts and services ordered, executed, and settled. The household goods motor carrier is often the final contact for individual shippers and is in the best position to educate and assist household goods shippers during their move. The regulations are intended to combat deceptive business practices by requiring household goods motor carriers to conduct physical surveys of shippers' items to be transported unless waived in writing by the shipper and to combat deceptive business practices by requiring the household goods motor carrier to prepare an inventory of the goods shipped and a bill of lading for each shipment. The regulations also require motor carriers to obtain weight tickets for each shipment, to generate and maintain additional documents associated with the status of shipment delays and to furnish shippers, upon request, the records of contact regarding delays, and to keep written or electronic records of all complaints received from shippers. They help enforcement personnel better protect consumers by verifying that shippers are receiving information as required by regulations. The information collection itself does not impose these requirements independently. It supports compliance with the regulatory provisions under 49 CFR part 375. The documents and records that household goods motor carriers must maintain and, in some cases, furnish—such as inventories, bill of lading, and weight tickets—are necessary to demonstrate that they are meeting regulatory obligations. This collection enables FMCSA and consumers to verify adherence to consumer protection standards and helps facilitate enforcement. There is an information collection associated with the regulations because FMCSA requires household goods motor carriers to keep records and provide documents.

FMCSA revises the total annual burden to 3,722,704 hours. This is an increase of 14,609 annual burden hours from the currently approved 3,708,095 burden hours estimate. The increase is due to Agency estimates of the number of active household goods motor carriers subject to the information collection requirements.

Public Comments Invited: You are asked to comment on any aspect of this information collection, including: (1) whether the proposed collection is necessary for the performance of FMCSA's functions; (2) the accuracy of the estimated burden; (3) ways for FMCSA to enhance the quality, usefulness, and clarity of the collected information; and (4) ways that the burden could be minimized without reducing the quality of the collected information.

Issued under the authority of 49 CFR 1.87.

Kenneth Riddle,

Acting Associate Administrator, Office of Research and Registration.

[FR Doc. 2025–11685 Filed 6–24–25; 8:45 am]

BILLING CODE 4910–EX–P

DEPARTMENT OF THE TREASURY

Office of Foreign Assets Control

Notice of OFAC Sanctions Actions

AGENCY: Office of Foreign Assets Control, Treasury.

ACTION: Notice.

SUMMARY: The U.S. Department of the Treasury's Office of Foreign Assets Control (OFAC) is publishing the names of persons whose property and interests in property are being unblocked and removed from the List of Specially Designated Nationals and Blocked Persons (SDN List).

DATES: The unblocking of property and interests in property and the removal of the individuals identified in this Notice from the SDN List is effective on the date of publication in the **Federal Register**.

FOR FURTHER INFORMATION CONTACT: OFAC: Associate Director for Global Targeting, 202–622–2420; Assistant Director for Licensing, 202–622–2480; the Assistant Director for Sanctions Compliance, 202–622–2490 or *https://ofac.treasury.gov/contact-ofac.*

SUPPLEMENTARY INFORMATION:

Electronic Availability

The SDN List and additional information concerning OFAC sanctions programs are available on OFAC's website: *https://ofac.treasury.gov.*

Notice of OFAC Actions

On May 28, 2003, the individuals listed below were included in the Annex to Executive Order (E.O.) 13304 of May 28, 2003, ''Termination of Emergencies With Respect to Yugoslavia and Modification of Executive Order 13219 of June 26, 2001'' and added to the SDN List. On May 28, 2025, OFAC determined that circumstances no longer warrant the inclusion of the following persons on the SDN List under this authority and that that they should be removed from the SDN List:

Individuals:

1. MILUTINOVIC, Milan; DOB 19 Dec 1942; POB Belgrade, Serbia and Montenegro; ex-President of Republika Srpska; ICTY indictee in custody (individual) [BALKANS].

2. SUBOTIC, Bogdan; DOB 25 Apr 1941; POB Bosanska Gradiska, Bosnia-Herzegovina (individual) [BALKANS].

Lisa M. Palluconi,

Acting Director, Office of Foreign Assets Control.

[FR Doc. 2025–11716 Filed 6–24–25; 8:45 am]

BILLING CODE 4810–AL–P

DEPARTMENT OF THE TREASURY

Internal Revenue Service

Agency Information Collection Activities; Comment Request on Commercial Revitalization Deduction (Revenue Procedure 2003–38).

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Notice of Information Collection; request for comments.

SUMMARY: In accordance with the Paperwork Reduction Act of 1995, the IRS is inviting comments on the information collection request outlined in this notice.

DATES: Written comments should be received on or before August 25, 2025 to be assured of consideration.

ADDRESSES: Direct all written comments to Andrés Garcia, Internal Revenue Service, Room 6526, 1111 Constitution Avenue NW, Washington, DC 20224, or by email to *pra.comments@irs.gov.* Include ''OMB Control No. 1545–1818'' in the subject line of the message.

FOR FURTHER INFORMATION CONTACT: Requests for additional information or

copies of this collection should be directed to LaNita Van Dyke, at (202) 317–6009.

SUPPLEMENTARY INFORMATION: The IRS, in accordance with the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3506(c)(2)(A)), provides the general public and Federal agencies with an opportunity to comment on proposed, revised, and continuing collections of information. This helps the IRS assess the impact and minimize the burden of its information collection requirements. Comments submitted in response to this notice will be summarized and/or included in the request for OMB approval. All comments will become a matter of public record. Comments are invited on: (a) Whether the collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the collection of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology; and (e) estimates of capital or start-up costs and costs of operation, maintenance, and purchase of services to provide information.

Title: Commercial Revitalization Deduction.

OMB Control Number: 1545–1818.

Revenue Procedure Number: Revenue Procedure 2003–38.

Abstract: Pursuant to § 1400I of the Internal Revenue Code, Revenue Procedure 2003–38 provides the time and manner for states to make allocations of commercial revitalization expenditures to a new or substantially rehabilitated building that is placed in service in a renewal community. The collections of information are third-party disclosures listed in Sections 4.02, 5, and 6.02 of the revenue procedure.

Current Actions: There is no change to the previously approved information collection.

Type of Review: Extension of a currently approved collection.

Affected Public: State, local, or tribal governments, and businesses or other for-profits.

Estimated Number of Responses: 80.

Estimated Time per Response: 2 hours, 30 minutes.

Estimated Total Annual Burden Hours: 200.

Dated: June 20, 2025.

LaNita Van Dyke,

Tax Analyst.

[FR Doc. 2025–11598 Filed 6–24–25; 8:45 am]

BILLING CODE 4830–01–P

DEPARTMENT OF THE TREASURY

United States Mint

Notice of Meeting

ACTION: Notice of meeting.

Pursuant to United States Code, Title 31, section 5135(b)(8)(C), the United States Mint announces the Citizens Coinage Advisory Committee (CCAC) public meeting scheduled for July 22, 2025.

Date: July 22, 2025.

Time: 12:00 p.m.–4:00 p.m. (Eastern Time).

Location: Remote via Videoconference.

Subject: Review and discussion of the 2026 FIFA World Cup 2026 Commemorative Coin Program; report from Numismatic Themes Working Group; and review and discussion of the obverse and reverse designs of the Everett Alvarez, Jr. Congressional Gold Medal.

Interested members of the public may watch the meeting via live stream on the United States Mint's YouTube Channel at *https://www.youtube.com/user/usmint.* To watch the meeting live, members of the public may click on the ''July 22, 2025'' icons under the Live Tab on the specific day.

The public should call the CCAC HOTLINE at (202) 354–7502 for the latest updates on meeting time and access information.

The CCAC advises the Secretary of the Treasury on any theme or design proposals relating to circulating coinage, bullion coinage, Congressional Gold Medals, and national and other medals; advises the Secretary of the Treasury with regard to the events, persons, or places to be commemorated by the issuance of commemorative coins in each of the five calendar years succeeding the year in which a commemorative coin designation is made; and makes recommendations with respect to the mintage level for any commemorative coin recommended.

For members of the public interested in watching on-line, this is a reminder that the remote access is for observation purposes only. Members of the public may submit matters for the CCAC's consideration by email to *info@ccac.gov.*

FOR ACCOMMODATION REQUEST: If you require an accommodation to watch the CCAC meeting, please contact the Office of Equal Employment Opportunity by July 15, 2025. You may submit an email request to *Reasonable.Accommodations@usmint.treas.gov* or call 202–354–7260 or 1–888–646–8369 (TTY).

FOR FURTHER INFORMATION CONTACT: Jennifer Warren, United States Mint Liaison to the CCAC; 801 9th Street NW, Washington, DC 20220; or call 202–354–7208.

(Authority: 31 U.S.C. 5135(b)(8)(C))

Eric Anderson,

Executive Secretary, United States Mint.

[FR Doc. 2025–11674 Filed 6–24–25; 8:45 am]

BILLING CODE 4810–37–P

DEPARTMENT OF VETERANS AFFAIRS

Advisory Committee on Homeless Veterans, Notice of Meeting

The Department of Veterans Affairs (VA) gives notice under the Federal Advisory Committee Act, 5 U.S.C. Ch. 10, that the Advisory Committee on Homeless Veterans (the Committee) will meet on August 13, 2025. The meeting session will take place virtually via Microsoft Teams conferencing platform—Eastern Standard Time (EST). The meeting session will begin and end as follows:

Date	Eastern standard time	Open session
August 13, 2025.	9:00 a.m.–4:00 p.m. EST	Yes.

The meeting session is to the public.

The purpose of the Committee is to provide the Secretary of Veterans Affairs with an ongoing assessment of the effectiveness of the policies, organizational structures, and services of VA in assisting Veterans at risk of and experiencing homelessness. The Committee shall assemble, and review information related to the needs of homeless Veterans and provide advice on the most appropriate means of assisting this Veteran population.

On August 13, 2025, the Committee will convene in an open session and the agenda will include introductions of new members and briefings from VA, other Federal, state, and local agencies and the public regarding services for homeless Veterans.

Time will be allocated at the August 13, 2025, meeting for receiving oral presentations from the public 12:30 p.m. to 1:00 p.m. EST. The comment period may end sooner, if there are no comments presented or they are

exhausted before the end time. By July 31, 2025, interested parties that would like to provide 3 minute oral presentations should provide written comments on issues affecting homeless Veterans to *achv@va.gov* for review by the Committee to Anthony Love, Designated Federal Officer, Veterans Health Administration Homeless Programs Office (11HPO), U.S. Department of Veterans Affairs, 810 Vermont Avenue NW (11HPO), Washington, DC 20420.

Additionally, members of the public who wish to attend the August 13, 2025, meeting virtually should notify Mr. Love at *achv@va.gov* no later than July 31, 2025, providing their name, professional affiliation, email address, and phone number. Attendees who require reasonable accommodations should also state so in their requests. Additionally, all attendees that are not Advisory Committee members or have not been recognized to speak by the Chair will be muted.

The meeting link and call-in numbers are noted below:

Microsoft Teams Virtual Link: https://teams.microsoft.com/l/meetup-join/19%3ameeting_OWU1MWMwMTItYTA5ZS00MGRlLTg5ZTYtNzM0YzA1YWI5OWQ1%40thread.v2/0?context=%7b%22Tid%22%3a%22e95f1b23-abaf-45ee-821d-b7ab251ab3bf%22%2c%22Oid%22%3a%22c4b32df5-4b31-4d2a-9d3d-e9f226fc0a82%22%7d.

Meeting ID: 243 021 231 461.

Passcode: W4Wz2Fp9.

Phone: 1–872–701–0185/Passcode: 139 940 604#.

Dated: June 23, 2025.

Jelessa M. Burney,

Federal Advisory Committee Management Officer.

[FR Doc. 2025–11670 Filed 6–24–25; 8:45 am]

BILLING CODE 8320–01–P

DEPARTMENT OF VETERANS AFFAIRS

[OMB Control No. 2900–0910]

Agency Information Collection Activity Under OMB Review: Statement of a Person Claiming Loan Fee Refund Due a Deceased Veteran, Service Member, or Surviving Spouse

AGENCY: Veterans Benefits Administration, Department of Veterans Affairs.

ACTION: Notice.

SUMMARY: In compliance with the Paperwork Reduction Act (PRA) of 1995, this notice announces that the Veterans Benefits Administration, Department of Veterans Affairs, will submit the collection of information abstracted below to the Office of Management and Budget (OMB) for review and comment. The PRA submission describes the nature of the information collection and its expected cost and burden, and it includes the actual data collection instrument.

DATES: Comments and recommendations for the proposed information collection should be sent by July 25, 2025.

ADDRESSES: To submit comments and recommendations for the proposed information collection, please type the following link into your browser: *www.reginfo.gov/public/do/PRAMain,* select ''Currently under Review—Open for Public Comments'', then search the list for the information collection by Title or ''OMB Control No. 2900–0910.''

FOR FURTHER INFORMATION CONTACT:

VA PRA information: Dorothy Glasgow, 202–461–1084, *VAPRA@va.gov.*

SUPPLEMENTARY INFORMATION:

Title: Statement of a Person Claiming Loan Fee Refund Due a Deceased Veteran, Service Member, or Surviving Spouse.

OMB Control Number: 2900–0910 *https://www.reginfo.gov/public/do/PRASearch.*

Type of Review: Extension without change of a currently approved collection.

Abstract: The information in VA Forms 26–10280 and VA FORM 26–10280a will be used by VA to determine whether a refund owed to a Veteran may be remitted to another individual, including the Veteran's spouse, the executor or administrator of the Veteran's estate, or another individual with a relationship to the Veteran. The information collected is necessary for VA to ensure that it is releasing the refund to an appropriate individual who will disburse the refund according to the laws of the state where the Veteran was a legal resident (*e.g.,* estate laws).

An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. The **Federal Register** Notice with a 60-day comment period soliciting comments on this collection of information was published at 90 FR 16597, April 18, 2025.

Affected Public: Individuals or Households.

Estimated Annual Burden: 250 Hours.

Estimated Average Burden per Respondent: 15 minutes.

Frequency of Response: One time.

Estimated Number of Respondents: 1,000.

Authority: 44 U.S.C. 3501 *et seq.*

Dorothy Glasgow,

Acting, VA PRA Clearance Officer, Office of Enterprise and Integration, Data Governance Analytics, Department of Veterans Affairs.

[FR Doc. 2025–11666 Filed 6–24–25; 8:45 am]

BILLING CODE 8320–01–P

DEPARTMENT OF VETERANS AFFAIRS

[OMB Control No. 2900–0021]

Agency Information Collection Activity: VA Loan Electronic Reporting Interface (VALERI) System and Title Requirements for Conveyance of Real Property to the Secretary

AGENCY: Veterans Benefits Administration, Department of Veterans Affairs.

ACTION: Notice.

SUMMARY: Veterans Benefits Administration (VBA), Department of Veterans Affairs (VA), is announcing an opportunity for public comment on the proposed collection of certain information by the agency. Under the Paperwork Reduction Act (PRA) of 1995, Federal agencies are required to publish notice in the **Federal Register** concerning each proposed collection of information, including each proposed extension of a currently approved collection, and allow 60 days for public comment in response to the notice.

DATES: Comments must be received on or before August 25, 2025.

ADDRESSES: Comments must be submitted through *www.regulations.gov.*

FOR FURTHER INFORMATION CONTACT:

Program-Specific information: Kendra McCleave, 202 461–9760, *Kendra.McCleave@va.gov.*

VA PRA information: Dorothy Glasgow, 202–461–1084, *VAPRA@va.gov.*

SUPPLEMENTARY INFORMATION: Under the PRA of 1995, Federal agencies must obtain approval from the Office of Management and Budget (OMB) for each collection of information they conduct or sponsor. This request for comment is being made pursuant to Section 3506(c)(2)(A) of the PRA.

With respect to the following collection of information, VBA invites comments on: (1) Whether the proposed collection of information is necessary for the proper performance of VBA's functions, including whether the information will have practical utility; (2) the accuracy of VBA's estimate of the

burden of the proposed collection of information; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or the use of other forms of information technology.

Title: VA Loan Electronic Reporting Interface (VALERI) System and Title Requirements for Conveyance of Real Property to the Secretary.

OMB Control Number: 2900–0021. *https://www.reginfo.gov/public/do/PRASearch* (Once at this link, you can enter the OMB Control Number to find the historical versions of this Information Collection).

Type of Review: Extension without change of a currently approved collection.

Abstract: VA uses the information collection in cases where loss mitigation efforts are unsuccessful and a VA-guaranteed loan goes into foreclosure. Statutory requirements for conveyance of properties to the Secretary are found in chapter 37 of title 38, United States Code. The implementing regulations are found in part 36 of title 38, Code of Federal Regulations (CFR). In 38 CFR 36.4323, titled ''Election to convey security'', VA explains that each conveyance or transfer of real property to the Secretary pursuant to this section shall be acceptable if:

The holder thereby covenants or warrants against the acts of the holder and those claiming under the holder (*e.g.,* by special warranty deed); and

It vests in the Secretary or will entitle the Secretary to such title as is or would be acceptable to prudent lending institutions, informed buyers, title companies, and attorneys, generally, in the community in which the property is situated.

Affected Public: Individuals and households.

Estimated Annual Burden: 3,027 hours.

Estimated Average Burden per Respondent: 11 minutes.

Frequency of Response: One time.

Estimated Number of Respondents: 16,509.

Authority: 44 U.S.C. 3501 *et seq.*

Dorothy Glasgow,

Acting, VA PRA Clearance Officer, Office of Enterprise and Integration/Data Governance Analytics, Department of Veterans Affairs.

[FR Doc. 2025–11724 Filed 6–24–25; 8:45 am]

BILLING CODE 8320–01–P

DEPARTMENT OF VETERANS AFFAIRS

[OMB Control No. 2900–0853]

Agency Information Collection Activity: Application for Approval of a Program in a Foreign Country

AGENCY: Veterans Benefits Administration, Department of Veterans Affairs.

ACTION: Notice.

SUMMARY: Veterans Benefits Administration, Department of Veterans Affairs (VA), is announcing an opportunity for public comment on the proposed collection of certain information by the agency. Under the Paperwork Reduction Act (PRA) of 1995, Federal agencies are required to publish notice in the **Federal Register** concerning each proposed collection of information, including each proposed revision of a currently approved collection, and allow 60 days for public comment in response to the notice.

DATES: Comments must be received on or before August 25, 2025.

ADDRESSES: Comments must be submitted through *www.regulations.gov*.

FOR FURTHER INFORMATION CONTACT:

Program-Specific information: Kendra McCleave, 202–461–9568, *kendra.mccleave@va.gov.*

VA PRA information: Dorothy Glasgow, 202–461–1084, *VAPRA@va.gov*.

SUPPLEMENTARY INFORMATION: Under the PRA of 1995, Federal agencies must obtain approval from the Office of Management and Budget (OMB) for each collection of information they conduct or sponsor. This request for comment is being made pursuant to Section 3506(c)(2)(A) of the PRA.

With respect to the following collection of information, VBA invites comments on: (1) whether the proposed collection of information is necessary for the proper performance of VBA's functions, including whether the information will have practical utility; (2) the accuracy of VBA's estimate of the burden of the proposed collection of information; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or the use of other forms of information technology. This is a revision with a decreased burden which considers data for calendar year periods 2022, 2023 and 2024.

Title: Application for Approval of a Program in a Foreign Country, VA Form 22–0976.

OMB Control Number: 2900–0976. *https://www.reginfo.gov/public/do/PRASearch* (Once at this link, you can enter the OMB Control Number to find the historical versions of this Information Collection).

Type of Review: Revision of a currently approved collection.

Abstract: The VA will use the information collected to determine if a program in a foreign country is approvable under CFR 21.4260. In order for a review and decision to be made, the VA needs supporting information from a foreign educational institution.

After completing the form, foreign institutions will continue to download the VA Form 22–0976 from the GI Bill website and submit it via email to *federal.approvals@va.gov.*

Affected Public: Educational Institutions.

Estimated Annual Burden: 137 hours.

Estimated Average Burden per Respondent: 20 minutes.

Frequency of Response: Annually.

Estimated Number of Respondents: 412.

Authority: 44 U.S.C. 3501 *et seq.*

Dorothy Glasgow,

Acting, VA PRA Clearance Officer, Office of Enterprise and Integration/Data Governance Analytics, Department of Veterans Affairs.

[FR Doc. 2025–11656 Filed 6–24–25; 8:45 am]

BILLING CODE 8320–01–P

DEPARTMENT OF VETERANS AFFAIRS

[OMB Control No. 2900–0495]

Agency Information Collection Activity: Martial Status Questionnaire

AGENCY: Veterans Benefits Administration, Department of Veterans Affairs.

ACTION: Notice.

SUMMARY: Veterans Benefits Administration, Department of Veterans Affairs (VA), is announcing an opportunity for public comment on the proposed collection of certain information by the agency. Under the Paperwork Reduction Act (PRA) of 1995, Federal agencies are required to publish notice in the **Federal Register** concerning each proposed collection of information, including each proposed extension of a currently approved collection, and allow 60 days for public comment in response to the notice.

DATES: Comments must be received on or before August 25, 2025.

ADDRESSES: Comments must be submitted through *www.regulations.gov.*

FOR FURTHER INFORMATION CONTACT:

Program-Specific information: Kendra McCleave, 202–461–9760, *kendra.mccleave@va.gov.*

VA PRA information: Dorothy Glasgow, 202–461–1084, *VAPRA@va.gov.*

SUPPLEMENTARY INFORMATION: Under the PRA of 1995, Federal agencies must obtain approval from the Office of Management and Budget (OMB) for each collection of information they conduct or sponsor. This request for comment is being made pursuant to Section 3506(c)(2)(A) of the PRA.

With respect to the following collection of information, VBA invites comments on: (1) whether the proposed collection of information is necessary for the proper performance of VBA's functions, including whether the information will have practical utility; (2) the accuracy of VBA's estimate of the burden of the proposed collection of information; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or the use of other forms of information technology.

Title: Marital Status Questionnaire (VA Form 21P–0537).

OMB Control Number: 2900–0495. *https://www.reginfo.gov/public/do/PRASearch* (Once at this link, you can enter the OMB Control Number to find the historical versions of this Information Collection).

Type of Review: Extension without change of a currently approved collection.

Abstract: The VA Form 21P–0537, Marital Status Questionnaire, is used to confirm the marital status of a surviving spouse in receipt of Dependency and Indemnity Compensation (DIC) benefits. If a surviving spouse remarries, he or she is no longer entitled to DIC unless the marriage begins after age 55 or has been terminated. This is an extension. The respondent burden has remained the same.

Affected Public: Individuals and households.

Estimated Annual Burden: 230 hours.

Estimated Average Burden per Respondent: 5 minutes.

Frequency of Response: On occasion.

Estimated Number of Respondents: 2,756.

Authority: 44 U.S.C. 3501 *et seq.*

Dorothy Glasgow,

Acting, VA PRA Clearance Officer, Office of Enterprise and Integration/Data Governance Analytics, Department of Veterans Affairs.

[FR Doc. 2025–11653 Filed 6–24–25; 8:45 am]

BILLING CODE 8320–01–P

DEPARTMENT OF VETERANS AFFAIRS

[OMB Control No. 2900–0002]

Agency Information Collection Activity: Application for Veterans Pension

AGENCY: Veterans Benefits Administration, Department of Veterans Affairs.

ACTION: Notice.

SUMMARY: Veterans Benefits Administration, Department of Veterans Affairs (VA), is announcing an opportunity for public comment on the proposed collection of certain information by the agency. Under the Paperwork Reduction Act (PRA) of 1995, Federal agencies are required to publish notice in the **Federal Register** concerning each proposed collection of information, including each proposed revision of a currently approved collection, and allow 60 days for public comment in response to the notice.

DATES: Comments must be received on or before August 25, 2025.

ADDRESSES: Comments must be submitted through *www.regulations.gov*.

FOR FURTHER INFORMATION CONTACT:

Program-Specific information: Kendra McCleave, 202–461–9568, *kendra.mccleave@va.gov.*

VA PRA information: Dorothy Glasgow, 202–461–1084, *VAPRA@va.gov*.

SUPPLEMENTARY INFORMATION: Under the PRA of 1995, Federal agencies must obtain approval from the Office of Management and Budget (OMB) for each collection of information they conduct or sponsor. This request for comment is being made pursuant to Section 3506(c)(2)(A) of the PRA.

With respect to the following collection of information, Veterans Benefits Administration (VBA) invites comments on: (1) whether the proposed collection of information is necessary for the proper performance of VBA's functions, including whether the information will have practical utility; (2) the accuracy of VBA's estimate of the burden of the proposed collection of information; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or the use of other forms of information technology.

Title: Application for Veterans Pension 21P–527EZ.

OMB Control Number: 2900–0002. *https://www.reginfo.gov/public/do/PRASearch* (Once at this link, you can enter the OMB Control Number to find the historical versions of this Information Collection).

Type of Review: Revision of a currently approved collection.

Abstract: The VA Form 21P–527EZ, Application for Pension, is the prescribed form for veterans applying for pension benefits.

Affected Public: Individuals and households.

Estimated Annual Burden: 19,000 hours.

Estimated Average Burden per Respondent: 30 minutes.

Frequency of Response: One time.

Estimated Number of Respondents: 38,000 per year.

Authority: 44 U.S.C. 3501 *et seq.*

Dorothy Glasgow,

Acting, VA PRA Clearance Officer, Office of Enterprise and Integration/Data Governance Analytics, Department of Veterans Affairs.

[FR Doc. 2025–11655 Filed 6–24–25; 8:45 am]

BILLING CODE 8320–01–P

FEDERAL REGISTER

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Part II

Department of Health and Human Services

45 CFR Parts 147, 155 and 156
Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability; Final Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Parts 147, 155, and 156

[CMS–9884–F]

RIN 0938–AV61

Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability

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

ACTION: Final rule.

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

DATES:

Effective Date: These regulations are effective on August 25, 2025.

Applicability Dates: See section III.D. of this final rule for further information on the applicability dates.

FOR FURTHER INFORMATION CONTACT: Jeff Wu, (301) 492–4305, Rogelyn McLean, (410) 786–1524, Grace Bristol, (410) 786–8437, for general information.

SUPPLEMENTARY INFORMATION:

I. Executive Summary

On January 20, 2025, President Trump issued a memorandum entitled ''Delivering Emergency Price Relief for American Families and Defeating the Cost-of-Living Crisis.'' [1] This memorandum instructed all executive departments and agencies to deliver emergency price relief for the American people and to increase the prosperity of the American worker. Health care represents a substantial portion of a family's budget and a tremendous cost to Federal taxpayers. To provide emergent relief from rising improper enrollments and health care costs, we are finalizing several regulatory actions aimed at strengthening the integrity of the Patient Protection and Affordable Care Act (ACA) eligibility and enrollment systems to reduce waste, fraud, and abuse that we proposed in the 2025 Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability proposed rule (90 FR 12942) (''2025 Marketplace Integrity and Affordability proposed rule'' or ''proposed rule''). We expect these actions will provide immediate premium relief to families who do not qualify for Federal premium subsidies and reduce the burden of improper ACA premium subsidy expenditures to the Federal taxpayer.

Based on our review of enrollment data and our experience fielding consumer complaints, the Department believes the temporary expansion of ACA premium subsidies resulted in conditions that were exploited to improperly gain access to fully-subsidized coverage. As we detailed in the 2025 Marketplace Integrity and Affordability proposed rule and reiterate in this final rule, the widespread availability of $0 premium plans created the incentive and opportunity for fraudulent and improper enrollments at scale, either by the enrollee's own doing or by a third party without the enrollee's knowledge, including consumers who were enticed to respond to misleading advertisements promising cash or gift cards, and provided enough personal information for the agent, broker, and web-broker to enroll the consumer in a qualified health plan (QHP). Exchange eligibility verification policies in effect at the time enhanced subsidies became available, as well as those adopted and implemented since that time, were not sufficient to protect against this consumer harm and fraud, waste, and abuse of Federal funds.

In particular, consumers are at risk for accumulating surprise tax liabilities and substantial inconvenience from resolving these liabilities, as well as other issues related to coverage changes and access to care, due to improper enrollment. The substantial and unprecedented increase in consumer complaints from people who were unaware that they had been enrolled by an agent, broker, or web-broker in Exchange coverage suggests many of these improper enrollments are due to fraud, improper actions that violate agency rules and agreements, or other improper processes that result in incorrect determinations.[2] Fraudulent enrollments involve enrollments obtained through willful misrepresentations whereas improper enrollments involve enrollments that result from or were affected by noncompliance with agency rules and regulations, which can include fraud.[3]

The expanded subsidy regime that gave way to this environment of fraudulent and improper enrollments is expiring at the end of this year. Given the high and demonstrable levels of improper enrollment creating long-term uncertainty and instability in the marketplaces, this rule takes a carefully curated set of temporary actions to immediately reduce the crisis-levels of improper enrollments over the short-term as the market readjusts to the new subsidy environment in which enhanced subsidies are no longer available. This final rule also enacts permanent reforms to help the markets reset to the changing subsidy environment to improve affordability and stability over the long-term.

The temporary enactment of numerous policies within this rule responds directly to concerns raised by commenters about potential negative effects of making such policies permanent, while balancing the need to address the current high levels of improper enrollments created by the expanded subsidies and the holdover improper enrollments that will remain in the immediate wake of the enhanced subsidy expiration. The temporary reforms then sunset, as we share many commenter concerns. We also considered comments that the causes of the improper enrollments this rule aims to address are not known with certainty and that data related to Exchange enrollments may be skewed or

[1] Executive Office of the President. (January 20, 2025). *Delivering Emergency Price Relief for American Families and Defeating the Cost-of-Living Crisis. https://www.federalregister.gov/documents/2025/01/28/2025-01904/delivering-emergency-price-relief-for-american-families-and-defeating-the-cost-of-living-crisis.*

[2] For example, from January 2024 through August 2024, CMS received 90,863 complaints that consumers had their FFE plan changed without their consent (also known as an ''unauthorized plan switch''). CMS (2024, October). *CMS Update on Action to Prevent Unauthorized Agent and Broker Marketplace Activity. https://www.cms.gov/newsroom/press-releases/cms-update-actions-prevent-unauthorized-agent-and-broker-marketplace-activity. See also,* U.S. Department of Justice. (2025, February 19). *President of insurance brokerage firm and CEO of marketing company charged in $161M Affordable Care Act enrollment fraud scheme* [Press release]. *https://www.justice.gov/opa/pr/president-insurance-brokerage-firm-and-ceo-marketing-company-charged-161m-affordable-care.*

[3] *See* U.S. Government Accountability Office, Improper Payments and Fraud: How They Are Related but Different, December 7, 2023, *https://www.gao.gov/products/gao-24-106608.*

misleading as marketplaces are still recovering from the COVID–19 public health emergency. The temporary codification of these policies attempts to strike a balance between these commenter concerns and the integrity of the Exchange program and the Federal funds that support it. We believe the policies will reduce the improper enrollments that can carry forward due to auto re-enrollment after the enhanced subsidies expire. The absence of the enhanced subsidies, most notably the absence of fully-subsidized plans, will substantially mitigate the threat of future improper enrollments.

Because Federal law limits the amount that enrollees with lower household incomes must repay when they reconcile advance payments of the premium tax credit (APTC) received, these improper enrollments ended up costing Federal taxpayers billions of dollars. One analysis of improper enrollments estimated the Federal Government may have spent up to $26 billion on improper enrollments in 2024, before reconciling enrollment data.[4] The policies being finalized in this rule aim to address these imminent program integrity problems while recognizing these problems are an outgrowth of temporary policy in order to deliver a streamlined enrollment and eligibility determination process for individual market consumers.

Before summarizing these policies, we believe it is important to review the interlocking policies the ACA put in place to expand access to coverage on the individual market.[5] A full understanding of how ACA individual market policies interact helps frame why we stated in the 2025 Marketplace Integrity and Affordability proposed rule (90 FR 12943) that we believe the program integrity and premium relief policies contained within these rules are necessary to respond to present-day challenges in the individual health insurance market. As a starting point, the ACA establishes American Health Benefit Exchanges, or ''Exchanges,'' to facilitate the purchase of QHPs. Many individuals who enroll in QHPs through individual market Exchanges are eligible to receive a premium tax credit (PTC) to reduce their costs for health insurance premiums and have their out-of-pocket expenses for health care services reduced through cost-sharing reductions (CSR). Most individuals who claim PTCs receive APTC, which subsidizes lower monthly premiums, before they must file taxes. Taxpayers must then reconcile APTC paid to issuers on their behalf when they file taxes. The ACA includes limits on how much excess APTC a taxpayer must repay based on household income.

The ACA's individual market rules require issuers to guarantee coverage (with limited exceptions) to all applicants regardless of pre-existing conditions and restrict issuers from setting premiums based on health status. These requirements create an inherent bias towards adverse selection—a situation where individuals with higher risk are more likely to select coverage than healthy individuals—by allowing people to wait to enroll in coverage until they need health services. In such situations, health insurance issuers offering coverage to a larger proportion of higher risk enrollees raise premiums, which causes healthier people to drop coverage. Enough cycles of rising premiums and healthier people dropping coverage would create a ''death spiral'' and undermine the viability of the individual market.

Several policies included in the ACA attempt to address its adverse selection bias. For example, the ACA permits issuers to limit enrollment periods to certain times. In addition, adverse selection between plans can occur when one plan enrolls a disproportionate number of people with higher risk conditions. The ACA's risk adjustment program transfers funds from issuers with relatively low-risk enrollees to issuers with relatively high-risk enrollees, though implementation of the risk adjustment program has been criticized by some commenters for creating further distortions that limit incentives for issuers to attract lower-risk enrollees.[6] To avoid adverse selection between plans sold on and off the Exchanges, the ACA also requires issuers to keep all individual market plans that are subject to the law's main coverage mandates in the same risk pool.

By tying an issuer's on-Exchange and off-Exchange individual market risk pools together, the ACA's unsubsidized off-Exchange market was intended to help anchor the subsidized Exchange enrollees to a more competitive and efficient market. A well-functioning market depends on consumers actively shopping for the best deal based on price and quality.[7] A well-functioning market also depends on there being 'low information asymmetry' where, for example, health insurance issuers, health care providers, and consumers have comparable information, instead of issuers and providers having more or better information than consumers. Information asymmetry in insurance markets can lead to imbalances in market predictions, inefficient operations, skewed decisions, and adverse selection.[8] Low information asymmetry generally ensures that buyers (consumers) and sellers (issuers and providers) are on a more equal footing, preventing one party from taking advantage of another due to superior knowledge. In recent years, HHS has taken steps to level the playing field between health insurance issuers, health care providers, and consumers by adopting regulations promoting transparency in health insurance coverage (85 FR 72158).

Despite the ACA's intent to create more competitive and efficient markets, in practice, the high premiums of off-Exchange plans have made these options largely unattractive to unsubsidized consumers, with only an estimated 2.5 million people enrolling in unsubsidized off-Exchange coverage (including some in plans not subject to all of the ACA's market rules, such as grandfathered and short-term plans) nationwide in 2023.[9] Further, price-linked subsidies like PTCs are directly tied to the price of a QHP such that when QHP premiums go up, PTC allowed also increases. Such price-linked subsidies generally distort markets and weaken competition because the subsidized enrollee is no

[4] Blase, B.; Gonshorowski, D. (2024, June). *The Great Obamacare Enrollment Fraud*. Paragon Health Institute. *https://paragoninstitute.org/private-health/the-great-obamacare-enrollment-fraud*.

[5] The Patient Protection and Affordable Care Act (Pub. L. 111–148, 124 Stat. 119) was enacted on March 23, 2010. The Healthcare and Education Reconciliation Act of 2010 (Pub. L. 111–152, 124 Stat. 1049), which amended and revised several provisions of the Patient Protection and Affordable Care Act, was enacted on March 30, 2010. In this rulemaking, the two statutes are referred to collectively as the ''Patient Protection and Affordable Care Act,'' ''Affordable Care Act,'' or ''ACA''.

[6] Cruz, D; Fann, G. (2024, Sept.). *It's Not Just the Prices: ACA Plans Have Declined in Quality Over the Past Decade*. Paragon Health Institute. *https://paragoninstitute.org/private-health/its-not-just-the-prices-aca-plans-have-declined-in-quality-over-the-past-decade/*.

[7] Garrod, L.; Waddams, C.; Hvvid, M.; and Loomes, G. (2009). Competition Remedies in Consumer Markets. *Loyola Consumer Law Review*. 21. 439–495. *https://www.researchgate.net/publication/271701344_Competition_Remedies_in_Consumer_Markets*. (last accessed Febuary 23, 2025).

[8] Akerlof, George A. (August 1970). ''The Market for 'Lemons': Quality Uncertainty and the Market Mechanism''. The Quarterly Journal of Economics. 84 (3): 488–500. doi:10.2307/1879431. JSTOR 1879431.

[9] Ortaliza, J.; Amin, K.; and Cox, C. (2023). As ACA Marketplace Enrollment Reaches Record High, Fewer Are Buying Individual Market Coverage Elsewhere. *https://www.kff.org/private-insurance/issue-brief/as-aca-marketplace-enrollment-reaches-record-high-fewer-are-buying-individual-market-coverage-elsewhere/#*.

longer price sensitive to the full cost.[10] In a market where everyone is subsidized, prices would generally be much higher due to the subsidized consumers' lower level of price sensitivity.[11] When Congress enacted the ACA, the Congressional Budget Office (CBO) projected the law would enroll 15 million unsubsidized consumers—about the same as without the law—and another 19 million subsidized consumers.[12] Those 15 million unsubsidized consumers actively shopping for the best deal were expected to support a competitive and efficient market. In turn, the benefits from this competition would spill over to the subsidized consumers who benefit from the availability of higher quality health plans and the Federal taxpayers funding the subsidies who benefit from lower premium subsidies.

The ACA did not roll out as intended when the ACA's main coverage mandates went into effect in 2014. Premiums increased much more and enrollment levels among both the subsidized and the unsubsidized were much lower than projected. Higher premiums then led to a substantial decline in unsubsidized enrollment, which undermined the competitiveness of the market. By 2019, our data showed that subsidized enrollment on the Exchanges had reached only 8.3 million while unsubsidized enrollment across the entire individual market subject to the ACA's market rules had dropped to 3.4 million.[13] To improve the attractiveness of the market, several States implemented reinsurance programs that lowered premiums for the unsubsidized by funding high-cost claims across the individual market. These policies helped retain unsubsidized enrollees who anchor the market in a more competitive and efficient position.

In 2021, Congress passed the American Rescue Plan of 2021 (ARP),[14] which temporarily expanded the generosity of ACA premium subsidies. In 2022, Congress extended the enhanced subsidies through 2025 under the Inflation Reduction Act of 2022 (IRA).[15] These subsidies compounded the problems associated with price-linked subsidies like PTC, but they also created the incentive and opportunity for unprecedented fraud and improper enrollments. Specifically, the enhanced subsidies provide ''zero-dollar premium'' benchmark silver plans for individuals with projected annual household income between 100 and 150 percent of the Federal Poverty Level (FPL). By fully subsidizing the premium for these plans, individuals could be enrolled into these plans once every month through a special enrollment period (SEP) by predatory agents and brokers without the individual's knowledge. Individuals for whom Federal law limits the amount of PTC they must repay also have a strong incentive to sign up for such plans improperly. There have been widespread reports of consumers in this income cohort having their plan switched without their knowledge. As displayed in Table 14 of this rule, there are millions of people improperly enrolled in fully-subsidized QHPs. These imminent concerns prompted our rapid rulemaking and informed our nuanced response in this final rule that balances the need to urgently reduce the high level of improper enrollments while understanding the subsidy environment that largely created the incentive and opportunity for such improper enrollment is coming to an end.

In the 2025 Marketplace Integrity and Affordability proposed rule (90 FR 12944), we stated that we believe that after reviewing individual market data and responding to a substantial increase in consumer complaints, we needed to implement program integrity protections to mitigate and reverse the substantial increase in improper enrollments on the Exchanges caused by the availability of enhanced premium subsidies. Some of those protections included eligibility verifications related to qualifying for APTC and CSR subsidies. Others focused on enrollment period policies by re-thinking when and under what conditions a consumer can enroll. We also stated that we believe the data and analysis presented in this preamble show how these protections could lower premiums and costs for consumers and taxpayers alike. Therefore, we proposed regulatory changes to improve program integrity and protect against adverse selection. We proposed this while also emphasizing the importance of keeping the enrollment process streamlined and accessible, especially for low-income consumers who utilize Exchanges for subsidized individual market coverage. These considerations helped inform our thinking as we amended our proposals into policies being finalized in this rule. Specifically, the finalized policies balance the urgent need to reduce the high level of improper and fraudulent enrollments with this desire to promote an efficient enrollment process over a longer-term.

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

In section III. of this final rule, we provide a summary of each proposed provision, a summary of the public comments received and our responses to them, and the policies we are finalizing. Below, we summarize the policies being finalized.

We are finalizing revisions to § 147.104(i) that reverse the current policy prohibiting an issuer from denying coverage due to an individual's or employer's failure to pay premiums owed for prior coverage, including by attributing payment of premium for new coverage to past-due premiums from prior coverage. The current policy, in effect, prohibits issuers from establishing premium payment policies that require enrollees to pay past-due

[10] *See* Sonia Jaffe and Mark Shepard, ''Price-Linked Subsidies and Imperfect Competition in Health Insurance,'' *American Economic Journal: Economic Policy,* Vol 12, No. 3, August 2020.

[11] While subsidized consumers are willing to tolerate higher prices than unsubsidized consumers, there are certain limits on how much prices can rise overall. The ACA's rate review provision (section 2794 of the Public Health Service Act (PHS Act)) restrains prices prospectively by placing scrutiny on proposed premium rate increases before they go into effect, which can discourage or prevent issuers from implementing unreasonable rate increases. The ACA's medical loss ratio provision (section 2718 of the PHS Act) limits prices retrospectively by requiring issuers to pay rebates to consumers if premium rates end up being excessive relative to actual medical costs.

[12] Congressional Budget Office. (2010, March 20). *Letter to Nancy Pelosi.* Congress of the U.S. Table 4, *https://www.cbo.gov/sites/default/files/111th-congress-2009-2010/costestimate/amendreconprop.pdf.*

[13] CMS. (2020, Oct. 9). *Trends in Subsidized and Unsubsidized Enrollment.* p. 11. *https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Trends-Subsidized-Unsubsidized-Enrollment-BY18-19.pdf.* Note that, in 2019, an additional 1.4 million unsubsidized people remained enrolled in grandfathered and grandmothered individual market plans that were not subject to all of the ACA's market rules. Grandmothered coverage refers to certain non-grandfathered health insurance coverage in the individual and small group market with respect to which CMS has announced it will not take enforcement action even though the coverage is out of compliance with certain specified market rules. *See* CMS. (2022, March 23). *Extended Non-Enforcement of Affordable Care Act-Compliance with Respect to Certain Policies. https://www.cms.gov/files/document/extension-limited-non-enforcement-policy-through-calendar-year-2023-and-later-benefit-years.pdf.*

[14] Public Law 117–2.

[15] Public Law 117–169.

premiums to effectuate new coverage. While we previously concluded that this prohibition would remove an unnecessary barrier and make it easier for consumers to enroll in coverage, recent enrollment data suggest people are manipulating guaranteed availability and grace periods to time enrollment in coverage to when they need health care services. Under this final rule, issuers may, to the extent permitted by applicable State law, add past-due premium amounts owed to the issuer (or owed to another issuer in the same controlled group) to the initial premium the applicant must pay to effectuate new coverage and not effectuate new coverage if the past-due and initial premium amounts are not paid in full. As this adverse selection issue was not created by the expansion of APTCs and is not related to the levels of improper enrollment brought on by them, we are finalizing this policy, which will be applicable as of the effective date of this rule and beyond. We believe this change will strengthen the risk pool and lower gross premiums.

We are finalizing modifications to the definition of ''lawfully present'' currently articulated at § 155.20 and used for the purpose of determining whether a consumer is eligible to enroll in a QHP through an Exchange or a Basic Health Program (BHP) in States that elect to operate a BHP.[16] The BHP regulations at 42 CFR 600.5 cross-reference the definition of lawfully present at 45 CFR 155.20. This change reflects the best view of the statutory requirements of the ACA by once again excluding ''Deferred Action for Childhood Arrivals'' (DACA) recipients from the definition of ''lawfully present'' that is used to determine eligibility to enroll in a QHP through an Exchange, for PTC, APTC, and CSRs, and for a BHP in States that elect to operate a BHP. We are finalizing this policy to be applicable upon the effective date of this final rule and beyond.

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

We are finalizing revisions to the failure to file and reconcile (FTR) process at § 155.305(f)(4) to reinstate the 1-year policy in PY 2026 that Exchanges must determine a tax filer ineligible for APTC if: (1) HHS notifies the Exchange that the tax filer (or their spouse if the tax filer is a married couple) received APTC for a prior year for which tax data will be utilized for verification of income, and (2) the tax filer or tax filer's spouse did not comply with the requirement to file a Federal income tax return and reconcile APTC for that year. This change will reduce the number of ineligible enrollees who continue to receive APTC in 2026 as a result of lingering improper and fraudulent enrollments resulting from the expansion of APTCs. As such, this policy will sunset on December 31, 2026 after addressing the imminent improper enrollment concerns and Exchanges would revert back to the two-year policy where Exchanges may not determine a tax filer eligible for APTC if HHS notifies the Exchanges that the tax filer (or either spouse if the tax filer is a married couple) received APTC for two consecutive years for which tax data would be utilized for verification of income, and (2) the tax filer or tax filer's spouse did not comply with the requirement to file a Federal income tax return and reconcile APTC for that year and the previous year beginning in coverage year 2027. We believe this change will reduce the number of ineligible enrollees who continue to receive APTC in 2026, which will lower APTC expenditures and protect ineligible enrollees from accumulating surprise tax liabilities while the market and enrollment rolls readjust to the absence of the subsidy expansion. Finally, we are also finalizing amendments to the notice requirement at § 155.305(f)(4)(i) and removing the notice requirement at § 155.305(f)(4)(ii) for 2026 to conform with the notice policy under the previous FTR policy, while the noticing requirements will revert back to align with the 2-year policy in 2027.

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

To further protect against consumers receiving APTC and CSR subsidies when they do not meet eligibility requirements and root out the improper and fraudulent enrollments holding over from the subsidy expansion, we are finalizing temporary policies to address immediate concerns with the verification process when there is an income inconsistency with trusted data sources. We also are finalizing for the remainder of plan year (PY) 2025 starting at the effective date of the rule and PY 2026 revisions to § 155.320(c)(3)(iii) to specify that Exchanges on the Federal platform must generate annual household income inconsistencies when a tax filer's attested projected annual household income would qualify the taxpayer as an applicable taxpayer according to 26 CFR 1.36B–2(b) and trusted data sources indicate that projected household income is under 100 percent of the FPL. Finally, we are finalizing, for the remainder of PY 2025 starting the effective date of the rule and PY 2026, the pause of § 155.320(c)(5), which pauses the exception to the standard household income inconsistency process that requires the Exchange to accept an applicant's attestation of household income and family size without verification when the Internal Revenue Service (IRS) does not have tax return data to verify household income and family size. Removing this exception will in most circumstances require Exchanges to verify household income with other trusted data sources when a tax return is unavailable and follow the alternative verification process to verify the income, which strengthens program integrity by improving the accuracy of eligibility determinations across all Exchanges. These policies directly address program integrity issues brought on by the proliferation of fully-subsidized, zero-premium benchmark plans and therefore we are finalizing them until PY 2027.

[16] Currently, Minnesota and Oregon operate a BHP. *See* their approved BHP Blueprints, available at: *https://www.medicaid.gov/basic-health-program/index.html.* New York had implemented a BHP since April 1, 2015 and suspended its implementation on April 1, 2024.

To prevent fully-subsidized enrollees from being automatically re-enrolled without taking an action to confirm their eligibility information, we are finalizing a temporary amendment to the annual eligibility redetermination regulation. We are finalizing that, when an enrollee does not submit an application for an updated eligibility determination for the future coverage year (2026) by the last day to select a plan for January 1, 2026 coverage, in accordance with the effective dates specified in § 155.410(f), and the enrollee's portion of the premium for the entire policy is zero dollars after application of APTC through the annual redetermination process, Exchanges on the Federal platform must decrease the amount of the APTC applied to the policy such that the remaining monthly premium owed by the enrollee for the entire policy equals $5 for the first month and for every following month that the enrollee does not confirm their eligibility for APTC. Consistent with § 155.310(c) and (f), enrollees automatically reenrolled with a $5 monthly premium after APTC under this policy will be able to update their Exchange application at any point to confirm eligibility for APTC that covers the entire premium, and re-confirm their plan to thereby reinstate the full amount of APTC for which the enrollee is eligible on a prospective basis. We are finalizing that the Federally-facilitated Exchanges (FFEs) and the State-based Exchanges on the Federal platform (SBE–FPs) must implement this change with annual redeterminations for benefit year 2026. We believe implementing these policies for 2026 will strengthen the program integrity of the Exchanges and protect consumers by ensuring that those fraudulently or improperly enrolled in fully-subsidized, zero-premium plans are not unknowingly enrolled in those plans for an additional year while the market readjusts to the expiration of the expanded subsidies. In the 2025 Marketplace Integrity and Affordability proposed rule, we also sought comment on a range of other options to ensure program integrity with respect to automatic re-enrollment that would provide a more meaningful incentive to confirm eligibility for APTC, as the millions estimated to currently receive improper APTC could simply pay the $5 premium while continuing to improperly receive generous subsidies on their behalf, potentially incurring significant future surprise tax liabilities in the process. As such, we sought comment on whether $5 is the appropriate premium amount for affected individuals to pay under the proposed policy. Another such option could include requiring individuals who qualify for fully-subsidized plans to re-confirm their plan and re-verify their income before they are eligible to receive APTC. Finally, we sought comment on removing the option for Exchanges to auto-re-enroll individuals who qualify for fully or partially subsidized plans, ensuring individuals affirmatively choose their plan and verify their income during the Open Enrollment Period (OEP), dramatically reducing the likelihood of improper payments of the APTC.

We are finalizing amendments to the automatic reenrollment hierarchy by removing § 155.335(j)(4), which currently allows Exchanges to move a CSR-eligible enrollee from a bronze QHP and re-enroll them into a silver QHP for an upcoming plan year, if a silver QHP is available in the same product, with the same provider network, and with a lower or equivalent net premium after the application of APTC as the bronze plan into which the enrollee would otherwise have been re-enrolled. We also clarify that State Exchanges may retain their flexibility regarding their re-enrollment hierarchies at the discretion of the Secretary of Health and Human Services (the Secretary) per § 155.335(a)(2)(iii) and that Exchanges may seek approval from the Secretary to conduct their own annual eligibility redetermination process. We believe the consumer awareness problem the current policy aimed to address is substantially less today than it was at the time we adopted a re-enrollment hierarchy allowing Exchanges on the Federal platform to switch a consumer's enrollment from a bronze to a silver plan. As a result, consumer awareness concerns no longer outweigh the negative consequences of not automatically re-enrolling consumers whose current plan is still available for the upcoming plan year without their active consent. These negative consequences include potential consumer confusion, undermining of consumer choice, and unexpected tax liabilities. We believe this policy is important to honor the decisions of consumers, regardless of the subsidy environment. Given that we did not find this policy as being substantially associated with fraudulent and improper enrollments, we are finalizing this policy, which will be effective for PY 2026 and beyond.

We are temporarily finalizing modifications to § 155.400(g) to pause paragraphs (2) and (3), which establish an option for issuers to implement a fixed-dollar and/or gross percentage-based premium payment threshold, with the following modification: the removal of the fixed-dollar and gross-premium threshold flexibilities will sunset after the completion of one new coverage year, PY 2026, on December 31, 2026. Thereafter, the FFE and SBE–FP will, and State Exchanges may, offer issuers the flexibility to implement the premium payment threshold flexibilities that were finalized in the Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2026; and Basic Health Program final rule (2026 Payment Notice) (90 FR 4424). As previously stated, we have significant program integrity concerns with the availability of fully-subsidized plans. Therefore, to preserve the integrity of the Exchanges, we believe it is important to ensure that enrollees do not remain enrolled in coverage without paying at least some of the premium owed, as there are situations where the fixed-dollar and/or gross percentage-based thresholds would have allowed an enrollee to remain enrolled in coverage for extended periods of time after payment of the binder. Because this problem is effectively an outgrowth of the subsidy expansion, we are finalizing these proposals only through PY 2026 to allow the market to readjust to the non-expanded subsidy environment.

For benefit years starting January 1, 2027, and beyond, we are finalizing a change to the annual OEP for coverage through all individual market Exchanges. Rather than specifying November 1 through December 15 as the OEP period as proposed, the final rule at § 155.410(e) provides that the OEP must begin no later than November 1 and end no later than December 31 of the calendar year preceding the benefit year of enrollment. Exchanges have flexibility to determine their specific OEP dates within these guidelines as long as the OEP length does not exceed 9 weeks per § 155.410(e)(5)(ii) and all OEP plan selections are effective on January 1 of the plan year per § 155.410(f)(4). Beginning with benefit year 2027, the dates of the OEP each year for Exchanges operating on the Federal platform will be November 1 through December 15. Non-grandfathered individual health insurance coverage offered outside of an Exchange must also align with the OEP dates in the applicable State Exchange. The length of the open enrollment period is fundamentally unrelated to subsidy levels and we have not determined it to be a major source of improper and fraudulent enrollments. Therefore, we are finalizing these

changes, which will be applicable for benefit year 2027 and beyond.

We are temporarily finalizing the removal of § 155.420(d)(16) and making conforming changes to pause the monthly SEP for qualified individuals or enrollees, or the dependents of a qualified individual or enrollee, who are eligible for APTC and whose projected household income is at or below 150 percent of the FPL through PY 2026. This policy is directly related to the availability of fully-subsidized plans, as under the subsidy expansion individuals with projected annual incomes between 100 and 150 percent of the FPL are eligible for fully-subsidized plans and the SEP. Therefore, to fully ensure that improper and fraudulent enrollments are fully exercised from this population, we are pausing the SEP for PY 2026 as the market readjusts to the lack of a subsidy expansion.

Further, based on recent evidence [17] suggesting an increase in the misuse and abuse of SEPs to gain coverage primarily in fully-subsidized plans outside of the OEP, we are finalizing temporary amendments to § 155.420(g) to enable HHS to reinstate pre-enrollment verification of eligibility of applicants for all categories of individual market SEPs. We are further finalizing temporary amendments to § 155.420(g) to require all Exchanges to conduct pre-enrollment verification of eligibility for at least 75 percent of new enrollments through SEPs. Given the primary concern with fully-subsidized plans, we are finalizing these proposals through PY 2026, to give the market the opportunity to fully shed improper enrollments resulting from the subsidy expansion.

We are finalizing amendments to § 156.115(d) to provide that an issuer of coverage subject to EHB requirements may not provide coverage for specified sex-trait modification procedures as an EHB beginning with PY 2026. In response to comments, we are also adding a definition of ''specified sex-trait modification procedure'' at § 156.400. These changes are effective for PY 2026 and beyond, as they are a furtherance of existing EHB requirements and are not associated with subsidy levels or improper enrollments.

We are finalizing updates to the premium adjustment percentage methodology to establish a premium growth measure that comprehensively reflects premium growth in all affected markets for PY 2026 and beyond. This premium growth measure is used to ensure that certain parameters change with health insurance market premiums over time, including parameters related to annual limits on cost sharing, eligibility for certain exemptions based on access to affordable premiums, and employer shared responsibility payment amounts. The premium adjustment percentage is also used as part of the calculation of the reduced annual limitation on cost sharing applicable to silver plan variations. This final policy re-adopts the premium growth measure that was in place for PY 2020 and PY 2021 and applies it to the related parameters starting with PY 2026. As such, we also are finalizing the PY 2026 maximum annual limitation on cost sharing, reduced maximum annual limitations on cost sharing, and required contribution percentage under § 155.605(d)(2) using the premium adjustment percentage methodology finalized in this rule.

Beginning in PY 2026, we are finalizing changes to the de minimis thresholds for the Actuarial Value (AV) for plans subject to EHB requirements to +2/−4 percentage points for all individual and small group market plans subject to the AV requirements under the EHB package, other than for expanded bronze plans,[18] for which we are finalizing a de minimis range of +5/−4 percentage points, as well as finalizing wider de minimis thresholds for income-based CSR plan variations. These changes are effective for PY 2026 and beyond as they are unrelated to the subsidy level set by Congress, but are rather important measures to promote affordability and choice.

II. Background

A. Legislative and Regulatory Overview

Section 2702 of the Public Health Service (PHS) Act, as added by the ACA, establishes requirements for guaranteed availability of coverage in the group and individual markets.

Section 2703 of the PHS Act, as added by the ACA, and sections 2712 (former) and 2742 of the PHS Act, as added by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), require health insurance issuers in the group and individual markets to guarantee the renewability of coverage unless an exception applies.

Section 1302 of the ACA provides for the establishment of an EHB package that includes coverage of EHBs (as defined by the Secretary), cost-sharing limits, and AV requirements. Among other things, the law directs that EHBs be equal in scope to the benefits provided under a typical employer plan, and that they cover at least the following 10 general categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Sections 1302(b)(4)(A) through (D) of the ACA establish that the Secretary must define EHB in a manner that: (1) reflects appropriate balance among the 10 categories; (2) is not designed in such a way as to discriminate based on age, disability, or expected length of life; (3) takes into account the health care needs of diverse segments of the population; and (4) does not allow denials of EHBs based on age, life expectancy, disability, degree of medical dependency, or quality of life.

To set cost-sharing limits, section 1302(c)(4) of the ACA directs the Secretary to determine an annual premium adjustment percentage, a measure of premium growth that is used to set the rate of increase for three parameters: (1) the maximum annual limitation on cost sharing (section 1302(c)(1) of the ACA); (2) the required contribution percentage used to determine whether an individual can afford minimum essential coverage (MEC) (section 5000A of the Internal Revenue Code of 1986 (the Code), as enacted by section 1501 of the ACA); and (3) the employer shared responsibility payment amounts (section 4980H of the Code, as enacted by section 1513 of the ACA).

Section 1302(d) of the ACA describes the various levels of coverage based on their AV. Consistent with section 1302(d)(2)(A) of the ACA, AV is calculated based on the provision of EHB to a standard population. Section 1302(d)(1) of the ACA requires a bronze plan to have an AV of 60 percent, a silver plan to have an AV of 70 percent, a gold plan to have an AV of 80 percent, and a platinum plan to have an AV of 90 percent. Section 1302(d)(2) of the ACA directs the Secretary to issue regulations on the calculation of AV and its application to the levels of coverage. Section 1302(d)(3) of the ACA directs

[17] This conclusion is drawn from current and historic SEP data available to the Exchanges on the Federal platform through the Monthly SEP report and is current as of January 3, 2025.

[18] Expanded bronze plans are bronze plans currently referenced in § 156.140(c) that 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 within the meaning of section 223(c)(2) of the Internal Revenue Code of 1986.

the Secretary to develop guidelines to provide for a de minimis variation in the AVs used in determining the level of coverage of a plan to account for differences in actuarial estimates.

Section 1311(c)(6)(B) of the ACA directs the Secretary to require an Exchange to provide for annual OEPs after the initial enrollment period.

Section 1311(c)(6)(C) of the ACA authorizes the Secretary to require an Exchange to provide for SEPs specified in section 9801 of the Code and other SEPs under circumstances similar to such periods under part D of title XVIII of the Act. Section 1311(c)(6)(D) of the ACA directs the Secretary to require an Exchange to provide for a monthly enrollment period for Indians, as defined by section 4 of the Indian Health Care Improvement Act.

Section 1311(c) of the ACA provides the Secretary the authority to issue regulations to establish criteria for the certification of QHPs. Section 1311(c)(1)(B) of the ACA requires among the criteria for certification that the Secretary must establish by regulation that QHPs ensure a sufficient choice of providers. Section 1311(e)(1) of the ACA grants the Exchange the authority to certify a health plan as a QHP if the health plan meets the Secretary's requirements for certification issued under section 1311(c) of the ACA, and the Exchange determines that making the plan available through the Exchange is in the interests of qualified individuals and qualified employers in the State.

Section 1312(e) of the ACA provides the Secretary with the authority to establish procedures under which a State may allow agents or brokers to (1) enroll qualified individuals and qualified employers in QHPs offered through Exchanges and (2) assist individuals in applying for APTC and CSRs for QHPs sold through an Exchange.

Sections 1312(f)(3), 1401, 1402(e), and 1412(d) of the ACA require that an individual must be either a citizen or national of the United States or an alien lawfully present in the United States to enroll in a QHP through an Exchange, to be eligible for PTC, APTC, and CSRs. Sections 1313 and 1321 of the ACA provide the Secretary with the authority to oversee the financial integrity of State Exchanges, their compliance with HHS standards, and the efficient and non-discriminatory administration of State Exchange activities. Section 1313(a)(5)(A) of the ACA directs the Secretary to provide for the efficient and non-discriminatory administration of Exchange activities and to implement any measure or procedure the Secretary determines is appropriate to reduce fraud and abuse. Section 1321 of the ACA provides for State flexibility in the operation and enforcement of Exchanges and related requirements.

Section 1321(a) of the ACA provides broad authority for the Secretary to establish standards and regulations to implement the statutory requirements related to Exchanges, QHPs and other components of title I of the ACA, including such other requirements as the HHS Secretary determines appropriate.

Section 1321(a)(1) of the ACA directs the Secretary to issue regulations that set standards for meeting the requirements of title I of the ACA with respect to, among other things, the establishment and operation of Exchanges.

Section 1331 of the ACA provides States the option to establish a BHP and provides that only ''qualified individuals'', as defined in section 1312 of the ACA, are eligible for BHP coverage. Section 1312(f)(3) of the ACA provides that if an individual is not, or is not reasonably expected to be for the entire period for which enrollment is sought, a citizen or national of the United States or an alien lawfully present in the United States, the individual shall not be treated as a qualified individual. Accordingly, persons who are not lawfully present are not eligible for BHP enrollment.

Section 1401(a) of the ACA added section 36B to the Code, which, among other things, requires that a taxpayer reconcile APTC for a year of coverage with the amount of the PTC the taxpayer is allowed for the year.

Section 1402(c) of the ACA provides for, among other things, reductions in cost sharing for essential health benefits for qualified low- and moderate-income enrollees in silver level health plans offered through the individual market Exchanges, including reduction in out-of-pocket limits.

Section 1411 of the ACA directs the Secretary to make advance determinations for the PTC with respect to income eligibility for individuals enrolling in a QHP through the individual market. Section 1411 of the ACA further specifies that the Secretary verify income with the Secretary of the Treasury based on the most recent tax return information, and then implement alternative procedures to verify income on the basis of different information to the extent that a change has occurred or for individuals who were not required to file an income tax return.

Section 1411(f)(1)(B) of the ACA directs the Secretary to establish procedures to redetermine the eligibility of individuals on a periodic basis in appropriate circumstances.

Sections 1402(f)(3), 1411(b)(3) and 1412(b)(1) of the ACA provide that data from the most recent tax return information available must be the basis for determining eligibility for APTC and CSRs to the extent such tax data is available. Section 1412(c)(2)(B) of the ACA establishes requirements on issuers with regards to an individual enrolled in a health plan receiving an APTC.

Section 1412(d) of the ACA states that nothing in the law allows Federal payments, credits, or CSRs for individuals who are not lawfully present in the United States.

Section 1413 of the ACA directs the Secretary to establish, subject to minimum requirements, a streamlined enrollment process for enrollment in QHPs and all insurance affordability programs and requires Exchanges to participate in a data matching program for the determination of eligibility on the basis of reliable, third-party data.

Section 1414 of the ACA amends section 6103 of the Code to direct the Secretary of the Treasury to disclose certain tax return information to verify and determine eligibility for APTC and CSR subsidies.

1. Guaranteed Availability and Guaranteed Renewability

In the April 8, 1997 **Federal Register** (62 FR 16894), HHS published an interim final rule relating to the HIPAA health insurance reforms that established rules applying guaranteed availability in the small group market and guaranteed renewability in the large and small group market. Also, in the April 8, 1997 **Federal Register** (62 FR 16985), HHS published an interim final rule relating to the HIPAA health insurance reforms that, among other things, established rules applying guaranteed renewability in the individual market. In the February 27, 2013 **Federal Register** (78 FR 13406) (2014 Market Rules), we published the health insurance market rules. In the May 27, 2014 **Federal Register** (79 FR 30240) (2015 Market Standards Rule), we published the final rule, ''Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond.'' In the December 22, 2016 **Federal Register** (81 FR 94058) (2018 Payment Notice), we provided additional guidance on guaranteed availability and guaranteed renewability, and in the April 18, 2017 **Federal Register** (82 FR 18346) (Market Stabilization Rule) we provided further guidance related to guaranteed availability. In the May 6, 2022 **Federal**

Register (87 FR 27208) we amended the regulations regarding guaranteed availability.

2. Deferred Action for Childhood Arrivals

HHS issued an interim final rule in the July 30, 2010 **Federal Register** (75 FR 45014) to define ''lawfully present'' for the purposes of determining eligibility for the Pre-Existing Condition Insurance Plan (PCIP) program. In the March 27, 2012 **Federal Register** (77 FR 18310) (Exchange Establishment Rule), HHS defined lawfully present for purposes of determining eligibility to enroll in a QHP through an Exchange by cross-referencing the existing PCIP definition. In the August 30, 2012 **Federal Register** (77 FR 52614), HHS adjusted the previous definition of ''lawfully present'' used for PCIP and QHP eligibility, which had considered all recipients of ''deferred action'' to be lawfully present, to add an exception that excluded DACA recipients from the definition. In the March 12, 2014 **Federal Register** (79 FR 14112), HHS established the framework for governing a BHP, which also adopted the definition of ''lawfully present'' for the purpose of determining eligibility to enroll in a BHP through a cross-reference to § 155.20. In the May 8, 2024 **Federal Register** (89 FR 39392) (DACA Rule), HHS reinterpreted ''lawfully present'' to include DACA recipients and certain other noncitizens for the purposes of determining eligibility to enroll in a QHP through an Exchange, PTC, APTC, CSRs, and to enroll in a BHP in States that elect to operate a BHP.

3. Program Integrity

We have finalized program integrity standards related to the Exchanges and premium stabilization programs in two rules: the ''Program Integrity: Exchange, SHOP, and Eligibility Appeals Rule'' published in the August 30, 2013, **Federal Register** (78 FR 54069), and the ''Program Integrity: Exchange, Premium Stabilization Programs, and Market Standards; Amendments to the HHS Notice of Benefit and Payment Parameters for 2014 Rule'' published in the October 30, 2013, **Federal Register** (78 FR 65045). We also refer readers to the 2019 Patient Protection and Affordable Care Act; Exchange Program Integrity final rule published in the December 27, 2019, **Federal Register** (84 FR 71674).

In the May 6, 2022 **Federal Register** (87 FR 27208), we finalized policies to address certain agent, broker, and web-broker practices and conduct. In the April 27, 2023 **Federal Register** (88 FR 25740) (2024 Payment Notice), we finalized allowing additional time for HHS to review evidence submitted by agents and brokers to rebut allegations pertaining to Exchange agreement suspensions or terminations. We also introduced consent and eligibility documentation requirements for agents and brokers. In the 2025 Payment Notice, issued in the April 15, 2024 **Federal Register** (89 FR 26218), we finalized that the CMS Administrator, who is a principal officer, is the entity responsible for handling requests by agents, brokers, and web-brokers for reconsideration of HHS' decision to terminate their Exchange agreement(s) for cause. We also finalized changes to §§ 155.220 and 155.221 to apply certain standards to web-brokers and Direct Enrollment (DE) entities assisting consumers and applicants across all Exchanges. In the January 15, 2025 **Federal Register** (90 FR 4424) (2026 Payment Notice), we addressed our authority to investigate and undertake compliance reviews and enforcement actions in response to misconduct or noncompliance with applicable agent, broker, and web-broker Exchange requirements or standards occurring at the insurance agency level to hold lead agents of insurance agencies accountable. We also finalized changes to § 155.220(k)(3) to reflect our authority to suspend an agent's or broker's ability to transact information with the Exchange in instances where HHS discovers circumstances that pose unacceptable risk to accuracy of Exchange eligibility determinations, Exchange operations, applicants, or enrollees, or Exchange information technology systems until the circumstances of the incident, breach, or noncompliance are remedied or sufficiently mitigated to HHS' satisfaction.

4. Premium Adjustment Percentage

In the March 11, 2014 **Federal Register** (79 FR 13744), HHS established a methodology for estimating the average per capita premium for purposes of calculating the premium adjustment percentage. Beginning with PY 2015, we calculated the premium adjustment percentage-based on the estimates and projections of average per enrollee employer-sponsored insurance premiums from the National Health Expenditure Accounts (NHEA), which are calculated by the CMS Office of the Actuary. In the April 25, 2019 **Federal Register** (84 FR 17454), HHS amended the methodology for calculating the premium adjustment percentage by estimating per capita insurance premiums as private health insurance premiums, minus premiums paid for Medigap insurance and property and casualty insurance, divided by the unrounded number of unique private health insurance enrollees, excluding all Medigap enrollees. Additionally, in response to public comments to the 2021 Payment Notice proposed rule (85 FR 7088), in the May 14, 2020 **Federal Register** (85 FR 29164), HHS stated that we will finalize payment parameters that depend on NHEA data, including the premium adjustment percentage, based on the data that are available as of the publication of the proposed rule for that plan year, even if NHEA data are updated between the proposed and final rules. In the December 15, 2020 **Federal Register** (85 FR 81097), HHS published the Grandfathered Group Health Plans and Grandfathered Group Health Insurance Coverage final rule, along with the Departments of Labor and the Treasury, that finalized using the premium adjustment percentage as one alternative in setting the parameters for permissible increases in fixed-amount cost-sharing requirements for grandfathered group health plans. In the May 5, 2021 **Federal Register** (86 FR 24140), Part 2 of the 2022 Payment Notice amended the methodology for calculating the premium adjustment percentage by reverting to using the NHEA employer-sponsored insurance (ESI) premium measure previously used for PY 2015 to PY 2019 and established that the premium adjustment percentage could be established in guidance for plan years in which the premium adjustment percentage is not methodologically changing.

5. Failure To File Taxes and Reconcile APTC

In the March 27, 2012 Exchange Establishment Rule (77 FR 18310), we required the Exchange to determine a primary taxpayer ineligible to receive APTC if HHS notifies the Exchange that the taxpayer received APTC from a prior year for which tax data would be utilized for income verification and did not file a tax return and reconcile APTC as required by implementing regulations proposed by the Department of the Treasury. In the May 23, 2012 **Federal Register** (77 FR 30377), the Department of the Treasury finalized implementing regulations to require every taxpayer receiving APTC to file an income tax return.

In the December 22, 2016 **Federal Register** (81 FR 94058) (2018 Payment Notice), we provided that Exchanges cannot determine a taxpayer ineligible for APTC due to failure to file a tax return unless the Exchanges send a direct notification to that tax filer stating

that their eligibility will be discontinued for failure to comply with the requirement to file taxes. We then revisited this notice requirement in the April 17, 2018 **Federal Register** (83 FR 16930) (2019 Payment Notice) and removed the notice requirement.

In the April 27, 2023 **Federal Register** (88 FR 25740) (2024 Payment Notice) we required Exchanges to wait to discontinue APTC until the tax filer has failed to file a tax return and reconcile their past APTC for 2 consecutive years rather than ending APTC after a single year. In the April 15, 2024 **Federal Register** (89 FR 26218) (2025 Payment Notice), we required Exchanges to send notices to tax filers for the first year in which they have been identified by the IRS as failing to reconcile APTC. In the January 15, 2025 **Federal Register** (90 FR 4424) (2026 Payment Notice), we required Exchanges to send notices to tax filers for the second year in which they have been identified by the IRS as failing to reconcile APTC.

6. Income Inconsistencies

In the April 17, 2018 **Federal Register** (83 FR 16930) (2019 Payment Notice), we revised income verification provisions in § 155.320(c)(3)(iii) to require the Exchange to generate annual household income inconsistencies in certain circumstances when a tax filer's attested projected annual household income is greater than the income amount represented by income data returned by IRS and the Social Security Administration (SSA) and current income data sources. On March 4, 2021, the United States District Court for the District of Maryland decided *City of Columbus* v. *Cochran,* 523 F. Supp. 3d 731 (D. Md. 2021) and vacated these revisions to income verification. We then implemented the court's decision in the May 5, 2021 **Federal Register** (86 FR 24140) (Part 2 of the 2022 Payment Notice) and rescinded the income verification provisions in § 155.320(c)(3)(iii) that the court invalidated.

In the March 27, 2012 **Federal Register** (77 FR 18310) (Exchange Establishment Rule), we established the alternative verification process in § 155.320(c) for situations when a household income inconsistency occurs with IRS data or when tax return data is unavailable. This process required the Exchange to provide the applicant notice of the income inconsistency and requires applicants to provide documentary evidence to verify their income or otherwise resolve the inconsistency within a period of 90 days from which notice is sent. In the April 27, 2023 **Federal Register** (88 FR 25740) (2024 Payment Notice), we revised this process to require Exchanges to accept an applicant's or enrollee's self-attestation of annual household income when a call to IRS is completed but tax return data is unavailable and add that household income inconsistencies must receive an automatic 60-day extension in addition to the 90 days provided to applicants to resolve their income inconsistency.

7. Annual Eligibility Redetermination

In the March 27, 2012 **Federal Register** (77 FR 18310) (Exchange Establishment Rule), we implemented the Affordable Insurance Exchanges (''Exchanges''), consistent with title I of the ACA. This included standards for annual eligibility redeterminations and renewals of coverage. In the January 22, 2013 **Federal Register** (78 FR 4594), we sought comment on whether the redetermination notice should describe how the enrollee's deductibles, co-pays, coinsurance, and other forms of cost sharing would change. In the July 15, 2013 **Federal Register** (78 FR 42160) (2013 Eligibility Final Rule), we amended the notice to remove the requirement to provide the data used for the eligibility redetermination and the data used for the most recent eligibility determination, even though we did not previously propose to change the annual redetermination notice. In the September 5, 2014 **Federal Register** (79 FR 52994), we amended the annual redetermination standards to allow for an Exchange to choose from one of three methods for conducting annual redeterminations. In the January 24, 2019 **Federal Register** (84 FR 227) (2020 Payment Notice proposed rule), we sought comment on the automatic re-enrollment processes to address program integrity concerns. In the February 6, 2020 **Federal Register** (85 FR 7088) (2021 Payment Notice proposed rule), we solicited comment on modifying the automatic re-enrollment process such that any enrollee who would be automatically re-enrolled with APTC that would cover the enrollee's entire premium would instead be automatically re-enrolled without APTC, and we solicited comments on a variation where APTC for this population would be reduced to a level that would result in an enrollee premium that is greater than zero dollars, but not eliminated entirely. We did not finalize any changes in the final rules.

8. Automatic Re-Enrollment Hierarchy

In the March 27, 2012 **Federal Register** (77 FR 18309) (Exchange Establishment Rule), we implemented the Exchanges, consistent with Title I of the ACA. This included implementation of components of the Exchanges and standards for annual eligibility redetermination and renewal of coverage. In the September 5, 2014 **Federal Register** (79 FR 52994) (Annual Eligibility Redeterminations Rule), we modified the standards for re-enrollment in coverage by adding a re-enrollment hierarchy to address situations when the enrollee's plan or product is not available through the Exchange for renewal. In the March 8, 2016 **Federal Register** (81 FR 12204) (2017 Payment Notice), we amended the hierarchy to give Exchanges flexibility to prioritize re-enrollment into silver plans for all enrollees in a silver-level QHP that is no longer available for re-enrollment, and re-enroll consumers into plans of other Exchange issuers if the consumer is enrolled in a plan from an issuer that does not have another plan available for re-enrollment through the Exchange.

In the January 5, 2022 **Federal Register** (87 FR 584) (2023 Payment Notice proposed rule), we solicited comments on revising the re-enrollment hierarchy at § 155.335(j) at a later date. After considering comments, we proposed and finalized amendments and additions to the re-enrollment hierarchy in the April 27, 2023 **Federal Register** (88 FR 25740) (2024 Payment Notice), including changes to allow Exchanges to direct re-enrollment for enrollees who are eligible for CSRs from a bronze QHP to a silver QHP, if certain conditions are met.

9. Premium Payment Threshold

In the December 2, 2015 **Federal Register** (80 FR 75532), we published a proposed rule to allow issuers to adopt an optional premium payment threshold policy under which issuers could collect a minimal amount of premium, less than that which is owed, without triggering the consequences for non-payment of premiums. We established the option for issuers to implement a net premium percentage-based premium payment threshold in the 2017 Payment Notice (81 FR 12271 through 12272). In the October 10, 2024 **Federal Register** (89 FR 82366 through 82369), we proposed to add additional optional premium payment threshold flexibilities, proposing an option for issuers to adopt a fixed-dollar premium threshold amount of $5 or less and/or a percentage-based threshold based on the gross premium of 99 percent or more or the existing net premium of 95 percent or more of the premium after application of APTC. We modified and finalized this proposal in the 2026

Payment Notice (90 FR 4475 through 4480), allowing issuers to adopt a fixed-dollar premium threshold amount of $10 or less and/or a percentage-based threshold based on the gross premium of 98 percent or more or net premium of 95 percent or more of the premium after application of APTC.

10. Special Enrollment Periods (SEPs)

In the July 15, 2011 **Federal Register** (76 FR 41865), we published a proposed rule establishing SEPs for the Exchange. We implemented these SEPs in the Exchange Establishment Rule (77 FR 18309). In the January 22, 2013 **Federal Register** (78 FR 4594), we published a proposed rule amending certain SEPs, including the SEPs described in § 155.420(d)(3) and (7). We finalized these rules in the July 15, 2013 **Federal Register** (78 FR 42321).

In the June 19, 2013 **Federal Register** (78 FR 37032), we proposed to add an SEP when the Federally Facilitated Exchange (FFE) determines that a consumer has been incorrectly or inappropriately enrolled in coverage due to misconduct on the part of a non-Exchange entity. We finalized this proposal in the October 30, 2013 **Federal Register** (78 FR 65095). In the March 21, 2014 **Federal Register** (79 FR 15808), we proposed to amend various SEPs. In particular, we proposed to clarify that later coverage effective dates for birth, adoption, placement for adoption, or placement for foster care would be effective the first of the month. The rule also proposed to clarify that earlier effective dates would be allowed if all issuers in an Exchange agree to effectuate coverage only on the first day of the specified month. Finally, that rule proposed adding that consumers may report a move in advance of the date of the move and established an SEP for individuals losing medically needy coverage under the Medicaid program even if the medically needy coverage is not recognized as minimum essential coverage (individuals losing medically needy coverage that is recognized as minimum essential coverage already were eligible for an SEP under the regulation). We finalized these provisions in the May 27, 2014 **Federal Register** (79 FR 30348). In the October 1, 2014 **Federal Register** (79 FR 59137), we published a correcting amendment related to codifying the coverage effective dates for plan selections made during an SEP and clarifying a consumer's ability to select a plan 60 days before and after a loss of coverage.

In the November 26, 2014 **Federal Register** (79 FR 70673), we proposed to amend effective dates for SEPs, the availability and length of SEPs, the specific types of SEPs, and the option for consumers to choose a coverage effective date of the first of the month following the birth, adoption, placement for adoption, or placement in foster care. We finalized these provisions in the February 27, 2015 **Federal Register** (80 FR 10866). In the July 7, 2015 **Federal Register** (80 FR 38653), we issued a correcting amendment to include those who become newly eligible for a QHP due to a release from incarceration. In the December 2, 2015 **Federal Register** (80 FR 75487) (2017 Payment Notice proposed rule), we sought comment and data related to existing SEPs, including data relating to the potential abuse of SEPs. In the 2017 Payment Notice, we stated that in order to review the integrity of SEPs, the FFE will conduct an assessment by collecting and reviewing documents from consumers to confirm their eligibility for the SEPs under which they enrolled.

In an interim final rule with comment published in the May 11, 2016 **Federal Register** (81 FR 29146), we made amendments to the parameters of certain SEPs (2016 Interim Final Rule). We finalized these in the 2018 Payment Notice, published in the December 22, 2016 **Federal Register** (81 FR 94058). In the April 18, 2017 Market Stabilization Rule (82 FR 18346), we amended standards relating to SEPs and announced HHS would begin pre-enrollment verifications for all categories of SEPs in June 2017. In the 2019 Payment Notice, published in the April 17, 2018 **Federal Register** (83 FR 16930), we clarified that certain exceptions to the SEPs only apply to coverage offered outside of the Exchange in the individual market. In the April 25, 2019 **Federal Register** (84 FR 17454), the final 2020 Payment Notice established a new SEP. In part 2 of the 2022 Payment Notice, in the May 5, 2021 **Federal Register** (86 FR 24140), we made additional amendments and clarifications to the parameters of certain SEPs and established new SEPs related to untimely notice of triggering events, cessation of employer contributions or government subsidies to COBRA continuation coverage, and loss of APTC eligibility. In part 3 of the 2022 Payment Notice, in the September 27, 2021 **Federal Register** (86 FR 53412), which was published by HHS and the Department of the Treasury, we established a temporary new monthly SEP for those eligible for APTC with projected household incomes at or below 150 percent of the FPL. In the May 6, 2022 **Federal Register** (87 FR 27208), we finalized updates to the requirement that all Exchanges conduct SEP verifications and limited pre-enrollment verification for Exchanges on the Federal platform to only consumers who attest to losing minimum essential coverage. In the April 27, 2023 **Federal Register** (88 FR 25740) (2024 Payment Notice), we lengthened the SEP from 60 to 90 days to those who lose Medicaid coverage. In the April 15, 2024 **Federal Register** (89 FR 26218) (2025 Payment Notice), we aligned effective dates for coverage after selecting certain SEPs across all Exchanges and removed limitations on the monthly SEP for those eligible for APTC with incomes up to 150 percent of the FPL.

11. Essential Health Benefits

We established requirements relating to EHBs in the Standards Related to Essential Health Benefits, Actuarial Value (AV), and Accreditation Final Rule, which was published in the February 25, 2013 **Federal Register** (78 FR 12834) (EHB Rule). In the EHB Rule, we included at § 156.115 a prohibition on issuers from providing routine non-pediatric dental services, routine non-pediatric eye exam services, long-term/custodial nursing home care benefits, or non-medically necessary orthodontia as EHB. In the 2019 Payment Notice, published in the April 17, 2018 **Federal Register** (83 FR 16930), we added § 156.111 to provide States with additional options from which to select an EHB-benchmark plan for PY 2020 and subsequent plan years. In the 2023 Payment Notice, published in the May 6, 2022 **Federal Register** (87 FR 27208), we revised § 156.111 to require States to notify HHS of the selection of a new EHB-benchmark plan by the first Wednesday in May of the year that is 2 years before the effective date of the new EHB-benchmark plan, otherwise the State's EHB-benchmark plan for the applicable plan year will be that State's EHB-benchmark plan applicable for the prior year. We displayed the Request for Information; Essential Health Benefits (EHB RFI), published in the December 2, 2022, **Federal Register** (87 FR 74097), to solicit public comment on a variety of topics related to the coverage of benefits in health plans subject to the EHB requirements of the ACA. In the 2025 Payment Notice (89 FR 26218), we removed the regulatory prohibition at § 156.115(d) on issuers from providing routine non-pediatric dental services as an EHB beginning with PY 2027.

In the 2026 Payment Notice, published in the January 15, 2025 **Federal Register** (90 FR 4424), we revised § 156.80(d)(2)(i) to require the

actuarially justified plan-specific factors by which an issuer may vary premium rates for a particular plan from its market-wide index rate include the AV and cost-sharing design of the plan, including, if permitted by the applicable State authority, accounting for CSR amounts provided to eligible enrollees under § 156.410, provided the issuer does not otherwise receive reimbursement for such amounts.

III. Summary of the Proposed Provisions, Public Comments, and Responses to Comments on the Proposed Rule

A. Part 147—Health Insurance Reform Requirements for the Group and Individual Health Insurance Markets

1. Limited Open Enrollment Periods (OEPs) (§ 147.104(b)(2))

As further discussed in the 2025 Marketplace Integrity and Affordability proposed rule (90 FR 12950) and section III.B.8. of this final rule regarding the proposal to remove the monthly SEP for APTC-eligible qualified individuals with a projected household income at or below 150 percent of the FPL (§ 155.420(d)(16)), we proposed a conforming amendment to remove § 147.104(b)(2)(i)(G), which currently excludes § 155.420(d)(16) as a triggering event for a limited OEP for coverage offered outside of an Exchange. We proposed to remove § 147.104(b)(2)(i)(G) to reflect the removal of the SEP at § 155.420(d)(16). We sought comment on this proposal.

After consideration of comments and for the reasons outlined in the proposed rule and section III.B.8. of this final rule, including our responses to comments, we are finalizing a pause of the SEP at § 155.420(d)(16), and therefore are temporarily finalizing the proposed conforming change to remove § 147.104(b)(2)(i)(G). We summarize and respond to public comments received on the proposed removal of the SEP at § 155.420(d)(16) in section III.B.8. of this final rule.

2. Coverage Denials for Failure To Pay Premiums for Prior Coverage (§ 147.104(i))

In the 2025 Marketplace Integrity and Affordability proposed rule (90 FR 12950 through 12953), we proposed to remove § 147.104(i) that prohibits an issuer from denying coverage due to failure of an individual or employer to pay premiums owed under prior coverage, including by attributing payment of premium for new coverage to past-due premiums from prior coverage. Similar to the policy in the Market Stabilization Rule (82 FR 18349 through 18353), we proposed to allow issuers to attribute the initial premium the enrollee pays to effectuate new coverage to past-due premium amounts owed for prior coverage and then to not effectuate new coverage if the initial premium and past-due amounts are not paid in full. Under the proposal, consistent with the Market Stabilization Rule, an issuer would be required to apply its past-due premium payment policy uniformly to all employers or individuals in similar circumstances in the applicable market regardless of health status, and consistent with applicable nondiscrimination requirements,[19] and would be prohibited from conditioning the effectuation of new coverage on payment of past-due premiums by any individual other than the person contractually responsible for the payment of premium.

Unlike the policy in the Market Stabilization Rule (82 FR 18346), the proposal would not limit the policy to past-due premium amounts accruing over the prior 12 months or require the issuer to provide any notice of the policy. States would remain free to apply additional parameters governing issuers' premium payment policies, to the extent permitted under Federal law.

We sought comments on the proposal and specifically on whether we should leave other parameters to States or codify additional parameters to establish a more uniform Federal regulatory approach. We also sought comment on whether issuers should be required to establish terms of coverage that attribute the initial premium an enrollee pays for subsequent coverage to past-due premium amounts owed, and the associated costs for issuers to implement such a requirement.

After consideration of comments and for the reasons outlined in the proposed rule and this final rule, including our responses to comments, we are finalizing this policy with a modification by removing the regulatory text that prohibited this policy, and replacing it with regulatory text that codifies the proposed policy. Under the finalized policy, States may choose whether to allow issuers in their market and State to attribute the initial premium paid to effectuate new coverage to past-due premium amounts owed and to refuse to effectuate new coverage if the past-due and initial premium amounts are not paid in full. If an issuer does so, then under the final rule, it must apply its past-due premium payment policy uniformly to all employers or individuals in similar circumstances in the applicable market and State regardless of health status, and consistent with applicable nondiscrimination requirements, and are not permitted to condition the effectuation of new coverage on payment of past-due premiums by any individual other than the person contractually responsible for the payment of premium. We are codifying this policy by revising § 147.104(i) instead of removing § 147.104(i) as proposed. As the issue this provision is intended to resolve was not created by the expansion of APTCs that are expiring after PY 2025, this policy will not sunset. We are finalizing this policy to be applicable as of the effective date of this rule and beyond.

We summarize and respond to public comments received on the proposed policy below.

Comment: Several commenters supported the proposal, stating it would incentivize enrollees to maintain 12 months of continuous coverage, provide issuers with a tool to reduce adverse selection, reduce opportunities for enrollees to game the system by circumventing required premium payments, and allow issuers to more accurately price products. One commenter stated that the proposal would reduce premium inflation caused by gaming the rules, ultimately easing the burden on taxpayers and ensuring that ACA subsidies are better targeted.

Response: We agree that finalization of the policy contained in the proposal will help to promote continuous coverage, reduce gaming and adverse selection, ensure that ACA subsidies are targeted to those who are eligible, and allow issuers to more accurately predict costs and price plans.

Comment: Several commenters agreed with the proposal to defer to the States to determine whether issuers in their State are permitted to attribute payments for new coverage to past-due premiums and to refuse to effectuate new coverage unless both the past-due premium and the initial payment for new coverage are paid. One commenter stated that States, who maintain the closest interaction with their consumers and issuers, are best positioned to regulate issuers' premium payment policies. Another commenter acknowledged that issuers in some areas of the country are facing high fraud rates and the proposal could reduce gaming, adverse selection, and ultimately premiums by requiring payment of past-due premiums. However, the

[19] Issuers may also have obligations under other applicable Federal laws prohibiting discrimination, and issuers are responsible for ensuring compliance with all applicable laws and regulations. There may also be separate, independent nondiscrimination obligations under State law.

commenter stated that issuers in areas with little evidence of gaming would likely not want to require payment of past-due premiums to effectuate new coverage.

Response: We agree that States are in the best position to decide whether it is appropriate to permit or prohibit this policy. For that reason, we proposed, and are finalizing, the policy contained in the proposal in such a way that States may choose whether to allow issuers in their State to attribute the initial premium an enrollee pays to effectuate new coverage to past-due premium amounts the issuers are owed and to refuse to effectuate new coverage if the past-due and initial premium amounts are not paid in full.

We solicited comment in the proposed rule about whether to make the premium payment policy mandatory or optional. Comments in response to that solicitation are discussed below.

Comment: Many commenters, some of whom supported and some of whom opposed the proposal, stated that if the proposal is adopted, there should be parameters around how issuers implement the policy. For example, commenters suggested the final rule should prohibit issuers that apply the past-due premium policy from collecting past-due premiums for debts older than 12 months; provide advance notice of their past-due premium policy; accept installment payments; take into account the individual's payment history; prohibit charging interest; set limits on amounts owed; allow enrollment after partial repayment; create exemptions for low-income individuals, those experiencing hardship, or those whose failure to pay was not their fault or whose enrollment was due to fraud; prohibit an issuer from insisting on payment of past-due premiums for other lines of insurance; and require issuers to allow consumers to appeal the amount of past-due premiums owed and to effectuate coverage pending appeal.

Response: Under this final rule, an issuer adopting the past-due premium policy must apply it uniformly to all employers or individuals in similar circumstances in the applicable market and State regardless of health status, and consistent with applicable nondiscrimination requirements, is not permitted to condition the effectuation of new coverage on payment of past-due premiums by any individual other than the person contractually responsible for the payment of premium, and the amount required to be paid must be subject to any premium payment threshold the issuer has adopted pursuant to 45 CFR 155.400(g). We are codifying these minimum standards in the regulation and defer to States on any additional parameters or standards that issuers must satisfy when implementing the past-due premium policy, as States are best positioned to set and oversee parameters of this nature. States that permit issuers to adopt the past-due premium policy are encouraged to require such issuers to provide advance notice of the policy to applicants. We will consider addressing acceptable past-due premium payment policies in future guidance.

Comment: One commenter noted that, based on the analysis of Exchange data in the 2026 Payment Notice, over 10 percent of enrollees, or about 180,000 consumers, were terminated for non-payments in which the amount owed was less than or equal to $10 and stated that HHS should carefully balance the goals of securing program integrity with achieving operational efficiency.

Response: While the debt owed by some individuals might be relatively small, all individuals who enroll for coverage, including those who benefit from APTC, are required to pay their share of the premium for every month of coverage. In addition, issuers of individual or small group market coverage subject to section 2701 of the PHS Act are not permitted to forgive debt owed for past-due premiums, and allowing issuers to attribute payment for new coverage to past-due premiums may create operational efficiencies for issuers in how they collect payment for such debts. We note that States and issuers have flexibility with regard to the past-due premium policy under this final rule. This includes the flexibility to decide that the policy will not apply with respect to de minimis amounts owed consistent with 45 CFR 155.400(g), as long as an issuer's past-due premium payment policy applies uniformly to all employers or individuals in similar circumstances in the applicable market and State regardless of health status and consistent with applicable nondiscrimination requirements.

Comment: One commenter stated that the best way to address the problem of people waiting to get sick before getting coverage is for the individual shared responsibility payment to be a positive dollar amount. According to the commenter, requiring individuals to make such a payment if they do not have minimum essential coverage would provide an incentive to pay premiums to maintain continuous coverage.

Response: In 2017, the Tax Cuts and Jobs Act [20] set the amount of the individual shared responsibility payment to zero dollars, effective 2019, for non-exempt individuals who do not maintain minimum essential coverage. Statutory changes would be needed to change that amount.

Comment: One commenter asserted that once coverage is terminated, the enrollee would be responsible for paying his or her own medical bills. Therefore, according to the commenter, if enrollees are required to pay for any outstanding premiums for any plan year, they are likely paying for coverage from which they will not benefit. By contrast, another commenter expressed concerns that individuals could owe a large bill because they followed instructions to stop paying premiums in order to terminate coverage. One commenter stated that if the proposal is adopted, issuers should be required to effectuate new coverage without requiring payment of past-due premiums if no claims were made during the period of delinquency.

Response: For any period of time after coverage is terminated, no premium would be due. Therefore, ''past-due premiums'' under this final rule refers to premiums due but not paid for periods during which the individual was covered, such as during a grace period. During such a coverage period, individuals have the benefit of financial protection from unforeseen medical expenses, even if they do not ultimately receive covered benefits. However, the grace period rules function in a manner that allows enrollees to avoid paying their premium while maintaining that financial protection for a short period of time. The policy finalized in this rule provides issuers with an additional tool to collect payments owed for months of coverage, regardless of whether the individual incurs medical expenses during the period for which they owe premiums.

Because applying the past-due premium policy with regard to claims history would discriminate based on health status, we do not adopt the commenter's suggestion to require issuers that adopt the past-due premium policy to create exceptions for instances in which no claims are incurred during the period in which past-due premiums are owed. These practices are not permitted under this final rule.

Comment: One commenter asked how the policy related to past-due premiums would impact claims payment.

Response: If an individual pays past-due premiums for months during which

[20] Public Law 115–97.

the individual was covered, the issuer must pay any unpaid claims incurred during such month. For example, if an individual seeks to enroll in new coverage while in the 3-month grace period and pays past-due premiums owed for prior coverage, any claims that a QHP issuer pended for services rendered to the enrollee in the second and third months of the grace period, as permitted under § 156.270(d)(1), must be paid in accordance with the terms of the coverage.[21]

Comment: One commenter asked how the policy would impact enrollment in new coverage.

Response: Under the past-due premium policy in this final rule, an issuer, to the extent permitted by applicable State law, may attribute a payment for new coverage to past-due premiums for prior coverage. The issuer then could lawfully refuse to effectuate new coverage unless the individual or employer, as applicable, pays any past-due premium amounts owed for prior coverage and the initial premium (also known as a binder payment) for new coverage by the applicable payment deadline. For example, if an individual applies for coverage during the individual market open enrollment period and owes 1 month of premiums in the amount of $10, and the individual fails to pay past-due premiums of $10 and the binder payment for new coverage by the applicable premium payment deadline, the issuer could refuse to effectuate the individual's enrollment in coverage, subject to any premium payment threshold the issuer has adopted pursuant to 45 CFR 155.400(g). Following the open enrollment period, the individual could enroll in coverage for that benefit year only through a special enrollment period and may be required to satisfy any past-due premium obligations at that time.

Comment: Many commenters, while acknowledging incentives for individuals not to pay premiums and enroll in coverage only when medical needs arise, asserted that the guardrails in place, such as short grace periods and requirements to retroactively pay medical expenses, limit these incentives.

Response: We believe that those who seek to circumvent paying premiums have already weighed their personal health and financial risks of doing so. Therefore, we believe that existing guardrails, such as the prospect of having to pay medical expenses not covered by insurance, are not sufficient to discourage individuals from taking advantage of grace period and guaranteed availability rules.

Comment: One commenter asserted that those who are unable to effectuate enrollment due to unpaid premiums may end up in other forms of ''non-ACA compliant'' coverage, such as short-term, limited-duration insurance, leading to market distortions and further driving up health insurance premiums in the individual market risk pool. In addition, since these types of plans do not have to cover essential health benefits, the commenter observed that increased reliance on such plans would lead to more uncompensated care, putting hospitals and emergency departments at significant risk of financial instability.

Response: We agree that individuals with unpaid past-due premiums might seek other types of coverage (for example, in markets where the types of coverage described by the commenter are more prevalent). However, in other markets, that might not be the case. This is why we defer to the States, who know their markets best, to determine whether issuers in their State are permitted to adopt the past-due payment policy set forth in this final rule.

Comment: One commenter supporting the policy related to past-due premiums stated that, in deferring to States on parameters for applying the policy uniformly and consistently, HHS should ensure States are not requiring issuers to apply the past-due premium policy, but rather allowing for the option to do so, consistent with the intent of the proposal. Some commenters commented on the applicability of the policy for issuers offering coverage through State Exchanges. One commenter asked that State Exchanges be permitted, but not required, to implement the policy. One commenter said that some State Exchanges perform premium collection, making the requirement administratively challenging for issuers that do not have premium collection capabilities, and another commenter noted that implementing a past-due premium policy would require significant configuration of the Exchange's system.

Response: This final rule removes the Federal prohibition on attributing payments for new coverage to past-due premiums owed for prior coverage and leaves it to States to determine whether to permit the practice, and if permitted, any restrictions on the practice. States are permitted, but not required, to allow issuers participating in their State Exchanges to implement a past-due premium policy. We recognize that some Exchanges may not have the functionality in place to allow QHP issuers to apply the past-due premium policy to coverage purchased through that State's Exchange. States may take these and other considerations into account in determining whether to allow the past-due payment policy finalized in this rule.

Comment: One commenter was in favor of the proposal, so long as the issuer is the party that must deal with outstanding balances, and not the agent or broker. Other commenters were concerned that agents and brokers will be forced to spend unpaid time navigating billing issues instead of focusing on helping clients get covered.

Response: This final rule does not address which entity is responsible for collecting premiums owed, including any past-due premiums. To the extent an issuer adopts the past-due premium policy in this final rule, the party that collects the past-due premium, for example, the issuer, agent, or broker, would be determined by State law or by agreement of those parties.

Comment: A few commenters expressed concern about the effects of the proposal on the individual market risk pool, asserting that young and healthy individuals are more price-sensitive and less likely to enroll if they must pay past-due premiums. One commenter also observed that these young and healthy enrollees are far more likely to have fallen out of coverage in the first place for past non-payment of premiums.

Response: We believe that, regardless of an individual's age or health status, they potentially will be more inclined to remain in their coverage if they have to pay past-due premiums in order to effectuate new coverage. In addition, to the extent young and healthy enrollees fell out of coverage due to non-payment of premium, the extra effort to resume coverage suggests they may need coverage due to a change in their health status. A policy that keeps them continuously covered is better for them and the risk pool. Moreover, there are minimum standards that must be met to enroll regardless of the impact on the risk pool. Improving the risk pool is no

[21] Section 156.270(d) requires issuers to observe a 3-consecutive month grace period before terminating coverage for those enrollees who when failing to timely pay their premiums are receiving APTC. Section 155.430(d)(4) requires that when coverage is terminated following this grace period, the last day of enrollment in a QHP through the Exchange is the last day of the first month of the grace period. Therefore, individuals whose coverage is terminated at the conclusion of a grace period would owe at most 1 month of premiums, net of any APTC paid on their behalf to the issuer. Individuals who attempt to enroll in new coverage while in a grace period (and whose coverage has not yet been terminated) could owe up to 3 months of premium, net of any APTC paid on their behalf to the issuer.

argument to excuse non-payment of premium.

We also note that, under the premium rating rules in section 2701 of the PHS Act, young peoples' premiums are lower in most States, making it likely (particularly for unsubsidized individuals) that, to the extent they have accrued past-due premiums, the amount owed would be lower than it would be for older individuals.

Comment: Many commenters asserted that the proposal is inconsistent with the guaranteed availability requirements in section 2702 of the PHS Act. One commenter stated that the proposed policy is unconstitutional.

Response: We continue to believe that allowing issuers to require payment of past-due premiums is consistent with the guaranteed availability requirements in section 2702 of the PHS Act. In the Market Stabilization Rule (82 FR 18350 through 18351), we noted it is clear from reading the guaranteed availability provision in section 2702 of the PHS Act, together with the guaranteed renewability provision in section 2703 of the PHS Act, that an issuer's sale and continuation in force of an insurance policy is contingent upon payment of premiums. Notably, this recognizes how the guaranteed renewability requirement is not just about renewals but also includes a requirement on issuers to continue the coverage in force throughout the year. Read together, we concluded that the guaranteed availability provision is not intended to require issuers to provide coverage to applicants who have not paid for such coverage. To the extent an individual or employer makes payment in the amount required to effectuate new coverage, but the issuer lawfully credits all or part of that amount toward past-due premiums, we conclude that the consumer has not made sufficient initial payment for the new coverage. We also note that decisions regarding payment of the first month's premium (the binder payment) have traditionally been business decisions made by issuers, subject to State rules. Accordingly, as noted in the proposed rule (90 FR 12953), although we have established certain uniform standards for premium payment deadlines, we ultimately defer to issuers, subject to State rules. Thus, we conclude that refusing to effectuate coverage to an individual or employer who does not pay past-due premiums is indeed permissible under section 2702 of the PHS Act, though a State does not need to allow for it.

Finally, with respect to the commenter raising constitutional concerns, the commenter did not offer any rationale to explain why the proposal would be unconstitutional, and we have not identified any reason why it would be unconstitutional.

Comment: Many comments opposing the proposal asserted that the proposal would disproportionately harm marginalized people, such as individuals with lower economic status. One commenter asserted that the proposed rule did not provide evidence to support the statement that any past-due amounts would be ''quite small'' or ''would not impose a substantial financial burden'' and that the proposed rule made no attempt to quantify that amount in dollars, compare it to the incomes of affected individuals, rebut the findings in the 2023 Payment Notice, or address the potential for multiple years of lookback. One commenter challenged our assertion in the proposed rule that enrollment loss from the proposed changes would be ''minimal'' because a large proportion of enrollees receive APTCs and therefore would not experience financial hardship because of the proposed changes. According to the commenter, this is not accurate, because people who receive APTCs have very low incomes and lack the funds to pay multiple months of past-due premiums while also paying the premium to effectuate coverage for a new year.

Response: We anticipate that enrollment loss from requiring payment of past-due premiums would be minimal and not impose a substantial financial burden. APTCs are paid on behalf of the vast majority of individuals who enroll in coverage through the Exchanges. The APTC lowers the amount of premium that they pay out of pocket, and therefore also reduces the amount of past-due premium debt that can accrue. In addition, rules regarding grace periods and termination of coverage for individuals receiving APTC result in such individuals generally owing no more than 1 to 3 months of past-due premium amounts per year.[22] Therefore, we conclude that past-due premium amounts generally would not impose a substantial financial burden to enroll in coverage. States can also take additional steps to limit the potential for individuals to owe significant amount of past-due premium by prohibiting the policy, or limiting the lookback period, or capping the amount of past-due premium due to effectuate coverage, based on factors including the socioeconomic demographics of their populations.

Comment: Several commenters stated that this proposal would cause the uninsured population to increase, causing more medical debt, illness, and death. Some commenters also stated that the proposed rule did not provide sufficient evidence for the assertion that the proposal would cause the uninsured population to decrease and the assertion that the similar policy implemented in the Market Stabilization Rule encouraged individuals to continue to pay their premiums and stated that HHS did not provide data to show that the proposal was needed.

Response: We acknowledge there is always some uncertainty regarding the net effects of any new policy. Here, we cannot know with certainty whether the coverage gains resulting from more moderate premium trends and the promotion of continuous coverage will be higher than any coverage losses resulting from issuers requiring payment of past-due premiums to effectuate new coverage. However, given the importance of health coverage and the fact that most consumers are accustomed to paying in full for one contract before they are allowed to enter another with the same contracting party, we anticipate that any discouragement from enrollment will be minimal. When a similar policy was previously in place, the percentage of enrollees in Exchanges using the Federal platform who had their coverage terminated for non-payment of premiums dropped substantially. While there could have been other reasons for this substantial drop, it is reasonable to conclude the policy was, at least in part, a driving factor by encouraging more people to maintain continuous coverage.

Comment: One commenter observed that HHS had concluded in the 2023 Payment Notice that the past-due premium policy in the 2017 Market Stabilization Rule ''had the unintended consequence of creating barriers to health coverage that disproportionally affect low-income individuals.'' The commenter explained that the proposal to reinstate the past-due premium policy without the 12-month maximum lookback period would create even more significant barriers for low-income individuals and that HHS had not provided a reasoned explanation for its conclusion that these individuals would not be significantly impacted.

Response: In neither the proposed rule nor this final rule do we deny that the past-due premium policy as finalized in this rule will possibly have at least some negative impacts on low-income individuals. Nor does the change in policy in this final rule rely on any belief or assertion that low-income individuals will be less harmed by this policy, as compared to the policy adopted in the 2017 Market

[22] Id.

Stabilization Rule. Rather, the change in policy in this final rule is supported by the fact that data suggest that more individuals, including low-income individuals, might maintain coverage as a result of the policy in this final rule, as compared to the current policy, which prohibits the past-due premium policy. Continued enrollment suggests that individuals, including those with lower incomes, will not be harmed by the policy, as they will remain covered for any unexpected health issues. Each State, however, including those with large numbers of low-income individuals, are free to disagree, based on their specific market dynamics, and not permit issuers to adopt the policy.

Comment: Several commenters observed that if the expanded premium subsidies sunset at the end of 2025, coverage will become less affordable for a large number of individuals, thereby exacerbating the number of individuals who will not be able to pay their premiums and making the payment of past-due premiums (plus the binder payment for new coverage) that much more difficult.

Response: At the time of publication of this final rule, the expanded subsidies will sunset on December 31, 2025, under current law. States may take this sunset into account in determining whether to permit issuers to apply the past-due premium policy finalized in this rule.

Comment: In the preamble to the proposed rule (90 FR 12951 through 12952), we noted that Exchange enrollment data show a steady decline in the percent of enrollees in Exchanges using the Federal platform that had their coverage terminated for non-payment of premiums between 2017 and 2020. Based on these enrollment trends, we suggested that the past-due premium policy in the Market Stabilization Rule (82 FR 18346) may have successfully encouraged enrollees to continue paying premiums, while acknowledging limitations on our ability to draw a causal inference. One commenter took issue with this analysis, suggesting that it failed to account for the fact that overall Exchange enrollment also fell, and premiums rose significantly, during this time period—suggesting that a combination of policies led to fewer healthy enrollees retaining coverage, increasing the percentage of total enrollees who might be at risk of health events remaining in coverage, who are more likely to pay premiums throughout. The commenter stated that the proposed rule failed to account for these negative effects on this risk pool.

Response: In the preamble to the proposed rule, we stated that the decline in the rate of enrollees who had their coverage terminated from 2017 to 2020 might have occurred in part because of the interpretation of the guaranteed availability requirement in the Market Stabilization Rule. We acknowledged that due to data limitations, we were unable to directly attribute any changes in enrollment behavior in the Exchanges using the Federal platform to that interpretation. We continue to believe these data, though not conclusive, suggest that the past-due payment policy in the Market Stabilization Rule may have contributed to fewer individuals losing coverage due to non-payment of premiums. However, to the extent States do not believe this would be the case in their specific markets, they may refrain from allowing issuers in their State to adopt the past-due premium policy.

Comment: Several commenters disputed that there are large numbers of individuals who intentionally stop paying premiums in order to gain 1 month of free coverage through the coverage grace period when they know they will submit medical claims for that month, go without coverage for subsequent months when they are confident they will not need it, and then purchase new coverage. Rather, commenters stated that there are a number of legitimate reasons why individuals fail to pay premiums, such as illness, unemployment or job loss, caregiving responsibilities, a natural disaster, household changes that result in higher premiums, and not realizing that they missed a payment or payments. One commenter stated that some people intentionally stop paying their premiums because their eligibility changes—for example, they become eligible for Medicaid—without understanding the need to terminate their Exchange plan or how to terminate it. Many commenters stated that individuals often experience insurance churn with job loss or access to new coverage. This churn can confuse what plans, coverage, and support are available to them, and patients may not realize they need to terminate coverage, especially if they are not using the insurance.

Response: We acknowledge that many individuals cease paying premiums for various reasons, such as those mentioned by the commenters. In instances where an individual's household income decreases during the policy year, due to illness, job loss, or other circumstances, the individual has the opportunity to report their changed income to the Exchange and might qualify for new or additional APTC to help with their premiums. We also believe that in the overwhelming majority of cases where individuals cannot pay their premiums, the individual has the ability to contact their issuer and terminate coverage before becoming delinquent, avoiding the need to pay past-due premiums. We also note that, even where issuers adopt the past-due premium policy under this final rule, individuals may purchase coverage on a guaranteed issue basis from a different issuer (in all cases, outside the controlled group of the issuer to whom past-due premiums are owed), without having to pay past-due premiums.

Comment: A few commenters stated that denying individuals health insurance, due to not paying past-due premiums or other reasons, would be detrimental not only to those individuals, but to providers and health care systems, with effects reaching well beyond Exchange enrollees.

Response: As we stated in the proposed rule and reiterate in this final rule, we generally believe the past-due premium policy will result in more individuals retaining their coverage.

Comment: Under the proposed rule, an issuer could not condition the effectuation of new coverage on payment of past-due premiums by any individual other than the person contractually responsible for the payment of premium. One commenter asked which individual is considered the contractually responsible person for payment of premium with respect to a child-only policy and with respect to a family covered by an individual market policy.

Response: For purposes of the past-due premium policy in this final rule, the person contractually responsible for payment of premium is the policyholder. In the case of child-only coverage, the policyholder would typically be the covered child's parent or legal guardian. In the case of an individual market policy covering a family, the policyholder would not be one of the covered dependents. In the case of coverage in the group market, the policyholder is typically the employer or union, not covered employees or their dependents. This means, for example, that a dependent spouse on an individual market policy cannot be required to pay past-due premiums if that dependent spouse wishes to purchase coverage as a policyholder. Similarly, an employer's failure to pay premiums for group health insurance coverage would not result in an employee or dependent owing past-due premiums for coverage in the individual market.

Comment: Several commenters raised concerns that consumers enrolling in coverage with an issuer that applies a past-due premium policy would not be fully informed or would not fully understand the implications of such a policy, and noted potential consumer confusion, as well as financial harm if consumers incorrectly believe they have enrolled in coverage that was never effectuated.

Response: We encourage issuers to be transparent about the application of any past-due premium policy to help ensure that individuals understand how much they must pay to effectuate coverage as well as the consequences of non-payment. Issuers, as a matter of practice, instruct their agents and brokers on how to collect premiums in order to effectuate new coverage, how to determine the amount due in order to effectuate new coverage, and the payment due date. We anticipate that issuers adopting the past-due premium policy would continue to work with their agents and brokers to ensure that consumers understand what payments must be made, thus minimizing potential confusion.

Comment: One commenter asked whether the proposed rule would permit application of past-due premiums when enrollees switch to a plan offered by a different issuer.

Response: Under the proposed rule and this final rule, subject to applicable State law, an issuer may require a consumer to pay past-due premiums owed to that issuer, or owed to another issuer in the same controlled group, plus the initial (binder) payment for new coverage, before effectuating the new coverage. This reflects the fact that, to the extent an applicant makes payment in the amount required to effectuate new coverage, but the issuer lawfully credits all or part of that amount toward past-due premiums, the applicant has not made sufficient payment for new coverage. There is no mechanism, however, by which an issuer can credit amounts paid to premiums owed to an unrelated issuer. Therefore, an issuer cannot deny coverage under section 2702 of the PHS Act based on an individual's or employer's failure to pay past-due premiums owed to any issuer other than that same issuer or another issuer in the same controlled group.

Comment: Several commenters observed that the proposal to shorten the length of the OEP would give applicants for new coverage less time to figure out how to acquire the funds to pay past-due premiums.

Response: As explained in section III.B.7 of this final rule, the changes to the OEP will take effect beginning with the OEP for PY 2027. Because the proposal to shorten the OEP will not be implemented in PY 2026, enrollees and other interested parties will have sufficient time to adjust to the changes to the OEP such that they understand and are better prepared for the changes when the time period for active enrollment during OEP is shortened for PY 2027.

Comment: Several commenters asserted it would be inappropriate for an issuer to condition enrollment in new coverage on payment of past-due premiums where the non-payment resulted from actions of the issuer or third parties. The commenters gave examples in which non-payment of premiums was due to actions, inactions, or delays on the part of issuers, Exchanges, agents, and brokers, including cases of fraudulent enrollment, or lag time between when an individual reports information and when an Exchange processes and effectuates changes related to that information.

Response: In instances where an issuer or an Exchange was responsible for non-payment of premium, or incorrectly determined that an individual did not pay premium, we expect the issuer or Exchange to expediently work with the consumer to resolve the situation and enroll them in new coverage without requiring payment of past-due premiums. If there is a delay between when an individual reports changes to their income or household size and when that change is processed, we expect Exchanges to internally document that, so that there is evidence that the individual should not have been charged a higher premium during the lag time. We also note that in situations where an individual was improperly enrolled in coverage, and coverage is rescinded (that is, cancelled or discontinued retroactively to the date of enrollment), as permitted under § 147.128, the individual would not owe any past-due premiums.

Comment: Several commenters raised concerns about the potential impacts on coverage access, particularly in markets with limited competition, where there may be a limited number of issuers servicing that geographic area.

Response: We note that this policy provides States flexibility to address adverse selection based on their specific market conditions and allows for appropriate market-specific solutions that recognize the differences between competitive and less competitive regions. We believe this flexible approach strikes an appropriate balance between preserving consumer access to coverage and accounting for varying market conditions across regions.

Comment: Several commenters observed that there are other mechanisms by which issuers can attempt to collect debt in form of past-due premiums, other than by requiring past-due premiums be paid in order to effectuate new coverage.

Response: Although issuers may have other methods to collect debt, we note that other forms of debt collection, such as placing the debt into collections, can be costly and time consuming. In addition, although the past-due premium policy will facilitate issuer premium collection efforts, it is principally intended to prevent the premium debt in the first instance by ensuring that individuals pay premiums for months in which they have coverage.

Comment: One commenter raised concerns about how the past-due premium policy would interact with an individual coverage health reimbursement arrangement (ICHRA) or a qualified small employer health reimbursement arrangement (QSEHRA). Specifically, the commenter observed that the past-due premium policy could complicate the enrollment process and necessitate additional administrative procedures and costs for employers if they are unable to make an ICHRA offer because employees cannot enroll in individual health insurance coverage. The commenter suggested this could subject the employer to a possible tax penalty if the employer has no way to make another offer of affordable health coverage to their employees. The commenter recommended that employees offered an ICHRA should not be required to pay past-due premiums.

Response: The commenter does not explain why allowing issuers to attribute initial premium payments to past-due premiums would make it so that employers cannot offer ICHRAs, and we do not see a reason why that would be the case. Therefore, we do not believe it is necessary to prohibit an issuer that chooses to apply the past-due premium policy from applying the policy to individuals offered an ICHRA or have a QSEHRA.[23]

ICHRAs must have reasonable procedures for covered participants and beneficiaries to substantiate that they

[23] In the event an individual is initially enrolled in individual health insurance coverage and subsequently fails to timely pay premiums for the coverage, with the result that the individual is in a grace period, the individual is considered to be enrolled in individual health insurance coverage and the ICHRA must reimburse qualified medical expenses incurred by the individual during that time period to the extent the qualified medical expenses are otherwise covered by the ICHRA.

are enrolled in individual health insurance coverage, or enrolled in Medicare Parts A and B or Part C, for each month that they are covered under the ICHRA. ICHRAs also must require participants to forfeit the ICHRA if they are not enrolled in individual health insurance coverage or Medicare.

However, nothing prevents an employer from offering an ICHRA to employees who do not have individual health insurance coverage and reimbursement from an ICHRA for the initial payment of premiums to effectuate the coverage will often not be for the full amount owed.[24] [25] In addition, an employer's liability for the employer shared responsibility tax under section 4980H of the Code is determined with respect to whether the employer offered a plan (including an ICHRA) that meets certain requirements, not whether employees enrolled or received benefits under the plan.[26] We note that QSEHRAs are similarly prohibited from providing tax-favored reimbursements to employees for any month that the employee does not have MEC and may only be offered by small employers that are not subject to the employer shared responsibility tax.[27]

Comment: Under the proposed rule, issuers would be permitted to apply the past-due premium policy taking into account premium amounts owed to an issuer in the same controlled group. One commenter replied that this should be left to the States, while two commenters opposed allowing issuers to demand past-due premiums from an issuer in the same controlled group. One commenter recommended the final rule establish the definition of a controlled group rather than leaving the definition to the States.

Response: Consistent with the proposed rule, we are finalizing that States adopting the proposal regarding past-due premiums may determine whether to allow issuers to attribute payment for new coverage to past-due premiums owed to an issuer in the same controlled group. This is consistent with our broader objective to give States flexibility with regard to the past-due premium policy, and we believe that permitting issuers to collect past due premiums owed to other issuers in the same controlled group would be reasonable approach for States to adopt, as solvency is typically measured at the parent-company level, as opposed to the licensed-entity level. The final rule refers to the definition of controlled group in the guaranteed renewability regulations at § 147.106(d)(4), which is a group of two or more persons that is treated as a single employer under sections 52(a), 52(b), 414(m), or 414(o) of the Code. States have flexibility to adopt a narrower definition of a controlled group.

Comment: We solicited comments on whether issuers should be required to establish terms of coverage that attribute the premium the enrollee initially pays for subsequent coverage to past-due premium amounts owed to an issuer. One commenter suggested that States are better situated to set and oversee parameters of this nature. One commenter stated that *requiring* issuers to adopt the past-due premium policy could result in more adverse selection than making the policy optional. This is because, as the commenter explained, less healthy individuals would be most likely to pay past-due premiums in order to effectuate new coverage, while healthier individuals opt for alternative coverage or no coverage. The commenter stated that the impact could be larger in markets where individuals may lack both alternative options for comprehensive coverage and the funds to repay premiums. In contrast, in areas with greater competition, the commenter stated that healthy individuals who have past-due premiums may have the option to pursue coverage with other issuers, which could reduce the overall level of anti-selection relative to regions with fewer coverage options. In these regions, issuers that *choose to* collect past-due premiums may benefit from lower premiums due to reduced anti-selection and potentially a reduction in uncollectable premium amounts, which could attract more enrollees into the market relative to less competitive regions. As such, adverse selection is likely to be more limited, particularly in competitive regions, where lookback periods are shorter, or where recoupment is optional. Another commenter stated that because every issuer does not have the necessary data or technology to operationalize this change, it is important to keep this provision optional for issuers, as proposed. The commenter emphasized the importance of providing issuers and State Exchanges flexibility in how they implement the proposed policy and to continue deferring to issuers on payment and business decisions. Furthermore, according to this commenter, due to the nominal amount many enrollees owe in past-due premiums, for many issuers the implementation costs may outweigh revenue from potential collections of past-due premiums. Another commenter stated that issuers need the flexibility to set billing policies based on unique factors in their environments. Another commenter stated that States maintain the closest interaction with their consumers and issuers and are best positioned to regulate issuers' premium payment policies. One commenter stated that a mandatory approach could create significant operational burdens on issuers, particularly in managing delinquent accounts, enrollment files and billing procedures. One commenter said that one particular State's existing statutes and regulations, which include grace periods, notice, and restatement of coverage requirements, aim to balance consumer protection with a health insurance issuer's fiscal health. Therefore, the commenter asserted that a uniform Federal regulatory approach is not necessary. One commenter stated that the policy should be optional, because issuers may not be able to identify enrollees whose coverage was terminated for non-payment during the enrollment process. In addition, many commenters asserted that States should be free to either permit or prohibit the practice.

Response: We agree with commenters who stated that the final rule should not require issuers to adopt the policy related to past-due premiums. States are most familiar with their local insurance markets and are therefore best

[24] The Department of the Treasury and the IRS assisted with the consideration and response to this comment. In general, the Treasury and the IRS take the position that, in the case of an HRA, sections 105 and 106 of the Code do not permit a payment to be excluded from a taxpayer's gross income in one plan year if the reimbursed expense was incurred in a different year. This is why the IRS provided a special rule in Notice 2020–33, section IV, that allows ICHRAs to pay premiums for individual health insurance coverage prior to the beginning of the plan year (for example, the plan can pay the initial premium due in December for coverage that starts in January). However, if an issuer attributes an initial premium payment to past-due premiums from the previous year, the issuer is, in effect, applying a surcharge on the initial premium needed to effectuate new coverage that is equivalent to the past-due amount, so long as the individual was covered during the period for when the premiums are past-due and there has not been a rescission. Although the issuer might have pended some claims from the period when premiums were not being paid and those claims would be freed up as a result of the payment, that is secondary to the fact that the payment is being made for the purpose of effectuating the new coverage.

[25] An ICHRA must provide that if any individual covered by the HRA ceases to be covered by individual health insurance coverage, the HRA will not reimburse medical care expenses that are incurred by that individual after the individual health insurance coverage ceases. In addition, if the participant and all dependents covered by the participant's HRA cease to be covered by individual health insurance coverage, the participant must forfeit the HRA. Furthermore, ICHRAs are prohibited from reimbursing amounts for expenses incurred after an individual's individual health insurance coverage ceases.

[26] 26 U.S.C. 4980H.

[27] 26 U.S.C. 9831(d)(3)(B).

positioned to determine whether allowing issuers in their State and market to adopt the past-due premium policy is appropriate. We also recognize that some issuers' operations may not currently support such practices. For these reasons, should the State in which an issuer operates allow issuers to condition the effectuation of new coverage on payment of past-due premiums, the final business decision will remain at the discretion of individual issuers and what they determine is in their best interest.

Comment: With respect to the applicability date of the past-due premium policy, one commenter supported this provision applying on the effective date as proposed, stating that consumers will continue to have all the applicable protections of Federal and State law, including protection from discrimination in the application of this policy and Federal and State law grace periods. Several other commenters recommended delaying implementation to PY 2027, stating that issuers need time to make appropriate system and operational changes, and arguing that applying the policy any earlier would effectively change the terms of individuals' current coverage by affecting their ability to purchase future coverage.

Response: The past-due premium policy finalized in this final rule applies on the effective date of the final rule. We are not persuaded that a later applicability date is necessary because the final rule removes the current Federal regulatory prohibition and does not impose any new burdens on States or issuers. Nothing in this final rule requires States to permit, or issuers to implement, the past-due premium policy. Nor does the final rule prevent States or issuers from implementing the policy at a later date. We do not agree that allowing issuers to start applying the past-due premium policy on the effective date of the final rule changes the terms of an insured individual's current coverage, as insurance policies commonly include contract provisions addressing timely premium payment. Moreover, the past-due premium policy relates to an individual's or employer's ability to purchase a new contract of insurance rather than the existing contract.

Comment: One commenter urged HHS to actively monitor compliance with the past-due premium policy, should we finalize it, to protect both patients and providers.

Response: Under section 2723 of the PHS Act, States are the primary enforcers of the requirements of title XXVII of the PHS Act, including section 2702, with respect to health insurance issuers. We enforce against issuers in a State only if we determine that the State has failed to substantially enforce one or more of the requirements. Therefore, States with primary enforcement authority for section 2702 of the PHS Act will enforce the past-due premium policy in this final rule, to the extent they decide to permit it. We will enforce the policy against issuers in States where HHS is responsible for enforcement of the guaranteed availability requirements in section 2702.

B. Part 155—Exchange Establishment Standards and Other Related Standards Under the Affordable Care Act

The Marketplace Integrity and Affordability proposed rule included a number of proposed revisions to 45 CFR part 155 of title 45 of the Code of Federal Regulations that were intended to improve the integrity of the Exchanges, protect Federal funds, and protect consumers from the ill-effects of unauthorized enrollments, including surprise tax liability. We received a substantial number of comments weighing both for and against these proposals. The Department has concluded, after careful consideration of public comments, that while most of the proposals should be finalized as proposed, some proposals should not be finalized for State Exchanges, and other proposals will adopt a temporary position under which we will finalize the policies to be effective through the end of PY 2026. We address in this section policies the Department is finalizing to address acute improper and fraudulent enrollment concerns brought about by the expansion of APTC. Given the expiration of the enhanced APTC, the Department has concluded it would be reasonable to accept some risk of future improper enrollments after these policies sunset, in favor of limiting overall disruptions as the market adjusts and sheds holdover improper enrollments. The Department will finalize the following policies temporarily, requiring them to sunset at the end of PY 2026:

- Failure to File Taxes and Reconcile APTC Process; Delay of FTR Process until after 2 consecutive years of FTR removed (§ 155.305(f)(4));
- Income Verification When Data Sources Indicate Income Less Than 100 Percent of the FPL (§ 155.320(c)(3)(iii));
- Income Verification When Tax Data is Unavailable (§ 155.320(c)(5));
- Annual Eligibility Redetermination (§ 155.335)
- Premium Payment Threshold (§ 155.400);
- Monthly Special Enrollment Period for APTC-Eligible Qualified Individuals with a Projected Household Income at or Below 150 Percent of the Federal Poverty Level (§ 155.420); and
- Pre-enrollment Verification for Special Enrollment Period (§ 155.420(g)).

The Department is of the view that immediate action to codify these proposed policies in this final rule represents the best policy to swiftly stop the substantial fraud, waste, and abuse in connection with expanded subsidies for Exchange coverage. However, based on the broad range of feedback for and against these policies and the difficulty in assigning with certainty the causes of improper enrollments, we believe there could be more efficient long-term solutions to these immediate problems. We expect that after the market has purged the massive amounts of improper and fraudulent enrollments it is currently experiencing that it would be reasonable to accept the risk that some improper enrollments will come back after the policies sunset. As such, we are finalizing these provisions only through PY 2026.

The expiration of enhanced subsidies creates a level of uncertainty within the individual health insurance market regarding the expected level of enrollment and morbidity of the risk pool for PY 2026 and beyond. Moving into PY 2021, the individual market had experienced an increasing level of stability. Since then, various policy decisions introduced a high level of uncertainty by pulling back enforcement of various regulatory requirements that had previously maintained more predictable enrollment patterns. For instance, Medicaid periodic data matching regulations have not been enforced since the fall of 2020. This nonenforcement posture likely contributed to the substantial increase in enrollment experienced over the past four years. Data presented in this rule suggest this allowed millions of additional people to enroll in the individual market risk pool with subsidized coverage who are otherwise not eligible for premium subsidies. In addition, as described throughout the rule, Federal law enacted in 2021 temporarily increased the level of premium tax credit subsidies which, in particular, made fully-subsidized health plans available to people with incomes between 100 percent and 150 percent of the Federal poverty level. This law dramatically changed the market composition as improper and fraudulent enrollments soared. This temporary policy is now set to expire at the end of PY 2025 and, as such, we believe it is

imperative to take decisive action to address improper and fraudulent enrollments to help the market shed the waste, fraud, and abuse currently obscuring evaluation of the market. These actions will help the market gradually reset in the context of a renewed subsidy environment that should inherently reduce improper and fraudulent enrollments through the lack of fully-subsidized benchmark plans.

Given these dynamics, coupled with extensive public feedback, the Department has determined it would be reasonable to sunset certain policies after PY 2026 and accept some risk that improper enrollments will become more likely once the policies sunset. Regulatory sunsets can be an especially useful strategy to adapt to uncertain circumstances, like those created by the vast amount of improper and fraudulent enrollments created by the subsidy expansion, which the Department feels it must address as the subsidy expansion winds down to prevent short-term consumer pain. Once those currently improperly or fraudulently enrolled have been removed, the potential for consumer harm is significantly lessened as fully-subsidized benchmark plans will no longer exist. As such, while these policies are critical short-term tools to allow the market to readjust to the expanded subsidy expiration, it is not clear that the long-term burden associated with these policies outweighs the program integrity benefits in the absence of abuse-prone fully-subsidized plans. Accordingly, we follow the example of other Federal agencies that have codified short-term, temporary rules in response to urgent needs.[28]

We believe striking this balance will reduce improper and fraudulent enrollments in the near-term without implicating longer-term concerns over these policies, for which it is less clear that the benefits would outweigh such concerns in the absence of the high level of improper enrollments held over from the subsidy expansion. For these reasons, we are finalizing these policies for PY 2026 only, with a reversion to the previous policies for PY 2027 and beyond.

We address each of the policies we are finalizing to sunset after PY 2026 in section III. of this final rule.

1. Definitions; Deferred Action for Childhood Arrivals (§ 155.20)

Section 1312 of the ACA specifically excludes individuals who are not ''lawfully present'' from eligibility for enrollment in a QHP or for insurance affordability programs.[29] Section 36B of the Internal Revenue Code, and sections 1412 and 1402 of the ACA provide that PTC,[30] APTC,[31] and CSRs,[32] respectively, are not allowed for individuals who are not lawfully present. Section 1331 of the ACA excludes individuals who are not ''lawfully present'' from eligibility and enrollment in a BHP in States that elect to operate a BHP.[33] From 2012 through 2024, HHS long took the position that a noncitizen in the United States under the Deferred Action for Childhood Arrivals (DACA) policy was not ''lawfully present'' for purposes of determining eligibility to enroll in a QHP through an Exchange or for these insurance affordability programs.[34] However, in the DACA Rule (89 FR 39392), HHS updated the definition of ''lawfully present'' to include DACA recipients for purposes of determining eligibility to enroll in a QHP through an Exchange, to be eligible for PTC, APTC, and CSRs, and to enroll in a BHP in States that elect to operate a BHP. In the 2025 Marketplace Integrity and Affordability proposed rule (90 FR 12953 through 12955), we proposed to realign our policy with the longstanding view of the text of the ACA by updating the definition of ''lawfully present'' such that DACA recipients are no longer considered ''lawfully present'' for purposes of enrollment in a QHP through an Exchange, eligibility for PTC, APTC, and CSRs, and for BHP coverage in States that elect to operate a BHP.

On June 15, 2012, the United States Department of Homeland Security (DHS) issued a memorandum entitled ''Exercising Prosecutorial Discretion with Respect to Individuals who Came to the United States as Children'' (''DHS Memo'').[35] The DHS Memo established, for the first time, the DACA policy, and set forth three principles. First, certain individuals who were brought to the United States as children from another country and who were in the United States in violation of immigration laws were not considered to be an immigration enforcement priority. Second, with respect to these individuals, DHS officials were instructed to exercise enforcement discretion and generally defer from placing them into removal proceedings. Finally, United States Citizenship and Immigration Services (USCIS) was instructed to accept applications to determine whether these individuals were eligible for work authorization during a period of deferred action.

On August 30, 2012, HHS issued an Interim Final Rule (77 FR 52615 through 52616) that amended the definition of ''lawfully present'' at § 155.20 to conform with the law as enacted by the ACA by making clear that an individual whose case had been deferred under the DACA policy ''will not be able to enroll in coverage through the Affordable Insurance Exchanges and, therefore, will not receive coverage that could make them eligible for premium tax credits.'' The Interim Final Rule noted at that time (77 FR 52615) that ''the reasons that DHS offered for adopting the DACA process do not pertain to . . . extend[ing] health insurance subsidies under the [ACA] to these individuals.'' For that reason, HHS explained that it did not intend to ''inadvertently expand the scope of the DACA process'' (77 FR 52615).

On May 8, 2024, after notice and comment, HHS issued the DACA Rule (89 FR 39392) reversing this longstanding interpretation. In the final rule, HHS announced that it had chosen to ''reconsider'' its prior interpretation from 2012. The DACA Rule, which became effective on November 1, 2024, advanced several arguments for reversing the agency's prior interpretation.[36] Consistent with our statutory authority[37] to define ''lawfully present'' for use in determining eligibility for our programs, we are now reconsidering these arguments.

In the DACA Rule (89 FR 39392 through 39395), HHS concluded that because DHS had determined that a

[28] *See, e.g.,* Home Mortgage Disclosure (Regulation C) Final Rule, 82 FR 43088 (Sep. 13, 2017) (in response to comments that it set a reporting threshold to low, the Consumer Financial Protection Board finalized a new, temporary rule increasing the reporting threshold for only two years to allow the agency to study the issue and consider whether to initiate another rulemaking to address the appropriate level for the reporting threshold). *See also,* Securities and Exchange Commission Final Rule 202T, 69 FR 48008, 48012 (August 6, 2004) (adopting a temporary rule to facilitate the collection of data sufficient to assess the effectiveness of certain regulations concerning short sale prices on securities).

[29] 42 U.S.C. 18032(f)(3).

[30] 42 U.S.C. 18082(d); 26 U.S.C. 36B(e)(2).

[31] 42 U.S.C. 18082(d).

[32] 42 U.S.C. 18071(e).

[33] 42 U.S.C. 18051(e).

[34] *See* the definition of ''insurance affordability program'' at 45 CFR 155.300(a) and 42 CFR 435.4.

[35] Napolitano, J. (2012). *Exercising Prosecutorial Discretion with Respect to Individuals Who Came to the United States as Children.* U.S. Department of Homeland Security. *https://www.dhs.gov/xlibrary/assets/s1-exercising-prosecutorial-discretion-individuals-who-came-to-us-as-children.pdf.*

[36] On December 9, 2024, the United States District Court for the District of North Dakota issued a preliminary injunction in *Kansas* v. *United States of America* (Case No. 1:24–cv–00150) partially blocking implementation of the DACA Rule.

[37] Sec. 1411 of the ACA, 42 U.S.C. 18081(a).

DACA recipient is ''lawfully present'' for purposes of eligibility for certain Social Security benefits under 8 U.S.C. 1611(b)(2), the agency should ''align'' its position to that of DHS, even while acknowledging that we were operating under separate statutory and policy considerations. However, as demonstrated by HHS' prior policy with regard to DACA recipients (89 FR 39392 through 39395), the ''separate statutory authority and policy considerations'' did not compel HHS to ''align'' its position on DACA recipients with the position that DHS took with regard to DACA recipients' eligibility for certain Social Security benefits.

In the DACA Final Rule (89 FR 39395), HHS also posited that it saw ''no statutory mandate to distinguish between recipients of deferred action under the DACA policy and other deferred action recipients.'' The final rule noted that Federal agencies have considered deferred action recipients to be ''lawfully present'' for purposes of certain Social Security benefits since 1996.[38] However, DACA recipients, unlike other deferred action recipients, received deferred action under a large-scale presidential initiative whose purposes did not include extending ACA access to health insurance Exchanges. As HHS originally explained, it is not consistent with the reasons offered for adopting the DACA process to extend health insurance subsidies under the ACA to these individuals (77 FR 52615). This original policy reflected the better view of the appropriate intersection of DACA and the ACA.

The Fifth Circuit concluded in 2022 that ''Congress created an intricate statutory scheme for determining which classes of aliens may receive lawful presence, discretionary relief from removal, deferred action, and work authorization'' and that ''Congress's rigorous classification scheme forecloses the contrary scheme in the DACA Memorandum.'' [39] [40] In the DACA Rule, HHS acknowledged the Fifth Circuit's opinion but proceeded to consider DACA recipients ''lawfully present'' for purposes of eligibility to enroll in a QHP through an Exchange, to be eligible for PTC, APTC, CSRs, and to be eligible to enroll in a BHP in States that elect to operate a BHP because the ''rule reflects our independent statutory authority under the ACA to define 'lawfully present.' '' Upon further reconsideration and as stated in the proposed rule (90 FR 12954), we now believe HHS should not have defined ''lawfully present'' under the ACA in a way that departed from the longstanding understanding of that term with respect to DACA recipients.

To support the DACA Rule, HHS stated that the policy would increase insurance coverage, reduce delays in care, improve the ACA's risk pool, and make DACA recipients more productive members of society. However, these benefits the agency previously noted do not mean that DACA recipients should be considered to have met the ''lawfully present'' standard that Congress set in order to enroll in a QHP through an Exchange, for PTC, APTC, CSRs to be allowed for their Exchange coverage, and to enroll in a BHP in States that elect to operate a BHP. In the proposed rule (90 FR 12954), we stated that we believe the use of the term ''lawfully present'' in the ACA is best implemented by excluding DACA recipients for purposes of eligibility to enroll in a QHP through an Exchange, for PTC, APTC, CSRs to be allowed for their Exchange coverage, and to be eligible to enroll in a BHP in States that elect to operate a BHP. DHS' decision that DACA recipients are not priorities for removal does not, as DHS has acknowledged, mean that they have ''lawful status'' within the United States, nor does that DHS' decision control anything regarding ''eligibility rules'' for health-related benefits administered by ''[o]ther departments and agencies, such as HHS'' (87 FR 53211 through 53212). Therefore, in the proposed rule (90 FR 12955), we stated that we believe it was improper for HHS to have advanced a policy goal that was contrary to the ACA's statutory limitations as they had been understood since the inception of DACA. Furthermore, DHS' decision that enforcement resources should be focused on other unlawful immigrants does not compel the conclusion that taxpayer dollars should be expended to subsidize the healthcare of those unlawful immigrants, as HHS recognized in its 2012 rule. Indeed, Congress has expressed a clear immigration policy that ''aliens within the Nation's borders not depend on public resources to meet their needs'' and public benefits should ''not constitute an incentive for immigration to the United States'' (8 U.S.C. 1601(2)). While HHS acknowledged this goal in previous rulemaking (89 FR 39399), it did not explain why the understanding that it had adopted prior to the DACA Rule did not better comport with this statutory goal.

After reconsidering these arguments and as stated in the proposed rule (90 FR 12955), we believe that, with respect to DACA recipients, defining the term ''lawfully present'' as set forth in the August 30, 2012 Interim Final Rule (77 FR 52614 through 52616) better adhered to the policy considerations underlying the statutory scheme. As previously noted, HHS' statutory authority and policy considerations for defining ''lawfully present'' with regard to its programs are separate from DHS', and there is no requirement that HHS aligns its definition of ''lawfully present'' with DHS'. There is also no requirement that HHS align its treatment of DACA recipients with other recipients of deferred action, particularly given the fundamental differences between DHS' DACA policy and other policies under which DHS may grant deferred action. In the 2012 Interim Final Rule (77 FR 52614 at 52615), HHS noted that the reasons DHS offered in the DHS Memo for adopting the DACA process did not include providing access to insurance affordability programs, and that any such expansion would ''inadvertently expand the scope of the DACA process.'' Under section 42 U.S.C. 18032(f)(3), section 36B(e)(2) of the Code, 42 U.S.C. 18082(d), 42 U.S.C. 18071(e)(1)(A), and 42 U.S.C. 18051(e), enrollment in a QHP offered on an Exchange, PTC, APTC, CSRs, and enrollment in a BHP in States that elect to operate a BHP, respectively, is allowed only for individuals who are ''lawfully present'' in the United States, and the better view is that a DACA recipient does not meet that requirement and would therefore, under this rule, be ineligible for these benefits.

We sought comment on this proposal.

After consideration of comments and for the reasons outlined in the proposed rule and this final rule, including our responses to comments, we are finalizing this policy as proposed. This policy will be applicable immediately upon the effective date of this rule as it conforms regulatory policy to the best statutory reading of the ACA. We summarize and respond to public comments received on the proposed changes to the definition of ''lawfully present'' below.

[38] *See* Definition of the Term Lawfully Present in the United States for Purposes of Applying for Title II Benefits Under Section 401(b)(2) of Public Law 104–193, interim final rule (61 FR 47039).

[39] *Texas* v. *United States,* 50 F.4th 498, 526 (5th Cir. 2022).

[40] On January 17, 2025, the U.S. Court of Appeals for the Fifth Circuit issued a decision (*State of Texas, et al.* v. *U.S.A.,* et al., 23–40653) regarding DHS' final rule ''Deferred Action for Childhood Arrivals'' (87 FR 53152), which found the benefits granting provisions of the rule to be substantively unlawful, limited injunctive relief to the State of Texas, and remanded the case to the district court for further proceedings.

General Support

Comment: We received several comments in support of the proposed change to exclude DACA recipients from the definition of ''lawfully present.'' Commenters noted that including DACA recipients in the definition of ''lawfully present'' imposed additional costs on taxpayers and that reverting the definition to exclude DACA recipients would better protect taxpayers.

Response: We appreciate comments received in support of our proposal to modify the regulatory definition of ''lawfully present'' at § 155.20 in alignment with the definition set forth in the August 30, 2012 Interim Final Rule (77 FR 52614 through 52616) to exclude DACA recipients for purposes of eligibility to enroll in a QHP through an Exchange, for PTC, APTC, CSRs to be allowed for their Exchange coverage, and to be eligible to enroll in a BHP in States that elect to operate a BHP. We agree that this proposal would result in less PTC being paid out, given that DACA recipients would no longer be eligible to enroll.

Comment: Many commenters supported that the proposed rule did not propose to modify the technical and clarifying changes to the definition of ''lawfully present'' at § 155.20 that were made by the 2024 DACA rule (89 FR 39392). Commenters noted that these changes eliminated complexity in eligibility determinations and eased burden on service providers and consumers.

Response: We appreciate comments received in support of our proposal to retain these adjustments. We agree that these changes were primarily technical and clarifying in nature and that these changes simplify eligibility determinations.

General Opposition

We received several comments opposing the proposed change to the definition of ''lawfully present'' in this rule. The following is a summary of the comments we received and our responses.

Comment: The majority of commenters noted general opposition to CMS' proposal to exclude DACA recipients from the definition of ''lawfully present.'' Many commenters noted that DACA recipients are essential members of their community that contribute to the economy and that excluding DACA recipients delegitimizes their status. Many commenters stated that individuals undergo extensive vetting to obtain and maintain their DACA status and are hence ''legally present.'' Commenters also noted that DACA recipients have work authorization and pay taxes and therefore should have access to Exchange coverage. One commenter noted that the opportunity to purchase Exchange coverage is consistent with the goals of the DACA policy. Similarly, another commenter noted that giving DACA recipients access to the Marketplace does not change anything about their legal immigration status, and hence DACA recipients should be allowed to buy insurance on the Marketplace. One commenter noted that the ACA only states that the Exchange is unavailable to individuals who are not ''lawfully present'' without explicitly referencing any categories of noncitizens, and that the ACA instead ''defers to 45 CFR 155.20.''

Response: We note that individuals who are not ''lawfully present'' are ineligible for enrollment in a QHP through an Exchange and for insurance affordability programs.[41] As mentioned in the proposed rule consistent with our statutory authority[42] to define ''lawfully present'' for use in determining eligibility for our programs, we are reconsidering our prior interpretation from the 2024 DACA rule at 89 FR 39392. As noted in the 2012 DHS Memo, the DACA process was designed to provide temporary relief from removal for certain individuals on a case-by-case basis as a mechanism to preserve governmental resources for high-priority removal cases. We note that the reasons for adopting the DACA process did not pertain to health insurance affordability programs, such as access to Exchange coverage. We believe that the original interpretation of the term ''lawfully present'' better reflects the appropriate intersection of DACA and the ACA.

Comment: Some commenters noted that HHS has maintained Exchange eligibility for all other individuals with deferred action, and DACA recipients should be allowed to enroll in Exchange coverage such that eligibility standards are consistently applied to all recipients of deferred action. One commenter noted that deferred action is a long-standing administrative mechanism that predates the ACA, and that DACA recipients are therefore not unique among deferred action recipients to the extent that the policy under which they were granted deferred action was not explicitly intended to extend access to Exchange coverage. Another commenter noted that DACA recipients can be considered as having ''quasi-legal'' status, which warrants access to care. One commenter noted that HHS has no authority to independently define ''lawfully present,'' and the Congress did not intend to confer on HHS the authority to define lawful presence for immigrants.

Response: As noted in the proposed rule, DACA recipients, unlike other deferred action-recipients, received deferred action under a large-scale presidential initiative, the purpose of which did not include extending ACA access to health insurance Exchanges. We note that in prior rulemaking, the Department of Homeland Security (DHS) acknowledged that DACA has ''never conferred lawful immigration status on recipients,'' and further declined to label DACA as ''identical'' to all other forms of deferred action (87 FR 53211 through 53212). We reiterate that HHS maintains its separate and independent statutory authority to codify a regulatory definition of ''lawfully present''' for use in determining eligibility to enroll in a QHP through an Exchange, in a BHP in States that elect to operate a BHP, and eligibility for PTC, APTC, CSRs. We believe that the definition of ''lawfully present'' as set forth in the August 30, 2012 Interim Final Rule (77 FR 52614 through 52616) best adheres to the statute and is consistent with the benefits afforded by the DACA policy, which are forbearance from removal from the United States and employment authorization. We note that HHS retains separate statutory authority and policy considerations to define the term ''lawfully present'' for its programs. This authority does not compel HHS to align its definition of ''lawfully present'' with DHS, especially since the reasons DHS offered for adopting the DACA policy do not pertain to eligibility for insurance affordability programs.[43] We also note that other definitions of ''lawfully present,'' such as those by DHS, should not be used as a criterion to gauge eligibility for health insurance coverage. Therefore, extending health insurance subsidies and cost-sharing reductions to DACA recipients for Exchange coverage, or coverage through a BHP in states that elect to operate a BHP, would improperly expand the scope of the DACA process.

Legal Concerns

We received several comments that highlighted legal concerns with the proposed change to the definition of ''lawfully present'' in this rule. The

[41] 42 U.S.C. 18032(f)(3), 42 U.S.C. 18032(f)(3), 42 U.S.C. 18082(d), 42 U.S.C. 18071(e)(1)(A), 42 U.S.C. 18051(e).

[42] 42 U.S.C. 18081(a).

[43] As defined in 45 CFR 155.300(a); 42 CFR 435.4.

following is a summary of the comments we received and our responses.

Comment: Some commenters opposed the modification of the definition of ''lawfully present'' and stated that the change is inconsistent with the intent and goals of the ACA. Specifically, one commenter noted that the exclusion of DACA recipients may constitute discrimination based on national origin, which is prohibited under section 1557 of the ACA. Another commenter noted that the proposed rule did not address section 1554 of the ACA, which disallows HHS from promulgating regulations that may constitute unreasonable barriers to care or impede timely access to services. Several commenters highlighted that excluding DACA recipients from the definition of ''lawfully present'' restricts their ability to access medical care, which violates the Equal Protection Clause of the Fourteenth Amendment of U.S. Constitution. Commenters also stated that the proposed definition of ''lawfully present'' denies DACA recipients' rights under title VI of the Civil Rights Act.

Response: The Department disagrees that excluding DACA recipients from the definition of lawfully present violates sections 1554 or 1557 of the ACA, the Equal Protection Clause of the Fourteenth Amendment, or title VI of the Civil Rights Act.

Section 1557 of the ACA (42 U.S.C. 18116) prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in a health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, except where otherwise provided in title I of the ACA. Section 1557 of the ACA also prohibits discrimination on the basis of race, color, national origin, sex, age, or disability under any program or activity that is administered by an executive agency, or any entity established under title I of the ACA or its amendments. We disagree that this rule's proposal to define ''lawfully present'' for purposes of HHS programs constitutes discrimination on the basis of national origin, as DACA status may be obtained by individuals who came to the United States as children regardless of their national origin, if they meet all other DHS eligibility criteria. Additionally, as outlined in prior rulemaking (89 FR 37522), section 1557 of the ACA does not include immigration status. Similarly, this proposal does not violate section 1554 of the ACA. In *California* v. *Azar,* the Ninth Circuit held that section 1554 of the ACA is intended to ensure that HHS does not ''improperly impose regulatory burdens on doctors and patients,'' not to restrict HHS' ability to ''ensure government funds are not spent for an unauthorized purpose.'' [44]

Furthermore, we do not agree that the proposed change to the definition of ''lawfully present'' violates the Equal Protection Clause of the Fourteenth Amendment or title VI of the Civil Rights Act. The Equal Protection Clause prohibits States from denying anyone within their jurisdiction the equal protection of the laws and thus is not applicable here. Nevertheless, we note that HHS' action to modify the definition of ''lawfully present'' is consistent with the Equal Protection Clause as the Federal government has a rational basis to distinguish between DACA recipients and other categories of ''lawfully present'' noncitizens, as detailed in this section.[45] Title VI of the Civil Rights Act, 1964, likewise, is not relevant here. Title VI provides that no person shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance and reaches only acts of intentional discrimination.[46] A rule providing that DACA recipients do not qualify as lawfully present is consistent with the premise of the DACA program under which DACA recipients have no lawful immigration status, but enjoy deferred deportations given the low priority the Federal government places on their deportations. Moreover, the policy we finalize does not constitute discrimination based on any protected ground, as it does not distinguish based on a DACA recipient's particular race, color, or national origin. As we explain earlier in this preamble, lawful presence is one of many critical eligibility criteria required by the ACA. We reiterate that HHS has the authority under the ACA to facilitate the operation of its programs, including the issuance of regulations that define ''lawfully present,'' and we believe the exclusion of DACA recipients represents the best interpretation of Congressional intent.

Comment: A few commenters noted that there is ongoing litigation regarding HHS' 2024 DACA rule and that the proposed change to the definition of ''lawfully present'' is improper and attempts to prevent a judicial decision.

Response: We note that there is ongoing litigation regarding the 2024 DACA rule. In August 2024, several plaintiff States filed a lawsuit in the United States District Court for the District of North Dakota in response to the agency's 2024 DACA rule that newly included DACA recipients in the definition of ''lawfully present.'' [47] On December 9, 2024, the court issued a preliminary injunction applicable to the plaintiff States, and as a result DACA recipients are ineligible for Exchange coverage in the nineteen plaintiff States involved in the lawsuit.[48] On December 16, 2024, the preliminary injunction was appealed to the Eighth Circuit Court of Appeals. Ultimately, this rulemaking may render as moot the pending legal challenge to the DACA Rule, and the appeals court granted the Government's motion to hold the appeal in abeyance. At present, DACA recipients in all other States continue to be eligible for Exchange coverage. We disagree that it is improper to propose and finalize this change to the definition of ''lawfully present.'' We note that the resolution and timing of a final disposition for this litigation is unknown and without this proposed modification, the agency would fail to align with the better interpretation of the term ''lawfully present'' and would continue to incorrectly expend taxpayer dollars.

Impact on Health and Health Care Systems

We received many comments opposing the proposed change to the definition of ''lawfully present'' in this rule out of concern for the health and well-being of individuals, families, communities, and health care organizations. Commenters expressed concerns regarding increased costs associated with shifts from preventive care to emergency room care, a weaker individual market risk pool, and increased tax burdens on Americans with the removal of eligibility of DACA recipients under the ACA. The following is a summary of the comments we received and our responses.

Comment: Many commenters shared that increasing access to health insurance coverage and health care has positive impacts on individual and

[44] *California* v. *Azar,* 950 F.3d 1067 (9th Cir. 2020).

[45] *Toro* v. *Sec'y, U.S. Dep't of Homeland Sec.,* 707 F.3d 1224, 1230 (11th Cir. 2013)

[46] *Alexander* v. *Sandoval,* 532 U.S. 275, 280 (''Title VI itself directly reach[es] only instances of intentional discrimination.'') (internal citations and quotations omitted).

[47] *Kansas* v. *United States of America* (Case No. 1:24–cv–00150).

[48] These States are Alabama, Arkansas, Florida, Idaho, Indiana, Iowa, Kansas, Kentucky, Missouri, Montana, Nebraska, New Hampshire, North Dakota, Ohio, South Carolina, South Dakota, Tennessee, Texas, and Virginia. All States are served by Federal platform, except for Idaho, Kentucky, and Virginia, which are State Exchanges that operate their own platforms.

population health, and, conversely, that decreasing access to coverage harms individual and population health.[49] Many commenters stated that they expected the provision would result in decreased community public health and decreased well-being for DACA recipients as these individuals become uninsured, noting that leaving thousands of DACA recipients without health coverage could lead to dire health consequences in their communities.

Commenters noted that insured individuals are more likely to have a regular source of care and to receive timely and appropriate preventive care and are less likely to experience certain health complications than uninsured individuals. Nonprofit medical and advocacy organizations commented that having access to health insurance is associated with increased utilization of preventive care, and that early testing is critical to detect life threatening health conditions like lung, blood, and breast cancer, HIV/AIDS, diabetes, chronic conditions, and disabilities.[50] Commenters also noted that access to health insurance is associated with preventing maternal mortality in immigrant women.

Commenters expressed concerns that without access to health insurance, the cost to treat complex health conditions within the DACA population would be higher than if DACA recipients remained eligible for health insurance and received preventive care. Some commenters noted the disproportionate rate of uninsurance among DACA recipients is due to their prior exclusion from Exchange coverage and continued exclusion from Medicaid. Some commenters noted that taking away eligibility for DACA recipients undermines the goal of the ACA to expand access to health care services.

Response: We appreciate commenters' feedback and acknowledge that one of the broad goals of the ACA is to increase access to health insurance coverage. We also acknowledge commenters' concerns regarding the potential impacts of the changes proposed in this rule on the ability of some DACA recipients to access health care services. We note that, because DACA recipients generally have employment authorization, they may have the option to access health insurance coverage through their employer. Additionally, we note that DACA recipients remain eligible for limited Medicaid coverage for the treatment of an emergency medical condition, if they meet all other eligibility requirements for Medicaid in the state (for example, income and state residency), except for U.S. citizenship or satisfactory immigration status.

We reiterate that the ACA's broad goal of increasing access to health insurance exists within a specific statutory scheme that requires that individuals be lawfully present in order to access coverage. HHS is obligated to promulgate regulations that best effectuate the statutory guardrails of the ACA, and as previously stated, we believe that the definition of ''lawfully present'' finalized in this rule best achieves Congress's intent.

Comment: Commenters noted that decreased access to health insurance coverage and preventive care would increase the burdens on hospitals, Federally Qualified Health Centers (FQHCs), State and community programs, safety-net providers, and emergency departments which would provide more urgent and emergent care to uninsured individuals as a result. Commenters stated that visits to hospitals and emergency rooms are more costly than preventive care visits, and commenters argued that an increase in emergency services would increase the overall cost of health care.[51] Some commenters stated that an increase in emergency room visits would put undue strain on hospitals and emergency room providers who already face overcrowding. Other commenters noted that FQHCs see patients regardless of insurance status and that the removal of DACA recipients from Exchange eligibility would require FQHCs to make challenging decisions about the services they can provide.

Commenters cited that, on average, uninsured individuals generate over $1,000 in uncompensated costs annually, which the rest of the health care system absorbs.[52] In addition to the potential burdens on providers, commenters expressed concerns that DACA recipients would face undue financial hardship when they finally seek care. Commenters noted DACA recipients' fear of medical debt, which contributes to skipping needed preventive medical and dental care and difficulty finding resources to improve their mental health.[53]

Comments from providers expressed concerns about the possibility that DACA recipients may lose coverage in the middle of a treatment program or may return to the emergency room or other acute care settings after their health has deteriorated. These providers commented that these emergency services are much more expensive and less effective than if treatment had continued in the patients' primary care setting. One commenter, who is a provider, noted that epilepsy has a higher cost associated with emergency care rather than preventive care and has higher incidence in immigrant populations. Additionally, some commenters noted that DACA recipients face unique stressors that impact their acute mental health and can lead to increased vulnerability to chronic medical conditions.[54] These stressors include trauma from violence, persecution, and poverty in addition to general fear and anxiety compounded by the stress of the unknown future of the DACA program and immigration status implications.

Many commenters stated that an increase in the cost of health care, due to increased emergency room use, would mean that American taxpayers would pay even higher amounts to insurance companies to defray these increased costs. Commenters also stated that removing eligibility of DACA recipients would not deliver the economic relief needed for American families and may instead increase the financial burden on individual, American taxpayers. Other commenters noted that HHS did not provide evidence of how this proposed change would generate cost savings.

Response: We acknowledge commenters' feedback regarding the potential impact of uninsurance on DACA recipients, and that some DACA recipients may become uninsured as a result of the changes proposed in this rule. Although we are unable to quantify potential costs related to shifting care to

[49] American Hospital Association. *Report: The Importance of Health Coverage. https://www.aha.org/guidesreports/report-importance-health-coverage#:~:text=Impact%20of%20Coverage&text=Studies%20confirm%20that%20coverage%20improves,on%20individuals%2C%20families%20and%20communities.*

[50] ''Access to Primary Care.'' Office of Disease Prevention and Health Promotion, 2020, *www.odphp.health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/access-primary-care.*

[51] American Hospital Association. Report: The Importance of Health Coverage. *https://www.aha.org/guidesreports/report-importance-health-coverage#:~:text=Impact%20of%20Coverage&text=Studies%20confirm%20that%20coverage%20improves,on%20individuals%2C%20families%20and%20communities.*

[52] Kaiser Family Foundation. Key Facts About the Uninsured Population (2023). *https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/.*

[53] Center for American Progress. The Demographic and Economic Impacts of DACA Recipients: Fall 2021 Edition. (2022). *https://www.americanprogress.org/article/the-demographic-and-economic-impacts-of-daca-recipients-fall-2021-edition/.*

[54] Henderson, S.W., & Baily, C.D. Parental deportation, families, and mental health. Journal of the American Academy of Child & Adolescent Psychiatry (2013). 52(5), 451–453.

emergency settings, uncompensated care, or changes to the risk pool as a result of this provision, we expect that this proposal will result in savings in the form of reduced PTC expenditures. We refer to this rule's Regulatory Impact Assessment for further information regarding these estimates. Additionally, we believe that the concerns expressed here, such as emergency room strain or changes in coverage during a course of treatment, represent common, existing issues that healthcare providers are generally well-equipped to address. Finally, we note that these concerns do not overcome Congress's direction in the ACA that only ''lawfully present'' individuals are eligible for Exchanges coverage.

Comment: Many commenters cited concerns about how removing access to Exchange coverage for DACA recipients would impact the 300,000 U.S. citizen children who have at least one parent that is a DACA recipient.[55] These commenters noted that insurance coverage for parents is also tied to the health of their children, where children are more likely to access health insurance and health care services when their parents are insured, a phenomenon known as the ''welcome mat'' effect.[56] They noted that barriers to health insurance access for parents often increases the uninsured rate of their children who are U.S. born and U.S. citizens, but that children who have access to preventive care often have better health outcomes as adults. Commenters also noted that access to health insurance is linked to the financial stability of the family as insured parents are better equipped to support their families.[57]

Response: While we acknowledge these commenters' concerns, we note that the U.S. citizen children of DACA recipients remain eligible for QHPs through an Exchange, for PTC, APTC, and CSRs, as well as for Medicaid, CHIP, and BHP in States that elect to operate a BHP, if they meet all eligibility requirements in the state. This rule's provisions do not impact their eligibility.

Comment: Many commenters stressed the important role that DACA recipients hold in our communities and workforce, noting that during the COVID–19 pandemic nearly 203,000 DACA recipients worked at the frontlines in health care, education, and food distribution.[58] Commenters also noted that DACA recipients contribute billions of dollars in Federal and State taxes each year, paying into the ACA Exchanges that they would not be eligible for if this rule was finalized as proposed. Additionally, these commenters noted that if DACA recipients were not eligible for health insurance through the ACA, there could be a negative impact on the economy as sickness or the need for emergency care rather than preventive care would impact these frontline workers and frontline communities. Commenters also noted that studies [59] show DACA recipients may avoid seeking medical attention out of fear that doing so would impact their immigration status, and these commenters express concern that this will increase for DACA recipients when they are no longer eligible for coverage under the ACA.

Response: We disagree that these factors constitute a compelling reason to maintain a regulatory definition of ''lawful presence'' that we do not believe is consistent with the statute.

Comment: Many commenters stated that removing the eligibility of DACA recipients from Exchange coverage would negatively impact the risk pool. Commenters noted that DACA recipients are generally younger and healthier, which would benefit the risk pool, citing studies of likely eligible DACA recipient self-reporting excellent or very good health.[60] Commenters noted that the removal of DACA recipients from the Exchange risk pool would increase the overall cost of the health care system, including the cost of premiums and copays for other consumers. One State Exchange also noted that the elimination of DACA recipients from their Exchange would erode their merged market and would result in premium increases for all market segments and ultimately increasing costs for families and individuals in their State. One commenter suggested that DACA recipients who are currently enrolled in Exchange coverage should be ''grandfathered'' in to reduce the impact of individuals' exclusion on the risk pool. The same commenter noted that State Exchanges should be given the option to allow DACA recipients in their Exchanges if doing so would benefit their population.

Response: While we are unable to quantify the potential impacts of this policy on Exchange risk pools, we note that HHS is obligated to promulgate regulations that best effectuate the guardrails outlined in the ACA. HHS believes the definition of ''lawfully present'' finalized in this rule best achieves Congress' intent. Accordingly, granting State Exchanges the flexibility to cover DACA recipients if they choose is not appropriate.

Implementation Concerns and Effective Date

We received several comments that highlighted concerns with the time within which all Exchanges would be required to exclude DACA recipients from Exchange (or BHP) participation and the associated operational concerns. The following is a summary of the comments we received and our responses.

Comment: Many commenters expressed significant concerns that the proposed modification to the definition of ''lawfully present'' would be applicable upon the effective date of the rule, as a mid-year eligibility change would negatively impact consumers. Many commenters noted that due to rapid policy shifts, additional time is necessary to identify and communicate with impacted consumers. Several State Exchanges that do not use the Federal platform underscored the need for additional lead time to implement changes, including information technology (IT) system changes, modifications to business operations, and retraining staff. Commenters noted that implementing changes without additional lead time impacts system accuracy, market stability, and overall member experience. Commenters also highlighted that two State Exchanges indicated that IT system changes require lead time to ensure alignment with other State agency partners to coordinate IT release schedules. One State Exchange indicated that they utilize an integrated eligibility system which requires additional time to

[55] Center for American Progress. The Demographic and Economic Impacts of DACA Recipients: Fall 2021 Edition. (2022). *https://www.americanprogress.org/article/the-demographic-and-economic-impacts-of-daca-recipients-fall-2021-edition/.*

[56] Hudson, Julie L., and Asako S. Moriya. ''Medicaid Expansion for Adults Had Measurable ''Welcome Mat'' Effects on Their Children.'' Health Affairs, vol. 36, no. 9, Sept. 2017, pp. 1643–1651, *https://doi.org/10.1377/hlthaff.2017.0347.*

[57] Wright Burak, Elisabeth. ''Parents' and Caregivers' Health Insurance Supports Children's Healthy Development.'' Society for Research in Child Development, June 2019, *https://www.srcd.org/research/parents-and-caregivers-health-insurance-supports-childrens-healthy-development.*

[58] Nicole Svajlenka, A Demographic Profile of DACA Recipients on the Frontlines of the Coronavirus Response, Ctr. for Am. Progress (Apr. 6, 2020), *https://www.americanprogress.org/article/demographic-profile-daca-recipients-frontlines-coronavirus-response/.*

[59] National Immigration Law Center (2024, May 29). DACA Recipients' Access to Health Care: 2024 Report. Retrieved April 8, 2025, from *https://www.nilc.org/wpcontent/uploads/2024/05/NILC_DACA-Report_2024_06-27-24.pdf.*

[60] Key Facts on Deferred Action for Childhood Arrivals (DACA) (2025), *https://www.kff.org/racial-equity-and-health-policy/fact-sheet/key-facts-on-deferred-action-for-childhood-arrivals-daca/.*

coordinate a planned technical release and testing. Several commenters strongly urged HHS to delay the effective date of this provision until January 1, 2026. One commenter also noted that a mid-year eligibility change would affect assumptions that carriers make about their enrollees in a plan year.

Several commenters noted that an effective date earlier than January 1, 2026, would impact rate filing submissions by issuers. One issuer noted that the proposed effective date does not provide sufficient time for State Exchanges to accurately identify individuals, share necessary documentation with issuers, and send termination notices to consumers following termination. The same commenter noted that insufficient time may result in delayed or erroneous terminations, which may result in consumer harm and increased administrative burden for Exchanges and issuers. Two issuer commenters noted that issuers do not have information on the immigration status of enrollees and requested additional clarification on how Exchanges will terminate DACA recipients, including if the proposed change impacts current or future enrollees. One commenter suggested that HHS consider grandfathering in current DACA recipients for PY 2026 to promote continuity of care. Another commenter requested flexibility in the timeline to terminate and notify consumers for any current DACA recipient enrollees without any penalty to the consumer.

Response: We acknowledge commenters' concerns about operational challenges regarding the implementation of this provision, as well as commenters' suggestions on alternative approaches. While we understand that there are existing technical and operational constraints that impact interested parties, including issuer concerns with rate filing submissions for PY 2026, we reiterate that without the proposed modification to the definition of ''lawfully present,'' the agency would fail to align with the better interpretation of the term ''lawfully present'' and incorrectly expend taxpayer dollars. This provision will continue to be applicable on the effective date of this final rule and will apply to current and future enrollees who are DACA recipients for enrollment in a QHP offered on an Exchange and eligibility for PTC, APTC, CSRs, and enrollment in a BHP in States that elect to operate a BHP. We acknowledge concerns regarding technical and operational constraints that may hinder some State Exchanges that are not on the Federal platform from implementing this provision. We intend to provide technical assistance and educational materials targeted at State Exchanges not on the Federal platform and state agencies that operate BHPs in states that elect to operate BHPs (BHP agencies) to assist in successful implementation of this rule. We intend to begin providing such technical assistance after the publication date of this rule and in advance of its effective date. Importantly, we note that Exchanges and BHP agencies should continue to submit requests to verify an applicant's immigration status through a data match with DHS via the Hub using DHS' Systematic Alien Verification for Entitlements (SAVE) system, which allows Exchanges and BHP agencies to correctly identify enrollees who are DACA recipients. We anticipate that Exchanges and BHP agencies will be responsible for terminating coverage for any DACA recipients currently enrolled in coverage upon the effective date of the rule. Pursuant to 45 CFR 156.270(b)(1), we note that issuers must send termination notices to enrollees for all termination events, even when a termination is initiated by an Exchange. We also acknowledge the possibility of erroneous terminations as Exchanges implement this provision. If Exchanges inadvertently and erroneously disenroll eligible individuals during the course of implementing this provision, Exchanges have broad authority to take steps to reinstate coverage under 45 CFR 155.430(e)(3).

Out of Scope

Comment: Some commenters noted that DACA recipients pay taxes and contribute positively to U.S. society and requested that the Federal government create pathways for DACA recipients to obtain U.S. citizenship.

Response: We note that this rule does not address the DACA policy itself, only the eligibility of DACA recipients for coverage under an Exchange (and related eligibility for insurance affordability programs) or BHP in States that elect to operate a BHP. While these comments are related to the DACA policy broadly, they do not seek to support or change specific provisions set forth in the proposed rule, and no response is required.

Comment: A few commenters stated that they opposed declaring DACA recipients illegal and excluding DACA recipients from receiving Medicare coverage.

Response: This rule does not address the DACA policy itself, and DACA recipients are not eligible for Medicare under current law. While these comments are related to the DACA policy broadly, these topics are out of scope for this final rule, and no response is required.

After consideration of comments and for the reasons outlined in the proposed rule and this final rule, including our responses to comments, we are finalizing this policy as proposed to modify the definition of ''lawfully present'' at § 155.20 used for the purpose of determining whether a consumer is eligible to enroll in a QHP through an Exchange, to be eligible for PTC, APTC, CSRs, and to be eligible to enroll in a BHP in States that elect to operate a BHP, which excludes DACA recipients from Exchange (and from eligibility for insurance affordability programs) and BHP coverage. As previously discussed, this policy will be applicable immediately upon the effective date of this rule.

2. Standards for Termination of an Agent's, Broker's, or Web-Broker's Exchange Agreements for Cause (§ 155.220(g)(2))

As discussed in the 2025 Marketplace Integrity and Affordability proposed rule and this final rule, there have been dramatic levels of improper enrollments involving agents, brokers, and web-brokers. Examining agent, broker, and web-broker practices and taking enforcement action against noncompliant agents, brokers, and web-brokers is critical to program integrity and safeguarding consumer personally identifiable information (PII), and HHS is committed to holding noncompliant agents, brokers, and web-brokers accountable to protect Exchanges and consumers. In the 2025 Marketplace Integrity and Affordability proposed rule (90 FR 12955 and 12956), we proposed to amend § 155.220(g)(2) to improve transparency in the process for holding agents, brokers, and web-brokers accountable for compliance with applicable law, regulatory requirements, and the terms and conditions of their Exchange agreements.[61]

[61] Consistent with § 155.220(d), there are currently three Exchange agreements with CMS that extend to agents, brokers, and web-brokers assisting consumers in the FFEs and SBE–FPs: (1) the Agent Broker General Agreement for Individual Market FFEs and SBE–FPs, (2) the Agent Broker Privacy and Security Agreement for Individual Market FFEs and SBE–FPs, and (3) the Agent Broker SHOP Privacy and Security Agreement. Web-brokers assisting consumers in the FFEs and SBE–FPs are required to sign the Web-broker General Agreement, and web-brokers who are primary Enhanced Direct Enrollment (EDE) entities that assist consumers in the FFEs and SBE–FPs are required to sign the EDE Business Agreement and the Interconnection Security Agreement.

Section 1312(e) of the ACA provides that the Secretary shall establish procedures under which a State may allow agents or brokers to enroll individuals and employers in any QHPs in the individual or small group market as soon as the plan is offered through an Exchange in the State; and to assist individuals in applying for PTC and CSRs for plans sold through an Exchange. Regulations at 45 CFR 155.220 implement this statutory requirement.[62] Among other things, § 155.220 includes termination for cause standards in paragraphs (g)(1) through (3), which generally provide that if, in HHS' determination, a specific finding of noncompliance or pattern of noncompliance is sufficiently severe, HHS may terminate an agent's, broker's, or web-broker's agreements with the FFE for cause. Consistent with § 155.220(l), the termination for cause standards apply to agents, brokers, and web-brokers participating in SBE–FPs. Paragraph (h) sets forth procedures for subsequent review (that is, ''reconsideration'') of the termination action.

We proposed to improve transparency in the process for holding agents, brokers, and web-brokers accountable for noncompliance with applicable law, regulatory requirements, and the terms and condition of their Exchange agreements. Specifically, we proposed to add text to § 155.220(g)(2) stating that HHS would apply a ''preponderance of the evidence'' standard of proof with respect to issues of fact to assess potential noncompliance under § 155.220(g)(1) and make a determination there was a specific finding or pattern of noncompliance that is sufficiently severe. We proposed at § 155.20 to capture a new definition, similar to definitions adopted by other HHS agencies and offices,[63] which would state that ''preponderance of the evidence'' means proof by evidence that, compared with evidence opposing it, leads to the conclusion that the fact at issue is more likely true than not.[64]

In proposing the preponderance of the evidence standard, we considered the severity of the potential consequences involved in our termination for cause framework in § 155.220(g)(1) through (3),[65] and how evidentiary standards have traditionally been used in court cases. Federal administrative and civil cases generally use a preponderance of the evidence standard, while criminal cases, in order to sustain a conviction, demand the highest standard, guilt ''beyond a reasonable doubt,'' under which evidence must be so strong that there is no reasonable doubt about a defendant's guilt.[66] Between those two evidentiary standards are the ''clear and convincing evidence'' standard, under which a trier of fact must have an abiding conviction that the truth of the factual contention is ''highly probable,'' [67] and the ''substantial evidence'' standard, which means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion.[68]

As stated in the proposed rule (90 FR 12956), HHS is of the view that the preponderance of the evidence standard is appropriate in our termination for cause framework under § 155.220(g)(1) through (3) because it is the standard used in most Federal civil cases and administrative proceedings. However, we stated in the proposed rule that we also appreciate that the termination of an agent's, broker's, or web-broker's Exchange agreements may affect their State licensure, given that we inform State insurance oversight agencies of these enforcement actions.[69] In addition, after the applicable period in § 155.220(g)(3) elapses and the Exchange agreement(s) under § 155.220(d) are terminated, the agent, broker, or web-broker will no longer be permitted to assist with or facilitate enrollment of a qualified individual in coverage in a manner that constitutes coverage through an FFE or SBE–FP, or be permitted to assist individuals in applying for APTC and CSRs for QHPs offered through an FFE or SBE–FP.[70] Once an agent's, broker's, or web-broker's Exchange agreements are terminated, they are unable to assist with applying for or enrolling in QHPs offered through the Exchange in any of the more than 30 States served by Exchanges on the Federal platform. Given these potential consequences, we sought comment not only on the proposal to use a ''preponderance of evidence'' standard of proof in assessing potential noncompliance under § 155.220(g)(1), but also whether a different standard would be more appropriate to make a determination there was a specific finding or pattern of noncompliance by agents, brokers, and web-brokers that is sufficiently severe. We also sought comment on our proposed definition for this new ''preponderance of evidence'' standard.

In addition, we stated in the proposed rule (90 FR 12956) that we intend to provide greater specificity and precision in the Exchange agreements for PY 2026 and beyond regarding impermissible conduct by agents, brokers, and web-brokers, and to address the requirements for ensuring agents, brokers, and web-brokers have obtained and documented receipt of consumer consent to collect their personally identifiable information and help them apply for and/or enroll in QHP coverage offered through the applicable FFE or SBE–FP. These changes will provide additional, clear guidance to agents, brokers, and web-brokers, as well as additional information on how HHS will address compliance failures. In the proposed rule, we solicited comment on what should be addressed in the Exchange agreements for PY 2026 and beyond, States' oversight practices, guidance for obtaining and documenting consumer consent, how to protect consumers from improper enrollments, and oversight enhancement for agents, brokers, and web-brokers.

After consideration of comments and for the reasons outlined in the proposed rule and in our responses to comments later in this section of this final rule, we are finalizing this provision as proposed. These provisions are important consumer protections that address longstanding concerns with enforcement against noncompliant agents, brokers, and web-brokers. As these concerns exist regardless of the subsidy levels set by Congress, we are finalizing these provisions to be

[62] *See also* §§ 155.221 and 155.222.

[63] *See* 42 CFR 93.228 (preponderance of the evidence means ''proof by evidence that, compared with evidence opposing it, leads to the conclusion that the fact at issue is more likely true than not''); 45 CFR 412.001 (''Preponderance of the evidence means proof, after assessing the totality of available information, that leads to the conclusion that the fact at issue is more probably true than not.''); and 45 CFR 1641.2 (''Preponderance of the evidence means proof by information that, compared with that opposing it, leads to the conclusion that the fact at issue is more probably true than not.'').

[64] *See also INS* v. *Cardoza-Fonseca,* 480 U.S. 421 (1987) (defining ''more likely than not'' as a greater than 50 percent probability of something occurring).

[65] HHS acknowledged in the proposed rule that there are additional enforcement actions under 45 CFR 155.220(g) that are not addressed by this proposal (90 FR 12955 through 12956). We noted in the proposed rule that we are considering future rulemaking to implement additional regulation changes to the frameworks for those actions that may further strengthen our oversight and the integrity of the program.

[66] *See* Maurice, R.; updated by Barrett, S. (2024, Oct. 31). *Legal Standards of Proof.* Nolo. *https://www.nolo.com/legal-encyclopedia/legal-standards-proof.html* (from lowest to highest standard: preponderance of the evidence, substantial evidence, clear and convincing evidence, and beyond a reasonable doubt). *See* Maurice, R., & Barrett, S. (2024, October 31). Legal standards of proof: You've probably heard that prosecutors have to prove criminal charges ''beyond a reasonable doubt.'' But do you know about the other legal standards of proof? NOLO. *https://www.nolo.com/legal-encyclopedia/legal-standards-proof.html.*

[67] Ibid. (citing *Colorado* v. *New Mexico,* 467 U.S. 310 at 316 (1984)).

[68] *See Reed* v. *Sec. of Health and Human Serv.,* 804 F. Supp. 914 at 918 (E.D. Mich. 1992).

[69] *See* § 155.220(g)(6).

[70] *See* § 155.220(g)(4) and (l).

applicable as of the effective date of this rule and beyond. We summarize and respond to public comments received on the use of a ''preponderance of the evidence'' standard when taking enforcement actions for agent, broker, and web-broker noncompliance under § 155.220(g)(1) through (3) later in this section, as well as on our proposed definition of ''preponderance of the evidence'' in § 155.20.

Comment: Numerous commenters stated that adopting the ''preponderance of the evidence'' standard will create a fair, uniform, and universal standard for assessing noncompliance by agents, brokers, and web-brokers assisting consumers with enrollment through the FFEs and SBE–FPs, while adding greater transparency to the enforcement process under § 155.220(g)(1) through (3).

Response: We appreciate commenters' support and agree that holding all compliant agents, brokers, and web-brokers to this same evidentiary standard supports fairness and uniformity in agent, broker, and web-broker enforcement actions under § 155.220(g)(1) through (3). We also agree that, as we explained in the proposed rule (90 FR 12944, 12955), adoption of the ''preponderance of the evidence'' standard will improve transparency in the process for holding agents, brokers, and web-brokers accountable for noncompliance with applicable law, regulatory requirements, and the terms and conditions of their Exchange agreements.

Comment: We received several comments expressing that adopting the ''preponderance of the evidence'' standard will enhance agent, broker, and web-broker accountability and build on past protections added in previous years, leading, ultimately, to greater consumer protection.

Response: We agree with the commenters that utilizing the ''preponderance of the evidence'' standard in agent, broker, and web-broker enforcement actions under § 155.220(g)(1) through (3) enhances agent, broker, and web-broker accountability and builds on protections added in previous years, including our agent, broker, and web-broker policies finalized in the 2026 Payment Notice (90 FR 4431 through 4432): to hold lead agents at insurance agencies responsible for agency-level misconduct and noncompliance and expand our authority to suspend an agent or broker's ability to transact information with the FFEs and SBE–FPs if we discover circumstances that pose an unacceptable risk to the accuracy of FFE or SBE–FP eligibility determinations, operations, applicants, or enrollees under § 155.220(k)(3). In particular, using this evidentiary standard will ensure that when an agent, broker, or web-broker is subject to enforcement action under § 155.220(g)(3)(i), CMS will generally terminate their Exchange agreements unless the evidence they submit to resolve the matter to CMS' satisfaction consists of proof that, compared with the evidence supporting CMS' determination of a specific finding or pattern of noncompliance that is sufficiently severe, leads to the conclusion that the agent, broker, or web-broker was more likely than not compliant with applicable law, regulatory requirements, and the terms and condition of their Exchange agreements. This will help ensure that agents, brokers, and web-brokers are held accountable for noncompliance with applicable law, regulatory requirements, and the terms and condition of their Exchange agreements and will help ultimately prevent agents, brokers, and web-brokers who are noncompliant from assisting consumers with enrollment in coverage through the FFEs and SBE–FPs.

Comment: We received several comments expressing that adopting the ''preponderance of the evidence'' standard is appropriate because it is the standard used in civil cases at the Federal level.

Response: We agree with commenters and appreciate their support. As we explained in the proposed rule (90 FR 12942) and previously in this final rule, we have determined the preponderance of the evidence standard is appropriate for use in our termination for cause standards framework under § 155.220(g)(1) through (3) because it is the standard used in most Federal civil cases and administrative proceedings.

Comment: We received one comment in favor of the ''preponderance of the evidence'' standard stating that compliant agents, brokers, and web-brokers will benefit from our use of the standard and asking HHS to also pair the new standard with continuous monitoring tools to further target noncompliant agents, brokers, and web-brokers.

Response: We agree with the commenter that compliant agents, brokers, and web-brokers will benefit from the ''preponderance of the evidence'' standard, which clarifies the termination for cause process for agents, brokers, and web-brokers under § 155.220(g)(1) through (3). We will continue to assess the need for additional agent, broker, and web-broker continuous monitoring tools, particularly after we develop experience implementing our agent, broker, and web-broker policies finalized in the 2026 Payment Notice: to hold lead agents at insurance agencies responsible for agency-level misconduct and noncompliance and expand our authority to suspend an agent or broker's ability to transact information with the FFEs and SBE–FPs if we discover circumstances that pose an unacceptable risk to the accuracy of FFE or SBE–FP eligibility determinations, operations, applicants, or enrollees under § 155.220(k)(3). We continue to believe that all of these policies will enhance agent, broker, and web-broker accountability and public trust in the FFEs and SBE–FPs and reduce the risk of misconduct that puts consumers' healthcare coverage at risk.

Comment: We received several comments stating that the ''preponderance of the evidence'' standard is too demanding of an evidentiary standard to use to assess potential noncompliance by agents, brokers and web-brokers. In particular, commenters asserted that adopting the ''preponderance of the evidence'' standard would make it too easy for CMS to terminate agent, broker, and web-broker Exchange agreements, punish agents, brokers, and web-brokers for ''minimal'' errors, eliminate agent, broker, and web brokers' due process rights, and deprive agents, brokers, and web-brokers of their livelihoods.

Response: We disagree with comments asserting that the proposed standard is inappropriate for use in our termination for cause framework under § 155.220(g)(1) through (3). As we explained previously in this final rule and in the proposed rule, in proposing the preponderance of the evidence standard, we considered how evidentiary standards have traditionally been used in court cases and the severity of the potential consequences involved in our termination for cause standards framework in § 155.220(g)(1) through (3), including those consequences' impact on the ability of agents, brokers, and web-brokers to assist consumers with enrollment in coverage through the FFEs and SBE–FPs. Federal administrative and civil cases generally use a preponderance of the evidence standard, while criminal cases, in order to sustain a conviction, demand the highest standard, guilt ''beyond a reasonable doubt,'' under which evidence must be so strong that there is no reasonable doubt about a defendant's guilt. Between those two evidentiary standards are the ''clear and convincing evidence'' standard, under which a trier of fact must have an abiding conviction that the truth of the factual contention is ''highly probable,''

and the ''substantial evidence'' standard, which means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion. In the proposed rule, we explained—and we continue to believe—that the preponderance of the evidence standard is appropriate in our termination for cause framework under § 155.220(g)(1)–(3) because it is the standard used in most Federal civil cases and administrative proceedings.

In addition, using the preponderance of the evidence standard will ensure that when an agent, broker, or web-broker is subject to enforcement action under § 155.220(g)(3)(i), CMS will generally terminate their Exchange agreements unless the evidence they submit to resolve the matter to CMS' satisfaction consists of proof that, compared with the evidence supporting CMS' determination of a specific finding or pattern of noncompliance that is sufficiently severe, leads to the conclusion that the agent, broker, or web-broker was more likely than not compliant with applicable law, regulatory requirements, and the terms and condition of their Exchange agreements. This will help ensure that agents, brokers, and web-brokers are held accountable for noncompliance with applicable law, regulatory requirements, and the terms and condition of their Exchange agreements, prevent agents, brokers, and web-brokers who are noncompliant from assisting consumers with enrollment in coverage through the FFEs and SBE–FPs, and support consistent decision-making in our enforcement actions under § 155.220(g)(1) through (3).

With respect to commenters' points that this evidentiary standard will punish agents, brokers, and web-brokers for ''minimal'' errors and deprive them of their livelihoods, we remind commenters that CMS only takes enforcement action under § 155.220(g)(3)(i) when, in its determination, an agent, broker, or web-broker's conduct reflects a specific finding of noncompliance or pattern of noncompliance that is sufficiently severe, and an agent, broker, or web-broker may be determined noncompliant only if CMS finds that they violated applicable law, regulatory requirements, or the terms and condition of their Exchange agreements.[71]

As to commenters' claim that this evidentiary standard eliminates agents, brokers, and web-brokers' due process rights, we remind commenters that this policy only finalizes an evidentiary standard used in enforcement actions under § 155.220(g)(1) through (3). When an agent, broker, or web-broker is subject to enforcement action under § 155.220(g)(3)(i), CMS will notify the agent, broker, or web-broker of the specific finding of noncompliance or pattern of noncompliance made under paragraph (g)(1) of this section, and the agent, broker, or web-broker has 30 days from the date of the notice to resolve the matter to CMS' satisfaction. If the agent, broker, or web-broker does not submit rebuttal evidence resolving the matter to CMS' satisfaction and CMS terminates their Exchange agreements under § 155.220(g)(3)(i), the agent, broker, or web-broker has the right to submit a request for reconsideration to the CMS Administrator within 30 calendar days of the written notice from CMS.[72] The CMS Administrator will provide the agent, broker, or web-broker with a written notice of the reconsideration decision within 60 calendar days of the date the CMS Administrator receives the request for reconsideration, and this decision will constitute the agency's final determination.[73] Use of the ''preponderance of the evidence'' standard to determine whether an agent, broker, or web-broker violated applicable law, regulatory requirements, or the terms and condition of their Exchange Agreement(s) does not alter this existing rebuttal and appeal framework.[74]

Comment: We received several comments stating that the preponderance of the evidence standard is too lenient of an evidentiary standard for CMS to use in assessing potential noncompliance by agents, brokers, and web-brokers under § 155.220(g)(1) through (3). Some commenters claimed that lowering evidentiary standards helps agents, brokers, and web-brokers exploit consumers by reducing the number of noncompliant agents, brokers, and web-brokers whose Exchange Agreements are suspended and/or terminated. Further, some commenters asserted that this standard weakens accountability and makes it more difficult to prevent noncompliant agents, brokers, and web-brokers from assisting consumers with enrollment through the FFEs and SBE–FPs. Some commenters suggested that HHS should use a ''beyond a reasonable doubt'' or other stricter standard. One commenter asserted that the proposed evidentiary standard lacks strength because it relies on what a ''prudent'' person would do.

Response: We disagree with comments asserting that the proposed standard is too lenient, risks endangering consumers, or weakens agent, broker, and web-broker accountability. We refer commenters to previous responses to comments in this section of this final rule for detailed discussions on these issues, including our explanation of why we continue to believe the ''preponderance of the evidence'' standard is appropriate for us to use to assess potential noncompliance by agents, brokers, and web-brokers under § 155.220(g)(1) through (3).

Comment: A few commenters stated applying a ''preponderance of the evidence'' standard will increase agent, broker, and web-broker scrutiny, leading to a reduction in the number of agents, brokers, and web-brokers who will be willing to assist consumers with enrollment through the SBE–FPs and FFEs in the future.

Response: We believe that adoption of the ''preponderance of the evidence'' standard is unlikely to increase agent, broker, and web-broker scrutiny in a manner that will reduce the number of agents, brokers, and web-brokers willing to assist consumers with enrollment through the SBE–FPs and FFEs in the future. As we explained previously in this final rule, in proposing the preponderance of the evidence standard, we considered how evidentiary standards have traditionally been used in court cases and the severity of the potential consequences involved in our termination for cause standards framework in § 155.220(g)(1) through (3), including those consequences' impact on the ability of agents, brokers, and web-brokers to assist consumers with enrollment in coverage through the FFEs and SBE–FPs. We considered but declined to adopt several evidentiary standards that demanded that agents, brokers, and web-brokers subject to enforcement action under § 155.220(g)(1) through (3) meet a higher evidentiary bar, and we decided that the preponderance of the evidence standard is appropriate in our termination for cause framework under § 155.220(g)(1) through (3) because it is the standard used in most Federal civil cases and administrative proceedings.

In addition, as we explained previously in this final rule, our adoption of the ''preponderance of the evidence'' standard will enhance transparency for agents, brokers, and web-brokers and enhance public trust in the FFEs and SBE–FPs, which in turn may spur consumers to enroll in coverage through the FFEs and SBE–FPs with the assistance of agents, brokers,

[71] *See* § 155.220(g)(1) and (2).

[72] *See* § 155.220(h)(1) and (2).

[73] *See* § 155.220(h)(3).

[74] *See* § 155.220(g)(2).

and web-brokers. We believe that this increased transparency for agents, brokers, and web-brokers and improved public trust are likely to encourage agents, brokers, and web-brokers to continue assisting consumers with enrollment through the FFEs and SBE–FPs.

Comments: Some commenters suggested that applying a ''preponderance of the evidence'' standard will increase the cost of healthcare, limit availability for vulnerable populations, and increase discrimination against consumers. Commenters also suggested that States should have sole jurisdiction to agent, broker, and web-broker oversight.

Response: We disagree with comments asserting that applying a preponderance of the evidence standard in the context of enforcement actions under § 155.220(g)(1) through (3) will increase the cost of healthcare, limit availability for vulnerable consumers, or increase discrimination. The proposed ''preponderance of the evidence'' standard will have no direct effect on the pricing or availability of health insurance available to consumers in FFE and SBE–FP States.[75] If commenters intended to suggest that use of the ''preponderance of the evidence'' standard will deter agents, brokers, and web-brokers from assisting consumers with enrollment through the FFEs and SBE–FPs and thereby reduce healthcare accessibility and affordability and increase discrimination, we refer commenters to previous discussion in this section of this final rule explaining our belief that adopting the ''preponderance of the evidence'' standard in enforcement actions under § 155.220(g)(1) through (3) is likely to encourage agents, brokers, and web-brokers to continue assisting consumers with enrollment through the FFEs and SBE–FPs.

We remind commenters that section 1312(e) of the ACA states the Secretary shall establish procedures under which a State may allow agents or brokers (1) to enroll individuals and employers in any QHPs in the individual or small group market as soon as the plan is offered through an Exchange in the State; and (2) to assist individuals in applying for premium tax credits and cost-sharing reductions for plans sold through an Exchange. Section 1321(a)(1) of the ACA authorizes the Secretary to promulgate regulations for meeting the requirements of Title I of the ACA (which includes section 1312 of the ACA) with respect to the establishment and operation of Exchanges, the offering of QHPs through such Exchanges, and such other requirements as the Secretary determines appropriate. Finally, Section 1313(a)(5)(A) of the ACA directs the Secretary to provide for the efficient and non-discriminatory administration of Exchange activities and implement any measure or procedure the Secretary determines is appropriate to reduce fraud and abuse in the administration of Title I of the ACA.

After consideration of comments received, we are finalizing as proposed our proposal to permanently revise § 155.220(g)(2) to apply a ''preponderance of the evidence'' standard of proof for terminations for cause by HHS of an agent's, broker's, or web-broker's Exchange agreements under § 155.220(g)(1) through (3), and our proposal to add a definition of ''preponderance of the evidence'' to § 155.20.

3. Annual Eligibility Redetermination (§ 155.335)

In the 2025 Marketplace Integrity and Affordability proposed rule (90 FR 12969 through 12973), we proposed an amendment to the annual eligibility redetermination regulation by adding § 155.335(a)(3) and (n) to prevent enrollees from being automatically re-enrolled in coverage with APTC that fully covers their premium without taking an action to confirm their eligibility information. Specifically, we proposed under our authority in section 1411(f)(1)(B) of the ACA, which directs the Secretary to establish procedures by which the Secretary redetermines eligibility on a periodic basis, to require at § 155.335(a)(3) and (n) that when an enrollee does not submit an application for an updated eligibility determination on or before the last day to select a plan for January 1 coverage, in accordance with the effective dates specified in § 155.410(f) and 155.420(b), as applicable, and the enrollee's portion of the premium for the entire policy would be zero dollar after application of APTC through the Exchange's annual redetermination process (hereafter ''fully-subsidized enrollees'' for purposes of this section), all Exchanges must decrease the amount of the APTC applied to the policy such that the remaining monthly premium owed by the enrollee for the entire policy equals $5 for the first month and for every following month that the enrollee does not confirm or update the eligibility determination. Consistent with §§ 155.310(c) and (f), enrollees automatically re-enrolled with a $5 monthly premium after APTC under this policy would be able to submit an application at any point to confirm eligibility for APTC that covers the entire monthly premium, and re-confirm their plan to thereby reinstate the full amount of APTC for which the enrollee is eligible on a prospective basis.

We proposed at new § 155.335(n)(1) that the FFEs and the SBE–FPs must implement this change starting with annual redeterminations for benefit year 2026. We proposed at new § 155.335(n)(2) that the State Exchanges must implement it starting with annual redeterminations for benefit year 2027. We are finalizing this proposal with modifications.

In the proposed rule (90 FR 12969), we stated that we recognize that $5 may not provide a meaningful enough incentive for individuals to re-confirm their income and plan and, as such, sought comment on other options available to us to ensure program integrity in re-enrollments. As discussed in the proposed rule and this preamble, we stated that we are increasingly concerned about the level of improper enrollments in QHPs and believe that automatic re-enrollment of consumers into zero premium plans poses a significant risk to continuing high levels of improper payments of the APTC. We sought comment on the appropriate dollar amount individuals could be required to pay under the proposed policy such that they would be meaningfully incentivized to re-confirm their income and desired plan after being automatically re-enrolled. We also sought comment on whether any APTC payments should be made on behalf of individuals with fully-subsidized plans who have been automatically re-enrolled without confirming their plan and income consistent with the limitation on annual redeterminations when an Exchange does not have authorization to obtain tax data as part of the redetermination process. Additionally, we sought comment on if the program integrity concerns with automatic re-enrollments outweigh any potential benefit of allowing Exchanges to automatically re-enroll consumers without the consumer taking any action to affirmatively consent to continuing coverage for the following plan year.

Previously in the proposed rule and this final rule, we discussed the dramatic increase in the number of improper enrollments in QHPs with APTC through the FFEs and SBE–FPs.

[75] *See* § 156.255(b).

Among the most concerning problems are situations where an agent, broker, or web-broker improperly enrolls a consumer in a fully-subsidized QHP without their knowledge. Because these enrollees do not receive a monthly premium bill requiring action on their part, they may not be aware they are enrolled. This lack of awareness allows agents, brokers, and web-brokers to continue earning monthly commission payments from issuers for these enrollments. Improper enrollments present the most concerning situation, but the availability of fully-subsidized QHPs that require no action on the part of enrollees also leads to situations where enrollees inadvertently and improperly remain enrolled after obtaining other coverage. As a result of either of these scenarios, the enrollee is at risk of accumulating surprise tax liabilities and the financial stress of resolving these liabilities. Ultimately, the financial cost of consumers unknowingly or inadvertently remaining enrolled in fully-subsidized QHPs would fall almost entirely on the Federal Government as Federal law limits repayments of the PTC for certain consumers,[76] and the Federal Government only recoups APTC payments from issuers for enrollments that are cancelled after a consumer or other third party, such as an issuer, discovers an improper enrollment and reports it to the Exchanges.

The expansion of tax credits under the ARP[77] and IRA,[78] significantly increased the number of enrollees who initially enrolled in a fully-subsidized QHP. As a result, this significantly increased the number of enrollees who remained enrolled in fully-subsidized QHPs through the automatic re-enrollment process. For the Exchanges on the Federal platform, 2.68 million enrollees were automatically re-enrolled for benefit year 2025 with APTC that fully covered their premium, compared to 270,000 for benefit year 2019 (84 FR 229). The enhanced tax credits are set to expire at the end of benefit year 2025, which means there will be fewer enrollees who initially enroll in a fully-subsidized QHP and fewer enrollees who remain enrolled in fully-subsidized QHPs through the automatic re-enrollment process. However, as demonstrated in Table 14, there are millions of people improperly enrolled in fully-subsidized QHPs, and therefore temporary action to ensure these individuals are properly enrolled in a QHP that they are eligible for is a necessary consumer protection.

That said, the expiration of the enhanced premium tax credits will dramatically reduce the number of individuals eligible for fully-subsidized plans and anyone being automatically re-enrolled into a silver plan will almost assuredly be required to pay a premium once the enhanced tax credits expire. While one-time action to ensure fully-subsidized automatic re-enrollees update or confirm their application information or else pay a $5 monthly premium is necessary to shed improper and fraudulent enrollments, we do not believe the ongoing burden associated with this policy is justified by its benefits if fully-subsidized benchmark plans are not widely available. Therefore, we are finalizing this policy for Exchanges on the Federal platform for PY 2026 only.

In the 2021 Payment Notice proposed rule (85 FR 7088), we sought comment on a proposal to modify the automatic re-enrollment process such that any enrollee who would be automatically re-enrolled with APTC that would cover the enrollee's entire premium would instead be automatically re-enrolled without APTC. This would ensure that any enrollee in this situation would need to return to the Exchange and obtain an updated eligibility determination prior to having any APTC paid on the consumer's behalf for the upcoming benefit year. We also requested comments on a variation on this approach, in which APTC for this population would be reduced to a level that would result in an enrollee premium that is greater than zero dollar but not eliminated entirely. Both approaches elicit, to varying degrees, a consumer's active involvement in re-enrollment because any enrollment in a plan with an enrollee premium that is greater than zero would require the enrollee to take an action by making a premium payment to maintain coverage or else face eventual termination of coverage for non-payment.

All but one commenter opposed modifying the automatic re-enrollment process in these ways. Many believed that adopting the proposed changes could disadvantage the lowest income group of Exchange enrollees by taking away financial assistance for which they are eligible without evidence that they are at greater risk of incurring overpayments of APTC. Some commenters were specifically opposed to any requirement that State Exchanges modify their automatic re-enrollment processes because it would require costly IT system reconfigurations, consumer noticing changes, and additional investments to support increased Exchange customer service capacity that would be necessary to address consumer confusion caused by the change.

Most commenters supported the current automatic re-enrollment process, citing benefits such as the stabilization of the risk pool due to the retention of lower risk enrollees who are least likely to actively re-enroll, the increased efficiencies and reduced administrative costs for issuers, the reduction of the numbers of uninsured, lower premiums, and promotion of continuity of coverage. Many commenters also believed that existing processes, including annual eligibility redetermination, periodic data matching, and APTC reconciliation, sufficiently safeguard against potential eligibility errors and increased Federal spending. As a result, we did not finalize any changes to the automatic re-enrollment process in the 2021 Payment Notice (85 FR 29164), citing our belief that existing safeguards against APTC overpayments were sufficient.

Given the heightened urgency of program integrity concerns with enhanced APTCs, fully-subsidized plans, and automatic re-enrollments, as previously outlined in the proposed rule (90 FR 12970), we sought comment on these proposals once again. We also stated that we would consider whether other methods—such as outreach—could sufficiently prompt fully-subsidized enrollees to update or confirm their eligibility information and actively re-enroll in coverage. Current outreach methods for the FFEs and SBE–FPs, such as notices, emails, texts, and advertising, before and during the OEP are extensive and already successfully prompt over half of re-enrollees to actively confirm or update their information and actively select a plan. Most enrollees on the FFEs and the SBE–FPs actively re-enroll by the applicable deadlines for January 1 coverage. Based on our experience operating the Exchanges on the Federal platform, we stated in the proposed rule that we do not believe additional or different notifications would prompt action from fully—subsidized enrollees who choose not to submit an application for an updated eligibility determination and actively re-enroll. However, we sought comment on this idea.

Instead, we stated in the proposed rule (90 FR 12970) that we believe that it is necessary to prompt an affirmative action by enrollees who would otherwise be fully subsidized through the automatic re-enrollment process, whether such action be through a

[76] Section 1401 of the ACA; Sec. 36B(f)(2)(B) of the Code.

[77] Public Law 117–2.

[78] Public Law 117–169.

premium payment or re-confirming their plan choice altogether. We stated that we are again considering whether to automatically re-enroll these enrollees without any APTC, which would require them to return to the Exchange and obtain an updated eligibility determination prior to having any APTC paid on their behalf for the upcoming year, or else be charged for the full-price premium during automatic re-enrollment. As described in the proposed rule, we proposed to permit issuers to attribute past-due premium amounts they are owed to the initial premium the enrollee pays to effectuate new coverage. Removing all APTC during automatic re-enrollment for fully-subsidized enrollees is likely to create a significant debt to the issuer, since the enrollee is unlikely to be able to pay the full gross premium, which would harm the enrollee financially and could impact their ability to effectuate new QHP coverage. We therefore stated in the proposed rule that we believe that this approach would create undue financial hardship for these enrollees and act as a significant barrier to accessing health coverage. We also stated that we believe this approach could result in the loss of lower-risk enrollees, who are least likely to actively re-enroll due to an inability to pay, which could destabilize the market risk pool and increase premiums and the uninsured rate. We sought comment on this idea and whether it would more sufficiently mitigate the program integrity concerns we have described.

We then considered what enrollee portion of premium amount greater than zero but less than the full price of the QHP would avoid consumer harm but still achieve active participation by the enrollee. We proposed an amount of $5, which we stated in the proposed rule (90 FR 12970) that we believe would sufficiently balance the need to require an enrollee to take action, without substantially increasing the risk of undue financial hardship, such as termination for non-payment of premiums, that a greater amount could cause.

Additionally, we stated in the proposed rule (90 FR 12970) that we believe that the $5 would still achieve the desired effect of requiring an enrollee's active participation even if their issuer has adopted a net percentage-based premium payment threshold, under which enrollees must always pay at least 95 percent of the enrollee-responsible portion of the premium. We stated that if issuers adopt such a threshold, enrollees who have a $5 premium payment due to this amendment to the annual redetermination process would be required to pay at least $4.75 or else be placed in a grace period.

We stated in the proposed rule (90 FR 12970) that we believe our proposal, which decreases the amount of the APTC applied to the policy such that the remaining premium owed by the enrollee for the entire policy equals $5, strikes an appropriate balance between encouraging active confirmation of eligibility information and enrollment decision making and ensuring market stability.

We sought comment on this proposal. Specifically, we sought comment on whether an amount other than $5 would better address the program integrity concerns we have described. In addition, we sought comment on whether there are different policies or program measures that would help to reduce eligibility errors and potential Federal Government misspending, without adding additional burden for consumers.

A comparison of QHP enrollments to estimates of consumer-reported QHP enrollments from national health insurance coverage surveys strongly suggests there has been a large increase in the number of people unknowingly enrolled in subsidized QHPs. Researchers regularly track and study the ''Medicaid undercount'' which represents the difference in actual Medicaid enrollments to what people report on Census surveys.[79] This research finds that U.S. Census Bureau surveys undercount actual Medicaid enrollments, mostly due to people misreporting that they do not have Medicaid and found an increase in the Medicaid undercount between 2019 and 2022. At least part of such undercounts may be attributable to consumer misunderstanding when responding to surveys—for example a Medicaid enrollee may erroneously report not being enrolled in Medicaid due to the enrollee's familiarity with the program under a different, State-specific name (for example, Medicaid is called DenaliCare in the State of Alaska). We undertook a similar analysis to assess whether there is a similar undercount for subsidized coverage through the Exchanges. The comparison of actual subsidized QHP enrollments to QHP enrollments reported on Census surveys confirms this undercount exists and has grown substantially since 2021. As Table 1 shows, the Current Population Survey (CPS) undercount for enrollment in a QHP with APTC grew from 25 percent in 2021 to 50 percent in 2024. The undercount is even larger for consumers with incomes less than 250 percent of the FPL who likely qualify for CSRs. The undercount for these consumers grew from 33 percent in 2021 to 57 percent in 2024.

TABLE 1—CPS UNDERCOUNT OF CSR AND APTC SUBSIDIZED COVERAGE

	CPS current subsidized exchange coverage (March supplement)		CMS effectuated enrollment (February)		CSR and APTC undercount	
	Subsidized <250% of the FPL	Subsidized total	Feb CSR	Feb APTC	CSR (%)	APTC (%)
2019	3,750,261	7,055,972	5,468,004	9,250,243	−31	−24
2020	2,896,282	6,292,926	5,348,201	9,232,225	−46	−32
2021	3,663,155	7,335,480	5,449,070	9,722,533	−33	−25

[79] *See* Peter Nelson, What the Medicaid Undercount reveals about the Medicaid 'Unwinding' (Center of the American Experiment May 2024); Robert Hest, Elizabeth Lukanen, and Lynn Blewett, Medicaid Undercount Doubles, Likely Tied to Enrollee Misreporting of Coverage (SHADAC December 2022), available at *https://www.shadac.org/publications/medicaid-undercount-doubles-20-21;* State Health Access Data Assistance Center, Phase VI Research Results: Estimating the Medicaid Undercount in the Medical Expenditure Panel Survey Household Component (MEPS–HC) (January 2010), available at *https://www.shadac.org/publications/snacc-phasevi-report;* State Health Access Data Assistance Center, Phase IV Research Results: Estimating the Medicaid Undercount in the National Health Interview Survey (NHIS) and Comparing False-Negative Medicaid Reporting in NHIS to the Current Population Survey (CPS) (May 2009), available at *https://www.shadac.org/publications/snaccphase-iv-report;* and State Health Access Data Assistance Center, Phase II Research Results: Examining Discrepancies between the National Medicaid Statistical Information System (MSIS) and the Current Population Survey (CPS) Annual Social and Economic Supplement (ASEC) (March 2008), available at *https://www.shadac.org/publications/snacc-phase-ii-report.*

TABLE 1—CPS UNDERCOUNT OF CSR AND APTC SUBSIDIZED COVERAGE—Continued

	CPS current subsidized exchange coverage (March supplement)		CMS effectuated enrollment (February)		CSR and APTC undercount	
	Subsidized <250% of the FPL	Subsidized total	Feb CSR	Feb APTC	CSR (%)	APTC (%)
2022	3,693,063	7,652,083	6,788,231	12,483,707	−46	−39
2023	3,799,900	7,789,723	7,566,232	14,295,339	−50	−46
2024	4,441,847	9,562,392	10,395,544	19,306,162	−57	−50

Methodology: This table reports subsidized Exchange enrollment estimates from the U.S. Census CPS, including coverage estimates for people with incomes less than 250 percent of the FPL who are more likely to be eligible for CSR subsidies. The CPS is generally completed in March which provides a point in time estimate of insurance coverage. The final two columns report the CPS undercount of the actual CSR and APTC enrollment which equals the CPS estimate minus effectuated enrollment divided by effectuated enrollment.

Sources: CMS, Effectuated Enrollment; and U.S. Census, Current Population Survey Annual Social and Economic Supplement.

Table 2 draws a similar comparison between the reported level of Exchange coverage on the National Health Interview Survey (NHIS) [80] and total effectuated enrollment through the Exchanges. Prior to the enhanced PTC becoming law in 2021, the NHIS coverage estimates roughly matched the actual effectuated QHP enrollment counts. But in 2022, the NHIS undercounted effectuated QHP enrollment through Exchanges by 14.1 percent. This undercount increased to 19.3 percent in 2023 and edged up to 20.2 percent in the first quarter of 2024.

TABLE 2—NHIS COVERAGE UNDERCOUNT

[In millions]

	People reporting QHP coverage at time of interview	Average monthly effectuated enrollment	Undercount (%)
2019	10	9.8	2.0
2020	10.1	10.3	−1.9
2021	11.6	11.7	−0.9
2022	11.6	13.5	−14.1
2023	13	16.1	−19.3
2024 (1st Qtr)	16.6	*20.8	−20.2

*February effectuated enrollment.

Sources: CMS, Effectuated Enrollment; and Centers for Disease Control and Prevention, National Health Interview Survey.

The research on the Medicaid undercount referenced previously links people with Medicaid coverage to their Census survey responses, which shows most people who misreport not being enrolled in Medicaid report having another form of coverage. Among this group, the largest portion reports having employer coverage, followed by Medicare coverage, and then Exchange coverage.[81] Some of these people may have confused their Medicaid coverage for Medicare or Exchange coverage. But these findings suggest that many people who misreport not having Medicaid unknowingly retained multiple forms of coverage after assuming they lost Medicaid coverage when they enrolled in new private coverage or aged into Medicare.

Similar to the experience with the Medicaid undercount, the increase in the undercount of people with APTC-subsidized coverage is likely due to the increase in people with multiple forms of coverage. CBO estimates that in 2023, approximately 28.7 million people [82] had multiple types of coverage, up from 27.7 million people in 2022 [83] and 18 million in 2021.[84] Considering that research identifies response errors from survey participants as the main reason for the Medicaid undercount, it is reasonable to assume the same is true for the Exchange undercount. Both Medicaid managed care plans and subsidized QHPs—as a result of the enhanced premium tax credits—can have very low to no premium, can go unused by healthier people, can be confused for other types of coverage, and are available through the Exchanges. In addition, subsidized QHP enrollees tend to share similar characteristics with Medicaid enrollees who misreport at higher rates. This includes Medicaid enrollees who are adults,[85] employed,[86] at higher income levels overlapping with APTC income

[80] OMB Control Number 0920–0214.

[81] Blewett, Lynn A. et al. State Health Data Assistance Center, (2022, December) Medicaid Undercount Doubles, Likely Tied to Enrollee Misreporting of Coverage. Available at *https://www.shadac.org/publications/medicaid-undercount-doubles-20-21.*

[82] Congressional Budget Office, (2024, June) Health Insurance and Its Federal Subsidies: CBO and JCT's June 2024 Baseline Projections. Available at *https://www.cbo.gov/system/files/2024-06/51298-2024-06-healthinsurance.pdf.*

[83] Congressional Budget Office, (2003, May) Health Insurance and Its Federal Subsidies: CBO and JCT's May 2023 Baseline Projections. Available at *https://www.cbo.gov/system/files/2023-09/51298-2023-09-healthinsurance.pdf.*

[84] Congressional Budget Office, (2002, May) Federal Subsidies for Health Insurance Coverage for People Under Age 65: CBO and JCT's May 2022 Baseline Projections. Available at *https://www.cbo.gov/system/files/2022-06/51298-2022-06-healthinsurance.pdf.*

[85] Davern M, Klerman JA, Baugh DK, Call KT, Greenberg GD. An examination of the Medicaid undercount in the current population survey: preliminary results from record linking. Health Serv Res. 2009 Jun;44(3):965–87. doi: 10.1111/j.1475–6773.2008.00941.x. Epub 2009 Jan 28. PMID: 19187185; PMCID: PMC2699917. Available at *https://pmc.ncbi.nlm.nih.gov/articles/PMC2699917/.*

[86] Boudreaux MH, Call KT, Turner J, Fried B, O'Hara B. Measurement Error in Public Health Insurance Reporting in the American Community Survey: Evidence from Record Linkage. Health Serv Res. 2015 Dec;50(6):1973–95. doi: 10.1111/1475–6773.12308. Epub 2015 Apr 12. PMID: 25865628; PMCID: PMC4693849. Available at *https://pmc.ncbi.nlm.nih.gov/articles/PMC4693849/.*

eligibility levels,[87] and qualify for automatic re-enrollment.[88] The fully-subsidized nature of this group, under the enhanced premium tax credits, furthers these comparisons. Therefore, the dramatic increase in the Exchange undercount after 2021 in both the CPS and NHIS strongly suggests a substantial increase in the number of individuals with subsidized Exchange coverage who misreport not having such coverage on surveys. People may misreport coverage for various reasons, but the most likely reason for the increase in this level of misreporting in 2022 is the statutory change in 2021 expanding access to fully-subsidized QHPs.[89] Research on the increase in the Medicaid undercount links the increase to the Medicaid continuous coverage condition under the COVID–19 PHE that kept people unknowingly covered after they obtained other coverage.[90] Similar to the Medicaid continuous coverage condition, Federal policy regarding subsidized QHP coverage changed in response to the COVID–19 PHE in a manner that increased the risk of people remaining enrolled in fully-subsidized QHP without their knowledge. The expansion of eligibility to a fully-subsidized QHP in combination with the current Exchange annual eligibility redetermination process substantially increased the number of people with a fully-subsidized QHP able to remain continuously enrolled in a QHP from year to year without taking any action.[91] The 2022 OEP was the first year where people with fully—subsidized QHPs provided under the ARP entered the annual redetermination process. Other policy changes and factors may have contributed to the dramatic change in the Exchange undercount in 2022. However, based on the similar experience with the Medicaid undercount, we stated in the proposed rule (90 FR 12971) that we believe the ARP's expansion of fully-subsidized QHP coverage in combination with the existing annual eligibility redetermination process that does not require the enrollees' acknowledgement or active participation, increases the risk that ineligible consumers without knowledge of their enrollments will remain enrolled, improperly increases Federal APTC expenditures.

As the data discussed previously shows, individuals with Exchange coverage appear increasingly less likely to accurately report their coverage in survey data. Recent APTC changes that increased the availability of fully-subsidized coverage likely enabled more people to stay enrolled in Exchange coverage without their knowledge, which we stated in the proposed rule (90 FR 12971) is clearly a program integrity issue. To address this issue, we stated that we believe it is important to require qualified enrollees who are redetermined to be eligible for APTC that fully subsidizes their premium to take an active step to confirm their eligibility information before continuing with fully—subsidized coverage.

We sought comment on this proposal.

After consideration of comments and for the reasons outlined in the proposed rule and this final rule, including our responses to comments, we are finalizing this policy for Exchanges on the Federal platform for PY 2026. We think this policy represents an important program integrity measure to help the Exchanges on the Federal platform shed improper and fraudulent enrollments in the currently fully-subsidized QHP cohort of enrollees, which is highly concentrated in Exchanges on the Federal platform. Given the appreciably smaller estimates of improper enrollments on State Exchanges, coupled with our belief that this policy will help Exchanges shed holdover improper and fraudulent enrollments associated with fully-subsidized QHPs, we are not finalizing a parallel requirement for State Exchanges. After further evaluation and considering public comments on this proposal discussed later in this section, the Department has determined the burden this policy would have imposed on State Exchanges would not be worth it given that State Exchanges could not implement the policy before PY 2027, long after the expiration of the enhanced premium tax credits. For these reasons, we are finalizing this policy for PY 2026 only for Exchanges on the Federal platform, with a reversion to the previous policy for PY 2027 and beyond.

We also clarify this policy applies when an applicable enrollee does not submit an application for an updated eligibility determination specifically for the immediately forthcoming coverage year by the deadline to select a plan for January 1, 2026, coverage specified only at § 155.410(f) (and not at § 155.420(b) as proposed). Therefore, we are finalizing the following: When an enrollee does not submit an application for an updated eligibility determination for the immediately forthcoming coverage year (2026) by the last day to select a plan for January 1, 2026, coverage, and the enrollee's portion of the premium for the entire policy would be zero dollars after application of APTC, Exchanges on the Federal platform must decrease the amount of the APTC applied to the policy, such that the remaining monthly premium owed by the enrollee for the entire policy equals $5 for the first month and for every following month until the enrollee confirms or updates the information relevant to their annual redetermination of eligibility. Consistent with § 155.310(c) and (f), enrollees automatically re-enrolled with a $5 monthly premium after APTC under this policy would be able to update their application at any point to confirm information relevant to their annual redetermination for APTC and confirm their plan to reinstate the full amount of APTC for which they are eligible on a prospective basis.

We sought comment on whether the $5 amount would provide enough incentive for fully-subsidized individuals to confirm their information and whether fully-subsidized individuals should be re-enrolled without any APTC. We sought comment on other options available to us to ensure program integrity in re-enrollments. We sought comment on whether program integrity concerns outweigh the benefit of permitting Exchanges to automatically re-enroll consumers at all.

We summarize and respond to public comments received on this proposed annual redetermination policy below.

Comment: Some commenters generally supported this proposal. Many

[87] Davern M, Klerman JA, Baugh DK, Call KT, Greenberg GD. An examination of the Medicaid undercount in the current population survey: preliminary results from record linking. Health Serv Res. 2009 Jun;44(3):965–87. doi: 10.1111/j.1475–6773.2008.00941.x. Epub 2009 Jan 28. PMID: 19187185; PMCID: PMC2699917. Available at *https://pmc.ncbi.nlm.nih.gov/articles/PMC2699917/;* and Boudreaux MH, Call KT, Turner J, Fried B, O'Hara B. Measurement Error in Public Health Insurance Reporting in the American Community Survey: Evidence from Record Linkage. Health Serv Res. 2015 Dec;50(6):1973–95. doi: 10.1111/1475–6773.12308. Epub 2015 Apr 12. PMID: 25865628; PMCID: PMC4693849. Available at *https://pmc.ncbi.nlm.nih.gov/articles/PMC4693849/.*

[88] Kincheloe, Jennifer, et al. Health Affairs (2006), GrantWatch: Report Can We Trust Population Surveys To Count Medicaid Enrollees And The Uninsured? Volume 25, Number 4. Available at *https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.25.4.1163.*

[89] Public Law 117–2.

[90] Robert Hest, Elizabeth Lukanen, and Lynn Blewett, Medicaid Undercount Doubles, Likely Tied to Enrollee Misreporting of Coverage (SHADAC December 2022), available at *https://www.shadac.org/publications/medicaid-undercount-doubles-20-21.*

[91] Note that existing procedures under § 155.335 prohibit the indefinite continuation of APTC through auto re-enrollment in various circumstances, including for tax filers who do not comply with the failure to file and reconcile rules or whose authorization for the Exchange to obtain tax data from the IRS has expired (which is limited to 5 years).

of these commenters stated that this proposal would require fully-subsidized enrollees to confirm their information, which would incentivize these enrollees to actively enroll, receive updated eligibility determinations, and discourage improper and fraudulent enrollments that undermine program integrity. Some commenters stated that this proposal would help protect consumers from APTC repayment by requiring their confirmation or updated eligibility information. However, several of these commenters proposed additional recommendations: delay the effective date to PY 2027 to ensure Exchanges and issuers have sufficient time to educate enrollees and develop, test, and implement necessary changes; and preserve an OEP from November 1 to January 15 so that individuals impacted by this proposal have sufficient time to actively re-enroll.

Response: We appreciate these comments in support of the proposal and acknowledge commenters' concerns regarding the proposed change. We note that an effective date in PY 2026 provides sufficient time for Exchanges on the Federal platform to educate enrollees through updated notices (for example, Marketplace Open Enrollment Notice and Marketplace Automatic Enrollment Confirmation Message),[92] which are sent before and during Open Enrollment. Exchanges on the Federal platform will also provide robust training and technical assistance to interested parties, including agents, brokers, assisters, navigators, and issuers, so they can assist enrollees in understanding the proposed change.

For reasons stated in this final rule, the proposal to shorten the OEP at III.B.7. is finalized with modifications. The changes to the OEP will take effect beginning with the OEP for PY 2027 and the rule will provide flexibility for Exchanges within set parameters. Because the proposal to shorten the OEP will not be implemented in PY 2026, and this policy at 45 CFR 155.335 (a)(3) and (n) will only be effective for PY 2026, enrollees and other interested parties will have sufficient time to take the required action to avoid the $5 monthly premium.

Comment: Most commenters opposed the proposal. Many of these commenters stated the proposal is likely to cause a decrease in enrollment as some low-income enrollees will be terminated due to non-payment of the $5 premium. Generally, commenters believed the proposal would compromise the Exchange risk pool because younger and healthier individuals are most likely to lose coverage, which will ultimately discourage carrier participation and lead to higher premiums. Some cited data showing that a nominal monthly payment causes coverage losses specifically for younger enrollees.[93] [94] A few commenters cited research on Massachusetts' pre-ACA exchange, which found that consumers who were passively enrolled into fully-subsidized plans were younger and healthier (44 percent lower medical spending per month).[95] [96] A few commenters opposed the proposal because they do not believe it achieves the stated objective of reducing improper enrollments. These commenters stated that an agent or broker could update the application by the applicable deadlines to continue an improper fully-subsidized premium enrollment. Many commenters cited other program integrity measures that they believe are sufficient to safeguard against errors in Federal spending without undue risk of coverage losses, such as the 1-year FTR policy in the proposed rule, income verification, periodic data matching, and APTC reconciliation. Some of these commenters believe HHS should directly address agent and broker fraud in the Exchanges on the Federal platform rather than imposing this requirement on consumers.

Response: We acknowledge these comments in opposition to the proposal. While other program integrity measures also safeguard against errors in Federal spending, we maintain that this policy change is necessary in 2026 to ensure the fully-subsidized population confirms or updates their information, which will help lower the currently high level of improper enrollments and dual enrollment in the Exchanges on the Federal platform with financial assistance and other minimum essential coverage, such as Medicaid or employer sponsored coverage, that persist through the annual redetermination and re-enrollment specifically. After considering these comments, we believe that an ongoing requirement is likely unnecessary as once the level of improper enrollments is reduced and the amount of fully-subsidized plans has decreased, the incentive and opportunity for ongoing improper and fraudulent enrollments is substantially lower, and the burdens associated with this policy are not justified by its benefits. Therefore, we are finalizing this policy for PY 2026 only.

With respect to the amount, we believe $5 is a nominal amount that sufficiently balances requiring action by the enrollee without the risk of undue financial hardship that a greater amount could cause. These enrollees will be incentivized to return to an Exchange, evaluate available coverage options and premiums, and make an active enrollment decision. We therefore anticipate that this policy will lead to better matches between consumers' coverage preferences and available coverage offerings in the individual market.

We do not anticipate the Exchange risk pool will be compromised as this policy retains automatic re-enrollment while introducing a nominal premium amount to encourage active consumer engagement for the fully-subsidized population. We believe $5 does not risk undue financial hardship and that fully-subsidized enrollees will be incentivized to actively enroll or make a refundable $5 payment, rather than be dropped from Marketplace coverage, due to this policy.

Exchanges on the Federal platform will educate enrollees through updated notices (for example, Marketplace Open Enrollment Notice and Marketplace Automatic Enrollment Confirmation Message),[97] and issuers can update their discontinuation and renewal notices with information about this change. Exchanges on the Federal platform will also provide robust training and technical assistance to interested parties, including agents, brokers, assisters, navigators, and issuers, so they can assist enrollees in understanding the proposed change and continue coverage as needed.

We note that § 155.220(j)(2)(iii) and (l) require agents, brokers, and web-brokers who are assisting with consumer

[92] Samples of PY 2025 notices can be found here *https://www.cms.gov/marketplace/in-person-assisters/applications-forms-notices/notices.* CMs will revise this page with updated samples for PY 2026.

[93] The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings. Samantha Artiga, Petry Ubri, and Julia Zur. Kaiser Family Foundation. *https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-94*?.

[94] McIntyre A, Shepard M, Layton TJ. Small Marketplace Premiums Pose Financial and Administrative Burdens: Evidence from Massachusetts, 2016–17. Health Affairs. Published online January 8, 2024.

[95] Automatic Insurance Policies—Important Tools for Preventing Coverage Loss, Adrianna McIntyre, Ph.D., M.P.H., M.P.P., and Mark Shepard, Ph.D. *https://www.nejm.org/doi/full/10.1056/NEJMp2114189.*

[96] Do Ordeals Work for Selection Markets? Evidence from Health Insurance Auto-Enrollment by Mark Shepard and Myles Wagner, June 7, 2024. *https://scholar.harvard.edu/files/mshepard/files/shepard_wagner_autoenrollment.pdf.*

[97] Samples of PY 2025 notices can be found here *https://www.cms.gov/marketplace/in-person-assisters/applications-forms-notices/notices.* CMS will revise this page with updated samples for PY 2026.

enrollments through the Exchanges on the Federal platform to obtain and document consumer consent before making an application or enrollment update on behalf of the consumer, a measure intended to ensure that consumer information is accurate. We also established procedures under § 155.220(g) for HHS to suspend or terminate an agent's, broker's, or web-broker's Exchange agreement(s) in circumstances that involve certain fraudulent or abusive conduct or where there are sufficiently severe findings of non-compliance. We also established other standards of conduct under § 155.220(j) for agents, brokers, and web-brokers that assist consumers with enrolling in coverage through the FFEs to, protect consumers and ensure the proper administration of the FFEs, and under § 155.220(l) we extended this standard to agents, brokers, and web-brokers who assist consumers with enrollment through the SBE–FPs. CMS will continue to monitor and take enforcement action in response to any agent, broker, or web-broker activity that is deemed to be non-compliant under § 155.220(g)(2).

Comment: Several commenters opposed the proposal because they believe the $5 amount would be insufficient to incentivize individuals to confirm their eligibility information and that agents would pay the $5 premium on behalf of the enrollee or offer inducements to the enrollee such that the enrollee pays the $5. One commenter also opposed the proposal because they believe that fraud is not limited to fully-subsidized plans.

Response: Data supports the conclusion that lower income enrollees who may be eligible for zero-dollar premium plans after application of APTC are price sensitive.[98] We cannot be certain that $5 is the best amount to produce the desired outcome. However, after consideration of higher and lower amounts, we concluded $5 was a reasonable amount to encourage most low-income enrollees to act without being cost prohibitive such that it prevents their action. In other words, low-income enrollees who are price sensitive may interpret an invoice with a larger premium payment as insurmountable and choose not to take action to update their information to see if they can lower the bill nor pay the bill because they can't afford it. Therefore, we finalize this $5 amount to prompt enrollees to act while also balancing debt consideration for low-income enrollees if they don't act. We are finalizing this provision for Exchanges on the Federal platform for PY 2026 only.

Additionally, our experience investigating improper enrollments by agents, brokers, and web-brokers does not suggest that these entities commonly enroll consumers in non-zero plans by paying premiums on their behalf. Doing so would reduce the profit available to the agent, broker, or web-broker from commissions, as well as increase the risk of being discovered as engaging in unauthorized activity (for example, because an issuer could identify if payment was made using a check or credit card belonging to the agent, broker, or web-broker). Rather, improper enrollments typically involve agents, brokers, or web-brokers enrolling consumers in fully-subsidized plans without their knowledge or consent. Therefore, we believe it is appropriate to target this proposal to fully-subsidized enrollments, where we know unauthorized activity by agents, brokers, and web-brokers is most likely.

Comment: Many commenters requested that State Exchanges be excluded from this proposal because State Exchanges are less likely to have fraudulent and improper enrollment compared to Exchanges on the Federal platform and because they believe States are best positioned to evaluate whether updates to the redetermination process are necessary for their Exchange. Many of these commenters stated that State Exchanges have sufficient verification safeguards in place due to State-specific data for eligibility verification and closer oversight, and a few commenters stated that State Exchanges have more robust system controls to prevent fraudulent activity than the Exchanges on the Federal platform, all of which they stated contributes to low instances of fraud and improper enrollment. Commenters requested that States retain flexibility to implement alternative policies and procedures to improve consumer awareness of their options for renewal. Commenters stated that State Exchange operations related to this proposal would be costly and some could not implement the proposal based on the proposed timeline. One State Exchange commented that all of the enrollees in their State already have a non-zero premium after their full APTC amount is applied. We received three comments from State Exchanges noting the numerous program integrity safeguards they currently have in place as part of their annual redetermination and re-enrollment processes that minimize their risks for unauthorized enrollments, such as their use of approved state-based data sources, which supplement the required Federal data sources to verify consumer eligibility, and the timing and specificity of their redetermination and re-enrollment notices.

Response: We appreciate these comments. As described above, we are not finalizing these requirements for State Exchanges. Much of the concerning improper and fraudulent enrollment is concentrated on Exchanges on the Federal platform. Given the temporary nature of the policy and burdens this requirement would put on State Exchanges, we are exempting them from the requirement.

Comment: Many commenters requested that HHS delay implementation to PY 2027 or later to evaluate whether the policy is necessary after implementing other program integrity measures in this rule and after expiration of the enhanced PTC. Some commenters stated this proposal is not worth the cost to implement if the enhanced PTCs expire because relatively few enrollees will qualify for a zero-dollar premium. One commenter asked HHS to collaborate with issuers to design an implementation that avoids administrative costs and minimizes consumer confusion.

Response: We appreciate these comments and are only finalizing this requirement for PY 2026 for Exchanges on the Federal platform. We understand there will be fewer consumers eligible for fully-subsidized QHPs after the expiration of the enhanced PTCs than are eligible for fully-subsidized QHPs now and, as such, do not believe that the ongoing burden associated with this policy is justified by its benefits once the Exchanges shed the improper enrollments associated with fully-subsidized QHPs.

Comment: Many commenters questioned the statutory authority Exchanges have to reduce the amount of APTC used toward an enrollee's coverage. These commenters believe the ACA does not provide any construct for Exchanges to take independent action to

[98] *See, e.g.,* The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings. Samantha Artiga, Petry Ubri, and Julia Zur. Kaiser Family Foundation. *https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-94*?. McIntyre A, Shepard M, Layton TJ. Small Marketplace Premiums Pose Financial and Administrative Burdens: Evidence from Massachusetts, 2016–17. Health Affairs. Published online January 8, 2024. Automatic Insurance Policies—Important Tools for Preventing Coverage Loss, Adrianna McIntyre, Ph.D., M.P.H., M.P.P., and Mark Shepard, Ph.D. *https://www.nejm.org/doi/full/10.1056/NEJMp2114189.* Do Ordeals Work for Selection Markets? Evidence from Health Insurance Auto-Enrollment by Mark Shepard and Myles Wagner, June 7, 2024. *https://scholar.harvard.edu/files/mshepard/files/shepard_wagner_autoenrollment.pdf.*

adjust the tax credit based on policy preferences and expressed concern that Exchanges may arbitrarily interfere with qualified individuals' access to the full amount of the APTC. Many of these commenters stated that the Exchange must permit a qualified individual to use their tax credit in advance and must act as a facilitator of the tax credit once the qualified individual is determined eligible based on statutory criteria. Commenters believed that section 36B of the Code defines the criteria for APTC and HHS did not consider necessary modifications to that part of the law.

Some commenters believed that after an individual is determined as qualifying for APTC under section 1411 of the ACA, section 1412 compels the Federal government to pay APTC using the calculation of PTC rules in section 36B of the Code. They argued this means it is mandatory to pay the full amount of APTC for which the individual qualifies.

A few commenters believed that section 1411(f)(1)(B) of the ACA does not give HHS the authority to withhold APTC it is legally obligated to pay on behalf of every individual who is automatically re-enrolled without a redetermination finding that they are not entitled to the full APTC amount. The commenters believed that withholding payment is not a procedure to redetermine eligibility, and therefore, this proposal exceeds statutory authority.

One commenter stated that the proposal conditioning re-enrollment on the $5 enrollee premium contravenes guaranteed availability established by Vermont State law.

Another commenter stated this policy will be subject to litigation and will result in wasteful government spending that could be avoided by not finalizing the policy.

Response: We believe we have authority under the ACA to implement this provision. Section 1411(f)(1)(B) directs the Secretary to establish procedures by which it ''redetermines eligibility on a periodic basis in appropriate circumstances.'' We believe that recent history of improper enrollments in unsubsidized plans is an appropriate circumstance to temporarily require that the amount of PTC paid in advanced to be reduced by $5, unless and until an enrollee verifies their eligibility for a fully-subsidized premium. We emphasize that 45 CFR 155.335(n) would not independently reduce the amount of PTC an enrollee is eligible for under section 36B of the Code, but rather would reduce the amount of PTC paid in advance.

Comment: A few commenters shared that this proposal would result in additional administrative steps for agents and brokers, resulting in slower transaction times by agents and brokers and increased demand for their services in a condensed period of time if the OEP is shortened to November 1 through December 15.

Response: We acknowledge commenters' feedback. As stated above, we are finalizing this policy for Exchanges on the Federal platform for PY 2026 only, and the changes to the OEP at III.B.7. do not take effect until PY 2027. Therefore, agents and brokers will have sufficient time to help enrollees take the required action to avoid the $5 monthly premium.

Comment: A few commenters stated that consumer outreach is essential and that they would like more information from HHS about how enrollees will be informed of their individual responsibility amount.

Response: We agree with the commenters and will provide more information about consumer outreach through existing interested party forums, which include assister, agent and broker, navigator and issuer trainings.

Comment: Commenters offered the following operational suggestions if this policy is finalized as proposed: simplify the annual renewal process by allowing enrollees to confirm their eligibility information without having to recomplete the entire application; permit EDE partners to offer new features to support the active renewal process; provide information about re-enrollees to EDE partners so EDE partners and their agent and broker users can assist in outreach to enrollees who have a new financial obligation as a result of this proposal; and ensure income updates are effective on the first of the following month to limit the financial impact for enrollees subject to this proposal.

Response: We appreciate these suggestions and will consider them as we develop IT changes for this policy. We note that some EDE partners already simplify the annual renewal process by allowing agents and brokers to confirm an enrollee's eligibility information without having to click through the entire application. EDE partners may be approved by CMS to offer new features to support the active renewal process; EDE partners already have information about how to submit proposed features for CMS review and approval. We will evaluate whether more information about re-enrollment can be provided to EDE partners and their agent and broker users for their outreach purposes. We will ensure interested parties understand applicable effective dates for changes submitted by consumers.

Comment: A commenter recommended that HHS encourage State Exchanges to implement EDE. EDE is predominantly a pathway to service agents and brokers who assist consumers with Exchange enrollment, so this commenter is recommending HHS encourage State Exchanges to implement EDE, thereby increasing their agent and broker service capabilities to meet increased consumer support needs resulting from this policy.

Response: State Exchanges presently have the option to implement EDE (*see* 45 CFR 155.221(j)) and may make the decision to do so based on the needs of consumers in their State. HHS currently provides technical assistance to State Exchanges interested in the EDE model. State Exchanges are exempt from the requirement being finalized at 45 CFR 155.335(a)(3) and (n).

Comment: Commenters recommended HHS finalize different premium amounts other than the proposed $5. A few commenters suggested that if HHS moves forward with the proposal, it should be less than $5, such as $1. A few commenters suggested that if HHS moves forward with the proposal, it should be more than $5 but did not specify an amount. One commenter believed the amount should be similar to issuers' commission payments to agents and brokers—such as $25 for the first plan member and $20 for each additional plan member—to remove the incentive for third parties to pay the premium amount for the enrollee. However, this commenter recommended ending APTC altogether for the fully-subsidized population or for all enrollees who qualify for any amount of APTC because they believed those proposals would do the most to ensure the Federal government does not pay excess APTC, and they believed automatic re-enrollment is detrimental to the quality and price of health insurance.

Response: As described earlier, our experience investigating improper enrollments by agents, brokers, and web-brokers does not suggest that they commonly pay premiums on behalf of enrollees to secure enrollment. For the reasons described above, we believe $5 sufficiently balances requiring action by the enrollee without the risk of undue financial hardship a greater amount could cause while the market adapts to the changing subsidy environment.

Comment: Almost all commenters strongly opposed other ideas we solicited comments on, such as ending APTC during automatic re-enrollment

for enrollees who would otherwise be fully subsidized, and they robustly supported continuing to permit Exchanges to automatically re-enroll consumers altogether. These commenters believed automatic re-enrollment is critical to supporting a strong risk pool and preventing premium increases. Many commenters believed alternatives such as removing all APTC or not renewing their coverage at all for individuals who do not verify their eligibility for full-subsidized coverage would cause widespread loss of legitimate enrollments that support a healthy risk pool. Many commenters believed automatic re-enrollment promotes continuity of coverage and removes unnecessary burden for enrollees who are satisfied with their health coverage and note it is a standard practice in the industry. As described above, a few commenters cited research on Massachusetts' pre-ACA exchange, which found that consumers who were passively enrolled into fully-subsidized plans were younger and healthier (44 percent lower medical spending per month) and that eliminating auto-enrollment for health insurance reduced enrollment by 33 percent and differentially excluded young, healthy, and economically disadvantaged people.

Response: We appreciate these comments. We are not finalizing the alternative proposals to modify the automatic re-enrollment process such that any enrollee who would be automatically re-enrolled with APTC that would cover the enrollee's entire premium would instead be automatically re-enrolled without APTC, or to prohibit Exchanges from automatically re-enrolling consumers. Similar to the commenters, we believe that these proposals present too great a risk of widespread coverage loss to legitimate enrollments. To minimize the risk of disruption while taking a necessary step to shed excess improper enrollments, we are finalizing this policy for PY 2026 for Exchanges on the Federal platform only.

4. Annual Eligibility Redetermination (§ 155.335(j))

In the 2025 Marketplace Integrity and Affordability proposed rule (90 FR 12973 through 12974), we proposed to amend the automatic re-enrollment hierarchy by removing § 155.335(j)(4), which currently allows Exchanges to move a CSR-eligible enrollee from a bronze QHP and re-enroll them into a silver QHP for an upcoming plan year, if a silver QHP is available in the same product with the same provider network and with a lower or equivalent net premium after the application of APTC as the bronze plan into which the enrollee would otherwise have been re-enrolled. In effect, this current policy allows Exchanges to terminate an enrollee's coverage through a bronze QHP without the enrollee's active participation. These proposals would leave in place the requirements for Exchanges to take into account network similarity to the enrollee's current year plan when re-enrolling enrollees whose current year plans are no longer available, but would remove the re-enrollment hierarchy policy at § 155.335(j)(4) that allows Exchanges to move a CSR-eligible enrollee from a bronze QHP and re-enroll them into a silver QHP for an upcoming plan year, if a silver QHP is available in the same product with the same provider network and with a lower or equivalent net premium after the application of APTC as the bronze plan into which the enrollee would otherwise have been re-enrolled.

We sought comment on this proposal, and after consideration of comments, we are finalizing this policy as proposed. Based on certain public comments as further discussed below, we also clarify the flexibility that State Exchanges have regarding the re-enrollment hierarchy at the discretion of the Secretary per § 155.335(a)(2)(iii). As the re-enrollment hierarchy policy is an important policy to honor consumer choice, and is not addressing enhanced-subsidy related improper enrollment, we are finalizing this policy to be effective for PY 2026 and beyond. We summarize and respond to public comments below.

Comment: Some commenters supported the proposal and agreed that removing the option at § 155.335(j)(4) for Exchanges to re-enroll CSR eligible bronze enrollees into a silver QHP when certain conditions are met would help preserve consumer choice. Some of these commenters further stated that consumers select plans for a variety of reasons, such as affordability, provider network, or health savings account (HSA) eligibility, and that it is not appropriate to re-enroll them into a different plan when their current plan remains available in the coming year, even if the different plan provides higher actuarial value and the plan change would not result in a change to the consumer's product or provider network. Several of these commenters also agreed that removing § 155.335(j)(4) would reduce the risk of unexpected tax liabilities for bronze enrollees who appear, based on their most recent household income attestation, to be CSR eligible.[99] Several commenters who supported the proposal stated that removing § 155.335(j)(4) would help reduce consumer confusion. A few of these cited past experiences of consumers' mistaken belief that their health insurance agent changed their coverage when, in fact, the change was due to a re-enrollment pursuant to the reenrollment hierarchy at § 155.335(j). Based on these experiences, these commenters believed that allowing enrollees to stay in the same plan if it continues to be available unless they actively choose a different option would significantly reduce complaints and improve transparency. One commenter who supported the proposal asked that HHS consider delaying this change to PY 2027 to allow for issuers to incorporate this change into their product planning and filings.

Response: We agree with commenters that amending the re-enrollment hierarchy to remove the option for Exchanges to auto re-enroll bronze enrollees into a silver plan even when their same bronze plan remains available helps preserve consumer choice. We also agree with the commenter who emphasized the role that this final policy will play in helping reduce consumer confusion, as it aligns with an approach of preserving consumer choice whenever possible. We strongly agree with commenters who stated that removing this policy would reduce the risk of unexpected tax liabilities for bronze enrollees who appear, based on their most recent household income attestation, to be CSR eligible, and with those who cited HSA eligibility as a potential factor in bronze plan selection. Finally, we will not delay this change because, as noted in the proposed rule (90 FR 13015), we do not anticipate that it would result in significant burden to issuers, given that, as discussed in the 2024 Payment Notice (88 FR 25822), Exchanges were primarily responsible for the policy's implementation.

Comment: Several commenters who supported the proposal also emphasized the importance of decision support tools to help consumers select the best plan for themselves and their family's needs. These commenters stated that enhancing consumer decision support tools could help consumers understand all aspects of cost-sharing, including premiums, deductibles, out-of-pocket costs, and become more familiar with how health insurance coverage works in

[99] *See* discussion in the 2024 Payment Notice (88 FR 25823), regarding this potential risk in cases where APTC amount is determined based on inaccurate household income for the future year.

general. Commenters recommended developing more personalized tools to illustrate individuals' expected health care utilization or prescription drug needs and to help them use that information to choose a plan that is best suited to their needs. They also noted that focused training for navigators, agents, and brokers could boost take-up of silver plans among those eligible for CSRs.

Response: We agree with honoring and supporting consumer choice instead of re-directing enrollment on behalf of consumers when their current plan remains available in the following coverage year. Providing consumers with the information they need to make informed choices, and then honoring consumer choices, is a matter of trust. As we stated in the proposed rule (90 FR 12974), we believe the policy at § 155.335(j)(4) unnecessarily risked undermining this trust, and we will continue to explore and work to improve upon strategies that help consumers to make decisions that are best for themselves and their families based on their financial situations and health care needs. We agree with commenters who advocated for more robust decision support tools, and over the past several years we have made enhancements to the *HealthCare.gov* application and plan selection platforms to help income-based CSR eligible consumers understand the financial benefits of selecting a silver plan. For example, when they begin their plan selection process, these CSR eligible consumers view language explaining that they qualify for extra savings on out-of-pocket costs with a silver plan, and are offered the option to see silver plans only. Silver plans have ''Extra Savings'' tags, and consumers who qualify for CSRs of 94 percent or 87 percent and select a non-silver plan see a pop-up that encourages them to choose a silver plan instead. We believe that these changes, implemented over the past 5 years, have made a meaningful difference in these consumers' ability to make an informed choice about their coverage, though we will continue exploring ways to best provide consumers with information they need.

Comment: Many commenters opposed the proposal to remove § 155.335(j)(4) from the auto re-enrollment hierarchy based on their belief that the policy improved access to higher actuarial value coverage for enrollees who did not previously realize that such coverage was available to them. These commenters cited concerns that consumers are largely confused about their health insurance plan options and how to choose the plan that meets their health care and financial needs, and provided studies and other references to support this concern. These commenters cited factors including the high volume of plans to choose from in certain areas, resulting in choice overload; cuts to HHS Navigator grantee funding that decreases the in-person assistance available to potential enrollees; and the lack of data or other evidence to support the assertion that confusion had decreased. One commenter who stated the policy led to better outcomes for enrollees said that consumers should not be required to have a robust understanding of actuarial values, cost-sharing, co-payments, and deductibles. Multiple commenters stated that this policy would result in a family with a household income up to two times the FPL being re-enrolled in a plan with a $21,200 maximum out-of-pocket limit rather than a plan with a $7,000 out-of-pocket limit. One commenter who opposed the proposal asked that we wait until 2027 to consider this policy based on whether Congress would renew the enhanced PTC. Another commenter said that given this policy has only been in place for two plan years, it is not yet possible to determine whether it has been successful.

Response: We disagree that many consumers remain confused or unaware about their health insurance plan options and available cost savings and strongly disagree that consumers should not need to understand how generous a plan is in terms of the percentage of benefit costs that enrollees generally must pay (*i.e.,* actuarial value) and other aspects of health insurance coverage in order to make their own decisions regarding their health insurance coverage. When we proposed this policy in 2024 Payment Notice proposed rule (87 FR 78259), we highlighted that some CSR eligible bronze enrollees may have been initially enrolled before the more generous APTC became available with the passage of the ARP as extended by the IRA,[100] may not have been initially income-based CSR-eligible when they first enrolled, or may have been helped by an agent, broker, web-broker, or Navigator who did not adequately explain the benefits of silver enrollment for CSR-eligible enrollees.

In contrast, as of the start of the OEP for 2026 Exchange health insurance coverage, these enhanced subsidies will have been available to Exchange enrollees for a full five years. During this time, potential Exchange enrollees have had the chance to benefit from outreach and education services provided in part by tens of millions of dollars in Federal funding for HHS Navigator grantees, and enrollment increased significantly. Additionally, as discussed earlier, over the past five years we have made a number of enhancements to the *HealthCare.gov* application and plan selection platforms to help income-based CSR eligible consumers understand the financial benefits of selecting a silver plan. Therefore, as we stated in the proposed rule (90 FR 12974), we believe consumers and the agents, brokers, web-brokers, and Navigators who help them are largely aware of the more generous subsidies.[101] Further, we disagree that it makes sense to delay this policy until PY 2027 because, regardless of whether Congress continues the enhanced subsidies under the IRA, these investments and resulting increase in consumer awareness will persist. Finally, we also disagree that the removal of the policy at § 155.335(j)(4) will definitively result in auto re-enrollment of CSR eligible individuals and families into a particular bronze plan, because during the OEP, such individuals can actively choose to enroll in a silver plan.

Comment: A number of commenters who opposed the proposal asked if State Exchanges would continue to have flexibility to design their re-enrollment hierarchies.

A few commenters cited examples of State Exchanges' success in reducing inadvertent forfeiture of CSRs and ensuring better access to health care for those with access to a plan with a higher actuarial value with the same or similar benefit design and provider network as the lower actuarial value plan that they had actively selected. For example, a commenter described Covered California's practice since 2022 of re-enrolling CSR eligible enrollees into silver coverage, targeting individuals with incomes below 250 percent of the FPL with access to the same benefits and providers with equal or better value at the same or lower premium. This commenter emphasized that the Exchange informs these enrollees of the change and provides sufficient time to opt out of the change. The commenter also described other auto re-enrollment policies Covered California adopted that

[100] With the passage of the IRA, these enhanced subsidies were extended for an additional 3 years (through 2025).

[101] For example, *see* the January 2025 Marketplace 2025 Open Enrollment Period Report: National Snapshot (*https://www.cms.gov/newsroom/fact-sheets/marketplace-2025-open-enrollment-period-report-national-snapshot-2*) and informational materials such as those available on *HealthCare.gov: https://www.healthcare.gov/more-savings/.*

reportedly had strong approval ratings, did not cause consumer confusion, and led to 34,000 consumers enrolled in a higher-value plan at a lower cost for PY 2024, and noted that platinum and gold crosswalks to silver plans could result in lower PTC expenditures for the Federal Government in cases where the applicable silver plan is the lowest cost silver plan. The commenter strongly recommended that CMS continue to allow States the freedom to adopt these innovative policies that make it easier for consumers to obtain the best coverage, value, and affordability for them. A few commenters raised concerns about the time and cost associated with requiring State Exchanges to implement changes to their systems, including to their re-enrollment processes.

Response: For reasons discussed earlier in this preamble, we are finalizing this policy as proposed. While we appreciate that some State Exchanges have had success with modifying their approaches to auto re-enrollment and have not received consumer complaints, based on our experience operating the Federal Exchange and Exchanges on the Federal platform, we believe that the potential consumer harm related to this policy outweighs these potential benefits. In particular, we discussed several comments earlier in this preamble that described confusion consumers in Exchanges on the Federal platform have experienced related to this policy, including a few that cited examples of consumers who assumed that their health insurance agent had re-enrolled them in a different plan against their wishes. In the 2024 Covered California Member survey, the sample size of over 2,000 auto re-enrolled people drops to under 500 when restricted to those who reported being ''Aware that their Plan Changed,'' [102] suggesting many enrollees did not understand the Exchange's change to their plan. Additionally, commenters did not address the risk that switching enrollees to a higher actuarial value plan without their knowledge could increase these enrollees' risk of tax liability.[103] We believe that this potential negative impact, combined with consumer confusion, presents sufficient risk to outweigh the potential benefits that these commenters cite. Even bronze enrollees who are aware that they have been auto re-enrolled into a silver plan and who voiced support for this change according to Covered California's 2024 Member Survey might not be aware of potential implications to their tax liability, and those who are not aware of the change are even more at risk for incurring tax liability without realizing it.

Finally, in response to requests for clarification on flexibility for State Exchanges in this area, we clarify that Exchanges can request flexibility regarding the annual redetermination processes described in § 155.335(b) through (m), which include the auto re-enrollment hierarchy, per § 155.335(a)(2)(iii). That is, § 155.335(a)(2) provides Exchanges with three options to conduct annual redeterminations: under § 155.335(a)(2)(i), an Exchange can apply the procedures described in paragraphs (b) through (m) of this section, and under (a)(2)(ii), an Exchange can apply alternative procedures specified by the Secretary for the applicable benefit year. Section 155.335(a)(2)(iii) allows Exchanges to apply alternative procedures approved by the Secretary based on certain criteria. In the 2025 Payment Notice (89 FR 26313), we explained that State Exchanges that cannot implement or choose not to implement the re-enrollment hierarchy at § 155.335(j) may seek approval from the Secretary to conduct their own annual eligibility redetermination process as described in § 155.335(a)(2)(iii). We already approve State Exchanges' requests for flexibility in this area on an annual basis, as part of their submission of their eligibility re-determination and re-enrollment plans, both in order to mitigate burden and to permit innovation that allows Exchanges to best serve their enrollees.

Specifically, regulations at §§ 155.1200 and 155.1210 outline HHS's authority to oversee the Exchanges after their establishment. In 2014, HHS developed the State Marketplace Annual Reporting Tool (SMART) to facilitate State Exchanges' reporting to HHS on how they are meeting Federal program and operational requirements, including compliance with Federal eligibility and enrollment program requirements under 45 CFR part 155.[104] On an annual basis, HHS gathers information about State Exchanges' Open Enrollment readiness and practices. Alongside this process, HHS also collects information on State Exchange plans for auto re-enrollment implementation, and conducts follow up discussion of any related questions or concerns prior to providing approval. During years where there have been regulatory changes that impact the Exchange functions this review covers, we provide technical assistance and targeted support for State Exchanges that have questions, and as needed, conduct further follow-up during Open Enrollment to ensure their operations were successful.

5. Verification Process Related to Income Eligibility for Insurance Affordability Programs (§§ 155.305, 155.315, and 155.320)

The ACA provides Federal subsidies to reduce premium and cost sharing payments for lower-income households who purchase QHPs through the Exchanges. To guard against fraud and abuse, the ACA establishes a set of standards and processes to verify that consumers meet the eligibility requirements for APTC and CSR subsidies. In the 2025 Marketplace Integrity and Affordability proposed rule (90 FR 12956 through 12968), we proposed several changes to the processes specifically related to verifying income eligibility for APTC and CSR subsidies.

Under the statutory framework, HHS is responsible for verifying and determining income eligibility. The ACA further directs HHS to establish compatible electronic information exchange systems for enrollment applications and eligibility verification and determination. This creates a clear expectation for HHS to develop a robust data matching program between Federal agencies, State Exchanges, and other trusted data sources to determine APTC payments using the most accurate income estimates. Giving a Federal agency like HHS primary responsibility for verifying and determining APTC eligibility follows from the fact that APTC payments are Federal expenditures.

Exchanges operate as the intermediary between HHS and the applicant. They provide the applicant's information to HHS and then HHS has the primary responsibility for verifying the information. However, when the IRS cannot verify the income information, HHS may delegate its responsibility to verify household income to the Exchanges. Still, HHS retains authority to regulate and guide how Exchanges verify this household income information, as well as responsibility for the data matching program used to establish, verify and update income eligibility. As the intermediary, the

[102] NORC at the University of Chicago and Covered California. (2024, Nov. 21). Covered California's 2024 Member Survey. *https://hbex.coveredca.com/dataresearch/library/Member_Survey_2024_Public_Report.pdf.*

[103] *See* discussion in the 2024 Payment Notice (88 FR 25823) regarding this potential risk in cases where APTC amount is determined based on inaccurate household income for the future year.

[104] The SMART is currently approved under OMB control number: 0938–1244 (CMS–10507).

Exchanges must also make the final connection with the applicant to resolve any outstanding income inconsistencies. The Exchanges' role here is to provide notice to the applicant, collect any documentary evidence from the applicant, and facilitate any final effort to resolve the inconsistency with the IRS or other trusted data sources.

Applicants also bear important responsibilities in this process. This primarily includes a responsibility to file Federal income taxes for any year that they receive APTC and, if they have had a change in circumstances or were not required to file taxes, to report and attest to accurate income information. The ACA, however, requires verification of applicants' attestations of household income under section 1411(c) or (d), as referenced in section 1411(e)(4) of the ACA. If the applicant's household income cannot be verified, the applicant is responsible for providing satisfactory documentary evidence or taking further steps to resolve the inconsistency with the Federal information sources. If the applicant fails to resolve the inconsistency, the APTC amount must be based on the income data from Federal sources provided to HHS under section 1411(c) of the ACA.

There is a critical balance HHS must achieve between assuring responsible stewardship of taxpayer dollars with protecting access to Federal program for those who qualify for them. In circumstances presenting higher-than-normal risks, it is appropriate for the agency to take greater-than-normal precautions against waste, fraud, and abuse while balancing access to Federal benefits over the long-term.

With that as background, we proposed the following changes to the processes in place related to verifying income eligibility for APTC and CSR subsidies.

a. Failure To File Taxes and Reconcile APTC Process (§ 155.305(f)(4))

i. Delay of FTR Process Until After 2 Consecutive Years of FTR Removed

In the 2025 Marketplace Integrity and Affordability proposed rule (90 FR 12958 through 12961), we proposed to amend paragraph § 155.305(f)(4) to reinstate the previous policy that an Exchange may not determine a tax filer or their enrollee eligible for APTC if: (1) HHS notifies the Exchange that APTC were paid on behalf of the tax filer, or their spouse if the tax filer is a married couple, for a year for which tax data would be utilized for verification of household and family size, and (2) the tax filer did not comply with the requirement to file a Federal income tax return and reconcile APTC for that year.

In the 2024 Payment Notice (88 FR 25814), we amended the FTR process to restrict an Exchange from determining a tax filer ineligible for APTC until they have failed to file a Federal income tax return and reconcile APTC for 2 consecutive tax years. We made this change to address operational challenges that required Exchanges to determine someone ineligible for APTC without having up-to-date information on the tax filing status of tax filers, to help consumers who may be confused or may have received inadequate education on the requirement to file and reconcile, to promote continuity of coverage for consumers who may not be aware of the requirement to file and reconcile, and to reduce the administrative burden on HHS.

When we adopted this 2-tax year FTR process, we acknowledged it could place consumers at risk of increased tax liability. To mitigate this concern, in the 2025 Payment Notice (89 FR 26298 through 26299), we required Exchanges to issue FTR warning notices for enrollees in Exchanges on the Federal platform who have not filed and reconciled for 1-tax year. We also acknowledged the risk for improper enrollment by consumers who know they can ignore their FTR status for an additional year, but concluded these instances would be limited as the majority of enrollees comply with FTR. Despite the potential for large tax liabilities and the risk of improper enrollment, we concluded that this policy would have a positive impact on consumers, while still ensuring program integrity as it would provide better continuity of coverage for consumers who may not be aware of the requirement to file and reconcile. We noted that we would continue to monitor the implementation of this new policy, including whether certain populations continue to experience large tax liabilities, and would consider whether additional guidance, or any additional policy changes in future rulemaking, are necessary.

Upon further analysis of enrollment data, as we previously stated in the proposed rule (90 FR 12959), we believe the 2-year FTR process places a substantially higher number of tax filers at a greater risk of accumulating increased tax liabilities.[105] We also stated that we believe this is because the current FTR process could incentivize tax filers to not file and reconcile because they are allowed to keep APTC eligibility for an additional year without filing their Federal income tax return and reconciling APTC. If tax filers do not file and reconcile for 2 consecutive tax years, they could have an increasing tax liability due to APTC that is not reconciled on the tax return. For example, if a tax filer had projected their household income to be less than 200 percent of the FPL but had household income over 400 percent of the FPL when filing their Federal income tax return, the requirement to repay their excess APTC could constitute a major tax liability. Average APTC per month for those receiving it is $548 for OEP 2024.[106]

Considering new evidence regarding unauthorized enrollments, it became apparent that the 2-year FTR process established under the 2024 Payment Notice could impede Exchange efforts to mitigate unauthorized enrollments. At the time, we did not estimate the number of people with an FTR status who entered the OEP and either disenrolled, actively reenrolled without APTC, or resolved their FTR status and reenrolled with APTC. Due to concerns related to the safeguarding of Federal Taxpayer Information (FTI), the Exchanges on the Federal platform are unable to track specifically how many consumers originally identified as FTR prior to the OEP ultimately resolved their FTR status. This kind of information would have helped us fully understand the population that might take advantage of the current FTR process. Nor did we attempt to estimate the portion of people with FTR status who were likely ineligible for APTC. Rather, we assumed continuity of coverage with APTC was appropriate for everyone with an FTR status.

Moreover, we did not consider how changing the notice to reflect the new FTR process would impact enrollment decisions. The prior FTR direct notice (for PY 2020 and earlier) gave notice that access to APTC would end if tax filers failed to file and reconcile for 1-tax year, while the current 1-tax year FTR direct notice for PY 2025 provides notice for tax filers identified as having a 1-tax year FTR status that they *may* lose their APTC in the future if they do not file and reconcile their APTC. Tax filers with a 1-tax year FTR status or their enrollees are directed to file their Federal income tax returns and reconcile their APTC as soon as possible in the current 1-tax year FTR direct notice. Indirect notices for tax filers in both the 1-tax year and 2-tax year FTR status cannot directly tell an enrollee that they need to file their Federal

[105] Marketplace Open Enrollment Period Public Use Files, *https://www.cms.gov/data-research/statistics-trends-reports/marketplace-products/2024-marketplace-open-enrollment-period-public-use-files.*

[106] Ibid.

income tax return but encourage doing so in order to ensure that they remain eligible for APTC, along with other reasons why they may be at risk of losing APTC to mask FTI.

Upon further analysis of enrollment and tax filing data, we believe that Exchanges on the Federal platform currently have a substantially higher than normal number of enrollees who have not filed and reconciled as compared to the previous 1-year FTR process. We also stated that we revisited the enrollment and tax filing data from the OEP for PY 2020, as well as more recent enrollment data. During OEP 2025, the initial year in which FTR was resumed, the data shows that approximately 356,000 potential reenrollments entered OEP 2025 with a 2-tax year FTR status and approximately 1,500,000 potential reenrollments entered OEP 2025 with either a 1-tax year FTR status, an extension of the deadline to file their Federal income taxes, or had filed their Federal income taxes but had not attached IRS Form 8962 to reconcile their APTC. Under the current 2-year policy for PY 2025, enrollees with a 2-tax year FTR status could have actively reenrolled (but not auto-reenrolled) and attested to having filed and reconciled while IRS data still shows them as not having filed taxes for the 2022 or 2023 tax years, and the enrollees with a 1-tax year FTR status could have either actively or automatically reenrolled in an Exchange QHP without meeting the requirement to file taxes for the 2023 tax year. Historically, internal analysis of agency data has shown that, under the 1-tax year FTR process, between 15 percent and 20 percent of consumers originally identified at OEP as FTR end up losing their APTC due to the FTR Recheck process.

As of February 2025, we did not have information on the number of consumers who were identified as having a 2-tax year FTR status before the OEP and who have filed and reconciled in order to remain eligible for APTC. We stated in the proposed rule that it is probable that due to the increase in enrollment under the 2-tax year FTR policy, the number of consumers who would remain covered into the second year would be greater than the 81,600 we previously estimated (90 FR 12960). Since publishing the proposed rule, we are updating our initial data projections as we initiated FTR Recheck operations in March 2025. Of the approximate 1,500,000 potential re-enrollments who entered OEP 2025 with either a 1-tax year FTR status, a valid tax filing extension from IRS, or had filed their Federal income taxes but had not attached IRS Form 8962 to reconcile their APTC (non-reconcilers), approximately 400,000 enrollees with either a 1-tax year FTR status or a non-reconciler status were identified during FTR Recheck. This represents a drop of 73 percent of the initially identified FTR population, suggesting that the 1-year notices sent during the OEP were relatively effective and also followed historical trends observed by HHS. The 2-year FTR status population decreased from 356,000 to approximately 270,000, a decrease of 24 percent. This suggests that the 2-year population is less responsive to notices than the 1-year population.

Furthermore, in the proposed rule (90 FR 12960), we stated that we believe the proposed 1-tax year FTR process can serve as a backstop to improper enrollments. The Paragon Health Institute provided evidence that lead generation companies associated with noncompliant agents, brokers, and web-brokers are misleading enrollees with the promise of free coverage and other enticements.[107] In these cases, some people are likely not aware they are enrolled in QHP coverage with APTC because, in response to misleading advertisements promising cash or gift cards, they provided enough personal information for agents, brokers, and web-brokers to improperly enroll them in such coverage with APTC without their knowledge.[108] These schemes tend to target low-income people, many of whom likely have a projected annual household income of less than 100 percent of the FPL. Under these schemes, some agents, brokers, or web-brokers improperly enroll people in QHP coverage with APTC who would not otherwise qualify. Individuals who were improperly enrolled may not realize they are enrolled in Exchange coverage until they receive a Form 1095–A. These individuals can obtain a voided Form 1095–A and avoid improper tax liabilities, but the process is burdensome and could lead to delays or errors in tax filing. Improvements have been made to the Unauthorized Enrollment (UE) casework process to reduce consumer burden; in addition, CMS and IRS have several resources about what a consumer should do if they believe they were enrolled in a UE and they need a voided Form 1095–A.[109] In the proposed rule we stated that we believe that FTR status may provide a strong indicator that a current enrollee entering the OEP has income that makes the household ineligible for APTC. Generally, people with lower incomes do not need to file taxes unless their income is over the filing requirement. Because the income filing requirement for a single filer with no self-employment income aligns with the eligibility threshold for APTC—$14,600 for 2024 tax filing compared to $14,580 for 2024 APTC eligibility—people who inflate their income to qualify for APTC will often have an income low enough to, absent the receipt of APTC, not require them to file taxes. In this case, the FTR status likely reflects a lack of understanding of the need to file taxes based on the receipt of APTC which, if they still think they do not meet the filing requirement based on their income, means they are likely to have an income too low to meet the APTC eligibility threshold.

We established the current 2-tax year FTR process at the end of the COVID–19 Public Health Emergency (PHE). At that time, we had paused the removal of APTC under the FTR process because the pandemic severely impacted the IRS's ability to process tax returns for the 2019, 2020, and 2021 tax years.[110] Continuing the FTR process during that time would have removed APTC from substantial number of eligible enrollees who timely filed tax returns but had not had their tax returns processed yet.

While many enrollees did in fact file their Federal income taxes and reconcile APTC while FTR was paused during the COVID–19 PHE, in light of the substantial increase in improper enrollments HHS observed during PY 2024, we stated in the proposed rule (90 FR 12960) that we believe that reverting back to the pre-existing FTR policy in place before the COVID–19 PHE, is a critical program integrity measure that could further protect Exchanges and enrollees from improper enrollments. Specifically, we stated that we are concerned that the current policy of pausing removal of APTC due to an FTR status for an additional year could potentially let improperly enrolled enrollees stay enrolled for another year undetected. If an improper enrollment is not detected by the other methods that the Exchange has implemented, the proposed 1-tax year FTR process should

[107] Blase, B; Kalisz, G. (2024, August). Unpacking The Great Obamacare Enrollment Fraud. Paragon Health Institute. *https://paragoninstitute.org/private-health/unpacking-the-great-obamacare-enrollment-fraud/.*

[108] Ibid.

[109] Resource on reporting UE to Marketplace Call Center: *https://www.cms.gov/files/document/agent-broker-infographic-2024-final.pdf.*

[110] CMS. (2022, July 18). Failure to File and Reconcile (FTR) Operations Flexibilities for PY 2023. *https://www.cms.gov/cciio/resources/regulations-and-guidance/ftr-flexibilities-2023.pdf.*

act as a backstop to ensure that an enrollee who is improperly enrolled loses APTC after 1 year of failing to file and reconcile instead of 2 years of failing to file and reconcile. For example, under the 1-tax year FTR process, people received a notice that they would lose their eligibility for APTC unless they met the requirement to file and reconcile. Whereas under the current 2-tax year FTR process, enrollees do not receive notification that they are imminently at risk of losing their APTC until they have had an FTR status for 2 years. As background, under the current process, Exchanges can choose to send (1) a direct notice to tax filers, (2) an indirect notice to enrollees, or (3) both a direct and indirect notice to enrollees with either 1-tax year and 2-tax year FTR status.[111] Enrollees with a 1-tax year FTR status can receive either a direct notice that they must file and reconcile, but they are not at risk for losing APTC for the current plan year if otherwise eligible, or an indirect notice that indirectly tells the enrollee to ensure they have done all the actions necessary to keep their APTC eligibility, including filing their Federal tax return and reconciling their APTC. It is not until an enrollee receives an FTR notice for the second tax year that they are instructed to file and reconcile as soon as possible to avoid losing APTC for the applicable plan year.

After reviewing the tax filing data, we stated in the proposed rule (90 FR 12960) that we remain concerned that enrollees are accumulating tax liabilities due to misestimating their income. Before the COVID–19 PHE, over 50 percent of people who filed tax returns and reconciled APTC received excess APTC for the 2016, 2017, 2018, and 2019 tax years.[112] For those who filed their taxes and reconciled their APTC, the accumulation of any tax liability is limited to a single year. In 2022, excess liability represented 11.5 percent of total APTC payments reported on tax returns.[113] This tax liability, if not paid by the taxpayer, will continue to be an outstanding debt to the IRS and may accrue interest and penalties. To mitigate any accumulation of liability, the longstanding FTR process had disenrolled people from APTC after giving them over 6 months to resolve their FTR status after initial notification. The current process could potentially provide up to 18 months after an initial FTR notice is received for a tax filer to comply with the requirement to file and reconcile their APTC. We stated in the proposed rule (90 FR 12961) that we no longer believe this provides reasonable protection against accumulating tax liabilities.

Furthermore, in the current environment, as Exchanges on the Federal platform attempt to ensure that unauthorized enrollments are removed from QHP coverage and have APTC ended, we believe that there are still a large number of ineligible enrollees, which is increasing the burden on taxpayers because, due to repayment limitations discussed previously, not all ineligible enrollees who receive APTC are required to fully repay any APTC improperly received. Those unpaid liabilities add to Federal APTC expenditures. We did not previously estimate the Federal cost of the current FTR process due to providing coverage and APTC continuity to enrollees who were ineligible for APTC and not liable for repaying the full excess of their APTC. In the proposed rule (90 FR 12961), we stated that we estimate up to 18.5 percent[114] of people currently in FTR status may be ineligible for APTC based on the overall growth in the 100 to 150 percent of the FPL population of the Exchanges on the Federal platform between 2019 and 2024, if the growth is due to noncompliant agents, brokers, and web-brokers enrolling enrollees who are actually below the 100 percent of the FPL threshold. However, we stated in the proposed rule that this population would also be impacted by numerous other proposals in the proposed rule as well as other actions that HHS has taken over the past year to protect the Exchanges, and we are unable to isolate the proposed impact of changing the FTR policy.

Overall, we stated in the proposed rule (90 FR 12961) that this new analysis of the enrollment and tax filing status suggests a large number of people with FTR status are ineligible for APTC and that pausing removal of APTC due to an FTR status allows ineligible enrollees to accumulate tax liabilities. These additional liabilities create a substantial financial burden for enrollees who must repay the excess APTC and increase the Federal APTC expenditures. Moreover, we stated our view in the proposed rule that the ACA does not allow HHS to determine someone eligible for APTC if they failed to meet the requirement to file a tax return. Therefore, to align regulations with the ACA, protect people from accumulating additional Federal tax liabilities, and reduce the Federal expenditures associated with APTC expenditures for ineligible enrollees, we proposed to reinstate the FTR process that requires Exchanges to determine enrollees ineligible for APTC when HHS notifies the Exchange that a taxpayer has failed to file a Federal income tax return and reconcile their past APTC for a year for which their tax data would be utilized to verify their eligibility.

We proposed to implement the proposed 1-year FTR process beginning with OEP 2026 in the fall of 2025. This would allow enrollees currently in a 1-tax year FTR status to receive appropriate noticing informing them of the urgent need to file their Federal income tax return and reconcile APTC in order to remain eligible for APTC.

We sought comment on this proposal.

After consideration of comments and for the reasons outlined in the proposed rule and this final rule, including our responses to comments, we are finalizing a modified policy under which all Exchanges will be required to deny APTC once an applicant has failed to file and reconcile APTC for 1 year, but only through the end of PY 2026. Thereafter, the 2-year FTR policy in effect today that allows an Exchange to deny APTC only once an applicant has failed to file and reconcile APTC for 2 consecutive years, will spring back into effect. While the 1-year FTR policy is needed right now to reduce the number of improper APTC payments in Exchanges on the Federal platform, its utility is less apparent in the context of the expiration of the expanded subsidies and fully-subsidized benchmark plans, which removes much of the incentive for unscrupulous agents and brokers to fraudulently enroll consumers into Exchange coverage who then may not know they need to file Federal income taxes and reconcile APTC. Commenters also expressed concern that the 1-year FTR may result in coverage losses because the tax filing process is complex, and many consumers are not fully aware of the requirements to file and reconcile. Commenters suggested that this could especially be true for young persons, which might result in a less healthy risk pool. Commenters also expressed concern that low-income consumers would be negatively affected by proposals requiring household income verification because persons in this group have a much more difficult time predicting and verifying income

[111] Direct notices contain Federal tax information (FTI) and are sent to tax filers, while indirect notices do not contain FTI and can be sent to enrollees who may not be their tax household's tax filer.

[112] IRS. (2024, Dec. 30). SOI Tax Stats—Individual Income Tax Returns Line Item Estimates (Publications 4801 and 5385). Dep't of Treasury. *https://www.irs.gov/statistics/soi-tax-stats-individual-income-tax-returns-line-item-estimates-publications-4801-and-5385.*

[113] *https://www.irs.gov/pub/irs-pdf/p4801.pdf.*

[114] Figure derived from CCIIO analysis of internal agency data.

due to unpredictable nature of their income.

Therefore, to balance competing concerns, this policy will sunset automatically after the completion of one new coverage year, PY 2026, on December 31, 2026. The two-year FTR policy will be in effect for PY 2027 and beyond, beginning with Open Enrollment for PY 2027. As such, we are adding a new special rule at § 155.305(f)(4)(iii), which states that for PY 2026, Exchanges must follow the 1-year FTR policy and 1-year FTR notice requirements.

Comment: Many commenters opposed the proposed policy change to revert to the 1-year FTR policy stating that the two-year policy strikes a better balance between ensuring that enrollees file their Federal income taxes and reconcile APTC, while also allowing for the fact that the IRS data is often delayed due to long processing times, especially for paper filers and amended income tax returns.

Response: While we agree that long IRS processing times of Federal income tax returns, especially for those filing paper and amended tax returns, may impact an Exchange's FTR operations, we believe this is unlikely a sufficient reason to maintain the current two-year FTR process for 1 year while addressing the imminent program integrity concerns. Further, we attempt to mitigate the long IRS processing times with the FTR Recheck process, which allows for enrollees who have filed by the October 15 extended filing date to attest to doing so, while maintaining eligibility for APTC for the following coverage year. FTR status is rechecked early in the coverage year to compare attestations with more recently updated FTR data. If a consumer is still showing as FTR after FTR Recheck, then the consumer receives a notification before a final check of FTR status before the Exchange terminates eligibility for APTC. Consumers who believe they have erroneously been found ineligible for APTC should contact the Marketplace Appeals Center.[115]

Comment: Many commenters expressed concern over the short time frame for implementing the 1-year FTR policy and asked to extend the implementation date until OEP 2027. They noted that many of their plans for OEP 2026 are already being finalized, and their time and State budgets have already been committed to different projects, which will prevent State Exchanges from completing the necessary IT infrastructure and eligibility logic changes to revert to a 1-year FTR policy.

Response: We understand these concerns, however, we believe that implementing this policy as soon as practicable and implementing the 1-year FTR policy during PY 2026 is most appropriate to address imminent improper enrollment concerns associated with fully-subsidized plans and the expanded subsidies generally. As we explain earlier in this section, under the 1-year FTR policy, consumers are more likely to discover their improper enrollments after 1 year, instead of 2 years, lessening their risk of increased tax liability due to premium subsidies paid on their behalf. That said, we understand that once the excess improper enrollments have been shed and the expanded subsidies are no longer shielding enrollees from all costs associated with coverage, the efficiency of maintaining the 1-year FTR policy is less clear. Thus, we are finalizing this policy as proposed, but with a modification that Exchanges will be required to implement the 1-year FTR policy through the conclusion of PY 2026 on December 31, 2026.

Comment: Many commenters expressed concern that the proposed 1-year policy would increase coverage loss, especially among those who are lower-income individuals and homeless as they would no longer be able to afford their monthly Exchange premium after APTC is terminated, as well as having a negative impact on the risk pool. Relatedly, many commenters expressed concern about the potential increase in IRS delays and the impact that delayed data could have on the 1-year process.

Response: We thank these commenters for their concern. We share commenters' concerns about the risk of coverage losses among lower-income individuals. However, we believe that imminent program integrity concerns merit the need for a temporary policy. As the Department is concerned with potentially unwarranted coverage loss, we are finalizing this policy for PY 2026 only, with a reversion to the previous 2-year policy for PY 2027 and beyond. This approach allows us to balance ensuring that consumers who have not filed their Federal income taxes and reconciled APTC due to improper enrollment, do not retain unwanted or unneeded coverage as well as preventing the loss of coverage by enrollees who have complied with tax filing requirements over the long-term. We also note that, if an enrollee believes that they lost APTC erroneously due to FTR, they can file an appeal with the Marketplace Appeals Center.

Comment: A few commenters stated that the change in the FTR policy does not meet the Administrative Procedure Act (APA) requirements for reasoned decision-making because they believe that HHS has failed to provide the public with adequate data to adequately comment on the proposed rule.

Response: In the proposed rule (90 FR 12959 through 12961), we provided historical data for the 1-tax year FTR process as well as data estimates provided in the 2024 Payment Notice for the 2-tax year FTR process to represent the FTR population prior to the publishing of the proposed rule. This data showed that more consumers would have an FTR status (either 1 year or 2 year) as compared to the prior 1-tax year process, which would increase Federal expenditures. In addition, we provided tax filing status data that supported the current 2-year FTR process placing a substantially higher number of consumers at risk of accumulating increased tax liabilities than compared to a 1-year FTR process. We believe that this data supports the need for and the reasonableness of the FTR policy change while providing adequate notice to the public to comment on this policy change.

As we explained in the proposed rule (90 FR 12959), the Initial FTR Recheck data from the 2-year policy was not available at the time of publishing the proposed rule. We have provided updated data in preamble of this final rule about the FTR population following the FTR Recheck process and is current as of April 2025. We believe this data further supports the need for this near-term policy change after which we can closely monitor its impacts. HHS is of the view that the best way forward is to act now to guard against improper payments of APTC and the potential for increased tax liability by finalizing the 1-year policy for all Exchanges effective for the 2026 coverage year.

We also note that some commenters may believe that we have additional data regarding the FTR population. We reiterate that due to FTI privacy concerns, we have a limited set of data regarding the FTR population and to protect FTI, the data generally, does not trace how an enrollee moves through the FTR process in order to protect FTI. Instead, we examined the overall population level data that shows how the FTR population decreases as tax filers either file and reconcile or lose eligibility for APTC or QHP coverage for other, non-FTR related reasons.

Comment: Commenters expressed concern that the change could increase coverage loss, as well as negatively impact the risk pool because healthy

[115] The Marketplace Appeals Center can be contacted at 1–855–231–1751.

individuals are less likely to jump through administrative hurdles to keep their coverage. They also expressed concern that many people will forgo their health coverage, thereby leading to lower levels of community health and increased incidence of communicable disease, potentially even increasing diseases such as HIV/AIDS if they are not well controlled due to lack of insurance and ability to purchase medications.

Response: We appreciate and share commenter concerns about the potential for increased coverage loss and potential negative impacts on the risk pools. For this reason and others outlined in section III.B of this final rule, we think it is prudent to closely monitor the effects of the implementation of this policy for a year to measure the impacts of the change in the FTR policy on the number of enrollees who lose coverage due to FTR. Finally, as mentioned above, consumers may submit an appeal to the Marketplace Appeals Center if they believe that they lost APTC erroneously due to FTR.

Comment: Many commenters expressed concern that the tax filing process is complex, and many consumers are not fully aware of the requirements to file and reconcile, especially for the population that is more transient, as well as those not as financially or technologically literate. They noted that many of these consumers are simply unaware of how the tax system works, and consumers are not trying to purposefully game it and potentially incur criminal penalties from not filing Federal income taxes. They recommended States partner with providers who serve those who are experiencing homelessness to ensure consumers are aware of the need to file and reconcile.

Response: We appreciate these concerns, but also note that HHS does not have authority over the Federal income tax rules in the Internal Revenue Code. We note that the IRS's Volunteer Income Tax Assistance (VITA) curriculum includes information on the requirement to file and reconcile and that through VITA, IRS-certified volunteers are available to help individuals who need assistance in preparing their own tax returns, including people who make $67,000 or less, persons with disabilities, and limited English-speaking taxpayers. We will continue to educate consumers about the requirement to file and reconcile using notices throughout the FTR process and also encourage State Exchanges to work with homeless service providers in their States to ensure consumers are aware of the need to file and reconcile.

Comment: A few commenters expressed support for the 1-year FTR policy and noted that the proposed changes would save taxpayer money by reducing APTC payments on behalf of ineligible enrollees or consumers who were unaware of their enrollment. One commenter agreed with HHS' concern for preventing accumulating balances of back taxes on behalf of consumers.

Response: We agree with the commenters and note that reverting back to a 1-year FTR policy will help mitigate the risk of improper enrollment in the Exchanges, while also protecting consumers from incurring large tax liabilities due to failing to file and reconcile APTC. Finalizing this policy for 2026 allows us to balance these imminent concerns with longer-term desires to streamline enrollment processes.

Comment: A State Exchange noted that only 1 percent of their enrollees failed to file a tax return for 2 consecutive tax years when they ran FTR Recheck this year.

Response: Due to IRS data constraints, if State Exchanges used the Hub service to call IRS for their consumers' FTR statuses between December 8, 2024 and March 29, 2025, it is highly likely that a consumer with a 2-year FTR status would return a 1-year FTR response from the IRS. Unfortunately, this error was not discovered until Exchanges on the Federal platform started FTR Recheck operations in January 2025. While we understand that many State Exchanges' FTR populations do not mirror the Exchanges on the Federal platform for a variety of reasons, it seems likely that the State Exchanges that had such low 2-year FTR rates may have called the IRS Hub service while the IRS's data was not being correctly reported. We understand that many State Exchanges did not perform FTR Recheck operations until later in the coverage year.

Comment: Many State Exchanges recommended that they should retain flexibility regarding their notices because they need to meet both Federal and State requirements and forced alignment with requirements for Exchanges on the Federal platform could open States to burdensome requirements and possible litigation. Other State Exchanges noted that they only provide enrollment options through their Exchange website and their Navigators work with their enrollees to help project their income and educate them on the need to file and reconcile.

Response: We acknowledge State Exchanges' request to retain flexibility in their notice requirements. HHS has retained the current flexibility regarding FTR notices allowed to State Exchanges in the finalized rule and these flexibilities would remain in place whether Exchanges are required to use a 1-year or 2-year FTR policy.

Comment: A few commenters stated that HHS should fully repeal FTR processes because there is no statutory authority for it.

Response: We disagree with commenters that there is no statutory authority for Exchanges to conduct FTR. Consumers who receive APTC are required to file income taxes pursuant to section 6011(a) of the Code and regulations prescribed by the Secretary of Treasury. Section 36B(f) of the Code requires taxpayers to reconcile their APTC under section 1412 of the ACA with their PTC allowed under section 36B of the Code. FTR regulations, implemented pursuant to the Secretary of HHS' general rulemaking authority under section 1321(a) of the ACA, facilitate compliance with those requirements and were implemented as part of the original Exchange Establishment Rule.

ii. Conforming Change to Notice Requirements

To conform with this proposed FTR process, in the 2025 Marketplace Integrity and Affordability proposed rule (90 FR 12961 through 12962), we proposed to revise the notice requirement at § 155.305(f)(4)(i) and remove the notice requirement at § 155.305(f)(4)(ii). When we finalized the current FTR process for PY 2025 in the 2024 Payment Notice (88 FR 25814) to require Exchanges to wait to discontinue APTC until the tax filer has failed to file a tax return and reconcile their past APTC for 2 consecutive tax years, we did not impose a requirement for Exchanges to notify such enrollee during the first year that they failed to file and reconcile. We then amended § 155.305(f)(4) in the 2025 Payment Notice (89 FR 26298 through 26299) to require that all Exchanges send one of two notices to tax filers or enrollees with an FTR status for 1 year, and again in the 2026 Payment Notice (90 FR 4472 through 4473) to require that all Exchanges send one of two notices to tax filers or enrollees with an FTR status for 2 consecutive tax years. Accordingly, for both an enrollee's first and second year with an FTR status, all Exchanges must have either (1) notified the tax filer directly of their FTR status and educate them of the need to file and reconcile or risk being determined ineligible for

APTC if they fail to file and reconcile for a second consecutive year, or (2) sent an indirect notification to either the tax filer or their enrollee that informs them they are at risk of being determined ineligible for APTC in the future. The indirect notice must do so without indicating that the tax filer has failed to file and reconcile their APTC for both the first year and the second year that they have been found not to have done so in order to protect FTI.

Because we proposed to amend § 155.305(f)(4) to require Exchanges to determine people ineligible for APTC after one tax year of FTR status rather than 2 consecutive tax years, the current notice requirement aimed at tax filers in a 2-tax year FTR status would no longer apply. Therefore, we proposed to revise the notice requirement at § 155.305(f)(4)(i) and remove the notice requirement at § 155.305(f)(4)(ii). We invited comment on this proposal.

To ensure tax filers and enrollees receive advanced notice of their FTR status and the risk for being determined ineligible for APTC after removing this notice requirement, we proposed to reinstate the notice procedures that existed before we established the current FTR process for Exchanges on the Federal platform. See Table 3 for summary of notices sent.

TABLE 3—FTR RECHECK NOTICES AND TIMING

Notices	Timing
Enrollees with FTR status receive Marketplace Open Enrollment Notice (MOEN) with FTR language & tax filers receive OE FTR direct notice.	Fall (prior to OEP beginning).
Tax filers receive FTR Recheck direct notice and enrollees receive FTR Recheck Indirect Notice upon completion of FTR Recheck.	Early winter (shortly after OEP ends).
Upon final recheck, enrollees losing APTC receive updated Eligibility Determination Notice (EDN) and tax filers receive Stop APTC direct notice.	Spring.

If enrollees have attested to filing and reconciling, enrollees would be discontinued from APTC only after the IRS checks and rechecks their FTR status four times. We stated in the proposed rule (90 FR 12962) that we believe this gives ample notice to enrollees who may have been confused about the requirement to file and reconcile and provides the IRS enough time to process tax returns for enrollees who complied. We also stated that we believe this procedure ensures that enrollees who are eligible for coverage continue to receive coverage. Under this proposed requirement at § 155.305(f)(4)(i)(B), State Exchanges would be responsible for administering their own notice procedure with flexibility to send either direct notices containing FTI, or indirect notices which do not contain any protected FTI, or both.

We sought further comment on whether State Exchanges should be required to align with Exchanges on the Federal platform on this consumer noticing and recheck process.

After consideration of comments and for the reasons outlined in the proposed rule, final rule, and our responses to comments, including the reasons outlined in Section III.B of this final rule, we are finalizing the addition of § 155.305(f)(4)(iii) for all Exchanges. Once these policies sunset at the end of PY 2026, the 2-year FTR policy will apply to all Exchanges, as well as the requirements to send FTR notices under the currently effective versions of §§ 155.305(f)(4)(i)(B) and (f)(4)(ii). We summarize and respond to public comments received on the proposed FTR notice policy below.

Comment: Several commenters were concerned with ensuring that enrollees receive adequate notice of appeal and extension rights if there is a mistake in the FTR process.

Response: We agree with commenters that enrollees should receive adequate notice about the requirement to file their Federal income taxes and reconcile APTC, which is why the Exchanges on the Federal platform exceed the requirements of this rule in notifying tax filers and/or their enrollees. Exchanges on the Federal platform provide a direct notification to the tax filer and an indirect notification that does not disclose FTI to the enrollee before the OEP, at the time of FTR Recheck, as well as when an enrollee's APTC is terminated. HHS includes instructions in both the APTC termination notice to the tax filer after removal of APTC as well as the enrollee's updated Eligibility Determination Notice on how to contact the Marketplace Appeals Center to appeal their FTR status if a consumer believes they have filed and reconciled.[116] We recommend that State Exchanges also include this information in their notices to enrollees and/or tax filers.

Comment: Many commenters expressed concern that the 1-year FTR process would not provide sufficient notice and would be insufficient to meet due process requirements because the notices are spread out over a year, and because the indirect notice does not explain in sufficient detail why the individual is losing APTC or what they could do to remediate the issue and be successful in appeal. They believed the current 2-year process, including the associated notices, should remain in place.

Response: While we appreciate the commenters' concern, we believe the 1-year FTR process would provide sufficient notice. A consumer would receive their first FTR notice approximately six months before losing their eligibility for APTC for failing to file their income taxes and reconcile their APTC. While an indirect notice may not specifically state that a consumer has been identified as failing to file their Federal income tax returns and reconcile, it should say that a consumer needs to file their Federal income tax return and reconcile APTC to remain eligible for APTC. We note that the notice policies that we finalize in this rule describe the minimum requirements for these notices, and States are free to provide a direct notice to the tax filer as well. We have provided guidance to State Exchanges to ensure the notice content is adequate.[117]

b. 60-Day Extension To Resolve Income Inconsistency (§ 155.315)

In the 2025 Marketplace Integrity and Affordability proposed rule (90 FR 12962 through 12963), we proposed to remove § 155.315(f)(7) which requires Exchanges to provide an automatic 60-day extension in addition to the 90 days currently provided by § 155.315(f)(2)(ii) to allow applicants additional time to provide documentation to verify household income.

According to section 1411(e)(4)(A) of the ACA, part of the process to verify the accuracy of information provided on

[116] *https://www.cms.gov/marketplace/in-person-assisters/applications-forms-notices/notices.*

[117] OMB Control No. 0938–1207.

applications requires Exchanges to provide applicants an opportunity to correct an inconsistency with HHS or other trusted data sources when the inconsistency or inability to verify the information is not resolved by the Exchange. This requires Exchanges to give applicants notice of the inability to resolve the inconsistency and verify the information. Exchanges must also provide the applicant an opportunity to either present satisfactory documentary evidence or resolve the inconsistency with HHS or other trusted data sources during the 90-day period beginning on the date on which the notice is sent to the applicant. Section 1411(e)(4)(A) of the ACA also states HHS may extend the 90-day period for enrollments occurring during 2014.

When we explained the legal basis for a 60-day extension in the 2024 Payment Notice (88 FR 25819), we stated the proposal aligns with current § 155.315(f)(3), which provides extensions to applicants beyond the existing 90 days if the applicant demonstrates that a good faith effort has been made to obtain the required documentation during the period. We noted that it is also consistent with the flexibility under section 1411(c)(4)(B) of the ACA to modify methods for verification of the information where we determined such modifications would reduce the administrative costs and burdens on the applicant. However, as discussed previously, section 1411(c)(4)(B) of the ACA specifically limits modifications on how information is exchanged and verified between HHS and trusted data sources and does not extend to other aspects of the verification process. Therefore, section 1411(c)(4)(B) of the ACA does not provide a statutory basis to modify the length of the 90-day response period.

Section 1411(e)(4)(A) of the ACA also limits modifications to the 90-day response period. This language allows HHS to extend the 90-day period in 2014. This flexibility was clearly intended to accommodate any issues that might arise during the first year HHS administered eligibility determinations for premium and cost-sharing subsidies. By expressly including this specific allowance to extend the 90-day period for 2014, the language strongly suggests Congress did not intend to allow any further extensions to the 90-day period. Therefore, we do not believe § 155.315(f)(7) conforms with the statute.

Based on this reading of the statute, we stated in the proposed rule (90 FR 12963) that we question whether the extension of the 90-day period when an applicant demonstrates a good faith effort to obtain documentation during the period under § 155.315(f)(3) conforms with the statute. Due to the *ad hoc* nature of this good faith effort extension, we stated that we believe this is likely an appropriate use of our authority. In contrast, the automatic 60-day extension, in effect, categorically suspends the 90-day period and replaces it with a 150-day period which we believe falls well outside our authority.

We stated in the proposed rule (90 FR 12963), that even if the statute allowed an automatic 60-day extension, our review of how applicants used the 60-day extension shows that the benefits we previously anticipated have not materialized. When we adopted the 60-day extension in the 2024 Payment Notice (88 FR 25819 through 25820), we determined the change would ensure consumers are treated equitably, ensure continuous coverage, and strengthen the risk pool. However, we stated in the proposed rule (90 FR 12963) that upon further review of the prior experience and the current experience using the 60-day extension, we find the 60-day extension largely does not deliver the benefits anticipated. Instead, we stated that we find the change weakened program integrity.

As we stated in the proposed rule (90 FR 12963), we previously determined that 90 days is often an insufficient amount of time for many applicants to provide income documentation, since it can require multiple documents from various household members along with an explanation of seasonal employment or self-employment, including multiple jobs. The previous review of income DMI data indicated that when consumers receive additional time, they are more likely to successfully provide documentation to verify their projected household income. We stated that between 2018 and 2021, over one third of consumers who resolved their DMIs on the Exchange did so in more than 90 days.

We further stated in the proposed rule (90 FR 12963) that while we previously found one-third of consumers who resolve income DMIs used an extension between 2018 and 2021, our review from 2024 shows that applicants who successfully used the extension represented 55 percent of the total income DMIs. We also found that the percent of all applicants with an income DMI who used an extension represented 60 percent of total income DMIs. We noted that after implementing the 60-day extension, we did not see that the extension improved these statistics. Of those who successfully resolved their income DMI in 2024, 58 percent used the extension which is about the same as before in 2022. This suggests that, before the automatic 60-day extension, anyone who needed a 60-day extension was granted one under § 155.315(f)(3), and the automatic 60-day extension only served to keep people who were able to provide documentation within 60 days (instead of 120 days) covered for a longer period. Additionally, we estimated this increased APTC expenditures by $170 million in 2024. Therefore, we determined that the automatic 60-day extension did not provide a meaningful benefit to consumers and weakened program integrity.

We sought comment on this topic and suggestions to alleviate this concern.

As we discussed in other aspects of the proposed rule, there are often countervailing impacts on the risk pool and program integrity from the policy decisions we make. In this case, we stated in the 2024 Payment Notice (88 FR 25820) that consumers in the 25–35 age group were most likely to lose their APTC eligibility due to an income DMI, resulting in a loss of a population that, on average, has a lower health risk, thereby negatively impacting the risk pool. Therefore, we concluded that adding the automatic 60-day extension would improve the risk pool by making it easier for younger and healthier populations to enroll.

In the proposed rule (90 FR 12963), we stated that we must weigh this potential positive impact on the risk pool against the substantial increase in APTC expenditures that we identified from ineligible people who stay enrolled and receive APTC for an additional 60 days. We stated that we believe the cost to taxpayers and decline in program integrity outweigh any possible benefit to the risk pool.

We stated in the proposed rule (90 FR 12963) that providing a 60-day extension for households with income DMIs only serves to increase APTC payments and tax liabilities for ineligible enrollees during the extension. Therefore, we stated that we believe the cost of the extension outweighs the benefits.

As stated previously and in the proposed rule, we now believe that the automatic 60-day extension falls outside of our authority and therefore statutory language compels us to make this change. As such, we must make this change permanent.

We sought comment on this proposal.

After consideration of comments and for the reasons outlined in the proposed rule and this final rule, including our

responses to comments, we are finalizing, as proposed, the removal of 155.315(f)(7). This amendment will be applicable as of the effective date of this rule. We summarize and respond below to public comments received on the proposed removal of the 60-day extension for households to resolve income DMIs.

Comment: Some commenters supported the proposal, most of whom were advocacy groups or large issuers who supported the proposal's focus on addressing fraud. One supportive commenter referenced surprise tax bills as an additional benefit of updated verification requirements.

Response: We acknowledge and appreciate the commenters' support for this proposal, which we believe will reduce fraud in Exchanges.

Comment: Many commenters expressed concern that the proposed policy would disproportionately impact some consumer groups and present barriers to enrollment. Specific groups referenced included, among others, low-income people, rural individuals, persons with disabilities, people of color, Tribal communities, and seniors.

Response: We acknowledge commenters' concern. While we do not believe the 60-day automatic extension is consistent with our statutory authority under the ACA, as discussed in the proposed rule (90 FR 12962 through 12963), consumers with difficulties resolving their data matching issues remain eligible for the extension outlined in § 155.315(f)(3). We will continue to evaluate program performance to identify inconsistency resolution trends among all groups and the impact of these operational changes on identified groups.

Comment: Many commenters expressed concerns that proposed policy would adversely affect consumers who are employed in the gig economy or seasonal work.

Response: We recognize that consumers with multiple streams of income information experience more complex income DMI verification processes and may encounter increased administrative burden in providing the documentation to resolve their DMIs. We believe that the policy we are finalizing in this rule still provides sufficient time for consumers to provide documentation for verification because a review of income inconsistency resolution data before and after the implementation of the extension did not demonstrate a significant increase in resolution with the additional 90 days, indicating under most conditions consumers across all income data matching issue scenarios, including gig workers, can verify their data matching issues in the provided timeframe. Furthermore, we want to emphasize that this change does not prevent consumers from receiving an extension as outlined in § 155.315(f)(3) should they meet the applicable criteria.

Comment: Some State Exchanges noted that the payment integrity data CMS proposed is inconsistent with their data and requested additional flexibilities in extensions for their distinct populations. The particulars of the inconsistencies noted by these State Exchanges varied by State, however, the Massachusetts Commonwealth Health Insurance Connector Authority provided an example, stating ''the Health Connector does not experience those challenges that CMS describes as occurring within the FFM.'' Specific concerns raised by States included, among others, a lack of analysis of Medicaid expansion vs non-expansion States and the lack of analysis in the proposed rule of which States utilize third party agents and brokers.

Response: We acknowledge that State Exchanges have nuances in their demographics and payment integrity data, however, we believe that this change is necessary given that the requirement to automatically provide a 60-day extension at § 155.315(f)(7) is inconsistent with our statutory authority. Because this is a statute-driven change, we believe that this change must be implemented across all Exchanges, regardless of the data matching dynamics in the particular context of implementation. Furthermore, we believe that consumers should have sufficient time to submit documentation to verify their projected household income within the inconsistency period without the automatic 60-day extension given that the income inconsistency resolution data before and after the 60-day extension as referenced in the proposed rule (90 FR 12963), indicating that this change is not anticipated to unreasonably adversely impact consumers in State Exchanges. Finally, we note that § 155.315(f)(3) already allows State Exchanges to extend the 90-day period in § 155.315(f)(2)(ii) when an applicant demonstrates that a good faith effort has been made to obtain the required documentation during the period. This finalized change removes the requirement for all Exchanges to provide an automatic, general 60-day extension, but it does not restrict a State Exchange's flexibility on exercising its extension authority on a case-by-case basis.

Comment: Some commenters, particularly individual advocacy groups, stated that CMS should evaluate the inclusion of other data sources into income verification processes rather than removing the 60-day extension in order to support program efficiency and integrity.

Response: We may continue to evaluate data sources which may be more appropriate for income verification procedures, however, we are making this change to fulfill our responsibility to align policy with statutory authority which is independent of considerations for additional verification methods. We believe that additional data sources could complement the changes we are finalizing to the automatic extension, however, their inclusion would not substitute for the necessity of making this change. We take the position that ultimately this change will improve program integrity, and believe that consumers should still have sufficient time to submit documentation to verify their projected household income within their inconsistency period with or without additional changes to the utilization of trusted data sources.

Comment: Commenters expressed concern with the data referenced in the proposed rule to support this proposal, reporting that they were not satisfied that the reported metrics sufficiently demonstrated evidence of widespread fraudulent behavior. Specifically, some commenters questioned the data findings referenced in the proposed rule, including the data limitations and exclusions, and the limited data regarding enrollment trends changing around the COVID–19 PHE. Others noted that the data referenced was not representative of State Exchange data dynamics.

Response: We acknowledge the need to collect and report on high quality metrics to evaluate and monitor program integrity across the Exchange. While this change is determined to be necessary on the grounds of statutory alignment and thus is independent of the identified data concerns, we will continue to evaluate data on income verification operations on an ongoing basis to assess the impact of this operational change and continue to evaluate opportunities to strengthen program integrity and efficiency.

Comment: Many commenters opposed this proposal, citing concerns that these administrative changes would create consumer and bureaucratic burden which could in turn destabilize the risk pool.

Response: We acknowledge commenters' concerns around administrative burden. However, as discussed in the proposed rule (90 FR

12963), this change is necessary given that the current 60-day extension is inconsistent with the statute, necessitating implementation of this change across the Exchanges. Ultimately, after an analysis of program data, we believe that the positive impact to program integrity will outweigh any negative impacts to the risk pool.

c. Income Verification When Data Sources Indicate Income Less Than 100 Percent of the FPL (§ 155.320(c)(3)(iii))

In the 2025 Marketplace Integrity and Affordability proposed rule (90 FR 12963 through 12967), we proposed to revise § 155.320(c)(3)(iii) to require Exchanges to generate annual household income inconsistencies in certain circumstances when a tax filer's attested projected annual household income is equal to or greater than 100 percent of the FPL and no more than 400 percent of the FPL, while the income amounts returned by the IRS, the SSA, and current income data sources is less than 100 percent of the FPL. This change would re-codify a provision the Department finalized in the 2019 Payment Notice (83 FR 16985), that was later vacated by the United States District Court for the District of Maryland in *City of Columbus* v. *Cochran,* 523 F. Supp. 3d 731 (D. Md. 2021), finding there was insufficient evidence of prevalent fraudulent behavior justifying the administrative burden and corresponding coverage impacts. In the proposed rule, we stated that though we believe we had a clear legal basis for finalizing the provisions in the 2019 Payment Notice, we also believe circumstances have changed substantially since the court vacated the prior rulemaking. The Department, in the proposed rule and this final rule, has provided a reasoned justification to reinstate the policy, supported by data and related estimates documenting the consumer harm and significant losses of taxpayer dollars illustrating the reasons this income DMI is necessary. While we previously acknowledged in the 2019 Payment Notice that we did not have firm data on the number of applicants who might be inflating their income to gain APTC eligibility, there is now clear evidence from enrollment data that shows potentially millions of applicants are inflating their incomes or having applications submitted on their behalf with inflated incomes.[118] Additionally, while concerns were raised in *City of Columbus* v. *Cochran* about consumers who may project a higher income than they receive due to the nature of low-wage work making it difficult to predict their annual household income, we stated that we believe enough consumers—and the agents, brokers, and web-brokers helping them apply—are intentionally inflating their incomes to qualify for fully-subsidized plans that justifies the creation of this income DMI type, as data shows below.

Section 155.320(c)(3)(iii) sets forth the verification process when household income attestations on applications increase from the prior tax year or are higher than trusted data sources indicate. Generally, if income data from our electronic data sources indicate a tax filer's attested projected annual household income is *more than* the household income amount represented by income data returned by the IRS and the SSA and current income data sources, § 155.320(c)(3)(iii) requires the Exchange to accept the attestation without further verification. Currently, Exchanges are generally not permitted to create inconsistencies for consumers when the consumers' attested household income is greater than the amount represented by income data returned by IRS and the SSA and other trusted data sources.

However, in the 2019 Payment Notice (83 FR 16985), we concluded that where electronic data sources reflect household income under 100 percent of the FPL and a consumer attests to household income between 100 percent of the FPL and 400 percent of the FPL and where the attested household income exceeds the income reflected in trusted data sources by more than a reasonable threshold, it would be reasonable to request additional documentation to protect against overpayment of APTC because the consumer's attested household income could make the consumer eligible for APTC when income data from electronic data sources suggest otherwise. Additionally, consumers who have attested household income higher than 100 percent of the FPL, but data sources show income below 100 percent of the FPL, may be motivated to overestimate their income to gain eligibility for APTC where they would not be eligible otherwise, especially in non-Medicaid expansion States. In contrast, consumers who have higher attested annual household income than trusted data sources reflect, but where both the attested and income from data sources is above 100 percent of the FPL, are not motivated to overestimate their income as they would simply receive less APTC. Still today, the risk of APTC overpayments under these circumstances is true because tax filers may be eligible for PTC with household income below 100 percent of the FPL if APTC was paid based on the tax filer having estimated household income of at least 100 percent of the FPL.[119] Barring other changes in circumstance, these tax filers will not have to repay any APTC. That taxpayers are not required to repay APTC in this situation magnifies the need for Exchanges to take additional reasonable steps to verify the household incomes of persons for whom Federal trusted data services report household income of less than 100 percent of the FPL.

In the 2019 Payment Notice (83 FR 16985), we concluded it would be reasonable to request additional documentation to protect against overpayment of APTC despite not having firm data on the number of applicants that might be inflating their income. We viewed this policy as a critical program integrity measure to address the findings from a U.S. Government Accountability Office (GAO) study on improper payments that determined our control activities related to the accuracy of APTC calculations were not properly designed.[120] Specifically, this study found that ''CMS does not check for potentially overstated income amounts, despite the risk that individuals may do so in order to qualify for advance PTC.'' [121]

Based on this finding, the GAO recommended that HHS direct the CMS Administrator to take the following action: ''Design and implement procedures for verifying with IRS (1) household incomes, when attested income amounts significantly exceed income amounts reported by IRS or other third-party sources, and (2) family sizes.'' To support this recommendation, the GAO cited its own testing of 93 applications which found 11 applications for individuals residing in States that did not expand Medicaid where IRS data provided to CMS during application review indicated incomes less than 100 percent of the FPL.[122] After citing these GAO findings and recommendations, we concluded in the 2019 Payment Notice (83 FR 16986) that, particularly to the extent funds

[118] *See* Hopkins, B.; Banthin, J.; and Minicozzi, A. (2024, Dec. 19). How Did Take Up of Marketplace Plans Vary with Price, Income, and Gender? *American Journal of Health Economics, 1(11). https://www.journals.uchicago.edu/doi/10.1086/727785.*

[119] *See* 26 CFR 1.36B–2(b)(6)(i). This rule does not apply if the taxpayer, with intentional or reckless disregard for the facts, provided incorrect information to the Exchange for the year of coverage. *See* 26 CFR 1.36B–2(b)(6)(ii).

[120] U.S. Government Accountability Office (2017, July). Improper Payments: Improvements Needed in CMS and IRS Controls over Health Insurance Premium Tax Credit. P. 36. *https://www.gao.gov/assets/d17467.pdf.*

[121] Ibid.

[122] Ibid. at 37.

paid for APTC cannot be recouped through the tax reconciliation process, it is important to ensure these funds are not paid out inappropriately in the first instance.

Though we cited evidence from the GAO study in the 2019 Payment Notice (83 FR 16986), the United States District Court for the District of Maryland in *City of Columbus* v. *Cochran* stated that HHS ''failed to point to any actual or anecdotal evidence indicating fraud in the record.'' [123] The court went on to conclude that ''HHS's decision to prioritize a hypothetical risk of fraud over the substantiated risk that its decision result in immense administrative burdens at best, and a loss of coverage for eligible individuals at worst, defies logic.'' With this final rule, we believe we have addressed concerns raised in this case through new data illustrating the findings raised in the GAO study.

After the court vacated HHS' income verification requirements, we reviewed data from a recent study analyzing the time period before the original income verification requirement was implemented and found data support that applicants inflated their income. A recent study analyzing CMS enrollment data for the 39 States that used *HealthCare.gov* between 2015 and 2017 found that many people with household incomes too low to qualify for APTC in States that did not expand Medicaid have a strong incentive to attest to income just above the eligibility threshold to obtain APTC.[124] While the data in the study predates the 2019 Payment Notice (83 FR 16986), the study was published in 2024, and identifies vulnerabilities that still exist today following the court's vacatur of the income verification requirement. The study's authors found far higher numbers of enrollees who reported household income just above the income threshold in non-Medicaid expansion States versus Medicaid expansion States. We stated in the proposed rule (90 FR 12964) that we believe this data is a strong indicator that increased enrollment volume since 2021 has exacerbated the vulnerabilities the study identified as existing between 2015 and 2017.

In addition, the study identified that enrollees attested to very precise household incomes that suggested they were aware of the income thresholds to gain eligibility for APTC.[125] This finding is consistent with applicants who did not provide their best household income estimate but instead provided an estimate to maximize the premium and CSR subsidies they receive or were assisted in their applications by entities who were aware of these thresholds and who could profit from their enrollment. In the proposed rule (90 FR 12964 through 12965), we stated that this led us to believe that while some consumers may have difficulty estimating their annual household income due to the uncertainty present in low wage work, many consumers are intentionally inflating their incomes. The study's authors then compared actual enrollment on *HealthCare.gov* for enrollees who reported household income just above the eligibility threshold from $11,760 to $12,500 to estimated potential enrollment from Census surveys and found actual enrollment was 136 percent higher than the total population of potential enrollments.[126]

A more recent analysis of 2024 open enrollment data shows plan selections on *HealthCare.gov* among people ages 19–64 who reported household income between 100 percent and 150 percent of the FPL in non-Medicaid expansion States were 70 percent higher than potential enrollments estimated from Census data at that same income level.[127] Based on this mismatch between enrollment and the eligible population, this study estimates four to five million people improperly enrolled in QHP coverage with APTC in 2024 at a cost of $15 to $20 billion.[128] These data provide substantial evidence that applicants with household incomes below the APTC income eligibility threshold are strategically inflating their household incomes—or, based on evidence described elsewhere in this rule, are getting assistance from agents, brokers, or web-brokers who have a financial incentive to misstate enrollee income to secure commissions from enrollments of consumers who, absent financial assistance, would not enroll—when they apply for APTC.[129] These individuals are then often being enrolled in fully-subsidized QHPs. We stated in the proposed rule (90 FR 12965) that we believe the scale of actual enrollments in excess of potential enrollments eligible for financial assistance in certain States suggests evidence of improper enrollments, some by agents and brokers.[130] In these cases, enrollees may not even know they are enrolled, and agents, brokers, and web-brokers strategically enroll them at income levels just above the income eligibility threshold so they qualify for fully-subsidized plans. Enrollees never need to pay a premium which would otherwise alert the enrollee to the improper enrollment.[131] Therefore, to strengthen program integrity and reduce the burden of APTC expenditures on taxpayers, we proposed to require all Exchanges to generate annual household income inconsistencies in certain circumstances when applicants report a household income that is *greater than* the income amount represented by income data returned by the IRS and the SSA and current income data sources.

[123] 523 F. Supp. 3d 731, 762 (D. Md. 2021).

[124] Hopkins, B.; Banthin, J.; and Minicozzi, A. (2024, Dec. 19). How Did Take-Up of Marketplace Plans Vary with Price, Income, and Gender? American Journal of Health Economics, 1 (11). *https://www.journals.uchicago.edu/doi/10.1086/727785.*

[125] Ibid.

[126] Ibid.

[127] Blase, B.; Gonshorowski, D. (2024, June). The Great Obamacare Enrollment Fraud. Paragon Health Institute. *https://paragoninstitute.org/private-health/the-great-obamacare-enrollment-fraud.*

[128] Ibid.

[129] We note that in the proposed rule (90 FR 12965), we included a table which showed a substantial increase in the percent of returns with APTC that report excess APTC at lower household income levels between 2019 and 2022. We concluded this suggests a substantial increase in people who earn less than the eligibility threshold for PTC who incorrectly report higher incomes and then qualify for APTC, which, in turn, provides further evidence that applicants with household incomes below the APTC income eligibility threshold are strategically inflating their household incomes to qualify for APTC. After reviewing comments and a closer examination of what is driving the increase in the percent of returns reporting excess APTC at lower income levels, we no longer believe these data provide additional evidence that people are strategically inflating their income. While the evidence presented in this final rule continues to strongly support the conclusion that people are inflating their incomes to qualify for APTC after access to fully-subsidized QHPs expanded, we now understand this expanded access to fully-subsidized plans in 2021 led to the increase in the percent of returns with excess APTC at lower income levels for a different reason. The reason stems from a discrepancy in how Exchanges on the Federal platform report the premium for the benchmark plan used to determine the APTC. The premium for the benchmark plan is generally reported as the full amount in dollars and cents while the APTC is rounded to the nearest dollar amount. This reporting discrepancy was generally not an issue before 2021 because everyone was subject to a required contribution percentage greater than zero. Where a required contribution percentage is set at zero, APTC that is rounded up creates excess APTC.

[130] *See* Ibid.

[131] For example, from January 2024 through August 2024, CMS received 183,553 complaints that consumers were enrolled in coverage through an Exchange on the Federal platform without their consent (also known as an ''unauthorized enrollment''). Additionally, from June 2024 through October 2024, CMS suspended 850 agents and brokers' Exchange agreements for reasonable suspicion of fraudulent or abusive conduct related to unauthorized enrollments or unauthorized plan switches. CMS (2024, October). CMS Update on Action to Prevent Unauthorized Agent and Broker Marketplace Activity. *https://www.cms.gov/newsroom/press-releases/cms-update-actions-prevent-unauthorized-agent-and-broker-marketplace-activity.*

Section 155.320(c)(3)(iii)(A) generally requires the Exchange to accept a consumer's attestation to projected annual household income when the attestation reflects a higher household income than what is indicated in data from the IRS and SSA. This approach makes sense from a program integrity perspective when both the attestation and data from trusted data sources are over 100 percent of the FPL, since an attestation that is higher than data from trusted data sources in that situation would reflect a lower APTC than would be provided if the information from trusted data were used instead. However, where electronic data sources reflect income under 100 percent of the FPL, a consumer attests to household income between 100 percent of the FPL and 400 percent of the FPL, and the attested household income exceeds the income reflected in trusted data sources by more than some reasonable threshold, we stated in the proposed rule (90 FR 12966) that we believe it would be reasonable, prudent, and even necessary in light of the program integrity weaknesses just outlined to request additional documentation, since the consumer's attested household income could make the consumer eligible for APTC that would not be available using income data from electronic data sources. In cases where a consumer receives this DMI, but they do legitimately have annual household income above 100 percent of the FPL, we stated that we believe that the existing DMI process and corresponding time frame provides them plenty of time and opportunities to confirm their annual household income with minimal burden.

Sections 1411 through 1414 of the ACA establish the framework for verifying and determining income eligibility for APTC and CSR subsidies. Requiring further documentation for verification when there is an income inconsistency between the household income provided on the application and the income indicated by the IRS and other data sources makes sense within this statutory framework. The statute compels HHS to, at a minimum, submit the income information provided by applicants to the IRS for verification without exception. Without additional documentation or other supporting evidence, HHS would generally deny eligibility for APTC and CSR subsidies based on the inconsistency with IRS data. When the IRS cannot verify an applicant's income, the statute requires HHS to take additional steps to verify income, thus providing HHS clear discretion to use additional trusted data sources. To support these verifications, section 1413 of the ACA further requires HHS to establish data matching arrangements to verify eligibility through reliable, third-party data sources. However, HHS must also weigh the administrative and other costs of a data matching program against its expected gains in accuracy, efficiency, and program participation, such as when an applicant reports higher household income than reported by trusted data sources and both household income amounts are above 100 percent of the FPL, illustrating no financial incentive for inflating household income. In addition to the program integrity weaknesses discussed previously, we stated in the proposed rule (90 FR 12966) that we believe this statutory framework compels HHS to request additional documentation when applicants attest to household income above 100 percent of the FPL, but trusted data sources show income below 100 percent of the FPL. We requested comments on whether adding these additional data matching issue requirements will outweigh its expected gains as described above.

Accordingly, we proposed to modify § 155.320(c)(3)(iii)(D) and (c)(3)(vi)(C)(2) to specify that Exchanges on the Federal platform would follow the procedures in § 155.315(f)(1) through (4) to create an annual income DMI for consumers if: (1) The consumer attested to projected annual household income that is greater than or equal to 100 percent but not more than 400 percent of the FPL; (2) the Exchange has data from IRS and SSA that indicates household income is below 100 percent of the FPL; (3) the Exchange has not assessed or determined the consumer to have income within the Medicaid or CHIP eligibility standard; and (4) the consumer's attested projected annual household income exceeds the income reflected in the data available from electronic data sources by a reasonable threshold established by the Exchange and approved by HHS. We proposed that a reasonable threshold must not be less than 10 percent and can also include a threshold dollar amount.[132] We sought comments on this proposed reasonable threshold, especially comments that furnish data that could help us ensure that it is properly calibrated to maximize program integrity while minimizing unnecessary administrative burden. Additionally, we stated that this requirement would not apply if an applicant is a non-citizen who is lawfully present and ineligible for Medicaid by reason of immigration status. In accordance with the existing process in § 155.315(f)(1) through (4), if the applicant fails to provide documentation verifying their household income attestation, we stated that the Exchange would redetermine the applicant's eligibility for APTC and CSRs based on available IRS data, which under this proposal would typically result in discontinuing APTC and CSR as required in § 155.320(c)(3)(vi)(G). We further stated that the adjustment and notification process would work like other inconsistency adjustments laid out in § 155.320(c)(3)(vi)(F). We also proposed to modify § 155.320(c)(3)(iii)(A) to add a cross-reference to paragraph § 155.320(c)(3)(iii)(D).

Finally, in the proposed rule (90 FR 12966), we stated that we estimate that answering verification questions and submitting supporting documents would take consumers approximately 1 hour. We stated that we believe such a burden is minimal and is significantly outweighed by the benefit of APTCs for those individuals found to be eligible for them as well as the benefits of reducing improper enrollment. Additionally, even if consumers end up needing longer than the 1-hour estimation due to difficulty in obtaining documentation that may be present, we stated that we believe that the period given to resolve this DMI gives them enough time, and if a consumer ends up needing more time, they are able to request an extension in certain circumstances as described in 45 CFR 155.315(f)(3).

We sought comment on this proposal.

After consideration of comments and for the reasons outlined in the proposed rule and this final rule, including our responses to comments, we are finalizing this policy as of the effective date of this final rule, but with a modification under which the policy and related requirements will sunset for all Exchanges at the end of PY 2026 with a reversion to the previous policy in PY 2027. Like other policies within this rule, we believe it is critical to addressing imminent concerns with improper enrollments related to fully-subsidized plans. As discussed, there is ample evidence of strategic behavior whereby predatory agents, brokers, and web brokers are enrolling people, often without their knowledge, into fully-subsidized plans and, because these individuals often are shielded from ever repaying subsidies, the taxpayer is on

[132] This 10 percent threshold aligns with Annual Income Threshold Adjustment FAQ guidance which was published on 10/22/21 here: *https://www.cms.gov/cciio/resources/regulations-and-guidance/income-threshold-faq.pdf.*

the hook for 100% of improperly paid APTCs on their behalf.

We respect the fraught history of this specific policy, however, and understand the importance of targeting it appropriately towards clear and demonstrable fraud concerns. We understand with the expiration of the enhanced subsidies the same concerns may not exist. Thus, we believe this policy should run through the remainder of PY 2025 after the rule is effective and all of PY 2026 to help the Exchanges shed excess improper enrollments and, once the market has readjusted to the changing subsidy environment in PY 2027, the policy will no longer be effective as concerns about holdover improper enrollments from fully-subsidized plans will likely have abetted. This means that, beginning in PY 2027, Exchanges will instead be required to consider an annual household income attestation verified if IRS returns tax data indicating that the household's annual income is less than the application's attestation of annual household income, even if that IRS data is below 100 percent of the FPL in scenarios where the attested projected annual household income would qualify the tax payer as an applicable taxpayer per 26 CFR 1.36B–2(b). As we explain in this section and in section III.B of this final rule, HHS is of the view that implementing this income verification policy in instances where a consumer is attesting to annual household income above 100 percent of the FPL, but IRS data shows income below 100 percent of the FPL, is a reasonable and necessary step to ensure accurate eligibility determinations based on projected household income during this time of clearly high levels of improper enrollments. However, in consideration of comments, we are finalizing this policy to be applicable only temporarily through the end of PY 2026. Additionally, while in the proposed rule we connected this to the statutory framework, and while it is clear this is allowed by statute, we recognize the statute includes in 1411(c)(4)(B) the provision to weigh the administrative and other costs of a data matching program against its expected gains in accuracy, efficiency, and program participation.

Additionally, independent of comments, we are including a minor modification to remove the reference to 400 percent of the FPL as the maximum to account for possibilities of subsidy eligibility beyond those at 400 percent of the FPL or below. Instead, we are stating that this income DMI is generated in circumstances where the attested projected annual household income would qualify the taxpayer as an applicable taxpayer per 26 CFR 1.36B–2(b). This change also better aligns with existing regulatory text. We summarize and respond to public comments received on the proposed policy to require Exchanges to generate annual household income inconsistencies when a tax filer's attested projected annual household income is equal to or greater than 100 percent of the FPL and no more than 400 percent of the FPL below but income from the IRS shows annual household income below under 100 FPL.

Comment: Some commenters supported the proposal, stating it would improve program integrity, especially as incorrect income estimations threaten program integrity. One commenter stated that the proposal will help address the increase in improper and fraudulent enrollments. Multiple commenters mentioned this will help stop the ''backdoor'' of getting ineligible people coverage in non-Medicaid expansion States.

Response: We agree that this policy will improve program integrity in response to urgent concerns. Given the large amount of improper behavior cited in the proposed rule and in this final rule, we agree that this policy may help limit associated improper enrollments largely resulting from fully-subsidized plans. We acknowledge that this is particularly impactful in non-Medicaid expansion States.

Comment: Some commenters expressed support for how the proposal could help the income verification process and the resulting positive effects of that. Multiple commenters believe that this proposal's improved income verification process could help with correct APTC determinations, with one commenter stating they believe these changes would help result in a more stable and affordable marketplace.

Response: We agree that this policy will help with the income verification process by ensuring income verification occurs when consumers may have an incentive to overestimate their income. Implementing this policy may help ensure accurate income amounts and corresponding APTC determinations and we believe that the improvement to the income verification process outweighs any temporary disruptions as the temporary policy assists Exchanges in reducing the current high levels of improper enrollment.

Comment: Some commenters supported our proposal but believed that CMS needs to take further actions to address program integrity issues such as eliminating or limiting the ''safe harbor'' provision in 26 CFR 1.36B–2(b)(6)(1) or making enrollment pending during the income DMI process rather than allowing for preliminary eligibility.

Response: We appreciate the concerns for program integrity from commenters. We note that HHS does not have regulatory authority over 26 CFR 1.36B–2(b)(6)(1) as this is an IRS regulation. We believe, however, that this policy is the best way to address the specific concern around overestimation of income for these individuals while balancing long-term need to ensure enrollment processes are as efficient as possible. It is not permissible under 1411(e)(4)(B) of the Affordable Care Act to prevent consumers from using their coverage until they submit documents to resolve their income DMIs. Additionally, we maintain that it is important to balance program integrity with ensuring access to coverage and believe this temporary policy maintains that balance.

Comment: Many commenters expressed concerns that this proposal would negatively impact consumers' ability to enroll in affordable coverage and recommended CMS not finalize the proposal. Specifically, commenters mentioned that the policy would result in a decrease of enrollment and would be a barrier to enrolling in the first place, in part due to the administrative burden of submitting documents to resolve their income inconsistency. Additionally, commenters mentioned expiration of an annual income DMI would typically lead to a loss of APTC, which means consumers would be forced to either drop coverage or pay unaffordable premiums, including if they are in process of appealing their DMI expiration. One commenter mentioned how many sick consumers end up having to take on debt or skip essential bills to pay for coverage after losing their financial assistance.

Response: We understand that some consumers may temporarily end up having their financial assistance reduced or removed, resulting in coverage loss and financial burden. However, the income DMI process allows 90 days [133] to submit documentation, including submitting new documents if their previously submitted documents were deemed insufficient to resolve, and we previously estimated that submitting documentation will only take 1 hour, so we believe that the administrative burden of submitting documents is

[133] In section III.A.3.b of this final rule, § 155.315(f)(7) is being removed. This regulation currently requires Exchanges to give an automatic 60-day extension to the 90-day income DMI period if the income DMI has not yet resolved after those 90 days.

minimal. Additionally, if consumers need more time to resolve their income inconsistency, they are able to request an extension to the 90-day period on a case-by-case basis. We also emphasize that it is important that consumers receive accurate APTC eligibility to help protect taxpayer spending on APTC, which is why we believe it is important to have this income DMI in place even if some consumers are unintentionally harmed through loss of APTC. We acknowledge the concern on how the continued loss of APTC occurs even during the appeals process but emphasize that it is important for consumers to resolve their income DMI before it expires to maintain continuous financial assistance and not end up having to go through an appeal. It is important to note that these are temporary measures enacted in response to unprecedented concerns over improper enrollments.

Comment: Many commenters stated that loss of coverage and financial barriers would result in poor health outcomes for many consumers, such as relying more on emergency services and threatening the ability of consumers to make timely, informed, and autonomous decisions about their health, in particular related to pregnancy. Many of these commenters stated these negative health outcomes would be compounded for those who are already experiencing difficulties in accessing health care. Additionally, nearly all community health centers that commented on this proposal stated that this would disproportionally affect consumers who use their services, resulting in negative health outcomes for them. Given this, these commenters did not recommend we finalize this proposal.

Response: While we understand the concerns of the commenters, we want to emphasize that many of these annual household income attestations are inaccurate and are made by agents, brokers, and web-brokers without consumers' knowledge as a part of other potentially inappropriate activity such as unauthorized enrollments, which can lead to consumers experiencing hardship when they go to use health coverage and find out they are enrolled in a plan they were unaware of. These are largely functions of the incentives and opportunities created by the existence of fully-subsidized plans and these outcomes in themselves represent consumer harms that we also must attempt to mitigate. By making this policy temporary to address these imminent concerns while Exchanges shed excess improper enrollment, we believe we strike the right balance of program integrity with long-term enrollment policy efficiencies.

Comment: Many commenters stated they are concerned that low-income consumers who would be more affected by this proposed policy have a much more difficult time than other consumers in predicting and verifying income due to unpredictable income. They stated this is compounded by the fact that Exchange eligibility is based on future income, rather than previous years' income, and therefore tax data is typically not able to accurately predict and verify their expected future annual household income. Additionally, some commenters pointed out that these lower income consumers typically are not required to file taxes, so they are more likely to not have tax data available to verify their income. Many commenters also listed reasons why a consumer may have unpredictable income—such as starting a new job or losing a job, pay raises, plans to work more in the future—and stated that consumers should not be penalized for these changes by losing APTC eligibility after DMI expiration.

Response: We acknowledge that consumers with more unpredictable income may have a more difficult time estimating their income. We have made improvements over the years to account for this concern, including creating an income calculator tool that we recommend consumers use if they are having difficulty estimating their income.[134] Additionally, we understand that income can change throughout the year and highly recommend that consumers update their Marketplace application when their household income changes to ensure they are receiving the most accurate eligibility determination. We also emphasize that in scenarios where new consumers to the Exchange may not have tax data available because they were not previously required to file tax returns, they would not receive the type of income DMI described in this policy, as this policy specifically generates an income DMI in scenarios where IRS returns data under 100 percent of the FPL but consumers attest to annual household income above 100 percent of the FPL. Without having filed taxes, they would not have IRS data returned for them and would therefore not generate the type of income DMI described in this policy, though they may be impacted by other income verification policies in this rule such as the one described in section III.B.3.d. Finally, even if a consumer would normally not be required to file a tax return due to their income, notifications include language to remind consumers that once they have received APTC, they are required to file a tax return to reconcile their APTC. As these policies are temporary, we believe they strike the right balance between urgent program integrity concerns and long-term enrollment efficiencies.

Comment: Many commenters stated how it is more difficult for low-income consumers to submit documents to resolve their DMIs. Specifically, they stated it can be more challenging to find documents that show their predicted annual household income because common documents such as tax documents and paystubs are either inaccurate or not available. One commenter requested that we add to this final rule what documentation CMS would accept for this new income DMI to prove anticipated income.

Response: We provide a robust list of acceptable documents that households can submit to resolve their income DMIs, many of which clearly can convey future year income and including potential documents self-employed consumers can submit, and include this list in multiple consumer notices and on CMS' website.[135] We recommend that consumers who cannot obtain tax forms or paystubs that reflect their projected household income submit other suggested income documents that may be more available and accurate.

Comment: Many commenters specifically noted the challenges that gig workers would face with this proposal. Commenters mentioned how this type of work has grown substantially since the ACA was passed, and recommended that CMS reconsider how this proposal and general verification processes account for the realities of the gig economy. One commenter stated that nearly a third of all gig workers are uninsured, and that 48 percent believe their work status has made it more difficult to access health insurance. One commenter suggested that CMS needs to do additional research around economic and employment trends since the ACA passed, with a particular focus on gig workers, and consider flexible updates related to that.

Response: We appreciate the concern for gig workers. We are aware of how gig workers may have a more difficult time verifying their income and we have made operational changes over the past few years to improve how our systems and processes better account for the

[134] *https://www.healthcare.gov/income-calculator/.*

[135] *https://www.healthcare.gov/help/how-do-i-resolve-an-inconsistency/#household-income.*

types of documents gig workers may use to verify their income. Regarding what documents gig workers should submit to verify their annual household income, we recommend they submit a self-employment ledger that outlines whose income it includes, where the income is from, the start date of the income, either the frequency (such as biweekly) of the income or the end date, and the specific income amounts. This can include documents from employers that employ gig workers or from online services that outline this information. We are open to additional changes and improvements to better assist consumers working in the gig economy on getting and staying in coverage. However, we do not believe that this policy is especially burdensome for consumers with legitimate income attestations and will help prevent fraudulent attestations from continuing to receive improper financial assistance. That said, by making this policy temporary, we believe we strike the right balance of program integrity with long-term enrollment efficiencies.

Comment: Many commenters expressed concerns about how this policy would impact the risk pool. Specifically, commenters stated that younger consumers, who are also typically healthier, tend to have lower and less predictable streams of income. Commenters also mentioned that healthier consumers are less motivated to get insurance, particularly when they encounter administrative burdens such as additional required paperwork, while sick consumers are often more motivated to overcome administrative barriers to coverage. Commenters stated that all of this results in fewer young and healthy consumers entering the risk pool, which would result in increased premiums for everyone, leading to a decrease in enrollment and increased health care costs for everyone.

Response: We disagree that requiring additional documents is a large administrative burden that will result in young, healthier, less motivated consumers not getting insurance. The 90 days Congress provided under the statute gives consumers sufficient time to identify documents and resolve their income DMI, and we estimate that identifying and submitting documentation for an income DMI typically takes consumers only 1 hour. The Department is of the view that younger individuals generally are accustomed to requirements to prove their eligibility for a variety of benefits and activities, including proving their identities and incomes, such that dedicating a single hour to verification activities is unlikely to lead to significant numbers of young persons abandoning their insurance applications once the process is started. Additionally, we are finalizing this policy temporarily to help the Exchange address urgently high levels of improper enrollments while balancing long-term enrollment efficiencies. This limited period of effectiveness will mitigate any adverse impacts on the risk pool that might result if this policy dissuades younger, healthier persons to abandon their applications for insurance.

Comment: Many commenters expressed concerns about the costs and burdens for this proposal on Exchanges. Commenters mentioned that they believe the proposal would increase administrative costs and be operationally challenging for Exchanges to implement, and that Federal funds would be better spent elsewhere. Many also said that State Exchanges do not currently have appropriated funds or other financial resources to implement this change by the applicability date of 60 days after this rule's finalization, with one State Exchange unsure if they can implement it at all due to their State's limits on how they can use Federal tax information. Finally, one commenter stated it was unclear that money would be saved through unspent APTC.

Response: We acknowledge the costs associated with implementing this proposal. We are confident that the Exchanges on the Federal platform can implement this proposal by the rule's effective date and are not concerned with implementation operations. Additionally, we believe that the costs associated with implementing and operating this policy are justified, as this is a critical program integrity measure to ensure consumers who may not be eligible for APTC are not erroneously receiving APTC throughout the entire plan year. Because of that, while we understand State Exchanges are concerned about the implementation and ongoing costs, we believe that the program integrity gains outweigh the potential costs to State Exchanges. Additionally, by requiring Exchanges to sunset this proposal starting in PY 2027, operational costs for Exchanges will only occur for the remainder of PY 2025 after this rule's effective date and all of PY 2026, resulting in lower costs to Exchanges for operations over time. As illustrated later in the regulatory impact analysis section of this rule, we estimate that APTC savings will be greater than operational costs.

Comment: Some commenters expressed concerns about potential administrative and cost burdens to other interested parties such as issuers and health care professionals who help consumers enroll. Commenters mentioned how historical data has illustrated that administrative complexity and uncertainty result in an increase in operational and administrative costs for issuers, particularly for smaller issuers and those serving in rural communities, which typically results in those costs being passed on to consumers.

Response: As outlined in the regulatory impact analysis section of this rule, the administrative and cost burden is minimal in comparison to the APTC savings. We will ensure that information on this policy, how it affects consumers and other interested parties, and best steps to address and easily resolve income DMIs are readily available to issuers and other interested parties. We will make sure this is made available on HHS' public-facing website within 60 days of the effective date of this rule to help all interested parties be prepared to address this policy with their clients and, therefore, minimize potential burden. Additionally, we believe benefits on program integrity likely outweigh potential minimum administrative or cost burdens on issuers, especially due to the temporary nature of the provisions to address program integrity while Exchanges adapt to the changing subsidy environment, as the primary concern is related to fully-subsidized plans, which are due to dramatically decrease in PY 2026 prior to the provisions sunsetting in PY 2027. We reiterate our commitment to helping interested parties understand and account for changes in this rule.

Comment: Many commenters did not agree with the assertion that numerous consumers are intentionally overestimating their income. These commenters did not believe we provided enough evidence of such behavior being widespread. Additionally, many commenters stated that these discrepancies between attestation and final annual household income are due to consumers honestly projecting their annual household income to be above 100 percent of the FPL but instead finishing the year with their actual annual household income below it, such as due to working less than anticipated or because of the difficulty of estimating future year income. A few commenters also pointed towards the enhanced subsidies causing more people to enroll in the Exchange and as a result, simply having more discrepancies. As a conclusion, many commenters believed that this proposal would not improve program integrity, with many stating that nothing has

changed since this DMI type was vacated by the court in *City of Columbus* v. *Cochran,* and therefore recommended against finalizing the policy as proposed.

Response: We acknowledge that many consumers may be estimating their household income accurately based on the best information available to them at the time. However, we have also identified data suggesting that consumers—or agents, brokers, or web-brokers assisting them—may be intentionally misestimating income. As laid out in the proposed rule, one study illustrated that many consumers attested to very precise annual household income amounts, suggesting that they knew the exact income thresholds to gain eligibility for APTC.[136] For people who attested to those precise thresholds, this same study found that enrollment in corresponding plans was 136 percent higher than the total population of potential enrollments. These numbers, combined with other data sources that are cited and discussed earlier in this section III.A.3.c of the preamble, show clear indications of some consumers intentionally attesting to annual household income just above 100 percent of the FPL to gain APTC eligibility they may not have been eligible for with a more accurate annual household income attestation.

While we believe this was also the case during the time that the 2019 Payment Notice originally implemented this proposal, we did not have clear data available to outline in the 2019 Payment Notice illustrating this, something that is mentioned in *Columbus* v. *Cochran* as a reason why this policy was originally struck down. However, given the data we now have now as set forth in the proposed rule, higher enrollment data illustrates that this problem is much more prevalent than it was prior to 2021. We respect the concerns many have with this proposal and, as such, are finalizing a temporary policy targeted at the most demonstrable program integrity concern—fully-subsidized plans and the holdover improper enrollment that data suggests will persist temporarily following the expiration of the expanded subsidies. After allowing this policy to work to right-size enrollment to ensure those receiving subsidies are eligible for such subsidies, this policy will sunset as the reduction in fully-subsidized plans reduces the urgency of its program integrity features.

[136] Blase, B.; Gonshorowski, D. (2024, June). The Great Obamacare Enrollment Fraud. Paragon Health Institute. *https://paragoninstitute.org/private-health/the-great-obamacare-enrollment-fraud.*

Comment: Some commenters, while they agreed with the widespread problem of improper payment of APTC caused by overinflating incomes above 100 percent of the FPL, did not believe that this proposal is the best way to address it. Most of these commenters believed that CMS should focus on improving agent, broker, and web-broker enforcement rules, as many commenters believed they primarily are driving this fraudulent behavior. Some commenters also expressed concerns with the Exchanges on the Federal platform's usage of Enhanced Direct Enrollment (EDE) platforms, claiming that having third parties host the eligibility and enrollment platform allowed agents, brokers, and web-brokers to more easily engage in fraud or improper behavior.

Response: We acknowledge commenters' concerns that some agents, brokers, and web-brokers are fraudulently attesting to household income on behalf of consumers, oftentimes without their knowledge, and that this is often done through direct enrollment pathways. Both States and the Federal Government are taking steps to address agents, brokers, and web-brokers participating in actions or schemes that result in improper enrollments. We have increased program integrity measures aimed at non-compliant agents, brokers, and web-brokers, including, for example, requiring agents, brokers, and web-brokers to perform a three-way call with their client and the *HealthCare.gov* call center to effect certain changes to some consumers' applications or coverage. We also work closely with EDE partners on program integrity issues. Improving program integrity may require multiple approaches, and we believe this policy will work well in partnership with agent, broker, and web-broker enforcement actions to help prevent this type of improper behavior.

Comment: Many commenters expressed concerns with the data and studies the proposed rule cited as proof of program integrity concerns. These commenters cited concerns related to studies' methodology and analytical approach, limitations and usage of data, inconsistent income definitions, and that they did not account for other factors at the same time such as the COVID–19 PHE and Medicaid disenrollment. Many commenters stated that the estimation of 4–5 million fraudulently enrolled consumers is inaccurate and an overestimation. One commenter also stated that CMS should gather more data to see how program integrity changes made in 2024 have affected this fraudulent behavior and wait to implement this proposal until that is available to show the impact of those policies.

Response: We disagree with the commenters' concerns on the validity of data sources utilized in the proposed rule to support the proposal. We believe the various data sources cited suggest that households are fraudulently attesting to income directly above the FPL. Notwithstanding, in light of commenters' concerns and as explained in section V.C.18 of this final rule, we are finalizing this policy so that it will be applicable only for PY 2026, providing further opportunities to monitor this policy's effects instead of codifying it to be applicable indefinitely. We clarify that consumers will have the opportunity in the DMI process to show through documents that their attestation of estimated household income is accurate. We will continue to monitor and collect data regarding DMIs and how changes, such as those made in 2024 and this final rule, have impacted enrollment.

Comment: A handful of commenters mentioned that CMS should address better how Medicaid and CHIP eligibility intersects with the population of consumers who may overestimate their income for Exchange coverage. They state that some consumers may be eligible for Medicaid or CHIP one month but not the next, meaning that it is possible they could be eligible for Exchange coverage in those months they are not Medicaid/CHIP eligible. Some commenters pointed out how many State Exchanges have more robust integration with Medicaid and CHIP eligibility systems, resulting in more accurate and timely eligibility determinations. One commenter also sought clarification on why the Exchanges on the Federal platform would fail to determine if someone is Medicaid or CHIP eligible.

Response: We acknowledge commenters' concerns regarding the intersection of the Medicaid and CHIP population and the Exchange population. We continue to improve on our integration with State Medicaid and CHIP agencies to facilitate Medicaid and CHIP eligibility determinations, but we do not currently have the same capabilities as State Exchanges. However, we do collect both monthly and annual projected income as a part of the application process for the Federal Exchange, and we base Medicaid eligibility on monthly, not annual, income. Exchanges on the Federal platform determines or assesses eligibility for Medicaid and CHIP based on State rules for eligibility. If a consumer was previously determined

eligible for Medicaid or CHIP, but their income has changed such that they believe they will no longer be eligible for Medicaid or CHIP coverage, we encourage them to return to the Exchange to update their income and receive an updated eligibility determination.

Comment: All State Exchanges, as well as many other commenters, expressed concerns related to the proposed requirement for State Exchanges to implement this proposal. Most commented that State Exchanges do not have the type of fraudulent behavior this proposal attempts to address because nearly all State Exchanges have expanded Medicaid. States also said they are not seeing any indication of agents, brokers, or web-brokers purposefully overestimate income to be above 100 percent of the FPL in their State. Some also commented that they do not have agents, brokers, web-brokers or EDE partners in their Exchange, which they attribute in part for the lack of this type of program integrity concern. Additionally, some commenters mentioned that many State Exchanges have more robust and cost-effective income verification processes, and that implementing this new requirement would stifle innovation.

Response: We appreciate that State Exchanges may not have experienced the same challenges of agents, brokers, and web-brokers improperly overestimating income resulting in improper payment of APTC. We also acknowledge that many State Exchanges have robust income verification processes and can integrate well with additional data sources and their State's Medicaid and CHIP programs and appreciate that State Exchanges continue to ensure accurate income eligibility determinations. However, the persistently high levels of fraud associated with fully-subsidized plans, which are widely available on both Federal and State Exchanges, lead us to still believe this is a vital program integrity policy that is important for all Exchanges, including State Exchanges, to implement. Specifically, data illustrated in this section of the preamble shows that all States, including State Exchanges in non-Medicaid expansion States, experience some instances of consumers overestimating their annual household income. Even in States where this may occur in lower numbers, we still believe it is vital to have this policy in place to ensure that these consumers' annual household income is fully verified and they are receiving the correct eligibility determinations. However, given these concerns by State Exchanges, we believe that instituting the requirement that all Exchanges sunset this proposal after PY 2026 will balance the need for program integrity with overall costs to Exchanges. This modification is also intended to be responsive to State Exchange comments noting that this measure may not be necessary to ensure program integrity in these State Exchanges in the long term. We also acknowledge that while we have found that agents, brokers, and web-brokers intentionally overestimate income, consumers also often intentionally overestimate their annual household income without the assistance of an agent, broker, or web-broker, so we believe this is still necessary in State Exchanges that choose not to allow agents, brokers, or web-brokers on their Exchange. As this is primarily a function of the incentive and opportunity created by the expanded subsidies, we believe it to be necessary to implement on all Exchanges until excess improper enrollment levels have abetted. We reiterate that State Exchanges will continue to be able to check additional income data sources after IRS to attempt to verify a household's income which may minimize the burden of reviewing paper documents submitted for verification.

Comment: Some commenters believed that, in addition to making this proposal optional for State Exchanges, CMS should only implement this proposal for States that have not expanded Medicaid. Commenters recommended this because consumers in non-expansion States with annual household incomes below 100 percent of the FPL may fall in a ''coverage gap'' because they do not meet the income requirements for Medicaid in their State or for APTC. Such consumers typically do not have another affordable option for coverage available. Given this, those consumers are potentially motivated to intentionally overestimate their income in order to gain eligibility for APTC. In contrast, consumers in expansion States do not fall into this ''coverage gap'' and therefore have less reason to intentionally overestimate their income since they likely will be eligible for Medicaid or CHIP if their income is below 100 percent of the FPL and they meet all other eligibility criteria.

Response: We understand commenters' concerns that consumers in Medicaid expansion States may have less motivation to intentionally overestimate their annual household income than those in non-expansion States. In order to balance urgent program integrity concerns with long-term operation costs and enrollment efficiencies, we are sunsetting this policy after PY 2026. We do want to emphasize that agents, brokers, and web-brokers who are intentionally misrepresenting a household's annual household income attestation are motivated to do so regardless of Medicaid expansion status, as any commissions they are trying to receive that are tied to those enrollments would occur regardless. We also note the potential selection issues that may exist among people who reside in Medicaid expansion States with State Exchanges who may take advantage of the lack of income verifications to select coverage through State Exchanges with APTC over Medicaid based on their health status. To the extent coverage through State Exchanges provides better access to providers or other benefits to people with higher health care needs compared to Medicaid, the lack of income verification could harm the individual market risk pool.

Comment: A few commenters requested that CMS delay the implementation of this proposed rule, with the earliest timeline suggested being the beginning of PY 2026 rather than 60 days from the effective date of the final rule, given concerns about operational challenges and administrative burdens, especially for issuers.

Response: We do not believe that a delay in implementing this rule is necessary or appropriate given it is a temporary policy designed to address urgent program integrity concerns. Exchanges on the Federal platform are able to implement this policy by the final rule's effective date, and, given the minimal implementation burden on the Federal Exchange, we believe State Exchanges should similarly be able to implement this policy by the rule's effective date. With respect to concerns about burden on issuers, CMS will ensure that issuers are informed of the change in policy and what they should do to help enrollees, both current and new, prepare for potentially receiving a DMI ahead of the policy's implementation. Additionally, since consumers will still receive the full time period to resolve their income DMI and receive temporary eligibility during that period as is the case for other DMI types, we believe issuers will have enough time to help their enrollees determine documents to submit to resolve their DMI before clients' DMIs would potentially expire and result in loss of APTC. Given that the time frame of when this type of DMI could actually expire and affect an enrollee's coverage is at least 150 days from the rule's effective date (accounting for this

policy's implementation of 60 days after the rule's effective date and the 90 days households have to resolve this type of DMI), as well as our plans to inform and prepare issuers for this change, we believe that this implementation timeline is feasible for issuers.

Comment: Some commenters suggested other types of improvements to the income verification processes. Many of these commenters encouraged Exchanges on the Federal platform to use other data sources to verify income, such as the State Wage Information Collection Agency; data from State agencies that have unemployment or human service programs; and the National Directory of New Hires. They suggested that using such additional data sources would reduce the reliance on Federal tax data, align better with State Exchanges that use some of these data sources, and help the APTC verification process become more streamlined and accessible. One commenter said that Exchanges should be required to leverage income data through the Verify Current Income Hub, as this would help reduce improper enrollments and better direct consumers to the correct coverage pathway, and that the data's accuracy and efficiency outweighs the cost of using the service. One commenter suggested that Exchanges on the Federal platform should implement a ''facilitated enrollment'' program. Some commenters suggested changes to how APTC and PTC work, including basing APTC on prior year income and working with Congress on legislation changes on APTC recoupment rules.

Response: We appreciate the comments with additional ways in which Exchanges on the Federal platform can improve the income verification process. We continue to explore utilizing additional data sources to verify income as well as other innovations and improvements. However, additional data checks would take additional time and resources to set up and integrate with existing processes, and some of the data sources State Exchanges utilize are unavailable on the Federal level. As outlined in 155.320 (c)(3)(vi)(A), the Federal Exchange must weigh whether the available data will provide sufficiently accurate income information for enough consumers to justify the costs of both connecting to these data sources and continuing to pay for the data. Additionally, we do not believe that those would replace the need for this policy, as even with additional trusted data sources available to potentially verify household income above 100 percent of the FPL, there will still be consumers for whom the Exchange is unable to verify household income. We would like to clarify that we currently use the Verify Current Income Hub that one commenter suggested but continue to allow State Exchanges flexibility in what additional data sources they use beyond IRS.

Comment: One commenter stated that because this policy was originally vacated in *City of Columbus* v. *Cochran,* the proper place to contest this is in court rather than through this rule.

Response: We believe that the proposed and final rule address the concerns raised in *City of Columbus* v. *Cochran* and therefore reinstating this policy via rulemaking is appropriate. Specifically, we have provided additional data demonstrating that consumers overestimate their income so it is above 100 percent of the FPL when IRS data sources show their income is below 100 percent of the FPL in order to be determined eligible for APTC. Additionally, circumstances have changed since the original proposal in the 2019 Payment Notice with many more consumers being aided by agents, brokers, or web-brokers, some of whom have used this gap in the income verification process to enroll consumers with subsidies without their knowledge, making setting income DMIs for this population even more needed than it was in the original 2019 Payment Notice proposal.

Comment: One commenter expressed concerns that that the proposed language could allow a State to perform Periodic Data Matching (PDM) more than twice a year, resulting in consumers erroneously losing their coverage without any legitimate increase in program integrity.

Response: We clarify that this proposal does not relate to PDM. This proposal only refers to the process that occurs when a consumer applies for coverage or updates their Marketplace application, and does not involve Exchange-initiated verification of income.

Comment: Some commenters expressed concern that we are denying APTC to low-income consumers if they do not immediately verify with tax data.

Response: We clarify that if tax data from the IRS does not verify an applicant's attestation of annual household income, we then check other available income data sources and, if those do not verify their attested annual household income, the household would be given an income DMI. The applicant would be given 90 days [137] to submit documentation to verify their projected annual household income, during which time the applicant would be given temporary eligibility for financial assistance based on their application attestation allowing them to use APTC to enroll in coverage. It is only after that 90-day period has passed that the household, if they had not yet verified their income DMI, would have their APTC decreased based on tax data, potentially to zero if IRS data indicates they would be ineligible for APTC altogether. Given this, we highly recommend consumers submit documents to verify their income during that 90-day period to ensure they maintain their financial assistance and health coverage, and, if they need more time beyond that 90-day period, they can request additional time on a case-by-case basis.

Comment: We requested comments on our proposal's minimum income threshold of 10 percent for all Exchanges, and the inclusion of an optional dollar amount. This minimum income threshold is utilized by Exchanges to compare an applicant's attested annual household income with income amounts provided from trusted data sources or documents submitted by the applicant. This information allows the Exchange to determine whether applicant's attested annual household income is within a reasonable threshold of the income reported from a trusted data source or documents, such that the Exchange can consider the applicant's attested annual household income verified. Comments on the threshold proposal were mixed. Most commenters believed that 10 percent is not a generous enough threshold as it does not account for variability in projected annual household income from documents, but there was no consensus on whether 20, 25, or 50 percent was the correct percentage. One commenter cautioned CMS against having too generous of a threshold, as they believed this could lead to income being verified despite substantial variation between attested annual household income and income from trusted data sources or documents, but they did not suggest an alternative threshold. None of these commenters mentioned the inclusion of an optional dollar amount.

Response: We appreciate the comments on the proposed minimum threshold amount and would like to clarify that this is simply a minimum, and not a maximum, threshold level

[137] In section III.A.3.b of this final rule, § 155.315(f)(7) is being removed. This regulation currently requires Exchanges to give an automatic 60-day extension to the 90-day income DMI period if the income DMI has not yet resolved after those 90 days.

that all Exchanges must have. Because Exchanges may have a threshold higher than the one specified in regulation, no commenters requested a threshold lower than the 10 percent threshold or recommended against including an optional dollar amount as considered in the proposed rule, and because no comments were received expressing concerns with the ability to include an optional dollar amount in addition to the percentage difference, we are finalizing this as proposed, and will not specify a specific threshold dollar amount or provide flexibility for Exchanges to adopt one.

d. Income Verification When Tax Data is Unavailable (§ 155.320(c)(5))

In the 2025 Marketplace Integrity and Affordability proposed rule (90 FR 12967 through 12968), we proposed to remove § 155.320(c)(5), which requires Exchanges to accept an applicant's or enrollee's self-attestation of projected annual household income when the Exchange requests tax return data from the IRS to verify attested projected annual household income, but the IRS confirms there is no such tax return data available. This requirement currently operates as an exception to the requirement to verify household income with other trusted data sources under § 155.320(c)(1)(ii) and the alternative verification process under § 155.320(c)(3)(vi). These provisions generally require that, in the event the IRS and other trusted data sources cannot resolve a DMI, applicants must submit documentary evidence or otherwise resolve the DMI with the inconsistent information source. Therefore, by removing this exception, this proposal would require Exchanges to verify household income with other trusted data sources when tax return data is unavailable and follow the full alternative verification process.

As we detailed previously in this preamble, there is a growing body of evidence that shows a substantial number of improper enrollments on the Exchanges. Some agents, brokers, and web-brokers and applicants are taking advantage of weaknesses in the Exchanges' eligibility framework to enroll consumers in coverage with APTC subsidies without their knowledge and when consumers are not eligible. We believe the recent change in the 2024 Payment Notice (88 FR 25818 through 25820) to allow applicants to self-attest to income when IRS data is unavailable may have contributed to weakening the Exchange eligibility system.

We made the change to accept attestation when HHS successfully contacted the IRS but IRS data was unavailable because we believed that the standard alternative verification process was overly punitive to consumers and burdensome to Exchanges when IRS data is unavailable. To explain the punishing aspects of the prior alternative verification process, we itemized the legitimate reasons for a tax return to be unavailable aside from a consumer's failure to file a tax return, including tax household composition changes (such as birth, marriage, and divorce), name changes, or other demographic updates or mismatches. We then concluded the consequence of receiving an income DMI and being unable to provide sufficient documentation to verify projected household income outweighs program integrity risks as, under § 155.320(c)(3)(vi)(G), consumers are determined completely ineligible for APTC and CSRs.

After revisiting this issue, we stated in the proposed rule (90 FR 12967) that we no longer believe the prior alternative verification process was overly punitive. We stated that our use of the term punitive to characterize the process improperly suggests the process involved a punishment when the process solely involved establishing eligibility to receive a government benefit and did not involve a judgment to mete out consequences of bad behavior. Instead, the process focused on ensuring that applicants are eligible for APTC to both protect against making improper payments and to protect the applicant from accumulating unnecessary tax liabilities. In the proposed rule, we stated that as we reassess the current verification process, we note that the existence of legitimate reasons for tax return data to be unavailable does not diminish the need to have an accurate estimate of income. As discussed previously, an accurate household income estimate is a critical program integrity element of the ACA's framework for verifying and determining eligibility for APTC.

In making our reassessment, we investigated the difficulty of providing documentation to verify household income and believe eligible applicants can meet the requirement with relative ease. People with legitimate reasons for not having tax data available like marriage, the birth of child, name changes, and other demographic updates would have the opportunity to be verified through other trusted data sources. However, if other trusted data sources cannot verify the household income and applicants must provide documentation, we previously estimated (88 FR 25893) that consumers would take 1 hour to submit documentation on average. We sought comment on the accuracy of this estimate of administrative burden. We stated in the proposed rule (90 FR 12967) that we believe eligible applicants would likely have documentation to verify their household income as readily available to them as the standard tax filer without an income DMI.

For these people, prior to the implementation of the 2024 Payment Notice, we found that half of all resolved income DMIs generated when IRS income data was unavailable were resolved within 90 days. Therefore, to the extent applicants failed to resolve their income DMI, we believe this largely reflects how the prior process successfully stopped ineligible people from enrolling.

Regarding the burden on Exchanges, we previously estimated the administrative task under the prior policy accounts for approximately 300,000 hours of labor annually on the Federal platform. We concluded this was proportionally mirrored by State Exchanges, which may also access approved State specific data sources to verify income data. We expect APTC subsidized enrollment to be lower in the coming years.

Considering the amount of improper enrollments under the current policy, we stated in the proposed (90 FR 12967) rule that we believe this administrative burden of requiring people with an income DMI due to unavailable IRS data to provide documentation to verify income is more than offset by the program integrity benefits.

In addition to the policy concerns mentioned above, we stated in the proposed rule (90 FR 12967) that the Department now believes this policy violates statutory requirements for verifying income under section 1411(d) of the ACA and addressing income inconsistencies under section 1411(e)(4)(A) of the ACA, including by restricting Exchanges from using the process under § 155.315(f)(1) through (4), as well as 1411(c)(4)(B) and 1412(b)(2). We previously stated in the 2024 Payment Notice that the requirements for Exchanges under § 155.320(c)(5) complied with section 1411(c)(4)(B) of the ACA and section 1412(b)(2) of the ACA, but stated in the proposed rule (90 FR 12967), that we believe our previous statutory justifications for this policy were mistaken and inconsistent with Congress' intent.

Therefore, to strengthen the program integrity of the eligibility determination

process for APTC, we proposed to remove § 155.320(c)(5).

We sought comment on this proposal.

After consideration of comments and for the reasons outlined in the proposed rule, this final rule, and our responses to comments, we are finalizing this policy as proposed, but with a modification under which the policy and related requirements will sunset for all Exchanges at the end of PY 2026. Beginning in PY 2027, the income verification policy under § 155.320(c)(5), which was in effect prior to the finalization of this rule, will become effective again. As we explain in this section and in section III.B of this final rule, HHS is of the view that the best way to address program integrity concerns created by the proliferation of fully-subsidized plans policy is to require further verification when the IRS reports no tax return data is available for a tax-filer. Notwithstanding, we share concerns related to the risk of coverage loss by low-income persons. For this reason, we will codify this policy to be applicable only from this rule's effective date until the end of PY 2026 to balance these concerns.

We summarize and respond to public comments received on the proposed policy below.

Comment: Many commenters supported the proposal, including many advocacy groups and issuers who stated the proposal would reduce fraud. Additionally, one professional association and one advocacy group supported the proposal because it would protect enrollees against surprise tax bills by verifying attested information.

Response: We appreciate the commenter's support and agree that this proposal will help mitigate currently high levels of fraud in Exchanges. An accurate annual household income estimate is a critical program integrity element for verifying and determining eligibility for APTC. We believe that verifying annual household income with other trusted data sources and then following the alternative verification process when a tax return is unavailable will strengthen program integrity.

We also agree with the commenters who stated that removing this exception to verification of annual household income may protect consumers from incurring large tax liabilities, due to incorrect income information. Once these provisions have helped reduce holdover fraud from the expansion of subsidies, they will go away.

Comment: Some commenters supported the proposal but provided recommendations such as: providing exceptions for certain situations, providing State Exchanges with implementation flexibility, ensuring Exchanges are prepared to implement this proposal without undue harm to consumers, requiring Exchanges to check additional data sources when tax data is unavailable, obtaining new data sources for income verification (such as the National Database for New Hires), and delaying implementation.

Response: We appreciate the commenters' recommendations on additional ways to improve the income verification process. We do not agree that exceptions to the verification process should be provided because the policy is temporary in nature and that would not align with our goal of addressing urgent program integrity concerns. Once these policies sunset at the end of PY 2026, the requirement for Exchanges to accept an applicant's or enrollee's self-attestation of projected annual household income when the Exchange requests tax return data from the IRS to verify attested projected annual household income, but the IRS confirms there is no such tax return data available will once again apply to all Exchanges.

Comment: Most professional associations, provider groups, and advocacy groups opposed this proposal, stating that it would create barriers for vulnerable consumers, increase administrative costs, and destabilize the risk pool because these changes could increase adverse selection because sicker individuals have greater incentive to put in the time and effort necessary to resolve income verification issues.

Response: We acknowledge commenters' concerns around administrative burdens like cost and potential extra verifications steps and risk pool impacts. Reintroducing income verification for applicants for whom no tax return data is available would increase burden on some applicants, but the currently high level of improper enrollments, which we believe to be driven by the incentives and opportunities created by the expanded subsidy regime, call for immediate action to improve program integrity. That said, we understand that reactions to crisis levels of improper enrollments may not strike the right balance with proper enrollment access over the long term and, as such, are making this policy temporary. Additionally, while in the proposed rule we connected the need to use alternative income verification methods when the IRS returns no data to the statutory framework, and while the proposal is allowed by statute, we recognize the statute includes in section 1411(c)(4)(B) the provision to weigh the administrative and other costs of a data matching program against its expected gains in accuracy, efficiency, and program participation. In response to comments detailed later in this section related to consumer and State Exchange burden and risk pool concerns, and as explained in section III.B. and elsewhere in this final rule, we are finalizing this policy to be effective only through the end of the PY 2026. This will allow this policy, as well as the other policies in this rule, to reduce the high levels of holdover improper enrollments while mitigating long-term burden.

Comment: Some providers, provider groups, and organizations expressed concern that it could take vulnerable enrollees longer than 1 hour to submit documentation related to this income verification requirement.

Response: We recognize that it may take certain consumers longer than 1 hour to submit documentation related to this income verification requirement, and note that the 1-hour estimate is an average. However, there are no data to support an alternative estimate of the time it would take a consumer to submit income verification documentation.

Comment: Many commenters who opposed the proposal believed that when self-attestation does not match trusted data sources, this is not indicative of fraud, but rather people whose income fluctuates often or dramatically enough that their projected household annual income would not match records for previous years.

Response: We acknowledge the commenters' concern about the variable nature of consumer income. We proposed to require Exchanges verify household income when data from the IRS is unavailable. This is different from when a consumer's attestation does not match trusted data sources. If the additional verification processes result in the consumer's attestation not matching the trusted data sources, the Exchange would generate an income DMI. We acknowledge that many income DMIs are created by eligible consumers and during the income DMI resolution process, eligible consumers have the opportunity to verify their income using a list of acceptable documents. Nevertheless, based on the data set forth in this rule, we maintain our concern that agents, brokers, and web-brokers may make improper attestations without consumers' knowledge leading to unauthorized enrollments, and that further income verification is needed to protect consumers from the resulting harm.

Comment: Many State Exchanges opposed this proposal, stating that it would cause unnecessary income DMIs and significantly increase administrative burdens for applicants and members and lead to coverage erosion that would adversely affect the States' risk pool since younger people are more likely to not have IRS data available.

Response: We acknowledge the increase in DMIs that may result from finalization of this proposal. We believe that the increases in program integrity outweigh the increased administrative burdens that may be encountered and believe that it is necessary to ensure accurate projected household income attestations and eligibility determinations. Although reintroducing income verification for applicants with no tax return data would increase the burden on some applicants, we do not anticipate this burden would deter many eligible people from enrolling. This is because eligible applicants would likely have documentation other than tax information, such as pay stubs, to verify their household income as readily available to them as the standard tax filer who is verified through the IRS. Because of the availability of these documents to verify annual household income, the removal of § 155.320(c)(5) would not deter many eligible people from enrolling and will not destabilize the risk pool, especially given the provision's temporary nature.

Comment: Multiple States stated that State Exchanges should retain flexibility to determine the income verification processes and procedures necessary and appropriate to meet program integrity standards when determining eligibility for coverage and financial assistance. Some States also opposed implementing this policy on the grounds that the problem it would address is not present on their State Exchanges according to internal State analysis.

Response: We appreciate the various comments highlighting how this program integrity risk looks different for State Exchanges and the recommendation to allow State Exchanges to retain flexibility to determine income verification operations. We acknowledge that many State Exchanges have robust income verification processes and can integrate well with additional data sources and their State's Medicaid and CHIP programs and appreciate the State Exchanges continue to ensure accurate income eligibility determinations. States have existing flexibilities, such as the option to call other data sources if the IRS does not have data available when verifying income, therefore we do not believe that additional flexibilities in implementing this rule are necessary. For this reason and others outlined in section III.B of this final rule, we think the temporary nature of this sunset modification is also intended to be responsive to State Exchange comments noting that this measure may not be necessary to ensure program integrity in these State Exchanges in the long term.

Comment: Two Tribal organizations opposed this proposal because it would create barriers to enrollment for American Indian and Alaskan Native people who are not required to file taxes. They stated that the proposal would complicate enrollment, delay access to care, and increase administrative strain on Exchanges.

Response: We acknowledge that there are cases where consumers, including Tribal members, are exempt from filing Federal income taxes and thus the IRS may have no tax data upon which to verify the consumer's household income. Tax data, however, is not the only way for Exchange applicants to verify annual household income. When tax return data is unavailable to immediately verify a consumer's attestation of annual household income, the Exchange would trigger the rest of the verification and data matching process. Specifically, an Exchange can check other available income data sources and, if those do not verify the annual household income, the household would be given an income DMI. During the 90-day period, they would be given temporary eligibility for financial assistance based on their application attestation and can use that APTC to enroll in and start coverage. It is only after that 90-day period has passed that the applicant or tax-filer, if they had not yet resolved their income DMI, would have their APTC decreased based on available tax data. The Department is of the view that this 90-day period provided under statute provides ample time for applicants to provide proof of their household income before their APTC is reduced. While we understand this may result in negative outcomes for some consumers and increased administrative burden on the Exchanges, we believe implementing this policy is necessary due to the program integrity benefits and protection of consumers enrolled without their knowledge. The temporary nature of this policy strikes the right balance between urgent program integrity concerns and long-term enrollment efficiencies.

Comment: Some commenters expressed concern that APTC would be denied to consumers if they do not have IRS data available to verify their income.

Response: We clarify that when tax return data is unavailable to immediately verify a consumer's attestation of annual household income, they would go through the rest of the verification and data matching process. Specifically, we then check other available income data sources and, if those do not verify the annual household income, the household would be given an income DMI. During the 90-day period, they would be given temporary eligibility for financial assistance based on their application attestation and can use that APTC to enroll in and start coverage. It is only after that 90-day period has passed that the household, if they had not yet verified their income DMI, would have their APTC decreased based on tax data, potentially to zero. Given this, we highly recommend consumers submit documents to verify their income during that 90-day period to ensure they maintain their financial assistance and health coverage.

6. Premium Payment Threshold (§ 155.400)

In the 2025 Marketplace Integrity and Affordability proposed rule (90 FR 12974 through 12976), we proposed to modify § 155.400(g) to remove paragraphs (2) and (3), which establish an option for issuers to implement a fixed-dollar and gross percentage-based premium payment threshold (if the issuer has not also adopted a net percentage-based premium threshold), and modify 155.400(g) to reflect the removal of paragraphs (2) and (3). Under these provisions, issuers on the Exchanges can implement (1) a percentage-based premium payment threshold policy; and (2) a fixed-dollar premium payment threshold policy. However, to preserve the integrity of the Exchanges, we stated in the proposed rule that we believe it is important to ensure that enrollees do not remain enrolled in coverage for extended periods of time without paying at least some of the premium owed, and therefore proposed to limit issuers to the net percentage-based premium payment threshold established in the 2017 Payment Notice (81 FR 12271), and modified in the 2026 Payment Notice (90 FR 4475 through 4478) to allow issuers to set at 95 percent of the net premium or higher. We are finalizing these changes as proposed with the following modification: the removal of the fixed-dollar and gross-premium threshold flexibilities will sunset after the completion of one new coverage year, PY 2026, on December 31, 2026.

In the 2026 Payment Notice (90 FR 4475 through 4478), we implemented an option for issuers to establish a fixed-dollar premium payment threshold policy, under which issuers can consider enrollees to have paid all amounts due during the following circumstance: the enrollees pay an amount that is less than the total premium owed and the unpaid remainder of which is equal to or less than a fixed-dollar amount of $10 or less, adjusted for inflation, as prescribed by the issuer. In addition, we implemented a gross percentage-based premium payment threshold policy, under which issuers can consider enrollees to have paid all amounts due when the enrollee pays an amount that is equal to or greater than 98 percent of the gross premium, including payments of APTC, as prescribed by the issuer. If an enrollee satisfies the fixed-dollar or gross percentage-based premium payment threshold policy, the issuer may avoid triggering a grace period for non-payment of premium or avoid terminating the enrollment for non-payment of premium. However, these premium payment thresholds may not be applied to the binder payment.

As we noted in the proposed rule (90 FR 12975), we have compiled data regarding enrollments effectuated during the OEP. Those data reflect a continuing increase in improper enrollments on the Exchanges. For example, in December 2024 HHS received 7,134 consumer complaints of improper enrollments, an increase from the 5,032 complaints received in December 2023. We stated in the proposed rule (90 FR 12975) that although these numbers represent a decrease from the high of 39,985 complaints received in February 2024,[138] the fact that the number of complaints for 2024 remains substantially higher than for 2023 demonstrates that previous program integrity measures [139] have not resulted in a decrease in improper enrollments, and additional measures are necessary to prevent rampant waste and abuse of Federal funds and protect consumers from surprise tax liabilities and other negative impacts that may flow when consumers are enrolled in coverage without their knowledge. We further stated that this has caused us to reconsider the need for additional program integrity measures, as reflected throughout this proposed rule, and in particular whether the new premium threshold provisions appropriately safeguard program integrity and whether the value of the new premium threshold provisions outweighs the potential harms to program integrity. We also explained that given the increased need to protect program integrity reflected in the enrollment data, and the limited probability that any issuer has implemented one of the new types of available premium threshold policies, we believe the burden of eliminating these policies on issuers and consumers is outweighed by the potential increase in program integrity.

We stated in the proposed rule that under both the fixed-dollar and gross percentage-based thresholds, it is possible for enrollees in certain circumstances to avoid paying premium for multiple months before entering delinquency or losing coverage. For example, an enrollee whose premium after the application of APTC was $1 (and where the issuer had adopted a $10 premium threshold policy) could, after paying binder, not pay any premium for the next 9 months before they would enter delinquency, and due to the APTC grace period would not have coverage terminated for an additional 3 months (though the termination would be effective the last day of the first month of grace). In instances where an issuer implemented a gross premium threshold of 98 percent, an enrollee's gross premium might be $600, making their threshold $12; if the consumer owed $2 after application of APTC, they could, after paying binder, not pay any premium for the next 6 months before they would enter delinquency, and due to the APTC grace period would not have coverage terminated for an additional 3 months (though the termination would be effective the last day of the first month of grace). We stated in the proposed rule (90 FR 12975) that this policy therefore increases the risk that improper enrollments remain undetected, since the enrollee is less likely to receive invoices, and a delinquency [140] or termination notice alerting them to the improper enrollment in the case that the individual or entity submitting the improper enrollment used false contact information. In addition, we stated that an enrollee who stops paying premiums in the belief that this would lead to termination of coverage may instead find that the coverage has continued for several months due to the issuer having implemented a fixed-dollar or gross percentage-based premium threshold, with the additional risk that the enrollee has accumulated a large amount of debt if the issuer has adopted a gross premium percentage-based threshold and the enrollee's pre-APTC premium is much higher than the de minimis $10 fixed-dollar threshold. We noted that, in contrast, this is not the case with the long-established net percentage-based threshold, under which enrollees must always pay at least some premium to avoid delinquency or loss of coverage (in cases where the premium is not covered 100 percent by APTC).

As we explained in the proposed rule (90 FR 12976), because of these program integrity concerns, we remain concerned that these policies allow enrollees to unknowingly remain in coverage they did not consent to be enrolled in or remain in coverage that they no longer need or are utilizing, if a third party or agent, broker, or web-broker paid the enrollee's binder payment on their behalf in order to effectuate enrollment. In the October 10, 2024 **Federal Register** (89 FR 82366 through 82369), we provided an analysis of Exchange data for PY 2023, where we found that there were 184,111 total policies terminated for non-payment in which $10 or less was owed by the enrollee, representing approximately 12.25 percent of the total number of policies terminated for non-payment that year. As such, in the proposed rule, we estimated that, if finalized, the proposed rule would likely result in about 184,111 policy terminations after application of the available grace period. We noted that this would likely be representative of both enrollees who desired coverage but failed to take the necessary action, and enrollees who were unaware of their coverage either because they had intended for it to terminate due to nonpayment, or because they were improperly enrolled by agents, brokers, or web-brokers.

In the proposed rule (90 FR 12976), we stated that we have also become

[138] From internal HHS data, using the most recent numbers available. HHS has previously published data on consumer complaints of unauthorized enrollments, such as in the update published in October 2024. CMS (2024, October). CMS Update on Action to Prevent Unauthorized Agent and Broker Marketplace Activity. *https://www.cms.gov/newsroom/press-releases/cms-update-actions-prevent-unauthorized-agent-and-broker-marketplace-activity.*

[139] Measures such as those announced in our update from October 2024 on preventing unauthorized agent and broker activity. CMS (2024, October). CMS Update on Action to Prevent Unauthorized Agent and Broker Marketplace Activity. *https://www.cms.gov/newsroom/press-releases/cms-update-actions-prevent-unauthorized-agent-and-broker-marketplace-activity.*

[140] Per § 156.270(f), if an enrollee is delinquent on premium payment, the QHP issuer must provide the enrollee with notice of such payment delinquency. Issuers offering QHPs in Exchanges on the Federal platform must provide such notices promptly and without undue delay, within 10-business days of the date the issuer should have discovered the delinquency.

aware of instances in which consumers who are enrolled in Medicaid are, without their knowledge or consent, enrolled into unwanted QHP coverage with APTC for which they are not eligible. In 2024, we received 44,151 complaints alleging that Medicaid beneficiaries were enrolled without their consent into QHP plans, of which 12,954 were deemed medically urgent.[141] These cases have caused disruptions in coverage for consumers, due to Medicaid's refusal to pay for services [142] when the consumer is enrolled in a QHP, and has also caused delays in payments to health care providers. As noted previously, we stated that we expect that the removal of these premium threshold options would make it more difficult for some agents, brokers, and web-brokers to keep consumers enrolled without their knowledge or consent, and thereby reduce the potential for these kinds of disruptions in coverage.

We refer readers to the proposed rule (90 FR 12974 through 12976) for a more detailed discussion of our proposal.

We sought comment on this proposal.

After consideration of comments and for the reasons outlined in the proposed rule and this final rule, including our responses to comments, we are finalizing this policy as proposed for all Exchanges, with the following modification: the removal of the fixed-dollar and gross-premium threshold flexibilities will sunset after the completion of one new coverage year, PY 2026, on December 31, 2026. This will address the urgent improper enrollment concerns previously noted, and allow the Department to collect additional data on the effects of this policy. Thereafter, the FFE and SBE–FPs will, and State Exchanges may, offer issuers the flexibility to implement the premium payment thresholds outlined in the 2026 Payment Notice (90 FR 4424). We summarize and respond to public comments received on the proposed modifications to the premium payment thresholds below.

Comment: Most commenters opposed the proposal because removing premium payment thresholds could create barriers to coverage for low-income enrollees who struggle to pay full premiums. For example, many commenters stated that health center patients are disproportionately financially strained compared to other patients, and that 61 percent have incomes below 200 percent of the FPL.

Response: We recognize that it may be more difficult for low-income consumers to pay premiums but believe that the urgent concern of addressing the high level of improper enrollments driven in part by individuals not paying any premium outweighs, at least temporarily, the burdens associated with enrollees being terminated for failure to pay a portion of their premium. Once the high levels of improper enrollment have been addressed, those concerns may no longer persist. The Department also acknowledges that collection of additional data, as well as gaps or losses in coverage due to this provision would be possible under a more permanent policy, and in response to comments, the Department is finalizing this policy so that it addresses the urgent program integrity concerns in PY 2026 without ongoing effects after PY 2026.

Comment: Some commenters opposed the proposal because it could disproportionately impact vulnerable populations, increase the uninsured rate, and destabilize insurance markets. Commenters stated that consumers with chronic conditions might be able to utilize either the gross-premium percentage-based or fixed-dollar thresholds to avoid coverage gaps. Commenters also stated that the resulting loss of coverage could lead to poorer outcomes and increased healthcare costs. Many commenters stated that the additional thresholds allow issuers to focus on collecting most of the premium rather than pursuing small outstanding amounts that might lead to coverage loss.

Response: We agree that it is in the best interest of all enrollees to remain in steady coverage that they desired to obtain. However, under a fixed-dollar or gross premium percentage-based threshold, a consumer could unknowingly remain in unwanted coverage for a longer period of time than under the net premium percentage-based threshold before entering delinquency, while also accumulating debt, a dynamic that has been exacerbated by the currently high levels of improper enrollment.

Comment: Many commenters stated that removing the fixed-dollar and gross premium percentage-based thresholds would not address program integrity concerns, since both require the enrollee to pay their binder in full before such thresholds would apply. One commenter recommended that HHS increase efforts to monitor third party premium payments so that agents and brokers are not paying binder payments or subsequent premiums, and noted that some issuers have seen increased third party payment activity in recent months, and would appreciate the Exchange's increased vigilance to monitor third party premium payments, particularly as these payments do not fall under the exceptions at § 156.1250.

Response: We disagree that rescinding the fixed-dollar and gross premium percentage-based thresholds would not address program integrity concerns, because although payment of binder is required, both policies permit issuers to keep consumers enrolled in coverage for multiple months without making any payments or otherwise indicating they are aware of the coverage they are enrolled in. This policy balances the urgent need for program integrity with the long-term desire for flexibility and enrollment efficiencies.

Comment: Many commenters stated that the proposed rule did not provide sufficient evidence that agent and broker fraud has anything to do with premium payment thresholds or that these flexibilities have been abused by anyone. In addition, commenters stated that the data on unauthorized enrollments from PYs 2023–2024 did not reflect the effect that new premium payment policies would have on improper enrollments because these provisions did not take effect until January 15, 2025. Commenters recommended instead that CMS wait to rescind these thresholds until there has been sufficient time to gather and analyze data on the impacts of these new premium payment thresholds and continue to prohibit fixed-dollar thresholds for binder payments.

Response: As we noted previously, CMS continues to observe a high level of unauthorized enrollments, which we attribute largely to the proliferation of fully-subsidized plans. Although the fixed-dollar and gross percentage-based premium thresholds have only been in place for a short amount of time, the Department believes that allowing the use of fixed-dollar and gross percentage-based premium payment thresholds by issuers at this time is likely to exacerbate this problem at a critical period. In order to protect consumers from fraudulent enrollments and ensure that they are only enrolled in healthcare coverage that they want and need, rather than in coverage that they are unaware of and do not want, we believe it is important to safeguard against potential vulnerabilities added to this dynamic by the fixed-dollar and gross-premium thresholds. As with other policies, this addresses the imminent program integrity concerns while reverting back to the previous policy once the market has had a year to address the lack of expanded subsidies.

[141] *See* § 156.1010(e).

[142] As required by section 1902(a)(25) of the Social Security Act, Medicaid is the payer of last resort.

Comment: One commenter stated that CMS is inappropriately prioritizing concerns about enrollees' future tax liabilities over the potential for future health care liabilities.

Response: We disagree that we are prioritizing concerns about enrollees' future tax liabilities over the potential future health care liabilities. This temporary policy balances urgent program integrity concerns with the long-term desire for flexibility and enrollment efficiencies.

Comment: One commenter stated that if enhanced PTCs expire at the end of 2025, many more people will be enrolled in plans with nominal premiums (rather than fully-subsidized premiums) in future years, exacerbating the risk of disenrollment due to nonpayment of small premium amounts.

Response: Although expiration of the enhanced subsidies may lead to an increase in the number of enrollees whose coverage is terminated for non-payment, including non-payment of small amounts of premium, it is also important to ensure that consumers are protected from improper enrollment. Temporarily eliminating the fixed-dollar and gross percentage premium thresholds, while maintaining the net premium thresholds, appropriately strikes a balance between ensuring that Exchange enrollees do not lose coverage for owing only a small percent of their net premium, while ensuring they do not remain enrolled in coverage for extended periods of time without paying any premium. After allowing the temporary program integrity policies in this rule to help the Exchanges shed the currently high levels of improper enrollment, our policies revert back to those in effect prior to this rule, balancing urgent program integrity needs with long-term desire for flexibility and enrollment efficiencies.

Comment: Several commenters stated that disruptions due to non-payment terminations may mean a loss for providers of anticipated reimbursement revenue and an increase in uncompensated care—further challenging the financial health of health centers, which will lead to less access to care for patients.

Response: We recognize that temporary interruptions in care may mean a temporary loss of revenue for providers and increase uncompensated care. However, since issuers have not yet implemented either the fixed-dollar or gross premium percentage-based thresholds, the risk of lost revenue is minimal as a result of this temporary policy.

Comment: Several State Exchanges and State-specific advocacy organizations stated that this provision would limit the ability of their State to manage their own unique health insurance market, where most State Exchanges already see lower rates of fraud.

Response: We appreciate these comments and concerns raised by State Exchanges, but we maintain that the policy proposals above are an appropriate balance of temporary measures to address urgent program integrity concerns with long-term flexibility for State Exchanges. The temporary actions are necessary to protect consumers from accruing large tax liabilities and ensure program integrity, but the rule reverts back to existing policy once immediate concerns have been addressed, and State Exchanges regain the flexibility those policies created. Given our expectation that the expiration of enhanced subsidies will substantially decrease improper enrollments, the Department believes it is reasonable to adopt certain policies temporarily in response to commenter concerns.

Comment: Several commenters stated that issuers have historically managed payment thresholds and are best positioned to implement these thresholds due to their deep understanding of enrollee needs and local market dynamics.

Response: While issuers have insight into payment habits of their enrollees, Exchanges must provide guardrails to ensure the integrity and affordability of their markets.

Comment: Several commenters stated that many issuers may have already made substantial investments to implement the new thresholds. Reversing course now could render those investments as sunk costs and could exert modest upward pressure on premiums. Commenters also stated that promoting continuous coverage contributes to a more stable and balanced risk pool, and in turn reduces premiums.

Response: We recognize that some issuers may have begun implementation of one or both of these premium payment thresholds. However, we believe that the urgent program integrity concerns outlined in this final rule outweigh the costs that may be associated with issuers modifying their systems to eliminate the fixed-dollar and gross percentage-based premium payment thresholds. Further, these measures are temporary and work to implement these premium payment thresholds will be relevant once again as issuers prepare for PY 2027.

Comment: A few commenters supported the proposal because of its intention to address existing program integrity concerns.

Response: We agree that eliminating the fixed-dollar and gross percentage-based premium payment threshold will address program integrity concerns, as it will ensure that consumers must always pay some amount of their monthly premium (at least 95 percent) and will prevent consumers, especially those who are victims of unauthorized enrollments, from accruing significant premium debts. We believe finalizing these proposals through PY 2026 strikes the right balance in addressing urgent program integrity concerns with long-term desires for flexibility and enrollment efficiencies.

Comment: One commenter stated that the grace period for premium payments would be shortened with the finalization of this rule.

Response: We clarify that this final rule does not modify the grace period for enrollees receiving the benefit of APTC described in § 156.270(d).

Comment: One commenter stated that the net premium threshold amount (which must be at least 95 percent of net premium) was being modified with this proposal.

Response: We clarify that this final rule does not modify the net percentage-based premium payment threshold described in § 155.400(g)(1).

7. Annual Open Enrollment Period (§ 155.410)

In the 2025 Marketplace Integrity and Affordability proposed rule (90 FR 12976 through 12979), we proposed to amend § 155.410(e), which provides the dates for the annual individual market Exchange OEP in which qualified individuals and enrollees may apply for or change coverage in a QHP. Specifically, we proposed to add § 155.410(e)(5) and (f)(4) to change the OEP for benefit years starting January 1, 2026, and beyond so that it begins on November 1 and runs through December 15 of the calendar year preceding the benefit year and to set an effective date of January 1 for QHP selections received by the Exchange on or before this December 15 OEP end date. The Exchange OEP is extended by cross-reference to non-grandfathered individual health insurance coverage, both inside and outside of an Exchange, under the guaranteed availability regulations at § 147.104(b)(1)(ii). We also proposed conforming revisions to § 155.410(e)(4) and (f)(3).

In previous rulemaking, we have adjusted the length of the OEP to account for various circumstances

impacting the stability of the risk pool, Exchange operations, and the consumer experience (see Table 4). In setting the OEP, as we explained when we set the initial enrollment period in the Exchange Establishment Rule (77 FR 18387), we attempt to balance the risk of adverse selection—a situation where individuals with higher risk are more likely to select coverage than healthy individuals—with the need to ensure that consumers have adequate opportunity to enroll in QHPs through an Exchange.

TABLE 4—SUMMARY OF OPEN ENROLLMENT PERIOD LENGTH FOR EXCHANGES ON THE FEDERAL PLATFORM

[PY 2014–2027]

Plan year	OEP start date	OEP end date	Duration (days)	Notes
2014	10/1/2013	3/31/2014	182	Lengthy first enrollment period to allow time for consumers to explore new options and to raise awareness.
2015	11/15/2014	2/15/2015	93	Planned OEP for PY 2015 was October 15 to December 7, but challenges and delays meant the OEP was extended.
2016	11/1/2015	1/31/2016	92	Proposed a shorter OEP but finalized more modest change primarily to limit the burden of a shift on Exchanges still experiencing implementation challenges.
2017	11/1/2016	1/31/2017	92	
2018	11/1/2017	12/15/2017	45	Cleanup for late Exchange activity [143] occurred between December 16, 2017 and December 23, 2017 for the 39 States that used *HealthCare.gov.*
2019	11/1/2018	12/15/2018	45	Cleanup for late Exchange activity [144] occurred between December 16, 2018 and December 22, 2018 for the 39 States that used *HealthCare.gov.*
2020	11/1/2019	12/15/2019	45	Cleanup for late Exchange activity [145] occurred between December 16, 2019 and December 21, 2019, which included the additional time from December 16–18 provided to consumers who were unable to enroll by the original deadline.
2021	11/1/2020	12/15/2020	45	Cleanup for late Exchange activity [146] occurred between December 16, 2020 and December 21, 2020 for the 36 States that used *HealthCare.gov.*
2022	11/1/2021	1/15/2022	76	
2023	11/1/2022	1/15/2023	76	
2024	11/1/2023	1/16/2024	77	In 2024, January 15 was a Federal holiday; accordingly, consumers had until midnight on Tuesday, January 16 (5 a.m. EST on January 17) to enroll in coverage.
2025	11/1/2024	1/15/2025	76	
2026	11/1/2025	1/15/2026	76	
2027	11/1/2026	12/15/2026	45	

Sources: Marketplace Open Enrollment Period Public Use Files and Marketplace Open Enrollment Fact Sheets.

Consistent with our original policy establishing a December OEP end date for PY 2015 that promotes a full year of coverage, we maintained an OEP set to November 1 to December 15 for PYs 2018, 2019, 2020, and 2021. During this time, we observed several benefits from a 45-day OEP that ends on December 15 for coverage starting January 1 compared to OEPs ending on February 15 for benefit year 2015 and January 31 for benefit years 2016 and 2017. As discussed in the 2022 Payment Notice proposed rule (86 FR 35167 through 35168), prior enrollment data suggested that the majority of new consumers to the Exchange selected plans prior to December 15 so they had coverage beginning January 1. We stated in the proposed rule (90 FR 12978) that we believe this data shows consumers became accustomed to the deadline. Also, we stated that it reduces consumer confusion by aligning more closely with the open enrollment dates for other coverage for many employer-based health plans. We also observed that consumer casework volumes related to coverage start dates and inadvertent dual enrollment decreased in the years after the December 15 end date was adopted, suggesting that the consumer experience, as well as program integrity, was improved by having a singular deadline of December 15 to enroll in coverage for the upcoming plan year. We noted how confusion over the deadline could cause someone to wait until January 15 and miss out on a whole month of coverage. In addition, the extended OEP requires enrollment assisters to stretch budget resources over an additional month.

In the 2022 Payment Notice proposed rule (86 FR 35168), we also identified negative impacts from a 45-day OEP that ends on December 15. In particular, we observed that consumers who receive financial assistance, who do not actively update their applications during the OEP, and who are automatically re-enrolled into a plan are subject to unexpected plan cost increases if they live in areas where the second lowest-cost silver plan has dropped in price relative to other available plans. In this situation, consumers would experience a reduction in their allocation of APTC based on the second lowest-cost silver plan price but are often unaware of their increased plan liabilities until they receive a bill from the issuer in early January, after the OEP has concluded. We noted that extending the OEP end date to January 15 would allow these consumers the opportunity to change plans after receiving updated plan cost information from their issuer and to select a new plan that is more affordable to them. We also noted concerns from some Navigators, certified application counselors (CACs), agents, and brokers

[143] *See* CMS (2018). Public Use Files: FAQs, *https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/marketplace-products/downloads/2018_public_use_file_faqs.pdf.*

[144] *See* CMS (2019). Public Use Files: FAQs. *https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/marketplace-products/downloads/2019publicusefilesfaqs.pdf.*

[145] *See* CMS (2020). Public Use Files: FAQs. *https://www.cms.gov/files/document/2020-public-use-files-faqs.pdf.*

[146] *See* CMS (2021). Public Use Files: FAQs. *https://www.cms.gov/files/document/2021-public-use-files-faqs.pdf.*

regarding a lack of time to fully assist all interested Exchange applicants with comparing their different plan choices. In light of these negative impacts, we sought comment on whether an extended OEP would provide a balanced approach to provide consumers additional time to make informed choices and increase access to health coverage, while mitigating risks of adverse selection, consumer confusion, and issuer and Exchange operational burden. While some commenters expressed substantial concern over these risks, we concluded the experience from State Exchanges that extend their OEP suggested an extension in January does result in increased enrollments and would not introduce adverse selection into the market. Therefore, we concluded the negative impacts of an OEP ending in December justified extending the OEP to end on January 15 for PY 2022 and beyond. This extension to the OEP has now been in place for PYs 2022, 2023, 2024, and 2025. We refer readers to Table 4 for a summary of OEPs in effect from PY 2014 to PY 2025.

We noted in the proposed rule that with our experience implementing this extended OEP over the past 4 years, we have had the opportunity to more closely assess whether this extension achieves the right balance between an adequate opportunity to enroll in a QHP and the added risk for adverse selection, consumer confusion, and unnecessary burden on issuers and Exchanges. This assessment reveals that only a small number of consumers took advantage of the additional time to switch to a lower-cost plan after receiving a bill from their issuer in January with higher plan costs. During the most recent OEP, fewer than 3 percent of enrollees (470,000 individuals) ended their FFE or SBE–FP coverage between December 15, 2024, and January 15, 2025, including those enrollees who switched to other plans as well as those who did not. We also compared the enrollment growth for Exchanges on the Federal platform to State Exchanges under the previous December 15 end date. While most State Exchanges (12 out of 20) use the same enrollment schedule as Exchanges on the Federal platform, 7 State Exchanges use enrollment windows past January 15.[147] For the best comparison, we focused on enrollment among people enrolled in APTC subsidized plans without CSRs. This controlled for the variable of whether States expanded Medicaid or not.[148] From 2017 (the year before the end date changed to December 15) to 2021 (the last year of the December 15 end date), we found that Exchanges on the Federal Platform experienced a larger (47 percent) growth in enrollment among people who enrolled in coverage with only APTC compared to 28 percent growth among people enrolled with only APTC through State Exchanges. This suggests the change to the December 15 OEP end date did not compromise access to coverage for people selecting plans through the Exchanges on the Federal platform. Some of these people may have switched to a more affordable plan after receiving a bill in January with unexpected plan costs. However, we stated in the proposed rule (90 FR 12978) that we expect that upon finalizing the proposed addition of § 155.335(n), a higher proportion of enrollees will actively re-enroll and compare their plan options prior to December 15, reducing the need for changes after December 15. To the extent people are switching coverage during the extended period, this may also be due, in part, to improper plan switching. In the 2024 OEP for Exchanges on the Federal platform, 1,490,000 consumers were added to coverage between 12/15 and 1/15. Overall, this is about 9 percent of all consumers (~16.4 million) who selected coverage in the entire 2024 OEP. After implementation of a shorter OEP, we expect some portion of these 1,490,000 consumers will adjust their behavior and enroll earlier, some portion will acquire coverage through another means, and the remainder will miss the opportunity to enroll due to this change to the OEP duration.

As we have noted elsewhere, we recently began receiving substantially more consumer complaints alleging improper enrollments by agents and brokers who switch enrollees to new QHPs offered on the Exchange or update enrollees' current policies without their knowledge, to capture commissions.[149] However, in the proposed rule, we also noted that when the enhanced subsidies made available under the ARP and IRA expire at the end of 2025, plan costs for the majority of Exchange enrollees will increase, so there may be an increase in the proportion of enrollees seeking to drop coverage or change plans for PY 2026 after December 15, 2025. Due to changing plan costs, enrollees may need more time to make their PY 2026 plan selections. We sought comment on whether to delay the effective date for the proposal to update the OEP end date until the OEP preceding PY 2027, given the special circumstances for PY 2026 financial assistance.

Based on the foregoing analysis, we stated in the proposed rule (90 FR 12979) that we do not anticipate that changing the OEP end date from January 15 to December 15 would have a negative impact on a consumer's opportunity to enroll in QHPs through an Exchange. We sought comment on how changing the OEP end date to December 15 would impact QHP enrollment opportunities, consumer confusion, and burden.

In making this proposal, we stated in the proposed rule (90 FR 12979) that the OEP plays a crucial role in protecting the stability of the individual market risk pool within the structure of the ACA. Adverse selection remains a serious concern under the ACA's guaranteed availability and modified community rating requirements. The average plan liability risk score in the individual market remains substantially higher than the small group market, showing that higher-than-average risks continue to select into the individual market. This higher risk leads to higher premiums for those who purchase coverage through the individual market.

We understood there was still an ongoing risk of adverse selection when we decided to extend the OEP end date to January 15. However, we concluded this risk of adverse selection was outweighed by the benefits of increased consumer enrollments and opportunities to switch plans for consumers with unexpected plan costs.

In the proposed rule (90 FR 12979), we stated that our new analysis of this experience extending the OEP to end January 15 suggests that these benefits did not materialize. Accordingly, without any clear benefit, we stated that we no longer believe the benefits of the OEP extension outweigh the risk of adverse selection. We sought comment on whether the risk of adverse selection supports changing the OEP end date to December 15.

We anticipated in the proposed rule (90 FR 12979) that if an OEP end date of December 15 were finalized, this change would apply to all Exchanges,

[147] *See* CMS. (2024, Oct. 17). State-based Marketplaces: 2025 Open Enrollment. *https://www.cms.gov/files/document/state-exchange-oe-chart-py-2025.pdf*.

[148] Whether or not a State expanded Medicaid affects the lower end of the CSR eligibility income range. In States that have expanded Medicaid, the lower income threshold for CSR eligibility is 138 percent of the FPL, while in non-expansion States it is 100 percent of the FPL. As a result, whether or not a State has expanded Medicaid can have a substantial impact on enrollment differences between States.

[149] Based on internal CMS data, in the first 3 months of 2024, we received 50,000 complaints of improper enrollments and 40,000 complaints of improper plan switches attributed to agent or broker noncompliant behavior.

including State Exchanges, for the 2026 coverage year and beyond.

Given our proposal to adopt a standard OEP, we sought comment on whether we should also prohibit Exchanges from extending an OEP through application of a blanket SEP. Where available, we requested that comments include data demonstrating the impact of the OEP end date on enrollment and adverse selection. Additionally, we sought comment on the overall effects and impacts of OEP duration and OEP placement within the calendar year, including suggestions regarding the ideal duration and placement to minimize adverse selection and maximize consumer choice.

We sought comment on this proposal.

After consideration of comments and for the reasons outlined in the proposed rule and this final rule, including our responses to comments, we are finalizing this policy with the following modifications: the changes to the OEP period will take effect beginning with the OEP for PY 2027 and the rule will provide flexibility for all Exchanges within set parameters. Newly added § 155.410(e)(5)(i) states that the OEP must begin by November 1 of the year preceding the coverage year and must end by December 31 of the year preceding the coverage year. Newly added § 155.410(e)(5)(ii) limits all Exchange OEPs to a maximum of nine weeks in duration. Each State's Exchange OEP is also extended by cross-reference to non-grandfathered individual health insurance coverage outside of the Exchange per § 147.104(b)(1)(ii). Thus, beginning with the OEP for PY 2027, the dates of the OEP each year for Exchanges operating on the Federal platform will be November 1 through December 15 of the preceding year; however, the final rule provides flexibility for all Exchanges, including those on the Federal platform, to adjust OEP dates, within the outlined parameters, in future years as operational processes evolve.

For example, in some cases the timelines and operations established by Exchanges for premium rate filings and consumer noticing may currently preclude beginning the OEP earlier than November 1. In addition, while some Exchanges already have a December 31 cutoff date for January 1 coverage, many Exchanges, including the Exchanges on the Federal platform, have generally made coverage effective on February 1 when a plan selection is made between December 16 and December 31. Per § 155.410(f)(4), as finalized in this rule, all plan selections made during the OEP must be effective as of January 1 of the plan year. Therefore, in order to elect a December 31 end date to the OEP, the Exchange and its issuers must be capable of making coverage effective the very next day following a December 31 plan selection. Under this final rule, Exchanges may adopt any start date on or before November 1, and may adopt an end date as late as December 31, as long as operational processes allow for meeting all other Exchange requirements associated with the OEP. As we believe the open enrollment period length is largely independent of subsidy levels set by Congress and the current high levels of improper enrollment we are attempting to mitigate, we are finalizing these changes for PY 2027 and beyond. We summarize and respond to public comments received on the proposed change in OEP dates below. and respond to public comments received on the proposed change in OEP dates below.

Comment: Almost all commenters expressed support for delaying implementation of a shorter OEP, if finalized as proposed. Most commenters cited the sunset of enhanced PTC as a potential cause for consumer confusion during the upcoming OEP, which will require additional consumer support and staffing on the part of issuers, agents, brokers, web-brokers and Exchanges. Commenters expressed concern that these dynamics would be exacerbated by a shorter OEP. Many issuers asserted that shortening the OEP in a year when consumers most need additional time to assess and change plans has the potential to create market instability. Some stated that there is not adequate time to incorporate this change into premium rate filings for PY 2026.

Several organizations stated that there is insufficient time to notify consumers and conduct educational outreach about this provision prior to the OEP for PY 2026, and decreased Navigator enrollment support funding for PY 2026 [150] may contribute to consumer confusion.

Some commenters said that technical modifications and testing were already underway for PY 2026 OEP, so adding modifications would be challenging and costly for Exchanges and their issuers to incorporate.

Response: We recognize that finalizing a rule that changes the OEP dates only a few months prior to the start of an OEP for a plan year during which nearly all enrollees receiving financial assistance will experience changes in their APTC eligibility or amount has the potential to be challenging for consumers, Exchanges, and issuers. In light of these concerns, we are modifying the effective date for the OEP change to begin for the PY 2027 OEP rather than the PY 2026 OEP.

Comment: Commenters addressing the proposal to amend § 155.410(e) to shorten the annual OEP in all individual market Exchanges, including State Exchanges, all expressed support for States to retain flexibility to set their own OEP dates. Issuers and issuer associations that supported the proposal for a shorter OEP for the FFEs recommended that CMS permit State Exchanges to continue setting their own OEP dates. All State Exchanges that submitted comments also supported giving State Exchanges flexibility to set their own OEP, primarily stating that States better understand local market conditions, such as consumer demographics, enrollment patterns, fraud, risk, and adverse selection, and therefore are better positioned to decide the length of OEP that will work best for their residents. These commenters also noted the need for flexibility in case of natural disasters.

Response: After consideration of the comments received, we are modifying our proposal to provide flexibility for States to set their own OEP dates, with the condition that, beginning with the OEP for PY 2027, the end date is no later than December 31 of the preceding year and all Exchange OEPs have a maximum length of 9 weeks. We specify the 9-week duration because it will allow most Exchanges to maintain their OEP start date of November 1 and extend their OEPs through the latest allowed end date of December 31. If an Exchange preferred to start the OEP earlier, such as on October 15, the 9-week durational limit would ensure that the Exchange's OEP length does not place excessive burden on issuers and enrollment partners. We believe that a 9-week OEP provides more than sufficient time for consumers to submit an application, compare their plan options, and enroll in advance of the new year. During the PY 2025 OEP, 97 percent of all Exchange enrollments occurred by the end of the ninth week. The latest allowable OEP end date of December 31, coupled with the finalized effective date rules in § 155.410(f) will ensure that all OEP enrollees have full year coverage effective January 1 of the plan year for which they are enrolling. We also note that throughout the year, Special Enrollment Periods are available for consumers who live in areas that are experiencing a natural disaster (or other national or State-level emergency) when

[150] *See* CMS (2025, Feb 14). Press Releases: CMS Announcement on Federal Navigator Program Funding. *https://www.cms.gov/newsroom/press-releases/cms-announcement-federal-navigator-program-funding.*

it is designated a Federal Emergency Management Agency (FEMA) incident.

Comment: Several commenters supported shortening the annual OEP as proposed, beginning with PY 2027 or later. One commenter cited consistency across Exchanges to help consumers remember key dates and reduce confusion from having two deadlines for two different coverage start dates. Two commenters opined that the shorter OEP would reduce adverse selection and ensure the stability of the individual market. One commenter noted that an OEP that ends before the start of the next calendar year begins allows health plans to better predict risk and pricing models.

Response: We agree with these comments and are finalizing the policy to end the annual OEP for all Exchanges no later than December 31 of the calendar year preceding the applicable benefit year, beginning with PY 2027. This approach balances State flexibility with consistency, because beginning with the PY 2027 OEP all Exchange OEP enrollments across the country will have a January 1 effective date. The single effective date ensures that consumers have only one deadline. Ending the OEP before the plan year begins will mitigate adverse selection because consumers will not be able to switch plans in January based on emergent health needs or delay enrollment by forgoing January coverage with the option of enrolling later instead. The December 31 end date and the 9-week durational limit will shorten the OEP for all Exchanges once effective for the PY 2027 OEP.

Comment: Many interested parties expressed concerns about the proposed revision to the annual OEP. Commenters noted that a shorter OEP would have potential for reduced enrollment and an increase in the uninsured population. Some commenters commented on the importance of the OEP providing enough time to support consumer choice and informed decisions about coverage, noting in particular that vulnerable populations, including those in rural areas with limited digital access, those with language barriers, and those with disabilities, may need additional time and assistance to enroll. Many commenters also noted that some consumers need enough time to switch plans.

Response: We agree that the OEP must provide sufficient time for all entities involved in the annual open enrollment process to conduct outreach, provide assistance, and enroll in coverage. We intend to conduct outreach to consumers in States with Exchanges operating on the Federal platform to ensure that they are aware of the newly shortened OEP are prepared to enroll or re-enroll in 2027 coverage. By providing flexibility to State Exchanges to set their OEP dates within set parameters, we anticipate that Exchanges can time their OEP period to best accommodate the needs of the specific populations in their States, including vulnerable populations. By delaying the effective date until PY 2027, Exchanges can increase outreach to vulnerable populations or consider tactics other than an extended OEP to promote their participation.

Comment: Many commenters said that a shortened enrollment period would strain agents, brokers, enrollment assisters, and call center capacity as they would be supporting the same number of people in a shorter timeframe. Some commenters noted that the reduction in Federal funding for Navigators compounds the capacity concerns regarding consumer assistance.

Response: A shorter enrollment period may require agents, brokers, web-brokers, enrollment assisters, and the Marketplace call center to assist the same number of people over a shorter timeframe. As noted above, during the PY 2025 OEP, 97 percent of all Exchange enrollments occurred by the end of the ninth week. The final rule provides States flexibility to set their OEPs up to nine weeks in length. We encourage Exchanges to work with the enrollment support interested parties in their States to establish the OEP dates that best align with their capacity.

Comment: Several commenters shared data from California, New York, Massachusetts and Virginia State Exchanges showing that those who enroll later in the OEP may on average be younger, healthier, and therefore less costly consumers. Commenters worried that if some such consumers miss the shortened deadline, it could destabilize the risk pool and increase premiums. Many said that long-term effects would lead to higher uninsurance rates, uncompensated care, and clinician burnout that could strain the health care ecosystem.

Response: We noted the crucial role that the OEP plays in protecting the stability of the individual market risk pool within the structure of the ACA. Adverse selection remains a serious concern when a longer OEP allows consumers to wait until the coverage year begins before deciding whether to enroll. Enrollment periods are one of the few tools established by the ACA to mitigate adverse selection and contribute to a more stable, affordable market. Under the final rule, beginning in PY 2027, consumers will have one clear and consistent deadline for January 1 coverage within their Exchange that will not differ from the end date of the OEP. By delaying the effective date until PY 2027, Exchanges have sufficient time to message the clearer OEP end date to consumers, especially the younger and healthier consumers who may tend to enroll later in the OEP. While we cannot foresee to what extent younger and healthier consumers will enroll before the updated deadline, we do believe consumers are deadline-driven. Given that State Exchange markets may experience unique patterns of enrollment and have State-specific history of OEP dates and enrollment outcomes, we are maintaining flexibility for State Exchanges to set their own OEP dates in this final rule within set parameters. Moreover, we believe that addressing adverse selection through all the provisions of this rule will lead to lower premiums that will do more to encourage younger and healthier consumers to enroll than additional time does today. Therefore, we believe that the adjusted OEP period will not lead to negative long-term consequences.

Comment: A few commenters responded to our request about the overall effects and impacts of OEP placement within the calendar year. Several commenters recommended that if CMS moves up the OEP end date to December 15, the Exchanges should also move up the OEP start date to October 15 to ensure consumers have sufficient time to enroll while still maintaining a deadline for a January 1 coverage start. Others suggested that December 31 be the last date of OEP for coverage effective January 1. Several also mentioned that the OEP falls during a busy holiday season, which brings its own time constraints and financial challenges for consumers and business owners.

Response: We appreciate the comments noting potential benefits of an OEP start date prior to November 1st. Therefore, the final regulation at § 155.410(e)(5) allows all Exchanges to set an earlier start date for their OEP if desired. This change provides additional flexibility to States as compared to the previous policy at § 155.410(e)(4)(iii) which did not allow an Exchange to set a start date for their OEP earlier than November 1 unless that earlier start date was already in place as of November 1, 2023. The rule does not require any Exchange to establish an earlier OEP start date given that the timing for issuer rate filings may make it difficult to a start OEP prior to November 1. We agree that an end date

of December 31 or earlier coupled with the effective date rules at § 155.410(f) will ensure that all effective dates (other than those pursuant to a SEP) will be on the same day (January 1 of the coverage year).

Comment: A commenter noted that that many brokers write both Medicare and individual market business, and a shorter OEP would reduce agents' ability to balance these overlapping enrollment periods. Some commenters worried that the overlap of the Exchange OEP with the Medicare Advantage OEP may confuse consumers or strain the capacity of agents and brokers.

Response: Ending the Exchange OEP prior to January will align more closely with enrollment periods for other coverage such as employer coverage which benefits consumers because it allows consumers to compare their options within the same timeframe when they need to switch from one coverage type to another at the end of the plan year. In addition, each year since 2010 the Medicare Annual Enrollment Period has run from October 15 to December 7, and this rule provides flexibility for Exchanges to partially align their OEP with that period. However, given the capacity concerns voiced by agents and brokers and associated organizations, the final OEP policy strikes a balance between goals of consistency with other OEPs and not straining the capacity of enrollment assistance entities. We note that the Medicare Advantage OEP occurs annually from January 1 to March 31, so the Exchange OEP, with its last possible end date of December 31, will not overlap.

Comment: Some commenters noted that future Medicaid changes could cause more consumers to be eligible for Exchange coverage and therefore the OEP would need to be long enough to ensure an opportunity for them to enroll.

Response: We are not aware at this time of Medicaid eligibility changes that would disrupt Exchange enrollment expectations. Consumers who lose eligibility for Medicaid or CHIP qualify for a Special Enrollment period under § 155.420 and thus would not be limited to the annual OEP for Exchange enrollment.

Comment: Some commenters noted that an OEP that extends beyond January 1 allows a valuable ''free look'' period during which consumers can change plans. One commenter noted that Exchange enrollees who are automatically re-enrolled into a plan may not learn of cost increases until after they receive their first bill in January. Another commenter noted that an enrollee may discover their plan's clinician directory included inaccurate information only after the enrollment period begins.

Response: We provide notice in advance of the OEP to consumers about the importance of updating information for the future plan year and actively comparing plan options and prices. We note that section 2799A–5 of the Public Health Service Act requires issuers to verify and update their provider directories on a regular basis. They are required to verify that their provider directories are accurate at least once every 90 days and to update the directory within 2 business days of provider or facility notice of network agreement termination. Additionally, if a plan participant receives information from the issuer's provider directory that a provider or facility is in-network when the provider or facility is in fact not in network, the issuer may not charge a cost-sharing amount greater than the cost-sharing amount that would apply to the item or service if the provider or facility was in-network.

8. Monthly Special Enrollment Period for APTC-Eligible Qualified Individuals With a Projected Household Income at or Below 150 Percent of the Federal Poverty Level (§ 155.420)

In the 2025 Marketplace Integrity and Affordability proposed rule (90 FR 12979 through 12982), we proposed to remove § 155.420(d)(16) to repeal the monthly SEP for APTC-eligible qualified individuals with a projected annual household income at or below 150 percent of the FPL, which we refer to as the ''150 percent FPL SEP.'' To conform existing regulations to the repeal of this SEP, we also proposed to remove § 155.420(a)(4)(ii)(D) (which adds plan category limitations and permits eligible enrollees and their dependents to use the 150 percent FPL SEP to change to a silver level plan) and § 155.420(b)(2)(vii) (regarding when coverage is effective for this SEP), and § 147.104(b)(2)(i)(G) (as discussed in section III.A.1 of this final rule). We also proposed to amend the introductory text of § 155.420(a)(4)(iii) to remove reference to paragraph (d)(16). Finally, we also proposed to revise paragraphs (a)(4)(ii)(B) and (a)(4)(ii)(C) to move the placement of the word ''or'' for clarity given the proposed removal of paragraph (a)(4)(ii)(D).

We created the 150 percent FPL SEP to provide additional opportunities for low-income consumers to take advantage of free or low-cost coverage that section 9661 of the ARP made available on a temporary basis during the COVID–19 PHE. When we first finalized this SEP and then made it permanent in the 2025 Payment Notice (89 FR 26320), we projected that it would increase premiums due to adverse selection and, as a result, increase both the financial hardship on consumers who pay the full premium and the Federal cost of APTC. While we previously concluded the enrollment benefits of this SEP outweighed these costs and risks for adverse selection, we now believe that the SEP in combination with the widespread availability of zero-dollar premium plans has increased opportunities and incentives to conduct improper enrollments, as well as increased the risk for adverse selection, as the 150 percent FPL SEP incentivizes consumers to wait until they are sick to enroll in Exchange coverage. In the proposed rule (90 FR 12979), we encouraged commenters and other interested parties to provide comments on whether and how the 150 percent FPL SEP has exacerbated these issues. Finally, we stated that we believe that the single, best interpretation of the statute is that it does not authorize the Secretary to add the 150 percent FPL SEP to the list of SEPs enumerated at sections 1311(c)(6)(C) and (D) of the ACA.

As background, section 9661 of the ARP amended section 36B(b)(3)(A) of the Code to decrease the applicable percentages used to calculate the amount of household income a taxpayer is required to contribute to their second lowest cost silver plan for tax years 2021 and 2022.[151] For those with household incomes at or below 150 percent of the FPL, the new applicable percentage is zero. The IRA extended this provision to the end of PY 2025. As a result of these changes, many low-income consumers whose QHP coverage can be fully subsidized by the APTC have one or more options to enroll in a silver-level plan without needing to pay a premium after the application of APTC.

To provide certain low-income individuals with additional opportunities to newly enroll in this fully-subsidized or low-cost coverage, in part 3 of the 2022 Payment Notice (86 FR 53429 through 53432), we finalized, at the option of the Exchange, a new monthly SEP for APTC-eligible qualified individuals with projected household income at or below 150 percent of the FPL. We also finalized a provision stating that this SEP is available only during periods of time when a taxpayer's applicable percentage, which is used to calculate the amount of household income a tax filer is required to contribute to their second lowest cost

[151] Public Law 117–2.

silver plan, is set at zero, such as during tax years 2021 through 2025, as provided by section 9661 of the ARP and extended by the IRA. As background, the applicable percentages are used in combination with other factors, including annual household income and the cost of the benchmark plan, to determine the PTC amount for which a taxpayer can qualify to help pay for a QHP on an Exchange for themselves and their dependents. These decreased percentages generally result in increased PTC for PTC-eligible tax filers.

In the 2025 Payment Notice (89 FR 26320), we removed the limitation that the 150 percent FPL SEP is available only during periods of time when the applicable percentage is set to zero. However, given concerns regarding the growth of improper enrollments using this SEP, we proposed that this SEP would end as of the effective date of the final rule, and not in December 2025, when the provisions extended by the IRA sunset. We stated in the proposed rule (90 FR 12980) that we believe ending the 150 percent FPL SEP across all Exchanges immediately is necessary due to the rise in improper enrollments, as the 150 percent FPL SEP was one of the primary mechanisms that certain agents, brokers, and web-brokers used to conduct unauthorized enrollments to improperly enroll consumers in fully-subsidized Exchange plans.

We stated in the proposed rule (90 FR 12980) that while we previously concluded that the benefits of increased access outweighed the risk of premium increases, new information suggests the expanded availability of fully-subsidized plans (referred to as zero-dollar plans in previous rulemaking),[152] combined with easier access to these fully-subsidized plans through the 150 percent FPL SEP, led to a substantial increase in improper enrollments. We stated that the existence of fully-subsidized plans by itself creates an opportunity for some agents, brokers, and web-brokers to conduct improper enrollments of consumers in Exchange coverage without them knowing, because without a premium, there is no ongoing need for consumer engagement following completed enrollment in an Exchange plan. We noted that based on our own analysis, we have identified various mechanisms that some agents, brokers, and web-brokers have exploited to conduct unauthorized enrollments to improperly enroll consumers in Exchange coverage without their consent. For example, an agent, broker, or web-broker can enroll a consumer without the consumer's knowledge and earn a commission for each consumer enrolled. An agent, broker, or web-broker can also change the agent of record for an existing enrollee and take the commission from the existing agent, broker, or web-broker. An agent, broker, or web-broker can switch an enrollee to a new health plan without the consumer's consent to capture the new commission. An agent, broker, or web-broker can also split up a household and enroll them in multiple plans to capture multiple commissions.

We noted that this pattern of agents, brokers, and web-brokers targeting low-income individuals with deceptive practices to entice enrollment in fully-subsidized plans is illustrated in multiple indictments recently pursued by the Department of Justice (DOJ). In one case, an insurance brokerage firm allegedly schemed to maximize commission payments by preying on vulnerable, low-income individuals, using deceptive practices to improperly inflate the incomes of consumers projected to earn no income.[153] In another case, a different insurance brokerage executive pleaded guilty to deceptive marketing practices and fraudulently enrolling ineligible consumers into fully-subsidized ACA plans by inflating their incomes.[154]

Because of these practices, in 2024, we implemented various system and logic changes to prevent some improper agent, broker, and web-broker behavior and we have observed some improvements. However, we stated in the proposed rule (90 FR 12980) that we believe that so long as there is no premium cost for the consumer, these enrollments can continue to go unnoticed until an enrollee tries to use a health plan that has been improperly cancelled by an agent, broker, or web-broker, or eventually learns they must reconcile APTC when they file their Federal income tax return.

In December 2024 the FFE received 7,134 consumer complaints of improper enrollments, an increase from the 5,032 complaints received in December 2023. Although these numbers represent a decrease from the high of 39,985 complaints received in February 2024, the fact that the number of complaints for 2024 remains substantially higher than for 2023 demonstrates that previous program integrity measures have not resulted in a decrease in potential improper enrollments such that additional measures are not necessary. We stated in the proposed rule (90 FR 12980) that this has caused us to reconsider the 150 percent FPL SEP, as it continues to serve as a mechanism for some agents, brokers, and web-brokers to circumvent the protections that we have put into place, and even reverse some of the gains we have made in mitigating agent, broker, and web-broker improper enrollments.

On April 12, 2024, a class of plaintiffs, including Exchange consumers and insurance agents, filed a complaint against certain agents and marketing companies alleging a conspiracy to conduct unauthorized enrollments and change enrollments to improperly capture commissions.[155] The complaint alleges that the false ads created by the defendants ''resulted in hundreds of thousands of enrollments by class members.'' [156] We noted in the proposed rule (90 FR 126980) that enrollment data for the 2024 OEP suggest improper enrollments may be significantly more widespread than the parties involved in this case. A comparison of plan selections during the 2024 OEP and U.S. Census Bureau population estimates show the number of plan selections among people reporting household incomes between 100 and 150 percent of the FPL exceeded the number of potential enrollees within this FPL range in nine States.[157] This analysis estimates between 4 to 5 million improper enrollments in 2024 at a cost of $15 to $26 billion in improper PTC payments.[158]

We stated in the proposed rule (90 FR 12980) that our own analysis confirms the number of plan selections for people with household incomes between 100 and 150 percent of the FPL exceeds the population of people at that income level based on U.S. Census Bureau surveys. At the extreme, 2.7 million Floridians claimed a household income between 100 and 150 percent of the FPL and selected plans through

[152] In previous rulemaking, we referred to fully-subsidized plans as zero-dollar plans. This former characterization suggested there is no premium. But health issuers do receive a full premium for every plan they sell. For people with incomes between 100 and 150 percent of the FPL, this premium is fully subsidized by the Federal taxpayer.

[153] Press Release, Department of Justice *https://www.justice.gov/opa/pr/president-insurance-brokerage-firm-and-ceo-marketing-company-charged-161m-affordable-care#:~:text=The%20indictment%20alleges%20that%20Lloyd,initially%20projected%20having%20no%20income.*

[154] Press Release, Department of Justice, *https://www.justice.gov/opa/pr/executive-vice-president-insurance-brokerage-pleads-guilty-133m-affordable-care-act-fraud.*

[155] Complaint, *Turner* v. *Enhance Health, LLC,* No. 24–cv–60591–MD. (S.D. Fla. Apr. 12, 2024).

[156] Id. at 56.

[157] Blase, B.; Gonshorowski, D. (2024, June). The Great Obamacare Enrollment Fraud. Paragon Health Institute. *https://paragoninstitute.org/private-health/the-great-obamacare-enrollment-fraud.*

[158] Ibid.

HealthCare.gov during the 2024 OEP. Yet, 2022 Census surveys estimated that only 1.5 million people who live in Florida fell within that income level.[159] We stated that this disparity between the number of plan selections and Census population estimates suggests there were likely over 1 million improper enrollments in Florida alone. We noted that several other States have similar patterns of more enrollees reporting household income between 100 and 150 percent of the FPL than people who would be eligible in the State for Exchange coverage with income in that category.[160] A detailed discussion of the limitations of this data analysis can be found in section V.C.18 of this final rule. In the proposed rule, we encouraged commenters and other interested parties to share their experiences in their respective States, including the extent of improper enrollments and other data disparities.

We stated in the proposed rule (90 FR 12981) that the 150 percent FPL SEP expands the opportunities for some agents, brokers, and web-brokers to conduct unauthorized enrollments for people in fully-subsidized plans at any time during the year. We noted that by design, anyone who reports a projected household income at or below 150 percent of the FPL on their application can enroll in a QHP or change from one QHP to another at any time during the year. We stated that this allows agents, brokers, and web-brokers to conduct unauthorized enrollments or enrollment changes any time during the year when they gain access to the personally identifiable information that allows them to falsely represent someone. Before the implementation of the 150 percent FPL SEP, we received a handful of complaints from consumers about improper enrollments or plan switching. In contrast, in the first 3 months of 2024, we received 50,000 complaints of improper enrollments and 40,000 complaints of unauthorized plan switches attributed due to agent or broker noncompliant conduct and improper enrollments. For these reasons, in the proposed rule (90 FR 12981) we stated that by immediately ending this SEP as of the effective date of the final rule, Exchanges would be protecting consumers by preventing improper enrollments in addition to working to mitigate the negative effects of adverse selection on the risk pool, thus moving towards a more stable individual market risk pool.

In addition to concerns over improper enrollments, we stated in the proposed rule (90 FR 12981) that we remain concerned over the ability of consumers at or below 150 percent of the FPL to wait to enroll until they need health care services, resulting in adverse selection. We stated that additional research is necessary to accurately quantify the negative impacts of this behavior to the risk pool, and we sought comment on this issue from the public. With respect to improper enrollments, we recognized the need to revise the Federal platform process for pre-enrollment verification for SEPs and to reinforce that process so that SEPs are not being misused. In the proposed rule, we stated that this reinforcement of pre-enrollment verification for SEPs would strengthen program integrity measures, deter agents, brokers, and web-brokers from engaging in improper enrollments and enrolling unsuspecting consumers in QHP coverage through the Exchanges without their knowledge or consent, and stabilize the individual market risk pool. We proposed changes to pre-enrollment verification for SEPs at § 155.420(g).

In the proposed rule (90 FR 12981), we stated our concern that the risk of people waiting to enroll until sick is substantially heightened by the flexibility consumers, as well as agents, brokers, and web-brokers acting on behalf of consumers, receive when estimating their annual household income on their application, along with the limits on how much low-income individuals must pay to reconcile any misestimate on their taxes. We noted that while a tax filer would need to reconcile a poor income estimate on their taxes, under statute, some tax filers need only repay a small portion of excess APTC. This is referred to as the excess APTC repayment limit. For single filers with household incomes less than 200 percent of the FPL, the amount they must pay back was limited to $375 in 2024.[161] The limit is $950 for single filers with household incomes from 200 to less than 300 percent of the FPL and $1,575 for single filers with household incomes from 300 to less than 400 percent of the FPL. We stated in the proposed rule that with wide flexibility in estimating household income and minimal penalties for misestimates, the 150 percent FPL SEP is an ideal enrollment loophole for some agents, brokers, and web-brokers seeking to increase enrollment commissions. Additionally, we noted that it can result in a large portion of people who fail to enroll in coverage until they incur significant health care expenses, introducing high adverse selection risks for issuers, which are then reflected in higher premiums and associated Federal spending on premium subsidies. We further noted that this SEP has certainly been abused by some agents, brokers, and web-brokers, who are aware of the excess APTC repayment limits and who have inappropriately marketed ''free'' plans to enrollees.[162] [163]

We stated in the proposed rule (90 FR 12981) that this wide flexibility in estimating income may also be open to misuse by Navigators and Certified Application Counselors (CACs). We noted that while Navigators and CACs may not receive a direct financial incentive for improper enrollments, they may still have incentives to encourage or allow applicants to underestimate their income to take advantage of fully-subsidized plans outside of the OEP. Navigators and CACs, for example, still have incentives to hit and exceed enrollment targets. The number of consumers assisted with enrollment or re-enrollment in a QHP is one of the project goals we list in the Navigator grant application.[164] Navigators must provide progress reports to CMS and future grant funding levels are based in part on progress toward this goal.[165] Navigators and CACs may even believe it is appropriate to encourage applicants to understate their income to gain more affordable coverage. We sought comment on this issue and the proposal generally.

We stated in the proposed rule (90 FR 12981) that we are working hard to address the increase in improper enrollments to ensure only eligible people enroll in all plans, but especially fully-subsidized plans. While we stated that we believe stronger enforcement measures can substantially reduce improper enrollments, we also stated that we believe improper enrollments would continue to be a problem so long as there is access to fully-subsidized

[159] U.S. Census Bureau (2022). American Community Survey. Dep't of Commerce. *https://www.census.gov/programs-surveys/acs/data.html.*

[160] Ibid.

[161] IRS (n.d.) Rev. Proc. 2023–34. Dep't of Treasury. *https://www.irs.gov/pub/irs-drop/rp-23-34.pdf.*

[162] Appleby, J. (2024, April 8). Rising Complaints of Unauthorized Obamacare Plan-Switching and Sign-Ups Trigger Concern. KFF Health News. *https://kffhealthnews.org/news/article/aca-unauthorized-obamacare-plan-switching-concern/.*

[163] Chang, D. (2023, June 12). Florida Homeless People Duped into Affordable Care Act Plans They Can't Afford. Tampa Bay Times. *https://www.tampabay.com/news/florida-politics/2023/06/12/florida-homeless-people-duped-into-affordable-care-act-plans-they-cant-afford/.*

[164] Centers for Medicaid and Medicare Services, Cooperative Agreement to Support Navigators in Federally Facilitated Exchanges, CMS NAV 001, June 7, 2024, at 33. OMB 0938–1215.

[165] Id. at 32.

plans combined with even easier access through the 150 percent FPL SEP. We noted that even if we were able to reduce the problem of some agents, brokers, and web-brokers enrolling consumers in Exchange coverage without their knowledge or consent, substantial issues remain with consumers taking advantage of the 150 percent FPL SEP by falsely representing their household income on their Exchange applications. Because of this, we stated that we believe that ending the 150 percent FPL SEP remains one of the most critical ways to mitigate this risk of improper enrollments and protect the individual risk pool. We also stated that we believe that the loopholes and incentives created by the 150 percent FPL SEP are too large to simply police retrospectively.

In the 2025 Payment Notice (89 FR 26321), we reviewed the enrollment experience and found that the percent of Exchange enrollees on the Federal platform who had projected annual household income of less than 150 percent of the FPL increased from 41.8 percent in 2022 to 46.9 percent in 2023, after the implementation of the 150 percent FPL SEP. At the time, we concluded this suggested the policy was successful. We also analyzed the availability of fully-subsidized plans in 2020 before enhanced subsidies became temporarily available under the ARP and IRA. We found 77 percent of the consumer population at or below 150 percent of the FPL had access to fully-subsidized bronze plans and 16 percent had access to fully-subsidized silver plans. Based on this finding, we concluded the risk of adverse selection was mitigated by the broad access to fully-subsidized plans because consumers with fully-subsidized plans would not have a financial incentive to drop their Exchange plan when healthy and resume coverage when sick. Nevertheless, we still projected the 150 percent FPL SEP would increase premiums by 3 to 4 percent (89 FR 26405).

In the proposed rule (90 FR 12982), we stated that these conclusions no longer seem valid considering the recent *Turner* v. *Enhance Health, LLC* litigation, higher numbers of consumer complaints about unauthorized plan switching and improper enrollments, and a sharp increase in enrollment relative to the population with household income under 150 percent of the FPL in PY 2024. We noted that this new information suggests the increase in the proportion of Exchange enrollees who report household incomes under 150 percent of the FPL is driven by improper enrollments. In addition, we explained that it highlights how the adverse selection issue for the 150 percent FPL SEP does not primarily involve concerns over consumers dropping coverage when healthy and resuming coverage when sick. We stated that people already enrolled in fully-subsidized plans clearly have little incentive to drop their plan. We further stated that the adverse selection issue surfaces from people who do not enroll in a fully-subsidized plan during the OEP and, instead, wait to enroll when sick. We noted that people who wait can avoid enrollment if they never become sick and, therefore, avoid contributing when healthy. We further noted that many consumers can also wait and know, if they do become sick, they would qualify for the 150 percent FPL SEP, due to the widespread evidence that millions of people have enrolled at this income level who do not have such household income and are subject to limitations on repayments of excess tax credits.

Based on this analysis, we stated in the proposed rule (90 FR 12982) that we believe the impact of the 150 percent FPL SEP on premiums absent IRA subsidies is less than the 3 to 4 percent we previously projected in the 2025 Payment Notice. We stated in the proposed rule that after fully accounting for the impact of people not enrolling during the OEP and waiting to enroll until sick, we projected the premium impact of the current policy would be between 0.5 to 3.6 percent. In this final rule, we have revised this estimate. We now estimate that removing the current monthly SEP for people with incomes below 150 percent of the FPL will result in premiums being 3 to 4 percent lower than they would be if the SEP were to remain in place.[166] A point estimate of 3.4 percent is used in the RIA, and an explanation of this estimate can be found in section V.C.12 of this rule.

Based on the premium increase and the increase in improper enrollments which was exacerbated by our previous SEP policy, we also stated that we do not believe that the benefits of increased access to coverage for low-income consumers outweighs the risk of higher premiums and improper enrollments. In fact, we stated that we believe that the costs may exceed the benefits and we encouraged commenters and other interested parties to provide comments on the cost impact of the 150 percent FPL SEP.

In the proposed rule (90 FR 12982), we noted that improper enrollments resulting from the 150 percent FPL SEP may mitigate premium increases caused by adverse selection from this SEP. Individuals who are unknowingly enrolled through the 150 percent FPL SEP would not file insurance claims and, therefore, would improve the risk pool. We stated that while these negative impacts from the 150 percent FPL SEP are related, we account for them separately in our consideration. We explained that the ACA authorizes the Secretary only to require an Exchange to provide for the SEPs listed at sections 1311(c)(6)(C) and (D) of the ACA, and nothing more. We also explained that where a statute such as sections 1311(c)(6)(C) and (D) of the ACA provides a list, the ''specific and comprehensive statutory list necessarily controls over the [Secretary's] general authorization,'' [167] such as the one in in sections 1321(a)(1)(A), (B), and (C) of the ACA, which authorizes the Secretary to ''issue regulations setting standards for meeting the requirements . . . with respect to'' the establishment and operation of Exchanges, the offering of qualified health plans through Exchanges, and ''such other requirements as the Secretary determines appropriate.''

Section 1311(c)(6)(C) of the ACA mandates that the Secretary require an Exchange to provide for ''special enrollment periods specified in section 9801 of the Code of 1986 and other special enrollment periods under circumstances similar to such periods under part D of title XVIII of the Act.'' We noted in the proposed rule (90 FR 12982) that the circumstances underlying the 150 percent FPL SEP are dissimilar to the circumstances for Medicare Part D SEPs under section 1860D–1(b)(3) of the Act, which are: involuntary loss of creditable prescription drug coverage; errors in enrollment; exceptional conditions; Medicaid coverage; and discontinuance of a Medicare Advantage Prescription Drug (MA–PD) election during the first year of eligibility. We stated that the 150 percent FPL SEP is likewise not one of the SEPs specified in section 9801 of the Code, nor similar to such SEPs.

We stated in the proposed rule (90 FR 12982) that this interpretation aligns with our overall experience regarding the role that enrollment periods play in mitigating adverse selection within the

[166] Based on internal CMS Office of the Actuary analysis, removing this provision is expected to reduce premiums within the range of 3 to 4 percent, and we use the point estimate of 3.4 percent to estimate expected claims impact and the shift in average months of enrollment.

[167] *Texas Med. Ass'n* v. *U.S. Dep't of Health & Hum. Servs.,* 110 F.4th 762, 775 (5th Cir. 2024) (citing *Nat'l Pork Producers Council* v. *EPA,* 635 F.3d 738, 753 (5th Cir. 2011); *Texas* v. *United States,* 809 F.3d 134, 179, 186 (5th Cir. 2015), aff'd by an equally divided court, 579 U.S. 547 (2016)).

structure of the ACA. We stated that we have thoroughly considered our experience with the program before and after the implementation of the 150 percent FPL SEP and assessed the fit between the rationale for this SEP and the policy consequences that flow from it. Based on this expanded body of experience, we also stated that we believed that Congress was correct to provide the Secretary with a comprehensive statutory list of SEPs that omitted the 150 percent FPL SEP. We sought comments on this proposal.

We stated in the proposed rule (90 FR 12982) that a commenter on the 2025 Payment Notice (89 FR 26323) also questioned whether it was lawful for HHS to implement the 150 percent FPL SEP. We noted that the statute requires a specific set of SEPs that focus on giving people an opportunity to enroll mid-year if they experience a change in their life circumstances, such as a move or the loss of job. We further noted that, in contrast, the 150 percent FPL SEP allows people to enroll at any time during the year based on their existing income, not a change in their income. We requested further comment on this proposal.

After careful consideration of comments and for the reasons outlined in this final rule, we are finalizing this policy with a modification under which the policy and related requirements will sunset for all Exchanges at the end of PY 2026. Thereafter, the 150 percent FPL SEP that was available at the option of the Exchange prior to the finalization of this rule will become available again. As mentioned throughout this proposed rule, there are currently high levels of improper enrollment in the 100 to 150 percent of the FPL cohort as a result of the fully-subsidized benchmark plans available to them. Despite the expiration of the fully-subsidized benchmark plans, we expect there to be significant numbers of improperly enrolled individuals in this income cohort that remain enrolled and receiving APTC for which they are ineligible for some time before markets normalize. That said, we received significant comments in opposition to our proposal to end the 150 percent FPL SEP with commenters raising significant concerns over its impacts on low-income Americans that properly utilize this pathway to receive coverage.

While we agree that low-income Americans properly seeking coverage should not be locked out of it, the 150 percent FPL SEP for individuals with fully-subsidized premiums—as a result of the expanded subsidies—has enabled significant improper enrollment. That said, once the expanded subsidies expire and individuals are exposed to greater premium costs, the ability of individuals or actors on behalf of individuals to improperly enroll in plans that the 100 to 150 percent of the FPL cohort are eligible for is significantly diminished. In order to address the currently high rate of improper enrollments, we believe it to be necessary to pause the 150 percent FPL SEP temporarily. Coupled with the other temporary policies in this rule and the expiration of fully-subsidized plans, we expect the level of improper enrollments to come down drastically in PY 2026, diminishing the need for ongoing crisis-level program integrity policies. This dynamic, combined with the significant concerns raised by commenters on our proposal, has led us to finalize a pause on the 150 percent FPL SEP thorough PY 2026, with a reversion to the previous policy for PY 2027 and beyond.

We summarize and respond to public comments received on the proposed repeal of the 150 percent FPL SEP below.

Comment: Some commenters supported the proposed repeal of the 150 percent FPL SEP, including issuers and advocacy groups. Commenters acknowledged that the 150 percent FPL SEP was created to accommodate individuals losing Medicaid while States worked to ''unwind'' from the Families First Coronavirus Response Act (FFCRA) continuous enrollment condition and to return to regular eligibility and enrollment processes in Medicaid and CHIP. However, now that State Medicaid Agencies have generally completed unwinding activities, commenters stated that consumers should utilize other SEPs based on qualifying life events to enroll into coverage outside of the OEP. Commenters expressed that with numerous existing pathways to coverage, income level alone is not a compelling reason to offer a SEP, and that the 150 percent FPL SEP departed from the ACA's structure to reserve SEPs for those experiencing life events necessitating a coverage change.

Response: We appreciate the commenters' support for our proposal. That said, given the substantial uncertainty over the future of the Exchanges and individual health insurance market, we don't believe a permanent repeal is appropriate, and as explained previously, we are finalizing a pause to best balance the urgent need for program integrity with the long-term desire for enrollment efficiencies.

Comment: Some actuaries, community advocacy organizations, and issuers supported the repeal of the 150 percent FPL SEP, as the SEP contributes to adverse selection. Commenters wrote that the SEP introduces volatility, making it challenging for issuers to distribute enrollee risk and gauge the market, resulting in higher premiums. Commenters cited CMS data showing that five million enrollees have utilized the SEP since it was implemented. They further noted that, in PY 2024, nearly half of Exchange enrollees had incomes below 150 percent of the FPL, and the sheer volume of the SEP contributed to the challenges issuers faced gauging the market. Commenters also noted that they expect the risk of adverse selection through this SEP to significantly increase once the enhanced IRA subsidies expire. One commenter indicated that they expected the removal of the 150 percent FPL SEP, in concert with the other policies listed in the rule, would improve the risk pool and reduce premiums.

Response: We appreciate the commenters sharing their insights on how they believe this SEP affected the market. That said, once the enhanced IRA subsidies expire, fewer consumers with income below 150 percent FPL will have fully-subsidized QHPs available to them, making it less likely that the SEP can be abused for inappropriate enrollment. We believe the pause best balances the need for urgent program integrity measures with the long-term desire to promote enrollment efficiencies.

Comment: Some issuers and advocacy groups agreed that removing the 150 percent FPL SEP would reduce opportunities for noncompliant agents, brokers, web-brokers to perform improper enrollments. Commenters stated that removing this SEP would reduce taxpayer costs in the form of improper APTC outlays and would protect low-income individuals from unauthorized enrollments and plan switching. Commenters noted the many ways in which unauthorized enrollments and plan switches harm consumers, who may face disruptions in care, inability to fill needed prescriptions, or tax liabilities as a result. One commenter estimated that this SEP led to billions of dollars in fraudulent subsidy expenditures, based on analysis of HHS reports of 50,000 complaints of unauthorized enrollment and 40,000 complaints of unauthorized plan switches in the first three months of 2024.

Response: We appreciate these comments highlighting that this policy will have the desired effect of increasing program integrity and addressing fraud in Exchanges on the Federal platform. We believe the pause best balances the

urgent program integrity concerns with the long-term desire to promote enrollment efficiencies.

Comment: One commenter said they supported repealing the 150 percent FPL SEP because it allows individuals with income below 100 percent of the FPL, who would not otherwise be eligible for APTC, to gain access to APTC.

Response: We clarify that the 150 percent FPL SEP does not have any bearing on whether an individual is eligible for APTC. Individuals with income below 100 percent of the FPL who are not otherwise eligible for APTC are not made eligible for APTC by the 150 percent FPL SEP.

Comment: Some individuals, local and national advocacy groups, and healthcare providers opposed the repeal of the 150 percent FPL SEP. Commenters stated that the 150 percent FPL SEP provides an important pathway into coverage, acting as a safety net for uninsured individuals who may face barriers enrolling during the annual OEP or other SEPs. Commenters noted many populations to whom this SEP is particularly valuable, including individuals who experience income fluctuations throughout the year, individuals who move in-and-out of Medicaid coverage frequently, and individuals who reside in States that have not expanded Medicaid coverage to adults. Commenters further expressed that this SEP is helpful for individuals who may face barriers to navigating enrollment during the annual OEP or other SEPs, including individuals with low health literacy, limited English proficiency, disabilities, or high health care needs. Commenters expressed concern that more individuals may face administrative challenges related to enrollment during the annual OEP or other SEPs due to recent cuts to Navigator funding, as well as the proposals in this rule to instate new SEP verification requirements and to shorten the annual OEP.

Response: We acknowledge commenters' concerns. However, pausing the 150 percent FPL SEP simply provides a year to allow the market to shed excess levels of improper enrollments while allowing the market to adjust to the expiration of the expanded subsidies that enabled such high levels in the first place. After PY 2026, the SEP will return to a market without fully-subsidized premiums and exposure to premium costs should mitigate the fraud that previously proliferated under the expanded subsidies. We believe that the pause best balances the need to address urgent program integrity concern with the long-term desire to promote enrollment efficiencies.

We acknowledge commenters' concerns about the number of consumers that may be served by Navigators due to changes in funding, but do not believe that that is a compelling reason not to pursue this proposal.

Comment: Some issuers and advocacy groups agreed that removing the 150 percent FPL SEP would reduce opportunities for noncompliant agents, brokers, and web-brokers to perform improper enrollments. Commenters stated that removing this SEP would reduce taxpayer costs in the form of improper APTC outlays and would protect low-income individuals from unauthorized enrollments and plan switching. Commenters noted the many ways in which unauthorized enrollments and plan switches harm consumers, who may face disruptions in care, inability to fill needed prescriptions, or tax liabilities as a result. One commenter estimated that this SEP led to billions of dollars in fraudulent subsidy expenditures, based on analysis of HHS reports of 50,000 complaints of unauthorized enrollment and 40,000 complaints of unauthorized plan switches in the first three months of 2024.

Response: We appreciate these comments highlighting that this policy will have the desired effect of increasing program integrity and addressing fraud in Exchanges on the Federal platform. While noncompliant agents, brokers, and web-brokers contributed to these issues, we want to acknowledge that most comply with CMS rules and regulations and act in good faith. The expiration of the enhanced subsidies will diminish the incentive and opportunity for improper enrollments.

Comment: Commenters anticipated that this policy change could result in more individuals having longer periods of uninsurance, resulting in decreased access to care, worse health outcomes, and increased financial instability for impacted individuals. Commenters noted that in addition to impacting individual health outcomes, increased uninsurance would also have a negative impact on community and public health, and on businesses that rely on a healthy workforce. Commenters expressed concerns that care would shift from primary and preventive care settings to more costly urgent and emergency care settings, and that increased uncompensated care costs would negatively impact hospitals, community health centers, issuers, municipalities, and States. Commenters anticipated that increased risks of uninsurance would disproportionately impact vulnerable populations, including individuals with substance use disorders, individuals at risk of or living with HIV, individuals with cancer, individuals with multiple sclerosis, and individuals recently released from incarceration. One commenter noted that repealing this SEP without modifying existing limits on Short-Term Limited Duration Insurance (STLDI) would result in coverage gaps for low-income individuals. One commenter raised concerns that consumers who become uninsured due to the proposed the repeal of this SEP would instead need to utilize Medicaid if they have a medical emergency.

Response: We acknowledge commenters' concerns and note that we are simply finalizing a 1-year pause to the 150 percent FPL SEP to address urgent program integrity concerns. At the beginning of PY 2027, the 150 percent FPL SEP will begin again.

We appreciate the commenter's analysis of the intersection between STLDI and the repeal of this SEP and acknowledge the commenter's suggestions for future changes to STLDI policy. We agree that STLDI coverage may be a valuable option for uninsured individuals who are not able to enroll in Exchange coverage through an SEP, given that STLDI policies generally offer year-round enrollment.[168]

We disagree with the commenter who expressed concerns about individuals who would have otherwise used this SEP during the pause needing to rely on Medicaid instead. The 150 percent FPL SEP is only available to individuals who are eligible for APTC, meaning that they are not eligible for Medicaid. Therefore, individuals who would have otherwise used the 150 percent FPL SEP during the pause are generally not otherwise eligible for Medicaid. Individuals who are eligible for Medicaid can and should continue to utilize Medicaid's year-round enrollment.

Comment: Comments from States, individuals, and advocacy groups opposed the repeal of the 150 percent FPL SEP and expressed their view that it is not a major driver of adverse selection, as claimed in the proposed rule. Commenters asserted that people do not wait until they are sick to enroll in coverage as they have no incentive to wait when their monthly premiums are zero or nearly zero dollars. Commenters further noted that it is not prudent for individuals to wait until they are sick to

[168] *https://www.cato.org/policy-analysis/biden-short-term-health-plans-rule-creates-gaps-coverage#short-term-limited-duration-insurance.*

enroll in coverage through this SEP because their plan effective date and their access to care are not instantaneous.

Some commenters stated that even if individuals wait until sick to enroll into coverage, the opportunity to enroll via the 150 percent FPL SEP should be made available as it could result in a net positive impact because it promotes continuous coverage in the future. One commenter cited a study showing that even if there is some evidence of adverse selection amongst SEP enrollees, most care that was sought was ''nondiscretionary''. One State Exchange cited data showing that 85 percent of the 150 percent FPL SEP enrollees remained enrolled throughout the rest of the plan year, claiming that this shows the SEP supports continuous coverage. One organization noted that in 2024, only half of Coloradans who qualified for subsidized coverage enrolled in coverage, demonstrating that not everyone who is eligible enrolls into coverage regardless of their health needs. The organization also stated that in prior rulemaking we found that the risk of adverse selection associated with this SEP was lower than anticipated.

Response: We appreciate commenters' analysis of the extent to which the 150 percent FPL SEP may contribute to adverse selection and we acknowledge commenters' concerns. While we are not able to quantify the extent to which the 150 percent FPL SEP may drive adverse selection, we still believe it is reasonable to conclude that this SEP creates a risk of adverse selection.

We are committed to ensuring that consumers have continuous coverage, however, and we believe that finalizing the pause of the 150 percent FPL best balances the need to address urgent program integrity concerns with the long-term desire to promote enrollment efficiencies. We will continue to evaluate adverse selection in the marketplace after the enhanced subsidies expire.

Comment: Commenters from States, individuals, and advocacy groups opposed the repeal of the 150 percent FPL SEP by stating that removing the 150 percent FPL SEP could deter young and healthy people from enrolling in coverage and destabilize the risk pool, given that healthy individuals may be more easily deterred by administrative hurdles to coverage. State Exchanges cited their own research and researchers cited State Exchange data showing that the per member per month claims costs associated with SEP enrollees were lower than costs for non-SEP enrollments. One commenter referenced actuarial research specific to the State of New York suggesting that lower-income APTC enrollees had better risk than their higher income counterparts. Commenters additionally cited studies demonstrating that States that offered broad, continuous SEPs during the COVID–19 PHE saw greater decreases in consumers' prospective risk scores, indicating a healthier enrollee population, than States that did not. One commenter shared an analysis conducted by industry pricing actuaries showing that premiums could increase after the repeal of 150 percent FPL SEP, based on data demonstrating that loss ratios for SEP enrollees as compared to OEP enrollees have improved since the 150 percent FPL SEP was introduced. Commenters encouraged HHS to include data in this rulemaking regarding the claims costs, loss ratios, or risk profiles of individuals who utilized the 150 percent FPL SEP to enroll in coverage through the FFM, and one commenter suggested that failing to do so constituted a violation of the APA.

Response: We appreciate commenters' narrative on how repealing the 150 percent FPL SEP along with the administrative barriers to enrollment may disproportionately deter individuals who are healthy from enrolling in coverage. As explained in this rule, we are not repealing the 150 percent FPL SEP, we are pausing it through PY 2026 to address the surge in improper enrollments for ineligible consumers as the expanded subsidies expire.

Comment: Commenters also disagreed with the agency's claim that the 150 percent FPL SEP is a major driver of fraud and stated that efforts to address improper enrollments, while laudable, should be more focused on preventing abuses by agents and brokers instead of limiting enrollment pathways. Many commenters expressed their belief that HHS' estimate of improper enrollments was flawed and noted that HHS' analysis of Census data in Florida to Exchange data was an ''apples-to-oranges'' comparison and was not generalizable nationwide. One State Exchange highlighted that they performed a similar analysis of Census data in their State and found that they had fewer enrollees with incomes at or below 150 percent of the FPL than were reported in Census data. Some asserted that increased enrollment among low-income enrollees could be explained by Medicaid Unwinding, improved messaging and outreach, enhanced premiums subsidies. and other factors.

Many commenters responded to our concerns that, in addition to well-documented instances of improper agent and broker behavior, Navigators and Certified Application Counselor (CACs) may encourage individuals to underreport their income so that they qualify for the 150 percent FPL SEP. Commenters noted that enrollment assisters are subject to strict integrity guardrails and that, if anything, assisters tend to encourage consumers to overestimate their income to reduce risk of tax liability. One commenter pointed out that Navigators and CACs were instrumental in sounding the alarm about increases in fraudulent agent and broker behavior in 2023 and 2024, including by participating in meetings with CMS to relay the experiences of their clients. They noted that Navigators and CACs often spend significant time working to resolve issues for clients who have experienced unauthorized enrollments or plan switches performed by agents and brokers, and that there have been no media reports or Department of Justice investigations related to Navigators or CAC misconduct.

Response: Our conclusion that the 150 percent FPL SEP was a source of improper enrollments and plan switches for fully-subsidized enrollees was informed by our work responding to the influx of consumer complaints; these complaints included detailed narratives that often implicated the 150 percent FPL SEP as a pathway for unauthorized behavior. The Department of Justice (DOJ) has recently initiated action against several brokers alleging that they have inflated consumers' income levels to make them appear eligible and enroll in coverage they do not qualify for, resulting in improper payments of APTC and improper commissions for agents, brokers, and web-brokers.

We acknowledge that with the expiration of the expanded subsidies there is diminished incentive and opportunity for fraud and improper enrollment. That said, the current rates of such improper enrollment are exceedingly high and necessitate some action as the subsidy environment normalizes. Pausing the 150 percent FPL SEP will help the Exchanges shed the excess levels of improper enrollments they are currently experiencing in PY 2026 before reverting back to current policy in PY 2027.

We further acknowledge commenters' appreciation for navigators and CACs. However, we also note that commenters did not provide any data supporting the assertion that navigators and CACs are not contributing to improper enrollments.

Comment: Commenters offered other policy and operational solutions to curb the adverse selection and program

integrity concerns that we expressed in the rule, including limiting the SEP to new enrollments, limiting consumers to one enrollment or plan change through the SEP every three months, limiting consumers to one enrollment or plan change through the SEP per year, and requiring that consumers' income be verified in order to utilize the SEP. Some commenters proposed alternative approaches to protecting consumers from unauthorized enrollments and plan switches, including requiring two-factor authentication, requiring verbal authorization from a consumer before certain changes can be made, better monitoring of DE/EDE pathways, additional monitoring requirements for agents and brokers with fully-subsidized clients, new penalties for agents and brokers, and more resources for State Departments of Insurance to investigate fraud.

Response: We appreciate the suggestions to focus on alternative methods to enhance program integrity and to explore other solutions to curb fraudulent activities. We agree that these issues require a multi-faceted approach, and we have already been taking actions to address fraud, safeguard the consumers from fraud and harm, and reduce improper payments of APTC. This rule takes a holistic approach to improving integrity and affordability in the individual market through a series of temporary policies designed to address urgent integrity issues and permanent policies designed to improve affordability. We are continuing to explore additional operational solutions to further curb improper enrollments, including two-factor verification. We believe that at least temporarily pausing the 150 percent FPL SEP is an important step to curb improper enrollments while the subsidy environment normalizes. This policy will sunset after the end of PY 2026 and Exchanges will again be permitted to offer 150 percent FPL SEPs.

Comment: Some commenters pointed out that the ACA directs HHS to establish SEPs in circumstances similar to those in Medicare Part D and that Part D has a similar low-income SEP that allows individuals with low incomes to change plans once per month. Commenters also expressed that HHS has a broad legal authority under section 1321(a) and that 1311(c)(6)(C) of the ACA to offer Exceptional Circumstances SEPs as it sees fit.

Response: Section 1311(c)(6)(C) of the ACA states that the HHS Secretary shall require Exchanges to provide SEPs ''under circumstances similar to such periods under part D of title XVIII of the Social Security Act,'' which prescribes SEPs for Medicare Part D coverage. The Medicare Part D SEPs enumerated in title XVIII of the Act primarily include changes in circumstance that necessitate a change in coverage, such as involuntary coverage loss. While we acknowledge that Medicare Part D offers a low-income SEP in regulation at 42 CFR 423.38(c)(4),[169] section 1311 of the ACA only requires that Exchanges provide SEPs similar to those established in title XVIII of the Act, and title XVIII of the Act does not include income-based SEPs. Therefore, the Department is of the view that the best reading of section 1311 of the ACA is that it does not require CMS to allow Exchanges to offer income-based SEPs. That said, after evaluating comments we have decided that pausing the income-based SEP is the best course of action to balance urgent program integrity needs with long-term desires to promote enrollment efficiencies. The pause will honor commenter concerns that additional data is necessary to discern the causes of improper enrollments.

We further agree with commenters that, since SEPs for exceptional circumstances are allowed under title XVIII of the Act, that Exchanges are required by statute to offer exceptional circumstance SEPs. This requirement is also reflected in Exchange regulations at § 155.420(d)(9). While both the statute and Exchange regulations do not define what constitutes an exceptional circumstance, we believe that a plain understanding of the term compels the conclusion that simply having a low income is not an exceptional circumstance. This interpretation is further supported by longstanding FFE sub-regulatory guidance, which notes that exceptional circumstance SEPs are generally granted on a case-by-case basis.[170]

Comment: Commenters stated that nearly all State Exchanges currently offer the 150 percent FPL SEP or income-based SEPs with higher income thresholds. Many State Exchanges that offer income-based SEPs indicate that they are aware of zero reports of unauthorized plan switching or enrollments in their Exchanges, due to factors including more stringent security measures as compared to the FFM's DE and EDE pathways. One State Exchange noted it has an integrated eligibility and enrollment system that prevents Medicaid-eligible consumers from utilizing this SEP and experiences limited utilization of the SEP, along with no program integrity issues. As such, commenters pointed out that State Exchanges should be able to maintain the flexibility to design their Exchanges to meet local needs. Commenters also stated that Federal law specifies required SEPs, but does not preclude States from establishing additional SEPs. One State Exchange expressed concerns that the proposal reverses standing deference to State authority regarding the establishment of SEPs. They also stated that the effective date to repeal the 150 percent FPL SEP imposes major costs on State Exchanges which were not accounted for in the proposed rule.

Response: While we appreciate commenters' concerns, we feel it is critical to pause this SEP pathway as soon as possible and for all Exchanges, due to its potential to drive improper enrollments in the fully-subsidized QHP policy environment. We also believe that there will be residual improper enrollments extending into PY 2026, necessitating a pause through the end of PY 2026, at which time the 150 percent FPL SEP will resume. We acknowledge that State Exchanges, unlike the FFE, have not experienced high rates of unauthorized enrollments or unauthorized plan switches driven by noncompliant agents, brokers, and web-brokers. However, as discussed in detail in section V.C.18. of this final rule, improper enrollments also include individuals with incomes below 100 percent of the FPL who intentionally overstate their incomes in order to qualify for subsidized Exchange coverage, as well as for the 150 percent FPL SEP. We believe that pausing the 150 percent FPL SEP best balances the need to address urgent program integrity concerns with the long-term desire to promote enrollment efficiencies. This modification is intended to be responsive to State Exchange comments noting that this measure may not be necessary to ensure program integrity in these State Exchanges in the long term. We further note that Exchange regulations at § 155.410(a)(2) require that all Exchanges, including State Exchanges, only permit individuals to enroll in or change their QHP during OEP or during a special enrollment period described in § 155.420.

We acknowledge that we did not fully account for State Exchanges' implementation costs in the proposed rule and have updated section V.C.12. of this final rule to include an estimate of such costs.

Comment: Some commenters expressed concerns with the proposal's effective date and asked that the effective date be delayed until PY 2026 or PY 2027 to give State Exchanges more

[169] Social Security Act § 1860D–01(b)(3)(A).

[170] *See* Section 5.8 of the FFE Enrollment Manual: *https://regtap.cms.gov/reg_librarye.php?i=5507.*

time to make IT changes and to give consumer-facing organizations time to update education and outreach strategies.

Response: Because of concerns regarding improper enrollment and in order to protect the integrity of all Exchanges, we are maintaining our proposed effective date. Due to the primary concerns of fraudulent enrollments, unauthorized plan switching, and the 150 percent FPL SEP's overall impact on the risk pool, the provisions in this section will be effective 60 days following the effective date of this rule. In response to concerns, however, we are simply pausing the 150 percent FPL SEP through PY 2026, at which time Exchanges will be permitted to begin offering the SEP again.

Comment: Some commenters expressed concerns related to the proposed change at § 147.104(b)(2), stating that they opposed changes to eliminate the 150 percent FPL SEP for all group and individual market coverage.

Response: We clarify that the conforming amendment to § 147.104(b)(2) does not substantively impact group or individual market SEP availability. Rather, the change to § 147.104(b)(2) pauses the 150 percent FPL SEP from a list of SEPs that issuers are not required to provide for individual market coverage offered outside of the Exchange through PY 2026.

Comment: One commenter expressed concern about the impact of the proposed removal of the 150 percent FPL SEP on the monthly SEP available to members of a Federally recognized Tribe.

Response: We clarify that the proposal to pause the 150 percent FPL SEP does not impact the monthly SEP for members of Federally recognized Tribes under 45 CFR 155.420(d)(8).

Comment: One commenter, a State Insurance Commissioner, noted that they opposed the proposed repeal of the 150 percent FPL SEP but did not have adequate time to fully analyze the impact of the proposed change due to the limited comment window and requested that interested parties be granted additional time.

Response: We acknowledge the commenter's concerns and have accounted for them by finalizing a pause to the 150 percent FPL SEP to best balance urgent program integrity concerns with a long-term desire to promote enrollment efficiencies.

9. Pre-Enrollment Verification for Special Enrollment Period (§ 155.420(g))

In the 2025 Marketplace Integrity and Affordability proposed rule (90 FR 12982 through 12985), we proposed to amend § 155.420(g) to reinstate (with modifications) the requirement that Exchanges on the Federal platform must conduct pre-enrollment verification of eligibility of applicants for other categories of individual market SEPs in line with operations prior to the implementation of the 2023 Payment Notice and to eliminate the provision that states that Exchanges on the Federal platform will conduct pre-enrollment special enrollment verification of eligibility only for SEPs under paragraph (d)(1) of this section.[171] We proposed to further amend § 155.420(g) to require all Exchanges to conduct pre-enrollment verification of eligibility for at least 75 percent of new enrollments through SEPs.

In the 2018 Payment Notice proposed rule (81 FR 61456, 61502), we expressed a commitment to making sure that SEPs are available to those who are eligible for them and equally committed to avoiding any misuse or abuse of SEPs. To avoid misuse and abuse, we implemented verification processes for SEPs in the Market Stabilization Rule (82 FR 18357 through 18358). In setting these processes, we acknowledged in the Market Stabilization Rule (82 FR 18357 through 18358) competing concerns over how verification can impact the individual market risk pool and, in turn, impact premium affordability.

Verification protects the risk pool from ineligible individuals enrolling only after they become sick or otherwise need expensive health care services or medical products/equipment. However, verification can also undermine the risk pool by imposing a barrier to eligible enrollees, which may deter healthier, less motivated individuals from enrolling. After analyzing enrollment and risk pool data against these competing concerns, we stated in the proposed rule (90 FR 12983) that we believe the current SEP verification requirements do not provide enough protection against misuse and abuse. This negatively impacts both the risk pool and program integrity around determining eligibility for APTC and CSR subsidies. We stated that we believe the positive impact of verification on the risk pool far exceeds the potential negative impact on the risk pool. Therefore, we proposed to amend § 155.420(g) to remove the provision that limits Exchanges on the Federal platform from conducting pre-enrollment verification for only the loss of minimum essential coverage SEP, which would allow us to reinstate pre-enrollment verification for other SEPs on Exchanges on the Federal platform. We further proposed to amend § 155.420(g) to require all Exchanges to conduct pre-enrollment eligibility verification for SEPs.

Section 1311(c)(6) of the ACA requires that Exchanges establish enrollment periods, including SEPs for qualified individuals, for enrollment in QHPs. Section 1311(c)(6)(C) of the ACA directs the Secretary to require Exchanges to provide for the SEPs specified in section 9801 of the Code and other SEPs under circumstances similar to such periods under part D of title XVIII of the Act. Section 2702(b)(2) of the PHS Act also directs issuers in the individual and group market to establish SEPs for qualifying events under section 603 of the Employee Retirement Income Security Act of 1974. Section 1321(a)(1)(A) of the ACA and section 2792(b)(3) of the PHS Act directs the Secretary to issue regulations with respect to these requirements.

Prior to June 2016, we largely permitted individuals seeking coverage through the Exchanges to self-attest to their eligibility for most SEPs and to enroll in coverage without further verification of their eligibility or without submitting proof of prior coverage. After a GAO undercover testing study of SEPs observed that self-attestation could allow applicants to obtain subsidized coverage they would otherwise not qualify for and then found 9 of 12 of GAO's fictitious applicants were approved for coverage on the Federal and selected State Exchanges, we began implementing policies to curb potential abuses of SEPs.[172] In 2016 we added warnings on *HealthCare.gov* regarding inappropriate use of SEPs. We also eliminated several SEPs and tightened certain eligibility rules.[173] Also in 2016, we announced retrospective audits of a random

[171] Currently, § 155.420(g) provides that Exchanges on the Federal platform will conduct pre-enrollment special enrollment verification of eligibility only for SEPs for loss of minimum essential coverage. Prior to the implementation of the 2023 Payment Notice, Exchanges on the Federal platform conducted manual verification for five SEPs: marriage, adoption, moving to a new coverage area, loss of minimum essential coverage, and Medicaid/CHIP Denial.

[172] GAO. (2016 Nov.). Patient Protection and Affordable Care Act: Results of Enrollment Testing for the 2016 Special Enrollment Period, GAO–17–78. *https://www.gao.gov/products/gao-17-78.*

[173] CMS. (2016, Feb. 24). Fact Sheet: Special Enrollment Confirmation Process. *https://www.cms.gov/newsroom/fact-sheets/fact-sheet-special-enrollment-confirmation-process.*

sampling of enrollments through SEPs for loss of minimum essential coverage and permanent move, two commonly used SEPs. Additionally, we created the Special Enrollment Confirmation Process under which consumers enrolling through common SEPs were directed to provide documentation to confirm their eligibility.[174] Finally, we proposed to implement (beginning in June 2017) a pilot program for conducting pre-enrollment verification of eligibility for certain SEPs.[175]

In response to the deteriorating stability of the individual health insurance market leading into PY 2017, we implemented the Market Stabilization Rule (82 FR 18355 through 18356) in 2017 which sidestepped the pilot program and, instead, took quick action to require pre-enrollment verification for most SEPs. Understanding the potential for verifications to deter eligible people from enrolling, we studied the initial consumer experience with this pre-enrollment verification process and published our findings in 2018.[176] For PY 2017, this report showed that we averaged a response time of 1-to-3 days to review consumer-submitted documents. In addition, the vast majority (over 90 percent) of SEP applicants who made a plan selection and were required to submit documents to complete enrollment were able to successfully verify their eligibility for the SEP. We conducted additional research for the following plan years through 2021. Based on data from PY 2019, the last year prior to the PHE which greatly impacted SEPV processing, the majority of consumers (73 percent) were able to submit documents within 14 days of their SEP verification issue (SVI) being generated. Also, we found that the majority of consumers (63 percent) were able to fully resolve their SVI within 14 days of it being generated. That resolution percentage increases to 86 percent by 30 days.[177] We also found that for PY 2019, only approximately 14 percent or 75,500 individuals were unable to resolve their SVI out of the total population of SEP consumers who received an SVI.

In the 2023 Payment Notice (87 FR 27278), we noted that pre-enrollment verification can also negatively impact the risk pool. At that time, we did not analyze the experience of people applying for SEPs to assess the impact on the risk pool. Rather, it was our perception that the extra step required by verification can deter eligible consumers from enrolling in coverage through an SEP, which in turn, can negatively impact the risk pool because younger, often healthier, consumers submit acceptable documentation to verify their SEP eligibility at much lower rates than older consumers. To mitigate this potential negative impact on the risk pool and streamline the consumer experience, we then scaled back pre-enrollment verification for every SEP type, with the exception of the SEP for new consumers who attest to losing minimum essential coverage.

Since the implementation of pre-enrollment verification for SEPs in the Market Stabilization Rule, we continue to monitor pre-enrollment verification to determine its impact, including on enrollments by different groups of individuals affected by the process. After 3 years of experience applying pre-enrollment verification to only the SEP for losing minimum essential coverage, we reviewed whether this policy achieves the right balance between reducing enrollment barriers and protecting against abuse and misuse of SEPs. This review shows the prior use of pre-enrollment verification for all SEPs achieved the better balance. As noted previously in this section, our initial review of pre-enrollment verification during PY 2017 did not find any substantial enrollment barrier. We applied this same analysis to PY 2018 and PY 2019 before the COVID–19 PHE changed patterns of SEP use and found pre-enrollment verification continued to not present any substantial enrollment barrier. We also compared the use of SEPs before and after the implementation of pre-enrollment verification for PY 2017. This comparison revealed a substantial shift to SEPs that were not subject to pre-enrollment verification that required consumers to submit documentation, suggesting agents, brokers, and people had been previously abusing SEPs and shifted to special enrollment that did not require document submissions to continue this potential abuse of SEPs.

When we sought feedback on the proposal to reduce pre-enrollment verification for SEPs in PY 2023 in the 2023 Payment Notice (88 FR 27278 through 27279), one commenter pointed out that data from the HHS-operated risk adjustment model, specifically the factors related to partial-year enrollments, showed a significant decrease in the negative impact of these enrollments on the overall risk pool from 2017 to 2022.[178] This suggests that individuals who enroll for only part of the year—who are more likely to use SEPs—now pose a smaller risk to the insurance pool than they did in the past. The commenter concluded that a likely factor is that fewer people are abusing SEPs to wait to get coverage until they need care due to pre-enrollment SEP verification. Another commenter noted how loss ratios for SEP enrollments, as compared to OEP enrollments, increased after pre-enrollment verifications were relaxed during the COVID–19 public health emergency.[179] We reviewed enrollment patterns and found there was a substantial increase in the enrollment duration after the implementation of pre-enrollment verification for all SEPs, which adds another data point suggesting pre-enrollment verification helped encourage continuous enrollment by making it more difficult to engage in strategic enrollment and disenrollment. Consistent with the comment to the 2023 Payment Notice, partial year enrollment factors did improve after PY 2017. Issuer-level enrollment data similarly shows a decline in the percent of disenrollments as a percent of total enrollments from about 20 percent in PY 2017 to about 12 percent in PY 2019.[180] After we reduced pre-enrollment verification for SEPs for PY 2023, the average number of months enrolled per consumer declined from 4.5 months in PY 2022 to 4.3 months in PY 2023.[181] While this decline may be due, in part, to an increase in mid-year enrollments from people being disenrolled from Medicaid after the Medicaid continuous enrollment condition ended on April 1, 2023, it may also be linked to the reduction in pre-enrollment verification for SEPs.

In the proposed rule (90 FR 12984), we stated that we acknowledge pre-enrollment verification can deter eligible consumers from enrolling in coverage through an SEP because of the burden of document verification. However, as noted previously, our prior analyses show the verification process does not impose a substantial burden and therefore should not be a barrier to

[174] Ibid.

[175] CMS. (n.d.). Pre-Enrollment Verification for Special Enrollment Periods. *https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/downloads/pre-enrollment-sep-fact-sheet-final.pdf.*

[176] CMS. (2018, July 2). The Exchanges Trends Report. *https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/2018-07-02-Trends-Report-3.pdf.*

[177] Consumers who resolve an SVI in more than 30 days are able to do so through extensions they are eligible to receive.

[178] Comment ID CMS–2021–0196–0196, 01/27/2022 available at *https://www.regulations.gov/comment/CMS-2021-0196-0196.*

[179] Comment ID CMS–2021–0196–0222, 01/27/2022 available at *https://www.regulations.gov/comment/CMS-2021-0196-0222.*

[180] Derived from issuer enrollment data, CMS. (2024, Sept. 10). Issuer Enrollment Data. *https://www.cms.gov/marketplace/resources/data/issuer-level-enrollment-data.*

[181] Ibid.

enrollment. We also stated that documentation to verify SEPs is generally easy for applicants to access and provide to Exchanges. Applicants should have ready access to official documents acknowledging employer separations, loss of minimum essential coverage, marriage, divorce, births, adoptions, death, gaining lawful presence or citizenship certificates, a new address, or a release from incarceration. Pre-Enrollment SEP verification takes place simultaneously with the consumer's SEP timeline on the Federal platform currently. This means that Pre-Enrollment SEP verification takes place while the consumer's SEP timeline is running.[182] Typically, the SEP window on the Exchanges on the Federal platform is 60 days from when a consumer experiences a qualifying event, and a Special Enrollment Period Verification Issue (SVI) is triggered when a consumer selects a plan during that timeframe.

In addition, we previously found younger people submit acceptable documentation to verify their SEP eligibility at lower rates than older consumers, which can negatively impact the risk pool as younger consumers use less health care on average.[183] While successful submission rates might be lower for younger people, the overall effect on the risk pool is minimal because it is a very small number of younger enrollees relative to older enrollees. This small impact on the total enrollment among younger people from SEPs would not lead to a meaningful increase in the proportion of young people enrolled and, as a result, not lead to a meaningful improvement to the risk pool. Therefore, in the proposed rule (90 FR 12984), we stated that we expect any negative impact on the risk pool would be minimal and substantially outweighed by the reductions in people misusing and abusing SEPs.

The weight of the data analysis presented here shows how the implementation of pre-enrollment verification for applicable SEPs reduced misuse and abuse of SEPs without deterring eligible people from enrolling in coverage in a measurable way. This improves the risk pool by restricting people from gaming SEPs to wait to enroll until they need health care services. An improved risk pool lowers premiums which, in turn, makes health coverage more affordable for unsubsidized enrollees and lowers the average APTC by lowering the average premium for the benchmark plan used to set APTC. Moreover, pre-enrollment verification for SEPs strengthens program integrity by denying ineligible enrollments and discouraging ineligible enrollees who know they cannot meet verification standards from attempting to enroll which, in turn, reduces Federal subsidies to ineligible consumers who would otherwise enroll and receive APTC and CSR subsidies. Consequently, we stated in the proposed rule (90 FR 12984) that this proposal would reduce Federal expenditures by both lowering the average APTC paid due to a reduction in the benchmark plan premium used to calculate APTC and reducing the number of ineligible people who would otherwise improperly enroll in APTC- and CSR-subsidized coverage. Therefore, we proposed to amend § 155.420(g) to remove the limitation on Exchanges on the Federal platform to conduct pre-enrollment verification for only the loss of minimum essential coverage special enrollment and also reinstate (with modifications) pre-enrollment verification requirement for other categories of SEPs.

In implementing pre-enrollment verifications for SEPs in the Market Stabilization Rule (82 FR at 18356), HHS did not require that all Exchanges conduct SEP verifications, to allow State Exchanges to determine the most appropriate way to ensure the integrity of the SEPs. Currently, all State Exchanges have flexibility under § 155.420(g) to conduct pre-enrollment verification of SEPs. Based on our analysis of the data showing how SEP verifications successfully encouraged continuous enrollment on Exchanges on the Federal platform, we stated in the proposed rule (90 FR 12985) that we believe State Exchange enrollments would benefit from implementing a similar policy.

In the proposed rule (90 FR 12985), we stated that we also believe State Exchanges now have more experience with conducting SEP verifications, which would make broader implementation less burdensome than before. We sought comments regarding this proposal including State Exchanges' expectations regarding the time and expense needed to comply. Currently, all but four State Exchanges conduct either pre- or post-enrollment verification of at least one special enrollment type, and most State Exchanges had previously implemented a process to verify the vast majority of SEPs requested by consumers. Therefore, we proposed to amend § 155.420(g) to require all Exchanges to conduct eligibility verification for SEPs.

We also proposed to require that Exchanges, including all State Exchanges, conduct SEP verification for at least 75 percent of new enrollments through SEPs for consumers not already enrolled in coverage through the applicable Exchange. We proposed that Exchanges must verify at least 75 percent of such new enrollments based on the current volume of SEP verification by Exchanges. In the proposed rule (90 FR 12985), we stated that the 75 percent threshold was chosen since we believe that most States would be able to meet this threshold by verifying at least their two or three largest SEP types based on current SEP volumes. If the Exchange is unable to verify the consumer's eligibility for enrollment through the SEP, then we stated that the consumer is not eligible for enrollment through the Exchange under that SEP, and any plan selection under that SEP would have to be canceled. Should an enrollment under an SEP for which eligibility cannot be verified become effectuated, the enrollment through the Exchange may be terminated in accordance with § 155.430(b)(2)(i). If an Exchange chooses to pend a plan selection prior to enrollment, and the Exchange cannot verify eligibility for the SEP, then the consumer would be found ineligible for the SEP, and the plan selection would not result in an enrollment. We stated in the proposed rule that the determination of how many enrollments would constitute 75 percent would be required to be based on enrollment through all SEPs. We stated that this would provide Exchanges with implementation flexibility so they can continue to decide which special enrollment types to verify and the best way to conduct that verification. Exchanges would not be required to verify eligibility for all SEPs, since the cost to verify eligibility for SEP triggering events with very low volumes could be greater than the benefit of verifying eligibility for them.

While we proposed to eliminate the current flexibility Exchanges have under § 155.420(g) to provide exceptions to SEP verification processes, we stated in the proposed rule (90 FR 12985) that we are continuing certain flexibilities that State Exchanges currently have to design eligibility verification processes that are appropriate for their market and Exchange consumers, such that State Exchanges may have such flexibility in their approaches for meeting the requirement proposed at § 155.420(g) to verify eligibility for an SEP. Specifically, under § 155.315(h), State

[182] Descriptions and information on the length of SEPs can be found at § 155.420(c).

[183] This statistic is based on SEPV resolution data from PY 2019.

Exchanges have the flexibility to propose alternative methods for conducting required verifications to determine eligibility for enrollment in a QHP under subpart D, such that the alternative methods proposed reduce the administrative costs and burdens on individuals while maintaining accuracy and minimizing delay. We proposed to use the existing authority at § 155.315(h) to allow State Exchanges to request HHS approval for use of alternative processes for verifying eligibility for SEPs as part of determining eligibility for SEPs under § 155.305(b).[184] We stated that this would allow, for instance, the State Exchanges that have administrative burden and cost concerns the option to coordinate with HHS to devise and agree upon the best approach for SEP verification for their specific population. We also stated that we recognize that State Exchanges may vary in their approach and technical capabilities relating to verification of SEPs and may need additional time to implement this requirement. Therefore, we proposed to allow Exchanges until PY 2026 to implement SEP verification. We sought comment on this topic and suggestions to alleviate this concern.

We sought comment on these proposals. With respect to SEP verification, we sought comment from States about the 75 percent verification threshold and whether it should be based on past year SEP enrollments or some other appropriate metric such as future year projections understanding that unforeseen events may occur that may drive up or down enrollments from year-to-year. In the proposed rule (90 FR 12985), we stated that we also understand that State Exchanges have matured and that even smaller State Exchanges may find applying pre-verification to all new enrollments through SEPs less burdensome than the first time we proposed this policy. Therefore, we also invited comment on whether State Exchanges believe it to be feasible to apply pre-enrollment verification to enrollments through SEPs beyond the stated 75 percent in alignment with our proposed goal for Exchanges on the Federal platform.

After careful consideration of public comments, we have decided to finalize and implement these policies with a significant modification—for Exchanges on the Federal platform, each of the rules outlined in this section will automatically sunset at the end of PY 2026, on December 31, 2026. As with other policies in this rule and as discussed in the Executive Summary and section III.B. earlier in this final rule, we recognize that the imminent program integrity concerns are being driven by the existence of fully-subsidized plans. The expiration of the enhanced subsidies coupled with the temporary program integrity requirements enacted by this rule will right-size marketplace enrollment in PY 2026 and should obviate the need for ongoing higher levels of program integrity policies. As the excess levels of improper enrollments are taken down in 2026, we expect the lower subsidy levels to appropriately deter future levels of improper enrollments from ever growing so high again, diminishing the returns of the temporary policies we are enacting in this rule. In other words, the burden of continuing such policies will reach a point at which they outweigh any benefits. For these reasons, we are finalizing this policy for PY 2026 only, with a reversion to the previous policy for PY 2027 and beyond.

Further, we are declining to finalize these provisions for State Exchanges. As discussed in great detail in this rule, the program integrity issues are largely concentrated in Exchanges utilizing the Federal platform. Given the lower levels of improper enrollment in States, we don't believe the burden that would be imposed by implementing these requirements for PY 2026 would be worth the benefits.

We summarize and respond to public comments received on the proposed adjustments to pre-enrollment SEP verification below.

Comment: The majority of commenters, including general advocacy groups, disease advocacy groups, providers, State agencies, State Exchanges, agents and brokers, and one health insurance issuer, noted that the increased SEP verification requirements would pose an additional burden to consumers and increase barriers to coverage for qualified individuals. These commenters also noted that these increased burdens and barriers would result in decreased enrollment and worse health outcomes for those impacted.

Response: We acknowledge commenters' concerns. However, we believe that the additional burden is not significant enough to outweigh the merits of SEP verification and the increases in program integrity that it provides, especially since we are only finalizing the requirement for a single year. We also note that the SEP verification policy we are proposing for the Exchanges on the Federal platform is not wholly new and is partially a return to the previous policy. When SEP verification was active for most SEP types prior to the changes implemented in the 2023 Payment Notice, most consumers who received SEP Verification Issues were able to resolve them in a timely manner as noted previously in this preamble.

Comment: Many commenters, particularly advocacy groups, individuals, labor groups, and State Exchanges, noted concerns that SEP verification negatively impacts younger consumers in particular who have lower resolution rates than other generations of consumers. These commenters noted that younger individuals improve the risk pool and help to lower premiums. On average, increased verification tends to deter younger individuals from enrolling, which could have the effect of raising enrollee premiums.

Response: We appreciate the concerns raised. As noted previously in this preamble, we acknowledge that younger consumers do resolve their SEP verification issues at a lower rate than older consumers. While we acknowledge that this policy can have the effect of deterring some young people from enrolling in coverage, we do not think that it outweighs the benefits of preventing improper enrollments in Exchanges on the Federal platform. Further, finalizing the policy for a single year is unlikely to have demonstrable effects on the risk pool over any longer term. This policy balances the need to address urgent program integrity concerns with the long-term desire to promote enrollment efficiencies.

Comment: Several commenters, which included health insurance issuers, providers, advocacy groups, and individuals, expressed support for this proposal. These comments cited concerns around fraud in the marketplace and how they believe that increased SEP verification would reduce or eliminate fraud related to SEPs. Several commenters, in particular, noted that increased verification would help to prevent agent, broker, and web-broker fraud. Overall, these commenters agreed that the SEP verification provision would have the desired effect of increasing program integrity on the Exchanges.

Response: We appreciate these comments highlighting that this policy will have the desired effect of increasing program integrity and addressing improper enrollments in the marketplace during its temporary implementation in PY 2026. While we do acknowledge that most agents, brokers, and web-brokers seek to comply with HHS rules in good bad

[184] Such requests would be made through the State-based Marketplace Annual Reporting Tool (SMART; OMB Control Number 0938–1244).

faith, we also believe that increased verification requirements for SEPs will deter agents, brokers, web-brokers, and consumers from completing enrollments when a consumer is not eligible. We believe that implementing SEP verification policy will ensure only qualified consumers are enrolling through SEPs and, as expressed previously, we anticipate benefits similar to those we experienced when SEP verification was first implemented as a result of the 2017 Market Stabilization Rule. This temporary policy will help stabilize the marketplace in PY 2026 as the subsidy environment normalizes and the high levels of improper enrollments are reduced before reverting back in PY 2027.

Comment: Many commenters, particularly State Exchanges, advocacy groups, providers, and individuals, noted concerns around the increased financial and administrative burdens the rule would have on State Exchanges and the Exchanges on the Federal platform. They also noted concern around a decrease in flexibility for State Exchanges to determine what verification methods work best for their States. Many State Exchanges expressed that they do not see any indications of SEPs being used fraudulently on their Exchange and believe that the proposed rule would place additional costs and burdens on them with no real benefit. Other State Exchanges did note that they were not concerned because they are already in compliance with this proposal.

Response: We appreciate commenters' concerns. We recognize that there is a great deal of variance between States in terms of levels of SEP verification and whether it is conducted pre or post enrollment. After careful consideration of public comments, we have decided we will not be finalizing these proposals for State Exchanges in an effort to address concerns around increased burdens and costs. Additionally, we have decided to finalize and implement the proposed policy with a significant modification—for Exchanges on the Federal platform, each of the rules outlined in this section will sunset by their terms after the completion of one new coverage year, PY 2026, on December 31, 2026. Sunsetting these rules after PY 2026 will allow the policy to achieve its desired effect of program integrity.

Comment: Several commenters, which included providers, advocacy groups, one State Exchange, one EDE partner, one health insurance issuer, and individuals, expressed that Exchanges should pursue alternate verification methods or focus on improving the current system as opposed to increasing SEP verifications for consumers. Some of these commenters noted that HHS should focus more on regulating agents and brokers and less on increasing consumer verifications.

Response: We appreciate the suggestions related to alternate methods of verification and system improvements to improve program integrity. While we will continue to identify and consider effective methods of verifying eligibility, we believe that solely focusing on agents, brokers, and web-brokers to the exclusion of adopting effective verification processes is not the best policy because it ignores identified weaknesses in Exchange verification processes as well as our responsibility to comply with the ACA. We acknowledge that improper enrollments are not conducted solely by agents, brokers, and web-brokers, and that most are compliant with HHS rules, and operate in good faith. We have already taken action to address improper enrollments by agents, brokers, and web-brokers as outlined elsewhere in this rule. We are committed to continuing to address those issues. We believe the temporary policies in this rule, including SEP verification, will help to directly address improper enrollments committed by agents, brokers, and web-brokers, while promoting flexibility and efficiencies in enrollment processes over the long-term.

C. Part 156—Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges

1. Prohibition on Coverage of Specified Sex-Trait Modification Procedures as an EHB (§§ 156.115(d) and 156.400)

In the 2025 Marketplace Integrity and Affordability proposed rule (90 FR 12985 through 12987), we proposed to amend § 156.115(d) to provide that issuers of non-grandfathered individual and small group market health insurance coverage—that is, issuers of coverage subject to EHB requirements—may not provide coverage for sex-trait modification as an EHB beginning with PY 2026.

Section 1302(a) of the ACA provides for the establishment of an EHB package that includes coverage of EHB (as defined by the HHS Secretary), cost-sharing limits, and AV requirements. Among other things, the law directs that the scope of the EHB be equal in scope to the benefits provided under a typical employer plan and that they include at least the 10 general categories outlined in the statute and the items and services covered within those categories.[185]

Section 156.115(d) currently provides that for plan years beginning on or before January 1, 2026, an issuer of a plan offering EHB may not include routine non-pediatric dental services, routine non-pediatric eye exam services, long-term/custodial nursing home care benefits, or non-medically necessary orthodontia as EHB; and, for plan years beginning on or after January 1, 2027, an issuer of a plan offering EHB may not include routine non-pediatric eye exam services, long-term/custodial nursing home care benefits, or non-medically necessary orthodontia as EHB. In the EHB Rule (78 FR 12845), we stated that routine non-pediatric dental services are not typically included in the medical plans offered by employers and are often provided as excepted benefits by the employer. We accordingly proposed and finalized the rule prohibiting issuers from covering these services as EHB.[186]

Because the scope of EHB must be equal in scope to the benefits provided under a typical employer plan, and coverage of sex-trait modification is not typically included in employer-sponsored plans, in the proposed rule (90 FR 12986), we proposed to add ''sex-trait modification'' to the list of items and services that may not be covered as EHB beginning in PY 2026. As noted in the proposed rule (90 FR 12986), such procedures sometimes are referred to as ''gender affirming care,'' and were referred to in the proposed rule as ''sex-trait modification.'' The proposed rule (90 FR 12986) stated that the term ''sex'' is defined as a person's immutable biological classification as either male or female; the term ''female'' is a person of the sex characterized by a reproductive system with the biological function of producing eggs (ova); and the term ''male'' is a person of the sex characterized by a reproductive system with the biological function of producing sperm.[187]

[185] *See* section 1302(b)(2)(A) of the ACA. *See also* section 1302(b)(1) of the ACA, delineating the 10 general categories of EHB: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

[186] In the 2025 Payment Notice (89 FR 26343), we finalized the removal of the regulatory prohibition at § 156.115(d) on issuers from including non-pediatric dental services as EHB for plan years beginning on or after January 1, 2027.

[187] *See also,* Section 2 of E.O. 14168 and Office of Women's Health (2025, Feb. 19). Sex-Based

In the proposed rule (90 FR 12986), we stated that although the fact that sex-trait modification is not typically included in employer-sponsored plans is an independent, sufficient, and legally compelling reason for our proposal, we acknowledged recent executive orders [188] that have been subject to preliminary injunctions. We stated that the agency made this proposal independently of the executive orders because sex-trait modification is not typically included in employer health plans and therefore cannot legally be covered as EHB. The agency acknowledged in the proposed rule that two courts have issued preliminary injunctions relating to the executive orders described above and stated that it did not rely on the enjoined sections of the executive orders in making this proposal.

In particular, we noted in the proposed rule (90 FR 12986) that the United States District Court for the Western District of Washington has issued a preliminary injunction that enjoined defendant agencies ''from enforcing or implementing section 4 of Executive Order 14187 within the Plaintiff States,'' as well as ''sections 3(e) or 3(g) of Executive Order 14168 to condition or withhold Federal funding based on the fact that a health care entity or health professional provides gender-affirming care within the Plaintiff States.'' *Washington* v. *Trump,* No. 2:25–CV–00244–LK, 2025 WL 659057, at *28 (W.D. Wash. Feb. 28, 2025), appeal docketed, No. 25–1922 (9th Cir. Mar. 24, 2025). The United States District Court for the District of Maryland has issued a preliminary injunction that enjoins the Federal defendants in that case ''from conditioning, withholding, or terminating Federal funding under section 3(g) of Executive Order 14168 and section 4 of Executive Order 14187, based on the fact that a healthcare entity or health professional provides gender-affirming medical care to a patient under the age of nineteen'' and required a written notice ''instruct[ing] the aforementioned groups that Defendants may not take any steps to implement, give effect to, or reinstate under a different name the directives in section 3(g) of Executive Order 14168 or section 4 of Executive Order 14187 that condition or withhold Federal funding based on the fact that a healthcare entity or health professional provides gender-affirming medical care to a patient under the age of nineteen.'' *PFLAG, Inc.* v. *Trump,* No. CV 25–337–BAH, 2025 WL 685124, at *33 (D. Md. Mar. 4, 2025), appeal docketed, No. 25–1279 (4th Cir. Mar. 24, 2025). We stated in the proposed rule that if our proposal were finalized, it would not conflict with those preliminary injunctions because, among other things, it would be based on independent legal authority and reasons and not the enjoined sections of the executive orders. We further stated that any final rule on this issue would not be effective until PY 2026, and would not be implemented, made effective, or enforced in contravention of any court orders.[189]

In the proposed rule (90 FR 12986), we noted that with regard to whether sex-trait modification is typically included in employer-sponsored plans, we are aware that employer-sponsored plans often exclude coverage for some or all sex-trait modification, and it is our understanding that these exclusions may include use of puberty blockers, sex hormones, and surgical procedures identified in E.O. 14187. We stated that this includes many small group plans that do not cover such services and noted that 42 States chose or defaulted to small group plans as their EHB-benchmark plan selections in 2014 and 2017.[190] In addition, we stated that, of those employer-sponsored plans that do cover sex-trait modification, these EHB-benchmark plan documents would indicate that there is inconsistency nationwide with respect to the scope of benefits included. We noted that the infrequent and inconsistent coverage of such benefits is also apparent in the treatment of sex-trait modification by the States and territories, which provides further support that coverage of these benefits is not typical, and we stated our understanding that the majority of States and territories do not include coverage for sex-trait modification in State employee health benefit plans or mandate its coverage in private health insurance coverage.[191] In addition, we noted that 12 States and 5 territories do not mention or have no clear policy regarding sex-trait modification in their employee health benefit plans, and 14 States explicitly exclude sex-trait modification from their State employee health benefit plans.[192]

As explained in the proposed rule (90 FR 12986 through 12987), we believe that coverage of sex-trait modification may be sparse among typical employer plans because the rate of individuals utilizing sex-trait modification is very low; less than 1 percent of the U.S. population seeks forms of sex-trait modification,[193] and this low utilization is apparent in the External Data Gathering Environment (EDGE) limited data set.[194] In this data set, which encompasses the majority of health insurance enrollees covered outside of large group plans, approximately 0.11 percent of enrollees in non-grandfathered individual and small group market plans utilized sex-trait modification during PYs 2022 and 2023.[195]

We noted that nothing in this proposal would prohibit health plans from voluntarily covering sex-trait modification as a non-EHB consistent with applicable State law, nor would it prohibit States from requiring the coverage of sex-trait modification, subject to the rules related to State-mandated benefits at § 155.170.

We stated in the proposed rule (90 FR 12987) that we are also aware that some interested parties do not believe that sex-trait modification services fit into any of the 10 categories of EHB and, therefore, do not fit within the EHB framework even if some employers cover such services. As discussed in the proposed rule (90 FR 12987), the items and services that comprise sex-trait modification are performed to align or transform an individual's physical

Definitions. Dep't of Health and Human Services. Retrieved March 6, 2025, from *https://womenshealth.gov/article/sex-based-definitions.*

[188] Executive Order 14168, ''Defending Women From Gender Ideology Extremism and Restoring Biological Truth to the Federal Government'' (E.O. 14168); Executive Order 14187, ''Protecting Children From Chemical and Surgical Mutilation'' (E.O. 14187).

[189] HHS intends to notify the courts in both cases about this rule after it has been published in the **Federal Register**.

[190] CMS. (2016, April 8). Final List of BMPs. *https://www.cms.gov/cciio/resources/data-resources/downloads/final-list-of-bmps_4816.pdf.*

[191] Movement Advancement Project. 2025. ''Equality Maps: Healthcare Laws and Policies.'' *https://www.mapresearch.org/equality-maps/healthcare_laws_and_policies.* Accessed Feb. 23, 2025.

[192] Ibid.

[193] *See* Hughes, L.; Charlton, B.; Berzansky, I.; et al. (2025, Jan. 6). Gender-Affirming Medications Among Transgender Adolescents in the US, 2018–2022. *JAMA Pediatr. 179*(3):342–344. *https://jamanetwork.com/journals/jamapediatrics/fullarticle/2828427; see also,* Dai, D.; Charlton, B.; Boskey, E.; et. al. (2024, June 27). Prevalence of Gender-Affirming Surgical Procedures Among Minors and Adults in the US. *JAMA Netw Open. 7(6)*:e2418814. *https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2820437.*

[194] The EDGE limited data set contains certain masked enrollment and claims data for on- and off-Exchange enrollees in risk adjustment covered plans in the individual and small group (including merged) markets, in States where HHS operated the risk adjustment program required by section 1343 of the ACA, and is derived from the data collected and used for the HHS-operated risk adjustment program.

[195] *See https://www.cms.gov/data-research/files-order/limited-data-set-lds-files/enrollee-level-external-data-gathering-environment-edge-limited-data-set-lds.* To request the EDGE limited data set, refer to the instructions at *https://www.cms.gov/data-research/files-for-order/limited-data-set-lds-files.*

appearance with an identity that differs from his or her sex. We stated that we are also concerned about the scientific integrity of claims made to support their use in health care settings. As such, we sought comment on whether it would be appropriate to exclude sex-trait modification as an EHB.

Consistent with the other listed benefits that issuers must not cover as an EHB at § 156.115(d), we did not propose a definition of ''sex-trait modification.'' However, we sought comment on whether we should adopt a formal definition of ''sex-trait modification,'' whether there are current issuer standards with regards to what is considered ''sex-trait modification''; and how such a definition could best account for the items and services currently covered or excluded as sex-trait modification by plans subject to the EHB requirement.

We also recognized in the proposed rule (90 FR 12987) that there are some medical conditions, such as precocious puberty, or therapy subsequent to a traumatic injury, where items and services that are also used for sex-trait modification may be appropriate. We sought comments regarding whether we should define explicit exceptions to permit the coverage of such items and services as EHB for other medical conditions, and what those conditions are, for potential inclusion in finalizing as part of this rule.

We noted in the proposed rule (90 FR 12987) that pursuant to § 155.170(a)(2), a covered benefit in a State's EHB-benchmark plan is considered an EHB. There is no obligation for the State to defray the cost of a State mandate enacted after December 31, 2011, that requires coverage of a benefit covered in the State's EHB-benchmark plan. If a State mandates coverage of a benefit that is in its EHB-benchmark plan, the benefit will continue to be considered EHB and the State will not have to defray the costs of that mandate. However, if at a future date the State updates its EHB-benchmark plan under § 156.111 and removes the mandated benefit from its EHB-benchmark plan, the State may have to defray the costs of the benefit under the factors set forth at § 155.170 as it will no longer be an EHB after its removal from the EHB-benchmark plan.

In the proposed rule (90 FR 12987), we also noted that there are some State EHB-benchmark plans that currently cover sex-trait modification as an EHB. Other State EHB-benchmark plans provide coverage for sex-trait modification, but do not explicitly mention sex-trait modification or any similar term.[196] We stated that if this proposal were finalized as proposed, health insurance issuers would be prohibited from providing coverage for sex-trait modification as an EHB in any State beginning in PY 2026. We further stated that if any State separately mandates coverage for sex-trait modification outside of its EHB-benchmark plan, the State would be required to defray the cost of that State mandated benefit as it would be considered in addition to EHB pursuant to § 155.170. We explained, however, that if any such State does not separately mandate coverage of sex-trait modification outside of its EHB-benchmark plan, there would be no defrayal obligation. We noted that States may consider mandating coverage of sex-trait modification in the future, in which case defrayal obligations at § 155.170 would apply, and CMS would enforce the defrayal obligations appropriately. Further, we explained that issuers in States in which sex-trait modification is currently an EHB would also be prohibited from covering it as an EHB beginning in PY 2026. However, we explained that they may opt to continue covering sex-trait modification consistent with applicable State law, but not as an EHB. We sought comment on whether additional program integrity measures would be necessary to ensure Federal subsidies do not continue to fund sex-trait modification if this proposal is finalized.

Lastly, we sought comment on the proposed effective date of this proposal. We proposed PY 2026 as the effective date for when issuers subject to EHB requirements would be prohibited from covering sex-trait modification as an EHB. We sought comment specifically on the impact that this proposal would have, if finalized, on health insurance coverage in the individual, small group, and large group markets for PY 2026, or whether an earlier or later effective date is justified.

After consideration of comments and for the reasons outlined in the proposed rule and this final rule, including our responses to comments, we are finalizing this policy with the following modification. In response to comments, we are finalizing at § 156.400 the addition of a definition of ''specified sex-trait modification procedure,'' which means 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. This policy is applicable for PY 2026 and beyond.

We summarize and respond below to public comments received on our proposal to prohibit issuers subject to EHB requirements from covering sex-trait modification as an EHB beginning with PY 2026.

Comment: Many commenters disagreed with the proposition that coverage for sex-trait modification is not included under a typical employer plan. These commenters cited various reports, including a report from Marsh McLennan,[197] a major employee benefit services company, to dispute this proposition. Many commenters raised as evidence that in the 2025 Corporate Equality Index,[198] the Human Rights Campaign Foundation found that 72 percent of Fortune 500 businesses, and 91 percent of businesses listed on the Corporate Equality Index, offer coverage of treatment for gender dysphoria. These commenters noted that, as a result, over 1,300 major employers nationwide cover this care, 28 times as many businesses as in 2009. These commenters further stated that coverage for gender dysphoria is widespread among State employee plans (24 States and DC), Medicaid (27 States, Puerto Rico, and DC), and QHPs offered on the Exchanges (55 percent of QHPs across all 50 States covered this care in PY 2025) and that many States prohibit exclusions of coverage for gender

[196] The EHB-benchmark plans for California, Colorado, New Mexico, Vermont, and Washington specifically include coverage of some sex-trait modification. The EHB-benchmark plans of six other States do not expressly include or exclude coverage of sex-trait modification. The EHB-benchmark plans of 40 States include language that excludes coverage of sex-trait modification.

[197] Umland, B; Hifer, E. Health benefits that matter to the LGBTQ+ community: By the numbers. US Health News, Marsh McLennan, available at *https://www.mercer.com/en-us/insights/us-health-news/health-benefits-that-matter-to-the-lgbtq-community/.*

[198] Human Rights Campaign Foundation. ''Corporate Equality Index 2025'' available at *https://reports.hrc.org/corporate-equality-index-2025.*

dysphoria (24 States and DC).[199] Many of these same commenters stated that the KFF 2024 Employer Health Benefit Survey found that only one-third of employers with 200 or more employees responded that they did not offer coverage for sex-trait modification hormone therapy. These commenters further stated that the survey found that the largest firms in the country (5,000 or more employees) employ 43 percent of people with job-based coverage and were significantly more likely to report covering hormone therapy in relation to sex-trait modification in their largest plan by enrollment. Another commenter pointed to a study by Out2Enroll of 2025 silver plans in all 50 States and DC, which found that 92.9 percent of the 2,138 silver plans did not exclude certain services for transgender-identifying people and that over half of all reviewed plans (54.6 percent) included affirmative language indicating that medically necessary care is covered.

Some commenters opined that CMS failed to include evidence in the proposed rule that coverage for sex-trait modification is not typically included in employer-sponsored coverage.

One commenter disagreed with the proposed rule's reliance on the Movement Advice Project (MAP) report to support the claim that sex-trait modification generally is not covered under typical employer-sponsored plans for treatment of gender dysphoria. This commenter stated that the MAP report conflicts with several studies, HHS did not include portions of the report that did not support its conclusions, and that the MAP report conflates States' transgender-identifying population numbers with an analysis of how many employers categorically exclude from coverage sex-trait modification services as treatment for gender dysphoria.

One commenter disagreed that the fact that some States that do not mention or have no clear policy on coverage of sex-trait modification services is evidence that sex-trait modification is not covered in typical employer plans. This commenter stated that this lack of clarity is likely because sex-trait modification encompasses a wide array of services that are also used to treat other health conditions, in addition to treatment for gender dysphoria, so coverage of such services for sex-trait modification purposes may not explicitly be stated in some health plans.

Response: We disagree with commenters' assertion that sex-trait modification is covered under typical employer-sponsored plans. In fact, according to the KFF 2024 Employer Health Benefits Survey, which was cited by many commenters, only 24 percent of employers with 200 or more employees responded that they cover gender-affirming hormone therapy; [200] and an additional 45 percent of such employers were unable to confirm whether they offer coverage for such services. It is also reasonable to assume that, compared to gender-affirming hormone therapy coverage rates, an even lower percentage of the employers surveyed by KFF cover more invasive, higher cost sex-trait modification surgeries. We believe this evidence substantiates the claim that typical employer plans are not covering specified sex-trait modification procedures, as defined in this rule.

Additionally, we disagree with the commenter who took issue with the MAP report as a basis for this policy change. The Department is of the view that we appropriately relied on and represented the materials, and that they represent a sound statistical basis to inform our final policy. This is consistent with the statutory requirement that EHB align with the coverage provided by a typical employer plan,[201] and CMS history of excluding by regulation such services from EHB.[202]

We acknowledge that very large employers that represent a larger share of employees may be more likely to cover the specified sex-trait modification procedures that are the focus of this policy. However, in the Department's experience, this mainly reflects the fact that larger employers tend to have more financial resources to provide a more generous benefit set. The statute specifically references the typical employer and not the typical employee, which acts to restrain the EHB from reflecting the more generous and costly health plans offered by very large employers. Moreover, very large employers also receive more pressure from advocacy organizations to cover sex-trait modification procedures and, therefore, likely do not represent the typical employer to the degree a portion respond to this pressure. In regard to the Human Rights Foundation Corporate Equality Index findings, we note that the employers referenced in this report volunteered to participate in the advocacy organization's program and such voluntary participation suggests these employers do not represent the typical employer and, instead, align with the advocacy organization's views.

Comment: Some commenters stated that the argument that typicality is equivalent to a benefit's utilization rate is flawed, and that no one would argue against coverage for people with rare cancers that affect few people, or heart transplants, for example. Some commenters also stated that the utilization data cited in the proposed rule did not support CMS' claims regarding typical employer coverage because they: (1) spoke to actual utilization and not available coverage, and (2) reflect consumer experience for consumers participating in Exchange rather than employer-sponsored insurance. Other commenters raised concerns that the observed low utilization of sex-trait modification services may reflect the relative rarity of gender dysphoria as a diagnosis, rather than low levels of coverage for such services under Exchange or employer-sponsored coverage.

Response: We continue to believe that utilization data from the EDGE limited data set offers a useful picture of the coverage offered by a typical employer. While commenters raised concerns that the observed low utilization of sex-trait modification services may reflect the relative rarity of gender dysphoria as a diagnosis, rather than low levels of coverage for such services under Exchange or employer-sponsored coverage, low utilization, as evidenced by EDGE data, also supports the contention that specified sex-trait modification procedures, as defined in this final rule, are not covered by typical employer plans. Specifically, we believe these data reflect the coverage experiences of consumers receiving coverage through the small business health options program (SHOP), which we believe to be more reflective of the coverage typically provided by the majority of employers, which are significantly smaller [203] than those employers surveyed by, for example, the Corporate Equity Index or KFF. We disagree with commenters' concern that utilization, as measured through the EDGE database, does not accurately

[199] Movement Advancement Project. ''Equality Maps: Healthcare Laws and Policies'' available at *https://www.lgbtmap.org/equality-maps/healthcare_laws_and_policies.Accessed05/28/2025.https://www.lgbtmap.org/equality-maps/healthcare_laws_and_policies.* Accessed 05/28/2025.

[200] Claxton, G. Et al. (2024, October 9). Employer Health Benefits. KFF. *https://www.kff.org/health-costs/report/2024-employer-health-benefits-survey/.*

[201] 42 U.S.C. 18022(b)(2).

[202] 45 CFR 156.115(d).

[203] Bureau of Labor Statistics data (available at: *https://www.bls.gov/charts/county-employment-and-wages/employment-by-size.htm*) suggest that approximately 58% of U.S. employers employ 99 or fewer employees—substantially fewer than the employers surveyed by KFF or the Corporate Equity Index.

reflect the level of coverage available to the enrollees receiving employer-sponsored coverage, given that all plans available to Exchange consumers (those upon whom EDGE data are based), must adhere to the requirements for EHB, which are themselves closely tied to typical employer-sponsored coverage.

Comment: One commenter noted that gaps in coverage or ambiguity regarding coverage because the issuer's plan documents do not reference sex-trait modification often means issuers will adjudicate medical necessity on a case-by-case basis and do not justify a claim that sex-trait modification is not typically covered by employer plans. Another commenter suggested that the typicality standard should be understood only as setting a guideline for minimum benchmark coverage and that typical employer plans have historically excluded coverage for the same services that the EHB provision was intended to expand. This commenter therefore suggested that CMS should not take the requirement that EHBs be equal in scope to a typical employer plan to mean that (1) EHB-benchmark plans cannot or should not be more generous than a typical employer plan, nor that (2) just because a particular service is not commonly covered by typical employer plans, that that should automatically exclude those services from being EHB.

Other commenters stated that the proposal conflicts with CMS' regulations on typicality for EHB-benchmark plans, which allow States to require coverage beyond what is covered in a typical employer plan, so long as the scope of benefits is not more generous than the scope of benefits in the most generous plan in the State. Other commenters urged that the appropriate analysis regarding the typical employer plan per CMS' own regulations is not whether most other States include sex-trait modification in their EHB-benchmark plans or the number of enrollees utilizing this care nationwide, but instead whether such care is covered by typical employer plans in the State selecting it as EHB. These commenters emphasized that a requirement that States exclude sex-trait modification from their State EHB-benchmark plans would be inconsistent with typical employer plans in their respective States.

Response: We disagree with commenters' position that the statutory requirement that EHB be equal in scope to the benefits provided by a typical employer plan was intended to close gaps in coverage by setting a floor for coverage. We further disagree that sex-trait modification procedures, if not covered by typical employer plans, are required to be covered as an EHB to correct gaps in coverage. The position that EHB be defined in a manner that addresses gaps in coverage must conform to the typicality requirement.

Comment: Some commenters stated that CMS should consider in its analysis of typical employer plan coverage for sex-trait modification that half of all States have interpreted Federal and State laws to prohibit discrimination based on sexual orientation and gender identity, which extends to most public and private health insurance plans.

Response: We acknowledge that several States have interpreted Federal and State laws to prohibit discrimination against sexual orientation and gender identity, which may influence employer coverage of sex-trait modification services. We have considered this and have found that, despite such State efforts, coverage of sex-trait modification in employer-sponsored plans remains atypical. After finalizing the section 1557 nondiscrimination rules in 2016 that added a definition of sex discrimination to incorporate discrimination on the basis of gender identity, some State departments of insurance issued policy bulletins making clear that exclusion of such types of coverage are discriminatory based on section 1557.[204] Immediately after our amendment to section 1557 nondiscrimination regulations in 2020 (amending the 2016 definition of sex discrimination to incorporate discrimination on the basis of gender identity), an advocacy organization that tracks coverage of sex-trait modification procedures on the Exchanges found ''the number of insurers using transgender-specific exclusions . . . more than doubled.'' [205] Since 2021, over half of States have taken action to restrict sex-trait modification procedures for minors.[206] We believe these swings in State and Federal policy reflect the relatively recent emergence and ongoing controversy over coverage of the specified sex-trait modification procedures we address in this final rule, which supports the conclusion that such procedures are not typically covered by employer-plans.

Comment: One opposing commenter stated that HHS provided no evidence in the proposed rule that treatment for gender dysphoria has ever been offered by issuers under an excepted benefit plan and noted that treatment for gender dysphoria is therefore dissimilar to the other benefits in § 156.115(d) that are excluded from being covered as EHB. This same commenter stated that the other benefits at § 156.115(d) are excluded as EHB by general designation (eye exam services, home care benefits, and non-medically necessary orthodontia), but that here HHS seeks to categorically prohibit specific medical services used by a specific population (people diagnosed with gender dysphoria) even when they are medically necessary. Many commenters raised concerns that this could be a slippery slope to excluding other medically necessary benefits as EHB.

Some opposing commenters urged CMS to preserve the framework that allows States to adopt an EHB-benchmark plan that best fits their unique market dynamics. Such commenters stated that this proposal would be a significant departure from the existing EHB-benchmark plan framework because it would prohibit coverage of services as EHB at a more granular level than before and that this could restrict the ability of States to respond to local needs, increase the price of coverage, limit plan and provider innovation, and hinder flexibility for issuers to respond to changes in scientific evidence and clinical practice. Many commenters noted that the impact of the proposal on individuals without gender dysphoria seeking care will also lead to higher out-of-pocket costs and access issues throughout the U.S.

Response: We disagree that the prohibition on coverage of specified sex-trait modification procedures as EHB, as finalized in this rule, is likely to create a slippery slope towards additional coverage exclusions. We acknowledge commenters' concern that other services are excluded from coverage as EHB on the grounds that they are excepted benefits and that specified sex-trait modification procedures are not generally covered as excepted benefits. However, the contention underlying the prohibition of other services (for example, routine adult vision) is the same as that at issue with respect to specified sex-trait modification

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[204] *See, e.g.,* Oregon Department of Consumer and Business Services, Division of Financial Regulation. Bulletin DFR 2016–1 (September 7, 2016), available at *https://dfr.oregon.gov/laws-rules/Documents/Bulletins/bulletin2016-01.pdf;* State of Vermont, Department of Financial Regulation. Insurance Bulletin 174 (rev. June 12, 2019), available at *https://dfr.vermont.gov/sites/finreg/files/regbul/dfr-bulletin-insurance-174-gender-dysphoria-surgery.pdf;* Pennsylvania Bureau of Life, Accident and Health, Office of Insurance Product Regulation. Notice Regarding Nondiscrimination; Notice 2016–05 (April 30, 2016), available at *https://www.pacodeandbulletin.gov/Display/pabull?file=/secure/pabulletin/data/vol46/46-18/762.html.*

[205] *AGLY* v. *USDHHS,* 557 F. Supp. 3d 224, at 239 (internal citations omitted).

[206] *https://www.lgbtmap.org/equality-maps/healthcare_youth_medical_care_bans.*

procedures—that they *are not* typically covered by employer-sponsored plans. Specifically, specified sex-trait modification procedures *have not* typically been provided by employers *through any coverage vehicle,* be that an excepted benefit plan or otherwise. As such, we are not concerned that prohibiting coverage of specified sex-trait modification procedures as EHB is likely to curtail the coverage of other services, given that nothing in this prohibition is intended to place limitations on services deemed EHB, so long as those services are in accordance with the statutory requirement that EHB be equal in scope to the benefits provided under atypical employer plan.

Additionally, while we are largely supportive of State flexibility with regard to establishing EHB, we take seriously the responsibility to ensure consistency with the parameters on EHB enumerated in the statute. As such, we have engaged in rulemaking on a number of occasions to refine our interpretation of the typicality standard. We believe the policy we are finalizing is neither a departure from our previous posture on prohibited benefits, in which we have considered whether such benefits are included in a typical employer plan, nor an action that exceeds the authority explicitly articulated in statute. Rather, we rely on the Secretary's broad regulatory authority to define EHB and the statutory requirement that EHB be equal in scope to the benefits provided under a typical employer plan.

Finally, we do not believe there is merit to commenters' concerns regarding unreasonable increases in out-of-pocket costs for consumers utilizing sex-trait modification services that do not meet the definition of specified sex-trait modification procedures finalized in this rule, or negative impacts to care based on alleged ambiguities introduced by this policy change. We believe that issuers have the appropriate flexibility to ensure that services that *may* or *must* remain covered as EHB retain such coverage, and that services that *may not* be covered as EHB will no longer be covered as such without disrupting enrollees' receipt of appropriate care. And, to the extent that out-of-pocket costs do increase for some consumers utilizing specified sex-trait modification procedures as defined in this rule, whose cost-sharing may increase as a result of such services no longer qualifying as EHB, we believe that will align with the degree of out-of-pocket costs for such services experienced by consumers covered by employer-sponsored plans.

Comment: Some commenters disagreed with the proposal to prohibit coverage of sex-trait modification as an EHB on the basis that numerous leading medical professional organizations, including the American Medical Association, American Academy of Pediatrics, American College of Obstetricians, and Pediatric Endocrine Society, and medical journal articles have found sex-trait modification to be medically necessary and that people who have received sex-trait modification services rarely regret those services. Many commenters stated that sex-trait modification is the standard of care for gender dysphoria and provided copies of or links to peer-reviewed journal articles in support of this assertion.

Other commenters supported the proposal and referenced peer-reviewed studies and medical evidence or anecdotal scenarios in support of the policy. For example, some commenters stated that patients, especially children, may feel regret after utilizing sex-trait modification services and may suffer negative effects on their future fertility and sexual function.

One commenter opined that use of puberty blockers to suppress puberty could possibly further gender dysphoria symptoms, and that those symptoms, but for the puberty blockers, might have otherwise naturally subsided over time. Some commenters stated that sex-trait modification treatment is ''experimental'' and ''dangerous,'' especially for children, and that it can lead to sexual dysfunction and/or sterility and place people at higher risk of other conditions such as obesity, diabetes, and cardiovascular disease. Some commenters argued that many States have prohibited sex-trait modification interventions for children and that this is evidence that science supporting such services is medically unsound.

Response: CMS understands the lack of consensus regarding the efficacy and necessity of sex-trait modification services for people with gender dysphoria, and especially children, as evidenced by the comments received and published peer-reviewed studies.[207] Likewise, on June 18, 2025, the Supreme Court upheld a State's ban on certain medical treatments for transgender minors, acknowledging that the dispute regarding these treatments ''carries with it the weight of fierce scientific and policy debates about the safety, efficacy, and propriety of medical treatments in an evolving field.'' [208] We carefully read each comment submitted and appreciate that commenters shared a myriad of opinions and personal stories, both in support of and against the proposal. However, we are not persuaded that the existence of journal articles and clinical guidelines supporting the use of sex-trait modification services for the treatment of gender dysphoria should require that specified sex-trait modification procedures be covered as an EHB. In fact, such a stance would be a departure from the current EHB

[207] *See* Treatment for Pediatric Gender Dysphoria, May 1, 2025, Department of Health and Human Services. (''The umbrella review found that the overall quality of evidence concerning the effects of any intervention on psychological outcomes, quality of life, regret, or long-term health, is very low. . . . The risks of pediatric medical transition include infertility/sterility, sexual dysfunction, impaired bone density accrual, adverse cognitive impacts, cardiovascular disease and metabolic disorders, psychiatric disorders, surgical complications, and regret.'') *https://opa.hhs.gov/gender-dysphoria-report.* Straub, J.J., Paul K.K., Bothwell, L.G., Deshazo, S.J., Golovko, G., Miller, M.S., & Jehle, D.V. (2024). Risk of Suicide and Self-Harm Following Gender-Affirmation Surgery. Cureus, 16(4):e57472. doi: 10.7759/cureus.57472. (''There is ongoing controversy surrounding the benefits of gender-affirmation surgery on mental health. This controversy reflects diverse perspectives within the medical and research communities, emphasizing the need for a more comprehensive understanding of the psychological outcomes of gender-affirming procedures.''); Surendran, S., Toh, H.J., Voo, T.C., De Foo, C., & Dunn, M. (2025). A scoping review of the ethical issues in gender-affirming care for transgender and gender-diverse individuals. BMC Med Ethics 26, 54. *https://doi.org/10.1186/s12910-025-01216-2* (''Despite extensive discussion, there remains significant disagreement and a lack of resolution on . . . ethical issues [related to sex-trait modification procedures].''); Effects of gender affirming therapies in people with gender dysphoria: evaluation of the best available evidence. Dr. Romina Brignardello-Petersen and Dr. Wojtek Wiercioch; Main report; May 16, 2022 (''[I]t is unknown whether people with gender dysphoria who use puberty blockers experience more improvement in gender dysphoria, depression, anxiety, and quality of life than those with gender dysphoria who do not use them. There is very low certainty about the effects of puberty blockers on suicidal ideation.''); Ludvigsson JF, Adolfsson J, Höistad M, Rydelius PA, Kriström B, Landén M. A systematic review of hormone treatment for children with gender dysphoria and recommendations for research. Acta Paediatr. 2023 Nov;112(11):2279–2292. doi: 10.1111/apa.16791. Epub 2023 May 1. PMID: 37069492 (this systematic literature review concluded that the long-term effects of treatment of gender dysphoria in children below 18 years old with gonadotropin-releasing hormone analogues (GnRHa) are unknown and that ''GnRHa treatment in children with gender dysphoria should be considered experimental treatment of individual cases rather than standard procedure); Straub J.J., Paul K.K., Bothwell L.G., et al. (April 02, 2024) Risk of Suicide and Self-Harm Following Gender-Affirmation Surgery. Cureus 16(4): e57472. doi:10.7759/cureus.57472 (''The results of this study indicate that patients who have undergone gender affirmation surgery are associated with significantly higher risks of suicide, self-harm, and PTSD compared to general population control groups in this real-world database.'').

[208] *See United States* v. *Skrmetti et al.,* No. 23–477 slip op. at *24 (U.S. June 18, 2025), available at *https://www.supremecourt.gov/opinions/24pdf/23-477_2cp3.pdf.*

framework which, with the very limited exceptions of the preventive services and prohibition on discrimination at § 156.125(a), makes no reference to clinical bases as a justification for whether something is EHB or not.

The basis for prohibiting the coverage of specified sex-trait modification procedures as an EHB, as previously stated in the proposed rule and in this final rule, is that such benefits are not covered under typical employer plans. Section 1302(a)(1) of the ACA gives the Secretary broad latitude to define EHB, subject to ensuring that EHB is equal in scope to the benefits provided under a typical employer plan pursuant to section 1302(b)(2) of the ACA and meets the other limitations enumerated in section 1302(b) of the ACA. We understand that EHB cannot include all possible items and services for all possible diagnoses, simply by the plain language of section 1302 of the ACA, such as the requirement that benefits be ''essential,'' limited to at least the 10 enumerated categories, and equal in scope to the benefits provided under a typical employer plan.

The Department has also examined these issues elsewhere, including in a commissioned review of evidence and best practices [209] regarding pediatric gender dysphoria. The report echoes some of the concerns commenters raised, however the report was distributed solely for the purpose of pre-dissemination peer review under applicable information quality guidelines. It has not been formally disseminated by the Department, therefore it does not represent and should not be construed to represent agency determination or policy. The report will undergo formal post-publication peer review involving interested parties with different perspectives according to the Information Quality Bulletin for Peer Review.

Comment: Numerous commenters commented on the need to specifically define what sex-trait modification is, so that issuers have certainty as to what they can cover as EHB and consumers can have certainty as to what their plans cover. Some commenters raised concerns with the use of the term sex-trait modification and stated that the proposed rule lacked clarity regarding what specific sex-trait modification services would be prohibited from being covered as EHB.

Commenters also provided numerous examples of services they believe should fall under the definition of sex-trait modification. One commenter urged CMS to provide examples of services that would be prohibited from being covered as EHB under the term sex-trait modification, including the following: puberty blockers; hormone therapy; genital surgery (amputation, building replica cross-sex organs); non-genital cosmetic surgeries (mastectomy, breast construction, cheek/chin implants, rhinoplasty, feminization surgeries, liposuction, voice surgery, hair removal, and ''Adam's Apple'' reduction), and ''erroneous'' sex-trait modification psycho-social interventions. One commenter suggested that issuers be required to cover as EHB services to reverse the effects of sex-trait modification.

Other opposing commenters noted that sex-trait modification is not the clinically appropriate terminology when referring to treatment of individuals with gender dysphoria, citing to medical professional organizations, such as the American College of Obstetricians and Gynecologists, the American Medical Association, the American Academy of Family Physicians, and the American Psychiatric Association, which recommend the use of the term ''gender-affirming care.'' Several commenters opposing the proposal raised concerns that the proposal is too broad and could lead to inappropriate exclusions of treatments that are clinically distinct from sex-trait modification services for gender dysphoria. Many commenters stated that while sex-trait modification services can be used to affirm an individual's physical appearance or body with an asserted identity that differs from the individual's sex, sex-trait modification services are not used most commonly for gender transition purposes (for example, a biological female receiving hormone therapy for symptoms of menopause). Numerous commenters expressed that most people will use at least one service that could be used for sex-trait modification purposes in their lifetime. They expressed concern that without clarification, numerous services and drugs could be excluded for people who do not have gender dysphoria but who need them to treat other conditions.

Commenters opposing the proposal listed the following as some of the treatments and conditions unrelated to gender dysphoria that may be implicated by the broad scope of the proposal: precocious puberty; hormone replacement therapy to mitigate symptoms of vaginal atrophy and menopause; hysterectomies and mastectomies for cancer treatment or prevention; birth control; endocrine disorders; facial reconstruction; hair removal; hair implants; speech therapy; counseling; oophorectomy; sexual organ removal due to cancer; treatment for endometriosis, polycystic ovary syndrome, and other gynecological conditions; treatment for intersex conditions; and other reconstructive procedures (such as for trauma victims or cancer patients). Many commenters opposing the proposal noted that several of these interventions may involve modifying secondary sex characteristics, but are clearly not related to gender transition, and that CMS should either remove the term ''sex-trait modification'' from the final rule or define it narrowly and with specificity, consistent with accepted medical usage, to allow exceptions for unrelated and medically necessary treatments.

A few commenters who supported the proposal also requested clarification regarding the scope of services that are included in the term sex-trait modification. These commenters supported the proposal, but requested that CMS define what sex-trait modification means and specify the precise exclusions from the proposed prohibition on coverage of sex-trait modification as EHB, emphasizing the importance of these clarifications for enforceability of the proposal. One commenter suggested that coverage of EHB include services to assess the origins of a person's gender dysphoria.

One commenter supporting the proposal stated that sex-trait modification should mean services that reinforce an erroneous identity inconsistent with one's sex but should exclude from the definition of sex-trait modification any services that are routine or medically necessary to maintain physiological integrity or organ functioning or that are aimed at restoring or reconstructing form and function consistent with one's sex. One commenter supported coverage of diagnostic testing of newborns with congenital anomalies such as ambiguous genitalia, ostensibly to determine if the newborn has a disorder of sexual development.

One commenter opposing the proposal stated that CMS should not define explicit exceptions to the proposal for conditions other than gender dysphoria, such as cancer or precocious puberty, as doing so would discriminate on the basis of health conditions as well as transgender status. Many commenters expressed concern that patient conditions could worsen if their access to drugs or services were disrupted abruptly after losing coverage

[209] HHS (2025, May 1). Treatment for Pediatric Gender Dysphoria. Office of Population Affairs, Office of the Assistant Secretary for Health, available at *https://opa.hhs.gov/sites/default/files/2025-05/gender-dysphoria-report.pdf.*

for a service due to ambiguity as to what is considered sex-trait modification. Another opposing commenter urged CMS to refrain from defining ''sex-trait modification,'' stating that attempting to codify a definition risks oversimplifying the range of medical treatments that could fall under this term. One commenter suggested that coverage of EHB include services to assess the origins of a person's gender dysphoria, while another commenter opposing the proposal disagreed with how the proposed rule defined sex because the commenter believed the policy would exclude individuals who identify with their sex assigned at birth, but who have medical conditions that make them unable to reproduce. Many commenters opposing the policy expressed specific concern regarding how the proposal would apply to intersex people. These comments asserted that persons with disorders of sexual development may have variations in chromosomes, external genitalia, hormones, and reproductive organs, among other characteristics, that make them neither ''male'' nor ''female.''

Response: We acknowledge concerns raised by commenters regarding the ambiguity of the term ''sex-trait modification'' as used in the proposed rule. As discussed elsewhere in this final rule, we are finalizing the addition of a definition of ''specified sex-trait modification procedure'' at § 156.400 to ensure greater clarity regarding what procedures related to sex-trait modifications may and may not be covered as EHB. Additionally, we acknowledge that issuers may not categorize some benefits as sex-trait modification services, because they may instead adjudicate claims for such care based on determinations of medical necessity and the specific condition the service in question is intended to treat. We note that this policy change will not prohibit issuers from covering specified sex-trait modification procedures when deemed medically necessary. This is both because (1) this prohibition does not prohibit issuers from covering any types or forms of care; the prohibition is only on covering specified sex-trait modification procedures *as EHB,* and (2) this prohibition only prohibits issuers from covering specified sex-trait modification procedures as EHB *if* they meet the definition we are finalizing at § 156.400.

We agree with commenters that providing a definition of the services implicated by this policy would provide issuers, consumers, health care providers, and other interested parties with greater certainty. Accordingly, after considering comments, we are finalizing the addition of a definition of ''specified sex-trait modification procedure'' at § 156.400. Specifically, the term ''specified sex-trait modification procedure'' means 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.

After closely reviewing public comments, we believe this definition of ''specified sex-trait modification procedure'' addresses commenters' concerns that regulated entities may be confused regarding the scope of services subject to the policy, as well as concerns that people be able to access benefits as EHB when provided 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, as discussed further below. For example, this final rule would not prevent an issuer from covering as EHB mastectomies or breast reconstruction after a mastectomy for women with breast cancer or hormone therapy for a person with precocious puberty, cancer, or infertility, if those services are otherwise covered.

In response to comments received regarding the applicability of the term ''sex-trait modification'' versus the term ''gender-affirming care'', we have adopted a narrowly tailored definition of ''specified sex-trait modification procedures,'' in part, because of commenter concerns that the term ''gender-affirming care'' generally encompasses a broader set of medical services, such as mental health services. For example, hormone replacement therapy may or may not be prohibited from coverage as EHB under our final policy, depending on whether or not that therapy is being provided in an attempt ''to align an individual's physical appearance or body with an asserted identity that differs from the individual's sex,'' among other defined considerations.

Although some commenters suggested including certain other services in the definition of sex-trait modification services, we decline to adopt an exhaustive list. We believe that the definition we are finalizing in this rule provides an appropriate and actionable degree of certainty and clarity for consumers, issuers, providers, and other interested parties, while also maintaining flexibility to accommodate changes in medical science and standards of care.

We agree with commenters that services or procedures that would constitute sex-trait modification procedures if 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'' do not constitute specified sex-trait modification procedures if provided for a different purpose. Specifically, the definition of a specified sex-trait modification procedure categorically excludes procedures undertaken: (1) to treat a person with a medically verifiable disorder of sexual development, and (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. We believe these exclusions are fully responsive to commenters' concerns that sex-trait modification be narrowly defined. These exclusions will ensure that services that may be employed to effectuate sex-trait modification are not categorically excluded from coverage as EHB for other purposes.

We note, for example, that this definition will allow people with medically verifiable disorders of sexual development to receive surgical services as EHB, if otherwise covered by the plan. Similarly, those needing hormone therapy for cancer, menopause, or other conditions will still be able to receive that therapy as an EHB, if otherwise covered by the plan, as this is 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. These are examples and not an exhaustive list. Additionally, services to reverse the effects of specified sex-trait modification procedures and to treat conditions caused by specified sex-trait modification procedures, such as testing, medication, and care for iatrogenic hypogonadism, osteoporosis, osteopenia, and low testosterone, are still covered as EHB if otherwise included by the State's EHB-benchmark

plan. Further, nothing in this rule precludes coverage of testing to determine disorders of sexual development, including for newborns, from being an EHB, nor is coverage of diagnostic treatment to determine the psychological and/or physiological origin of an individual's gender dysphoria diagnosis precluded from being covered as EHB by this rule, should such treatment exist.

Comment: Several commenters raised different issues regarding costs. One commenter stated that an issuer's ongoing implementation costs by virtue of, for example, having to modify its claims processes and systems, would be higher than what the issuer would reimburse providers for the sex-trait modification services themselves, if these services were covered benefits, and that such implementation costs are not minuscule. This commenter noted that the policy would disproportionately affect smaller issuers and those issuers that primarily cater to low-income and medically underserved populations. Other commenters noted that covering sex-trait modification services in insurance plans is cost-neutral or cost-saving as there is no actuarial basis to price sex-trait modification surgeries separately from any other type of surgery.

Many commenters noted their belief that issuers dropping coverage of sex-trait modification services due to this proposal would increase out-of-pocket consumer costs, as the cost of care would be shifted to consumers. Numerous commenters also expressed concerns that this proposal would block consumers from accessing sex-trait modification services with the same cost-sharing and benefit design protections as the same services covered for non-sex-trait modification still included in the EHB package, and that users of these services are more likely to be low-income and economically vulnerable.

Many commenters expressed concern that the proposal would increase overall health care costs by shifting current treatment costs for sex-trait modification to hospitals and State and local governments. Other commenters opposing the proposal stated that this proposal could lead to States with budget concerns removing State coverage requirements for sex-trait modification services because they would otherwise be forced to defray the cost of requiring such coverage. Some commenters stated that they believed that if sex-trait modification is not covered as an EHB, there will be an increased prevalence of more costly conditions, like severe depression or osteoporosis. Other commenters noted concern that individuals will seek sex-trait modification procedures through unregulated and unofficial channels if issuers stop covering it entirely which could lead to downstream health issues. Commenters noted that uncompensated care would likely increase; these commenters also noted concerns with the proposal leading to increased risk of psychiatric symptoms leading to more utilization of psychiatric services, including psychiatric hospitalizations for these patients if current treatments were no longer covered. One commenter believed that the proposal would have a destabilizing effect on insurance markets where sex-trait modification services were previously covered.

Response: We realize that smaller issuers often have outsized costs when new requirements are put into place that apply to all issuers, simply because they lack economies of scale that some of their larger, nationwide counterparts may have. However, we also believe that this final rule does not require issuers to undergo complex system builds or process changes in order to implement this policy and are not persuaded that the burden of any changes to processes and systems is a compelling basis for not finalizing this proposal. Specifically, issuers are already required to ensure that benefits that are not EHB are appropriately designated as such in the Plans & Benefits Template completed as part of the QHP certification application and that the percentage of premium attributable to EHB is accurately reflected, so that APTC does not erroneously subsidize non-EHB. Although under this final rule, there could be services that can or cannot be covered as EHB depending on diagnosis, we believe that issuers should already have the capability to differentiate between these claims since they already have to make these distinctions today. For example, currently, issuers must ensure that benefits that can never be EHB, such as routine non-pediatric eye exam services or non-medically necessary orthodontia pursuant to § 156.115(d), are not erroneously noted as EHB in plan filings and claims processing. We believe that what an issuer is required to do under this final policy to exclude coverage for specified sex-trait modification procedures as EHB is similar to how issuers currently handle coverage for other claims. Additionally, while issuers may not be currently differentiating claims for specified sex-trait modification procedures in this manner, in any State there exists the possibility of State mandated benefits changing the manner in which the issuer designates discrete covered services as either EHB or non-EHB—as such, we believe issuers have this capability for any benefit.

We do not believe that whether a benefit is cost-neutral from an actuarial perspective has bearing on whether it should be an EHB. A benefits package is comprised of numerous benefits, some of which are cost-neutral or even cost-saving, and some of which are not. If issuers seek to voluntarily cover specified sex-trait modification procedures as non-EHB, they would need to price the services accordingly.

We agree with commenters that for those States that wish to mandate coverage of specified sex-trait modification procedures, they will be responsible for defraying this cost pursuant to § 155.170(b). However, there is nothing inherently unique about specified sex-trait modification procedures as related to the overall defrayal policy; if a State wishes to mandate a benefit that is not EHB, it must defray the cost of that benefit, regardless of what that benefit is. This is a longstanding EHB policy and furthers State flexibility to regulate their own markets and ensure coverage of benefits that are most critical in their State.

We also understand concerns that there may be some people enrolled in plans that must cover EHB who seek specified sex-trait modification procedures who will now need to pay for the full cost out-of-pocket, unless the coverage is State-mandated or an issuer voluntarily offers such coverage. However, this is the case with any benefit that is not EHB. The framework for EHB as established in section 1302(b)(2) of the ACA requires EHB to be ''equal to the scope of benefits provided under a typical employer plan.'' There will necessarily be some benefits that are not EHB. This final rule better aligns coverage with the statutory requirements. In response to concerns that people seeking sex-trait modification services are often medically underserved, lower-income, and more economically vulnerable than the general population, we note that in defining the EHB, we have attempted to balance coverage generosity and affordability, with the realization that what makes coverage more affordable for some, may in turn make certain benefits less affordable for others.

In addition, while some commenters expressed concerns about costs being shifted to local governments and hospital uncompensated care, we emphasize that nothing in this final rule requires States or hospitals to develop

programs to fund specified sex-trait modification procedures. This policy is not likely to result in additional uncompensated care for mental health services because it does nothing to change the status of mental health services as EHB. We reiterate that mental health services will continue to be available, including for persons with gender dysphoria and those seeking specified sex-trait modification procedures, within their respective healthcare plans. We also expect that covered services 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 will continue to be available. Additionally, to the extent they are presently covered as EHB, services that become necessary due to discontinuation of specified sex-trait modification procedures, such as treatment for bone mineral density loss, will continue to be covered as EHB.

We disagree that prohibiting coverage of specified sex-trait modification procedures as EHB in States that previously required such coverage would be destabilizing for the insurance market. First, States have the option of requiring this coverage as long as they defray the cost pursuant to § 155.170. Second, the current EHB-benchmark plan framework at § 156.111(a) and substitution policy at § 156.115(b) allow benefits to change as long as they comply with other requirements related to EHB.

We also acknowledge commenters' concern that gender dysphoria is often associated with severe depression and individuals could seek specified sex-trait modification procedures through unregulated and unofficial channels. As we have noted, pursuant to 1302(b)(2) of the ACA, EHB must be ''equal to the scope of benefits provided under a typical employer plan'', and thus, not all benefits will fall under the definition of EHB. Just as States and issuers are not prohibited from covering specified sex-trait modification procedures as a non-EHB consistent with applicable State law, individuals have the ability to identify health care plans that provide coverage related to their conditions and health issues in an appropriate manner.

We also clarify that if an issuer were to voluntarily cover specified sex-trait modification procedures, as defined in this rule, as non-EHB, those services would not be subject to EHB protections such as the prohibition on discrimination at § 156.125, the prohibition on annual and lifetime dollar limits at § 147.126, and the requirement to accrue enrollee cost sharing towards the annual limitation on cost sharing at § 156.130. We note that because the premium attributable to these procedures would not be for an EHB, the portion of the premium attributable to specified sex-trait modification procedures would not be eligible for PTC or CSR, and the enrollee would be responsible for the cost of any associated premium and cost sharing. Similarly, if a State were to mandate coverage of specified sex-trait modification procedures, those procedures would not be EHB, and not subject to the prohibition on discrimination or annual and lifetime dollar limits applicable to EHBs. However, in such a case, the State would bear the cost of the portion of premium attributable to these procedures, though the enrollee would still be responsible for any applicable cost sharing.

Comment: Several commenters expressed concern with the proposal being effective for PY 2026, citing concerns about interruption of care as well as Federal and State filing deadlines. They noted they believed that the effective date was too soon and would be disruptive to issuers' plan filings for PY 2026, since that process generally began prior to the publication and the effective date of this rule. One commenter noted that some States have an April 25, 2025 QHP application filing deadline for PY 2026, and many others have QHP application filing deadlines of May 15. Another commenter opined that EHB-benchmark plans for PY 2026 have already been finalized, and that any EHB-benchmark plans that include sex-trait modification should be permitted to keep those benefits as EHB for PY 2026. Some commenters explained that issuers will need to make changes to claims systems and utilization management policies and processes as a result of this policy, which takes time. Other commenters stated that such quick finalization for PY 2026 could create market instability and disproportionately affect smaller safety net plans that are predominantly community-based, and local issuers that primarily serve lower-income consumers. Some commenters suggested that the policy be effective for fiscal year 2026, as opposed to PY 2026. Others suggested delaying the effective date of the proposal until calendar year 2027 and one commenter suggested delaying the effective date until no earlier than PY 2028. As support for requesting a later effective date, some commenters noted that when States make updates to their EHB-benchmark plans under § 156.111, States must submit their EHB-benchmark plan application 2 years in advance of the plan year for which the new EHB-benchmark plan will be effective.

Response: We are finalizing an effective date of PY 2026 for this policy. Although we acknowledge that issuers may need to alter their plan filings to ensure specified sex-trait modification procedures are either not covered at all or covered but as non-EHB, we believe this rule will be finalized with sufficient time for issuers to make such changes and ask that States permit changes to rate filings as appropriate to reflect such changes. Specifically, this rule will be finalized prior to the conclusion of QHP certification for PY 2026, such that we believe issuers will have time to adjust their plan offerings in accordance with this rule, regardless of the size, location, or resources of the issuer. We also reiterate that we do not believe issuers will be required to undergo complex system builds or process changes in order to implement this policy, as discussed in more detail above. We believe that finalizing this policy without delay, for PY 2026, is important to align issuer coverage of EHBs with section 1302 of the ACA. Additionally, we do not believe that this change is analogous to the changes States make to their EHB-benchmark plans (for which we require that changes are finalized well in advance of the applicable plan year). Rather, we believe that this change affects rarely utilized coverage, and will be uniformly applied across States, making this change easier for issuers to make for the upcoming plan year.

Comment: Many commenters presented a variety of legal arguments in support of their opposition to the proposal. Many commenters opposing the policy argued that the proposal violates the Supreme Court's holding in *Bostock* v. *Clayton County,* 590 U.S. 644 (2020), which held that discrimination based on transgender status constitutes sex discrimination under Title VII. Many commenters stated that this policy would violate Title IX and section 1557 which also prohibit discrimination on the basis of sex, and that the reasoning in *Bostock* has since been extended to Title IX and Section 1557 in a growing body of Federal case law holding that discrimination on the basis of gender identity and transgender status is prohibited sex discrimination. Many objecting commenters also stated the proposal would prohibit EHB coverage for a protected group on the basis of animus. Many commenters also raised that denying EHB coverage of sex-trait modification procedures such as hormone replacement therapy only to individuals with gender dysphoria

while permitting the exact same treatments to be covered as EHB for individuals without gender dysphoria is overtly discriminatory on the basis of sex in violation of section 1557 of the ACA. Many commenters further stated that the proposal discriminates on the basis of sex by reinforcing sex stereotypes and punishing gender nonconformity.

One commenter supporting the proposed policy stated it would not violate nondiscrimination requirements in the ACA or other applicable Federal nondiscrimination laws, because such laws do not support claims that exclusions for coverage of sex-trait modification are discriminatory.

Response: We disagree with comments questioning HHS's legal authority to make these policy changes. Section 1557 of the ACA prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs or activities. We disagree that the policy in the proposed rule, and as revised in this final rule, constitutes sex discrimination in violation of section 1557 of the ACA. On May 6, 2024, we finalized the Nondiscrimination in Health Programs and Activities final rule, issued in the **Federal Register** on May 6, 2024 (''2024 Section 1557 final rule'') (89 FR 37522), which expanded the definition of prohibited discrimination on the basis of sex to include, inter alia, discrimination on the basis of sex characteristics, including intersex traits, gender identity, and sex stereotypes. Several district courts stayed or preliminarily enjoined HHS from enforcing certain portions of the 2024 Section 1557 final rule—primarily those prohibiting discrimination on the basis of gender identity. *See Florida.* v. *Dep't of Health & Hum. Servs.,* 739 F. Supp. 3d 1091 (M.D. Fla. 2024); *Tennessee* v. *Becerra,* 739 F. Supp. 3d 467 (S.D. Miss. 2024); *Texas* v. *Becerra,* No. 6:24–CV–211–JDK, 2024 WL 4490621 (E.D. Tex. Aug. 30, 2024). Although the Secretary filed appeals in these cases, the United States Court of Appeals for the Fifth and Eleventh Circuits subsequently dismissed all appeals pursuant to motions filed after the change in administration, and HHS remains enjoined from enforcing the 2024 Section 1557 final rule's expanded interpretation of sex discrimination.[210] According to the reasoning in these cases, section 1557 of the ACA does not create an obligation to provide or extend coverage to specified sex-trait modification procedures.[211]

We also disagree that this policy would violate the ruling in *Bostock.* The Supreme Court's holding in *Bostock* applied to discriminatory employment decisions under Title VII of the Civil Rights Act of 1964. We reject the notion that *Bostock* would have any bearing on the prohibition of coverage of sex-trait modification as an EHB. Such an application would be outside the scope of the *Bostock* decision. As the United States District Court for the Southern District of Mississippi stated in the order granting a preliminary injunction on enforcement of the 2024 Section 1557 final rule, ''[T]he Court has found no basis for applying *Bostock*'s Title VII analysis to section 1557's incorporation of Title IX. HHS acted unreasonably when it relied on Bostock's analysis in order to conflate the phrase 'on the basis of sex' with the phrase 'on the basis of gender identity.' Specifically, the Bostock holding did not 'sweep beyond Title VII to other Federal or State laws that prohibit sex discrimination.' '' *See Tennessee* v. *Becerra,* 739 F. Supp. 3d 467, 482 (S.D. Miss. 2024). Further, the Supreme Court in *Bostock* made the intended limited application to Title VII claims clear when it stated, ''[N]one of these other [sex discrimination] laws are before us; we have not had the benefit of adversarial testing about the meaning of their terms, and we do not prejudge any such question today . . .'' *See Bostock,* 590 U.S. at 681, 140 S.Ct. 1731.

On June 18, 2025, the Supreme Court concluded that *Bostock* ''does not alter our analysis'' when they upheld a State ban on certain medical treatments for transgender minors.[212] In *Bostock,* the Supreme Court specifically ''held that an employer who fires an employee for being gay or transgender violates Title VII's prohibition on discharging an individual 'because of'' their sex'' after ''incorporat[ing] the traditional but-for causation standard'' to determine but-for cause.[213] Applying the *Bostock* reasoning to an example of a transgender boy who is restricted from receiving testosterone to treat gender dysphoria under the State law, the Supreme Court concluded ''neither his sex nor his transgender status is the but-for cause of his inability to obtain testosterone.'' [214] Consistent with this conclusion, neither an individual's sex nor transgender status is the but-for cause of their inability to obtain certain sex trait modification procedures as an EHB. Therefore, we likewise conclude the *Bostock* reasoning does not apply here.[215]

Comment: Commenters opposing the proposal also argued that it violates the authority granted to the Secretary to define EHB under section 1302 of the ACA because the proposal does not take into account health needs of diverse segments of the population. One commenter stated that because gender dysphoria is recognized by experts as a disability, this policy would be directly contrary to the plain language and intent of the ACA to provide patient protection and access to care. Some opposing commenters also claimed that the proposal conflicts with the EHB nondiscrimination standards at § 156.125 because the proposal creates discriminatory benefit designs that are not clinically based. Several commenters also stated that this proposal would violate § 156.125 because it discriminates on the basis of sex characteristics, which includes but is not limited to intersex traits, pregnancy or related conditions, sexual orientation, gender identity, and sex stereotypes, which is prohibited under § 156.125(b). Many commenters objecting to the proposal stated that prohibiting coverage as EHB for medical care for individuals with gender dysphoria, while expressly proposing to create exceptions to cover these same services for other indications, is discriminatory.

Many opposing commenters also expressed concern that the proposal is at odds with the State EHB benchmark approach at § 156.111 which relies on

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[210] In *Florida* v. *Department of Health and Human Services,* 739 F. Supp. 3d 1091 (M.D. Fla. 2024), the court stayed 45 CFR 92.101(a)(2)(iv), 92.206(b), 92.207(b)(3)–(5), and 42 CFR 438.3(d)(4), in Florida. OCR also may not enforce the interpretation of discrimination ''on the basis of sex'' in 45 CFR 92.101(a)(2)(iv), 92.206(b), or 92.207(b)(3)–(5) in Florida. In *Tennessee* v. *Becerra,* 739 F. Supp. 3d 467 (S.D. Miss. 2024), the court stayed nationwide the following regulations to the extent they ''extend discrimination on the basis of sex to include discrimination on the basis of gender identity'': 42 CFR 438.3, 438.206, 440.262, 460.98, 460.112; 45 CFR 92.5, 92.6, 92.7, 92.8, 92.9, 92.10, 92.101, 92.206–211, 92.301, 92.303, 92.304; and enjoined HHS from enforcing the 2024 Section 1557 final rule ''to the extent that the final rule provides that 'sex' discrimination encompasses gender identity.'' In *Texas* v. *Becerra,* No. 6:24–CV–211–JDK, 2024 WL 4490621 (E.D. Tex. Aug. 30, 2024), the court stayed nationwide the following regulations: 42 CFR 438.3(d)(4), 438.206(c)(2), 440.262, 460.98(b)(3), 460.112(a); 45 CFR 92.101(a)(2) (and all references to this subsection), 92.206(b), 92.207(b)(3)–(5).

[211] Office of Women's Health (2025, Feb. 19). Sex-Based Definitions. Dep't of Health and Human Services. Retrieved March 6, 2025, from *https://womenshealth.gov/article/sex-based-definitions.*

[212] *United States* v. *Skrmetti* et al., No. 23–477 slip op. at *18 (U.S. June 18, 2025).

[213] Ibid.

[214] Ibid. at *19.

[215] The Supreme Court declined to rule on whether the *Bostock* reasoning applies outside the context of Title VII because, under the State law at issue in the case, neither a person's sex nor their transgender status would be the but-for cause of their inability to obtain the services banned under the law. Ibid.

the States to address specific gaps in coverage affecting their populations. Some commenters also stated that the proposal exceeds the Secretary's EHB authority by imposing condition-based exclusions on health plans, providers, or enrollees. Many objecting commenters also stated it is unclear how § 156.110, which requires that an EHB-benchmark plan provide coverage for mental health and substance use disorder services, does not conflict with the removal of sex-trait modification as EHB, since care for gender dysphoria falls under the definition of mental health and substance use disorder services in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

Response: We disagree with commenters who stated that this policy violates EHB nondiscrimination rules at § 156.125. That regulation applies only to services that are covered as EHB under a plan. As finalized at § 156.115, specified sex-trait modification procedures will be prohibited from being covered as EHB. Therefore, the nondiscrimination requirements at § 156.125 will not apply to such procedures.

We also disagree with commenters who stated that this policy violates section 1302(b)(4)(C) of the ACA, which requires that in defining the EHB the Secretary take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups. Section 1302(b)(2)(A) of the ACA requires the Secretary to ensure that the scope of EHB be equal in scope to the benefits provided under a typical employer plan. We read these provisions together so that they do not conflict with one another. Therefore, although the Secretary must take into account the health care needs of diverse segments of the population, the Secretary must only do so insofar as it does not conflict with the requirement that the scope of the EHB be equal to the scope of the benefits provided under a typical employer plan. Because specified sex-trait modification procedures are not typically covered by employer plans, specified sex-trait modification procedures are not among the benefits the Secretary is required to consider under section 1302(b)(4)(C) of the ACA.

Similarly, we disagree with commenters that asserted that the proposed policy would violate the State benchmark-based approach. Although this approach provides States with flexibility in determining which benefits will be EHB in the State, such flexibility is not without limitations. States selecting EHB-benchmark plans must do so in accordance with § 156.111, which requires that the EHB-benchmark plan provide a scope of benefits equal to the scope of benefits provided under a typical employer plan. As explained, specified sex-trait modification procedures are not typically included in employer-sponsored plans. Therefore, this policy change aligns with the plain language and intent of section 1302 of the ACA.

We also disagree with commenters that the policy creates discriminatory circumstances under which individuals would be denied coverage of medical care for gender dysphoria as EHB, while others could receive the same services as EHB for other indications. This is not the case. We clarify that nothing in this rule prohibits issuers from providing coverage beyond the defined exceptions for specified sex-trait modification procedures as non-EHB.

We believe that the amendments we are finalizing to add a definition for specified sex-trait modification procedure at § 156.400 resolve commenters' concerns that an EHB-benchmark plan provide coverage for mental health and substance use disorder services, as the finalized definition at § 156.400 will permit non-pharmaceutical and non-surgical mental health and substance use disorder services to treat gender dysphoria to be covered as EHB.

Comment: Some commenters opposing the policy also argued that the proposal violates the Americans with Disabilities Act (ADA) and section 504 of the Rehabilitation Act. Commenters raising ADA concerns cited as support *Williams* v. *Kincaid,* 45 F.4th 759, 766–74 (4th Cir. 2022), which held that gender dysphoria is a covered disability for purposes of the ADA.

Response: We disagree with concerns that the policy violates the Americans with Disabilities Act or section 504 of the Rehabilitation Act; the final policy does not explicitly single out treatment for gender dysphoria or any particular medical condition for exclusion or prohibit any issuer's coverage of specified sex-trait modification procedures, but instead excludes specified sex-trait modification procedures from being covered as an EHB.

Comment: Many commenters opposing the proposal asserted that it violates the APA, with many of these commenters stating that the proposal is arbitrary and capricious because it fails to consider important facts, including the widespread coverage of sex-trait modification procedures by large employer-based health plans and the established clinical evidence that these services are medically necessary and considerably improve the lives and health outcomes for its recipients. Other commenters argued the proposal is an agency action that exceeds statutory authority in violation of the APA because the policy would discriminate on the basis of sex in violation of section 1557 of the ACA. Many commenters objecting to the proposal also stated that the proposal constitutes unlawful discrimination in violation of the Equal Protection Clause and several court opinions finding that medically unsupported exclusions of specific treatments for beneficiaries with gender dysphoria could constitute discrimination in violation of Federal law. Many opposing commenters raising Equal Protection Clause arguments noted that because they believe this policy discriminates against a protected class, the policy would trigger heightened scrutiny review, and stated that they believe HHS offers no legitimate justification showing that the proposal serves important governmental objectives or that the discriminatory means employed are substantially related to the achievement of those objectives. Such commenters argued that the justification provided—that sex-trait modification procedures are not typically included in employer-sponsored plans—lacks sufficient evidence or analysis and is readily disproven. These commenters also stated that the proposed rule suggested that part of the reasoning for the proposal is that the Secretary is concerned about the scientific integrity of claims made to support the use of sex-trait modification procedures in health care settings, but that the proposed rule did not cite any evidence to support this claim and, in failing to do so, cannot articulate a satisfactory explanation for its action.

One commenter supporting the proposal asserted that whether gender identity qualifies as a protected class under the Equal Protection Clause is not settled law. The commenter also argued that, even if it were a protected class, the proposed policy would not need to survive heightened constitutional scrutiny if reviewed by courts. As support, this commenter cited to the Supreme Court's decision in *Geduldig* v. *Aiello,* 417 U.S. 484 (1974), which found that ''[t]he regulation of a medical procedure'' specific to a protected class ''does not trigger heightened constitutional scrutiny'' absent ''invidious discrimination.'' This commenter also stated that the proposed policy lacks invidious discrimination

because the proposed change is required by law as most employer health plans do not cover sex-trait modifications.

Another commenter objecting to the proposal noted that the proposal conflicts with State law, because according to the commenter, half of all States have interpreted their State health laws to bar discrimination against people with gender dysphoria. Commenters objecting to the proposal also raised Federalism concerns, noting that the proposal goes against the premise that States determine the best way to enable and regulate health insurance within their borders. Commenters also raised concerns that the proposal contravenes section 1554 of the ACA, which prohibits the Secretary from promulgating a regulation that ''creates any unreasonable barriers to the ability of individuals to obtain appropriate medical care.'' One commenter explained it would violate section 1554 of the ACA because prohibiting coverage of sex-trait modification procedures as EHB in turn means removing important EHB protections for such services, such as requiring cost-sharing for EHBs to accrue towards the annual limitation on cost sharing and prohibitions on annual and lifetime dollar limits on EHBs.

Response: We disagree that the policy would violate the Equal Protection Clause, which provides that no State shall ''deny to any person within its jurisdiction the equal protection of the laws,'' because the policy applies equally to coverage for all persons, including both sexes. The policy also does not discriminate on the basis of transgender status, because it turns on the purpose and effect of the procedures at issue, not the status of the patient. Moreover, transgender persons do not exhibit ''obvious, immutable, or distinguishing characteristics that define them as a discrete group'' sufficient to make them a protected class under the Supreme Court's equal protection jurisprudence. *Bowen* v. *Gilliard,* 483 U.S. 587, 602 (1987). Additionally, on June 18, 2025, the Supreme Court upheld a State's ban on the provision of puberty blockers and hormones for minors to treat gender dysphoria, gender identity disorder, or gender incongruence for minors, concluding that the ban did not violate the Equal Protection Clause because the State only prohibited healthcare providers from administering puberty blockers or hormones to minors for certain medical uses, regardless of a minor's sex.[216] In any event, the policy would pass constitutional muster even under heightened equal protection scrutiny because it serves the important governmental interest of complying with the law governing the scope of EHBs under the ACA and is substantially related to achievement of that objective. The Department also agrees that the law is far from settled with regard to whether persons diagnosed with gender dysphoria or other identity-related conditions fit within the class of persons protected from discrimination under the Equal Protection Clause.

In response to comments arguing this policy violates conflicting State laws, we note that the policy we are finalizing does not prohibit health plans from voluntarily covering specified sex-trait modification procedures as non-EHB consistent with applicable State law, nor does it prohibit States from requiring the coverage of specified sex-trait modification procedures, subject to the rules related to State-mandated benefits at § 155.170. Likewise, we disagree with commenters' assertions that this policy would violate section 1554 of the ACA which prohibits the Secretary from promulgating a regulation that ''creates any unreasonable barriers to the ability of individuals to obtain appropriate medical care,'' as the finalized policy only prohibits coverage for specified sex-trait modification procedures as EHB but otherwise permits such coverage to continue, so long as it is not EHB.

In response to comments suggesting that part of the reasoning for the proposal is that the Secretary is concerned about the scientific integrity of claims made to support the use of sex-trait modification procedures in health care settings but that the proposed rule did not cite any evidence to support this concern, we note that concern about the scientific integrity of claims made to support the use of specified sex-trait modification procedures in health care settings supports our rationale that specific sex-trait modification procedures are not typically covered under employer-sponsored plans. As we stated and reiterated in the proposed rule and earlier in this final rule, specified sex-trait modification procedures are not typically included in employer-sponsored plans, which is an independent, legally-sufficient basis for adoption of this policy.

For the reasons cited in a previous response to comments addressing section 1557 of the ACA, we disagree with commenters that the policy proposed in the proposed rule, and as revised in this final rule, exceeds statutory authority in violation of the APA because it constitutes sex discrimination in violation of section 1557 of the ACA. We refer readers to our discussion of section 1557 of the ACA in the respective response above.

Further, commenter concerns regarding Federalism or the APA are misguided. The ACA expressly authorizes and provides broad flexibility to the Secretary to define the EHB under section 1302 of the ACA. While the ACA outlines 10 general categories that EHBs must include, the Secretary has the authority to determine the specific services and items within those categories. As discussed elsewhere in this final rule, there is ample data suggesting that the specified sex-trait modification procedures, as defined in this rule, are not benefits covered under a typical employer plan. Therefore, we disagree that this policy, as finalized, is arbitrary and capricious and exceeds statutory authority in violation of the APA.

Comment: Many commenters opposing the proposal also stated that the proposal conflicts with the preliminary injunctions on the executive orders cited in support of the proposal in the proposed rule (E.O. 14168 and E.O. 14187). Some commenters objecting to the policy stated it is premature in light of ongoing litigation and urged CMS to postpone consideration of finalizing this policy until the various lawsuits enjoining application of the executive orders are resolved. Another opposing commenter stated that E.O. 14187 is limited to sex-trait modification procedures for minors, whereas the proposal applies more broadly to both minors and adults. Two commenters supportive of the proposal stated that they do not believe the existing injunctions on the executive orders should preclude finalizing this policy as proposed, with one commenter noting that the proposal does not rely on the enjoined executive orders but also arguing that the injunctions rely on incorrect legal reasoning. One commenter noted support for the proposal because they noted it protects the rights of employers and enrollees who object to covering services or paying premiums that violate their deeply held religious or moral beliefs.

[216] *See United States* v. *Skrmetti et al.,* No. 23–477 slip op. at *10 (U.S. June 18, 2025), available at *https://www.supremecourt.gov/opinions/24pdf/23-477_2cp3.pdf.*

Response: We agree with commenters supporting the proposed policy in spite of the injunctions on the executive orders. As we stated in the proposed rule (90 FR 12986), we made this proposal independently of the executive orders because specified sex-trait modification procedures are not typically included in employer health plans and therefore cannot legally be covered as EHB. We acknowledge that two courts have issued preliminary injunctions relating to the E.Os described above, and we do not rely on the enjoined sections of the executive orders in making this proposal. The finalized policy does not conflict with those preliminary injunctions because, among other things, it is based on independent legal authority and reasons and not the enjoined sections of the executive orders. Further, this policy as finalized will not be effective until PY 2026, and will not be implemented, made effective, or enforced in contravention of any court orders.[217]

Comment: Numerous commenters opposed the proposal on the basis that it would lead to adverse mental health outcomes and increase suicide risk, though commenters both for and against the proposal universally supported mental health treatment for gender dysphoria. Many commenters who did not support the proposal noted that medical evidence indicates lack of access to services for sex-trait modification procedures, and especially hormone therapy, will lead to an overall increase in suicidality and self-harm and create or exacerbate mental health conditions. Many commenters noted that people with gender dysphoria and other identity-related conditions experience higher rates of violence, discrimination, and harassment, which often compounds mental health symptoms. One commenter expressed concern that their treatment would be stopped midstream if the proposal were finalized, and that this would put them at continued risk of violence.

Numerous commenters opposing the proposal also argued that, due to discrimination and stigma, suicide rates are four times higher for individuals with gender dysphoria than the general population, with one commenter stating this rate is even higher among people of color with gender dysphoria. Commenters stated this proposal would result in the denial of medically necessary care that has proven associations with lowering suicidal ideation and that denial of this care would subsequently lead to worse mental health outcomes for persons with gender dysphoria, including higher rates of depression, anxiety, suicide, and suicidal ideation. These commenters cited to multiple studies demonstrating that access to sex-trait modification procedures is associated with lower odds in both children and adults of depression, self-harm, and suicidal thoughts compared to individuals not receiving these services. Commenters opposing the proposal noted particular concern with the mental health impact of this proposal on youth with gender dysphoria.

Commenters opposing the proposal also expressed concern that inability to access certain care as a result of the proposal would exacerbate other conditions. One commenter opposing the proposal stated this would be particularly true for health care services that require risk assessment or consistent engagement with a provider. For example, this commenter noted that receiving a prescription for hormone therapy for sex-trait modification is associated with lower rates of acquiring HIV and increased rates of HIV viral suppression among patients with gender dysphoria and that limiting access to sex-trait modification services for Exchange enrollees will only exacerbate the HIV epidemic given the disproportionate impact of HIV among individuals with gender dysphoria. Other commenters opposing the proposal noted specific concerns regarding increased substance use in the absence of access to sex-trait modification procedures, as substance use may be used as a coping mechanism.

One commenter that supported the proposal stated that although deaths by suicide are higher than average among the population of persons with gender dysphoria there is no evidence supporting the claim that sex-trait modification procedures reduce this risk. One commenter supporting the proposal stated that there is no scientifically valid evidence that suicide risk among persons with gender dysphoria increases in the absence of sex-trait modification and that puberty blockers are associated with depression. This commenter stated that transition may exacerbate psychological distress, which could lead to suicide, and that persons with gender dysphoria would benefit from mental health services shown to be useful in treating other body dysphoria disorders such as anorexia nervosa, as well as counseling or other treatment for depression and anxiety.

Response: The Department agrees with commenters that mental health services are a critical part of treating gender dysphoria, and we are committed to improving the quality of, and access to, mental health care services.[218] As discussed earlier in this final rule, mental health services will continue to be covered as an EHB as required by section 1302(b)(1)(E) of the ACA, including for those who seek or undergo specified sex-trait modification procedures or are diagnosed with gender dysphoria. We note that the definition of ''specified sex-trait modification procedure'' we adopt in this rule places no prohibition on coverage of mental health services as EHB. Specifically, the definition neither prohibits coverage for mental health treatment for specific conditions as EHB (for example, for mental health treatment for gender dysphoria), nor prohibits coverage for mental health treatment for any specific populations as EHB (for example, mental health treatment for consumers with gender dysphoria).

Comment: Several commenters opposing the proposal also raised concerns that the proposal would conflict with the Mental Health Parity and Addiction Equity Act (MHPAEA). One such commenter stated that the prohibition of coverage for sex-trait modification is contrary to the MHPAEA prohibition on group health plans and health insurance issuers from imposing less favorable benefit limitations on mental health and substance abuse benefits as compared to medical/surgical benefits, as gender dysphoria is a mental health condition defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM–5–TR) as a serious medical condition characterized by distress due to incongruence between the patient's gender identity (that is, the innate sense of one's own gender) and sex. These commenters noted concern that complying with this proposal would put group health plans and issuers out of compliance with MHPAEA.

Response: On May 15, 2025, the Departments of Labor, HHS, and the Treasury (the Departments) announced that the Departments will not enforce the September 23, 2024 final rule ''Requirements Related to the Mental Health Parity and Addiction Equity Act,'' 89 FR 77586 (2024 MHPAEA Final Rule) or otherwise pursue enforcement actions based on a failure

[217] HHS intends to notify the courts in both cases about this Rule after it has been published in the **Federal Register**.

[218] Behavioral Health, CTRS. FOR MEDICARE & MEDICAID SERVS., *https://www.cms.gov/about-cms/what-we-do/behavioral-health* (last visited May 13, 2025).

to comply with the 2024 MHPAEA Final Rule that occur prior to a final decision in ongoing litigation regarding the 2024 MHPAEA Final Rule, plus an additional 18 months.[219] The Departments also announced their intention to reconsider the 2024 MHPAEA Final Rule, including whether to issue a notice of proposed rulemaking rescinding or modifying the regulation through notice and comment rulemaking. Further, the Departments announced that they will undertake a broader reexamination of each Department's respective enforcement approach under MHPAEA. Nothing in this final rule prevents a plan or issuer from providing benefits for treatment for gender dysphoria; the benefits simply would not be considered EHB if they fall under the definition of specified sex-trait modification procedures we are finalizing at § 156.400. Additionally, we reiterate that the definition of ''specified sex-trait modification procedure'' neither prohibits coverage for mental health treatment for specific conditions as EHB (for example, for mental health treatment for gender dysphoria), nor prohibits coverage for mental health treatment for any specific populations as EHB (for example, mental health treatment for consumers with gender dysphoria).

Comment: Many commenters objected to the proposal in general or did not state a basis for the objection. Some commenters stated that the proposal is motivated by animus against transgender-identified people and intended to cause harm to a specific group of people and others stated that the proposal would target individuals already at significantly higher risk for negative health and mental health outcomes. Some commenters stated they believed that the proposal is contrary to HHS' role in protecting the vulnerable, the Make America Healthy Again movement, and pro-life beliefs given the increased risk of suicide among persons with gender dysphoria. Other commenters opined that the proposal creates a double standard through which persons without gender dysphoria may continue to receive sex-trait modification services as EHB but persons with gender dysphoria cannot. Several commenters opined that a prohibition on coverage of sex-trait modification services as EHB is tantamount to eugenics or genocide and a crime against humanity. Other commenters stated that if the proposed rule were finalized as proposed, it would have downstream psychological effects on the friends and family of persons with gender dysphoria who had been seeking sex-trait modification services. Some comments were out of the scope of this rule.

Response: We share commenters' concern for vulnerable groups and individuals. However, we disagree with commenters that prohibiting coverage of specified sex-trait modification procedures as EHB is discriminatory or will be damaging to the health and wellbeing of the nation. Specifically, we disagree with commenters that finalization of the proposal would mean persons without gender dysphoria will have access to specified sex-trait modification procedures while persons with gender dysphoria will not. All people will be able to access covered items and services as EHB, so long as the items and services do not meet the definition of ''specified sex-trait modification procedures,'' in that they are not, in a given instance, surgical or pharmaceutical interventions being 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, or they otherwise fall within an exception. Additionally, we emphasize that we are not prohibiting any consumers from accessing specified sex-trait modification procedures when paid for out of pocket, or prohibiting issuers on the Exchanges from providing coverage for such services as non-EHB. We are only prohibiting the coverage of specified sex-trait modification procedures specifically as EHB, given that they are not within the scope of benefits provided by a typical employer plan, as directed in statute.

2. Premium Adjustment Percentage (§ 156.130(e))

In the 2025 Marketplace Integrity and Affordability proposed rule (90 FR 12987 through 12995), we proposed to update the premium adjustment percentage methodology to establish a premium growth measure that captures premium changes in the individual market in addition to ESI premiums for PY 2026 and beyond. In addition, based on this proposed updated methodology, we proposed values for the PY 2026 premium adjustment percentage, maximum annual limitation on cost sharing, reduced maximum annual limitations on cost sharing, and required contribution percentage.

Section 1302(c)(4) of the ACA directs the Secretary to determine an annual premium adjustment percentage, the measure of premium growth that is used to set the rate of increase for the following three parameters: (1) the maximum annual limitation on cost sharing (defined at § 156.130(a)); (2) the required contribution percentage used to determine eligibility for certain exemptions under section 5000A of the Code (defined at § 155.605(d)(2)(iii)); and (3) the employer shared responsibility payment amounts under section 4980H(a) and (b) of the Code (see section 4980H(c)(5) of the Code). Section 1302(c)(4) of the ACA and § 156.130(e) provide that the premium adjustment percentage is the percentage (if any) by which the average per capita premium for health insurance coverage for the preceding calendar year exceeds such average per capita premium for health insurance for 2013.

The 2015 Payment Notice (79 FR 13744) and 2015 Market Standards Rule (79 FR 30240) established a methodology for estimating the average per capita premium for purposes of calculating the premium adjustment percentage for PY 2015 and beyond. Beginning with PY 2015, the premium adjustment percentage was calculated based on the estimates and projections of average per enrollee ESI premiums from the NHEA, which are calculated by the CMS Office of the Actuary. In the 2015 Payment Notice proposed rule (78 FR 72359 through 72361), we proposed that the premium adjustment percentage be calculated based on the projections of average per enrollee private health insurance premiums from the NHEA. Based on comments received, we finalized in the 2015 Payment Notice (79 FR 13801 through 13804) use of per enrollee ESI premiums from the NHEA in the premium adjustment percentage methodology. We finalized use of per enrollee ESI premiums because these premiums reflected trends in health care costs without being skewed by individual market premium fluctuations resulting from the early years of implementation of the ACA market rules. However, recognizing that ESI premiums did not comprehensively reflect premiums for the entire market, we noted in the 2015 Payment Notice (79 FR 13801 through 13804) that we may change our methodology after the initial years of implementation of the market rules, once the premium trend is more stable.

In the 2020 Payment Notice proposed rule (84 FR 285 through 289), we noted that we believed the premium trend in the individual market had stabilized and, therefore, proposed to change the

[219] Statement of U.S. Departments of Labor, Health and Human Services, and the Treasury regarding enforcement of the final rule on requirements related to the Mental Health Parity and Addiction Equity Act, May 15, 2025, available at *https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-parity/statement-regarding-enforcement-of-the-final-rule-on-requirements-related-to-mhpaea.*

premium adjustment percentage methodology to comprehensively reflect premium changes across all affected markets as we had suggested in the 2015 Payment Notice (79 FR 13801 through 13804). As such, in the 2020 Payment Notice (84 FR 17537 through 17541), we finalized the use of per enrollee private health insurance premiums from the NHEA (excluding Medigap and property and casualty insurance) in the premium adjustment percentage calculation.

In the 2022 Payment Notice proposed rule (85 FR 78633 through 78635), we proposed a premium adjustment percentage using the methodology adopted in the 2020 Payment Notice (84 FR 17537 through 17541). In addition, we proposed to amend § 156.130(e) to, beginning with PY 2023, set the premium adjustment percentage in guidance separate from the annual notice of benefit and payment parameters, unless we were to propose a change to the methodology for calculating the parameters, in which case, we would do so through notice-and-comment rulemaking. We finalized this latter proposal (the amendment to § 156.130(e)) in part 2 of the 2022 Payment Notice (86 FR 24237 through 24238). Although we did not propose to change the methodology for calculating the premium adjustment percentage in the 2022 Payment Notice proposed rule (85 FR 78633 through 78635), we finalized a new methodology in part 2 of the 2022 Payment Notice (86 FR 24233 through 24237) that readopted the measure of premium growth for PY 2022 and beyond using the NHEA projections of average per enrollee ESI premium in response to comments requesting that we revert to the use of the NHEA ESI premium measure to estimate premium growth, which was the methodology used for PY 2015 through PY 2019. We finalized this change after concluding it was consistent with the will and interest of interested parties and would mitigate the uncertainty regarding premium growth during the COVID–19 PHE.

Because the COVID–19 PHE has ended and should no longer impact the premium adjustment percentage, and because evidence described in the proposed rule now suggests that the COVID–19 PHE did not impact premiums as we anticipated in part 2 of the 2022 Payment Notice (86 FR 24233 through 24237), in the proposed rule (90 FR 12987 through 12993), we proposed to revert to the methodology for calculating the premium adjustment percentage that we established in the 2020 Payment Notice (84 FR 17537 through 17541). Specifically, we proposed to calculate the premium adjustment percentage for PY 2026 and beyond using an adjusted private individual and group market health insurance premium measure, which is similar to NHEA's private health insurance premium measure.[220] NHEA's private health insurance premium measure includes premiums for ESI, ''direct purchase insurance,'' which includes individual market health insurance purchased directly by consumers from health insurance issuers, both on and off the Exchanges, Medigap insurance, and the medical portion of accident insurance (''property and casualty'' insurance). The measure we proposed to use includes NHEA estimates and projections of ESI and direct purchase insurance premiums but would exclude premiums for Medigap and property and casualty insurance (we refer to the proposed measure as ''private health insurance (excluding Medigap and property and casualty insurance),'') consistent with the approach finalized in the 2020 Payment Notice (84 FR 17537 through 17541).

We proposed to exclude Medigap and property and casualty insurance from the premium measure since these types of coverage are not considered primary medical coverage for individuals who elect to enroll.[221] For example, Medigap coverage supplements Original Medicare [222] coverage by helping to pay certain out-of-pocket costs not covered by Original Medicare such as co-payments, coinsurance, and deductibles. Specifically, we stated in the proposed rule that to calculate the premium adjustment percentage for PY 2026, the measures for 2013 and 2025 would be calculated as private health insurance premiums minus premiums paid for Medigap insurance and property and casualty insurance, divided by the unrounded number of unique private health insurance enrollees with comprehensive coverage (that is, excluding supplemental coverage such as Medigap and property and casualty insurance from the count of enrollees in the denominator). We stated that these results would then be rounded to the nearest $1 followed by a division of the 2025 figure by the 2013 figure rounded to 10 significant digits. We explained that the proposed premium measure would reflect cumulative, historic growth in premiums for private health insurance markets (excluding Medigap and property and casualty insurance) from 2013 onwards.

In addition to the proposal to use the private health insurance premium measure data (excluding Medigap and property and casualty insurance) to measure premium growth for the PY 2026 and beyond, in the proposed rule (90 FR 12991 through 12992), we also proposed the premium adjustment percentage value for PY 2026. Specifically, we proposed that the premium adjustment percentage for PY 2026 be the percentage (if any) by which the most recent NHEA projection of per enrollee premiums for private health insurance (excluding Medigap and property and casualty insurance) for 2025 ($7,885) exceeds the most recent NHEA estimate of per enrollee premiums for private health insurance (excluding Medigap and property and casualty insurance) for 2013 ($4,714).[223] Using this formula, in the proposed rule (90 FR 12992), we proposed a premium adjustment percentage for 2026 of 1.6726771319 ($7,885/$4,714). We stated in the proposed rule that this would represent an increase in private health insurance premiums (excluding Medigap and property and casualty insurance) of approximately 67.3 percent over the period from 2013 to 2025 and would reflect an overall growth rate for this period that is approximately 7.2 percentage points higher than the overall growth rate reflected by the previously published

[220] *See* Table 17 of the ''NHE Projections—Tables (ZIP)'' link available at *https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/projected.*

[221] Section 1302(c)(4) of the ACA refers to ''the average per capita premium for health insurance coverage in the United States.'' The term ''health insurance coverage'' is defined in 42 U.S.C. 300gg–91(b)(1) as ''benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer.''

[222] Original Medicare includes Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) and covers services such as inpatient hospital care, outpatient services and office visits, tests, and preventive services. *See,* for example, CMS. (n.d.). What Original Medicare Covers. *https://www.medicare.gov/providers-services/original-medicare.*

[223] The 2013 and 2025 premiums used for this calculation reflect the latest NHEA data. The series used in the determinations of the adjustment percentages can be found in Tables 1 and 17 on the CMS website, which can be accessed by clicking the ''NHE Projections 2023–2032—Tables'' link located in the Downloads section at *https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/projected.* A detailed description of the NHE projection methodology is available at CMS. (2024, June 12). Projections of National Health Expenditures and Health Insurance Enrollment: Methodology and Model Specification. *https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/downloads/projectionsmethodology.pdf.*

PY 2026 premium adjustment percentage (1.6002042901).[224]

We refer readers to the proposed rule (90 FR 12987 through 12997) for a more detailed discussion of our proposed methodology, including further information regarding the background, rationale, and expected impacts of this proposal.

Based on the proposed PY 2026 premium adjustment percentage, we proposed the cost-sharing parameters for PY 2026, including the maximum annual limitation on cost sharing, the reduced maximum annual limitations on cost sharing, and the required contribution percentage as further described in the following subsections.

a. Maximum Annual Limitation on Cost Sharing for PY 2026

Under § 156.130(a)(2)(i), for PY 2026, cost sharing for self-only coverage may not exceed the dollar limit for calendar year 2014 increased by an amount equal to the product of that amount and the premium adjustment percentage for PY 2026. Under § 156.130(a)(2)(ii), for other than self-only coverage, the limit is twice the dollar limit for self-only coverage. Under § 156.130(d), these amounts must be rounded down to the next lowest multiple of $50. Using the proposed premium adjustment percentage of 1.6726771319 for PY 2026, and the 2014 maximum annual limitation on cost sharing of $6,350 for self-only coverage, which was published by the IRS on May 2, 2013,[225] in the proposed rule (90 FR 12993), we proposed that the PY 2026 maximum annual limitation on cost sharing would be $10,600 for self-only coverage and $21,200 for other than self-only coverage. We stated in the proposed rule that this represents approximately a 15.2 percent increase from the PY 2025 parameters of $9,200 for self-only coverage and $18,400 for other than self-only coverage, and approximately a 4.4 percent increase from the previously published PY 2026 parameters of $10,150 for self-only coverage and $20,300 for other than self-only coverage.[226]

b. Reduced Maximum Annual Limitation on Cost Sharing for PY 2026

The reduced maximum annual limitations on cost sharing for cost-sharing plan variations are determined using the methodology we established in the 2014 Payment Notice (78 FR 15410). In the 2014 Payment Notice, we established standards related to the provision of these cost-sharing reductions (CSRs). Specifically, in 45 CFR part 156, subpart E, we specified that QHP issuers must provide CSRs by developing plan variations, which are separate cost-sharing structures for each eligibility category that change how the cost sharing required under the QHP is to be shared between the enrollee and the Federal Government.[227] At § 156.420(a), we detailed the structure of these plan variations and specified that QHP issuers must ensure that each silver plan variation has an annual limitation on cost sharing no greater than the applicable reduced maximum annual limitation on cost sharing specified in the annual HHS guidance or HHS notice of benefit and payment parameters. We noted in the proposed rule (90 FR 12993) that although the amount of the reduction in the maximum annual limitation on cost sharing is specified in section 1402(c)(1)(A) of the ACA, section 1402(c)(1)(B)(ii) of the ACA states that the Secretary may adjust the cost sharing limits to ensure that the resulting limits do not cause the AV of the health plans to exceed the levels specified in section 1402(c)(1)(B)(i) of the ACA (that is, 70 percent, 73 percent, 87 percent, or 94 percent, depending on the income of the enrollee).

As indicated in Table 8 of the proposed rule (90 FR 12994), we proposed the values of the PY 2026 reduced maximum annual limitation on cost sharing for self-only coverage at $3,500 for enrollees with household income greater than or equal to 100 percent of the FPL and less than or equal to 150 percent of the FPL, $3,500 for enrollees with household income greater than 150 percent of the FPL and less than or equal to 200 percent of the FPL, and $8,450 for enrollees with household income greater than 200 and less than or equal to 250 percent of the FPL, as calculated using the proposed PY 2026 premium adjustment percentage and proposed PY 2026 maximum annual limitation on cost sharing. We stated that these proposed values reflect 4.3 to 4.5 percent increases relative to the previously published PY 2026 parameters.[228]

We refer readers to the proposed rule (90 FR 12993 through 12995) for a more detailed discussion of the proposed values of the PY 2026 reduced maximum annual limitation on cost sharing, including further information regarding the background, rationale, and expected impacts of these proposed values. Table 5 outlines the final values for the PY 2026 reduced maximum annual limitation on cost sharing, as calculated using the final PY 2026 premium adjustment percentage and final PY 2026 maximum annual limitation on cost sharing.

TABLE 5—FINAL REDUCTIONS IN MAXIMUM ANNUAL LIMITATION ON COST SHARING FOR PY 2026

Eligibility category	Reduced maximum annual limitation on cost sharing for self-only coverage for BY 2026	Reduced maximum annual limitation on cost sharing for other than self-only coverage for BY 2026
Silver 94% AV CSR Plan Variant:* Individuals eligible for CSRs under § 155.305(g)(2)(i) (household income greater than or equal to 100 and less than or equal to 150 percent of the FPL)	$3,500	$7,000

[224] *See* CMS. (2024, Oct. 8). Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing, Reduced Maximum Annual Limitation on Cost Sharing, and Required Contribution Percentage for the 2026 Benefit Year. *https://www.cms.gov/files/document/2026-papi-parameters-guidance-2024-10-08.pdf.*

[225] *See* IRS. (n.d.) Rev. Proc. 2013–25. Dep't of Treasury. *http://www.irs.gov/pub/irs-drop/rp-13-25.pdf.*

[226] CMS. (2024, Oct. 8). Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing, Reduced Maximum Annual Limitation on Cost Sharing, and Required Contribution Percentage for the 2026 Benefit Year. *https://www.cms.gov/files/document/2026-papi-parameters-guidance-2024-10-08.pdf.*

[227] On October 12, 2017, the Attorney General issued a legal opinion that HHS did not have a Congressional appropriation with which to make CSR payments. Sessions III, J. (2017, Oct. 11). Legal Opinion Re: Payments to Issuers for Cost-Sharing Reductions (CSRs). Office of Attorney General. *https://www.hhs.gov/sites/default/files/csr-payment-memo.pdf.*

[228] *See* CMS. (2024, Oct. 8). Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing, Reduced Maximum Annual Limitation on Cost Sharing, and Required Contribution Percentage for the 2026 Benefit Year. *https://www.cms.gov/files/document/2026-papi-parameters-guidance-2024-10-08.pdf.*

TABLE 5—FINAL REDUCTIONS IN MAXIMUM ANNUAL LIMITATION ON COST SHARING FOR PY 2026—Continued

Eligibility category	Reduced maximum annual limitation on cost sharing for self-only coverage for BY 2026	Reduced maximum annual limitation on cost sharing for other than self-only coverage for BY 2026
*Silver 87% AV * CSR Plan Variant:* Individuals eligible for CSRs under § 155.305(g)(2)(ii) (household income greater than 150 and less than or equal to 200 percent of the FPL)	3,500	7,000
*Silver 73% AV * CSR Plan Variant:* Individuals eligible for CSRs under § 155.305(g)(2)(iii) (household income greater than 200 and less than or equal to 250 percent of the FPL)	8,450	16,900

* Under section 1402(d) of the ACA, American Indian/Alaska Native (AI/AN) enrollees with incomes under 300 percent of the FPL are eligible for Zero Cost Sharing plan variants. Additionally, all AI/AN QHP enrollees are eligible for no cost sharing for items and services provided by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services. Under § 155.305(g)(1)(ii), all other enrollees must be enrolled in a silver plan variant to be eligible for CSRs.

c. Required Contribution Percentage at § 155.605(d)(2) for PY 2026

We calculate the required contribution percentage for each plan year using the most recent projections and estimates of premium growth and income growth over the period from 2013 to the preceding calendar year (that is, the 2025 calendar year, in the case of PY 2026 required contribution percentage). Accordingly, in the proposed rule (90 FR 12995), we proposed the required contribution percentage for PY 2026, calculated using income and premium growth data for the 2013 and 2025 calendar years.

Section 5000A of the Code imposes an individual shared responsibility payment on non-exempt individuals who do not have MEC for each month. Under § 155.605(d)(2), an individual is allowed a coverage exemption (the affordability exemption) for months in which the amount the individual would pay for MEC exceeds a percentage, called the required contribution percentage, of the individual's household income. Although the Tax Cuts and Jobs Act [229] reduced the individual shared responsibility payment to $0 for months beginning after December 31, 2018, the required contribution percentage is still used to determine whether individuals ages 30 and above qualify for an affordability exemption that would enable them to enroll in catastrophic coverage under § 155.305(h).

The initial 2014 required contribution percentage under section 5000A of the Code was 8 percent. For plan years after 2014, section 5000A(e)(1)(D) of the Code and Treasury regulations at 26 CFR 1.5000A–3(e)(2)(ii) provide that the required contribution percentage is the percentage determined by the Secretary that reflects the excess of the rate of premium growth between the preceding calendar year and 2013, over the rate of income growth for that period.

As the measure of income growth for a calendar year, we established in the 2017 Payment Notice (81 FR 12281 through 12282) that we would use NHEA projections of per capita personal income (PI). The rate of income growth for PY 2026 is the percentage (if any) by which the NHEA Projections 2023–2032 value for per capita PI for the preceding calendar year ($74,083 for 2025) exceeds the NHEA Projections 2023–2032 value for per capita PI for 2013 ($44,559), carried out to ten significant digits. The rate of income growth from 2013 to 2025 is therefore 1.6625821944 ($74,083/$44,559). Using the proposed PY 2026 premium adjustment percentage, we stated in the proposed rule (90 FR 12995) that the excess of the rate of premium growth over the rate of income growth for 2013 to 2025 would be 1.6726771319 ÷ 1.6625821944, or 1.0060718427. We determined that this results in the proposed PY 2026 required contribution percentage under section 5000A of the Code of 8.00 × 1.0060718427 or 8.05 percent, when rounded to the nearest one-hundredth of 1 percent, an increase of approximately 0.77 percentage points above the 2025 value (7.28 percent) and an increase of approximately 0.35 percentage points above the previously published PY 2026 value [230] (7.70 percent).

We noted that these proposals do not alter the policy established in the 2022 Payment Notice (86 FR 24237 through 24238) that we will publish the premium adjustment percentage, along with the maximum annual limitation on cost sharing, the reduced maximum annual limitation on cost sharing, and the required contribution percentage, in guidance by January of the year preceding the applicable plan year, unless we are amending the methodology to calculate these parameters, in which case we would amend the methodology and publish the parameters through notice-and-comment rulemaking.

We stated in the proposed rule that if finalized as proposed, the values for the PY 2026 premium adjustment percentage, maximum annual limitation on cost sharing, reduced maximum annual limitations on cost sharing, and required contribution percentage proposed in the proposed rule would supersede the values published in the October 2024 PAPI Guidance.[231]

We sought comment on the proposal to revert to the premium adjustment percentage methodology finalized in the 2020 Payment Notice (84 FR 17537 through 17541) using private health insurance premiums (excluding Medigap and property and casualty insurance premiums) to estimate the growth in premiums for PY 2026 and beyond. We also sought comment on the resulting proposed values for the PY 2026 premium adjustment percentage, maximum annual limitation on cost sharing, reduced maximum annual limitations on cost sharing, and required contribution percentage.

After consideration of comments and for the reasons outlined in the proposed rule and this final rule, including our responses to comments, we are finalizing the use of private health insurance premiums (excluding Medigap and property and casualty insurance premiums) to estimate the growth in premiums for PY 2026 and beyond. We are also finalizing the values for the PY 2026 premium adjustment percentage, maximum annual limitation on cost sharing, reduced maximum annual limitations

[229] Public Law 115–97, 131 Stat, 2054.

[230] *See* CMS. (2024, Oct. 8). Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing, Reduced Maximum Annual Limitation on Cost Sharing, and Required Contribution Percentage for the 2026 Benefit Year. *https://www.cms.gov/files/document/2026-papi-parameters-guidance-2024-10-08.pdf*.

[231] Ibid.

on cost sharing, and required contribution percentage as proposed. Table 6 provides the final premium adjustment percentage index and related payment parameters for PY 2026:

TABLE 6—FINAL PREMIUM ADJUSTMENT PERCENTAGE INDEX AND RELATED PAYMENT PARAMETERS FOR THE PY 2026

Area	Metric	Value
Premium Adjustment Percentage	NHEA Projections 2023–2032 value [a] for per enrollee Private Health Insurance premiums (excluding Medigap and property and casualty insurance) for 2013.	$4,714
	NHEA Projections 2023–2032 value [a] for per enrollee Private Health Insurance premiums (excluding Medigap and property and casualty insurance) for 2025.	$7,885
	2026 Premium Adjustment Percentage	1.6726771319
Required Contribution	NHEA Projections 2023–2032 value [(a)] for of per capita personal income for 2013	$44,559
	NHEA Projections 2023–2032 value [(a)] for of per capita personal income for 2025	$74,083
	Income Growth	1.6625821944
	Premium Growth over Income Growth Index	1.0060718427
	2026 Required Contribution Percentage	8.05%
Maximum Annual Limitation on Cost Sharing—Self Only [b].	2026 Maximum Annual Limitation on Cost Sharing	$10,600
	2026 Reduced Maximum Annual Limitation on Cost Sharing—household income greater than or equal to 100 percent and less than or equal to 150 percent of the FPL.	$3,500
	2026 Reduced Maximum Annual Limitation on Cost Sharing—household income greater than 150 percent and less than or equal to 200 percent of the FPL.	$3,500
	2026 Reduced Maximum Annual Limitation on Cost Sharing—household income greater than 200 percent and less than or equal to 250 percent of the FPL.	$8,450

[a] For the calculation of the PY 2026 premium adjustment percentage, maximum annual limitation on cost sharing, reduced maximum annual limitation on cost sharing, and required contribution percentage, we are using the NHEA Projections 2023–2032 (published June 12, 2024), which were the most recent projections that had been released as of the publication of the proposed rule.[232]

[b] The maximum annual limitation on cost sharing and reduced maximum annual limitations on cost sharing for other than self-only coverage is twice the dollar limit for self-only coverage. *See* 45 CFR 156.130(a)(2)(ii). For example, for the PY 2026, the maximum annual limitation on cost sharing for other than self-only coverage is $21,200.

We summarize and respond below to public comments received on the proposed premium adjustment percentage methodology for the 2026 benefit year and beyond and the resulting proposed values for the PY 2026 premium adjustment percentage, maximum annual limitation on cost sharing, reduced maximum annual limitations on cost sharing, and required contribution percentage.

Comment: A few commenters supported the proposed change to the premium adjustment percentage methodology, stating that the proposed methodology would better align with the plain language of section 1302(c)(4) of the ACA, which directs the Secretary to determine the premium adjustment percentage for any calendar year based on the ''average per capita premium for health insurance in the United States.'' [233] These commenters also noted that basing the premium adjustment percentage on a more comprehensive measure of premiums in the market would provide issuers with more flexibility to design innovative plans that better meet consumer needs.

However, many other commenters expressed opposition to or concerns about the proposed change to the premium adjustment percentage methodology and the related proposed PY 2026 parameters. Many of these commenters indicated HHS should continue to use the current measure, ESI premiums, to measure premium growth because ESI premiums presently result in a lower premium adjustment percentage, maximum annual limitation on cost sharing, and reduced annual limitations on cost sharing than the proposed values using all private health insurance premiums (excluding Medigap and property and casualty insurance).

Additionally, several of these commenters noted that, because the IRS has historically adopted the same measure of premium growth as HHS for indexing under Section 36B(b) and (c) of the Code, the proposed change to the premium adjustment percentage methodology will likely impact the coverage ''affordability'' percentages that IRS releases annually, which are used by applicable employers to determine the affordability of their offers of coverage for purposes of the employer shared responsibility provisions, resulting in increased net premiums for enrollees who receive health insurance coverage through their employers.

Many commenters also expressed concerns about the impact of the proposal on the health insurance market and individuals and families, citing HHS' estimates of the impacts in the Regulatory Impact Analysis section of the proposed rule, including a decrease in enrollment and increase in net premiums, under the assumption that the IRS will adopt HHS' premium indexing methodology for the applicable percentage table, as it has historically done.

Among commenters who expressed concern that the increase in net premiums would lead to a decrease in health insurance enrollment, a few commenters noted that an increase in individuals without health insurance coverage would also lead to an increase in medical debt. Furthermore, many commenters expressed concerns about the impact of the higher proposed premium adjustment percentage on the maximum annual limitation on cost sharing and reduced maximum annual limitations on cost sharing, which they noted would increase out-of-pocket costs for consumers. Many of these commenters expressed concerns that the increased limits on cost sharing would disproportionately impact older enrollees, individuals with chronic health conditions, and other individuals who have a higher likelihood of incurring high medical costs. These commenters expressed concerns that the higher costs would lead to these enrollees choosing to forgo care to manage their conditions, leading to

[232] In the 2021 Payment Notice (85 FR 29228), we finalized a policy that we would calculate final payment parameters that depend on NHEA data based on the data that are available as of the publication of the proposed rule for that benefit year to increase the predictability of benefit design.

[233] *See* Section 1302(c)(4) of the ACA.

higher rates of complications and lower levels of overall health in the population. A few of these commenters noted that many people with chronic or serious health conditions have non-covered or out-of-network costs that are not subject to their plans' annual limitation on cost sharing and that the increase in the maximum annual limitation on cost sharing would compound the financial burden of these enrollees.

Several commenters also noted that the increase in net premiums is likely to have a disproportionate impact on enrollment in rural and low-income communities. Many of these commenters expressed concern that hospitals, community health clinics, and other providers that serve these low-income communities would see an increase in patients without insurance or who cannot afford the out-of-pocket costs of care, causing providers to be unable to cover their expenses and to close, increasing burdens on the health system and decreasing health care access. Additionally, several commenters expressed concern that the impact of the increase in net premiums would be further compounded when the expanded PTC subsidies made available under the American Rescue Plan Act of 2021 (ARPA) (and extended under the Inflation Reduction Act of 2022 (IRA) until the end of 2025) expire. One commenter requested more detailed modelling of the impact of the proposed change to the premium adjustment percentage methodology before implementation, stating that projections of the impacts on various income and demographic groups are necessary to ensure that interested parties can offer thoroughly informed feedback.

Regarding the impact on low-income consumers, some commenters stated the justification provided by HHS for this proposed change is inadequate and contrary to the legislative intent of the financial assistance structure of the ACA. A few commenters noted that the primary purpose of providing PTC to Exchange enrollees is so the Federal Government, rather than low-income individuals and families, bears the burden of any premium increases in the individual market.

Additionally, several commenters expressed concern that healthier enrollees are more likely to choose not to enroll in health insurance plans in response to higher net premiums than sicker enrollees, therefore increasing the average risk in the risk pool, prompting issuers to increase premiums across the entire risk pool.

Response: We appreciate the comments in support of the proposed change to the premium adjustment percentage methodology and are finalizing the change, as proposed, to use per enrollee private health insurance premiums (excluding Medigap and property and casualty insurance) as the premium growth measure for purposes of calculating the premium adjustment percentage because we agree that this approach allows us to better achieve the statutory and regulatory goals of adopting a more comprehensive and accurate measure of premium costs across the private health insurance market. Specifically, section 1302(c)(4) of the ACA and § 156.130(e) provide that the premium adjustment percentage is the percentage (if any) by which the average per capita premium for health insurance coverage for the preceding calendar year exceeds such average per capita premium for health insurance for 2013. As the purpose of this index is to measure growth in premiums, we believe it is appropriate to use a premium measure that comprehensively reflects the actual growth in premiums in the related insurance markets. We also agree that a measure of premium that more comprehensively includes plans from both the individual and employer-sponsored market is better aligned with the language of the ACA and that the resulting higher maximum annual limitation on cost sharing will provide issuers with more flexibility to set other cost sharing parameters to better meet consumer needs.

We acknowledge commenters' concerns about the assumption noted in the proposed rule (90 FR 13018) that the IRS will adopt the same premium growth indexing methodology as HHS, as it has historically done. IRS utilizes HHS' methodology for indexing the applicable percentage table that determines PTC payments and ''affordability percentages'' used by applicable employers to determine the affordability of their coverage offerings for the employer shared responsibility provisions. As we did in the proposed rule, we also acknowledge that these changes will increase net premiums for enrollees under 400 percent of the FPL, consistent with section 36B(b)(3) of the Code, potentially decreasing enrollment through the Exchange as noted in the Regulatory Impact Analysis section of this final rule and that the change may also lead to enrollees in ESI being required to pay more of their income towards their health insurance premiums, consistent with section 36B(c)(2)(C) of the Code.

Because the projected decrease in Exchange enrollment is driven by decreased PTC resulting in increased net premiums for lower income enrollees, we do not disagree with the commenters' statement that low-income enrollees are more likely to be impacted by this policy change. It is also reasonable to assume that providers who serve a disproportionate number of low-income patients, which may include providers in rural communities, may experience downstream impacts of the policy change and its impact on low-income consumers in the form of increased provision of unpaid care and reduced utilization by consumers. Specifically, we stated in the proposed rule (90 FR 13019) that the proposal may increase the number of uninsured, and that this may increase Federal and State uncompensated care costs and contribute to negative public health outcomes.[234]

Furthermore, we recognize commenters' concerns about the burden that an increase in the maximum annual limitation on cost sharing places on consumers who meet the annual limit for the plan in which they have enrolled. The proposed change will raise the cap on the dollar value an issuer may set for a plan's annual limitation on cost sharing, leading to higher out-of-pocket costs for enrollees who use enough medical services to reach the limit for their plan.

With the impacts on premiums, enrollment, and out-of-pocket costs in mind, to the extent that lack of coverage or higher out-of-pocket costs are correlated to medical debt, it is also reasonable to believe that rates of medical debt may increase for those enrollees who choose not to enroll due to higher net premiums or who cannot afford out-of-pocket costs associated with medical care. Likewise, it is reasonable to believe that some individuals, including those with chronic conditions, may choose to forgo care due to higher-out-of-pocket costs or lack of coverage, which may in turn worsen the state of overall health for those individuals.

Although we recognize commenters' concerns on these matters, we believe that the scope of the impacts on enrollee cost sharing and medical debt will be relatively limited. As we noted in the proposed rule (90 FR 13019), those plans that are required to comply with the maximum annual limitation on cost sharing are generally required to comply with AV (or with minimum value) requirements, constraining the range of cost-sharing parameter values that

[234] *See,* for example, Goldin, J., Lurie, I.Z., & McCubbin, J. (2021). Health Insurance and Mortality: Experimental Evidence from Taxpayer Outreach. The Quarterly Journal of Economics, 136(1), 1–49.

issuers can offer for those plans, regardless of the maximum annual limitation on cost sharing. This proposal allows issuers to set higher annual limitations on cost sharing for their plans, but higher annual limitations on cost sharing would generally also require lower deductibles, coinsurance, or copayment parameters for a plan to be able to meet AV requirements. As such, this proposal gives issuers additional flexibility to set cost-sharing parameters that meet their populations' needs without impacting the overall value of coverage.

Furthermore, we continue to believe the definition of the premium adjustment percentage in section 1302(c)(4) of the ACA as growth in the ''average per capita premium for health insurance coverage in the United States'' suggests that the measure of growth was intended to be comprehensive. Therefore, a premium growth measure should reflect premium growth in all affected markets and should not be limited to ESI premium growth. In effect, this change is a correction for measuring premium growth, as the previous exclusion of individual market data was not the most comprehensive method of premium growth measurement, but was deemed necessary as a result of the premium instability in the individual market immediately following implementation of the ACA market reforms (79 FR 13801 through 13804) and then again as a result of anticipated premium instability in the individual market during the COVID–19 PHE (86 FR 24233 through 24237). In both of these cases, our decision to exclude individual market premiums from the measure of premium growth was primarily intended to account for short-term market distortions and the impact of those potential distortions on various parameters, rather than to provide relief for specific groups of consumers or other interested parties. Moreover, as described in the proposed rule (90 FR 12988 through 12991), the COVID–19 PHE did not impact the individual market as we originally anticipated and conversely appears to have increased premiums in the employer-sponsored market more than in the individual market during this period, suggesting in hindsight that the primary justification for reverting to using only employer-sponsored premiums to calculate the premium adjustment percentage was unfounded.

Although the ACA does contain financial assistance provisions that shift costs from consumers to the Federal Government as noted by some commenters, increasing access to health insurance coverage and care for low-income communities, the indexing methodology of the premium adjustment percentage is not in itself one of those provisions. Instead, the premium adjustment percentage reflects the intent of Congress to appropriately index financial assistance provision related-parameters which were initially determined at the time of passage of the ACA. Because the role of the premium adjustment percentage is to appropriately index various parameters defined in the ACA, the primary consideration for setting the value of the premium adjustment percentage should be whether it accurately and comprehensively captures the rate of premium growth in the United States rather than the impact of the indexing methodology on net premiums, enrollment, access to health care, health outcomes, or out-of-pocket costs for those who receive non-covered or out-of-network care. Considering these other impacts when setting the premium adjustment percentage may result in a measure of premium growth that does not accurately reflect actual premium growth in the United States, artificially inflating the generosity of provisions of the ACA beyond the intent of Congress. Likewise, in response to the comments expressing concern that the impact of the change in the premium adjustment percentage methodology on net premiums would be further compounded when the expanded PTC subsidies made available under the ARPA and extended by the IRA expire, it would be beyond the intent of Congress as expressed in the ACA, ARPA, or IRA to take into account the expiring enhanced subsidies in setting the premium adjustment percentage indexing methodology.

As such, we believe that the measure of premium growth should aim to be comprehensive and accurate to best satisfy the statutory requirement that the premium adjustment percentage reflect growth in the ''average per capita premium for health insurance coverage in the United States,'' regardless of the impacts of a given premium adjustment methodology on specific groups of consumers, including rural and low-income consumers and consumers with chronic or severe conditions. Again, we note that we shifted away from utilization of a more comprehensive measure in Part 2 of the 2022 Payment Notice (86 FR 24233 through 24237) primarily due to concern that anticipated market distortions related to the COVID–19 PHE would distort the indexing set by the premium adjustment percentage. Because evidence appears to demonstrate that this anticipated distortion among private health insurance (excluding Medigap and property and casualty insurance) did not occur, we do not consider the continued exclusion of these premiums from the index to be appropriate. With these considerations, we do not think the premium adjustment percentage methodology in this rulemaking is contrary to the legislative intent of the financial assistance structure of the ACA because the Federal Government will continue to provide appropriately indexed premium assistance for enrollees with incomes less than 400 percent of the FPL and will continue to set appropriately indexed limitations on cost sharing and employer responsibility requirements. We also believe the premium adjustment percentage finalized in this rule is more consistent with the intent of the indexing provisions of the ACA than the previous premium adjustment percentage methodology. Because appropriately aligning with the intent of Congress is our primary consideration in setting the premium adjustment percentage methodology to include all private health insurance premiums (excluding Medigap and property and casualty insurance), we do not see the need to delay this change for the purposes of analyzing impacts on various income and demographic groups, as suggested by one commenter. Furthermore, we believe that section 1302(c)(4) of the ACA provides the Secretary with the authority to update and modify the premium adjustment percentage and premium growth rate measure as appropriate, and that our policy is within this authority.

Finally, we acknowledge commenters' concern that healthy enrollees may be less likely to enroll due to the higher net premiums that result from the change in the premium adjustment methodology, to the extent that consumers consider the costs and benefits of enrolling in health insurance coverage. However, as with the other concerns discussed above, we believe the consideration of the impact of this proposal on the risk pool to be outside the scope of the indexing provisions of the ACA because the purpose of the premium adjustment percentage is to accurately index program parameters against the growth in premiums, not to control the growth of those premiums. Nevertheless, we believe the impact of the change in the premium adjustment percentage methodology on enrollment, and likewise, the impact on the risk pool and overall premiums, will be relatively limited. As noted in the Regulatory

Impact Analysis sections of the proposed rule and this final rule, the decrease in enrollment for PY 2026 due to the premium adjustment percentage change is estimated to be 80,000 Exchange enrollees, approximately 0.3 percent of the number of individuals who selected coverage in the Exchange during the PY 2025 OEP.[235] Also, we estimated the impact of this proposal on gross premiums to be negligible, reflecting the limited impact of the change in the premium adjustment percentage methodology on the average risk in the risk pool.

Based on these considerations, we are finalizing the premium adjustment percentage, maximum annual limitation on cost sharing, reduced maximum annual limitations on cost sharing, and required contribution percentage as proposed, effective for PY 2026, and these values will supersede the PY 2026 values published in the October 2024 PAPI Guidance.[236]

Comment: A few commenters noted that because the premium adjustment percentage is a cumulative measure, including individual market premiums in the definition of premium growth implicitly incorporates the impact on premiums of the significant enhancement of benefits in the individual market as a result of the ACA's market reforms. As such, the commenters stated that individual market premiums should not be used to measure premium growth since 2013 because premiums in the early years of ACA were volatile, even in comparison to the growth in employer-sponsored premiums during the COVID–19 PHE that we cited in the proposed rule. Due to the cumulative nature of the premium adjustment percentage, these commenters stated that the early years of ACA implementation will continue to impact the premium adjustment percentage if individual market premiums are included in the measure. One of these commenters recommended HHS use a benchmark year no earlier than 2018 (rather than 2013) to avoid inclusion of premium increases resulting from the ACA market reforms and other Federal policy and legislative decisions such as the cessation of Federal funding for CSRs and the elimination of the individual mandate penalty. This commenter also suggested that individual market premiums may be impacted by the expansion of section 1332 waivers since the implementation of the ACA.

Response: As stated in the 2015 Payment Notice (79 FR 13801 through 13804), we previously excluded premiums from the individual market because they were most affected by the significant changes in benefit design and market composition in the early years of implementation of the ACA market rules and were most likely to be subject to risk premium pricing. Likewise, in part 2 of the 2022 Payment Notice (86 FR 24233 through 24237), we excluded premiums from the individual market because, at the time, we anticipated that these premiums would be more volatile in response to the COVID–19 PHE than employer-sponsored premiums. As noted in the 2020 Payment Notice (84 FR 17537 through 17541), the rule in which we first adopted a premium adjustment percentage methodology that incorporated all private health insurance (excluding Medigap and property and casualty insurance), the ACA is now past the initial years of implementation and issuers have had the opportunity to collect data on the risk composition of the individual market and adjust pricing accordingly. Additionally, as noted in the proposed rule (90 FR 12990 through 12991), premiums in the employer-sponsored market increased more rapidly than premiums in the individual market during the COVID–19 PHE, the impact of which has led to a decreasing gap in premium growth between the individual market and employer-sponsored market. As such, we believe that a comprehensive measure incorporating both individual market and employer-sponsored premiums will more accurately reflect true premium growth going forward. Therefore, we are finalizing our proposal to measure growth of premiums issuers charged enrollees more comprehensively by once more including individual market premiums. We acknowledge that the premium adjustment percentage is a cumulative measure and, as such, the market fluctuations in the early years of ACA implementation are included in the calculation when using private health insurance premiums (excluding Medigap and property and casualty insurance) as the data source for indexing. However, because it is a cumulative measure, the impact of these early years decreases as more time elapses between the applicable plan year and the benchmark year (2013). For example, for PY 2018, PY 2014 was 1 of 4 years of growth included in the premium adjustment percentage measure and therefore the weight of PY 2014 premium growth was approximately one quarter of the overall measure. For PY 2026, PY 2014 is 1 of 12 years of growth included in the measure. Therefore, for PY 2026, the weight of PY 2014 is only one twelfth of the overall measure. As such, the greater time between the benchmark year and the applicable plan year reduces the impacts of any individual year, even if the premium growth in that year is unusual.

Furthermore, as we have said in response to other comments on this proposal, the premium adjustment percentage reflects the intent of the Congress to appropriately index parameters which were initially determined at the time of passage of the ACA. Because the role of the premium adjustment percentage is to appropriately index various parameters defined in the ACA, the primary consideration for setting the value of the premium adjustment percentage should be whether it accurately and comprehensively captures the rate of premium growth in the United States. With the reduced impact over time of any individual year of premium growth, continuing to exclude individual market premiums from this measure because they may be impacted by States' approved section 1332 waivers or other policy actions could result in parameters that are indexed inaccurately relative to the actual rate of premium growth in the United States, contrary to the intent of Congress.

With respect to the comment requesting we use a different benchmark year, we did not propose and are not finalizing the use of a different benchmark year for individual market premiums. Moreover, the applicable statute, section 1302(c)(4) of the ACA, requires the Secretary to establish a premium adjustment percentage that measures premium growth between the preceding calendar year (2025, in this case) and 2013. Without legislative action, it is not permissible to change the benchmark year to any year other than 2013.

Comment: One commenter expressed concern about the evidence we presented in the proposed rule to support the assertion that individual market premiums remained stable during the COVID–19 PHE due to the commenter's perception that the predictions regarding the anticipated

[235] *See* the CMS press release ''Over 24 Million Consumers Selected Affordable Health Coverage in ACA Marketplace for 2025'' (January 17, 2025), available at: *https://www.cms.gov/newsroom/press-releases/over-24-million-consumers-selected-affordable-health-coverage-aca-marketplace-2025.*

[236] *See* CMS. (2024, Oct. 8). Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing, Reduced Maximum Annual Limitation on Cost Sharing, and Required Contribution Percentage for the 2026 Benefit Year. *https://www.cms.gov/files/document/2026-papi-parameters-guidance-2024-10-08.pdf.*

impacts of the COVID–19 PHE premiums were inaccurate.

Response: The analysis of the trends in premium growth during the COVID–19 PHE that we presented in the proposed rule were not based on predicted values but were based on the CMS Office of the Actuary's NHEA historical data,[237] which included data through the 2023 calendar year, encompassing the entirety of the COVID–19 PHE.[238] As described in the methodology documents for the NHEA historical data,[239] major data sources for the historical data include annual and quarterly Census Bureau surveys and annual American Hospital Association surveys. As such, these data represent point-in-time estimates (rather than projections) from calendar years impacted by the COVID–19 PHE. Given this, we are confident that the NHEA historical data accurately reflect the growth in premiums in the individual and employer-sponsored markets during the COVID–19 PHE and that employer-sponsored market premiums grew more rapidly than individual market premiums during this period.

Comment: A few commenters suggested that HHS delay adoption of this change to the premium adjustment percentage methodology until PY 2027 due to issuer and various States' timing constraints for rate setting. A few commenters recommended that HHS consider a more delayed or gradual phase-in of individual market premiums over several years.

Response: In finalizing these values for PY 2026, we recognize that some States have rate filing deadlines in April and May and that this rule may not be finalized in time for issuers in these States to adjust plan parameters and rates to take advantage of the additional flexibility afforded by the increased maximum annual limitation on cost sharing and reduced maximum annual limitations on cost sharing. However, because the values finalized in this final rule resulted in a higher maximum annual limitation on cost sharing than was previously released in guidance,[240] the vast majority of plans that met maximum annual limitation on cost sharing requirements under the previously released PY 2026 premium adjustment percentage methodology will also meet the maximum annual limitation on cost sharing requirements under the premium adjustment percentage methodology for PY 2026 as finalized in this rule. Therefore, issuers would not be required to modify all of their plans as a result of the methodology finalized in this final rule if those plans were already compliant with the values previously released in guidance.[241] Additionally, to aid in rate setting for issuers, CMS released an updated version of the AV calculator in March 2025 that reflected the proposed higher maximum annual limitation on cost sharing.[242]

Lastly, we note that we did not propose, and are not finalizing, a phased-in approach to using private health insurance premiums (excluding Medigap and property and casualty insurance) in defining the premium adjustment methodology for PY 2026. We do not believe that further delay meets the statutory and regulatory goals of using a comprehensive measure of premium growth. Additionally, as stated in the proposed rule (90 FR 12987 through 12991), we believe that the individual market is now sufficiently stable to justify the immediate inclusion of individual market premium growth in the indexing measure going forward. As such, we believe it is appropriate to prioritize better achieving the goals of comprehensiveness and accuracy of the premium adjustment percentage methodology over the limited effect on mitigating impacts that implementing our proposal using a phased-in approach would be likely to have. This also aligns with our previous approaches to implementing changes to the premium adjustment percentage methodology where we have not implemented a phased-in approach regardless of the premium adjustment percentage amount and whether the rate was increasing or decreasing.[243]

3. Levels of Coverage (Actuarial Value) (§§ 156.140, 156.200, 156.400)

In the 2025 Marketplace Integrity and Affordability proposed rule (90 FR 12995 through 12997), we proposed to change the de minimis ranges at § 156.140(c) beginning in PY 2026 to +2/−4 percentage points for all individual and small group market plans subject to the actuarial value (AV) requirements under the EHB package, other than for expanded bronze plans, for which we proposed a de minimis range of +5/−4 percentage points. We also proposed to revise § 156.200(b)(3) to remove from the conditions of QHP certification the de minimis range of +2/0 percentage points for individual market silver QHPs. We also proposed to amend the definition of ''de minimis variation for a silver plan variation'' in § 156.400 to specify a de minimis range of +1/−1 percentage points for income-based silver CSR plan variations.

Section 2707(a) of the PHS Act and section 1302 of the ACA direct issuers of non-grandfathered individual and small group health insurance plans (including QHPs) to ensure that these plans adhere to the levels of coverage specified in section 1302(d)(1) of the ACA. Section 1302(d)(2) of the ACA provides that a level of coverage of a plan, or its AV, is determined based on its coverage of the EHB for a standard population. Section 1302(d)(1)(A)–(D) of the ACA requires a bronze plan to have an AV of 60 percent, a silver plan to have an AV of 70 percent, a gold plan to have an AV of 80 percent, and a platinum plan to have an AV of 90 percent. Section 1302(d)(2) of the ACA directs the Secretary to issue regulations on the calculation of AV and its application to the levels of coverage. Section 1302(d)(3) of the ACA authorizes the Secretary to develop guidelines to provide for a de minimis variation in the AVs used in determining the level of coverage of a plan to account for differences in actuarial estimates.

In the EHB Rule (78 FR 12834), we established at § 156.140(c) that the allowable de minimis variation in the AV of a health plan that does not result in a material difference in the true dollar value of the health plan was +2/−2 percentage points. In the 2018 Payment Notice, we revised § 156.140(c) to permit a de minimis variation of +5/−2 percentage points for bronze plans that either 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 within the meaning of section 223(c)(2) of the Code.

In the 2017 Market Stabilization Rule, effective beginning in PY 2018, we expanded the de minimis range for standard bronze, silver, gold, and platinum plans to +2/−4 percentage points.[244] In that final rule (82 FR

[237] Available at: *https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/historical.*

[238] *See* ''National Health Expenditure Accounts: Methodology Paper, 2023: Definitions, Sources, and Methods'' available at *https://www.hhs.gov/coronavirus/covid-19-public-health-emergency/index.html.*

[239] *See https://www.cms.gov/files/document/definitions-sources-and-methods.pdf.*

[240] *See* CMS. (2024, Oct. 8). Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing, Reduced Maximum Annual Limitation on Cost Sharing, and Required Contribution Percentage for the 2026 Benefit Year. *https://www.cms.gov/files/document/2026-papi-parameters-guidance-2024-10-08.pdf.*

[241] Id.

[242] Available at *https://www.cms.gov/files/document/revised-final-2026-av-calculator.xlsm.*

[243] *See* the 2020 Payment Notice (84 FR 17537 through 17541) and part 2 of the 2022 Payment Notice (86 FR 24233 through 24237).

[244] We did not in that rule modify the de minimis range for the income-based silver CSR plan

18368), we stated that we believed that flexibility was needed for the AV de minimis range for metal levels to help issuers design new plans for future plan years, thereby promoting competition in the market. In addition, we noted that changing the de minimis range would allow more plans to keep their cost sharing the same as well as provide additional flexibility for issuers to make adjustments to their plans within the same metal level. We stated our view that a de minimis range of +2/−4 percentage points would provide the flexibility necessary for issuers to design new plans while ensuring comparability of plans within each metal level.

In the 2023 Payment Notice (87 FR 27306 through 27308), effective beginning in PY 2023, we narrowed the de minimis range for standard bronze, silver, gold, and platinum plans to +2/−2 percentage points, narrowed the de minimis range for expanded bronze plans to +5/−2 percentage points, and narrowed the de minimis range for income-based silver CSR plan variations to +1/0 percentage points. We also established, as a condition of QHP certification, that individual market silver QHPs must have an AV of 70 percent with a de minimis allowable AV variation of +2/0 percentage points. As discussed in the 2023 Payment Notice (87 FR 27307), we made these changes due to concerns that a wider de minimis range jeopardized the meaningful comparison of plans between the silver and bronze levels of coverage. In that rule (87 FR 27307), we also narrowed the de minimis range for individual market silver QHPs in order to maximize PTC and APTC for subsidized enrollees, noting that narrowing the de minimis range of individual market silver QHPs would influence the generosity of the second lowest cost silver plan (SLCSP), the benchmark plan for calculating PTC and APTC.

In the proposed rule (90 FR 12996), we explained that since we finalized these de minimis ranges in the 2023 Payment Notice, we have received considerable feedback from issuers that indicates narrower de minimis ranges substantially reduce issuer flexibility in establishing plan cost sharing. We noted that these issuers have expressed that any benefit to consumers that result from improvements to the comparability between the levels of coverage is outweighed by the harm to consumers caused by reduced issuer flexibility in setting non-standardized cost-sharing parameters, and as a result, harm to the health of the overall risk pool. We further noted that due to these effects, issuers have also voiced concern about their ability to continue to participate in the market generally. We stated that sustained, robust issuer participation in the market is key to ensuring overall market stability and keeping costs down.

Based on this feedback, we proposed to change the de minimis ranges at § 156.140(c) beginning in PY 2026 to +2/−4 percentage points for all individual and small group market plans subject to the AV requirement, other than for expanded bronze plans,[245] for which we proposed a de minimis range of +5/−4 percentage points. We stated that we believe reverting to the de minimis ranges in effect from PYs 2018 to 2022 offers the best balance between comparability between the levels of coverage and issuer flexibility in establishing competitive cost-sharing designs that appeal to wide segments of the population. With this proposal, we noted that an expansion of the universe of permissible plan AVs would not preclude issuers from continuing to design plans with an AV that is closer to the middle of the applicable de minimis ranges instead of plans at the outer limits. We stated that to the extent that issuers believe that plan designs that have a higher AV would attract enrollment, they would remain free to do so under this proposal.

We also proposed, through the authority granted to HHS in sections 1311(c) and 1321(a) of the ACA to establish minimum requirements for QHP certification, to revise § 156.200(b)(3) to remove from the conditions of QHP certification the de minimis range of +2/0 percentage points for individual market silver QHPs. We stated that under this proposal, we would amend § 156.200(b)(3) to revert to the original regulatory text finalized in the 2012 Exchange Establishment rule (77 FR 18469), which stated that, as a condition of QHP certification, issuers must ''[e]nsure that each QHP complies with benefit design standards, as defined in § 156.20.'' We stated that we believe the removal of this QHP certification requirement is justified because we are no longer of the view that this certification requirement, which was finalized in the 2023 Payment Notice, is in the best interests of the overall risk pool.

In the 2012 Exchange Establishment rule, we explained narrowing the de minimis range of individual market silver QHPs would influence the generosity of the SLCSP, the benchmark plan for calculating PTC and APTC for subsidized consumers. We noted in the proposed rule (90 FR 12996 through 12997) that while narrowing the de minimis range in this way has such an effect on PTC and APTC to improve affordability for subsidized consumers, it comes at the expense of affordability for unsubsidized consumers. We stated that we believe attracting these unsubsidized consumers to participate in the risk pool may help to drive down overall costs by expanding the risk pool. In turn, we stated that we believe premiums for all consumers in the risk pool may be lower.

As explained in the proposed rule (90 FR 12997), maximizing PTC with a +2/0 percentage point de minimis range for individual market silver QHPs created imbalance between access and affordability for all consumers, particularly for unsubsidized ones. We stated that we believe this certification requirement can have the effect of damaging the overall health of the risk pool, which in turn may make coverage less affordable overall than it could have been as healthier, unsubsidized enrollees are priced out of the market. We explained that while pushing for increased subsidies may make coverage more affordable for certain consumers in the very short term, this is a short-sighted approach to regulating the AV de minimis ranges. We stated that we believe that lower AVs would lead to lower premiums, and in turn potentially improve the risk pool as coverage becomes more affordable for generally healthy people who currently may opt to forgo coverage altogether. We noted that although this may mean that those eligible for APTCs receive less money in tax credits, we believe that in the long term there would be a sufficient choice of affordable plans. We stated that we also believe reverting the de minimis range of individual market silver QHPs back to +2/−4 percentage points is the best method for balancing the affordability of health plans for all segments of the population enrolled in non-grandfathered individual and small group market plans with the long-term viability of the overall risk pool.

variations (the plans with an AV of 73, 87 and 94 percent) under §§ 156.400 and 156.420. The de minimis variation for an income-based silver CSR plan variation is a single percentage point. In the Actuarial Value and Cost-Sharing Reductions Bulletin (2012 Bulletin) issued on February 24, 2012, available at: *https://www.cms.gov/cciio/resources/files/downloads/av-csr-bulletin.pdf,* we explained why we did not intend to require issuers to offer a silver CSR plan variation with an AV of 70 percent; to align with this change, we also modified the de minimis range for expanded bronze plans from +5/−2 to +5/−4.

[245] Expanded bronze plans are bronze plans currently referenced in § 156.140(c) that 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 within the meaning of section 223(c)(2) of the Code.

Finally, we proposed to revise the definition of ''de minimis variation for a silver plan variation'' at § 156.400 to change the de minimis variation for individual market income-based silver CSR plan variations from +1/0 percentage points to +1/−1 percentage points. We explained that similar to the removal of the de minimis certification requirement for individual market silver QHPs, this proposal would deliver further balance between affordability and market stabilization. We did not propose edits to the minimum AV differential in § 156.420(f) for silver QHPs and 73 percent income-based plan variations, where the AVs must differ by at least 2 percentage points. We noted for issuers that, similar to the current de minimis ranges, standard silver QHPs with plan AVs between 71 and 72 percent would require the corresponding 73 percent income-based plan variation AV to be at least 2 percentage points above the standard plan's AV.

We sought comment on these proposals.

After consideration of comments and for the reasons outlined in the proposed rule and this final rule, including our responses to comments, we are finalizing these policies as proposed. We summarize and respond to public comments received on the proposed changes to the de minimis ranges below.

Comment: Many commenters supported the proposal, noting that they agreed with the rationale provided in the proposed rule that wider de minimis ranges would improve issuer flexibility in plan design. These commenters explained that increased flexibility would allow issuers to better design plans that meet the needs of their enrollees.

Response: We agree that wider de minimis ranges will significantly improve issuer flexibility in plan design and are finalizing this proposal as proposed. As we noted in the proposed rule, issuers have indicated that narrower de minimis ranges substantially reduce issuer flexibility in establishing plan cost sharing, and that any benefits from improved comparability between coverage levels due to wider variation in metal levels are outweighed by the reduced flexibility in setting non-standardized cost-sharing parameters.

The wider de minimis ranges of +2/−4 percentage points (and +5/−4 percentage points for expanded bronze plans) offer several important benefits to the market.

First, these expanded ranges allow issuers to design plans that better promote competition in the market. With greater flexibility in adjusting actuarial values, issuers can create more differentiated combinations of premiums and cost-sharing structures. This enables issuers to develop innovative plan designs targeting specific consumer needs and respond more dynamically to competitor offerings without being constrained by overly narrow AV requirements.

Second, the wider ranges provide flexibility for issuers to make adjustments to their plans within the same metal level. This practical benefit allows issuers to implement year-to-year modifications based on changing healthcare costs, utilization patterns, and claims experience while maintaining their metal tier classification. Issuers can respond to provider network changes or drug formulary updates without disrupting their established metal level offerings, ensuring greater continuity for consumers.

Third, these expanded ranges help maintain robust issuer participation, which is important for overall market stability. By reducing compliance burdens that might otherwise drive issuers to exit markets, particularly those with challenging risk profiles, the wider ranges make market participation more attractive to a broader range of issuers. This helps prevent overly restrictive pricing and ensures consumers have multiple options to choose from, which is fundamental to a healthy, competitive marketplace. This is a particularly important considering that several issuers have publicly announced their intent to end participation in the Exchange in PY 2026.

We note that this increased flexibility does not prevent issuers from designing plans with AVs closer to the middle of the applicable de minimis ranges. Issuers will retain the ability to offer plans with higher AVs if they believe such designs would better attract enrollment.

Comment: Some commenters supported the proposal because it would maintain uniform AV standards for plans on- and off-Exchange.

Response: We agree that standardizing the de minimis ranges for plans on- and off-Exchange is important. As we stated in the proposed rule (90 FR 12997), while specifying different de minimis ranges for individual market silver QHPs pushed for increased subsidies in the very short term, it was a short-sighted approach to regulating the AV de minimis ranges that damaged the overall health of the risk pool long-term. Subjecting on- and off-Exchange plans to the same de minimis ranges will correct this short-sighted approach because it will help to ensure better balance between access and affordability for all consumers, particularly for those enrolling in off-Exchange plans.

Comment: Many commenters, both those in support of and in opposition to the proposal, recommended that, if the proposed de minimis variations are finalized, implementation of the proposal be delayed until PY 2027 instead of PY 2026. These commenters noted that it may be difficult for some issuers to take advantage of wider de minimis ranges for PY 2026 given the timing of the proposal and State rate submission deadlines.

Response: We decline to delay implementation of these wider de minimis ranges until PY 2027. By definition, wider de minimis ranges do not require issuers or States to take any additional action to revise existing plan designs. Issuers may choose not to take any action to revise their existing plan designs for PY 2026 and will still be compliant with these wider de minimis ranges. We recognize that some issuers in some States will not be able to modify plan designs in time to meet State-specific filing deadlines. However, making these wider de minimis ranges available as soon as possible will maximize the extent to which issuers are able to take advantage of them to create a wider array of benefit designs that appeal to a wider array of consumers. We therefore believe that finalizing these wider de minimis ranges beginning in PY 2026 is justified.

Comment: Many commenters did not support the proposal. These commenters primarily expressed concern that wider de minimis ranges would result in lower overall plan AVs. These commenters explained that this would lead to increased out-of-pocket consumer costs as plan cost-sharing generosity decreases and higher overall premiums for some consumers given a potential impact on the generosity of the SLCSP, the benchmark plan used to determine an individual's PTC.

Response: We acknowledge commenters' concerns regarding a decrease in plan cost-sharing generosity to the extent that plans utilize the lower end of the wider de minimis ranges, the impact on PTCs if the AV of the applicable SLCSP is lower than in previous years, and the burden that increased cost-sharing and decreased PTCs may have on enrollees in the short-term. However, this change is essential to restoring greater balance between access and affordability in the long term. As we explained in the proposed rule (90 FR 12997), we believe

that the overall benefits to the risk pool as a result of this change will better incentivize unsubsidized enrollees to enroll in coverage, which we expect to lower overall costs and further drive down premiums as the risk pool improves.

Comment: Other commenters opposing the proposal expressed concern that wider de minimis ranges would undermine the ability of consumers to meaningfully compare plans. These commenters were concerned that a silver plan at the lower end of the de minimis range (with a 66 percent AV) could be closer in AV to a bronze plan at the higher end of the expanded de minimis range (with a 65 percent AV) than it would be to another silver plan at the higher end of the de minimis range (with a 72 percent AV).

Response: We do not agree with the premise that consumers currently typically rely on material differences in AV percentages to compare plans. Communicating material differences between plan cost-sharing for plans of the same metal tier and plans of different metal tiers has always been essential to ensure that consumers make informed decisions about their plan selections, which includes deprioritizing AV as a comparison tool. This was the case with narrower de minimis ranges as well, when a bronze plan could have an AV at the higher end of the expanded de minimis range (with a 65 percent AV) and a silver plan could have an AV at the lower end of a -2 percentage point de minimis range (with a 68 percent AV). To consumers comparing plans, the difference in cost sharing is immaterial for a 3-percentage point separation between a 65 percent AV bronze plan and a 68 percent AV silver plan or a 1 percentage point separation between a 65 percent AV bronze plan and a 66 percent AV silver plan. Exchanges use an array of strategies to effectively communicate the meaningful differences between plans in terms that consumers—in addition to agents, brokers, web-brokers, Navigators, and other assisters—can understand and appreciate. Therefore, we are not concerned about material changes in the comparability between plan AVs with this change.

Comment: A few commenters noted the proposal's impact on silver loading. These commenters explained that if the relativity between the standard QHP silver plan and the CSR plan variations expands, there is potential for the ''silver load'' to increase. Commenters stated that where the ''silver load'' is applied only to silver QHPs, this would offset some portion of the potential silver premium decrease. Commenters also stated that where the ''silver load'' is applied to all plans, it would similarly offset premium decreases for other metal tiers as well.

Response: We acknowledge the commenters' observations regarding the potential impact of wider de minimis ranges on silver loading. The relationship between standard silver QHP AVs and CSR plan variation AVs could affect the magnitude of silver loading. The wider de minimis range ($+2/-4$ percentage points) for standard silver QHPs, combined with the $+1/-1$ percentage point range for CSR variations, could increase the relative difference between standard silver plans and CSR variations. This increased differential could result in higher silver loading amounts to account for the cost of CSR benefits.

We expect any impact on premiums would manifest differently depending on how issuers implement their loading strategy. In markets where silver loading is applied exclusively to silver QHPs, any potential premium decreases from lower AVs in silver plans may be partially offset by the increased loading amount. In markets where broad loading is implemented across all metal levels, the loading effects could moderate premium decreases throughout the entire market.

Despite these potential effects, we maintain that the wider de minimis ranges represent a necessary rebalancing of market dynamics. While silver loading may partially counteract some premium reductions, the broader benefits of this policy—including enhanced issuer flexibility, improved market stability, and potential risk pool improvements—remain compelling factors in our decision-making process.

Comment: A few commenters asserted that the proposal could weaken the risk pool because healthier people are more likely to drop coverage when net premiums rise. Other commenters asserted the proposal can help bring more stability to the risk pool by attracting more unsubsidized individuals who otherwise might choose to go uninsured.

Response: We acknowledge the differing viewpoints regarding the proposal's potential impacts on the risk pool. As explained above, after careful consideration of the evidence and interested parties' feedback, we believe that while there may be some initial weakening of the risk pool as some commenters note, the long-term benefits of wider de minimis ranges are likely to strengthen overall market stability.

Comment: A few commenters requested clarification on the applicability of uniform modification standards under § 147.106(e) to the proposal to widen the de minimis ranges.

Response: Under the exceptions to guaranteed renewability for uniform modification of coverage under § 147.106(e), an issuer may, only at the time of coverage renewal, modify the health insurance coverage for a product offered in the individual market or small group market if the modification is consistent with State law and is effective uniformly for all individuals or group health plans with that product. To be considered a uniform modification of coverage, among other things, each plan within the product that has been modified must have the same cost-sharing structure as before the modification, except for any variation in cost sharing solely related to changes in cost and utilization of medical care or to maintain the same metal tier level described in sections 1302(d) and (e) of the ACA. States have flexibility to broaden what cost-sharing changes are considered within the scope of a uniform modification of coverage and may, for example, consider uniform cost-sharing changes that result in plans having the same metal level based on the expanded de minimis range to be uniform modifications.

We note that under § 147.106(e)(2), modifications made uniformly and solely pursuant to applicable Federal or State requirements are considered uniform modifications if such modification is directly related to the imposition or modification of the Federal or State requirement and made within a reasonable time period after the imposition or modification of the Federal or State requirement. However, given that the de minimis ranges are being widened, an issuer is not required to modify a plan's cost-sharing structure as a result of this provision of the final rule. Therefore, changes to cost-sharing to take advantage of the wider de minimis ranges under this final rule would not be considered to have been ''made solely pursuant to a Federal requirement.'' Such a modification would have to meet the other criteria in § 147.106(e)(3) to be considered a uniform modification of coverage.[246]

[246] *See* Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond, Final rule (79 FR 30240, 30249) (''For example, if State legislation newly requires a minimum level of benefits (for example, imposing a new minimum visit limit on specific benefits) reducing covered benefits to meet the minimum requirement would not be directly related to the new requirement because the lesser coverage of the benefit coverage was previously permissible, and the modification did not have to be made in order for the issuer to comply with the State law.

Continued

Comment: Some commenters asserted that lower overall AVs could result in a reduction in the quality of provider networks.

Response: We disagree with this claim. In the proposed rule, we recognized that wider de minimis ranges may lower the generosity of plan cost sharing, and that this would result in lower premiums. However, plan cost sharing is only one of many factors involved with plan rate setting. Provider network quality can also be reflected in plan rate setting, and by allowing for lower AVs, plans can reallocate funds to improving network quality.

Comment: Some commenters requested clarification on whether the proposal would impact the standardized plan options finalized in the 2026 Payment Notice and whether issuers are required to offer these plans for PY 2026.

Response: For PY 2024 and beyond, § 156.201(b) requires QHP issuers in a FFE or SBE–FP to offer at least one standardized QHP option at every product network type, at every metal level (except the non-expanded bronze metal level), and throughout every service area that it also offers non-standardized QHP options (including, for silver plans, for the income-based cost-sharing reduction plan variations, as provided for at § 156.420(a)). We finalized the standardized QHP options required under § 156.201(b) for PY 2026 in the 2026 Payment Notice (90 FR 4493). We confirm that the widening of the de minimis ranges finalized in this final rule does not impact the plan designs for the standardized plan options finalized in the 2026 Payment Notice, nor does it impact the broader requirement for issuers to offer these plans for PY 2026 under § 156.201(b).

For PY 2025 and beyond, § 156.202(b) allows QHP issuers in an FFE or SBE–FP to offer two non-standardized plan options per product network type, metal level (excluding catastrophic plans), and inclusion of adult dental benefit coverage, pediatric dental benefit coverage, and adult vision benefit coverage (as defined in paragraphs § 156.202(c)(1) through (3)), in any service area. We confirm that QHP issuers in a FFE or SBE–FP may utilize the wider de minimis ranges finalized in this final rule to adjust the cost sharing of their non-standardized plan options under § 156.202(b), subject to uniform modification requirements at § 147.106(e) and the requirements under the definition of ''plan'' at § 144.103.

D. Applicability Dates

In the 2025 Marketplace Integrity and Affordability proposed rule, we proposed that some policies, if finalized, would become applicable for plan years beginning on or after January 1, 2026. We noted that these policies would include the proposed provisions requiring Exchanges on the Federal platform to conduct pre-enrollment verification of eligibility for individual market SEPs and to verify at least 75 percent of new enrollments through SEPs, as well as the proposed prohibition on issuers of coverage subject to EHB requirements from covering sex-trait modification as EHB. We also noted that for State Exchanges, the provisions requiring all Exchanges to conduct pre-enrollment verification of eligibility for Exchange SEPs and to verify at least 75 percent of new enrollments through SEPs would be applicable starting PY 2027. Also, the policies to update the premium adjustment percentage methodology and AV de minimis ranges would apply beginning with PY 2026. We noted that the policy to prevent re-enrollees from receiving APTC that fully covers their premium without taking an action to confirm their eligibility information would be applicable for Exchanges on the Federal platform starting with annual redeterminations for PY 2026, and State Exchanges would be required to implement the same policy or a comparable policy starting with annual redeterminations for PY 2027. We noted in the proposed rule that we believe these applicability dates provide issuers and Exchanges ample time to prepare for these changes. However, we noted that we understand that different States and issuers face different resource issues and implementation hurdles. We therefore sought comment on whether regulated entities would require additional time to comply with these proposals. We also sought comment on any operational considerations or other issues that may impede compliance with the proposed applicability dates.

In the proposed rule, we discussed that the remaining policies in that proposed rule would become applicable upon the effective date of the final rule. We stated that these proposals included, among others, the provision to pause the monthly SEP for APTC-eligible qualified individuals with a projected annual household income at or below 150 percent of the FPL. We noted that our experience with this SEP suggests it has substantially increased the level of improper enrollments, as well as increased the risk for adverse selection. We further stated that the remaining proposals in the proposed rule aimed to increase the program integrity of the Exchange and protect Federal tax dollars. We therefore stated in the proposed rule that we believed it would be appropriate for these policies to become applicable immediately upon the effective date of the final rule.

After consideration of comments and for the reasons outlined in the proposed rule and this final rule, including our responses to comments, we are finalizing the applicability dates with the following modifications as provided in Table 7. We note that all rules are effective 60 days after publication in the **Federal Register**, and we provide further specificity where applicability dates of certain provisions may vary.

TABLE 7—APPLICABILITY DATES OF FINALIZED PROVISIONS

Provision	Proposed applicability date	Finalized applicability date	Sunset at the end of PY 2026?
Coverage Denials for Failure to Pay Premiums for Prior Coverage (§ 147.104(i)).	Effective date of this rule	Effective date of this rule	No.
Deferred Action for Childhood Arrivals (DACA) (§ 155.20) ..	Effective date of this rule	Effective date of this rule	No.
Standards for Termination of an Agent's, Broker's, or Web-broker's Exchange Agreements for Cause (§ 155.220(g)(2)).	Effective date of this rule	Effective date of this rule	No.
Failure to File Taxes and Reconcile APTC Process (§ 155.305(f)(4)).	PY 2026	PY 2026	Yes.
60-Day Extension to Resolve Income Inconsistency (§ 155.315).	Effective date of this rule	Effective date of this rule	No.

Accordingly, the modification would not be considered to have been 'made solely pursuant to' the new requirement.'').

TABLE 7—APPLICABILITY DATES OF FINALIZED PROVISIONS—Continued

Provision	Proposed applicability date	Finalized applicability date	Sunset at the end of PY 2026?
Income Verification When Data Sources Indicate Income Less Than 100 Percent Federal Poverty Level (§ 155.320(c)(3)(iii)).	Effective date of this rule	Effective date of this rule	Yes.
Income Verification When Tax Data is Unavailable (§ 155.320(c)(5)).	Effective date of this rule	Effective date of this rule	Yes.
Annual Eligibility Redetermination (§ 155.335(a), (n))	Exchanges on Federal Platform: PY 2026. State Exchanges: PY 2027.	Exchanges on Federal Platform: PY 2026. State Exchanges: Not Finalized.	Yes.
Annual Eligibility Redetermination (Automatic Re-enrollment Hierarchy) (§ 155.335(j)).	PY 2026	PY 2026	No.
Gross Premium Percentage-based and Fixed-dollar Premium Payment Thresholds (§ 155.400(g)).	Effective date of this rule	Effective date of this rule	Yes.
Annual Open Enrollment Period (OEP) (§ 155.410)	PY 2026 OEP	PY 2027 OEP	No.
Monthly Special Enrollment Period for APTC-Eligible Qualified Individuals with a Household Income at or Below 150 Percent of the Federal Poverty Level (§ 155.420).	Effective date of this rule	Effective date of this rule	Yes.
All Exchanges Conducting Eligibility Verification for SEPs (§ 155.420(g)).	PY 2026	Exchanges on Federal Platform: PY 2026. State Exchanges: Not finalized.	Yes.
All Exchanges Conducting Eligibility Verification for 75 Percent of New Enrollments through SEPs (§ 155.420(g)).	PY 2026	Exchanges on Federal Platform: PY 2026. State Exchanges: Not finalized.	Yes.
Prohibition on Coverage of Specified Sex-Trait Modification Procedures as an EHB (§§ 156.115(d) and 156.400).	PY 2026	PY 2026	No.
Premium Adjustment Percentage Index (PAPI) (§ 156.130(e)).	PY 2026	PY 2026	No.
Levels of Coverage (Actuarial Value) (§§ 156.140, 156.200, 156.400).	PY 2026	PY 2026	No.

We summarize and respond to public comments received on the proposed applicability dates below. Public comments regarding the applicability date of individual provisions as well as our responses to these comments can be found in the respective provisions' sections of this final rule.

Comment: Many commenters expressed concerns about the proposed implementation timeline for the rule holistically. Some commenters noted their concern about the proposed rule's immediate and near-term changes adding to existing Exchange uncertainty in PY 2026, which includes the scheduled expiration of expanded PTC under the ARPA and IRA at the end of 2025 and possible Congressional action related to health programs like Medicaid. Several commenters noted several proposed policies (such as those that impact rates and plan designs like the premium adjustment percentage methodology) may not be compatible with existing processes and timelines, which creates financial and operational burdens for regulators, State Exchanges, issuers, agents, brokers, web-brokers and consumers. These commenters specifically cited needing time to analyze impact, implement, and test changes including administrative and IT operations, consumer education and assistance, marketing and outreach, staffing, and other mitigation strategies that address operational challenges, coverage loss, and consumer confusion. One commenter cited that there could be a disproportionate impact of uncertainty on safety-net or other smaller plans that are unable to make sweeping changes in short order. Moreover, these commenters noted that the implementation changes may not have been budgeted for in calendar year 2025. Many commenters recommended delaying implementation with the earliest applicability date being PY 2027 to allow States to fully adopt and be compliant with these changes. One commenter suggested effective dates should begin with the following plan year, at minimum, instead of the effective date of the final rule or mid-year. In consideration of provisions that impact PY 2026 plan design or rates, many commenters supported delaying implementation while a few recommended the final rule be published as soon as possible (including within a few weeks of the public comment deadline) to minimize regulatory uncertainty and timely finalize products.

Response: While we acknowledge the commenters' feedback regarding the general implementation timeline of the final rule and the issues associated with meeting the applicability dates of various provisions finalized as part of this final rule, we are generally finalizing the applicability dates as proposed. Specifically, the provisions in this rulemaking are intended to promote program integrity and prevent improper Exchange enrollments and given the pervasiveness of this issue,[247] we do not believe that a delay in implementation of these provisions is appropriate. That said, we acknowledge the concerns raised by commenters about the need to consider the effects of the expiring expanded subsidies. As such, we are finalizing a number of the policies associated with the improper enrollments associated with fully-subsidized plans through PY 2026, which provides the policies with enough time to work to shed improper enrollments without burdening the Exchanges over the long term. Further, where appropriate in this final rule, we are changing the implementation dates of certain provisions, as described in Table 7 in this section.

[247] As documented in a CMS press release from 2024, we received and resolved over 180,000 unauthorized enrollment complaints from January to August 2024. CMS (2024, October). CMS Update on Action to Prevent Unauthorized Agent and Broker Marketplace Activity. *https://www.cms.gov/newsroom/press-releases/cms-update-actions-prevent-unauthorized-agent-and-broker-marketplace-activity.*

E. Comments Regarding Public Comment Period

Many commenters expressed concerns about the 2025 Marketplace Integrity and Affordability proposed rule's 30-day public comment period. We summarize and respond to the public comments received regarding the length of the public comment period below.

Comment: Several commenters expressed concerns about the comment period being shorter than 30 days given that the rule was issued in the **Federal Register** on March 19, 2025 (90 FR 12942) and the comment period closed on April 11, 2025. These commenters suggested that such a window limits public comment and prevents interested parties from fully engaging with the proposed rule's reasoning in violation of the APA. Several commenters also expressed concerns about the scope and complexity of the proposed rule and requested the comment period be extended to 60 or 90 days to allow interested parties (including issuers, State Exchanges, providers, and consumers) additional time to analyze and respond to the impact of the proposed rule. These commenters cited the ruling in *National Lifeline Ass'n* v. *FCC,* 921 F.3d 1102, 1117–18 (D.C. Cir. 2019), which noted that a 30-day comment period is generally considered the shortest time period for interested persons to ''meaningfully review a proposed rule and provide informed comment.''

A commenter cited that HHS historically has provided substantially more time for public comments, stating that the comment periods for the 2025 and 2024 Payment Notice proposed rules were 45 and 41 days, respectively.

Response: We disagree with commenters that stated that we did not provide a 30-day comment period on the proposed rule, in violation of the APA. The proposed rule was displayed for public inspection at the **Federal Register** on March 12, 2025, with an opportunity to submit public comment electronically on *https://www.regulations.gov* or by regular, express, or overnight mail. Under 44 U.S.C. 1507, unless otherwise specifically provided by statute, filing of a document required or authorized to be published by 44 U.S.C. 1505,[248] except in cases where notice by publication is insufficient in law, is sufficient to give notice of the contents of the document to a person subject to or affected by it. Thus, consistent with 44 U.S.C. 1507, display of the proposed rule at the **Federal Register** on March 12, 2025 constituted public notice of the proposed rule on that date, and the 30-day comment period was held between March 12, 2025 and April 11, 2025. We note that we did in fact receive public comments between March 12, 2025 and March 19, 2025 (the date the proposed rule appeared in the **Federal Register**), demonstrating that the public had notice of the proposed rule on March 12, 2025.

We also disagree with the comments requesting that we extend the comment period to 60 or 90 days. If we were to do this, the publication of the final rule would be delayed, which would impact rate setting and plan finalization for PY 2026 that depend on the finalization of the policies set forth in this final rule (such as the changes to the premium adjustment percentage and the AV de minimis ranges). To provide individual and small group market issuers sufficient time to develop and price plan offerings for PY 2026, we will not be extending the comment period to 60 or 90 days.

F. Severability

As demonstrated by the number of distinct programs addressed in this rulemaking and the structure of this final rule in addressing them independently, HHS generally intends the rule's provisions as finalized to be severable from each other. For example, the final rule refines the interpretation of ''lawfully present'' for purposes of determining eligibility to enroll in a QHP offered on an Exchange or a BHP in States that elect to operate a BHP and eligibility for PTC, APTC, and CSRs. It also outlines the discontinuation of the SEP for individuals with an income less than 150 percent of the FPL and makes a change in the calculation of the premium adjustment percentage. It also updates the Exchange automatic re-enrollment hierarchy and changes the process of income verification where tax return data is unavailable. We believe that these provisions are generally capable of functioning sensibly on an independent basis. It is our intent that if any provision of this final rule is held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, the other provisions in the final rule shall be construed so as to continue to give maximum effect as permitted by law, unless the holding shall be one of utter invalidity or unenforceability. In the event a provision is found to be utterly invalid or unenforceable, we intend that provision to be severable.

We sought comment on the severability of these provisions in the proposed rule.

After consideration of comments and for the reasons outlined in the proposed rule and this final rule, including our responses to comments, we are finalizing the severability provision as proposed. We summarize and respond to public comments received on this provision below.

Comment: A few commenters supported the severability approach discussed in the proposed rule.

Response: We thank commenters for their support and are finalizing this approach as proposed such that it is HHS' position if any provision of this final rule is held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, the other provisions in the final rule shall be construed so as to continue to give maximum effect as permitted by law, unless the holding shall be one of utter invalidity or unenforceability. In the event a provision is found to be utterly invalid or unenforceable, that provision is severable.

IV. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA), we are required to provide a 60-day 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 should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comments on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of the agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the

[248] *See* 44 U.S.C. 1505(a) (providing that there shall be published in the **Federal Register**—(1) Presidential proclamations and Executive orders, except those not having general applicability and legal effect or effective only against Federal agencies or persons in their capacity as officers, agents, or employees thereof; (2) documents or classes of documents that the President may determine from time to time have general applicability and legal effect; and (3) documents or classes of documents that may be required so to be published by Act of Congress) and 44 U.S.C. 1505(b) (providing that, in addition to the foregoing there shall also be published in the **Federal Register** other documents or classes of documents authorized to be published by regulations prescribed under this chapter with the approval of the President, but comments or news items of any character may not be published in the **Federal Register**).

affected public, including automated collection techniques.

We solicited public comment on each of these issues for the following sections of this document that contain information collection requests (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.[249] Table 8 presents the median hourly wage, the cost of fringe benefits and overhead, and the adjusted hourly wage. These estimates were updated from the estimates used in the 2025 Marketplace Integrity and Affordability proposed rule due to the availability of more recent data between the publication of the proposed and final rules. The proposed rule estimates may be found at 90 FR 12998.

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

TABLE 8—ADJUSTED HOURLY WAGES USED IN BURDEN ESTIMATES

Occupation title	Occupational code	Median hourly wage ($/hr.)	Fringe benefits and overhead ($/hr.)	Adjusted hourly wage ($/hr.)
Database and Network Administrators and Architects	15–1240	51.67	51.67	103.34
Computer Programmers	15–1251	47.44	47.44	94.88
Eligibility Interviewers, Government Programs	43–4061	24.76	24.76	49.52

We 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 (ASPE) report on ''Valuing Time in U.S. Department of Health and Human Services Regulatory Impact Analyses: Conceptual Framework and Best Practices.'' [250] We started with a measurement of the usual weekly earnings of wage and salary workers of $1,159.[251] We divided this weekly rate by 40 hours to calculate an hourly pre-tax wage rate of approximately $28.98. We adjusted 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 $24.05. We adopt this as our estimate of the hourly value of time for changes in time use for unpaid activities.

We sought comment on the estimates and assumptions in the proposed rule.

We did not receive any comments in response to the proposed rule estimates and assumptions. We are using revised estimates as presented above as a result of more recent data being available at the time of this final rule.

B. ICRs Regarding Deferred Action for Childhood Arrivals

1. Basic Health Program (42 CFR 600.5)

The following changes will be submitted for review under OMB Control Number 0938–1218 (CMS–10510).

The changes in this final rule to 42 CFR 600.5 will again exclude DACA recipients from the definition of ''lawfully present'' used to determine eligibility for a BHP in those States that elect to operate the program, if otherwise eligible. A discussion of the proposed ICRs for this policy may be found in the 2025 Marketplace Integrity and Affordability proposed rule (90 FR 12998). We are updating the ICRs for this policy in this final rule to account for updated wage rates available after the publication of the proposed rule.

The impact of this change will be with regards to the two States that currently operate a BHP—Minnesota and Oregon. We assume for the purposes of this estimate that both States have completed the updates from the 2024 DACA Rule. We estimate that it will take each State 100 hours to develop and code the changes to its BHP eligibility and verification system to correctly evaluate eligibility under the revised definition of ''lawfully present'' to once again exclude DACA recipients as outlined in section III.B.1. of this final rule. To be conservative in our estimates, we are assuming 100 hours per State, but it is important to note that it may take each State less than 100 hours given that the work required to implement this rule for Minnesota's and Oregon's State Exchange systems may also be able to be leveraged for its BHPs.

Of those 100 hours, we estimate it will take a database and network administrator and architect 25 hours at $103.34 per hour and a computer programmer 75 hours at $94.88 per hour.[252] In the aggregate, we estimate a one-time burden of 200 hours (2 States × 100 hours) at a cost of $19,399 (2 States × [(25 hours × $103.34 per hour) + (75 hours × $94.88 per hour)]) for completing the necessary system updates to the application for BHP coverage, including any associated terminations for DACA recipients currently enrolled in BHP coverage.

These changes will reduce costs on States related to the decrease in applications for individuals who would have applied for coverage if not for this change. Those impacts are accounted for under OMB Control Number 0938–1191 (Data Collection to Support Eligibility Determinations for Insurance Affordability Programs and Enrollment through Health Insurance Marketplaces, Medicaid and Children's Health Insurance Program Agencies (CMS–10440)), discussed in section IV.B.3. of this final rule, which pertains to the streamlined application.

[249] *See* U.S. Bureau of Labor Statistics (n.d.). Occupational Employment and Wage Statistics, May 2024 Occupation Profiles. Dep't. of Labor. *https://www.bls.gov/oes/current/oes_stru.htm.*

[250] 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.*

[251] U.S. Bureau of Labor Statistics. Employed full time: Median usual weekly nominal earnings (second quartile): Wage and salary workers: 16 years and over [LEU0252881500A], retrieved from FRED, Federal Reserve Bank of St. Louis. *https://fred.stlouisfed.org/series/LES1252881500Q.* Annual Estimate, 2024.

[252] *See* U.S. Bureau of Labor Statistics (n.d.). Occupational Employment and Wage Statistics, May 2024 Occupation Profiles. Dep't. of Labor. *https://www.bls.gov/oes/current/oes_stru.htm.*

We sought comment on the estimates and assumptions in the proposed rule.

We did not receive any comments in response to the proposed burden estimates for this policy. For the reasons outlined in this final rule, we are finalizing these estimates, with updated wage rates, as proposed.

2. Exchanges and Processing Streamlined Applications (§ 155.20)

The following changes will be submitted for review under OMB Control Number 0938–1191 (CMS–10440).

As discussed previously, we are finalizing modifications to the definition of ''lawfully present'' at § 155.20 to exclude DACA recipients from the definition of ''lawfully present'' that is used to determine eligibility to enroll in a QHP through an Exchange, for PTC, APTC, and CSRs, and to enroll in a BHP in States that elect to operate a BHP. This change will apply to the 20 State Exchanges, as well as Exchanges on the Federal platform. A discussion of the proposed ICRs for this policy may be found in the 2025 Marketplace Integrity and Affordability proposed rule (90 FR 12999 through 13000). We are updating the ICRs for this policy in this final rule to account for updated wage rates available after the publication of the proposed rule.

On December 9, 2024, the United States District Court for the District of North Dakota issued a preliminary injunction in *Kansas* v. *United States,* Case No. 1:24–cv–00150, 2024 WL 5220178 (D.N.D. Dec. 9, 2024). Per the district court's ruling, the 2024 DACA Rule is enjoined in three States that operate State Exchanges—Kentucky, Idaho, and Virginia. Even though DACA recipients are not currently eligible for Exchange coverage in these three States, we are still estimating that these State Exchanges may still need to make eligibility system changes in order to correctly implement this rule. This is because these State Exchanges may need to make changes in order to correctly re-implement the clarifying and technical changes to the definition of ''lawfully present'' that were included in the 2024 DACA Rule, and that are not altered by this final rule, but that are currently blocked in these three State Exchanges due to the court's injunction. We estimate that it will take the Federal Government and each of the State Exchanges 1,000 hours in 2025 to develop and code changes to their eligibility systems to correctly evaluate and verify eligibility under the revised definition of ''lawfully present,'' such that DACA recipients are no longer considered lawfully present for purposes of enrolling in a QHP offered through an Exchange, APTC, PTC, CSRs, or BHP coverage in States that elect to operate a BHP, as outlined in section III.B.1. of this final rule. This estimate is informed by the FFE's prior experience implementing similar system changes. Of those 1,000 hours, we estimate it will take a database and network administrator and architect 250 hours at $103.34 per hour and a computer programmer 750 hours at $94.88 per hour. In aggregate for the States, we estimate a one-time burden in 2025 of 20,000 hours (20 State Exchanges × 1,000 hours) at a cost of $1,939,900 (20 States × [(250 hours × $103.34 per hour) + (750 hours × $94.88 per hour)]) for completing the necessary updates to State Exchange eligibility systems.[253] For the Federal Government, we estimate a one-time burden in 2025 of 1,000 hours at a cost of $96,995 ([250 hours × $103.34 per hour] + [750 hours × $94.88 per hour]). In total, the burden associated with all system updates will be 21,000 hours at a cost of $2,036,895.

Next, we estimate costs associated with termination operations to end Exchange coverage for any DACA recipients who are already enrolled. This work will need to be done by the Federal Government, which will take steps to end coverage for DACA recipients enrolled in States with FFEs and SBE–FPs and ensure that DACA recipients are not renewed for future coverage years. Additionally, we anticipate that termination operations will occur in the 17 States that operate State Exchanges where the 2024 DACA Rule is not currently enjoined. We assume that in the three States that operate State Exchanges where the 2024 DACA Rule is enjoined, the States have already undertaken the work necessary to end coverage for DACA recipients and therefore will not need to perform additional work as a result of this rule.

We estimate that it will take the Federal Government and each of the 17 State Exchanges 1,000 hours in 2025 to terminate Exchange coverage for DACA recipients.[254] [255] This estimate is informed by the FFE's prior experience implementing similar system changes. Of those 1,000 hours, we estimate it will take a database and network administrator and architect 250 hours at $103.34 per hour and a computer programmer 750 hours at $94.88 per hour. In aggregate for the States, we estimate a one-time burden in 2025 of 17,000 hours at a cost of $1,648,915 (17 States × [(250 hours × $103.34 per hour) + (750 hours × $94.88 per hour)]) in 2025 for all termination operations. For the Federal Government, we estimate a one-time burden in 2025 of 1,000 hours at a cost of $96,995 ([250 hours × $103.34 per hour] + [750 hours × $94.88 per hour]). Collectively, we estimate that it will take the Federal Government and each of the State Exchanges 18,000 hours at an associated cost of $1,745,910 to end coverage for DACA recipients. We sought comments on these burden estimates, including regarding additional costs and benefits anticipated as a result of this proposal.

''Data Collection to Support Eligibility Determinations for Insurance Affordability Programs and Enrollment through Health Benefits Exchanges, Medicaid and CHIP Agencies,'' OMB Control Number 0938–1191 (CMS–10440) accounts for burdens associated with the streamlined application for enrollment in the programs impacted by this rule. As such, the following information collection addresses the burden of processing applications and assisting enrollees with BHP and Exchange QHP enrollment, and those impacts are not reflected in the ICRs for BHP, discussed in section IV.B.1. of this final rule.

For assisting eligible enrollees and processing their applications, we estimate this will take a government programs eligibility interviewer 10 minutes (0.17 hours) per application at a rate of $49.52 per hour, for a cost of approximately $8.42 per application. This estimate is based on past experience with similar application changes. As outlined further in section IV.B.3. of this final rule, we anticipate that approximately 11,000 fewer individuals impacted by this change will complete the application annually. Therefore, the total application processing burden associated with this policy will be reduced by 1,870 hours

[253] On December 9, 2024, the United States District Court for the District of North Dakota issued a preliminary injunction in *Kansas* v. *United States,* Case No. 1:24–cv–00150, 2024 WL 5220178 (D.N.D. Dec. 9, 2024). Per the district court's ruling, DACA recipients in three State Exchanges—Kentucky, Idaho, and Virginia—are not eligible to enroll in Exchange coverage. As a result, these three States may have already incorporated the necessary changes to their eligibility system and mailed any required notices to impacted consumers.

[254] Section 155.310(g).

[255] On December 9, 2024, the United States District Court for the District of North Dakota issued a preliminary injunction in *Kansas* v. *United States,* Case No. 1:24–cv–00150, 2024 WL 5220178 (D.N.D. Dec. 9, 2024). In compliance with the Court's order, CMS terminated enrollments for PY 2025 for DACA recipients in 16 States that are served by the Federal platform. All impacted consumers received notices regarding their ineligibility for Exchange coverage. These States are Alabama, Arkansas, Florida, Indiana, Iowa, Kansas, Missouri, Montana, Nebraska, New Hampshire, North Dakota, Ohio, South Carolina, South Dakota, Tennessee, and Texas.

(0.17 hours × 11,000 applications) for a total cost savings of $92,602 (1,870 hours × $49.52 per hour). As discussed further in this section, we anticipate an overall reduction in application processing burden for States and the Federal Government.

As outlined in section VI.C.1. of this final rule, we estimate that as a result of this policy, 10,000 fewer individuals will enroll in QHP coverage and 1,000 fewer individuals will enroll in a BHP on average each year, including redeterminations and re-enrollments.

The entire information collection savings associated with changes to BHPs falls on the two States that currently operate a BHP—Minnesota and Oregon.[256] As such, we assume 100 percent of the BHP application processing savings will fall on these two States. Using the per-application processing burden of 10 minutes (0.17 hours) per application at a rate of $49.52 per hour, and the estimate that 1,000 fewer individuals will apply for BHP, we anticipate a burden reduction of 170 hours with an associated cost savings of $8,418, for States to process BHP applications.

For the Exchanges, we use data from the 2024 OEP to estimate the proportion of applications that are processed by States compared to the Federal Government, and we determined that 49 percent of Exchange applications were submitted to FFEs/SBE–FPs, and are therefore processed by the Federal Government, while 51 percent were submitted to and processed by the 20 State Exchanges.[257] As such, we anticipate that 49 percent of Exchange application processing savings will be attributed to the Federal Government and 51 percent of Exchange application processing savings will be attributed to States using their own eligibility and enrollment platforms.

For the Exchanges, if we estimate 10,000 fewer applications will be processed, 51 percent of those (5,100) will no longer be processed by State Exchanges and 49 percent (4,900) will no longer be processed by the Federal Government. Using the per-application processing burden of 10 minutes (0.17 hours) per application at a rate of $49.52 per hour, we anticipate cost savings of $42,934 or a reduction by 867 hours for State Exchanges to process applications. Additionally, we estimate cost savings of $41,250 or a reduction by 833 hours for the Federal Government to process applications at a rate of $49.52 per hour. Therefore, the total burden on State Exchanges to assist eligible beneficiaries and process their applications will be reduced by 1,037 hours annually beginning in 2025 (170 hours for BHP + 867 hours for State Exchanges) with a net cost reduction of $51,352. The total burden on the Federal Government will be reduced by 833 hours annually beginning in 2025 (entirely for Exchanges), with a net cost reduction of $41,250.

In addition, Exchanges would have required individuals completing the application to submit supporting documentation to confirm their lawful presence if it was unable to be verified electronically through a data match with DHS via the Hub using DHS' Systematic Alien Verification for Entitlements (SAVE) system.[258] An applicant's lawful presence may not be able to be verified if, for example, the applicant opts to not include information about their immigration documentation such as their alien number or employment authorization document (EAD) number when they fill out the application. Therefore, we anticipate cost savings for Exchanges due to the reduction in lawful presence inconsistencies for DACA recipients who were not able to have their immigration status verified electronically during the application process.

Of the 10,000 fewer DACA recipients who will apply for Exchange coverage as a result of this rule, we estimate that 20 percent, or 2,000, will have generated an immigration status inconsistency.[259] Of these 2,000 inconsistencies, we assume that 51 percent of those (1,020) will no longer be processed by State Exchanges and 49 percent (980) will no longer be processed by the Federal Government.[260] To adjudicate an inconsistency, we estimate that it would have taken an eligibility support worker (BLS occupation code 43–4061) 12 minutes, or 0.2 hours, at an hourly rate of $49.52 to review submitted documentation. Therefore, for State Exchanges, we anticipate a net burden reduction of 204 hours (0.2 hours × 1,020 inconsistencies) with an equivalent cost savings of $10,102 (204 hours × $49.52 per hour). For the Federal Government, we anticipate a net burden reduction of 196 hours (0.2 hours × 980 inconsistencies), with an equivalent cost savings of $9,706 (196 hours × $49.52 per hour). In sum, we expect a burden reduction due to processing fewer immigration status inconsistencies of 400 hours (204 hours + 196 hours), with cost savings of $19,808 (400 hours × $49.52 per hour).

We sought comment on the estimates and the methodology and assumptions used to calculate them in the proposed rule. We are using revised estimates as presented above as a result of more recent data being available at the time of this final rule.

Comment: Many commenters are concerned that the finalization of this rule would require considerable burden on State Exchanges, States that operate a BHP, and FFE States, including requiring them to reverse current processes and change their systems in the middle of the year in order to terminate coverage for existing enrollees and halt future enrollment for DACA recipients. Commenters stated that estimates included in the proposed rule regarding the impact on all the States and Exchanges do not take into account expenditures related to customer outreach and education, changing call center scripts and website copy, and training for call center workers and consumer assisters.

Response: We appreciate these commenters' concerns. The burden estimates included in this section are informed by the FFE's past experience conducting similar systems changes. We believe these estimates should allow Exchanges and States that operate a BHP to plan for any additional expenditures caused by the finalization of this rule. We note that due to differing State systems and processes, we cannot include estimates related to customer outreach, education, and website updates.

Comment: Many State Exchanges, BHP agencies, and SBE–FPs, and other commenters noted concerns about being able to implement these changes upon finalization of the rule. A few commenters requested a detailed implementation plan to assist impacted Exchanges.

Response: We understand that State Exchanges, States that elect to operate a BHP, SBE–FPs, and the FFE will need to make changes to their eligibility and enrollment systems to correctly determine eligibility for DACA recipients as of the applicability date. We are committed to providing all Exchanges and State agencies that

[256] Minnesota's BHP began January 1, 2015. Oregon's BHP began July 1, 2024. For more information, *see* CMS. (n.d.) Basic Health Program. *https://www.medicaid.gov/basic-health-program/index.html.*

[257] CMS. (2024, March 27). Health Insurance Markets 2024 Open Enrollment Report. *https://www.cms.gov/files/document/health-insurance-exchanges-2024-open-enrollment-report-final.pdf.*

[258] 45 CFR 155.315(f).

[259] Estimates are based on internal CMS data comparing the number of immigration DMIs generated to the number of noncitizen enrollees during similar time periods during 2024, rounded to the nearest 5 percent.

[260] CMS. (2024, March 27). Health Insurance Markets 2024 Open Enrollment Report. *https://www.cms.gov/files/document/health-insurance-exchanges-2024-open-enrollment-report-final.pdf.*

operate a BHP with technical assistance and any additional support needed to ensure that States are able to correctly determine eligibility for DACA recipients impacted by this final rule's effective date. We are also committed to working with all Exchanges and State agencies that operate a BHP to identify any potential manual workarounds that may be needed to correctly determine eligibility prior to full systems changes being in place. For the reasons outlined in this final rule, we are finalizing these estimates as they appear in this section.

3. Application Process for Applicants

The following proposed changes will be submitted for review under OMB Control Number 0938–1191 (CMS–10440).

As required by the ACA, there is one application through which individuals may apply for health coverage in a QHP through an Exchange and for other insurance affordability programs like Medicaid, CHIP, and a BHP in a State that chooses to operate a BHP.[261] We note that we proposed no changes to the eligibility application for Medicaid and CHIP. Hence, this section only includes data on the burden associated with completing an application and submitting additional information to verify lawful presence, if necessary, for health coverage in a QHP through an Exchange and for BHP coverage.[262] A discussion of the proposed ICRs for this policy may be found in the 2025 Marketplace Integrity and Affordability proposed rule (90 FR 13000 through 13001). We are updating the ICRs for this policy in this final rule and removing the potential cost savings associated with these ICRs upon further analysis and reflection in finalizing these provisions.

We sought comment on the estimates and assumptions in the proposed rule.

We did not receive any comments in response to the burden estimates for this policy in the proposed rule. We are using revised assumptions as presented above as a result of additional analysis conducted at the time of this final rule. For the reasons outlined in the final rule, we are finalizing these assumptions as presented earlier in this section.

C. ICRs Regarding Failure To File and Reconcile (§ 155.305(f)(4))

We are finalizing an amendment to the current regulation at § 155.305(f)(4), under which an Exchange may not find an enrollee eligible for APTC where an enrollee or their tax filer has failed to file a Federal income tax return reconciling their APTC for 2 consecutive tax years, to increase the program integrity of the Exchange. We are finalizing the requirement for Exchanges to find enrollees ineligible for APTC after they or their tax filer has failed to file and reconcile their APTC for 1-tax year for coverage year 2026. However, the 1-year policy would sunset on December 31, 2026 and Exchanges would revert back to the current 2-year policy in coverage year 2027 that allows an Exchange to not find an enrollee eligible for APTC when an enrollee or their tax filer has failed to file a Federal income tax return reconciling their APTC for 2 consecutive tax years. This allows Exchanges to collect data on the 1-year policy. We will consider these data to determine whether to make permanent the 1-year FTR policy or to revert back to the 2-year FTR policy that was in place in coverage year 2025. For Exchanges on the Federal platform, the FTR process will otherwise be conducted similarly to the previous iterations of FTR prior to the 2024 Payment Notice, except that those identified as being in a 1-tax year FTR status will be at risk for removal of APTC and there will no longer be a 2-tax year FTR status population. Minimal changes to the language of the Exchange application questions will be necessary to obtain relevant information; as such, we anticipate that the amendment finalized in this rule will not impact the information collection burden for consumers. We anticipate that there will no longer be a 2 year FTR population for coverage year 2026, and thus the notices sent to the FTR population will be similar to the current 2-tax year FTR notices in inciting an urgency to act, but that all consumers with an FTR status will be in a 1-tax year FTR status for coverage year 2026. Due to this, we do not anticipate PRA impacts related to noticing requirements.

We sought comment on the proposed assumptions and any information collection burdens not identified in this section.

We did not receive any comments in response to the proposed assumptions for this policy. For the reasons outlined in the final rule, we are finalizing these assumptions as proposed.

D. ICRs Regarding Income Verification When Data Sources Indicate Income Less Than 100 Percent of the FPL (§ 155.320(c)(3)(iii))

The following changes will be submitted for review under OMB Control Number 0938–1191 (CMS–10440).

We are finalizing amendments to § 155.320(c)(3)(iii) to specify that all Exchanges must generate annual income inconsistencies when a tax filer's attested projected annual income would qualify the taxpayer as an applicable taxpayer according to 26 CFR 1.36B–2(b) and trusted data sources indicate that projected income is under 100 percent of the FPL. This policy will be effective upon the effective date of this rule, but with a modification under which the policy and related requirements will be sunset for all Exchanges at the end of PY 2026. Thereafter, this policy will no longer be effective. A discussion of the proposed ICRs for this policy may be found in the proposed rule (90 FR 13001 through 13002). We are updating the ICRs for this policy in this final rule to account for updated wage rates available after the publication of the proposed rule.

We anticipate that adding this income verification requirement will result in approximately 1 hour of time spent by consumers to complete associated questions in the application, or to submit supporting documentation. Based on historical data from the FFE, we estimate that approximately 340,000 inconsistencies will be generated at the household level for the Exchanges on the Federal platform. On the State Exchanges, we estimate this figure to be 208,000 inconsistencies. Therefore, adding these inconsistencies will increase burden on consumers by approximately 548,000 hours across all Exchanges. Using the estimate of the hourly value of time for changes in time use for unpaid activities calculated at $24.05 per hour in section IV.A. of this final rule, we estimate that the increase in cost for each consumer in 2026 will be approximately $24.05, and the cost increase for all consumers who will generate this income inconsistency in 2026 will be approximately $13,179,400 (548,000 hours × $24.05 cost of unpaid activities).

Additionally, we estimate that adding this income verification requirement will result in an increase in burden on the Exchanges on the Federal platform. Based on historical FFE data, we anticipate that approximately 340,000 inconsistencies will be generated at the household level for Exchanges using the Federal platform, and 208,000 in State

[261] 42 U.S.C. 18083.

[262] We assume that the burden of completing an application is essentially the same regardless of whether the individual applies directly with the State agency responsible for administering the BHP or with an Exchange.

Exchanges. Once households have submitted the required verification documents, we estimate that it will take approximately 1 hour and 12 minutes for an eligibility support staff person (Eligibility Interviewers, Government Programs—BLS occupation code 43–4061), at an hourly cost of $49.52, to receive, review, and verify submitted verification documents as well as conduct outreach and determine DMI outcomes. Therefore, adding these inconsistencies will result in an increase in burden on the Federal Government of 408,000 hours (340,000 verifications × 1.2 hours per verification) at a cost of $20,204,160 (408,000 hours × $49.52 per hour) in 2026, and an increase in burden on the State Exchanges of 249,600 hours (208,000 verifications × 1.2 hours per verification) at a cost of $12,360,192 in 2026.

Finally, we estimate that adding this income requirement will require costs related to updating the technical systems, including the eligibility system. We estimate that it will take the Exchanges on the Federal platform and each State Exchange 8,000 hours in 2025 to make these updates. Of those 8,000 hours, we estimate it will take a database and network administrator and architect 2,000 hours at $103.34 per hour and a computer programmer 6,000 hours at $94.88 per hour. Given this, we estimate that Exchanges on the Federal platform will incur a one-time burden in 2025 of $775,960 (2,000 × $103.34 + 6,000 × $94.88) to make these eligibility system updates. State Exchanges will incur a one-time burden of $14,743,240 (2,000 × $103.34 + 6,000 × $94.88 × 19). We also estimate that the Exchanges would incur the same burdens in 2026 in order to sunset the policy at the end of that year. Therefore, we estimate that Exchanges on the Federal platform will incur a one-time burden in 2026 of $775,960 (2,000 × $103.34 + 6,000 × $94.88) to make these eligibility system updates. State Exchanges will incur a one-time burden of $14,743,240 (2,000 × $103.34 + 6,000 × $94.88 × 19).

We sought comment on the proposed estimates and assumptions.

After consideration of comments and for the reasons outlined in the proposed rule and this final rule, including our responses to comments, we are finalizing these burden estimates for this policy with modifications to account for updated general occupational cost estimations and the sunsetting of this policy following the completion of PY 2026. These updated estimates are reflected in the cost estimates already laid out in this section of the final rule. We summarize and respond to public comments received on the original proposed estimates below.

Comment: Some providers and provider groups and organizations expressed concern that it could take vulnerable enrollees longer than 1 hour to submit documentation related to this income verification requirement.

Response: We acknowledge commenters' concerns and emphasize that 1 hour is an average. These consumers will still have 90 days to submit documentation to verify their annual household income. We provide a robust list of acceptable documents that households can submit to resolve their Income DMIs, and this list is included in multiple consumer notices and on the CMS website. We recommend that consumers for whom more common documents like paystubs and tax forms are either not available or are inaccurate submit other suggested income documents that may be more available and accurate.

E. ICRs Regarding Income Verification When Tax Data Is Unavailable (§ 155.320(c)(5))

The following changes will be submitted for review under OMB Control Number 0938–1191 (CMS–10440).

We are finalizing amendments to remove § 155.320(c)(5) which currently requires Exchanges to accept attestations, and not set an Income DMI, when the Exchange requests tax return data from the IRS to verify attested projected annual household income, but the IRS confirms there is no such tax return data available. We are finalizing this with a modification under § 155.320(c)(5): this final provision removes this policy upon the effective date of this rule and will be reinstated for all Exchanges at the end of PY 2026. A discussion of the proposed ICRs for this policy may be found in the 2025 Marketplace Integrity and Affordability proposed rule (90 FR 13002). We are updating the ICRs for this policy in this final rule to account for updated wage rates available after the publication of the proposed rule.

Based on internal historical DMI data, we estimate that approximately 1,722,000 inconsistencies will be generated at the household level for Exchanges using the Federal platform, and 1,056,000 will be generated at the household level for State Exchanges due to this final policy. Once households have submitted the required verification documents, we estimate that it will take approximately 1 hour and 12 minutes for an eligibility support staff person (BLS occupation code 43–4061), at an hourly cost of $49.52, to receive, review, and verify submitted verification documents as well as conduct outreach and determine DMI outcomes. Therefore, the removal of § 155.320(c)(5) will result in an increase in burden for the Federal Government of 2,066,400 hours (1,722,000 verifications × 1.2 hours per verification) at a cost of $102,328,128 (2,066,400 hours × $49.52 per hour) in 2026 and an increase in burden on State Exchanges of 1,267,200 hours (1,056,000 verifications × 1.2 hours per verification) at a cost of $62,751,744 (1,267,200 hours × $49.52 per hour) in 2026.

In addition to the increased administrative burden on Exchanges, this change will increase the number of consumers who are required to submit documentation to verify their income. We estimate that consumers will each spend 1 hour to answer the associated question, or to submit documentation. Based on historical data from the FFE, we estimate that approximately 2,777,000 inconsistencies will be generated at the household level across all Exchanges. Using the estimate of the hourly value of time for changes in time use for unpaid activities calculated at $24.05 per hour in section IV.A. of this final rule, we estimate that the increase in cost for each consumer in 2026 will be approximately $24.05 and that the proposed change will increase burden on consumers by 2,777,000 hours per year at an associated cost of $66,786,850 (2,777,000 hours × $24.05 per hour).

Finally, we estimate that removing the current process of verifying income attestations when IRS returns no data will require costs related to updating the eligibility system. We estimate that it will take Exchanges on the Federal platform and each State Exchange 9,000 hours in 2025 to make these updates. Of those 9,000 hours, we estimate it will take a database and network administrator and architect 2,250 hours at $103.34 per hour and a computer programmer 6,750 hours at $94.88 per hour. Given this, we estimate that the Federal Government will incur a one-time burden of $872,955 (2,250 × $103.34 + 6,750 × $94.88) to make these eligibility system updates. State Exchanges will incur a one-time burden total in 2025 of $16,586,145 ($872,955 × 19) associated with a total of 171,000 (9,000 × 19) burden hours. We also estimate that the Exchanges would incur the same burdens in 2026 in order to sunset the policy at the end of that year. Therefore, we estimate that Exchanges on the Federal platform will incur a one-time burden in 2026 of $872,955 (2,250 × $103.34 + 6,750 × $94.88) to make these eligibility system updates.

State Exchanges will incur a one-time burden total in 2026 of $16,586,145 ($872,955 × 19) associated with a total of 171,000 (9,000 × 19) burden hours.

We sought comment on the proposed impacts and assumptions.

After consideration of comments and for the reasons outlined in the proposed rule and this final rule, including our responses to comments, we are finalizing these burden estimates for this policy with modifications to account for updated general occupational cost estimations. These updated estimates are reflected in the cost estimates already laid out in this section of the final rule. We summarize and respond to public comments received on the original proposed estimates below.

Comment: Some providers and provider groups and organizations expressed concern that it could take vulnerable enrollees longer than 1 hour to submit documentation related to this income verification requirement.

Response: We acknowledge commenters' concerns and emphasize that 1 hour is an average. These consumers will still have 90 days to submit documentation to verify their annual household income, and may be eligible for extensions granted by the Exchanges on the Federal platform or State Exchanges under § 155.315(f)(3). In order to assist consumers in a wide variety of circumstances, we provide a robust list of acceptable documents that households can submit to resolve their Income DMIs, and this list is included in multiple consumer notices and on the CMS website. We recommend that consumers for whom more common documents like paystubs and tax forms are either not available or are inaccurate submit other suggested income documents that may be more available and accurate.

F. ICRs Regarding Annual Eligibility Redetermination (§ 155.335)

Under § 147.106(c) and (f), health insurance issuers that discontinue or renew non-grandfathered coverage under a product in the individual market (including coverage offered through the Exchanges) (including a renewal with uniform modifications), or that non-renew or terminate coverage under a product in the individual market (including coverage offered through the Exchanges) based on movement of all enrollees in a plan or policy outside the product's service area, are required to provide written notices to enrollees, in a form and manner specified by the Secretary.[263] Under § 156.1255, QHP issuers in the individual market must include certain information in the applicable renewal and discontinuation notices.[264] To satisfy these notice requirements, issuers in the individual market must use Federal standard notices, unless a State develops and requires the use of a different form consistent with CMS guidance.

This final rule amends the automatic re-enrollment hierarchy by removing § 155.335(j)(4), which allowed Exchanges to direct re-enrollment for enrollees who are eligible for CSRs from a bronze QHP to a silver QHP in the same product if the silver QHP has a lower or equivalent net premium after the application of APTC, and if the silver QHP has the same provider network as the bronze plan into which the enrollee would otherwise have been re-enrolled. To align with this change, we remove language related to the bronze to silver crosswalk from the Federal standard notices.

This final rule also requires enrollees who would otherwise be automatically re-enrolled in a QHP with a zero-dollar premium after application of APTC (''fully-subsidized'') by the Exchanges on the Federal platform to instead be automatically re-enrolled with APTC applied to the policy reduced such that the enrollee owes a $5 premium in PY 2026. This policy sunsets after PY 2026 and reverts back to current policy. We updated the Federal standard notices to include language related to this requirement.

The burden to issuers related to sending the Federal standard notices is currently approved under OMB Control Number 0938–1254 (CMS–10527).[265] The information collection has been revised to incorporate the necessary language modifications in the Federal standard notices due to the changes in this final rule. However, we do not anticipate any change in burden to issuers.

[263] The requirement to provide notices of renewal applies to issuers in the individual or small group market. The requirement to provide notices of product discontinuation and notices of non-renewal or termination based on enrollees' movement outside the service area applies to issuers in the individual or group market. *See* section 2703 of the PHS Act and 45 CFR 147.106. These requirements also apply with respect to grandfathered coverage pursuant to sections 2712 (former) and 2742 of the PHS Act and §§ 146.152 and 148.122.

[264] Section 156.1255(a) through (d).

[265] OMB Control Number 0938–1254 (CMS–10527, Annual Eligibility Redetermination, Product Discontinuation and Renewal Notices).

G. ICRs Regarding Pre-Enrollment Verification for Special Enrollment Periods (§ 155.420)

The following changes will be submitted for review under OMB Control Number 0938–1191 (CMS–10440).

We are temporarily finalizing amendments to § 155.420(g) to require all Exchanges to conduct eligibility verification for SEPs. Specifically, are finalizing removal of the limit on Exchanges on the Federal platform to conducting pre-enrollment verifications for only the loss of minimum essential coverage SEP. With this limitation removed, we are finalizing the requirement to conduct pre-enrollment verifications for most categories of SEPs for Exchanges on the Federal platform in line with operations prior to the implementation of the 2023 Payment Notice. At this time, we are finalizing this policy for PY 2026 only, with a reversion to the previous policy for PY 2027 and beyond.

We are also temporarily finalizing that Exchanges must conduct SEP verification for at least 75 percent of new enrollments through SEPs for consumers not already enrolled in coverage through the applicable Exchange. We are finalizing that Exchanges must verify at least 75 percent of such new enrollments based on the current implementation of SEP verification by Exchanges. At this time, we are finalizing this policy for PY 2026 only, with a reversion to the previous policy for PY 2027 and beyond. A discussion of the proposed ICRs for this policy may be found in the 2025 Marketplace Integrity and Affordability proposed rule (90 FR 13003). We are updating the ICRs for this policy in this final rule to account for updated wage rates available after the publication of the proposed rule.

We anticipate that adding this expansion of pre-enrollment verification for SEPs will result in approximately 1 hour of time spent by consumers to complete associated questions in the application or submit supporting documentation. Based on historical data from the FFE, we estimate that approximately 293,073 new SEP verification issues will be generated at the household level for Exchanges on the Federal platform. Therefore, adding these inconsistencies will increase burden on consumers by approximately 293,073 hours. Using the estimate of the hourly value of time for changes in time use for unpaid activities calculated at $24.05 per hour in section IV.A. of this final rule, we estimate that the increase in cost for each consumer will be

approximately $24.05 in 2026, and the cost increase for all consumers who generate this income inconsistency will be approximately $7,048,406 in 2026.

Additionally, we estimate that expanding pre-enrollment verification for SEPs will result in an increase in burden on Exchanges using the Federal platform and State Exchanges. Based on historical FFE data, we anticipate that approximately 293,073 inconsistencies will be generated at the household level for Exchanges using the Federal platform, and 179,625 inconsistencies will be generated at the household level for Exchanges not using the Federal platform. Once households have submitted the required verification documents, we estimate that it will take approximately 12 minutes for an eligibility support staff person (BLS occupation code 43–4061), at an hourly cost of $49.52, to review and verify submitted verification documents. Therefore, expanding verification will result in an increase in burden on Exchanges using the Federal platform of 58,615 hours (293,073 verifications × 0.2 hours per verification) at a cost of $2,902,615 (58,615 hours × $49.52 per hour) in 2026.

We sought comment on the proposed estimates and assumptions.

As discussed, after careful consideration of public comments, we have decided to finalize and implement these policies with a significant modification—for Exchanges on the Federal platform, each of the rules outlined in this section will sunset by their terms after the completion of one new coverage year, PY 2026, on December 31, 2026. We are declining to finalize these proposals for State Exchanges. We have also added the one-time development cost estimate to this section.

Comment: States, providers, actuaries, labor groups, general advocacy groups, individuals, and one health insurance issuer raised general concern about the administrative burden and cost on States of implementing pre-enrollment SEP verification and expressed that States do not experience the same level of fraud cited for Exchanges on the Federal platform.

Response: We acknowledge commenters' concerns. However, after careful consideration of public comments, we have decided to finalize and implement the proposed policy with a significant modification—for all Exchanges, each of the rules outlined in this section will sunset by their terms after the completion of one new coverage year, PY 2026, on December 31, 2026 with a reversion to the previous policy for PY 2027 and beyond. We will not be finalizing these proposals for State Exchanges in an effort to address concerns around increased burdens and costs.

H. Summary of Annual Burden Estimates for Finalized Requirements

TABLE 9—FINALIZED ANNUAL RECORDKEEPING AND REPORTING REQUIREMENTS

Regulation section(s)	OMB control No.	Number of respondents	Number of responses	Burden per response (hours)	Total annual burden (hours)	Labor cost of reporting ($)	Total cost ($)
155.20 (Exchange)	0938–1191	−11,000	−11,000	0.17	−1,870	−$92,602	−$92,602
Total					−1,870		−92,602

I. Submission of PRA-Related Comments

We have submitted a copy of this final 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 OMB.

To obtain copies of the supporting statement and any related forms for the collections discussed above, please visit CMS' website at *www.cms.hhs.gov/PaperworkReductionActof1995,* or call the Reports Clearance Office at 410–786–1326.

V. Regulatory Impact Analysis

A. Statement of Need

We are finalizing the exclusion of DACA recipients from the definitions of ''lawfully present'' that are used to determine eligibility to enroll in a QHP through an Exchange, for PTC, APTC, and CSRs, and to enroll in a BHP in States that elect to operate a BHP, which will be applicable as of the effective date of this rule and beyond. This rule also finalizes the policy contained in the proposed rule to reverse the policy restricting an issuer from denying coverage due to an individual's or employer's failure to pay premiums owed for prior coverage, including by attributing payment of premium for new coverage to past-due premiums from prior coverage, which will be applicable as of the effective date of this rule and beyond. Additionally, we are finalizing temporary revisions to the FTR process at § 155.305(f)(4) to reinstate the policy that Exchanges must determine enrollees ineligible for APTC when HHS notifies the Exchange that they or their tax filer has failed to file a Federal income tax return and reconcile their past APTC for a year for which their tax data would be utilized to verify their eligibility. This policy is effective for PY 2026, and we are sunsetting this policy at the end of PY 2026 with a reversion to the previous policy for PY 2027 and beyond. We also are finalizing policies to strengthen the verification process around annual household income, which will be applicable as of the effective date of this rule, and we are sunsetting these policies pertaining to income verification when data sources indicate income less than 100 percent of the FPL and income verification when tax data is unavailable for State Exchanges at the end of PY 2026 with a reversion to the previous policies for PY 2027 and beyond. We are further finalizing a temporary requirement for Exchanges on the Federal platform that enrollees who would otherwise be automatically re-enrolled in a QHP with a zero dollar premium after application of APTC (''fully-subsidized'') will instead be automatically re-enrolled with APTC applied to the policy reduced such that the enrollees owe a 5-dollar premium if they do not submit an application for an updated eligibility determination to the Exchanges on the Federal platform. This requirement is being finalized as effective for PY 2026 only, with a reversion to the previous policy for PY 2027 and beyond. We also are finalizing an amendment to the automatic reenrollment hierarchy by removing § 155.335(j)(4) which currently allows Exchanges to move an enrollee from a bronze QHP to a silver QHP if the silver QHP has a lower or equivalent net premium after the application of APTC, and if the silver QHP is in the same product and has the same provider network as the bronze plan into which the enrollee would otherwise have been re-enrolled. We are finalizing this policy to be effective for

PY 2026 and beyond. We also are finalizing a temporary removal of the fixed-dollar and gross percentage-based premium payment thresholds at § 155.400(g), which will be applicable as of the effective date of this rule and we are sunsetting this policy at the end of PY 2026 with a reversion to the previous policy for PY 2027 and beyond. We are finalizing changing the annual OEP for coverage through all individual market Exchanges beginning with the PY 2027 OEP. We are finalizing flexibility for Exchanges to set their own OEP as long as: the start date is no later than November 1, the end date is no later than December 31, the OEP does not exceed 9 weeks, and all coverage pursuant to enrollments during the OEP begins January 1. Additionally, we are finalizing a pause of § 155.420(d)(16) and making conforming changes to repeal the monthly SEP for qualified individuals or enrollees, or the dependents of a qualified individual or enrollee, who are eligible for APTC, and whose projected household income is at or below 150 percent of the FPL. This finalized policy will be applicable as of the effective date of this rule, and we are sunsetting this policy at the end of PY 2026 with a reversion to the previous policy for PY 2027 and beyond. We also are finalizing an amendment to § 155.420(g) to enable HHS to temporarily reinstate (with modifications) pre-enrollment verification of eligibility of applicants for all categories of individual market SEPs. This policy is effective for PY 2026, and we are sunsetting this policy at the end of PY 2026 with a reversion to the previous policy for PY 2027 and beyond. Additionally, we are finalizing a prohibition on covering specified sex-trait modification procedures as an EHB and adding a definition of ''specified sex-trait modification procedure,'' which will be effective for PY 2026 and beyond. Finally, we are finalizing a change to the premium adjustment percentage methodology to establish a premium growth measure that comprehensively reflects premium growth in all affected markets, and we are finalizing revised AV de minimis ranges. These finalized policies will be effective for PY 2026 and beyond.

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''; the Regulatory Flexibility Act (RFA) (Pub. L. 96–354); section 1102(b) of the Social Security Act; section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4); and the Congressional Review Act (5 U.S.C. 804(2)).

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, 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 impact 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) must be prepared for a regulatory action that is significant under Executive Order 12866. Based on our estimates, OMB's Office of Information and Regulatory Affairs (OIRA) has determined this rulemaking is significant under section 3(f)(1). Pursuant to Subtitle E of the Small Business Regulatory Enforcement Fairness Act of 1996 (also known as the Congressional Review Act), OIRA has also determined that this is a rule as defined under 5 U.S.C. 804(2).

C. Impact Estimates of the Final Individual Market Program Integrity Provisions and Accounting Table

Consistent with OMB Circular A–4,[266] we have prepared an accounting statement in Table 10 showing the classification of the impact associated with the provisions of this final rule. We have included the undiscounted annual impacts in Table 11.

This final rule implements standards for programs that will have numerous effects, including supporting program integrity, reducing the impact of adverse selection, and stabilizing premiums in the individual and small group health insurance markets and in Exchanges. We are unable to quantify and monetize all the benefits and costs of this final rule. The effects in Table 10 reflect qualitative assessment of impacts and estimated direct monetary costs and transfers resulting from the provisions of this final rule for Exchanges, health insurance issuers, and consumers. The individual effects of each provision in this final rule are presented separately in Table 10 and collectively in Table 11, but we anticipate these estimates may overlap, as some individuals could be impacted by multiple provisions. Therefore, in section V.C.18. of this final rule, we present overall impact estimates of all provisions considered jointly. Due to the sunsetting of certain provisions, there is a risk that some improper enrollment returns with an adverse impact on the risk pool. This level of risk is not certain and difficult to estimate, but we have accounted for this uncertainty by providing a range of estimates in this analysis.

TABLE 10—ACCOUNTING TABLE

	Estimate (million)	Year dollar	Discount rate (percent)	Period covered
Benefits:				
Annualized Monetized ($/year)	$0.2	2025	7	2025–2029
Annualized Monetized ($/year)	$0.2	2025	3	2025–2029

Quantified:

[266] Available at *https://trumpwhitehouse.archives.gov/sites/whitehouse.gov/files/omb/circulars/A4/a-4.pdf.*

[267] Regarding references to APTC transfers from the Federal Government to issuers in this table and Accounting Table 11 in the proposed rule (90 FR 13006 through 13009), the Department notes that some of these dollars ultimately flow from issuers to other entities like providers and jurisdictions that reimburse uncompensated care, as referenced earlier in this table where we discuss potential costs to State governments and private hospitals in the form of charity care for individuals who become uninsured as a result of policies in this final rule.

TABLE 10—ACCOUNTING TABLE—Continued

- Annual reduction in costs starting in 2025 of $41,250 in application processing savings for the Federal Government and $51,352 total for State Exchanges and States that choose to operate BHPs as a result of fewer individuals applying for coverage associated with the policy regarding the definition of ''lawfully present.''
- Annual reduction in costs starting in 2025 of $10,102 total for State Exchanges and $9,706 for the Federal Government as a result of fewer individuals generating immigration status inconsistencies associated with the policy regarding the definition of ''lawfully present.''
- One-time reduction in costs in 2026 of $92,400 total for States and $292,000 for the Federal Government as a result of not sending an additional 2-tax year notice to consumers found as failing to file and reconcile.

Non-quantified:

- Reduction in the risk of adverse selection associated with the policy to permit attribution of payment for new coverage to past-due premium amounts.
- Reduction in outstanding premium debt amount for enrollees resulting in potential improvement in their financial standing over time and a reduced likelihood of any debt being placed into collections associated with the policy to permit attribution of payment for new coverage to past-due premium amounts.
- Improved continuous coverage for enrollees and premium collection rates and reduced administrative costs for issuers associated with the policy to permit attribution of payment for new coverage to past-due premium amounts.
- Increased transparency for agents, brokers, and web-brokers by establishing an evidentiary standard to be used during investigations of agent, broker, or web-broker noncompliance under § 155.220(g)(1)–(3).
- Reduced potential for APTC recipients to incur large tax liabilities in 2026 as a result of the policies regarding FTR and income verification in this final rule.
- Simplified operational processes for issuers and the Exchanges associated with the policy regarding the annual OEP length.
- Improved continuous coverage for the full year and improved risk pool associated with the policy regarding the annual OEP length.
- Increased issuer participation and improved coverage options, resulting in an improved overall risk pool and reduced overall costs associated with the policy to revise the AV de minimis ranges.
- Better matches between consumers' coverage preferences and available coverage offerings and a reduction in financial burden due to improper enrollment associated with the policies in this rule.
- Reduction in improper enrollments of fully-subsidized enrollees by agents, brokers, and web-brokers associated with the policies in this rule.

	Estimate (million)	Year dollar	Discount rate (percent)	Period covered
Costs:				
Annualized Monetized ($/year)	$132.0	2025	7	2025–2029
Annualized Monetized ($/year)	$125.6	2025	3	2025–2029

Quantified:

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

TABLE 10—ACCOUNTING TABLE—Continued

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

Non-quantified:

- Total reduced annual enrollment between 725,000 and 1,800,000 individuals in PY 2026, including:
  - Reduced annual QHP enrollment of 10,000 and annual BHP enrollment of 1,000 associated with the policy to exclude DACA recipients from the definition of ''lawfully present'' used to determine eligibility for enrollment in a QHP through an Exchange, for APTC and CSRs, and for a BHP in States that operate BHPs.
  - Potential increase in the number of people who owe past-due premiums who may be deterred from enrolling in new coverage due to a higher initial premium payment associated with the policy to permit attribution of payment for new coverage to past-due premium amounts.
  - Potential loss of coverage for PY 2026 only due to non-payment of premiums for some automatically re-enrolled, fully-subsidized enrollees associated with the annual eligibility redetermination provision, if these enrollees do not submit an application for an updated eligibility determination and subsequently experience a decrease in the amount of APTC applied to their policy such that the remaining monthly premium owed by the enrollee for the entire policy equals $5 for the first month and for every following month that the enrollee does not confirm or update the eligibility determination, and fail to make payment of the premium amount due.
  - Reduced annual enrollment by 80,000 beginning in 2026 due to decreases in PTC subsidies for enrollees, based on an assumption that the Department of the Treasury and the IRS will adopt the use of the same premium measure finalized for the calculation of the premium adjustment percentage in this rule for purposes of calculating the indexing of the PTC applicable percentage and the required contribution percentage under section 36B of the Code.
- Small negative impact on the individual market risk pool associated with the policy to exclude DACA recipients from the definition of ''lawfully present'' for purposes of enrolling in a QHP offered through an Exchange, APTC, PTC, CSRs, or BHP coverage in States that elect to operate a BHP, as well as the return to the FTR 1-year policy for QHPs offered on an Exchange, which is likely offset by the improvement in the risk pool as a result of the reduced premiums anticipated to result from this final rule.
- Potential costs to the Federal Government and to States to provide limited Medicaid coverage for the treatment of an emergency medical condition for DACA recipients who have an emergency medical condition and meet all other Medicaid eligibility requirements in their State, applicable to those DACA recipients who would become uninsured due to the policy regarding the definition of ''lawfully present.''
- Potential increase in costs and medical debt for individuals who are deterred from enrolling due to a higher initial premium payment, which could in turn lead to increased costs incurred by hospitals and municipalities associated with the policy to permit attribution of payment for new coverage to past-due premium amount.
- Potential costs to State governments and private hospitals in the form of charity care for individuals who become uninsured as a result of the policies in this final rule.
- Potential increase in Federal and State Medicaid expenditures by enrolling more people in Medicaid who would otherwise have enrolled in APTC-subsidized QHP coverage due to the policy regarding income verification for individuals with incomes below 100 percent of the FPL.
- Time costs to enrollees who would be automatically re-enrolled in their QHP with a $0 premium after application of APTC to submit an application for an updated eligibility determination to the Exchanges on the Federal platform associated with the annual eligibility redetermination provision for PY 2026 only.
- Costs to the Federal Government, State Exchanges, and issuers for outreach activities associated with the shortened OEP.
- Enrollment for 293,073 enrollees potentially delayed for 1–3 days for SEP verification.

	Low (billion)	High (billion)	Year dollar	Discount rate (percent)	Period covered
Transfers:					
Annualized Monetized ($/year)	−$3.8	−$3.9	2025	7	2025–2029
Annualized Monetized ($/year)	−$3.7	−$3.8	2025	3	2025–2029

Quantified:

- Reduced annual transfers from the Federal Government to issuers[267] of $34 million in APTC payments and $3.2 million in BHP payments associated with the policy to exclude DACA recipients from the definition of ''lawfully present'' for purposes of enrolling in a QHP offered through an Exchange, APTC, PTC, CSRs, or BHP coverage in States that elect to operate a BHP, beginning in 2026.
- Reduced one-time APTC transfers from the Federal Government to issuers of up to $1.28 billion associated with the policies regarding FTR in 2026.
- Annual reduction in APTC transfers from the Federal Government to issuers of $266 million beginning in 2025 for households across all Exchanges who receive fewer months of APTC due to no longer receiving an automatic 60 days of additional time to resolve their income DMI.

TABLE 10—ACCOUNTING TABLE—Continued

- Reduction in APTC transfers from the Federal Government to issuers of $191 million in 2026 for consumers across all Exchanges who receive fewer months of APTC due to reinstatement of DMIs where households attest to income that would qualify the tax payer as an applicable taxpayer per 26 CFR 1.36B–2(b) and data sources show income below 100 percent of the FPL.
- Reduction in APTC transfers from the Federal Government to issuers of $957 million in 2026 for households across all Exchanges who receive fewer months of APTC due to reinstatement of DMIs when IRS data is not available.
- One-time reduction in APTC transfers from the Federal Government to issuers of $817,571,843 in 2026 associated with the policy regarding premium payment thresholds.
- Reduction in APTC transfers from the Federal Government to issuers of approximately $3.4 billion in 2026 associated with the policy to pause the 150 percent FPL SEP, which is anticipated to reduce premiums by 3 to 4 percent.
- Reduction in APTC transfers from the Federal Government to issuers of approximately $105.4 million in 2026 associated with the policy to revise pre-enrollment verification requirements for SEPs, associated with a reduction in premiums of approximately 0.5–1.0 percent for PY.
- Reduced annual transfers from the Federal Government to issuers of between $1.27 billion and $1.55 billion in APTC payments beginning in 2026, assuming that the Department of the Treasury and the IRS will adopt the use of the same premium measure finalized for the calculation of the premium adjustment percentage in this rule for purposes of calculating the indexing of the PTC applicable percentage and the required contribution percentage under section 36B of the Code.
- Increased annual transfers from large employers to the Federal Government of between $3 million and $20 million in Employer Shared Responsibility Payments annually over the period of 2028 to 2030, based on an assumption that the Department of the Treasury and the IRS will adopt the use of the same premium measure finalized for the calculation of the premium adjustment percentage in this rule for purposes of calculating the indexing of the PTC applicable percentage and the required contribution percentage under section 36B of the Code.
- Reduced annual APTC transfers from the Federal Government to issuers of approximately $1.22 billion in 2026, $1.28 billion in 2027, $1.33 billion in 2028, and $1.40 billion in 2029 associated with an estimated 1 percent premium decrease on average for individuals eligible for PTC due to the policy to require individual market silver QHPs to provide an AV between 66–72 percent and associated income-based CSR plan variations to follow a de minimis range of +1/−1.

Non-quantified:

- Reduction in net Federal PTC spending associated with policy terminations during PY 2026 if enrollees do not pay their portion of the premium and a reduction in improper enrollments occurs due to the temporary annual eligibility redetermination provision.
- Reduced premiums and APTC cost to the Federal Government associated with the policy regarding the annual OEP length.
- Decreased premiums for plans that do not cover specified sex-trait modification procedures as an EHB as a result of this final rule.
- Reduction in commission payments from issuers to agents, brokers, and web-brokers associated with a reduction in improper enrollments of fully-subsidized enrollees by agents, brokers, and web-brokers due to the policies in this final rule.

TABLE 11—SUMMARY OF UNDISCOUNTED ANNUAL IMPACTS REPORTED IN ACCOUNTING TABLE

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

1. Coverage Denials for Failure To Pay Premiums for Prior Coverage (§ 147.104(i))

This final rule revises § 147.104(i) to reverse the policy prohibiting an issuer from denying coverage due to an individual's or employer's failure to pay premiums owed for prior coverage, including by attributing payment of premium for new coverage to past-due premiums from prior coverage. The final rule allows an issuer, to the extent permitted by applicable State law, to establish terms of coverage that add past-due premium amounts owed to the issuer (or owed to another issuer in the same controlled group) to the initial premium the applicant must pay to effectuate new coverage and to refuse to effectuate new coverage if the initial and past-due premium amounts are not paid in full. An issuer adopting this policy must apply its past-due premium payment policy uniformly to all individuals or employers in similar circumstances in the applicable market and State regardless of health status, and consistent with applicable nondiscrimination requirements, and not condition the effectuation of new coverage on payment of past-due premiums by any individual other than the person contractually responsible for the payment of premium. The amount of the past-due premium an issuer may require for this purpose is subject to any premium payment threshold the issuer has adopted pursuant to 45 CFR 155.400(g).

This policy aims to promote continuous coverage while providing issuers with an additional mechanism for past-due premium collection. The policy may help reduce outstanding premium debt amounts for enrollees, potentially benefiting their financial standing over time and reducing the likelihood of any debt being placed into collections. Additionally, this final rule may potentially improve premium collection rates and reduce administrative costs associated with repeated enrollment-termination cycles and other collection methods.

The comments and our responses are summarized below.

Comment: Some commenters highlighted important operational considerations, including the cost-benefit analysis issuers must undertake when implementing collection practices, and noted that some issuers may find that the implementation costs outweigh potential revenue from collections, particularly for nominal amounts.

Response: We acknowledge and recognize that, should the State in which an issuer operates allow issuers to collect past-due premiums to effectuate coverage, the final business decision will remain at the discretion of individual issuers and what they feel is in their best interest.

Comment: Some commenters expressed their support for the proposed

policy. One commenter specifically identified positive aspects of the policy, notably its potential to reduce administrative burden and address adverse selection.

Response: We recognize that the ability to require past-due premium payments to effectuate new coverage can assist in maintaining stable risk pools by promoting continuous coverage and, consequently, help to moderate premium costs for all enrollees.

Past-due premiums can influence both issuer operations and market dynamics. This can occur if enrollees choose to move in and out of coverage based on anticipated health care needs by taking advantage of certain features in the insurance system, such as the regulatory grace period provisions, and allowing coverage to lapse without addressing premium obligations even when seeking to enroll in new coverage. By addressing these circumstances, this policy encourages continuous coverage and reduces the burden on issuers to collect past-due premiums in other ways. This policy reduces the risk of adverse selection by consumers.

Comment: Many commenters raised concerns about the potential impacts on coverage access, particularly in markets with limited competition where there may be a limited number of issuers serving that geographic area, and noted the potential for varying effects in different market contexts.

Response: We note that this policy provides States flexibility to address adverse selection based on their specific market conditions and allows for appropriate market-specific solutions that recognize the differences between competitive and less competitive regions. We believe this flexible approach strikes an appropriate balance between preserving consumer access to coverage and accounting for varying market conditions across regions.

This policy may also increase enrollment by encouraging enrollees to maintain continuous coverage. These enrollment gains may be partially offset by people who owe past-due premiums and who may be deterred from enrolling in new coverage due to a higher initial premium payment. Some enrollees, particularly those facing financial constraints, may need to adjust their household budgets to maintain coverage or, if they are not able to, become uninsured. Depending on the circumstances, these enrollees, if they become uninsured, may face higher costs for care and medical debt if care is needed. These costs may, in turn, be incurred by hospitals and municipalities in the form of uncompensated care. While some consumers may face challenges paying past-due premiums and may become or remain uninsured, the longer-term effects can include more stable risk pools and potentially more moderate premium trends.

Comment: Many commenters expressed concerns about the potential impacts on vulnerable populations and healthcare access, particularly for low-income individuals, rural communities, and those facing unexpected financial hardships. These commenters highlighted specific challenges faced by individuals who miss payments due to unexpected life circumstances, economic hardship, or administrative confusion.

Response: We acknowledge the range of concerns noted by commenters related to barriers to coverage for those experiencing financial difficulties, potential impacts on rural communities with limited issuer competition, and effects on young and healthy enrollees who contribute to a stable risk pool. However, after reviewing the comments, we are finalizing this policy contained in the proposal by codifying it in regulation text. This decision reflects our assessment that the policy provides necessary tools for maintaining market stability within the existing framework. This policy aims to balance multiple objectives, including promoting continuous coverage, maintaining stable risk pools, addressing concerns about adverse selection, and respecting States' ability to regulate their insurance markets. We recognize that some enrollees may face challenges in maintaining continuous coverage or addressing past-due premium obligations. However, this policy's flexible framework allows States and issuers to make market-specific decisions about implementation based on their understanding of local conditions and population needs. This flexibility also enables issuers to balance past-due premium practices with member retention goals and market stability considerations.

There is some uncertainty regarding the net enrollment effects of this policy—that is, whether the coverage gains from moderate premium trends and promoting continuous coverage will be higher than coverage losses due to allowing issuers to require payment of past-due premiums to effectuate new coverage. We anticipate any discouragement from enrolling will be minimal. As discussed earlier in this preamble, when a similar policy was previously in place, the percentage of enrollees in Exchanges using the Federal platform who had their coverage terminated for non-payment of premiums dropped substantially. While the data analysis did not indicate any specific reason for this reduction, it is possible that the policy may have successfully encouraged more people to maintain continuous coverage. This likely reduced the number of people with past-due premium debt and lowered costs to issuers related to the collection of those past-due premiums. We expect this policy will result in similar benefits. While we lack data to quantify these effects, we believe that these effects will collectively contribute to more stable market conditions over time.

Comment: Several commenters noted their concern over the data limitations and the empirical basis for the proposed policy on past-due premium collection.

Response: We acknowledge commenters' concerns. While acknowledging these data limitations, based on our understanding of market dynamics and previous experience, we have decided to finalize the policy contained in the proposal. Although we cannot definitively quantify all effects, we have observed patterns suggesting that allowing issuers to condition the sale of new coverage on payment of past-due premiums can contribute to market stability. Additionally, as discussed in section III.A.2 of this final rule, States may choose whether to allow issuers to attribute the initial premium payment to past-due premiums and to refuse to effectuate new coverage until both amounts are paid. We believe States will make these determinations based on their specific markets, demographics, and anticipated outcomes for their constituents.

Finally, in terms of PTCs, given that this policy aims to encourage continuous coverage, we recognize that there could be varying effects in net Federal PTC spending. While some individuals might have their policies terminated due to non-payment, potentially reducing PTC spending, others might be encouraged by this policy to maintain coverage they would otherwise have dropped due to past-due premium issues, resulting in increased PTC spending for those months the individuals would otherwise not have maintained coverage. However, we do not anticipate any significant impact on PTCs.

2. Definitions; Deferred Action for Childhood Arrivals (§ 155.20)

We are finalizing modifications to the definition of ''lawfully present'' currently articulated at § 155.20 and used for the purpose of determining whether a consumer is eligible to enroll in a QHP through an Exchange and to

enroll in a BHP in States that elect to operate a BHP. This change will exclude DACA recipients from the definition of ''lawfully present'' that is used to determine eligibility to enroll in a QHP through an Exchange, for PTC, APTC, and CSRs, and for BHP coverage. We have updated the RIA for this policy due to revised wage rates and other data estimates available between the time of the proposed and final rule publication dates. The proposed 2025 Marketplace Integrity and Affordability RIA for this policy may be found at 90 FR 13010 through 13011.

We anticipate excluding DACA recipients from the definition of ''lawfully present'' will reduce annual QHP enrollment through the Exchanges by 10,000 and annual BHP enrollment by 1,000 in 2025. We project this decline in enrollment in QHP enrollment through the Exchanges will reduce annual APTC expenditures by $34.0 million and the decline in enrollment in BHP will reduce annual BHP expenditures by $3.2 million beginning in 2026.

While initial estimates under the ACA expansion to DACA recipients estimated 100,000 DACA recipients would receive coverage, actual Exchange enrollment of DACA recipients has been much lower. Comparing CMS internal data for participating FFE States to the count of active DACA recipients from U.S. Citizenship and Immigration Services (USCIS) [268] showed an enrollment rate of 2 percent among DACA recipients; however, 1.3 percent of enrollment was in States that received an injunction preventing enrollment in coverage. With this new information, we have updated our DACA enrollee assumptions to 10,000 Exchange enrollees and 1,000 BHP enrollees. With the average age of DACA recipients being 30.6, we assume an APTC amount of $283 per month, leading to an expected approximately $34 million reduction in APTC expenditures through the Exchange ($10,000 \times \$283 \times 12$ months = $33,960,000). Similarly, we expect approximately $3.2 million in lower BHP expenditures ($1,000 \times \$283 \times 0.95 \times 12$ months = $3,226,200) in States that choose to operate BHPs.

Because DACA recipients are young,[269] they generally tend to be healthier. We therefore anticipate that excluding DACA recipients from individual market QHP coverage offered through the Exchanges will have a small negative impact on the individual market risk pool. Some DACA recipients who lose Exchange or BHP coverage may be able to enroll in non-Exchange coverage. However, we anticipate the majority who lose Exchange or BHP coverage will become uninsured. This may result in costs to the Federal Government and to States to provide limited Medicaid coverage for the treatment of an emergency medical condition to DACA recipients who have a qualifying medical emergency and who become uninsured as a result of this rule.

We also anticipate that this change will result in costs to State Exchanges and the Federal Government to update eligibility systems in accordance with this policy. As discussed further in section IV.B. of this final rule, in aggregate for the States, we estimate a one-time cost in 2025 of $1,959,299 total ($1,939,900 for State Exchanges + $19,399 for BHPs) total and $96,995 for the Federal Government. We also estimate a one-time cost in 2025 for termination operations of $1,648,915 total for State Exchanges and $96,995 for the Federal Government, as discussed further in section IV.B.2. of this final rule. In addition, we estimate cost savings annually beginning in 2025 for State Exchanges and States that operate BHPs of $51,352 total and for the Federal Government of $41,250 associated with assisting fewer eligible beneficiaries and processing their applications as a result of this policy. We also estimate cost savings annually beginning in 2025 for State Exchanges of $10,102 in total and for the Federal Government of $9,706 associated with processing fewer immigration state inconsistencies.

We sought comment on the proposed impact estimates and assumptions, the details of which may be found in section IV.B. of the proposed rule.

Comment: Many commenters stated that CMS underestimated how many DACA recipients would apply in the next open enrollment. They stated that DACA recipient enrollment would increase over time as awareness of the coverage option grew. They further stated that enrollment was limited for PY 2025 because we published the 2024 DACA rule (89 FR 39424) only 6 months before open enrollment creating a short window for outreach campaigns, and because we cancelled 2025 enrollment for DACA recipients in 19 States to comply with *Kansas* v. *United States.*

Furthermore, one commenter stated that the estimates in the 2025 Marketplace Integrity and Affordability proposed rule, or even the estimates from the 2024 Final Rule (89 FR 39424) of 100,000 DACA recipients enrolled in the Exchanges and 1,000 enrolled in BHPs, sum to less than $345 million, which is far less than what DACA recipients contribute annually to Federal programs in taxes which is estimated at $2.1 billion. As such, this commenter believed DACA recipients should continue to remain eligible for Exchange or BHP coverage.

Response: We appreciate these commenters' concerns regarding the estimate of 11,000 DACA recipients enrolled in QHP plans or BHPs. However, our estimate of 10,000 applicants enrolling in a QHP and 1,000 applicants enrolling in a BHP are based on data from the 2024 Open Enrollment Period. We believe data from the 2024 OEP provides a reasonable estimate of DACA recipient enrollees, as that is when the majority of eligible consumers enroll in coverage. While consumers can continue to enroll throughout the year, they will need to qualify for an SEP to enroll in coverage outside of the Open Enrollment Period—this results in fewer DACA recipients who are eligible to enroll outside of OEP. As mentioned in Section IV.B.2. and outlined by commenters, DACA recipients continue to be ineligible for coverage in nineteen states due to a preliminary injunction in *Kansas* v. *United States,*[270] thus reducing the total number of DACA recipients enrolled in Exchange or BHP coverage. Collectively, we believe these numbers provide the most accurate representation of enrollment estimates for DACA recipients. We acknowledge that DACA recipients have valid work authorization and therefore pay taxes that fund Federal benefit programs. However, this does not impact our position that the best reading of the ACA compels us to exclude DACA

[268] U.S. Citizenship and Immigration Services. (n.d.) Immigration and Citizenship Data. Dep't of Homeland Security. *https://www.uscis.gov/tools/reports-and-studies/immigration-and-citizenship-data?topic_id%5B%5D=33602&ddt_mon=12&ddt_yr=2024&query=approximate+active+daca&items_per_page=10.*

[269] Per USCIS data, the average age of DACA recipients is 30 years old. Count of Active DACA Recipients by Month of Current DACA Expiration as of September 30, 2024. U.S. Citizenship and Immigration Services. (2024, Sept. 30). Count of Active DACA Recipients by Month of Current DACA Expiration as of September 30, 2024. Dep't of Homeland Security. *https://www.uscis.gov/sites/default/files/document/data/active_daca_recipients_fy2024_q4.xlsx.*

[270] On December 9, 2024, the United States District Court for the District of North Dakota issued a preliminary injunction in *Kansas* v. *United States,* Case No. 1:24–cv–00150, 2024 WL 5220178 (D.N.D. Dec. 9, 2024). As a result, DACA recipients are ineligible for Exchange or BHP coverage in nineteen states. These states are: Alabama, Arkansas, Florida, Idaho, Indiana, Iowa, Kansas, Kentucky, Missouri, Montana, Nebraska, New Hampshire, North Dakota, Ohio, South Carolina, South Dakota, Tennessee, Texas, and Virginia. All of those states except Idaho, Kentucky, and Virginia are served by the Federal Marketplace platform.

recipients from the definition of lawfully present used to determine eligibility for QHP or BHP coverage.

Comment: Additionally, commenters provided detailed analysis of the negative impacts they expected this rule would have if finalized. These impacts, discussed in detail in section II.B.1. of this final rule, include decreased access to care, worsened health outcomes, increased disparities, increased reliance on uncompensated care and emergency department care, and worsened local economies. Many commenters pointed out how the provisions of this rule may negatively impact not only DACA recipients, but their families and communities as well. Commenters further noted that this rule would worsen individual market Exchange risk pools, due to DACA recipients' age and health status as compared to current Exchange enrollees, and that a weaker risk pool could result in cost increases for health insurance issuers, cost increases for hospitals, and cost increases for individuals throughout the Exchanges in the form of higher health insurance premiums.

Response: We acknowledge that these are potential negative impacts of the policy finalized in this rule. We appreciate the insight from commenters that the policy in this rule will also negatively impact the families and communities of the DACA recipients impacted by the rule. We agree that it is possible that this rule could weaken the Exchange risk pools, which could result in cost increases for issuers and individuals due to higher claims costs and premiums. We are not able to quantify these potential impacts.

Comment: Commenters expressed concern that the burden estimates did not account for the economic burden the 11,000 currently enrolled DACA recipients will place on the health care system in the future without having health insurance.

Response: We acknowledge these concerns, but are not able to quantify these potential impacts.

After consideration of public comments, we are finalizing these estimates using the methodology as proposed without modifications.

3. Standards for Termination for Cause From the FFE (§ 155.220(g)(2))

As discussed in the preamble to this proposal, we are finalizing improvements to the transparency in the process for holding agents, brokers, and web-brokers accountable for noncompliance with applicable law, regulatory requirements, and the terms and conditions of their Exchange agreements. Specifically, we are finalizing the addition of text to § 155.220(g)(2) that clearly sets forth that HHS would apply a ''preponderance of the evidence'' standard of proof to assess potential noncompliance under § 155.220(g)(1) and to make a determination there was a specific finding or pattern of noncompliance that is sufficiently severe. Our regulatory change will put all agents, brokers, and web-brokers assisting consumers with enrollment on the FFEs and SBE–FPs on notice of the evidentiary standard we will use in leveraging our enforcement authority under § 155.220(g)(1) through (3). We believe this update will make the regulations easier to follow and more clearly articulate our enforcement process, improving transparency for agents, brokers, and web-brokers, consumers, and other interested parties.

We believe our change will have positive impacts on agents, brokers, and web-brokers. Codifying the evidentiary standard will provide agents, brokers, and web-brokers under investigation for noncompliant behavior more transparency in the process for holding agents, brokers, and web-brokers accountable for noncompliance with applicable law, regulatory requirements, and the terms and conditions of their Exchange agreements. We anticipate agents, brokers, and web-brokers will react positively to knowing more about our enforcement processes and how we determine regulatory compliance.

We do not anticipate any impact or burdens on agents, brokers, or web-brokers stemming from our policies as we did not expand the bases under which HHS may find them noncompliant under § 155.220(g)(1) through (3) or otherwise require more from agents, brokers, and web-brokers as part of this enforcement framework; rather, we finalized clarifications to an evidentiary standard that is not explicit at present.

We sought comment on these proposed impacts and assumptions.

We did not receive any comments in response to the proposed impact estimates for this policy. For the reasons outlined in the proposed and in this final rule, we are finalizing these estimates as proposed.

4. Annual Eligibility Redetermination (§ 155.335)

We are finalizing the temporary amendment to the annual eligibility redetermination regulation to prevent enrollees from being automatically re-enrolled in coverage with APTC that fully covers their premium without taking an action to confirm their eligibility information for Exchanges on the Federal platform. Specifically, when an enrollee does not submit an application for an updated eligibility determination for the immediately forthcoming coverage year (2026) by the last day to select a plan for January 1, 2026 coverage, in accordance with the effective dates specified in § 155.410(f), and the enrollee's portion of the premium for the entire policy would be zero dollars after application of APTC through the annual redetermination process, Exchanges on the Federal platform must decrease the amount of the APTC applied to the policy, consistent with § 155.340(f), such that the remaining monthly premium owed by the enrollee for the entire policy equals $5 for the first month and for every following month until the enrollee confirms or updates the eligibility determination. Consistent with §§ 155.310(c) and (f), enrollees automatically re-enrolled with a $5 monthly premium after APTC under this policy will be able to update their Exchange application at any point to confirm eligibility for APTC that covers the entire monthly premium, if eligible, and re-confirm their plan to thereby reinstate the full amount of APTC for which the enrollee is eligible on a prospective basis.

We require that Exchanges on the Federal platform must implement this change for annual redeterminations for benefit year 2026, with a reversion to the previous policy for benefit year 2027 and beyond. We are not finalizing this policy for State Exchanges for the reasons discussed in section III.B.3 of this preamble.

For Exchanges on the Federal platform, we estimate that 2.68 million enrollees were automatically re-enrolled in a QHP for benefit year 2025 with APTC that fully covered their premium. Given that the expanded PTC structure under the ARP and IRA expires at the end of 2025 and the number of Exchange enrollees, as well as the number of Exchange enrollees with APTC that fully covers their premium, is expected to decrease as a result,[271] we view this figure to be an upper-bound estimate of the number of enrollees with coverage through Exchanges on the Federal platform who may be affected by this temporary policy.

Regarding the benefits associated with this policy, we believe this change may lead to increased price sensitivity to premiums and premium changes among

[271] Baseline enrollment projections are presented in Tables 15 and 16 in section V.C.18. of this final rule. Enrollment among those with APTC that fully covers their premium was not projected separately but is expected to decline following the expiration of the expanded PTC structure.

enrollees whose premiums are fully subsidized and who would be automatically re-enrolled. This is because these enrollees will now pay $5 more in net premiums per month if they do not submit an application for an updated eligibility determination from an Exchange. These enrollees will therefore be incentivized to return to an Exchange, evaluate available coverage options and premiums, and make an active enrollment decision. We therefore anticipate that this policy will lead to better matches between consumers' coverage preferences and available coverage offerings in the individual market.

Comment: We received many comments expressing strong support for automatic re-enrollment as a valuable tool for maintaining continuous coverage and market stability. One commenter specifically noted that automatically re-enrolled consumers in the Washington Exchange maintain their coverage for an average of 10.3 months, compared to 9.5 months for new enrollees, demonstrating the policy's contribution to a stable risk pool.

Response: We want to reiterate that this policy maintains automatic re-enrollment while introducing a modest premium requirement to encourage active consumer engagement and participation for a specific population.

Comment: Several commenters expressed concerns about the policy's effectiveness in preventing fraud and the possibility of third-party premium payments.

Response: As noted earlier in the preamble, we are aware that some consumers have been improperly enrolled in a fully-subsidized QHP without their knowledge or consent and other consumers have remained enrolled in a fully-subsidized QHP after obtaining other coverage. This policy, as finalized (with modification), will contribute to reducing the financial stress that ineligible enrollees may experience by protecting them from accumulating surprise tax liabilities.[272]

As described earlier in this rule, § 155.220(j)(2)(iii) and (l) requires agents, brokers, and web-brokers who are assisting with consumer enrollments through the Exchanges on the Federal platform to obtain and document consumer consent before making an application or enrollment update on behalf of the consumer. Additionally, our experience investigating fraudulent or improper enrollments by agents, brokers, and web-brokers does not suggest that these entities fraudulently enrolling consumers in non-zero premium plans by paying premiums on behalf of enrollees is a common occurrence. Doing so would reduce the profit available to the agent, broker, or web-broker for the fraudulent activity, as well as increase the risk that it would be identified as fraudulent activity (for example, because an issuer could identify if payment was made using a check or credit card belonging to the agent, broker, or web-broker). Rather, improper enrollments typically involve agents, brokers, or web-brokers enrolling consumers in fully-subsidized plans without their knowledge or consent. Therefore, we believe it is appropriate to target this proposal to fully-subsidized enrollments, where we know fraudulent activity by agents, brokers, and web-brokers is most likely.

Comment: We received comments from several State Exchanges reporting different experiences with improper enrollments compared to the Exchanges on the Federal platform.

Response: We acknowledge that State Exchanges report varying experiences with improper enrollments compared to the Exchanges on the Federal platform. In recognition of these differences and the need for State flexibility, as well as the appreciably smaller estimates of improper enrollments on State Exchanges, we are not finalizing this policy for State Exchanges.

Comment: One commenter noted that it is the consumer's responsibility for managing duplicate coverage and associated tax liabilities.

Response: We agree that consumers have a responsibility to report coverage changes and to ensure they avoid excess tax liabilities upon filing their annual taxes; however, we believe implementing measures that encourage active eligibility confirmation serves both the consumer protection and program integrity goals.

Comment: Many commenters expressed concerns about potential coverage impacts and market stability.

Response: We believe the small premium requirement, combined with clear communication about how to maintain full subsidies, if eligible, will help mitigate these concerns while achieving the policy's objectives of reducing improper enrollments and protecting consumers from unexpected tax liabilities.

Regarding the potential costs associated with this policy, if some enrollees with fully-subsidized premiums are unaware of the APTC adjustments that will be made and the premium amounts that will be due because they have not submitted an application for an updated eligibility determination or decide not to pay the $5 per month premium amount, this policy, as finalized, may lead some enrollees to have their coverage terminated due to non-payment of premiums. This, in turn, can lead to adverse health outcomes for those enrollees who experience loss of coverage and a coverage gap. However, we expect the number of fully-subsidized enrollees who ultimately have their coverage terminated due to non-payment of premiums as a result of this policy will be low given the nominal expense associated with the proposed APTC adjustments and the expected reduction in enrollment associated with the expiration of the PTC eligibility expansions under the IRA.

Comment: Many commenters provided evidence about premium sensitivity among Exchange enrollees, including research showing that even nominal premium increases can affect enrollment decisions, with one commenter citing a study that indicated a 14-percent attrition rate when enrollees transition from zero-dollar to positive premiums. These commenters stated that auto-enrollment plays a significant role in maintaining a balanced risk pool. Another commenter referenced a study by the National Bureau of Economic Research that found that eliminating auto-enrollment reduced coverage by 33 percent, particularly among young, healthy, and economically disadvantaged individuals. Another commenter referenced research from the Massachusetts Exchange showing that auto-enrolled individuals typically have medical costs 44 percent below average.

Response: We acknowledge the research cited by commenters regarding premium sensitivity and its potential impact on enrollment decisions. While we previously determined that a $5 premium would be nominal enough to minimize coverage disruption, we recognize and acknowledge the evidence suggesting even small premium increases may affect enrollment patterns and risk pool composition and the potential effects this could have on enrollees and enrollment. We are finalizing the policy, with modifications described in section III.B.3 of this preamble, to achieve our program integrity objectives and believe the $5 premium will prompt enrollees to act without being cost prohibitive and balances debt consideration for low-income enrollees.

[272] Currently, the Exchanges on the Federal platform collaborate with the IRS to prevent surprise tax liabilities when Exchanges on the Federal platform receive reports from consumers who have been improperly enrolled.

Comment: Some commenters expressed concerns regarding the potential impact on uncompensated care in the healthcare system, noting that coverage disruptions may result in increased uncompensated care, particularly as individuals who lose coverage may still require medical services but lack the means to pay for them.

Response: We acknowledge commenters' concerns. While we understand these concerns, we believe the policy's design—including clear communication about maintaining full subsidies and minimal premium requirements—will help minimize coverage disruptions. Additionally, the ability for consumers to reinstate full APTC, if still eligible, by confirming eligibility at any time provides an important safeguard against prolonged coverage gaps that could lead to uncompensated care.

Enrollees who otherwise would not have obtained an updated eligibility determination will also incur time costs associated with the need to submit an application to the Exchanges on the Federal platform to obtain an updated eligibility determination notice and confirm their plan in order to obtain a $0 premium, if they are still eligible for one.

Comment: Some commenters noted the administrative burden and potential barriers associated with requiring consumers to submit updated eligibility determinations. These commenters raised concerns about the practical challenges consumers may face in completing this process. They noted specific barriers including limited access to technology and internet services and consumer confusion, to name a few.

Response: We acknowledge commenters' concerns. However, we would like to note that enrollees will continue to be able to update this information through the call center for Exchanges on the Federal platform. Because consumers have various ways in which they can update their eligibility information, we believe this policy will balance program integrity objectives with maintaining accessible coverage.

In the 2025 Marketplace Integrity and Affordability proposed rule, we estimated that Exchanges would incur costs to comply with this policy. Specifically, we estimated that Exchanges would need to make changes to their IT systems to be able to identify enrollees who will be automatically re-enrolled with a zero-dollar premium after annual redetermination procedures and decrease the amount of APTC applied to the policy such that the remaining premium owed by the enrollee equals $5, if the enrollee does not submit an application for an updated eligibility determination to the Exchange. We estimated that it would take the Federal Government and each of the State Exchanges 10,000 hours to develop and code the changes to their IT systems. Of those 10,000 hours, we estimated it would take a database and network administrator and architect 2,500 hours (at $103.34 per hour) and a computer programmer 7,500 hours (at $94.88 per hour). These estimates were based on past experience with similar system changes. However, as noted earlier in this preamble, we are only finalizing this policy for Exchanges on the Federal platform, and only for benefit year 2026.

We therefore estimate a burden to the Federal Government, in 2025, of 10,000 hours with an estimated cost of $969,950 ((2,500 hours × $103.34 per hour) + (7,500 hours × $94.88 per hour)). Because there will be a reversion to the previous policy for PY 2027 and beyond, the Federal Government will also incur a burden in 2026 to reverse the IT systems changes and other technical changes made in support of this temporary policy. We expect that the burden to reverse these changes will be comparable to the burden to initiate them. Relying on the same assumptions, we therefore estimate a burden to the Federal Government in 2026 of 10,000 hours, with an estimated cost of $969,950.

We recognized the burden the proposed policy would place on State Exchanges and sought comment on the impact of this burden estimated in the proposed rule.

Comment: No comments were received specifically related to our cost estimate above; however, many commenters identified several additional implementation components to State Exchange IT systems as a result of this policy. These include new APTC calculation logic development, billing process modifications, batch auto-renewal coding changes, and enrollment reconciliation system updates.

Response: As discussed previously in this preamble, we are not finalizing this policy for State Exchanges.

Comment: We received numerous comments related to additional costs associated with customer service, outreach, and education to implement this policy. Many commenters raised concerns about operational impacts across multiple interested parties and potential downstream effects on consumer experience. Specifically, many commenters noted the potential impacts to customer service, including the increased call center volume, the need for enhanced customer service capacity, and additional staffing and training requirements. Other commenters noted challenges related to education and outreach, specifically the substantial consumer education needs, resource constraints (especially regarding Navigator funding), and complex messaging requirements across multiple interested parties. Additional administrative burden concerns focused on new notification requirements and process changes for issuers and Exchanges.

Response: We acknowledge the commenters' concerns. As discussed previously in this preamble, we are not finalizing this policy for State Exchanges. We recognize that depending on the level of customer service, outreach, and education efforts, this policy could result in increased costs to Exchanges on the Federal platform.

Regarding the potential economic transfers associated with this policy, this policy is expected to reduce net Federal PTC spending if an enrollee's policy is terminated because the enrollee does not pay their portion of the premium.[273] The need for fully-subsidized enrollees to actively re-enroll in QHP coverage to continue with fully-subsidized coverage may also reduce improper enrollments that are not reported to CMS by consumers and reduce the likelihood that an enrollee who obtained other coverage errantly retains their current fully-subsidized QHP, which will also reduce net Federal PTC spending. These reductions represent transfers from consumers or other payers (such as providers of charity care) who would have directly or indirectly received improper APTC from the Federal Government. Lastly, this policy will reduce commission payments from issuers to agents, brokers, and web-brokers due to the expected reduction in improper enrollments of fully-subsidized enrollees by agents, brokers, and web-brokers. This represents a transfer from agents, brokers, and web-brokers to issuers. These transfer effects will be realized for PY 2026 only.

Comment: One commenter noted that the implementation requirements create additional connections between regulatory effects, as issuers must redirect resources to cover system

[273] In the regulatory impact analysis, a transfer is a shift in resources from one party (for example, the government) to another (for example, individuals) for which the quantification does not reflect a change in use of resources (such as goods or services).

updates, notification requirements, and premium collection processes. These administrative costs represent an indirect link from issuers to various service providers and operational entities, all of which must be managed within existing MLR requirements. The commenter argues that this effectively shifts resources from other issuer activities to administrative functions. While the $5 premium appears to be a direct transfer from PTC to direct consumer payment, the administrative costs create a net negative effect for issuers, as they must redirect resources to implement and maintain these new requirements without receiving offsetting revenue, which may be offset by increased premiums paid for by consumers (and potential APTC increases).

Response: We acknowledge the commenter's concerns. We understand that administrative costs create additional financial implications for issuers operating under MLR requirements. We believe that any potential broad increases in premiums and PTCs will be minimal and will be offset by the provisions of this final rule.

5. Annual Eligibility Redetermination (§ 155.335(j)(4))

We are finalizing an amendment to the automatic reenrollment hierarchy by removing § 155.335(j)(4) which currently allows Exchanges to move a CSR-eligible enrollee from a bronze QHP and re-enroll them into a silver QHP for an upcoming plan year, if a silver QHP is available in the same product, with the same provider network, and with a lower or equivalent net premium after the application of APTC as the bronze plan into which the enrollee would otherwise have been re-enrolled. These amendments will leave in place the policy to require Exchanges to take into account network similarity to current year plan when re-enrolling enrollees whose current year plans are no longer available, but would remove the re-enrollment hierarchy standards at § 155.335(j)(4) that allows Exchanges to move a CSR-eligible enrollee from a bronze QHP and re-enroll them into a silver QHP for an upcoming plan year, if a silver QHP is available in the same product with the same provider network and with a lower or equivalent net premium after the application of APTC as the bronze plan into which the enrollee would otherwise have been re-enrolled. We believe this change will improve the consumer experience by retaining consumer choice and reducing consumer confusion. In the 2025 Marketplace Integrity and Affordability proposed rule, we explained that we believe the removal of the bronze to silver crosswalk criteria in the Federal hierarchy for re-enrollment will result in some burden for Exchanges that have already implemented this policy, including for CMS as the operator of Exchanges on the Federal platform, because it will require operational and system changes to reverse the policy including related consumer outreach. We do not anticipate that these changes will result in significant burden to issuers, because, as discussed in the 2024 Payment Notice (88 FR 25822), Exchanges were primarily responsible for the policy's implementation, though we solicited comment on that assumption.

By retaining consumer choice, we also anticipated that this policy would lead to fewer low-income bronze enrollees being switched to silver QHPs. Because these silver QHPs have higher premiums than bronze QHPs and indirectly fund CSR subsidies, they require higher APTC subsidies. Therefore, we anticipate the reduction in people being switched to silver QHPs will reduce APTC expenditures. We are not able to quantify the reduction in APTC expenditures because we do not expect the current policy would have led to a substantial number of people switching from a bronze QHP to a silver QHP during the 2026 OEP. Therefore, we anticipate only a small reduction in APTC expenditures.

We sought comment on the proposed impacts and assumptions, and we received some comments citing concerns about persisting consumer confusion, which are further discussed in the preamble. After consideration of comments and for the reasons outlined in the proposed rule and this final rule, including our responses to comments, we are finalizing these impact estimates for this policy as proposed.

6. Failure To File and Reconcile (§ 155.305(f)(4))

We are finalizing the proposed amendments to the FTR process at § 155.305(f)(4) with a modification under which the amendments will only be effective through PY 2026. Under this modified policy, all Exchanges are required to determine a tax filer ineligible for APTC if HHS notifies the Exchange that the tax filer failed to file a Federal income tax return and reconcile APTC for any year for which tax data would be used to verify APTC eligibility for coverage year 2026 only. For PY 2027 onward, the current rule that requires Exchanges to disallow APTC eligibility when an enrollee or their tax filer has failed to file a Federal income tax return reconciling their APTC for 2 consecutive tax years will apply. Putting the 1-year policy in place through PY 2026 only will allow Exchanges to collect data on the 1-year FTR policy. This policy will remove the current flexibility that gives tax filers 2 consecutive tax years to file and reconcile before removing APTC for coverage year 2026, while allowing for data collection to determine the correct FTR policy for coverage year 2027 and beyond. To conform with this policy, we are finalizing amending the notice requirement at § 155.305(f)(4)(i) aimed at addressing the gap in notice from giving tax filers a second consecutive tax year to comply with the requirement to file Federal income taxes and reconcile APTC received under the current policy and to remove the notice requirement at § 155.305(f)(4)(ii) that requires notification for enrollees and tax filers that are found to be in a 2-tax year FTR status for coverage year 2026, while allowing for flexibility in coverage years 2027 and beyond. We have updated the RIA for this policy due to revised wage rate and other data estimates available between the time of the 2025 Marketplace Integrity and Affordability proposed and final rule publication dates. The proposed RIA for this policy may be found at 90 FR 13011 through 13012.

Previously, we estimated the cost of giving enrollees 2 consecutive tax years to meet the requirement to file and reconcile would increase APTC expenditures by approximately $373 million per year beginning in PY 2025 for those enrollees who have not filed and reconciled for only 1 tax year and retain their APTC eligibility. In 2024, we implemented various system and logic changes to decrease and/or prevent certain agent, broker, and web-broker noncompliant conduct in an effort to mitigate unauthorized enrollments, and we have observed some improvements. Due to these recent safeguards, as well as the fact that FTR notices were provided in the Fall 2024, it is likely that the FTR population identified prior to OEP 2025 represents a peak in the FTR population. In addition, it is likely that if enhanced subsidies are not extended, the total Exchange population would most likely drop, thereby also decreasing the FTR population. Due to these competing influences, it is difficult to determine the overall impact that this policy will have on APTC expenditures. While the current 2-tax year FTR process may inadvertently shield some unauthorized enrollments during PY 2025 for consumers who may have enrolled in Exchange coverage in PY 2023 (as most Exchange activity to

mitigate unauthorized enrollments was implemented in PY 2024), the 2-tax year FTR process will catch those fraudulently enrolled consumers for PY 2026, as will this change to the FTR process. Therefore, it is likely that the APTC savings resulting from this policy change will not be derived from the enrollees who lose their APTC eligibility after being found as failing to file their income taxes and reconcile their APTC, but rather from the decrease in unauthorized enrollments that will result from other provisions of this rule that we are finalizing. Taking all of these considerations into account, we still anticipate that APTC expenditures will decrease by more than what we previously estimated due to the increase in the overall Exchange population. While we initially sent out almost 1.8 million FTR notices (both the 1-year and 2-year notices) prior to OEP 2025, our run of FTR Recheck in March 2025 has reduced this number to approximately 670,000 households that we provided notices to this spring.

Approximately 270,000 households had a 2-year FTR status after FTR Recheck, which is a decrease from the OEP of approximately 85,000 households. In addition, the total 1-year FTR population of non-filers, non-reconcilers, and extension tax-filers dropped from almost 1,500,000 prior to the OEP to less than 420,000 during FTR Recheck, a decline of over seventy percent. While a significant percentage of that population was due to the number of households whose extension to file their Federal income tax expired, both 1-year non-filers and non-reconcilers also saw significant drops in the number of households.

It is difficult to draw historically similar comparisons for multiple reasons: FTR had been inactive for three consecutive plan years prior to PY 2025 due to the COVID–19 PHE, the increase in improper enrollments, and the newly implemented 2-tax year FTR process. However, historically, between removal of APTC at OEP and the FTR Recheck process, the overall population of enrollees that lose APTC has ranged from 18 percent to 43 percent from 2016 to 2020. On average, 30 percent of enrollees lost their APTC due to FTR between OEP and FTR Recheck. After accounting for a portion of the 420,000 households with a 1- year FTR status during FTR Recheck this year whose extension to file their Federal income tax has not expired, we estimate that approximately 210,000 current households with a 1-year FTR status will lose APTC due to FTR when Exchanges on the Federal platform revert back to a 1-year FTR policy for the 2026 coverage year. The average APTC received per consumer per month for 2024 among those receiving APTC is $548, and the average household has 1.4 consumers. Removing APTC after FTR Recheck can save up to 8 months of APTC. Therefore, it is possible that the average Federal APTC savings could be as much as $1.28 billion in 2026 ($210{,}000 \times \$548 \times 1.4 \times 8$); however, this policy change is not occurring on its own and this estimate is most likely an overstatement of the possible savings available in future years. This is due to the negative impact on enrollment of implementing the program integrity measures in the Exchange in response to unauthorized enrollment as well as the resumption of FTR noticing and termination of APTC eligibility for PY 2025. There are also other sections of this rule that will likely negatively impact the enrollment of the same population that is affected by the finalized 1-year FTR policy for coverage year 2026, as discussed further in section V.C.18. of this final rule.

This policy will support compliance with the filing and reconciling requirement under 36B(f) of the Code and its implementing regulations at 26 CFR 1.36B–4(a)(1)(i) and (a)(1)(ii)(A). By supporting greater compliance, this policy will also minimize the potential for APTC recipients to incur large tax liabilities for coverage year 2026.

Using the final notice policy for 2026 that is similar to our prior notice procedure before FTR was paused, we anticipate eligible enrollees will respond and take appropriate action to file and reconcile to maintain continuous coverage. To the extent enrollees are not aware of or confused by the requirement to file and reconcile, enrollees would receive an indirect notice that protects FTI prior to the OEP as well as a notice at the time of FTR Recheck. The tax filer (and enrollee if they are the same person) will also receive a direct notice prior to the OEP as well as a direct notice at the time of FTR Recheck. Enrollees whose APTC is terminated as a result of the FTR process would receive an updated eligibility determination notice that contains a full explanation of appeal rights. Enrollees who appeal may request to continue receiving financial assistance during the appeal, consistent with § 155.525. We believe the notices and appeal rights protect continuity of coverage for eligible enrollees that have complied with their requirement to file an income tax return and reconcile APTC and, therefore, anticipate the proposal would continue to avoid situations where eligible enrollees become uninsured when their APTC is terminated. Because the policy will discontinue APTC for a larger number of enrollees who are not eligible, we anticipate a portion of those enrollees would drop coverage and become uninsured. This may result in costs to State and county governments and private hospitals in the form of charity care for individuals who become uninsured because of this rule and have medical emergencies.

Currently, Exchanges must send separate notices to people with 1-tax year FTR status and 2 tax years of FTR status. This policy conforms the notice process to the finalized policy by eliminating the separate notice for enrollees in their second year of FTR status for 2026. Therefore, we anticipate this policy will also reduce the burden of providing notice to enrollees with an FTR status in 2026. In the 2026 Payment Notice (90 FR 4524), we estimated that sending 2-year notices would cost the Federal Government approximately $292,000 and cost State Exchanges approximately $92,400 (cost of $0.84 per notice for FY 2025 which is based on the cost for the Exchanges on the Federal platform to send an average notice $\times$ 110,000 FTR notices) annually through 2029. With respect to costs to the Federal Government, we are not publishing specific future contract estimates in this rule because publishing those contract estimates could undermine future contract procurements. For example, if we were to publish the projected future cost of the contracts used to provide print notifications, the Federal Government would be meaningfully disadvantaged in future contract negotiations related to Federal notice printing activities, as bidders would know how much we anticipate such a future contract being worth. We noted that this estimate could decrease specifically depending on the overall population size of the Exchange in response to whether increased subsidies are continued or not. By removing the additional year of APTC eligibility for FTR consumers in 2026, we will remove at least some of the associated noticing requirements and corresponding 2-tax year FTR population, yielding a cost savings that will provide a benefit to the Federal Government and State Exchanges for 2026.

We estimate that it will take the Federal Government and each State Exchange approximately 10,000 hours in 2025 to develop and code changes to the eligibility systems to evaluate and verify FTR status under the revised FTR process, such that enrollees are found to be FTR after 1-tax year of failing to file and reconcile their APTC. Of those

approximately 10,000 hours, we estimate it would take a database and network administrator and architect 2,500 hours at $103.34 per hour and a computer programmer 7,500 hours at $94.88 per hour based on our prior experience with system changes. In aggregate for the State Exchanges, we estimate a one-time burden in 2025 of 200,000 hours (20 State Exchanges × 10,000 hours) at a cost of $19,399,000 (20 States × [(50,000 hours × $103.34 per hour) + (150,000 hours × $94.88 per hour)]) for completing the necessary updates to State Exchange eligibility systems. We are aware of one additional State that is planning to transition to a State Exchange in 2026. If they do finalize their transition, we estimate that their cost would be an additional $969,950 in 2025. For the Federal Government, we estimate a one-time burden in 2025 of 10,000 hours at a cost of $969,950 ((2,500 hours × $103.34 per hour) + (7,500 hours × $94.88 per hour)). However, Exchanges would need to revert this cost in 2026 as the provision sunsets for 2027, and we assume the same estimates as 2025 would also apply in 2026.

We recognize the burden this policy may place on State Exchanges, and sought comment in the proposed rule on the impact of this burden and potential less burdensome alternatives that would still further the program integrity goals of this policy. The majority of State Exchanges expressed in comments that they could not make the technological changes to revert back to a 1-year FTR policy in time for OEP 2026. However, we are finalizing the effective date of the FTR policy so that all Exchanges must impose a 1-year FTR requirement beginning for PY 2026 to gather data from this plan year.

After consideration of comments and for the reasons outlined in the proposed rule and this final rule, including our responses to comments, we are finalizing these impact estimates for this policy. We summarize and respond to public comments received on the proposed estimates below.

Comment: Many State Exchanges expressed concern that implementing the 1-year policy after just switching to the 2-year policy would be costly and burdensome. They also expressed the fact that their planning for this year has already commenced, and it would be very hard to make the technical changes needed at this point for PY 2026. In addition, many State Exchanges noted that they have much lower incidences of fraud as compared to Exchanges on the Federal platform, so the return on their investment for the technical changes would not be as impactful.

Response: We appreciate the concern from these commenters. While we appreciate that State Exchanges do not currently have the levels of fraudulent activity that Exchanges on the Federal platform do, we believe that the 1-year FTR policy will also help to ensure that there is less of a risk of fraud in coverage year 2026. As mentioned above, we believe that the potential costs of paying APTC to those who have not filed and reconciled for a second consecutive tax year outweigh the benefits for State Exchanges.

7. 60-Day Extension To Resolve Income Inconsistency (§ 155.315(f)(7))

We are finalizing the removal of § 155.315(f)(7) which requires that applicants must receive an automatic 60-day extension in addition to the 90 days currently provided by § 155.315(f)(2)(ii) to allow applicants sufficient time to provide documentation to verify any DMI, including income inconsistencies. Using previous costs associated with implementing this policy and similar policies, we anticipate that taking out this extension will result in a one-time cost of approximately $500,000 to Exchanges. For the 19 State Exchanges, we anticipate this will be a total cost of approximately $9,500,000 ($500,000 × 19). We recognize the burden this policy may place on State Exchanges and sought comment in the 2025 Marketplace Integrity and Affordability proposed rule on the impact of this burden and potential less burdensome alternatives that would still further the program integrity goals of this policy.

By reducing the period to provide documentation to verify income from 150 days to 90 days, we anticipate households using the Exchanges on the Federal platform to experience a reduction in the number of months they receive APTC, and that, using our internal analysis of historical enrollment and DMI data, approximately 140,000 enrollees will lose APTC eligibility. For State Exchanges, we also anticipate households may experience a reduction in the number of months they receive APTC, resulting in approximately 86,000 enrollees losing APTC eligibility. In total, using the average monthly APTC amount of $588.07 and 2 months reduced APTC, this will result in approximately $266 million (140,000 × $588.07 × 2 + 86,000 × $588.07 × 2) less APTC expenditures annually across all Exchanges.

In the proposed rule, we sought comments on whether this number may be slightly less because of potential decreased enrollment if the enhanced PTC are no longer in effect.

We did not receive any comments in response to the proposed impact estimates for this policy. For the reasons outlined in the final rule, we are finalizing these estimates as proposed.

8. Income Verification When Data Sources Indicate Income Less Than 100 Percent of the FPL (§ 155.320(c)(3)(iii))

This final rule amends § 155.320(c)(3)(iii) to create annual income DMIs when applicants attest to income that would qualify the taxpayer as an applicable taxpayer per 26 CFR 1.36B–2(b), but trusted data sources show income below 100 percent of the FPL. We are finalizing this policy to become effective on the effective date of this rule, but with a modification under which the policy and related requirements will sunset for all Exchanges at the end of PY 2026. Thereafter, this policy will no longer be effective. We have updated the RIA for this policy due to revised wage rate and other data estimates available between the time of the proposed and final rule publication dates. The proposed 2025 Marketplace Integrity and Affordability RIA for this policy may be found at 90 FR 13013.

As discussed further in section IV.D. of this proposed and the final rule, we estimate an approximate increase in burden costs of $20.2 million for the Federal Government and $12.4 million in 2026 for State Exchanges to receive, review, and verify submitted verification documents as well as conduct outreach and determine DMI outcomes for applicants below 100 percent of the FPL, as well as approximate one-time costs in 2025 to update the eligibility systems and perform other technical updates for this change of $775,960 for the Federal Government and $14,743,240 for State Exchanges. Exchanges would incur the same one-time costs at the time of sunsetting this policy at the end of 2026, resulting in a one-time burden of $775,960 to the Federal Government and $14,743,240 to State Exchanges in 2026 as well. Finally, as also discussed further in section IV.D. of this final rule, we estimate an increase in burden of $13,179,400 across all Exchanges in 2026 for consumers to submit documentation to fulfill income verification requirements. We recognize the burden this policy may place on State Exchanges and sought comment in the proposed rule on the impact of this burden and potential less burdensome alternatives that would still further the program integrity goals of this policy.

By reducing the number of applicants who inflate income to qualify for APTC and the opportunities for improper enrollments, we anticipate this policy will substantially reduce Federal APTC expenditures. Based on our analysis of enrollment data from DMI generation numbers from when this DMI was previously in place, we estimate creating DMIs that require additional verification will reduce the number of people who receive APTC by 50,000 for Exchanges on the Federal platform. We estimate the reduction of people who receive APTC in the State Exchanges to be 31,000. Using an estimated average four months reduced APTC and an average monthly APTC rate of $588.07 per person, we estimate total APTC expenditures will be reduced by approximately $191 million in 2026 ($50{,}000 \times \$588.07 \times 4 + 31{,}000 \times \$588.07 \times 4$).

We also anticipate that stronger income verification standards will increase Federal and State Medicaid expenditures by enrolling more people in Medicaid who, by intentionally or unintentionally overestimating their annual household income and being unable to verify that overestimated income, would otherwise have enrolled in APTC subsidized coverage. We do not have the data necessary to provide specific estimates on the increase in Medicaid expenditures and sought comment in the proposed rule on the data sources we could use to further this analysis.

We anticipate the stronger income verification standards would have only a minimal impact on the number of eligible tax filers who enroll in APTC subsidized coverage. Although we acknowledge that income verification can be more challenging for lower-income tax filers due to less consistent employment, our experience with income verifications suggests the process does not impose a substantial burden. Moreover, the generosity of the subsidy for lower-income households creates a strong incentive for applicants to follow through and meet the verification requirements.

We sought comment on the proposed impacts and assumptions.

After consideration of comments and for the reasons outlined in the proposed rule and this final rule, including our responses to comments, we are finalizing this policy to become effective upon the effective date of this rule, but with a modification under which the policy and related requirements will be sunset for all Exchanges at the end of PY 2026. Thereafter, this policy will no longer be effective. We also made modifications to account for general updated occupational costs in this rule. We summarize and respond to public comments received on the proposed estimates below.

Comment: Many State Exchanges, as well as other commenters, expressed concerns with the burden this would place on their Exchanges. They emphasized that the program integrity gains that may justify this burden would be extremely minimal to non-existent, given that they have identified improper income estimates to the same extent as Exchanges on the Federal platform. Many State Exchanges pointed out that they already have implemented robust additional income verification processes, including leveraging additional income data sources, that make real-time verification of income much more effective. Finally, some State Exchanges stated they simply do not have the resources to implement and maintain this policy currently. Given this, State Exchanges and other commenters requested that we make this policy optional for State Exchanges.

Response: We acknowledge the commenters' concerns. However, we believe the program integrity concerns, which, while potentially less in number, are still present in State Exchanges including those that have expanded Medicaid, that this policy attempts to address outweigh the cost and burdens to Exchanges. Additionally, because this policy will sunset after PY 2026, the costs and benefits outlined in this rule will only occur for the reminder of PY 2025 after this rule's effective date and for PY 2026.

9. Income Verification When Tax Data Is Unavailable (§ 155.320(c)(5))

We are finalizing the removal of § 155.320(c)(5) which requires Exchanges to accept an applicant's income attestation without further verification when tax return data is unavailable. We are finalizing this with a modification under which § 155.320(c)(5), which this final policy is removing upon the effective date of this rule, will be reinstated for all Exchanges at the end of PY 2026. As further discussed in section IV.E. of the proposed and this final rule, we estimate an increase in burden costs of approximately $102.3 million for the Federal Government and approximately $62.8 million total for State Exchanges in 2026 to receive, review, and verify submitted verification documents as well as conduct outreach and determine DMI outcomes for applicants whose tax return data is unavailable, as well as approximate one-time costs to update the eligibility systems and perform other technical updates for this change of approximately $872,955 for the Federal Government and approximately $16.6 million total for State Exchanges in 2025. These costs would also be incurred at the sunset of this program at the end of 2026, resulting in a one-time burden of $872,955 to the Federal Government and approximately $16.6 million total State Exchanges in 2026 as well. As also further discussed in section IV.E. of this proposed and this final rule, we also estimate an increase in burden of $66,778,850 for consumers in 2026 to submit documentation to fulfill income verification requirements associated with this proposal. We recognize the burden this policy may place on State Exchanges, and in the proposed rule sought comment on the impact of this burden and potential less burdensome alternatives that would still further the program integrity goals of this policy.

The prior alternative verification process for applicants without tax return data in place from 2013 to 2023 provided a basic, frontline protection against improper APTC payments. Based on our analysis of enrollment data from DMI generation numbers from when this DMI was previously in place, as well as historical enrollment data, we estimate creating DMIs that require additional verification will result in a decrease in APTC, potentially to zero, for 252,000 enrollees for Exchanges on the Federal platform and 155,000 enrollees on State Exchanges. Using an estimated average 4 months reduced APTC and with an average monthly APTC rate of $588.07 per person, we anticipate that this change could result in a reduction of $957 million ($252{,}000 \times \$588.07 \times 4 + 155{,}000 \times \$588.07 \times 4$) in APTC expenditures in 2026. We accept comments on whether this number may be slightly less because of potential decreased enrollment if the enhanced PTC are no longer in effect.

Although reintroducing income verification for applicants with no tax return data will increase the burden on some applicants, we do not anticipate this burden will deter many eligible people from enrolling.

We sought comment on the proposed impacts and assumptions.

We did not receive any comments in response to the proposed impact estimates for this policy. We are finalizing these estimates with modifications as noted earlier in this section related to updated general occupational estimated costs as well as reinstating the policy as outlined in § 155.320(c)(5) for all Exchanges after the completion of PY 2026 on December 31, 2026.

10. Premium Payment Threshold (§ 155.400(g))

We are finalizing modifications to § 155.400(g) to remove paragraphs (2) and (3), which establish an option for issuers to implement a fixed-dollar and/or gross percentage-based premium payment threshold (if the issuer has not also adopted a net percentage-based premium threshold), and modify § 155.400(g) to reflect the removal of paragraphs (2) and (3), with the following modification: the removal of the fixed-dollar and gross-premium threshold flexibilities will sunset after the completion of one new coverage year, PY 2026, on December 31, 2026. Thereafter, the FFE and SBE–FPs will, and State Exchanges may, offer issuers the flexibility to implement the premium payment thresholds outlined in the 2026 Payment Notice (90 FR 4424). Removing the options for issuers to implement either a fixed-dollar and/or gross percentage will help address program integrity concerns by ensuring that enrollees cannot remain enrolled in coverage for extended periods of time without paying any premium, increasing the likelihood that consumers who were improperly enrolled become aware of their enrollment.

We anticipate that there will be some costs for issuers in PY 2026 who had already implemented a fixed-dollar or gross premium percentage-based threshold and will have to remove those policies or replace them with the remaining net premium percentage-based thresholds.

Since these threshold policies are optional, we do not know how many issuers adopted them. In the 2026 Payment Notice, we estimated that based on a fixed-dollar threshold of $10 or less, utilizing PY 2023 counts of 135,185 QHP policies terminated for non-payment where the enrollee had a member responsibility amount of $0.01–$10.00, with an average monthly APTC of $604.78 per enrollee (for PY 2023), that would at most result in a one-time APTC payment of $817,571,843 in 2026 for 10 months that excludes the binder payment and first month of the grace period (for which the issuer already received APTC and would not have to return it) that issuers would retain, rather than being returned to the Federal Government. We now estimate that this cost will not be incurred in 2026 with the removal of the fixed-dollar and gross premium percentage-based thresholds.

We sought comment on the proposed impacts and assumptions.

We did not receive any comments in response to the proposed impact estimates for this policy. For the reasons outlined in the final rule, we are finalizing these estimates as proposed.

11. Annual Open Enrollment Period (§ 155.410(e) and (f))

We are finalizing amendments to § 155.410(e)(5) with a modification to change the annual OEP for PY 2027 and beyond to begin no later than November 1 and end no later than December 31 of the calendar year preceding the benefit year. Additionally, paragraph (e)(5)(ii) specifies that the Exchange OEP has a maximum length of 9 weeks. Newly added paragraph (f)(4) ensures that all OEP enrollees have full year coverage effective January 1 of the plan year beginning in benefit year 2027. This is expected to have a positive impact on the risk pool by reducing the risk of adverse selection. Although we cannot quantify Federal savings, by reducing adverse selection, we expect premiums will decline and, in turn, reduce the cost of PTC to the Federal Government. Lower premiums may also increase enrollment among unsubsidized consumers and help lower the uninsured rate. In addition, we expect a higher proportion of Exchange enrollees to be covered continuously for the full year beginning in January.

While the final rule does provide flexibility for Exchanges, 19 of 20 of the State Exchanges would need to shorten their OEP because their OEPs for PY 2025 either extended past December 31 or exceeded 9 weeks in duration. We estimated in the 2025 Marketplace Integrity and Affordability proposed rule that it would take the Federal Government and each impacted State Exchange 4,000 hours to develop and code the changes to their IT systems. Of those 4,000 hours, we estimated it would take a database and network administrator and architect 1,000 hours and a computer programmer 3,000 hours. The median wage rates used in the proposed rule were $101.66 per hour for a database and network administrator and architect and $95.88 per hour for a computer programmer. The median wage rates used for our estimates were updated after the proposed rule was published to reflect the latest available rates. In this final rule, we use the updated median wages of $103.34 per hour for a database and network administrator and architect and $94.88 per hour for a computer programmer for the final rule as discussed in section IV.A. of this final rule. We did not expect States operating SBE–FPs to incur any implementation costs. These estimates were based on past experience with similar system changes.

For the Federal Government, we estimate a one-time burden in 2026 of 4,000 hours at a cost of $387,980 (1,000 hours × $103.34 per hour) + (3,000 hours × $94.88 per hour), which is a decrease from the proposed rule's estimate of $389,300. In aggregate, for State Exchanges, we estimate a one-time burden in 2026 of 76,000 hours (19 State Exchanges × 4,000) at a cost of $7,371,620 (19 States × [(1,000 hours × $103.34 per hour) + (3,000 hours × $94.88 per hour)]), which is a decrease from the proposed rule's estimate of $7,786,000. In total, the burden associated with all system updates would be 80,000 hours at a cost of $7,759,600, which is a decrease from the proposed rule's estimate of $8,175,580. We recognized the burden that the proposed policy would have placed on State Exchanges and modified the policy while keeping intact its impact on program integrity.

We did not anticipate that the change to the OEP end date would have a negative impact on enrollment or the consumer experience due to the maturity of the enrollment systems. This change is expected to simplify operational processes for the Exchanges by eliminating the burden of supporting an extra month of open enrollment and addressing consumer confusion related to administering two enrollment deadlines. Lower administrative costs may also contribute to lower premiums, but we noted that there also may be administrative costs for issuers and Exchanges associated with an increase in SEP casework. Consumers will benefit from clearer enrollment rules that will encourage all annual enrollment activities to be complete by a December OE end date and therefore ensure coverage for the month of January. The Federal Government, State Exchanges, and issuers may incur costs if additional consumer outreach is needed to educate people on the new policy. However, this should be temporary and largely offset by the elimination of the ongoing outreach necessary to educate people on the second January 15 deadline.

We sought comment on the proposed impacts and assumptions. After consideration of comments and for the reasons outlined in the proposed rule and this final rule, including our responses to comments, we are finalizing these impact estimates for this policy with the following modifications. As stated above, the new OEP dates will apply for PY 2027 instead of PY 2026, and we are allowing Exchanges to adopt their preferred OEP dates subject to timing and durational parameters. This delay and flexibility is aimed at

mitigating the operational burden and consumer experience and timeline concerns expressed by commenters, including State Exchanges. Because comments on these estimates were combined with general comments on this policy, we summarize and respond to public comments received on the proposed estimates in section III.B.7. of this final rule.

12. Monthly SEP for APTC-Eligible Qualified Individuals With a Projected Annual Household Income at or Below 150 Percent of the Federal Poverty Level (§ 155.420(d)(16))

We are finalizing the removal of § 155.420(d)(16) and pausing the 150 percent FPL SEP for all Exchanges only until the end of PY 2026. This includes making conforming changes to regulations established to support this SEP, including removing §§ 147.104(b)(2)(i)(G), 155.420(a)(4)(ii)(D), and 155.420(b)(2)(vii), as well as amending § 155.420(a)(4)(iii) introductory text.

As discussed in this final rule, the expanded availability of fully-subsidized plans combined with easier access to these fully-subsidized plans through the 150 percent FPL SEP (which allows people to enroll in fully-subsidized plans at any time during the year) opened substantial opportunities for improper enrollments. As discussed earlier in preamble, recent litigation from April 2024, *Turner* v. *Enhance Health, LLC,* higher numbers of consumer complaints, and a sharp increase in enrollment relative to the eligible population with household income under 150 percent of the FPL in PY 2024 all suggest a substantial increase in improper enrollments among consumers reporting incomes between 100 and 150 percent of the FPL on their application. We are working hard to reduce the level of improper enrollments, and we believe that these efforts necessitate repealing the 150 percent FPL SEP. However, we acknowledge that it is challenging to predict the level of improper enrollments in future years, as we are still in the process of taking enforcement actions to reduce the initial spike in improper enrollments that occurred after we established the 150 percent FPL SEP.

We believe that pausing the 150 percent FPL SEP will reduce adverse selection and, as a result, reduce premiums. Previous rulemaking projected the 150 percent FPL SEP would increase premiums by 0.5 to 2 percent with enhanced premium subsidies in place and projected the SEP would increase premiums from 3 to 4 percent if the enhanced premium subsidies expire. Based on our analysis of recent enrollment data, we believe these previous estimates underestimated the premium impact and overestimated the enrollment impact of the 150 percent FPL SEP. As discussed in the preamble, we believe that the 150 FPL SEP has substantially increased the level of improper enrollments, as well as increased the risk for adverse selection as this SEP incentivizes consumers to wait until they are sick to enroll in Exchange coverage. Unknown factors continue to make these impacts difficult to estimate, including the utilization of this SEP by healthy and unhealthy enrollees and the impact to the average duration of coverage for enrollees. However, we estimate pausing this SEP could decrease premiums by 3 to 4 percent compared to baseline premiums, and therefore decrease annual APTC outlays by approximately $3.4 billion in 2026. In the proposed rule, we sought comment on how this policy would impact premiums and APTC/PTC outlays.

However, quantifying the impact of the 150 percent FPL SEP on enrollment remains difficult to estimate. Although we can quantify the number of people who enroll through this SEP, the enrollment impact is likely less than the number of people who use the SEP. Some people may use this SEP as an alternative to an SEP they would have otherwise used. Without this SEP, consumers may have otherwise enrolled through the OEP. The substantial level of improper enrollments associated with fully-subsidized plans also obscures the number of eligible individuals who used the SEP.

For these reasons, and for the reasons outlined in section III.B.8. of this final rule, we are finalizing that this SEP will be paused through the end of PY 2026.

To repeal the monthly 150 percent FPL SEP, we estimated a one-time cost of approximately $387,980 to pause the functionality to grant the 150 percent FPL SEP and make any necessary updates to eligibility logic systems for Exchanges on the Federal platform. This is based on our estimate that it will take the Federal Government 4,000 hours in 2025 to remove the SEP. Here, we are assuming that 25 percent of the hours needed to end the 150 percent FPL SEP are being performed by a database and network administrator (hourly wage of $103.34) and 75 percent of the work is being performed by a computer programmer (hourly wage of $94.88). This estimate was informed by our experience with past system changes.

We sought comment on this proposed impact.

Because we are sunsetting the repeal of the 150 FPL SEP after PY 2026, we estimate a new additional one-time cost of $387,980 for Exchanges on the Federal platform to reinstate the 150 percent FPL SEP for years after PY 2026. This is based on our estimate that it will take the Federal Government 4,000 hours in 2026 to reinstate the SEP. Here, we are assuming that 25 percent of the hours needed to end the 150 percent FPL SEP are being performed by a database and network administrator (hourly wage of $103.34) and 75 percent of the work is being performed by a computer programmer (hourly wage of $94.88). This estimate was informed by our experience with past system changes.

We estimate a new one-time cost for State Exchanges that operate their own eligibility and enrollment systems and currently offer the 150 percent FPL SEP to pause the SEP. Based on public comments received, we believe that 18 State Exchanges are currently offering the 150 percent FPL SEP or other income-based SEPs that would need to be discontinued. We estimate a one-time cost in 2025 of approximately $387,980 for each of these 18 State Exchanges to pause the functionality granting the 150 percent FPL SEP and make any necessary updates to State Exchange eligibility logic systems. This results in a total cost of $6,983,640 for State Exchanges to pause the 150 percent FPL SEP in 2025. This is based on our estimate that it will take each State Exchange 4,000 hours in 2025 to pause the SEP. Here, we are assuming that 25 percent of the hours needed to end the 150 percent FPL SEP are being performed by a database and network administrator (hourly wage of $103.34) and 75 percent of the work is being performed by a computer programmer (hourly wage of $94.88). This estimate was informed by our experience with past system changes.

We also estimate a new one-time cost for State Exchanges that operate their own eligibility and enrollment systems and currently offer the 150 percent FPL SEP to reinstate the SEP after PY 2026. We assume that all 18 State Exchanges that currently offer the 150 percent FPL SEP will elect to reinstate it once the pause of this SEP sunsets at the end of 2026. We estimate a one-time cost in 2026 of approximately $387,980 for each of the 18 State Exchanges currently offering the SEP to reinstate their functionality to grant the 150 percent FPL SEP and make any necessary updates to State Exchange eligibility logic systems. This results in a total cost of $6,983,640 for State Exchanges to reinstate the 150 percent FPL SEP. This

is based on our estimate that it will take each State Exchange 4,000 hours in 2026 to reinstate the SEP. Here, we are assuming that 25 percent of the hours needed to end the 150 percent FPL SEP are being performed by a database and network administrator (hourly wage of $103.34) and 75 percent of the work is being performed by a computer programmer (hourly wage of $94.88). This estimate was informed by our experience with past system changes.

After consideration of comments and for the reasons outlined in the proposed rule and this final rule, including our responses to comments, we are finalizing these impact estimates for this policy with the addition of SEP reinstatement costs and State Exchange costs. We summarize and respond to public comments received on our proposed estimates below.

Comment: Commenters from local and State governments expressed that nearly all State Exchanges currently offer the 150 percent FPL SEP or income-based SEPs with higher income thresholds. The commenter expressed concerns about the resources needed for IT and messaging campaign changes for State Exchanges to dismantle these SEPs. They stated that requiring State Exchanges to terminate the 150 percent FPL SEP within 60 days of the final rule would impose major costs, and failure to account for these costs makes the proposal arbitrary and capricious under the APA.

Response: We appreciate the commenters' concerns regarding the repeal of the 150 percent FPL SEP and the timeline for Exchanges to implement this policy change, however, we are finalizing to pause the availability of 150 percent FPL SEP for PY 2026. We believe that this policy change and timeline are critical to protect all Exchanges from fraudulent activity and to ensure that only consumers who are eligible to receive APTC continue to do so. We also wish to reiterate that we do not consider having a low income to meet the definition of an exceptional circumstance per § 155.420(d)(9); therefore, State Exchanges are not permitted to use exceptional circumstances SEP authority to continue to offer a 150 percent FPL-like SEP, or any SEPs based on income for that matter. In response to not accounting for the full costs for State Exchanges, we have updated the estimates in this proposal.

Comment: One commenter expressed specific concerns regarding the methodology that HHS used to estimate the premium impacts of the proposal to rescind the 150 percent FPL SEP. The commenter expressed confusion about how HHS arrived at the assumption that removing the current monthly SEP for people with incomes below 150 percent of the FPL would reduce premiums by 3.4 percent. The commenter stated that in the preamble of the proposed rule, HHS referenced a prior estimate that the monthly SEP policy would result in premium increases of 3 to 4 percent in the absence of the IRA subsidies, then provided a revised range of 0.5 to 3.6 percent based on more recent data. Then, however, in the regulatory impact analysis, HHS reverted to the discarded 3 to 4 percent estimate, before adopting 3.4 percent as a point estimate. The commenter asked for clarification as to how HHS arrived at this point estimate.

Response: We appreciate the commenter bringing this discrepancy to our attention, and we would like to clarify we believe pausing the current monthly SEP for people with incomes below 150 percent of the FPL will result in premiums being 3 to 4 percent lower than they would be if the SEP were to remain in place. A point estimate of 3.4 percent is used in the RIA. With the expiration of enhanced subsidies, enrollees at this income level will see an increase in net premiums for the same coverage they can receive currently at $0 net premium. The ability to enroll in Exchange coverage every month creates an incentive for healthy enrollees to forego health insurance coverage and wait to enroll when they believe they will need coverage. We estimated the SEP would decrease the average number of months of enrollment from 10 months to around 9 months with minimal reduction in program costs, since these enrollees would be enrolled when they needed coverage. Overall, the expected claims impact and shift in average months of enrollment is estimated at 3.4 percent of premium. Pausing this provision is expected to have the opposite impact and reduce premiums by 3.4 percent for 2026. We believe this premium reduction will wear off with the sunset of this provision and have accounted for this in the RIA.

13. Pre-Enrollment Verification for Special Enrollment Periods (§ 155.420)

We are finalizing amendments to § 155.420(g) to require Exchanges on the Federal platform to conduct pre-enrollment eligibility verification for SEPs. Specifically, we are finalizing the removal of the limit on Exchanges on the Federal platform to conducting pre-enrollment verifications for only the loss of minimum essential coverage SEP. With this limitation removed, we are finalizing conducting pre-enrollment verifications for most categories of SEPs for Exchanges on the Federal platform in line with operations prior to the implementation of the 2023 Payment Notice.

We are also finalizing the requirement that Exchanges on the Federal platform conduct pre-enrollment SEP verification for at least 75 percent of new enrollments through SEPs for consumers not already enrolled in coverage through the applicable Exchange. We are finalizing that Exchanges must verify at least 75 percent of such new enrollments based on the current implementation of SEP verification by Exchanges. We have updated the RIA for this policy due to revised wage rates and other data estimates available between the time of the proposed and final rule publication dates. The proposed RIA for this policy may be found at 90 FR 13016 through 13017.

Both of the proposals outlined in this section will sunset by their terms after the completion of one new coverage year, PY 2026, on December 31, 2026. We are declining to finalize these provisions for State Exchanges.

We anticipate that revisions to § 155.420 will have a positive impact on program integrity by verifying eligibility for SEPs. Increasing program integrity through this policy will reduce improper subsidy payments and could contribute to keeping premiums low and therefore, further protecting taxpayer dollars. This policy may deter enrollments among younger people at higher rates, which could worsen the risk pool and increase premiums. However, we expect any such deterrence will impact a very small number of young people and, therefore, have only a minimal impact on the risk pool and premiums. We estimate that the net effect of pre-enrollment verification will reduce premiums by approximately 0.5–1.0 percent for PY 2026 and will reduce APTC spending by approximately $105.4 million.[274]

We anticipate this policy will moderately increase the regulatory burden on Exchanges using the Federal platform. Based on past experience, we estimate that the expansion in pre-enrollment verification to most individuals seeking to enroll in coverage through all applicable SEPs offered through Exchanges on the Federal platform will result in an additional 293,073 individuals having their enrollment delayed or ''pended'' annually until eligibility verification is

[274] The reduction in APTC was calculated by multiplying the estimated new SVIs by the previous SVI expiration rate (293,073 × .137 = 40,151) and then multiplying that number by the estimated annual APTC amount per SEP consumer (40,151 × $2,625 = $105,396,375).

completed, although for the vast majority of individuals the delays would be less than 1–3 days. As discussed further in section IV.G. of this final rule, we anticipate that the expansion of SEP verification will result in increased income inconsistencies, with an associated cost increase for consumers of approximately $7,048,406 in 2026. There will also be an increase in ongoing costs for Exchanges on the Federal platform due to an increase in the number of SEP enrollments for which they must conduct verification. We estimate that the total increase in ongoing processing costs to comply with this requirement for the FFE will be approximately $11.7 million for PY 2026. Furthermore, as discussed in section IV.G. of this final rule, we anticipate that expanding verification will result in an increase in annual burden in labor costs on Exchanges using the Federal platform at a cost of $2,902,615 for PY 2026.

Additionally, we anticipate that the expansion of SEP verification will have a one-time development cost in 2025 for Exchanges using the Federal platform of $2,973,300 (30,000 hours × $99.11). This assumes that 25 percent of the hours needed to expand SEP verification are being performed by a database and network administrator (hourly wage $103.34) and 75 percent of the work is being performed by a computer programmer (hourly wage $94.88). This allocation of work between network administrator and computer programmer was informed by our experience with past system changes. We do not anticipate this policy will increase regulatory burden or costs on issuers. We sought comment on the proposed impacts and assumptions.

After careful consideration of public comments, we have decided to finalize and implement these policies with a significant modification—for Exchanges on the Federal platform, each of the rules outlined in this section will sunset by their terms after the completion of one new coverage year, PY 2026, on December 31, 2026. We are declining to finalize these provisions for State Exchanges. We summarize and respond to public comments received on the proposed adjustments to pre-enrollment SEP verification below.

Comment: States, providers, actuaries, labor groups, general advocacy groups, individuals, and one health insurance issuer expressed general concern about the burden and cost on States of implementing pre-enrollment SEP verification and expressed that States do not experience the same level of fraud cited for Exchanges on the Federal platform.

Response: We acknowledge the commenters' concerns. After careful consideration of public comments, for Exchanges on the Federal platform, each of the rules outlined in this section will sunset by their terms after the completion of one new coverage year, PY 2026, on December 31, 2026. We are declining to finalize these provisions for State Exchanges.

14. Prohibition on Covering Specified Sex-Trait Modification Procedures as an EHB (§§ 156.115(d) and 156.400)

We are finalizing an amendment to § 156.115(d) to provide that an issuer of a plan subject to EHB requirements may not provide coverage for specified sex-trait modification procedures as an EHB beginning with PY 2026 and are finalizing the addition of a definition of ''specific sex-trait modification procedure'' at § 156.400. Finalization of this policy will mean that beginning with PY 2026, issuers of plans subject to EHB requirements may not provide coverage for specified sex-trait modification procedures that fall within the definition at § 156.400 as EHB. The EHB are subject to various protections under the ACA, including the prohibition on annual and lifetime dollar limits and the requirement to accrue enrollee cost sharing towards the annual limitation on cost sharing. As finalized, the prohibition on annual and lifetime dollar limits and requirement to accrue enrollee cost sharing towards the annual limitation on cost sharing will not apply to specified sex-trait modification procedures to the extent such care is included in health plans as non-EHB, including in large group market and self-insured group health plans. This includes a prohibition on covering specified sex-trait modification procedures as an EHB in the five States that currently include coverage for sex-trait modification services in their EHB-benchmark plans, as well as in States that do not have such coverage expressly mentioned in the State's EHB-benchmark plan.[275]

As we noted in the 2025 Marketplace Integrity and Affordability proposed rule, utilization of sex-trait modification services is low; therefore, the impact of this policy will be limited. As we noted, approximately 0.11 percent of enrollees in the EDGE data set gathered from issuers as part of the HHS-operated risk adjustment program utilized specified sex-trait modification procedures between PYs 2022 and 2023. In the aggregate, the total allowed cost of specified sex-trait modification procedures amounts to 0.08 to 0.09 percent of all claims in the EDGE data set for these years. Although EDGE does not distinguish between whether a benefit is EHB, we believe that a substantial majority of such claims are being covered as EHB by issuers submitting claims data to the EDGE server.

Given that a QHP's percentage of premium attributable to the EHB is used to determine the amount of available tax credits under the ACA, we expect an impact on the amount of available PTC. We believe, however, that finalizing a definition of specified sex-trait modification procedure at § 156.400 will help to further minimize premium impacts, since the definition adds needed clarity to what procedures cannot be covered as EHB and there will therefore be less opportunity for issuers to price for any uncertainty. Under our final policy, plans that stop covering specified sex-trait modification procedures as EHB will see premiums and PTC decrease as the generosity of plan benefit coverage decreases. Plans that decide to cover specified sex-trait modification procedures as non-EHB will see premiums rise or stay the same to account for this benefit generosity, but will see any existing PTC decrease as the benefits will no longer be covered as EHB. States that choose to mandate such coverage as a benefit in addition to the EHB will be required to defray its cost pursuant to § 155.170; in this circumstance, we expect premiums and PTCs to decrease to account for the State's defrayal obligations.

We sought comment on these proposed impacts and assumptions.

After consideration of comments and for the reasons outlined in the proposed rule and this final rule, including our responses to comments, we are finalizing these impact estimates for this policy as proposed. We summarize and respond to public comments received on the proposed estimates below.

Comment: Some commenters supported a prohibition on coverage of sex-trait modification services as an EHB because they stated it will prevent tax credits from applying to medical procedures they believe are dangerous or cosmetic in nature. One commenter incorrectly noted that costs associated with sex-trait modification services would not be borne by States if they mandate coverage. One commenter stated that an issuer's ongoing implementation costs by virtue of, for

[275] California, Colorado, New Mexico, Vermont, and Washington EHB-benchmark plans specifically include coverage of some sex-trait modification services. Six other States do not expressly include or exclude coverage of sex-trait modification services in EHB-benchmark plans. Forty States include language that excludes coverage of sex-trait modification services in EHB-benchmark plans.

example, having to modify its claims processes and systems, will be more costly than what the issuer would reimburse providers for the sex-trait modification services themselves, if these services were covered benefits, and that such implementation costs are not minuscule.

Response: This final rule will ensure that Federal tax credits are not used to pay for services that fall under the definition of ''specified sex-trait modification procedure'' at § 156.400. This will better align the statutory requirement that EHB be equal in scope to those benefits provided in a typical employer plan. If a State mandates coverage of specified sex-trait modification procedures, then it will need to defray that cost to the issuer or the enrollee pursuant to § 155.170(b). Though we recognize comments that stated costs associated with specified sex-trait modification procedures are relatively minor, which aligns with the data we provided in this rule, we are not persuaded that costs associated with implementation of this policy are costlier than paying for those services themselves. Issuers offering QHPs are required to ensure that benefits that are not EHB are appropriately designated as such in their plan filings as part of QHP certification. Based on this, there is good indication issuers internally have the capability of determining which benefits are not EHB, as evidenced by current requirements for issuers to note which benefits, if any, are not EHB, and will vary from issuer to issuer.

Regardless, we are required to adhere to the statute and believe that the policy finalized in this rule better aligns with the plain language of section 1302(b)(2)(A) of the ACA.

Comment: Several commenters opposing the proposal stated that it will increase overall healthcare costs for States and local governments, issuers, providers, and consumers as further detailed below. One commenter noted increased out-of-pocket consumer costs due to issuers dropping this coverage entirely as a result of this proposal and therefore shifting the cost for care to consumers. Other commenters noted that covering sex-trait modification services in insurance plans is cost-neutral or cost-saving as there is no actuarial basis to price sex-trait modification surgeries separately from any other type of surgery. Commenters also expressed concerns that this proposal would block consumers from accessing sex-trait modification services with the same cost-sharing and benefit design protections as the same services covered for non-sex-trait modification still included in the EHB package. Commenters also expressed concern that costs would shift to States or local governments if they want to continue to ensure sex-trait modification services are covered. Another commenter expressed concern that the proposal would increase overall costs by shifting current treatment from the community to the hospital and uncompensated care, with increased prevalence of more costly conditions, like severe depression or osteoporosis. This commenter also stated concerns that the proposal could lead to increased risk of psychiatric symptoms leading to more utilization of psychiatric services, including psychiatric hospitalizations for these patients if current treatments were no longer affordable.

Response: We acknowledge commenters' concerns that smaller issuers often have outsized costs when new requirements are put into place that apply to all issuers, because they lack economies of scale that some of their larger, nationwide counterparts may have. However, as we have noted in other parts of the finalized rule, we believe that this final rule does not require issuers to undergo complex system builds or process changes to implement it and are not persuaded that the burden of any changes to processes and systems is a basis for not finalizing this proposal. Specifically, issuers are already required to ensure that benefits that are not EHB are appropriately designated as such in the Plans & Benefits Template completed as part of the QHP certification application and that the percentage of premium attributable to EHB is accurately reflected, so that APTC does not erroneously subsidize non-EHB. Although under this final rule, there could be services that can be covered as EHB or not as EHB depending on diagnosis, we believe that issuers should already have the capability to differentiate between these claims since they already have to make these distinctions today. For example, currently issuers must ensure that benefits that can never be EHB, such as routine non-pediatric eye exam services or non-medically necessary orthodontia pursuant to § 156.115(d), are not erroneously noted as EHB in plan filings and claims processing. We believe that what an issuer is required to do under this final policy to exclude coverage for specified sex-trait modification procedures as EHB is similar to how issuers currently handle coverage for other claims.

We do not believe that whether a benefit is neutral from an actuarial perspective has bearing on whether it should be an EHB. A benefits package is comprised of numerous benefits, some of which are neutral or even cost-saving, and some of which are not. If issuers seek to voluntarily cover specified sex-trait modification procedures as non-EHB, they would need to price the services accordingly.

We agree with commenters that for those States that wish to mandate coverage of specified sex-trait modification procedures, they will be responsible for defraying this cost pursuant to § 155.170(b). We appreciate the concerns commenters, including States, raised. However, there is nothing inherently unique about sex-trait modification services as related to the overall defrayal policy; if a State wishes to mandate a benefit that is not EHB, it must defray the cost of that benefit, regardless of what that benefit is. This is longstanding EHB policy and furthers State flexibility to regulate their own markets and ensure coverage of benefits that are most critical in their State.

We also agree that there may be some people enrolled in plans that must cover EHB who seek specified sex-trait modification procedures who will now need to pay for the full cost out-of-pocket, unless the coverage is State-mandated or an issuer voluntarily offers such coverage. We understand that this is not what many commenters advocated for. However, this is the case with any benefit that is not EHB. The framework for EHB as established in section 1302(b)(2) of the ACA requires EHB to be ''equal to the scope of benefits provided under a typical employer plan.'' There will necessarily be some benefits that are not EHB. This final rule better aligns coverage with the statutory requirements. We understand commenters' concerns that people seeking sex-trait modification services are often lower-income and more economically vulnerable than the general population. In defining the EHB, we have attempted to balance coverage generosity and affordability, with the realization that what makes coverage more affordable for some may in turn make certain benefits less affordable for others

We also appreciate comments that expressed concerns about costs being shifted to local governments and hospital uncompensated care. Nothing in this final rule prohibits local governments or hospitals from voluntarily funding specified sex-trait modification procedures. However, nothing in this final rule requires States or hospitals to develop programs to fund specified sex-trait modification procedures. We think that additional uncompensated care for mental health services will be minimal if any, and we

reiterate that mental health services will continue to be available, including for persons with gender dysphoria and those seeking specified sex-trait modification procedures.

Comment: Several commenters objecting to the proposal agreed that utilization of sex-trait modification services procedures is low, given the small size of the population with gender dysphoria and the fact that individual medical needs will vary. Other commenters objecting to the proposal agreed that the cost of providing sex-trait modification services is minimal in light of such low utilization. One commenter noted as evidence that some States added sex-trait modification services to their EHB-benchmark plans without exceeding the actuarial limitations imposed by HHS and that the addition of such services had negligible impact on premiums. One supporting commenter stated that the proposal would reduce overall coverage by issuers for sex-trait modification procedures, reducing complications stemming from such procedures that could still be covered as EHB, and that this would lead to a small reduction in both premiums and premium tax credits and well as improvements in the health of these enrollees.

Response: We agree with commenters that utilization of specified sex-trait modification procedures is low. As we stated in the proposed rule, less than 1 percent of the U.S. population seeks forms of sex-trait modification [276] and this low utilization is also apparent in the EDGE limited data set.[277] We agree with commenters that, as result of this low utilization, we anticipate the premium impact of this policy will be minimal. This includes only minimal cost effects to the extent this policy results in decreased complications requiring care due to fewer sex-trait modification procedures.

15. Premium Adjustment Percentage Index (§ 156.130(e))

We are finalizing a premium adjustment percentage of 1.6726771319 for PY 2026 based on the change to the premium measure for calculating the premium adjustment percentage that we are finalizing in this rule. Under § 156.130(e), we are finalizing the use of average per enrollee private health insurance premiums (excluding Medigap and property and casualty insurance), instead of ESI premiums, which were used in the calculation since PY 2022, for purposes of calculating the premium adjustment percentage for PY 2026 and beyond. The annual premium adjustment percentage sets the rate of change for several parameters detailed in the ACA, including the annual limitation on cost sharing (defined at § 156.130(a)); the reduced annual limitations on cost sharing; the required contribution percentage used to determine eligibility for certain exemptions under section 5000A of the Code (defined at § 155.605(d)(2)); and the employer shared responsibility payments under sections 4980H(a) and 4980H(b) of the Code.

As explained in the 2025 Marketplace Integrity and Affordability proposed rule, our policy to use private health insurance premiums (excluding Medigap and property and casualty insurance) in the premium adjustment percentage calculation will result in a higher overall premium growth rate measure than if we continued to use ESI premiums as was used for prior plan years and in the October 2024 PAPI Guidance.[278] To further elaborate on the potential impacts of this policy change, in § 155.605(d)(2), we are finalizing a required contribution of 8.05 percent for PY 2026 using the finalized premium adjustment percentage in § 156.130 to supersede the previous required contribution of 7.70 percent for PY 2026 calculated from ESI premiums previously published in the October 2024 PAPI Guidance.[279] Pursuant to § 156.130(a)(2), we are finalizing a maximum annual limitation on cost sharing of $10,600 for self-only coverage for PY 2026 to supersede the maximum annual limitation on cost sharing of $10,150 for self-only coverage for PY 2026 calculated from ESI premiums previously published in the October 2024 PAPI Guidance.[280] The CMS Office of the Actuary estimates that the change in methodology for the calculation of the premium adjustment percentage may have the following impacts between PY 2026 and PY 2030: [281]

TABLE 12—IMPACTS OF FINAL MODIFICATIONS TO THE PREMIUM ADJUSTMENT PERCENTAGE METHODOLOGY, PYS 2026–2030

Calendar year	2026	2027	2028	2029	2030
Exchange Enrollment Impact (enrollees, thousands)	−80	−80	−80	−80	−80
Premium Impacts:					
Gross Premium Impact (%)	0%	0%	0%	0%	0%
Net Premium Impact (%)	2%	2%	2%	2%	2%
Federal Impacts:					
PTC (million, $)	−1,270	−1,340	−1,410	−1,480	−1,550
Employer Shared Responsibility Payment (million, $)	0	0	3	11	20
Total Federal Impact (million, $)*	−1,270	−1,340	−1,413	−1,491	−1,570

* **Note:** While the PTC impact figures are negative to signify reductions in Federal outlays, and the employer shared responsibility payment figures are positive to signify increased revenue to the Federal Government, they are totaled together to indicate savings for the Federal Government.

[276] *See,* Hughes, L.; Charlton, B.; Berzansky, I.; et. al. (2025, Jan. 6). Gender-Affirming Medications Among Transgender Adolescents in the U.S., 2018–2022. JAMA Pediatr. 179(3):342–344. *https://jamanetwork.com/journals/jamapediatrics/fullarticle/2828427; see also,* Dai, D.; Charlton, B.; Boskey, E.; et. al. (2024, June 27). Prevalence of Gender-Affirming Surgical Procedures Among Minors and Adults in the US. JAMA Netw Open. 7(6):e2418814. *https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2820437.*

[277] The EDGE limited data set contains certain masked enrollment and claims data for on- and off-Exchange enrollees in risk adjustment covered plans in the individual and small group (including merged) markets, in States where HHS operated the risk adjustment program required by section 1343 of the ACA, and is derived from the data collected and used for the HHS-operated risk adjustment program.

[278] CMS. (2024, Oct. 8). Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing, Reduced Maximum Annual Limitation on Cost Sharing, and Required Contribution Percentage for the 2026 Benefit Year. *https://www.cms.gov/files/document/2026-papi-parameters-guidance-2024-10-08.pdf.*

[279] Ibid.

[280] Ibid.

[281] CMS Office of the Actuary's estimates are based on their health reform model, which is an amalgam of various estimation approaches involving Federal programs, ESI, and individual insurance choice models that ensure consistent estimates of coverage and spending in considering legislative changes to current law.

As noted in Table 12, we expect that the change in measure of premium growth used to calculate the premium adjustment percentage for PY 2026 may result in:

- Net premium increases of approximately $530 million per year for PY 2026 through PY 2030, which is approximately 2 percent of PY 2024 net premiums. Net premiums are calculated for Exchange enrollees as premium charged by issuers minus APTC.
- A decrease in Federal PTC spending of between $1.27 billion and $1.55 billion annually from 2026 to 2030, due to an increase in the PTC applicable percentage and a decline in Exchange enrollment of approximately 80,000 individuals in PY 2026, based on an assumption that the Department of the Treasury and the IRS will adopt the use of the same premium measure finalized for the calculation of the premium adjustment percentage in this final rule for purposes of calculating the indexing of the PTC applicable percentage and the required contribution percentage under section 36B of the Code. We anticipate that enrollment may decline by 80,000 individuals in PY 2026, and enrollment will remain lower by 80,000 individuals in each year between 2026 and 2030 than it would if there were no change in premium measure for the premium adjustment percentage for PY 2026 and beyond.
- Increased Employer Shared Responsibility Payments of $3 to $20 million each year between 2028 and 2030.

The small increase in net premiums will reduce the number of people who qualify for fully-subsidized plans through the Exchanges. Therefore, by reducing the number of people who qualify for fully-subsidized plans, we anticipate this premium measure will reduce enrollments in APTC coverage and, in turn, reduce APTC expenditures.

Some of the 80,000 individuals estimated to not enroll in Exchange coverage as a result of the change in the measure of premium growth used to calculate the premium adjustment percentage may purchase short-term, limited-duration insurance, catastrophic coverage, or join a spouse's health plan, though some will become uninsured. Any of these transitions may result in greater exposure to health care costs, which previous research suggests reduces utilization of health care services, including unnecessary or counterproductive services.[282] However, some individuals who transition into short-term plans, catastrophic health plans, or who join their spouses' coverage may also experience an increase in health utilization because the provider networks for such plans tend to be more expansive than plans on the individual market.[283] [284] This means that such individuals may be able to better access providers who can address their specific health needs. However, the increased number of uninsured may increase Federal and State uncompensated care costs and may contribute to negative public health outcomes.[285] We sought feedback from interested parties about these impacts and the magnitude of these changes in the proposed rule.

As noted previously in this final rule, the premium adjustment percentage is the measure of premium growth that is used to set the rate of increase for the maximum annual limitation on cost sharing, defined at § 156.130(a). Pursuant to § 156.130(a)(2), we finalized a maximum annual limitation on cost sharing of $10,600 for self-only coverage for PY 2026. Additionally, we finalized reductions in the maximum annual limitation on cost sharing for silver plan variations (Table 5 in section III.C.2.b. of this final rule).

We sought comment on these proposed impact estimates and assumptions related to the proposed change to the premium measure for calculating the premium adjustment percentage for PY 2026 and beyond.

After consideration of comments and for the reasons outlined in the proposed rule and this final rule, including our responses to comments, we are finalizing these impact estimates for this policy as proposed. Because comments on these estimates were combined with general comments on this policy, we summarize and respond to public comments received on these proposed estimates in section III.C.2. of this final rule.

16. Levels of Coverage (Actuarial Value) (§§ 156.140, 156.200, 156.400)

We are finalizing changing the de minimis ranges at § 156.140(c) beginning in PY 2026 to +2/−4 percentage points for all individual and small group market plans subject to the AV requirements under the EHB package, other than for expanded bronze plans,[286] for which we are finalizing a de minimis range of +5/−4 percentage points. We are also finalizing revisions to § 156.200(b)(3) to remove from the conditions of QHP certification the de minimis range of +2/0 percentage points for individual market silver QHPs. We are also finalizing amendments to the definition of ''de minimis variation for a silver plan variation'' in § 156.400 to specify a de minimis range of +1/−1 percentage points for income-based silver CSR plan variations.

As noted in the 2025 Marketplace Integrity and Affordability proposed rule, we believe that changing the de minimis ranges for standard metal level plans (except for individual market silver QHPs) will not generate a transfer of costs for consumers overall. Wider de minimis ranges will allow issuers to design plans with a lower AV than is possible currently, which will reduce the generosity in health plan coverage for out-of-pocket costs. However, we expect that issuers will, in turn, lower overall premiums. We estimate the premiums could decrease approximately 1.0 percent on average because of benefit changes issuers will make with a wider de minimis range. Lower overall premiums will have positive effects for consumers over the longer term as issuer participation increases and coverage options improved, which will attract more young and healthy enrollees into health plans, improving the overall risk pool and reducing overall costs that could

[282] Manning, W.G., Newhouse, J.P., Duan, N., Keeler, E.B., & Leibowitz, A. (1987). Health insurance and the demand for medical care: evidence from a randomized experiment. The American economic review, 251–277; Keeler, E.B., & Rolph, J.E. (1988). The demand for episodes of treatment in the health insurance experiment. Journal of health economics, 7(4), 337–367; Buntin, M.B., Haviland, A., McDevitt, R. & Stood, N. (2011). Healthcare Spending and Preventive Care in High-Deductible and Consumer-Directed Health Plans. The American Journal of Managed Care, 17(3), 222–230; Finkelstein, A., et al. (2012). The Oregon health insurance experiment: evidence from the first year. The Quarterly journal of economics, 127(3), 1057–1106; Brot-Goldberg, Z.C., Chandra, A., Handel, B.R., & Kolstad, J.T. (2017). What does a Deductible Do? The Impact of Cost-Sharing on Health Care Prices, Quantities, and Spending Dynamics. The Quarterly Journal of Economics, 132(3). 1261–1318.

[283] Burns, A. et. al. (2019, Jan.) How CBO and JCT Analyzed Coverage Effects of New Rules for Association Health Plans and Short-Term Plans. Congressional Budget Office. p. 6. *https://www.cbo.gov/system/files/2019-01/54915-New_Rules_for_AHPs_STPs.pdf.*

[284] Cruz, D; Fann, G. (2024, Sept.). It's Not Just the Prices: ACA Plans Have Declined in Quality Over the Past Decade. Paragon Health Institute. *https://paragoninstitute.org/private-health/its-not-just-the-prices-aca-plans-have-declined-in-quality-over-the-past-decade/.*

[285] *See,* for example, Goldin, J., Lurie, I.Z., & McCubbin, J. (2021). Health Insurance and Mortality: Experimental Evidence from Taxpayer Outreach. The Quarterly Journal of Economics, 136(1), 1–49.

[286] Expanded bronze plans are bronze plans currently referenced in § 156.140(c) that 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 within the meaning of section 223(c)(2) of the Code.

mitigate any increase in consumer out-of-pocket costs.

As shown in Table 13, the policy to widen the de minimis range for individual market silver QHPs to +2/−4 percentage points will generate a transfer of costs in the short-term from consumers to the government and issuers in the form of decreased APTC, because widening the de minimis range for silver plans can affect the generosity of the SLCSP. The SLCSP is the benchmark plan used to determine an individual's PTC. A subsidized enrollee in any county that has a SLCSP that is currently at or above 70 percent AV will see the generosity of their current SLCSP decrease, resulting in a decrease in PTC.

TABLE 13—PTC IMPACT OF +2/−4 SILVER DE MINIMIS PLAN AVS, 2026–2029

Calendar year	2026	2027	2028	2029
Change in PTC	−$1.22 billion	−$1.28 billion	−$1.33 billion	−$1.40 billion.
Fiscal year	2026	2027	2028	2029
Change in PTC	−$0.92 billion	−$1.27 billion	−$1.32 billion	−$1.38 billion.

This policy, by itself, would not invalidate the cost-sharing design of any health plan an issuer currently plans to offer in PY 2026. As explained above, this policy only expands the universe of permissible plan AVs and will not preclude issuers from continuing to design plans with an AV that is closer to the middle of the applicable de minimis ranges instead of plans at the outer limits. To the extent that issuers believe that plan designs that have a particular AV will attract more enrollment, they will remain free to do so under this policy.

In addition, changing the de minimis range for standard silver plans will impact Individual Coverage Health Reimbursement Arrangements (ICHRAs), which use the Lowest Cost Silver Plan (LCSP) as the benchmark to determine whether an ICHRA is considered affordable to an employee. Under this policy, as premiums decrease, an employer will have to contribute less to an ICHRA to have it be considered affordable. This could encourage large employer use of ICHRAs because large employers need to offer affordable coverage to satisfy the employer shared responsibility provisions.

We sought comment on the proposed impact estimates and assumptions, as well as any timing considerations with its proposed implementation.

After consideration of comments and for the reasons outlined in the proposed rule and this final rule, including our responses to comments, we are finalizing these impact estimates for this policy as proposed. We summarize and respond to public comments received on the proposed estimates below.

Comment: A few commenters estimated that PTCs would decrease between $327 and $714 per year for a typical family of four as a result of this proposal.

Response: We thank these commenters for their estimates, and do not find these estimates to be incomparable to the PTC impact estimates in Table 13. Therefore, we have taken these estimates into account in deciding to finalize the widened de minimis ranges as proposed.

17. 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 total number of unique commenters on the 2025 Marketplace Integrity and Affordability proposed rule will be the number of reviewers of this final rule. We acknowledge that this assumption may understate or overstate the costs of reviewing this rule. It is possible that not all commenters reviewed the proposed rule in detail, and it is also possible that some reviewers chose not to comment on the proposed rule. For these reasons, we believe that the number of commenters to the proposed rule would be a fair estimate of the number of reviewers of this rule. We welcomed any public comments on the approach in estimating the number of entities that would review the proposed rule. We did not receive any public comments specific to our solicitation.

We also recognize that different types of entities are in many cases affected by mutually exclusive sections of this proposed rule, and therefore for the purposes of our estimate, we assume that each reviewer reads approximately 50 percent of the rule. We sought public comments on this assumption. We did not receive any public comments specific to our solicitation.

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 $113.42 per hour, including overhead and fringe benefits.[287] Assuming an average reading speed of 250 words per minute, we estimate that it would take approximately 5.25 hours for the staff to review half of this final rule. For each entity that reviews the rule, the estimated cost is approximately $595.46 (5.25 hours × $113.42). Therefore, we estimate that the total cost of reviewing this regulation is approximately $15,493,869 ($595.46 × 26,020 reviewers).

We sought comment on the analysis in the proposed rule.

We did not receive any comments in response to the analysis in the proposed rule. Therefore, we are finalizing this analysis as presented in the preceding paragraphs.

18. Overall Impact of the Final Individual Market Program Integrity Provisions

In the regulatory impact analysis of this final rule, we include impact analyses and estimates for each policy separately, as we intend for each provision to be severable from the rest. Please see section III.F. of this final rule for a more detailed discussion on the severability of the provisions of this rule. However, we anticipate that the provisions of this final rule, while 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 final rule will 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 with respect to enrollment, premiums, and APTC, that minimize the overlap of individuals affected. These estimates use a baseline of current law such that a reduction in enrollment attributable to the expiration of enhanced PTCs in the

[287] U.S. Bureau of Labor Statistics. (n.d.). Occupational Employment and Wage Statistics. Dep't. of Labor. *https://www.bls.gov/oes/current/oes_nat.htm.*

IRA on December 31, 2025, is generally accounted for separately from these estimates, as such a reduction would not be due to the provisions in this final rule. These estimates consider the enrollment, premium, and APTC impact solely due to the provisions in this final rule, compared to what would occur if these provisions were not finalized. We have updated this analysis due to revised policies in this final rule compared to the proposals in the 2025 Marketplace Integrity and Affordability proposed rule. The proposed analysis may be found at 90 FR 13020 through 13026.

As this updated analysis shows, we expect the provisions of this final rule that sunset after PY 2026 will work to more quickly remove improper enrollments that exploited the availability of fully-subsidized coverage. The Department acknowledges, however, that there are numerous uncertainties regarding how the expiration of enhanced subsidies and the policies in this final rule will affect market conditions and coverage, especially following the sunset of certain policies finalized in this rule. Although there is data available from which we can draw reasonable conclusions regarding the causes of improper enrollments over recent years, there are many unknowns. As the Department and commenters agree, it is not possible to know with certainty which $0 premium plan enrollments were for persons who improperly took advantage of enhanced subsidies and the availability of $0 premium plans, and which represent improper exploitation of those benefits. The inability to trace the causes of potentially millions of unauthorized enrollments is exacerbated by data collection challenges and infrastructure gaps caused and identified after March 2020 when the COVID–19 public health emergency started and today when various temporary policies are still in the process of being ended and their impact understood. For instance, under the Medicaid continuous coverage requirements, States were required to maintain Medicaid enrollment for beneficiaries (who may have been otherwise eligible for Exchange coverage) and were prohibited from disenrolling consumers in limited circumstances. This policy potentially increased dual enrollments in both Medicaid and Exchanges in prior years while the continuous coverage requirement was in place. The end of the continuous coverage requirement reasonably could have caused spikes in enrollment in $0 premium plans. These circumstances have led the Department to conclude that it is reasonable to codifying certain policies through the end of PY 2026 in response to commenter concerns. The estimates presented in this section consider the increased instability of the health care and insurance markets that resulted from these changes and the massive amounts of improper Exchange enrollments.

The estimates we present were calculated as follows. CMS Marketplace Open Enrollment Period (OEP) Public Use Files (PUFs) contain data on individual Marketplace activity, including the demographic characteristics of consumers who made a plan selection. The Integrated Public Use Microdata Series (IPUMS) USA data provides access to samples of the American population drawn from sixteen Federal censuses, including the U.S. Census Bureau's American Community Survey (ACS). A 2024 study published in the American Journal of Health Economics (AJHE) estimated and analyzed the take-up rate of Marketplace insurance in the 39 States that used *Healthcare.gov* by comparing confidential microdata on all FFE enrollees who selected a plan during an open or SEP and effectuated their enrollment between 2015 and 2017 with the ACS 5-year public-use microdata sample for 2013–2017.[288] This methodology was adapted in a 2024 paper by the Paragon Health Institute to calculate erroneous and improper enrollments for 2024 by comparing CMS Marketplace OEP PUF data with ACS 1-year microdata.[289] Both of these approaches use ACS data to identify the non-elderly adult population that is potentially eligible for Exchange coverage and exclude individuals who are enrolled in Medicare or Medicaid. The AJHE study additionally excludes individuals receiving health insurance through an employer or TRICARE. There are also methodological differences between the two studies in how income eligibility for subsidized Exchange coverage is determined with the AJHE study estimating and imputing modified adjusted gross income (MAGI) for ACS survey respondents. We have carefully considered both these sources and used the Paragon Health Institute methodology in the following analysis as a way to quantify erroneous and improper enrollments using CMS Marketplace OEP PUFs data and IPUMS USA data using the best available data.

The analysis in Table 14 below compares sign-ups during the OEP for people with expected income between 100 and 150 percent of the FPL by State to the number of State residents in this income range who are eligible for Exchange coverage for the years 2019, 2023, and 2024. The number of plan selections on the Exchanges among people with expected incomes between 100 and 150 percent of the FPL are from the CMS Marketplace OEP PUFs data.[290] This information is based on the consumer's attestation of income for those who actively submitted an application for coverage for the specified plan year. For PYs 2023 and 2024, it reflects verified data on the prior year's income for those consumers who were auto re-enrolled without actively submitting an application for the current plan year.[291] The number of State residents in the 100 to 150 percent of the FPL income range who are potentially eligible for Exchange coverage in each year is estimated using the 2019 and 2023 1-year ACS files from IPUMS USA.[292] State residents ages 19–64 with household incomes between 100 and 150 percent of the FPL who are not enrolled in Medicaid or Medicare are considered potentially eligible for Exchange coverage. This follows a methodology used in prior research and excludes children age 18 and under who are eligible for Medicaid or the Children's Health Insurance Program (CHIP) if their incomes are in this range,[293] as well as adults ages 65 and older who are likely eligible for Medicare.[294] Because the 2024 ACS microdata is not yet available, the number of individuals potentially eligible for Exchange coverage in this income range for each State during 2024 was estimated by applying State-level estimates of population change from

[288] Hopkins, B. et al. (2024). How Did Take-Up of Marketplace Plans Vary with Price, Income, and Gender? American Journal of Health Economics, 11(1 winter 2025). Retrieved from *https://doi.org/10.1086/727785.*

[289] Blase, B. & Gonshorowski, D. (n.d.). The Great Obamacare Enrollment Fraud. Retrieved from *https://paragoninstitute.org/private-health/the-great-obamacare-enrollment-fraud/.*

[290] Marketplace Products. (n.d.). Retrieved from *https://www.cms.gov/data-research/statistics-trends-and-reports/marketplace-products.*

[291] Public Use Files: Definitions. (2024). Retrieved from *https://www.cms.gov/files/document/2024-public-use-files-definitions.pdf; https://www.cms.gov/files/document/2023-public-use-files-definitions.pdf.*

[292] Ruggles, S., et al. (2023). IPUMS USA: Version 15.0 [dataset]. Retrieved from *https://www.ipums.org/projects/ipums-usa/d010.V15.0.*

[293] Medicaid/CHIP Upper Income Eligibility Limits for Children, 2000–2024. (n.d.). Retrieved from *https://www.kff.org/medicaid/state-indicator/medicaidchip-upper-income-eligibility-limits-for-children/.*

[294] Blase, B. & Gonshorowski, D. (n.d.). The Great Obamacare Enrollment Fraud. Retrieved from *https://paragoninstitute.org/private-health/the-great-obamacare-enrollment-fraud/.*

2023 to 2024 from the United States Census Bureau to the 2023 ACS estimates.[295] This adjustment assumes that changes in population within the 100 to 150 percent of the FPL range are similar to those within the State and ignores any potential distributional changes. Minnesota, New York,[296] and Oregon were excluded from the analysis due the presence of a BHP for low-income residents during at least part of the analysis period.[297] The District of Columbia was excluded from the analysis due to insufficient income information available in the OEP PUF. In addition, a 2019 estimate for Idaho is not reported due to unavailable income information in the OEP PUF for this year.[298]

The comparisons presented in Table 14 include columns that calculate the take-up of Exchange coverage by dividing Exchange enrollment for each State by the corresponding estimate of eligible State residents from the ACS and multiplying by 100. While these estimates are useful for understanding trends in Exchange enrollment over time and different patterns of enrollment across States, they should not be interpreted as precise measures of take-up of Exchange coverage for several reasons. First, this methodology relies on 1-year samples of the ACS to estimate eligible State populations, which provides a current portrait of residents meeting the 100 to 150 percent of the FPL criteria in each year but leads to less precise estimates than the use of multi-year ACS samples with larger sample sizes.[299] Second, it uses the Census definition of poverty to identify residents with family incomes between 100 to 150 percent of the FPL, which differs from the MAGI relative to poverty measure that is used to determine eligibility for PTC on the Exchanges and reported in the OEP PUFs.[300] There are differences in both the sources of income that are included in the definition of income, as well as which household members are included in the calculation.[301] In addition, the ACS is fielded throughout the calendar year and asks about income during the previous 12 months,[302] meaning that this survey measure does not align with income during the calendar/plan year. Third, there is a tendency for income to be underreported in survey data, including in the ACS.[303] Fourth, the eligible population estimated using the ACS includes certain individuals who would not be eligible for subsidized Exchange coverage, including those with access to affordable employer-based coverage,[304] those with Medicaid coverage that they did not report on the survey,[305] immigrants who are not lawfully present,[306] and people enrolled in Department of Veteran Affairs (VA) health care. Finally, the eligible population estimated using the ACS does not include certain individuals who are eligible for Exchange coverage and are included in the enrollment counts in the OEP PUFs, such as people aged 65 or older who do not qualify for premium-free Medicare.[307] We acknowledge these limitations and sought comment in the proposed rule on ways to improve these analyses in the final rule. For instance, possible revisions to this analysis could include the use of multi-year ACS samples or the refinement of the measures of income and family unit used in the ACS to more closely align with Exchange PTC eligibility determination.

Table 14 shows there is large variation in the take-up of Exchange coverage among potential enrollees across States. It also indicates that there has been a substantial increase in take-up from the estimated 43.8 percent of potential enrollees in this set of States who enrolled in Exchange coverage for PY 2019. The estimates for 2023 and 2024 are 94.2 percent and 143.9 percent, respectively. These overall take-up estimates by year exclude Idaho given the lack of income information available for this State in 2019.

Nine States have take-up rates that exceed 100 percent for PY 2024, indicating that there are a larger number of Exchange enrollees reporting incomes of between 100 and 150 percent of the FPL than residents reporting incomes in this range on the ACS. While estimates slightly above 100 percent could potentially be attributed to imprecision in population estimates or differences in the measurement of income as described above, these explanations seem less likely for take-up estimates that greatly exceed 100 percent, such as the 438 percent observed for Florida in 2024. Other possible explanations for such a high take-up rate include people misestimating their income for the plan year at the time of open enrollment, as sign-ups typically occurring in the fall prior to the plan year and individuals may earn more or less than they expected, or people not updating their income information if auto re-enrolled with the prior year's income data in 2023 and 2024. These would constitute errors. To the extent that people with incomes below 100 percent of the FPL intentionally overstate their income in order to qualify for subsidized Exchange coverage or are counseled to do so by an agent, broker, or web-broker, or if people outside this income range are unknowingly enrolled by an agent, broker, or web-broker who claim their income at 100 to 150 percent of the FPL, these types of improper enrollments would also contribute to a take-up rate that exceeds 100 percent. Of note, 7 of the 9 States with take-up rates above 100 percent in 2024 are States that have not implemented ACA Medicaid expansions.[308] Medicaid eligibility for

[295] State Population Totals and Components of Change: 2023–2024[Vintage 2024]. *https://www.census.gov/data/tables/time-series/demo/popest/2020s-state-total.html#v2024.*

[296] New York operated a BHP from April 1, 2015, through April 1, 2024. *See https://www.medicaid.gov/basic-health-program.*

[297] Basic Health Program. (n.d.). Retrieved from *https://www.medicaid.gov/basic-health-program/index.html.*

[298] Public Use Files: Definitions. Retrieved from *https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/marketplace-products/downloads/2019publicusefilesdefinitions-.pdf.; https://www.cms.gov/data-research/statistics-trends-and-reports/marketplace-products/2019-marketplace-open-enrollment-period-public-use-files.*

[299] Using 1-Year or 5-Year American Community Survey Data. (2020). Retrieved from *https://www.census.gov/programs-surveys/acs/guidance/estimates.html.*

[300] What's Included as Income. (n.d.). Retrieved from *www.healthcare.gov/income-and-household-information/income/.*

[301] State Health Access Data Assistance Center. (2023). Defining Family for Studies of Health Insurance Coverage. Retrieved from *https://shadac-pdf-files.s3.us-east-2.amazonaws.com/s3fs-public/publications/2023%20Defining%20families%20brief.pdf.*

[302] Rothbaum, J.L. (2015). Comparing Income Aggregates: How do the CPS and ACS Match the National Income and Product Accounts, 2007–2012. Retrieved from *https://www.census.gov/content/dam/Census/library/working-papers/2015/demo/SEHSD-WP2015-01.pdf.*

[303] About Income. (n.d.). Retrieved from *https://www.census.gov/topics/income-poverty/income/about.htmlhttps://www.census.gov/content/dam/Census/library/working-papers/2015/demo/SEHSD-WP2015-01.pdf.*

[304] People with coverage through a job. (n.d.) Retrieved from *https://www.healthcare.gov/have-job-based-coverage/options/.*

[305] O'Hara, Brett. (2009). Is there an undercount of Medicaid participants in the ACS Content Test? Retrieved from *https://www.census.gov/content/dam/Census/library/working-papers/2009/adrm/medicaid-participants-acs-content-test.pdf.*

[306] Coverage for lawfully present immigrants. (n.d.). Retrieved from *https://www.healthcare.gov/immigrants/lawfully-present-immigrants/.*

[307] FAQs: Health Insurance Marketplace and the ACA. I am turning 65 years old next month, but I am not entitled to Medicare without having to pay a premium for Part A because I have not worked long enough to qualify. Can I sign up for a Marketplace plan? (n.d.). Retrieved from *https://www.kff.org/faqs/faqs-health-insurance-marketplace-and-the-aca/i-am-turning-65-years-old-next-month-but-i-am-not-entitled-to-medicare-without-having-to-pay-a-premium-for-part-a-because-i-have-not-worked-long-enough-to-qualify-can-i-sign-up-for-a-marketplace-pla/.*

[308] Status of State Medicaid Expansion Decisions. (2025, February 12). Retrieved from *https://*

non-elderly and non-disabled adults in these States is limited to parents who meet a median income eligibility threshold of 27 percent of the FPL.[309] Previous research presents evidence suggesting that many people with incomes that exceed the Medicaid eligibility limit in non-ACA Medicaid expansion States, especially in Florida, obtain subsidized Exchange coverage by reporting income just above the FPL at enrollment.[310]

One approach to estimate the possible reduction in erroneous and improper enrollments under the changes in this rule is to sum the total number of enrollments in 2024 that exceed 100 percent of potential enrollees in Table 14. This calculation suggests that there are as many as 4.4 million erroneous or improper enrollments. This is expected to be an upper bound estimate of the scale of erroneous and improper enrollments. PY 2024 Exchange enrollments occurred prior to recent HHS actions to improve program integrity, which were expected to reduce the number of improper and erroneous enrollments prior to the implementation of the provisions in this final rule. Additionally, this estimate fully attributes excess enrollments to error and improper enrollments and does not adjust for the presence of general uncertainty around expected income among enrollees, which is not expected to change as a result of the provisions, nor does it take into account the imprecision inherent in the use of survey data to identify and measure the population eligible for Exchange coverage. However, despite HHS actions to improve program integrity, there was still a substantial increase in plan selections during the PY 2025 OEP, suggesting the possibility that erroneous and improper enrollments may have increased further this year. In addition, the excess enrollment estimate ignores the potential presence of erroneous and improper enrollments in States with take-up rates below 100 percent and, in this way, could underestimate the potential impact of the provisions. For all of these reasons, there is uncertainty present regarding the estimate derived from this analysis. We acknowledge this uncertainty and sought comment in the proposed rule on how we may improve this estimate in final rulemaking.

TABLE 14—EXCHANGE SIGN-UPS COMPARED TO POTENTIAL ENROLLEES AT 100–150 PERCENT OF THE FPL INCOME, BY STATE AND YEAR

	2019			2023			2024		
	Exchange sign-ups	Potential enrollees	Take-up rate (%)	Exchange sign-ups	Potential enrollees	Take-up rate (%)	Exchange sign-ups	Potential enrollees	Take-up rate (%)
Alabama	70,951	162,156	43.8	119,737	161,318	74.2	228,883	162,580	140.8
Alaska	1,896	16,161	11.7	2,050	11,860	17.3	2,317	11,918	19.4
Arizona	20,565	177,646	11.6	49,204	153,762	32.0	114,197	156,012	73.2
Arkansas	11,893	106,418	11.2	23,680	90,011	26.3	56,640	90,565	62.5
California	242,016	758,412	31.9	274,117	630,793	43.5	278,204	634,536	43.8
Colorado	15,222	104,067	14.6	14,327	85,286	16.8	14,786	86,098	17.2
Connecticut	8,292	51,747	16.0	8,315	46,834	17.8	12,991	47,246	27.5
Delaware	2,886	16,730	17.3	3,584	13,723	26.1	8,374	13,928	60.1
Florida	981,323	742,425	132.2	1,961,049	608,549	322.2	2,718,501	620,966	437.8
Georgia	219,261	362,003	60.6	496,628	326,102	152.3	834,058	329,534	253.1
Hawaii	2,352	20,557	11.4	2,571	24,026	10.7	3,006	24,105	12.5
Idaho	NR	NR	NR	4,768	43,826	10.9	8,193	44,504	18.4
Illinois	52,000	255,798	20.3	78,590	198,726	39.5	111,131	199,793	55.6
Indiana	19,172	173,981	11.0	41,719	131,311	31.8	112,127	132,154	84.8
Iowa	6,334	53,568	11.8	12,580	49,928	25.2	23,908	50,286	47.5
Kansas	28,266	88,955	31.8	47,693	83,239	57.3	82,256	83,778	98.2
Kentucky	10,401	94,295	11.0	4,748	83,064	5.7	8,534	83,754	10.2
Louisiana	19,207	114,770	16.7	36,199	97,572	37.1	93,833	97,778	96.0
Maine	15,854	28,318	56.0	4,312	22,190	19.4	4,581	22,275	20.6
Maryland	19,450	77,124	25.2	18,522	89,654	20.7	21,599	90,320	23.9
Massachusetts	37,759	66,807	56.5	17,045	67,287	25.3	30,595	67,950	45.0
Michigan	43,286	201,320	21.5	64,618	171,546	37.7	122,597	172,517	71.1
Mississippi	53,009	116,614	45.5	124,404	110,202	112.9	210,749	110,197	191.2
Missouri	83,499	195,867	42.6	90,907	159,071	57.1	154,459	160,030	96.5
Montana	4,924	25,305	19.5	4,296	23,278	18.5	8,522	23,400	36.4
Nebraska	22,677	53,748	42.2	15,563	36,846	42.2	25,158	37,172	67.7
Nevada	15,548	85,249	18.2	21,208	76,288	27.8	22,471	77,548	29.0
New Hampshire	5,077	19,425	26.1	5,238	13,681	38.3	8,484	13,748	61.7
New Jersey	37,653	142,831	26.4	53,173	135,983	39.1	69,867	137,740	50.7
New Mexico	5,744	42,939	13.4	4,016	45,821	8.8	6,747	46,017	14.7
North Carolina	186,358	357,623	52.1	347,551	278,562	124.8	507,098	282,782	179.3
North Dakota	2,149	16,765	12.8	3,019	10,854	27.8	3,770	10,957	34.4
Ohio	24,792	226,871	10.9	60,101	195,405	30.8	166,814	196,385	84.9
Oklahoma	51,744	144,964	35.7	70,349	124,195	56.6	120,013	125,158	95.9
Pennsylvania	63,304	213,444	29.7	62,303	187,117	33.3	81,714	187,994	43.5
Rhode Island	6,449	14,631	44.1	4,453	14,798	30.1	6,117	14,917	41.0
South Carolina	79,543	163,892	48.5	168,217	156,016	107.8	301,553	158,651	190.1
South Dakota	7,752	23,691	32.7	9,898	24,736	40.0	8,821	24,907	35.4
Tennessee	73,392	215,288	34.1	158,033	180,654	87.5	310,781	182,662	170.1
Texas	474,670	1,115,085	42.6	1,360,433	1,037,034	131.2	2,133,460	1,056,033	202.0
Utah	56,561	92,491	61.2	87,196	74,704	116.7	133,065	76,014	175.1

www.kff.org/status-of-state-medicaid-expansion-decisions/.

[309] Medicaid Income Eligibility Limits for Adults as a Percent of the Federal Poverty Level. (2024, 1 May). Retrieved from *https://www.kff.org/affordable-care-act/state-indicator/medicaid-income-eligibility-limits-for-adults-as-a-percent-of-the-federal-poverty-level/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.* Parental income eligibility limits for parents in a family of three as of May 1, 2024 for each of the 7 States are 18 percent of the FPL in Alabama, 27 percent of the FPL in Florida, 30 percent of the FPL in Georgia, 27 percent of the FPL in Mississippi, 67 percent of the FPL in South Carolina, 105 percent of the FPL in Tennessee, and 15 percent of the FPL in Texas. Other adults are not eligible.

[310] Hopkins, B. et al. (2024). How Did Take-Up of Marketplace Plans Vary with Price, Income, and Gender? American Journal of Health Economics, 11(1 winter 2025). Retrieved from *https://doi.org/10.1086/727785.*

TABLE 14—EXCHANGE SIGN-UPS COMPARED TO POTENTIAL ENROLLEES AT 100–150 PERCENT OF THE FPL INCOME, BY STATE AND YEAR—Continued

	2019			2023			2024		
	Exchange sign-ups	Potential enrollees	Take-up rate (%)	Exchange sign-ups	Potential enrollees	Take-up rate (%)	Exchange sign-ups	Potential enrollees	Take-up rate (%)
Vermont	2,326	5,584	41.7	1,626	6,076	26.8	2,227	6,074	36.7
Virginia	91,810	181,345	50.6	80,751	146,563	55.1	110,912	147,847	75.0
Washington	20,704	122,440	16.9	16,092	112,052	14.4	21,588	113,490	19.0
West Virginia	3,168	41,262	7.7	5,516	34,229	16.1	17,243	34,219	50.4
Wisconsin	46,353	119,818	38.7	39,856	104,583	38.1	64,398	105,122	61.3
Wyoming	5,317	16,606	32.0	6,767	18,034	37.5	8,054	18,113	44.5
Total (excluding Idaho)	3,252,909	7,427,036	43.8	6,082,254	6,453,563	94.2	9,387,203	6,525,270	143.9

Sources: 2019, 2023, and 2024 CMS Marketplace Open Enrollment Period Public Use Files (OEP PUF); 2019 and 2023 1-year American Community Survey (ACS) files from IPUMS USA. NR—Not reported.

Notes: Potential enrollees by State are estimated using the ACS as State residents ages 19–64 who are not enrolled in Medicaid or Medicare. The 2024 estimates are calculated by applying a State population growth rate to the 2023 estimates. Minnesota, New York, and Oregon are excluded due to the presence of a BHP during at least some portion of the analysis period. The District of Columbia is excluded due to the unavailability of income information in the OEP PUF.

Furthermore, we anticipate that IRA subsidies expiring after PY 2025 will reduce the availability of fully-subsidized plans and, therefore, is expected to also reduce the occurrence of improper enrollments that exploited the availability of enhanced subsidies. That reduction in improper enrollments is not attributable to the policies in this rule, but rather by current law causing IRA subsidies to expire after PY 2025. However, there is uncertainty regarding how many improper enrollments will be reduced by the expiration of IRA subsidies compared to the policies in this rule. Moreover, in response to commenters' concerns, we finalize certain verification requirements to sunset at the end of PY 2026, creating additional uncertainty related to the level of improper enrollments in PY 2027 and beyond. We believe that coverage in connection with the majority of improper enrollments will end as a result of the enhanced subsidies; therefore, in the proposed rule, we assumed a range of approximately 750,000 to 2,000,000 fewer individuals will enroll in QHP coverage in 2026 as a result of the policies in the proposed rule. In the proposed rule, we sought comment on the estimate and assumptions and respond to such comments later in this analysis.

Based on comments and revised analysis resulting from some policy changes between the proposed and final rules, as discussed previously in this final rule, we now assume a range of approximately 725,000 to 1,800,000 fewer individuals will enroll in QHP coverage in 2026 as a result of the policies in this final rule. We use this range moving forward in this analysis. The full proposed rule analysis may be found at 90 FR 13020 through 13026.

Starting with internal CMS data of enrollment by month, premiums, and APTCs, we summarize the data using average monthly amounts. These monthly averages are projected throughout the year using historical monthly patterns during a similar environment. For future years, the enrollment is trended by the projected growth in the under age 65 population. Spending amounts are trended using projected growth in NHEA less Medicare. With the expiration of enhanced subsidies, we assume approximately 42 percent of recent enrollment growth will discontinue coverage. We believe the discontinuing enrollees are likely to be healthier than those remaining in the risk pool, leading to higher overall premiums on a per member per month (PMPM) basis ($614.44 PMPM in 2025 increasing to $662.13 PMPM in 2026). Based on the analysis presented thus far in this section, we expect average enrollment for 2026 to decrease by approximately 725,000 to 1,800,000 enrollees compared to baseline estimates. Some enrollees dropping coverage will likely be healthier than those remaining in the risk pool, while other enrollees losing coverage due to improper enrollments could potentially be less healthy, so we estimated the claims impact to the risk pool to potentially range from −0.5 percent to +4 percent. The claims changes were then combined with the estimated 3.4 percent decrease for the expected impact of removing the monthly 150 percent FPL SEP, a 0.5 percent decrease for SEP verification, and 1 percent decrease for the de minimis AV change. The 2026 baseline claims per member was decreased by 5.4 percent for the 725,000 reduced enrollment scenario and 0.9 percent for the 1,800,000 reduced enrollment scenario. The revised premium was calculated assuming issuers will price to an average 84 percent loss ratio, yielding a revised PMPM of $626.37 for the 725,000 reduced enrollment scenario and $656.17 for the 1,800,000 reduced enrollment scenario for 2026 as a result of these jointly finalized policies. Estimated APTCs were assumed to be 88.8 percent of the premium PMPM ($626.37 × 0.888 = $556.22 and $656.17 × 0.888 = $582.68), and APTC enrollment was estimated to be 90.6 percent of total enrollment for 2026. For future years under this rule, we assume premium growth of 3.9 percent for 2027 and 2028 and 1.9 percent for 2029. Enrollment growth is estimated at 1.1 percent for 2027, 1.5 percent for 2028, and 3 percent for 2029. We assume the enrollment and claims impacts from the sunsetting policies wear off over 2027 and 2028, with 80 percent of the wear-off occurring in 2027 and 20 percent occurring in 2028.

Using the methodology described in the preceding paragraphs, we anticipate the provisions in this final rule, when considered jointly, could reduce enrollment, premiums, and APTC each year beginning in 2026. We provide lower bound estimates in Table 15 and upper bound estimates in Table 16.

TABLE 15—OVERALL ENROLLMENT AND APTC IMPACTS OF THE PROGRAM INTEGRITY RULE—LOWER BOUND ESTIMATES

Calendar year	2025	2026	2027	2028	2029
Baseline:					
Total Enrollment (millions)	21.625	17.240	17.426	17.682	18.213
APTC Enrollment (millions)	20.061	15.614	15.635	15.741	15.798
Premiums ($ billions)	159.448	136.980	143.822	151.597	159.043
APTC ($ billions)	130.960	110.188	115.911	122.564	128.584
Policies in this rule:					
Total Enrollment (millions)	21.625	16.515	17.273	17.672	18.203
APTC Enrollment (millions)	20.061	14.958	15.498	15.732	15.789
Premiums ($ billions)	159.448	124.134	139.070	148.953	156.270
APTC ($ billions)	130.960	99.854	112.081	120.427	126.342
Change:					
Total Enrollment (millions)	.....	−0.725	−0.153	−0.010	−0.010
APTC Enrollment (millions)	.....	−0.656	−0.137	−0.009	−0.009
Premiums ($ billions)	.....	−12.846	−4.752	−2.643	−2.773
APTC ($ billions)	.....	−10.334	−3.830	−2.137	−2.242

TABLE 16—OVERALL ENROLLMENT AND APTC IMPACTS OF THE PROGRAM INTEGRITY RULE—UPPER BOUND ESTIMATES

Calendar year	2025	2026	2027	2028	2029
Baseline:					
Total Enrollment (millions)	21.625	17.240	17.426	17.682	18.213
APTC Enrollment (millions)	20.061	15.614	15.635	15.741	15.798
Premiums ($ billions)	159.448	136.980	143.822	151.597	159.043
APTC ($ billions)	130.960	110.188	115.911	122.564	128.584
Policies in this rule:					
Total Enrollment (millions)	21.625	15.440	17.046	17.657	18.187
APTC Enrollment (millions)	20.061	13.984	15.295	15.719	15.776
Premiums ($ billions)	159.448	121.574	139.313	149.870	157.231
APTC ($ billions)	130.960	97.795	112.277	121.168	127.119
Change:					
Total Enrollment (millions)	.....	−1.800	−0.380	−0.025	−0.026
APTC Enrollment (millions)	.....	−1.630	−0.340	−0.022	−0.022
Premiums ($ billions)	.....	−15.406	−4.509	−1.727	−1.812
APTC ($ billions)	.....	−12.393	−3.634	−1.396	−1.465

Taken together, the provisions of this final rule are expected to address errors and improper enrollments, which means that as presented in the preceding paragraphs, we expect approximately 725,000 to 1,800,000 individuals to lose coverage as a result of the provisions in this rule. This range may overestimate the actual number of individuals impacted, as we believe that this range includes many individuals improperly enrolled by agents, brokers, and web-brokers without their knowledge or consent, as well as enrollees with multiple forms of coverage. Likewise, this range may underestimate the actual number of individuals impacted, as eligible enrollees may lose coverage as a result of the administrative burdens imposed by the provisions of this rule. Finally, as explained by the Department in the proposed rule and this final rule, as well by commenters, estimation of the number of individuals impacted may likely be skewed due to the general difficulty in assigning with certainty the causes of improper enrollments. We note that coverage losses are expected to be concentrated in nine States where erroneous and improper enrollment is most noticeable (that is, Alabama, Florida, Georgia, Mississippi, North Carolina, South Carolina, Tennessee, Texas, and Utah), although we also expect minor coverage losses across all States as the administrative burdens associated with this rule would be applied uniformly across the country.

An individual who loses coverage may be required to incur additional expense to obtain coverage or may go uninsured. An increase in the rate of uninsurance may impose greater burdens on the health care system through strain on emergency departments, additional costs to the Federal Government and to States to provide limited Medicaid coverage for the treatment of an emergency medical condition, and may cause an overall reduction to labor productivity.

In contrast, if individuals who do not maintain coverage following the finalization of this rule would otherwise be subsidized QHP enrollees, as we anticipate, there would be a savings to the Federal Government in the form of reduced APTC payments (net of increased QHP-related payments), thereby saving taxpayer dollars. As we explain earlier in this final rule, the Department has strong reason to believe many of the individuals who would lose coverage as a result of the policies in this rule may represent improper enrollments.

While we acknowledge the finalization of this rule may impact enrollment of self-employed individuals, some of whom may qualify for subsidies, we anticipate that premiums will decrease as a result of this final rule. We note that variables—including those impacting enrollment, premiums, and APTC—have changed over time and may continue to fluctuate. When considering the overall impact of the provisions in this final rule, 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 final rule could be outside of the estimates provided in this section.

We sought comment on the proposed impacts and assumptions.

After consideration of comments and for the reasons outlined in the proposed rule and this final rule, including our responses to comments, we are finalizing these impact estimates for this rule with the modifications presented earlier in this section. We summarize and respond to public comments received on the proposed estimates below.

Comment: Several commenters noted that a decrease in enrollment would result in increased emergency care utilization and increased costs of uncompensated care, Medicare, and State Medicaid expenditures. These commenters also discussed how uninsurance leads to disrupted continuity of care and poorer health outcomes. A few comments from State entities provided estimates of enrollment reductions and premium increases in their specific States.

Some commenters alleged that the proposed rule would negatively impact market stability, discourage issuer participation, worsen the risk pool, and increase premiums for all enrollees. A few of these commenters stated that coverage losses would be concentrated in healthy populations, resulting in premium increases that would especially impact unsubsidized enrollees.

Response: We appreciate the additional data provided by States and have considered it in the analysis in this final rule. As discussed previously in this RIA, we acknowledge that a decrease in enrollment may have the consequences noted by commenters. However, we anticipate that most of this decrease in enrollment will be attributable to improper enrollments that should never have enrolled in Exchange coverage. As documented in a CMS press release from 2024, we received and resolved over 180,000 unauthorized enrollment complaints from January to August 2024.[311] Therefore, we do not anticipate that the decrease in enrollment estimated in this final rule will impact many enrollees who are properly enrolled.

Furthermore, as discussed earlier in this final rule, we also acknowledge that some enrollees dropping coverage will likely be healthier than those remaining in the risk pool, but other enrollees losing coverage due to improper enrollments could potentially be less healthy as well. Earlier in this RIA, we discuss our methodology for estimating a premium reduction resulting from the provisions in this rule, which we anticipate will benefit all enrollees regardless of subsidy receipt. We do not believe this rule will destabilize the market or discourage issuer participation, as issuers expressed in their comments their appreciation for the finalization of these program integrity provisions. We did not receive issuer comments that the proposed policy would discourage issuer participation.

Comment: One commenter stated that the RIA failed to account for the expiration of enhanced subsidies in the IRA.

Response: As discussed earlier in this section, we account for the expiration of enhanced subsidies in the IRA by assuming approximately 42 percent of recent enrollment growth will discontinue coverage and will be healthier than enrollees maintaining coverage. We then use higher overall premiums PMPM as a starting point for our analysis of the impact of this rule.

Comment: A few commenters stated that the RIA only demonstrated problems with improper enrollments in nine States, which are all on the FFE, while the policies in this rule will impact all States regardless of Exchange type. One commenter also stated that publicly available State Exchange data directly contradicted the analysis in the proposed rule. One commenter alleged that the majority of the enrollment losses estimated in the proposed rule would not be attributable to improper enrollments but did not provide evidence to support this statement.

Response: The provisions finalized in this rule were designed to reduce improper enrollments while ensuring individuals who are eligible to enroll in QHP coverage, and those who are also eligible to receive subsidies, are able to demonstrate their eligibility appropriately. As discussed previously in this analysis, we anticipate that many of the individuals who may lose coverage as a result of this rule were improperly enrolled. More importantly, we maintain that enrollees who are eligible will still be able to enroll under the provisions in this rulemaking. This would be true for both FFE and State Exchange States. We also note that as discussed elsewhere in this final rule, we are modifying the proposals regarding annual eligibility redeterminations, the annual OEP, and SEP verification to finalize policies permitting more State flexibility in recognition of these and other comments expressing concerns about State burdens, the data provided by commenters, and the results of our analysis.

Comment: A few commenters urged HHS to fully inform individuals negatively impacted by the rule of alternative care options. Another commenter stated that the proposed rule failed to consider additional costs on States of customer service and education that would result from the rule.

Response: We always conduct outreach and education campaigns around open enrollment each year, and intend to fully inform consumers about the changes finalized in this rule. Furthermore, we acknowledge that States may face additional costs for outreach and education as noted in the accounting table (Table 10 in the proposed rule and this final rule) but are unable to estimate these costs, as each State conducts such activities differently.

Comment: Some commenters stated that the proposed rule failed to identify data for many proposals.

Response: As discussed throughout the proposed rule and in this final rule, we provided data and analysis to the best of our ability that was available to us and where possible, we do provide information on the sources of data being used for the analysis. For example, in this section of the final rule, we identify that we used the CMS OEP PUFs as the basis of our analysis. Furthermore, in this final rule, we have also updated the analyses to reflect newly available data to support the provisions in this rule, which may be found in this RIA.

Comment: Several commenters alleged that the proposed rule relied on unsound data from a 2024 paper by the Paragon Health Institute which fails to mention or account for income misestimations and exaggerates the extent of possible enrollment fraud. A few of these commenters stated that the numerator of the enrollment reduction calculation uses Exchange data, which includes children, while the denominator of the calculation uses ACS data, which excludes children. These commenters also noted that using 2023 ACS data in the denominator of the calculation to estimate improper enrollments for 2024 fails to account for the Medicaid continuous coverage requirement in place in 2023 that was no longer in place for 2024, inflating the denominator. Additionally, these commenters stated that the income estimate used in Exchange data in the numerator of the calculation is for the year after the current year, while the income estimate used in ACS data in the denominator is for the current year, so they are not comparable estimates.

[311] CMS (2024, October). CMS Update on Action to Prevent Unauthorized Agent and Broker Marketplace Activity. *https://www.cms.gov/newsroom/press-releases/cms-update-actions-prevent-unauthorized-agent-and-broker-marketplace-activity.*

Finally, a few of these commenters stated that the analysis did not consider the agent/broker fraud prevention efforts CMS engaged in starting with the 2024 OEP, which has decreased improper enrollments since that time. All of these commenters alleged that these analysis flaws overstated the extent of possible enrollment fraud.

Response: We noted these limitations in the proposed rule and continue to reference them in this final rule. The Paragon report analysis informed our analysis, but we also incorporated Exchange data for a more fulsome analysis. There was a large variance between the population observed in our data for the 100 to 150 percent of the FPL income range and external survey data. This indicated a potential for a large number of enrollments that were either unauthorized or people misestimating or misrepresenting their income. Our range of enrollment lost estimated in the proposed rule was between 750,000 and 2,000,000, but we could not discern the amount of lost enrollments that were fraudulent or due to misrepresented income from those lost to other controls proposed in the proposed rule. We updated these estimates in this final rule as a result of finalizing modifications of some proposals based on these and other comments, as discussed previously in this final rule.

D. Regulatory Alternatives Considered

We considered taking no action regarding our proposal to remove § 147.104(i), which currently prohibits an issuer from denying coverage due to an individual's or employer's failure to pay premiums owed for prior coverage, including by attributing payment of premium for new coverage to past-due premiums owed for prior coverage. Leaving this policy in place would provide the broadest enrollment rights for consumers. However, due to concerns about adverse selection, we believe that it is reasonable to allow issuers, to the extent permitted by applicable State law, to condition the sale of new coverage on payment of past-due premiums owed to the issuer. This policy will improve the risk pool by promoting continuous coverage without imposing a significant financial burden for most people who owe past-due premiums. We also considered prohibiting issuers from collecting past due premiums for periods of coverage dating back more than a specified time period, requiring issuers to provide enrollees notice of the past due premium policy, and other parameters. However, we decided to allow States the discretion to require and define such parameters, as they are most familiar with their markets, and to respect their traditional role of regulating insurance.

At § 155.20, we are finalizing adjustments to the definition of ''lawfully present'' used for purposes of determining eligibility to enroll in a QHP offered through the Exchange, eligibility for PTC, APTC, and CSR, or a BHP in States that elect to operate a BHP to exclude DACA recipients. We alternatively considered proposing to fully revert to the definition of ''lawfully present'' that was in place prior to the 2024 Final Rule ''Clarifying the Eligibility of Deferred Action for Childhood Arrivals (DACA) Recipients and Certain Other Noncitizens for a Qualified Health Plan through an Exchange, Advance Payments of the Premium Tax Credit, Cost-Sharing Reductions, and a Basic Health Program'' (89 FR 39392). However, proposing to fully reinstate the previous definition would have undone several technical and clarifying changes to the definition of ''lawfully present'' that were finalized in the 2024 rule (89 FR 39407).

We evaluated these technical and clarifying changes and found that some had no impact on who is considered ''lawfully present'' for purposes of enrolling in QHP coverage offered through the Exchange, eligibility for PTC, APTC, and CSR, and BHP coverage in States that elect to operate a BHP.[312] Other changes corrected unintentional errors in the prior definition.[313] Finally, some changes resulted in very small populations being newly considered ''lawfully present.'' Unlike DACA recipients, the small number of individuals in these discrete categories generally would have entered the United States with inspection and would generally be able to adjust status to lawful permanent resident on the basis of their status.[314] Because these changes were primarily technical and clarifying in nature, and because the small groups of noncitizens newly considered ''lawfully present'' as a result of these changes are different from DACA recipients in important ways, we did not propose to revert or amend these provisions at this time.

We considered taking no action regarding our proposal to modify § 155.305(f)(4), which currently allows Exchanges to remove APTC after an enrollee or their tax filer has been found as failing to file their income tax return and reconcile their APTC for 2 consecutive tax years. However, due to concerns about improper enrollments, as well as concerns related to the potential for increased tax liability for tax filers, we are finalizing the proposed policy that Exchanges are required to remove APTC after an enrollee or their tax filer has been identified as failing to file and reconcile for 1 tax year, but with a modification that the policy will sunset at the end of PY 2026. Exchanges will revert back to the 2-year policy for PY 2027. We believe that FTR serves as an important check on improper enrollments and will help protect low-income consumers from larger than expected tax liabilities. However, as the Department explains in Section III.B. of this final rule, sunsetting the rule responds to commenter concerns that the 2-year FTR policy we proposed would present an unreasonable impediment to continuous coverage for vulnerable persons, especially those who traditionally have not earned an amount sufficient to require them to file annual Federal tax returns. The Department shares commenter concerns that the Federal tax filing and APTC reconciliation process may be confusing to consumers who have not previously been required to file Federal tax returns. We also understand from comments by State Exchanges that the 2-year FTR policy has potentially helped avoid unnecessary gaps in some consumers' coverage. Still, the risk remains that once the 2-year FTR policy returns after PY 2026, the risk of increased consumer tax liability also returns, including for persons who genuinely believed they were eligible for the APTC paid on their behalf.

We considered taking no action regarding our policy to remove § 155.315(f)(7) which requires that applicants must receive an automatic 60-day extension in addition to the 90 days currently provided by § 155.315(f)(2)(ii) to allow applicants sufficient time to provide documentation to verify household income. However, we believe it is important we remove it to align with the 90-day statutory period. Additionally, we believe the cost to taxpayers caused by continued APTC beyond the 90-day period and decline in program integrity outweighs any possible benefits to the

[312] For example, technical changes to § 155.20(4) and 155.20(5) to adjust the language we use to refer to temporary resident status and Temporary Protected Status (TPS), as described in the 2024 final rule at 89 FR 39408.

[313] For example, technical changes to § 155.20(13) to refer to individuals with an approved petition for Special Immigrant Juvenile (SIJ) status, rather than only individuals with applications for such status, as described in the 2024 Final Rule at 89 FR 39411.

[314] For example, changes to § 155.20(6) to newly include individuals in the process of transitioning from certain employment-based immigrant visa petitions to lawful permanent resident (LPR) status, as described in the 2024 final rule at 89 FR 39408.

risk pool that were identified the 2024 Payment Notice.

We considered taking no action regarding our policy to add amendments to § 155.320(c)(3)(iii) to specify that all Exchanges must generate annual income inconsistencies when a tax filer's attested projected annual would qualify the taxpayer as an applicable taxpayer according to 26 CFR 1.36B–2(b) and trusted data sources indicate that projected income is under 100 percent of the FPL. Due to concerns related to applicants inflating their incomes or having applications submitted on their behalf with inflated incomes, as outlined in this final rule, the Department determined that immediate action is necessary to protect consumers and Federal funds. must take immediate action to we believe it is reasonable and necessary to carry out the alternative income verification process in this scenario. However, in response to commenter concerns and additional reasons we outline in Section III.B. of this final rule, the Department is finalizing the policy to be effective only through PY 2026. Exchanges may revert back to not setting income DMIs when an applicant's annual household income attestation would qualify the taxpayer as an applicable taxpayer according to 26 CFR 1.36B–2(b) and trusted data sources indicate that projected income is under 100 percent of the FPL for PY 2027. This will help to limit tax filers' potential liability at tax reconciliation to repay excess APTC.

We considered taking no action regarding our policy to remove § 155.320(c)(5) which currently requires Exchanges to accept attestations, and not set an Income DMI, when the Exchange requests tax return data from the IRS to verify attested projected annual household income, but the IRS confirms there is no such tax return data available. However, we believe that removing § 155.320(c)(5) is important for program integrity to address the level of improper enrollments due in large part to the enhanced premium subsidies. We too are cognizant of commenter concerns that this policy represents an impediment to coverage. Given this, for those reasons we outline in section III.B. of this final rule, we are finalizing this policy so that it is effective only through the end of PY 2026. Exchanges will revert back to requirements laid out in § 155.320(c)(5) for PY 2027. This policy respects the Department's duty to safeguard Federal funds, while allowing the Department, Exchanges, and other interested parties to collect additional data on these newly generated income DMIs and their impacts on consumers and coverage to support future policy analysis.

We are finalizing adding § 155.335(a)(3) and (n) to require that when an enrollee does not submit an application for an updated eligibility determination on or before the last day to select a plan for January 1, 2026 coverage and the enrollee's portion of the premium for the entire policy would be zero dollars after application of APTC through an Exchange on the Federal platform's annual redetermination process, all Exchanges on the Federal platform decrease the amount of the APTC applied to the policy such that the remaining monthly premium owed by the enrollee for the policy equals $5 for the first month and for every following month that the enrollee does not confirm or update the eligibility determination. This amendment is being finalized for benefit year 2026 only for Exchanges on the Federal platform, with a reversion to the previous policy for benefit year 2027 and beyond. We are not finalizing this amendment for State Exchanges.

We alternatively considered whether other methods, such as outreach, could sufficiently prompt fully-subsidized enrollees to update or confirm their eligibility information and actively re-enroll in coverage, but over half of enrollees in the Exchanges on the Federal platform actively re-enroll by the applicable deadlines for January 1 coverage. As discussed previously in this preamble, however, we do not believe additional or different notifications will prompt action from enrollees who choose not to submit an application for an updated eligibility determination and actively re-enroll.

In addition, we considered taking no action regarding our policy at § 155.335; however, we believe that it is important to address the significant increase in the number of enrollees who are automatically re-enrolled in a fully-subsidized QHP, and change is critical to reduce the financial impact of improper enrollments in QHPs with APTC through the Exchanges on the Federal platform. The current annual redetermination process puts fully-subsidized enrollees at risk of accumulating surprise tax liabilities and increases the cost of PTC to the Federal Government as Federal law limits repayments, and there is no provision to recoup overpayments from issuers when they follow the eligibility determinations made by the Exchanges.

We also considered modifying the Exchange's annual redetermination process to require that when an enrollee does not submit an application to obtain an updated eligibility determination on or before the last day to select a plan for January 1 coverage and the enrollee's portion of the premium for the entire policy would be zero dollars after application of APTC through the Exchange's annual redetermination process, the enrollee would be automatically re-enrolled without any APTC. This would ensure that enrollees in this situation need to return to the Exchange and obtain an updated eligibility determination prior to having any APTC paid on their behalf for the upcoming year. Ultimately, however, we determined that this approach would create undue financial hardship for these enrollees and act as a significant barrier to accessing health care coverage. The loss of lower-risk enrollees, who are least likely to actively re-enroll, due to an inability to pay could destabilize the market risk pool and increase premiums and the uninsured rate. Based on comments received on this approach in the 2021 Payment Notice proposed rule, we believe that our temporary amendment, which decreases the amount of the APTC applied to the policy such that the remaining premium owed by the enrollee for the policy equals $5, strikes an appropriate balance between encouraging active and proper enrollment and ensuring market stability.

The 2024 Payment Notice updated § 155.335(j) to allow Exchanges to move a CSR-eligible enrollee from a bronze QHP and re-enroll them into a silver QHP for an upcoming plan year, if a silver QHP is available in the same product, with the same provider network, and with a lower or equivalent net premium after the application of APTC as the bronze plan into which the enrollee would otherwise have been re-enrolled. We considered taking no action and leaving this policy in place; however, for reasons further discussed in section III.B.5. of this final rule, we believe that consumers, and the agents, brokers, web-brokers, and Navigators who help them, are largely aware of the more generous subsidies. Therefore, we believe that the consumer awareness problem the bronze to silver crosswalk policy aimed to address is substantially less today, and therefore the possible benefits of this policy no longer outweigh its potential to confuse consumers, undermine consumer choice, and create unexpected tax liability.

We considered taking no action regarding modifications to § 155.400(g) to remove flexibilities that would allow issuers to adopt a fixed-dollar premium payment threshold or a gross premium-based percentage payment threshold.

We also considered removing just the fixed-dollar threshold policy and allowing issuers the option to utilize the gross premium percentage-based premium threshold. However, given the continued and increased numbers of improper enrollments and plan switches and other improper enrollment trends, both the fixed-dollar and gross-premium percentage-based thresholds present program integrity risks that may allow consumers (and Medicaid beneficiaries who are victims of dual improper enrollment into a QHP) to remain in coverage for a much longer or indefinite amount of time, after payment of the binder. Consumers who never wanted, or no longer need, QHP coverage could remain enrolled for longer than the 3-month grace period, accruing premium debt and potentially facing complications when they file their taxes. Issuers will still have the option to implement the existing net premium percentage-based policy to allow consumers who pay the majority of their premium to avoid being put into a grace period.

We also considered finalizing the modifications at § 155.400(g) as proposed, instead of sunsetting the fixed-dollar and gross-premium thresholds after PY 2026. However, for the reasons specified earlier in this final rule, as well as the fact that this approach will enable interested parties to collect data regarding the impact of the removal of the fixed-dollar and gross-premium payment thresholds in order to inform future policy direction, we are finalizing this provision such that the fixed-dollar and gross-premium percentage-based thresholds will be removed as a flexibility for all Exchanges until and after PY 2026.

We considered maintaining the length of the OEP, and we considered designating November 1 to December 15 as the OEP for all Exchanges without flexibility, as proposed. However, based on comments, we are of the view that setting clear parameters for the date range and duration of the annual OEP, instead of proscribing specific OEP start and end dates, strikes the appropriate and best balance between providing flexibility for states and reducing the potential for adverse selection. Additionally, we considered moving the OEP to a different period in the calendar year—such as beginning March 1 and running to April 15—as a measure to both minimize adverse selection and maximize consumer choice (by moving the OEP to a season in which financial stress is generally lessened), but we recognize that mandating such a dramatic shift in the OEP would cause considerable disruption to the market. Instead, our final rule does allow flexibility for Exchanges to start their OEP at an earlier point in the calendar year, as long as the OEP does not extend more than 9 weeks and all plan selections made during the OEP are effective on January 1 of the plan year.

We also considered finalizing the 150 percent FPL SEP provision as proposed, instead of pausing the SEP until the end of PY 2026. However, for the reasons specified in section III.8. of this final rule, as well as the fact that this approach will enable CMS to collect data regarding the impact of the SEP discontinuation in order to inform future policy direction, we are finalizing this provision such that current regulations allowing the 150 percent FPL SEP will become effective again after PY 2026.

We are finalizing amendments to § 155.420(g) to require Exchanges on the Federal platform to conduct pre-enrollment eligibility verification for SEPs. Specifically, we are finalizing the removal of the limit on Exchanges on the Federal platform to conducting pre-enrollment verifications for only the loss of minimum essential coverage SEP. With this limitation removed, we are finalizing conducting pre-enrollment verifications for most categories of SEPs for Exchanges on the Federal platform in line with operations prior to the implementation of the 2023 Payment Notice. This provision will sunset after PY 2026 and we will return to previous policy for PY 2027 as discussed in section III.B.9. of this final rule. We considered leaving the limitation of SEP verification to loss of minimum essential coverage for Exchanges on the Federal platform in place. We determined that the risks associated with the potential enrollment of ineligible individuals were greater than the potential benefits of reducing administrative burden on consumers by only verifying loss of minimum essential coverage. We also determined that consumers will benefit from increased verification due to its potential to limit improper enrollments occurring without their awareness and to bring down risk in Exchanges on the Federal platform by ensuring that only qualified individuals are enrolling through SEPs throughout the year.

We are also finalizing the requirement that Exchanges on the Federal platform conduct pre-enrollment SEP verification for at least 75 percent of new enrollments through SEPs for consumers not already enrolled in coverage through the applicable Exchange. We are finalizing that Exchanges must verify at least 75 percent of such new enrollments based on the current implementation of SEP verification by Exchanges. This provision will sunset after PY 2026 and we will return to previous policy for PY 2027 as discussed in section III.B.9. of this final rule. We are declining to finalize this proposal for State Exchanges. We considered finalizing the provision with a modification for State Exchanges to implement SEP verification for PY 2027. After consideration of comments received regarding State administrative and financial burden and the assertion by many State Exchanges that they do not have similar issues with fraud, we decline to finalize the provision for State Exchanges.

We considered not finalizing the proposal to prohibit issuers of plans subject to EHB requirements from providing coverage for sex-trait modifications as EHB. We also considered finalizing the proposal but without a definition of ''specified sex-trait modification procedure.'' We also considered finalizing the proposal with the addition of a definition of ''specified sex-trait modification procedure'' but delaying the effective date until PY 2027. Although public comments overwhelmingly did not support the proposal, we are finalizing the prohibition to more closely align with statutory requirements. We also considered finalizing the proposal exactly as proposed, that is, without a definition of ''specific sex-trait modification procedure.'' However, we were persuaded by comments that by finalizing a definition that includes exceptions, affected parties will have greater certainty from consumer knowledge, issuer pricing, and issuer compliance perspectives. This will also minimize premium impacts, since there will be less opportunity for issuers to price for any uncertainty. While we appreciate concerns that the provision will require issuers to modify claims and other systems at significant cost and effort, issuers should already have processes in place to determine when a service is an EHB and when it is not. Therefore, we are finalizing this policy, which will be applicable for PY 2026 and beyond.

In proposing the change to the premium measure used in the premium adjustment percentage calculation under § 156.130, we considered continuing to use the current premium measure based on NHEA's estimates and projections of average per enrollee ESI premiums for purposes of calculating the premium adjustment percentage for PY 2026. We are finalizing the proposal to change this measure to instead use a private health insurance premium

measure (excluding Medigap and property and casualty insurance), so that the premium growth measure more closely reflects premium trends in the private health insurance market since 2013. Alternatively, we considered using NHEA estimates and projections of average per enrollee private health insurance premiums. NHEA's private health insurance premium measure includes premiums for ESI, direct purchase insurance (which includes Medigap insurance), and property and casualty insurance. However, we are finalizing the inclusion of only those premiums for expenditures associated with the acquisition of one's primary health insurance coverage purchased through their employer or purchased directly from a health insurance issuer. We believe it is inappropriate to include Medigap premiums in the measure as this type of coverage is not considered primary coverage for those enrollees who supplement their Medicare coverage with these plans. Moreover, although total spending for private health insurance in the NHEAs includes the medical portion of accident insurance (property and casualty insurance), we do not believe it is appropriate to include those expenditures for this purpose as they are associated with policies that do not serve as a primary source of health insurance coverage.

Accordingly, in § 156.130 we are finalizing the use of a measure that includes only premiums for ESI and direct purchase insurance, but not premiums for property and casualty, or Medigap insurance. We sought comment in the proposed rule on the source of premium data we proposed to use in the premium adjustment percentage calculation, and specifically the proposal to use average per enrollee private health insurance premiums (excluding Medigap and property and casualty insurance), or whether we should continue to use ESI premiums for purposes of calculating the premium adjustment percentage for PY 2026.

We are finalizing changing the allowable de minimis ranges in § 156.140 beginning in PY 2026 to +2/−4 percentage points for all individual and small group markets subject to AV requirements under the EHB package, other than for expanded bronze plans, for which we are changing to a de minimis range of +5/−4 percentage points. We are also finalizing a revision to § 156.200(b)(3) to remove from the conditions of QHP certification the de minimis range of +2/0 percentage points for individual market silver QHPs. We are also finalizing amendments to the definition of ''de minimis variation for a silver plan variation'' in § 156.400 to specify a de minimis range of +1/−1 percentage points for income-based silver CSR plan variations. In proposing these changes, we considered delaying the implementation until PY 2027, which was recommended by some commenters who noted that the timing of this rule's release would make it difficult for some issuers to take advantage of wider de minimis ranges in PY 2026. However, we maintain that the de minimis changes proposed do not require issuers to take additional action to revise their plan designs. Additionally, finalizing these changes earlier allows more time for consumers to benefit from plan designs that are more appropriate for their needs.

E. 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.'' The data and conclusions presented in this section, along with the rest of the RIA, amount to our final regulatory flexibility analysis under the RFA.

For purposes of the RFA, we believe that health insurance issuers would be classified under the NAICS code 524114 (Direct Health and Medical Insurance Carriers). According to SBA size standards, entities with average annual receipts of $47 million or less would be considered small entities for this NAICS code. Issuers could possibly be classified in 621491 (HMO Medical Centers) and, if this is the case, the SBA size standard will be $44.5 million or less.[315] We believe 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 2023 MLR reporting year, approximately 84 out of 479 issuers of health insurance coverage nationwide had total premium revenue of $47 million or less.[316] We estimate that approximately 80 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. We sought comment on these estimates and did not receive any comments on these estimates. We are providing additional detail in this final rule that we assume approximately 20 percent, or 16, of the 84 potential small issuers are in fact small issuers for purposes of this analysis. We believe this is an overestimate, as many if not all of these small issuers are likely to have non-health lines of business that result in their revenues exceeding $47 million, but we use 16 small issuers for purposes of this analysis.

We anticipate that small issuers could be impacted by the provisions in this final rule.

We are unable to quantify the 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 APTC receipts. However, we anticipate that there will not be a significant change in revenue for issuers since a reduction in APTC payments will mean consumers would be responsible for the balance of the premium not covered by APTC. We also anticipate that due to the small reduction in enrollment anticipated to result from the policies in this 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 impact on small issuers due to uncertainty and a lack of data. The alternative policies we considered in developing the proposed and final rules are discussed in section V.D. of this final rule. We considered not sunsetting certain policies in this final rule that would impose burdens on small issuers for operational and financial changes and therefore adopt them in perpetuity, but we determined sunsetting these policies would aid in understanding their impact on all issuers, including small issuers. We are of the view that none of these alternatives would both achieve the policy objectives and goals of this final rule as previously stated and be less burdensome to small entities.

We sought comment in the 2025 Marketplace Integrity and Affordability proposed rule on the proposed estimates

[315] SBA. (n.d.). Table of size standards. *https://www.sba.gov/document/support--table-size-standards.*

[316] CMS. (n.d.). Medical Loss Ratio Data and System Resources. *https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr.html.*

and assumptions. We did not receive any comments on the assumptions in the proposed rule.

As discussed in section V.C.17 of this final rule, we anticipate that entities such as issuers, including small issuers, will face regulatory review costs as a result of needing to familiarize themselves with this final rule. The cost per entity to review this final rule is estimated to be $595.46. The total cost for 16 small issuers to review this rule is estimated to be $9,527.36.

In addition, section 1102(b) of the Act requires us to prepare an RIA 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 604 of the RFA. For purposes of section 1102(b) of the 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. Although we acknowledge that this final rule may increase uninsurance and therefore increase uncompensated care as discussed previously in this RIA, this final rule is not subject to section 1102 of the Act and therefore a fulsome analysis under section 1102(b) of the Act is not required.

F. 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 2025, that threshold is approximately $187 million. Although we have not been able to quantify all costs, we expect that the combined impact on State, local, or Tribal governments and the private sector does not meet the UMRA definition of an unfunded mandate.

This final rule will not impose a mandate that will result in the expenditure by State, local, and Tribal Governments, in the aggregate, or by the private sector, of more than $187 million in any 1 year.

G. Tribal Government and Consultation

Executive Orders 12866 and 13175 directs that significant regulatory actions avoid undue interference with Tribal governments [317] and that Agencies respect Indian Tribal self-government and sovereignty, honor Tribal treaty and other rights, and strive to meet the responsibilities that arise from the unique legal relationship between the Federal Government and Indian Tribal governments Indian Tribal governments.[318] The Department does not believe that the final rule would implicate the requirements of Executive Orders 12866 and 13175 with respect to Tribal sovereignty. Executive Order 13175 directs agencies to consult with Tribal officials prior to the formal promulgation of regulations having Tribal implications. Because many Tribal members rely on Exchange coverage and benefits provided by other HHS programs, HHS conducts monthly outreach to Tribal officials through the CMS Tribal Technical Advisory Group to discuss Medicare, Medicaid, CHIP, and Exchange policies and issues, and specifically engaged the group in a discussion of the proposed rule. In doing so, HHS has met the requirements of Executive Order 13175.

H. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it issues a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications.

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

While developing this final rule, we attempted to balance the States' interests in regulating health insurance issuers with the need to ensure market stability. By doing so, we complied with the requirements of Executive Order 13132.

Because States have flexibility in designing their Exchange 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 data. 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 potential direct effects on the distribution of power and responsibilities among the State and Federal Governments relating to determining standards relating to health insurance that is offered in the individual and small group markets. For example, State Exchanges and States operating a BHP will be required to update their eligibility systems in order to no longer consider DACA recipients ''lawfully present'' for purposes of such programs. However, these Federalism implications may be balanced by the fact that we do not anticipate that these policies will impose substantial direct costs on the affected States, which in any event have chosen to operate their own Exchanges and eligibility and enrollment platforms, or the optional BHP. Additionally, the final rule will start the OEP for Exchanges on November 1 and end it on December 15 of the year preceding the benefit year, including for State Exchanges. For the 2025 annual OEP, 19 of 20 State Exchanges ended their OEP on or after January 15 of benefit year and one began before November 1 of the benefit year. This has Federalism implications because it will curtail flexibility in place to continue doing so. However, these implications may be balanced by limiting overall costs and burdens to State Exchanges on the basis of a truncated timeframe to hold open enrollment while maintaining flexibility to administer certain SEPs to support qualifying consumers. We intend that this final rule will preempt State law only to the extent such State law would prevent the application of these rules.[319]

This final rule also has Federalism implications as related to the provision finalizing a prohibition on coverage of specified sex-trait modification procedures as EHB. We understand that some States believe sex-trait modification services must be covered pursuant to State nondiscrimination laws, one State requires coverage of sex-trait modification services as EHB by virtue of explicitly adding it to its EHB-benchmark plan through the process described at § 156.111(a)(1), and some States consider sex-trait modification services to be covered as EHB because it is included in their State EHB-benchmark plan, even though they did not update their EHB-benchmark plan. If these States want to require coverage

[317] Executive Order 12866 at § 6(a)(3)(B).

[318] Executive Order 13175 at § 2(a).

[319] *See* section 1321(d) of the ACA.

of specified sex-trait modification procedures, as finalized in this rule, they will need to mandate that coverage outside of the EHB-benchmark update process at § 156.111(a)(2) and defray the cost. However, as noted earlier in this final rule, we believe that such costs would be very small, as reflected by both low utilization and comments made in response to the proposed rule that costs are at most minuscule and may in fact be cost-neutral. Further, we note that Colorado, when it updated its EHB-benchmark plan to include sex-trait modification procedures, estimated that adding such benefits would have a 0.04 percent cost impact.

This final regulation is subject to the Congressional Review Act provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801 *et seq.*) and has been transmitted to the Congress and the Comptroller General for review.

Mehmet Oz, Administrator of the Centers for Medicare & Medicaid Services, approved this document on June 10, 2025.

List of Subjects

45 CFR Part 147

Aged, Citizenship and naturalization, Civil rights, Health care, Health insurance, Individuals with disabilities, Intergovernmental relations, Reporting and record keeping requirements, Sex discrimination.

45 CFR Part 155

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

45 CFR Part 156

Administrative practice and procedure, Advertising, Advisory committees, Brokers, Conflict of interests, Consumer protection, Grant programs—health, Grants administration, Health care, Health insurance, Health maintenance organization (HMO), Health records, Hospitals, Indians, Individuals with disabilities, Loan programs—health, Medicaid, Organization and functions (Government agencies), Public assistance programs, Reporting and recordkeeping requirements, State and local governments, Sunshine Act, Technical assistance, Women, and Youth.

For the reasons set forth in the preamble, under the authority at 5 U.S.C. 301, the Department of Health and Human Services amends 45 CFR subtitle A, subchapter B as set forth below.

PART 147—HEALTH INSURANCE REFORM REQUIREMENTS FOR THE GROUP AND INDIVIDUAL HEALTH INSURANCE MARKETS

■ 1. The authority citation for part 147 continues to read as follows:

Authority: 42 U.S.C. 300gg through 300gg–63, 300gg–91, 300gg–92, and 300gg–111 through 300gg–139, as amended, and section 3203, Pub. L. 116–136, 134 Stat. 281.

■ 2. Section 147.104 is amended by—
■ a. Revising paragraphs (b)(2)(i)(E) and (F);
■ b. Removing paragraph (b)(2)(i)(G); and
■ c. Revising paragraph (i).

The revisions read as follows:

§ 147.104 Guaranteed availability of coverage.

* * * * *

(b) * * *

(2) * * *

(i) * * *

(E) Section 155.420(d)(12) of this subchapter (concerning plan and benefit display errors); and

(F) Section 155.420(d)(13) of this subchapter (concerning eligibility for insurance affordability programs or enrollment in the Exchange).

* * * * *

(i) *Coverage denials for failure to pay premiums for prior coverage.* To the extent permitted by applicable State law, a health insurance issuer may deny coverage to an individual or employer due to the individual's or employer's failure to pay premiums owed under a prior policy, certificate, or contract of insurance offered by the issuer (or, if the issuer is a member of a controlled group (as defined in § 147.106(d)(4)), any other issuer that is member of such controlled group), including by attributing payment of premium for a new policy, certificate, or contract of insurance to the prior policy, certificate, or contract of insurance, provided the issuer applies its past-due premium payment policy uniformly to all individuals or employers in similar circumstances in the applicable market and State regardless of health status, and consistent with applicable nondiscrimination requirements, and does not condition the effectuation of new coverage on payment of past-due premiums by any individual other than the person contractually responsible for the payment of premium. The amount of the past-due premium an issuer may require for this purpose is subject to any premium payment threshold the issuer has adopted pursuant to § 155.400(g) of this subchapter. The Secretary may specify additional clarifications of acceptable parameters for coverage denials for failure to pay premiums for prior coverage in guidance.

* * * * *

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

■ 3. 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.

■ 4. Section 155.20 is amended by—
■ a. In the definition of ''Lawfully present'', revising paragraph (9) and adding paragraph (14); and
■ b. Adding a definition of ''Preponderance of the evidence'' in alphabetical order.

The revision and additions read as follows:

§ 155.20 Definitions.

* * * * *

Lawfully present * * *

(9) Is granted deferred action;

* * * * *

(14) An individual with deferred action under the Department of Homeland Security's Deferred Action for Childhood Arrivals process, as described at 8 CFR 236.22, shall not be considered to be lawfully present as described in any of the above categories in paragraphs (1) through (13) of this definition.

* * * * *

Preponderance of the evidence means proof by evidence that, compared with evidence opposing it, leads to the conclusion that the fact at issue is more likely true than not.

* * * * *

■ 5. Section 155.220 is amended by revising paragraph (g)(2) introductory text to read as follows:

§ 155.220 Ability of States to permit agents and brokers and web-brokers to assist qualified individuals, qualified employers, or qualified employees enrolling in QHPs.

* * * * *

(g) * * *

(2) An agent, broker, or web-broker may be determined noncompliant under paragraph (g)(1) of this section if HHS finds by a preponderance of the evidence that the agent, broker, or web-broker violated—

* * * * *

■ 6. Section 155.305 is amended by revising paragraph (f)(4) introductory text and adding paragraph (f)(4)(iii) to read as follows:

§ 155.305 Eligibility standards.

* * * * *

(f) * * *

(4) *Compliance with filing requirement.* Except as set forth in paragraph (f)(4)(iii) of this section, the Exchange may not determine a tax filer eligible for advance payments of the premium tax credit (APTC) if HHS notifies the Exchange as part of the process described in § 155.320(c)(3) that APTC payments were made on behalf of either the tax filer or spouse, if the tax filer is a married couple, for 2-consecutive years for which tax data would be utilized for verification of household income and family size in accordance with § 155.320(c)(1)(i), and the tax filer or the tax filer's spouse did not comply with the requirement to file an income tax return for that year and for the previous year as required by 26 U.S.C. 6011, 6012, and in 26 CFR chapter I, and reconcile APTC for that period.

* * * * *

(iii) For plan year 2026 only, an Exchange may not determine a tax filer eligible for APTC if HHS notifies the Exchange as part of the process described in § 155.320(c)(3) that APTC payments were made on behalf of the tax filer or either spouse, if the tax filer is a married couple, for a year for which tax data would be utilized for verification of household income and family size in accordance with § 155.320(c)(1)(i), and the tax filer or the tax filer's spouse did not comply with the requirement to file an income tax return for that year as required by 26 U.S.C. 6011, 6012 and implementing regulations, and reconcile the advance payments of the premium tax credit for that period.

(A) If HHS notifies the Exchange as part of the process described in § 155.320(c)(3) that APTC payments were made on behalf of either the tax filer or spouse, if the tax filer is a married couple, for a year for which tax data would be utilized for verification of household income and family size in accordance with § 155.320(c)(1)(i), and the tax filer or the tax filer's spouse did not comply with the requirement to file an income tax return for that year as required by 26 U.S.C. 6011, 6012, and their implementing regulations and reconcile APTC for that period (''file and reconcile''), the Exchange must:

(*1*) Send a notification to the tax filer, consistent with the standards applicable to the protection of Federal Tax Information, that directly informs the tax filer that the Exchange has determined that the tax filer or the tax filer's spouse, if the tax filer is married, has failed to file and reconcile, and educate the tax filer of the need to file and reconcile or risk being determined ineligible for APTC if they fail to file and reconcile immediately upon receipt of notice; or

(*2*) Send a notification to either the tax filer or their enrollee, that informs the tax filer or enrollee that they may be at risk of being determined ineligible for APTC for the applicable coverage year. These notices must educate tax filers or their enrollees on the requirement to file and reconcile, while not directly stating that the IRS indicates the tax filer or their enrollee, or the tax filer's spouse, if the tax filer is married, has failed to file and reconcile.

(B) [Reserved]

* * * * *

§ 155.315 [Amended]

■ 7. Section 155.315 is amended by removing paragraph (f)(7).

■ 8. Section 155.320 is amended by revising paragraph (c)(3)(iii)(A), adding paragraph (c)(3)(vi)(C)(*2*), and revising (c)(5) to read as follows:

§ 155.320 Verification process related to eligibility for insurance affordability programs.

* * * * *

(c) * * *

(3) * * *

(iii) * * *

(A) For plan years before plan year 2027, except as specified in paragraphs (c)(3)(iii)(B), (C), and (D) of this section, if an applicant's attestation to projected annual household income, as described in paragraph (c)(3)(ii)(B) of this section, would qualify the tax payer as an applicable taxpayer according to 26 CFR 1.36B–2(b) for the plan year for which coverage is requested and is more than a reasonable threshold above the annual household income computed in accordance with paragraph (c)(3)(ii)(A) of this section, the data described in paragraph (c)(3)(ii)(A) of this section indicates that projected annual household income is under 100 percent of the FPL, and the Exchange has not verified the applicant's MAGI-based income through the process specified in paragraph (c)(2)(ii) of this section to be within the applicable Medicaid or CHIP MAGI-based income standard, the Exchange must proceed in accordance with § 155.315(f)(1) through (4). However, this paragraph does not apply if the applicant is a non-citizen who is lawfully present and ineligible for Medicaid by reason of immigration status through the process specified in § 155.305(f)(2). For the purposes of this paragraph, a reasonable threshold is established by the Exchange in guidance and approved by HHS, but must not be less than 10 percent, and can also include a threshold dollar amount.

* * * * *

(vi) * * *

(C) * * *

(*2*) For plan years before plan year 2027, if the data described in paragraph (c)(3)(vi)(A) of this section indicates that projected annual household income is under 100 percent of the FPL and the applicant's attestation to projected household income, as described in paragraph (c)(3)(ii)(B) of this section, would qualify the tax payer as an applicable taxpayer according to 26 CFR 1.36B–2(b) for the plan year for which coverage is requested and is more than a reasonable threshold above the annual household income as computed using data sources described in paragraph (c)(3)(vi)(A) of this section, in which case the Exchange must follow the procedures specified in § 155.315(f)(1) through (4). The reasonable threshold used under this paragraph must be equal to the reasonable threshold established in accordance with paragraph (c)(3)(iii)(D) of this section.

* * * * *

(5) *Acceptance of attestation.* For plan years 2027 and after, notwithstanding any other requirement described in this paragraph (c) to the contrary, when the Exchange requests tax return data and family size from the Secretary of Treasury as described in paragraph (c)(1)(i)(A) of this section but no such data is returned for an applicant, the Exchange will accept that applicant's attestation of income and family size without further verification.

* * * * *

■ 9. Section 155.335 is amended by—

■ a. Adding paragraph (a)(3);

■ b. Revising paragraphs (j)(1) introductory text and (j)(2) introductory text;

■ c. Removing paragraph (j)(4) and redesignating paragraph (j)(5) as paragraph (j)(4); and

■ d. Adding paragraph (n).

The revisions and additions read as follows:

§ 155.335 Annual eligibility redetermination.

(a) * * *

(3) The annual redeterminations described in paragraph (a)(2)(ii) of this section are subject to the requirements in paragraph (n) of this section.

* * * * *

(j) * * *

(1) The product under which the QHP in which the enrollee is enrolled remains available through the Exchange for renewal, consistent with § 147.106 of this subchapter, the Exchange will renew the enrollee in a QHP under that product, unless the enrollee terminates coverage, including termination of coverage in connection with voluntarily selecting a different QHP, in accordance with § 155.430, or unless otherwise provided in paragraph (j)(1)(iii)(A) of this section, as follows:

* * * * *

(2) No plans under the product under which the QHP in which the enrollee is enrolled are available through the Exchange for renewal, consistent with § 147.106 of this subchapter, the Exchange will enroll the enrollee in a QHP under a different product offered by the same QHP issuer, to the extent permitted by applicable State law, unless the enrollee terminates coverage, including termination of coverage in connection with voluntarily selecting a different QHP, in accordance with § 155.430, as follows:

* * * * *

(n) *Additional consumer protections.* For benefit year 2026 annual redeterminations, if an enrollee does not submit an application for an updated eligibility determination for the immediately forthcoming coverage year (2026) on or before the last day on which a plan selection must be made for coverage effective January 1, 2026, in accordance with the effective dates specified in § 155.410(f), and the enrollee's portion of the premium for a policy after the application of advance payments of the premium tax credit through the annual redetermination process would be zero dollars, the Exchange on the Federal platform must decrease the amount of the advance payment applied to the policy such that the remaining monthly premium owed for the policy equals $5.

■ 10. Section 155.400 is amended by revising paragraph (g) introductory text, paragraph (g)(2), and paragraph (g)(3) introductory text to read as follows:

§ 155.400 Enrollment of qualified individuals into QHPs.

* * * * *

(g) *Premium payment threshold.* Except as otherwise provided in this paragraph, Exchanges may, and the Federally-facilitated Exchanges and State-Based Exchanges on the Federal platform will, until December 31, 2026, allow issuers to implement a percentage-based premium payment threshold policy which can be based on the net premium after application of advance payments of the premium tax credit, provided that the threshold policy is applied in a uniform manner to all applicants and enrollees. Effective beginning January 1, 2027, an Exchange may allow issuers to implement a percentage-based premium payment threshold policy (which can be based on either the net premium after application of advance payments of the premium tax credit or gross premium) and/or a fixed-dollar premium payment threshold policy, provided that the threshold and policy are applied in a uniform manner to all applicants and enrollees.

* * * * *

(2) Effective beginning January 1, 2027, under a gross premium percentage-based premium payment threshold policy, issuers can consider enrollees to have paid all amounts due for the following purposes, if the enrollees pay an amount sufficient to maintain a percentage of the gross premium of the policy before the application of advance payments of the premium tax credit that is equal to or greater than 98 percent of the gross monthly premium owed by the enrollees. If an enrollee satisfies the gross premium percentage-based premium payment threshold policy, the issuer may:

(i) Avoid triggering a grace period for non-payment of premium, as described by § 156.270(d) of this subchapter or a grace period governed by State rules.

(ii) Avoid terminating the enrollment for non-payment of premium as, described by §§ 156.270(g) of this subchapter and 155.430(b)(2)(ii)(A) and (B).

(3) Effective beginning January 1, 2027, under a fixed-dollar premium payment threshold policy, issuers can consider enrollees to have paid all amounts due for the following purposes, if the enrollees pay an amount that is less than the total premium owed, the unpaid remainder of which is equal to or less than a fixed-dollar amount of $10 or less, adjusted for inflation, as prescribed by the issuer. If an enrollee satisfies the fixed-dollar premium payment threshold policy, the issuer may:

* * * * *

■ 11. Section 155.410 is amended by—

■ a. Revising paragraph (e)(4) introductory text;

■ b. Adding paragraph (e)(5);

■ c. Revising paragraph (f)(3) introductory text; and

■ d. Adding paragraph (f)(4).

The revisions and additions read as follows:

§ 155.410 Initial and annual open enrollment periods.

* * * * *

(e) * * *

(4) For benefit years beginning on January 1, 2022, through January 1, 2026—

* * * * *

(5) For benefit years beginning on or after January 1, 2027—

(i) The annual open enrollment period for all Exchanges must begin no later than November 1 and must end no later than December 31 of the calendar year preceding the benefit year.

(ii) The annual open enrollment period must not exceed 9 weeks in duration.

(f) * * *

(3) For benefit years beginning on January 1, 2022, through January 1, 2026, the Exchange must ensure that coverage is effective—

* * * * *

(4) For benefit years beginning on or after January 1, 2027, the Exchange must ensure that coverage is effective January 1, for QHP selections received by the Exchange on or before December 31 of the calendar year preceding the benefit year.

* * * * *

■ 12. Section 155.420 is amended by revising paragraphs (a)(4)(ii)(D), (a)(4)(iii) introductory text, (b)(2)(vii), (d)(16), and (g) to read as follows:

§ 155.420 Special enrollment periods.

(a) * * *

(4) * * *

(ii) * * *

(D) Beginning plan year 2027, if an enrollee or his or her enrolled dependents qualify for a special enrollment period in accordance with paragraph (d)(16) of this section, the Exchange must allow the enrollee and his or her enrolled dependents to change to any available silver-level QHP if they elect to change their QHP enrollment. If a qualified individual or a dependent who is not an enrollee qualifies for a special enrollment period in accordance with paragraph (d)(16) of this section and has one or more household members who are enrollees, the Exchange must allow the enrollee to add the newly enrolling household

member to his or her current QHP; or, to change to a silver-level QHP and add the newly enrolling household member to this silver-level QHP; or, to change to a silver level QHP and enroll the newly enrolling qualified individual or dependent in a separate QHP;

(iii) For the other triggering events specified in paragraph (d) of this section, except for paragraphs (d)(2)(i), (d)(4), and (d)(6)(i) and (ii) of this section for becoming newly eligible or ineligible for CSRs, and paragraphs (d)(8), (9), (10), (12), and (14) of this section, and beginning in plan year 2027, paragraph (d)(16) of this section:

* * * * *

(b) * * *

(2) * * *

(vii) Beginning plan year 2027, if a qualified individual or enrollee, or the dependent of a qualified individual or enrollee, who is eligible for advance payments of the premium tax credit, and whose household income, as defined in 26 CFR 1.36B–1(e), is expected to be no greater than 150 percent of the Federal poverty level, enrolls in a QHP or changes from one QHP to another one time per month in accordance with paragraph (d)(16) of this section, the Exchange must ensure that coverage is effective in accordance with paragraph (b)(1) of this section or on the first day of the month following plan selection, at the option of the Exchange.

* * * * *

(d) * * *

(16) Beginning plan year 2027, at the option of the Exchange, a qualified individual or enrollee, or the dependent of a qualified individual or enrollee, who is eligible for advance payments of the premium tax credit, and whose household income, as defined in 26 CFR 1.36B–1(e), is expected to be at or below 150 percent of the Federal poverty level, may enroll in a QHP or change from one QHP to another one time per month.

* * * * *

(g) *Special enrollment period verification.* Beginning January 1, 2026 unless a request for modification is granted in accordance with § 155.315(h), Exchanges on the Federal platform must conduct pre-enrollment verification of applicants' eligibility for special enrollment periods under this section. An Exchange meets this requirement if it verifies eligibility each plan year for the number of individuals newly enrolling in Exchange coverage through special enrollment periods that equals at least 75 percent of all special enrollments based on prior year enrollments. If the Exchange is unable to verify eligibility for individuals newly enrolling in Exchange coverage through a special enrollment period for which the Exchange requires verification, then the individuals are not eligible for enrollment through the Exchange. In accordance with § 155.505(b)(1)(iii), individuals have the right to appeal the eligibility determination. This requirement will apply through December 31st 2026, unless it is renewed through rulemaking prior to that date.

PART 156—HEALTH INSURANCE ISSUER STANDARDS UNDER THE AFFORDABLE CARE ACT, INCLUDING STANDARDS RELATED TO EXCHANGES

■ 13. The authority citation for part 156 continues to read as follows:

Authority: 42 U.S.C. 18021–18024, 18031–18032, 18041–18042, 18044, 18054, 18061, 18063, 18071, 18082, and 26 U.S.C. 36B.

■ 14. Section 156.115 is amended by revising paragraph (d) to read as follows:

§ 156.115 Provision of EHB.

* * * * *

(d) For plan years beginning before January 1, 2026, an issuer of a plan offering EHB may not include routine non-pediatric dental services, routine non-pediatric eye exam services, long-term/custodial nursing home care benefits, or non-medically necessary orthodontia as EHB. For plan years beginning on any day in calendar year 2026, an issuer of a plan offering EHB may not include routine non-pediatric dental services, routine non-pediatric eye exam services, long-term/custodial nursing home care benefits, non-medically necessary orthodontia, or specified sex-trait modification procedures (as defined at § 156.400) as EHB. For plan years beginning on or after January 1, 2027, an issuer of a plan offering EHB may not include routine non-pediatric eye exam services, long-term/custodial nursing home care benefits, non-medically necessary orthodontia, or specified sex-trait modification procedures (as defined at § 156.400) as EHB.

■ 15. Section 156.140 is amended by revising paragraph (c) to read as follows:

§ 156.140 Levels of coverage.

* * * * *

(c) *De minimis variation.* (1) The allowable variation in the AV of a health plan that does not result in a material difference in the true dollar value of the health plan is −4 percentage points and +2 percentage points, except if a health plan under paragraph (b)(1) of this section (a bronze health plan) either covers and pays for at least one major service, other than preventive services, before the deductible or meets the requirements to be a high deductible health plan within the meaning of section 223(c)(2) of the Internal Revenue Code, in which case the allowable variation in AV for such plan is −4 percentage points and +5 percentage points.

(2) [Reserved.]

■ 16. Section 156.200 is amended by revising paragraph (b)(3) to read as follows:

§ 156.200 QHP issuer participation standards.

* * * * *

(b) * * *

(3) Ensure that each QHP complies with benefit design standards, as defined in § 156.20;

* * * * *

■ 17. Section 156.400 is amended by revising the definition of ''De minimis variation for a silver plan variation'' and adding a definition of ''Specified sex-trait modification procedure'' in alphabetical order to read as follows:

§ 156.400 Definitions.

* * * * *

De minimis variation for a silver plan variation means a −1-percentage point and +1-percentage point allowable AV variation.

* * * * *

Specified sex-trait modification procedure means 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.

(3) This term does not include procedures undertaken:

(i) To treat a person with a medically verifiable disorder of sexual development; or

(ii) 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.

* * * * *

Robert F. Kennedy, Jr.,

Secretary, Department of Health and Human Services.

[FR Doc. 2025–11606 Filed 6–23–25; 4:15 pm]

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